AN ABSTRACT OF THE DISSERTATION OF

Kathyleen M. Tomlin for the degree of Doctor of Philosophy in Counseling presented on July 1, 2016.

Title: The Impact of Focusing on Self-Compassion Skills Training on the Frequency of Change Talk and Client Satisfaction Among Opioid-Dependent Young Adults

Abstract approved:

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Cass Dykeman

The illicit use of opioids among young adults (18–25) has resulted in an increase of clients needing substance abuse treatment. Treatment programs are struggling to keep up with the influx of these young adults. Traditional models of care have some impact; however, there are not enough treatment centers that can address the young adult treatment needs, and the treatment community has been challenged to find developmentally appropriate care for this age range. Additionally, clients who enter into care often struggle with a negative self-concept due to feelings of shame and guilt resulting from their addiction. Many have resorted to intravenous heroin use to manage the effects and cost of their daily habit. The purpose of this study was to combine existing research-based treatment with interventions designed to increase self-compassion. The study enlisted young adult clients entering a medically managed suboxone treatment program within a large metropolitan health maintenance organization (HMO). After an initial assessment, participants attended an intake session to determine whether they met the inclusion criteria to enter the study. Once

accepted into the study, patients were randomly assigned to one of two conditions: (a) three sessions of treatment-as-usual or (b) three sessions of treatment-as-usual with a focus on self-compassion. Treatment fidelity was examined and confirmed. ANCOVA was used to analyze data within the two groups related to the frequency of change talk. Independent *t*-tests were used to analyze data from the two groups related to client satisfaction. Results of the study indicated no significant difference between the two groups on both measures. Finally, a series of open-ended questions was asked at the last session of the study to identify common themes regarding client involvement in the self-compassion arm of the study to compare with the control group. The top three primary themes between the two treatment groups were a preference for (a) individual counseling (14/17), (b) structure (13/17), and (c) increased frequency of the program (11/17). The theme that emerged of a preference for individual treatments by the young adults in this study stands in contrast to treatment programs that focus on group-level interventions. A somewhat surprising finding was the willingness to attend more frequently; however, the type of frequency (more than once per week or weekly over a longer period of time) would need to be explored further. Finally, having a supportive place to go to stay out of trouble from temptations to use or hang around using peers was mentioned as important. Addressing unmet or delayed developmental needs for help with job skills, getting help with finishing or continuing their education, finding sober housing, meeting new friends, working on renewing family relationships, and learning how to manage finances are important skills that are often missing with this population. Having a safe place to go that focuses on these important life skills where the clients are

accepted could provide the type of structure they need to negotiate these life areas.

The Impact of Focusing on Self-Compassion Skills Training on the Frequency of Change Talk and Client Satisfaction Among Opioid-Dependent Young Adults

by
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I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader upon request.

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Kathyleen M. Tomlin, Author

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CONTRIBUTION OF AUTHORS

Drs. Denise Earnst and Christopher Bradley contributed to Chapter 3 by conducting statistical analysis on the data and writing partial sections of the results chapter. Mr. Charles Dickerman contributed to Chapter 3 with the qualitative review and analysis of data.

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Chapter 1: General Introduction

The purpose of this dissertation study was to demonstrate scholarly work by using a manuscript-style dissertation format as outlined by the Oregon State University Graduate School. In following this format, Chapter 1 provides an explanation as to how two journal-formulated manuscripts found in Chapters 2 and 3 are thematically tied and build toward research conclusions pertinent to the impact of focusing on self-compassion as an addition to treatment-as-usual for young adult (ages 18–25) opioid-dependent clients. Chapter 2 is a literature review entitled "A Literature Review Focusing on Self-Compassion With Opioid-Dependent Young Adults." Chapter 3 presents quantitative research in a manuscript entitled "Focusing on Self-Compassion Plus Treatment-as-Usual With Opioid-Dependent Young Adults." Both of these manuscripts focus on the construct of self-compassion. Manuscripts 1 and 2 are thematically tied by evaluating the impact of adding a focus on self-compassion to substance abuse treatment with opioid-dependent young adults. They are further connected by building hypotheses to determine if focusing on self-compassion will enhance evidence-based addictions treatment such as motivational interviewing (MI).

Introduction

Motivational interviewing emphasizes building a nonjudgmental, accepting relationship where the client and counselor work collaboratively to enhance the client's intrinsic motivation for change (Miller & Rollnick, 2002, 2013). Eliciting change talk is focused on specific or targeted behaviors. In substance abuse

treatment, the targeted behaviors can range from complete abstinence to harm reduction, attending treatment meetings, attending 12-step meetings, finishing assigned homework, and taking medications as prescribed. The counselor and client mutually agree upon the counseling goals.

Higher levels of self-compassion have been shown to be effective in reducing symptoms of depression and anxiety (Gilbert, 2009, 2010a, 2010b, 2010c). Clients who experience inner voices of negative self-criticism, shame, and trauma benefit from self-compassion practices. People with substance abuse and dependence suffer from shame, guilt, and trauma related to their drug use and the resultant lifestyles that come with those choices (Dearing & Tangney, 2011).

Treatments commonly used for substance abuse and dependence are effective for most clients; however, sometimes those clients who exhibit high degrees of shame can render regular treatments ineffective. Gilbert and Procter (2006) found that usually successful forms of cognitive behavioral treatments can still become helpful once the shame is addressed. Although shame is not specifically addressed in substance-abusing client populations, the purpose of this study was to determine if adding self-compassion to addictions treatment would have similar results for mental health outcomes, thereby increasing the potency of treatment models such as MI.

The first manuscript of this dissertation (Chapter 2) is a literature review that covers background information on young adult development, self-compassion, and discussion of the specific substance abuse treatment of MI; it concludes with looking at study measurements. The second manuscript (Chapter 3) presents client outcome

data on self-compassion and change talk. The data compare three MI-only counseling sessions with three MI counseling sessions with a focus on self-compassion.

Thematic Introduction: Shame and Self-Compassion

> Exposure to oneself lies at the heart of shame. We discover in experiences of shame the most sensitive, intimate and vulnerable parts of ourself.
>
> –Anonymous

> Compassion is like a multivitamin of the mind. (Gilbert, 2009, p. 79)

When a person is highly self-critical, traditional cognitive counseling strategies are less effective in treatment. New thoughts and behaviors that would be addressed and practiced by the client in cognitive behavioral therapy (CBT) tend to be received poorly with the internal negative tone of the client (Gilbert, 2010c; Gilbert & Procter, 2006). Gilbert (2010c) pointed out that although CBT and other behavioral therapies are effective with clients who exhibit a high level of self-critical thinking and shame experiences, inserting a compassionate mind therapy (CMT) component into their care may help them to continue the benefits gained from more traditional treatments.

Compassionate Mind Therapy

Compassionate mind therapy was originally developed to address clients who exhibit high self-criticism and shame levels and who have difficulty with early attachment, including the ability to self-soothe or to be compassionate toward themselves in times of stress (Gilbert & Procter, 2006). Compassionate mind therapy

incorporates neuroscience and evolutionary research. It is a counseling practice that teaches clients how to be less self-critical, more self-compassionate, and more ready to receive the benefits of traditional CBT. With accurate MI practice, clients experience less judgment, greater self-acceptance during the change process, and higher commitment to behavioral change (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003; Martin, Christopher, Houck, & Moyers, 2011; Miller & Rollnick, 2002).

Gilbert (2010b) proposed that CMT focuses specifically on the affect-regulation systems of the brain. These include the following: (a) the threat and protection system (the system that is designed to alert to any potential threats); (b) the drive, resource-seeking, and excitement system (the system that provides pleasurable feelings and motivation); and (c) the contentment, soothing, and safeness system (the system in the brain that is linked to naturally occurring opiates and provides feelings of contentment and peacefulness, enabling people to experience a sense of well-being). Research has indicated that this sense of connection with self and others is moderated through oxytocin, a neuro-hormone associated with positive experiences of trust, caring, comfort, kindness, and bonding in relationships with others (Gilbert, 2010a, 2010b).

The Significance of Compassion

In Latin, the word for compassion is *misericordia*, which means to suffer with. The definition of compassion is listed as "a feeling of deep sympathy and sorrow for another who is stricken by misfortune, accompanied by a strong desire to

alleviate the suffering" (Compassion, n.d., para. 1). What if clients are unable to have compassion for themselves? What if they are fearful of compassion? Gilbert (2009) and Gilbert and Procter (2006) have referred to this as a fear of positive emotion. The researchers also explained that, for clients, the endorphins and oxytocin that are released when they experience kindness or warmth can actually elicit fear of being vulnerable (Gilbert, 2009; Gilbert & Procter, 2006). The clients may have stored memories that, when soothing or kindness is experienced, activate the threat system to protect them from potential harm. The inability to be soothed may increase relapse vulnerability (Witkiewitz, Marlatt, & Walker, 2005). Obviously, for clients who have been abused, this makes sense. For example, if a client grew up in a substance-abusing home, the parent may have been loving and kind and only after a few drinks turned hostile and aggressive. The client may have become conditioned to respond to the loving and kind parent with trepidation once drinking occurred for fear of what was to follow. In the same scenario, grief for the loss of a consistent, loving parent can be another reason for being afraid of experiencing loving, compassionate feelings. Lacking a mature nurturing system or not developing one altogether is another barrier to accepting warmth; in essence, the client has a lack of practice. Giving up a definition of self as depressed or anxious and allowing compassion for oneself can cause some distress for clients if they have identified with their symptoms as a significant part of who they are in life. Redefining oneself as being worthy of forgiveness and kindness is difficult work for clients. Compassion consists of a range of behaviors, thoughts, and feelings with the ultimate outcome being to benefit

oneself and others. The aim of CMT is to activate that part of the mind that will elicit compassion (Gilbert, 2010a). Self-compassion can ease the pain of anxiety and depression in clients (Germer, 2009; Gilbert, 2005, 2009, 2010a, 2010b, 2010c; Kelly, Zuroff, & Shapira, 2008 Leary & Hoyle, 2009; Neff, Rude, & Kirkpatrick, 2007).

How is *self-compassion* defined? Neff (2011) defined self-compassion as having three components: (a) kindness toward self (self-kindness), which requires "being gentle and understanding of ourselves rather than harshly critical and judgmental" (p. 39); (b) recognition of common humanity, "feeling connected with others in the experience of life rather than feeling isolated and alienated by our own suffering" (p. 30); and (c) mindfulness, "that we hold our experience in balanced awareness, rather than ignoring our pain or exaggerating it" (p. 39).

According to Neff (2003b), it is in the combination and interaction of these three components where self-compassion is experienced. Neff (2003a) has researched and developed a self-compassion scale that has been successful in establishing self-compassion as a unique construct separate from self-pity or self-esteem. In the Self-Compassion Scale, there are three scales with three subscales. The scales are self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus overidentification. Research findings have shown individuals with a higher overall score of self-compassion had better coping skills, were able to tolerate and correct negative emotional states, had lower rates of anxiety

and depression, and seemed to have more positive connections to peers and family (Leary & Hoyle, 2009; Neff, 2011).

In the area of addictions, Dr. Alan Marlatt and colleagues created an aftercare program for addictions clients called mindfulness based relapse prevention (MBRP; Witkiewitz et al., 2005). This treatment combines cognitive behavioral strategies and mindfulness or movement meditation to address cues and triggers to substance use, discomforting thoughts, and unpleasant emotional and physical experiences. The goal is to integrate mindfulness practice into a lifestyle that includes daily recovery and relapse prevention strategies. The research found that those who participated in MBRP exhibited lower rates of substance use, decreased cravings, and increased acceptance and self-awareness.

Rationale

Self-compassion was chosen as a focus because of the high degree of shame, guilt, and trauma related to substance abuse and dependence. There has been a rise in young adults' (ages 18–25) illicit opioid use, abuse, and addiction in recent years. Given that individuals in this age range are not yet adults, they are still maturing physically, emotionally, cognitively, and socially. Young adults' development becomes extremely vulnerable when any substance abuse or addiction occurs, especially something as severe as opioid addiction (Arnett, 2005). In relationships with others, self-compassionate individuals tend to be more responsive to their partners and more forgiving, but not necessarily more empathetic (Neff, 2012). In research studies, a greater sense of self-compassion has been shown to indicate

greater relationship satisfaction and closer, more satisfying attachments. This is distinguished from enmeshment, as those with self-compassion are able to see interpersonal issues objectively (Leary & Hoyle, 2009). Gilbert (2009) indicated that self-compassion enhancement in therapy can repair ruptures in counseling relationships. This area of research is limited and needs further study to establish a causal relationship.

Motivational Interviewing, Change Talk, and Self-Compassion

Change talk is client language that favors movement toward change. Significant to the practice of MI, it is essential for the therapist to access client change talk. Miller and Rollnick (2013) defined change talk as "any client speech that favors movement toward a particular change goal" (p. 406). They asserted that the frequency of clients' talk about change and their level of commitment language serve as good predictors of their willingness to engage in making difficult behavioral changes.

Change talk as a focus in the research has had mixed results in terms of its component parts (Martin et al., 2011). Early research found that when clients talked about making changes, they would often speak of change as wanting to make a change (desire), thinking about whether they could change (ability), feeling like there was some urgency to make a change (need), or having good reasons to change (reasons). Motivational interviewing researchers found that when clients spoke in these ways, they were basically preparing themselves for change or preparatory change talk; that is, desire, ability, reason, and need. Then, as the session continued,

the frequency and strength of the client commitment language was identified as a predictor of change (Amrhein et al., 2003).

In a recent reexamination of initial sessions from Project MATCH using a different coding instrument, it was found that the clients' feeling that they can change (ability) combined with their level of commitment to change seemed to be the primary factors leading to change (Martin et al., 2011). In another study, increasing client change talk and elicitation of change talk by the therapist were found to be important in the reduction of substance abuse, as well as in overall client outcomes (Gaume, Bertholet, Faouzi, Gmel, & Daeppen, 2010; Glynn & Moyers, 2012; Moyers et al., 2007).

In further research, the predictor of behavioral change has been tied more closely to the strength of certain aspects of change talk, namely the desire to change and having good reasons to change. In a study looking at marijuana treatment outcomes, Walker, Stephens, Rowland, and Roffman (2011) found that these two factors played a significant role in subsequent addictive behaviors. The more the clients advocated for change, the more likely they were to achieve it. In the Amrhein et al. (2003) study, it was the strength of commitment language at the end of a session that seemed a strong indicator of change postsession. Whether it is commitment, intention, or confidence that is a necessary component in the client change process, what seems to be relevant is that, with the therapist's help, the client is able to enhance intrinsic motivations for change.

Motivation for change is a form of self-talk externalized in the therapy context. Important to the elicitation and exploration of change talk and fundamental to the practice of MI is the notion of the spirit and style of MI. Miller and Rollnick (2013) described the spirit and style of MI as "the set of heart and mind" (p. 15) that one adopts when practicing MI. These include partnership, acceptance, compassion, and evocation.

Partnership entails being able to communicate that one is collaborative and views the counseling relationship as one that is shared between two experts toward a mutual agenda for change. The components of this partnership include eliciting the clients' world view, being aware of one's agenda for clients and taking care not to impose it onto them, and having respect for the clients' wisdom about their lives and changes they need to make to improve their lives. Acceptance includes absolute worth (being nonjudgmental and respectful and acknowledging a person's worth as a human being), accurate empathy (being able to see the other perspective through the other person's eyes), autonomy support (acknowledging and accepting the right of an individual to choose his or her own path), and affirmation (recognizing an individual's strengths). Compassion is working toward the welfare of clients and in their best interest. The last component of the spirit and approach of MI is evocation. Evocation involves helping persons pull from their strength and knowledge of themselves to draw upon their own wisdom. Much of what Miller and Rollnick (2002, 2013) have described as the spirit of MI comes from the teachings of Carl

Rogers. The combination of partnership, acceptance, compassion, and evocation develops over time and deepens as one develops the practice of MI.

Obviously, if the client is not able to have pro-change-talk thoughts due to a poor relationship with the self, eliciting motivation for change could be challenging. Enhancing one's sense of self as being worthy of kindness, compassion, and connection with others may be an important first step toward improving life-affirming motivation. This study aimed to determine whether improving a sense of worthiness, as defined by Neff (2011) and Gilbert (2009), would result in increases in client statements toward change. By modeling a compassionate, accepting, nonthreatening approach, the MI practitioner may be in a good position to begin the healing from late-stage addiction to a more affirming, proactive sense of self based on clients' assessment of themselves not as unworthy, but rather as worthy of recovery and the hope it provides in life. It is important to note that the target behaviors will emerge from this improved sense of self and that they are likely to differ between clients.

Motivational interviewing was chosen as the primary treatment because it is effective at engaging hard-to-engage clients and its primary therapy goal is to elicit and resolve challenges toward behavioral change. Young adults have a tendency to minimize the harmfulness of their drug use, as often it is seen as a passage to adulthood, something that is part of the growing-up process. In fact, data from the Treatment Episode Data Set (TEDS; Substance Abuse and Mental Health Services Administration [SAMHSA], 2012) show a rise in the use of many substances during adolescence, peaking in the mid-20s. Seeking treatment for substance abuse during

adolescence can be difficult, especially when there is a perception that using is normal for someone of that age group. This can contribute to even more developmental challenges (Arnett, 2005).

Choosing a brief intervention is more suitable for young adults due to difficulties in paying for care, having transportation to treatment, and a host of other issues including stereotyping, decreased desire to have significant others involved, and fear of losing their educational and work conditions if discovered. Brief interventions such as MI have good research outcomes demonstrating reduction in use, sometimes with a single session (Miller & Rollnick, 2002).

Research Questions

1. What is the impact of TAU (treatment-as-usual) + SC (self-compassion) over TAU on frequency of change talk?
2. What is the impact of TAU + SC over TAU in terms of client satisfaction?
3. What themes emerge from the participants when asking open-ended questions of the experiences of the self-compassion interventions?

Addressing these questions fills a gap in the current research, as there is minimal research addressing how a focus on self-compassion affects treatment-as-usual models of care and client outcomes. A pretest–posttest control experimental design with randomization was utilized to measure the frequency of change talk. Change talk is a key concept addressed in the practice of MI counseling. Change talk and strengthening clients' commitment to change talk by helping them resolve and move through their natural ambivalence toward change is a primary treatment goal

within the practice of MI. In this study, clients were randomly assigned to one of two conditions: (a) three sessions of MI counseling or (b) three sessions of MI with a focus on self-compassion. Although the sample size was small (n = 17), it is likely that clinical significance can be established that would guide future research efforts. During the last session of the study, 2 weeks after completing Session 3 of the intervention, all clients' medical records were reviewed to look at lab results, school/education status, treatment attendance, outside support group attendance, and client satisfaction surveys. The focus of the survey was to gather information on clients' experiences going through the study and to determine if they would advise continuing a focus on self-compassion with other clients in care.

Hypotheses

1. What is the impact of TAU (treatment-as-usual) + SC (self-compassion) over TAU on frequency of change talk?

   $H_{0:}$ TAU + SC *does not impact* the frequency of change talk over TAU.

   $H_{1:}$ TAU + SC *does impact* the frequency of change talk over TAU.

2. What is the impact of TAU + SC over TAU in terms of client satisfaction?

   $H_{0:}$ TAU + SC *does not impact* client satisfaction.

   $H_{1:}$ TAU + SC *does impact* client satisfaction.

Glossary of Terms

Affect regulation systems: Primary emotion-regulation brain systems designed to control individual motivation around three main areas: (a) managing

threats and ensuring safety, (b) achieving and seeking pleasant experiences, and (c) forming bonds and experiencing well-being (Gilbert, 2010a, 2010b).

Brief interventions: A term used to describe treatment interventions. In substance abuse treatment, brief interventions are "time limited, structured, and directed toward a specific goal" (SAMHSA, 1999, p. 13).

Change talk: "Any self-expressed (client) language that is an argument for change" (Miller & Rollnick, 2013, p. 159).

Compassionate mind therapy: A therapy developed by Dr. Paul Gilbert (2010a) designed to address shame, depression, anxiety, and trauma that is nonresponsive to more traditional forms of CBT.

Emerging adulthood: A theory about young adult (ages 18–25) development proposed by J. J. Arnett in 2000.

MBRP: A substance abuse aftercare program built on the research of Dr. Allan Marlatt (Bowen, Chawla, & Marlatt, 2010) to address recovery and relapse strategies integrating Buddhist psychology beliefs and practices.

Motivational interviewing: In the third edition of MI, there are three definitions offered. For the purposes of this study, the following definition was used to describe MI (referred to as the technical definition):

> Motivational interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion. (Miller & Rollnick, 2013, p. 29)

Self-compassion: For the purpose of this research, self-compassion refers to the following: (a) kindness toward self (self-kindness) that requires "being gentle and understanding of ourselves rather than harshly critical and judgmental" (Neff, 2011, p. 89); (b) recognition of our common humanity, "feeling connected with others in the experience of life rather than feeling isolated and alienated by our own suffering" (p. 89); and (c) recognition of mindfulness, "that we hold our experience in balanced awareness, rather than ignoring our pain or exaggerating it" (p. 89).

Targeted behaviors: These behaviors can also be thought of as client outcomes, and they include specific behaviors of interest that either the client or the treating practitioner identifies in the course of treatment episodes. In substance abuse treatment, outcomes such as abstinence (number of days without using any substance), attendance at treatment meetings or self-help groups, and improvements at work, school, or home are common.

Treatment-as-usual: Refers to treatment in a therapeutic setting that is common among practitioners within both their agency or clinic and other similar treatment settings. An example is the use of CBT or MI within mental health or substance abuse and dependence care.

Organization

The organization of the dissertation follows a thematic review of the literature focusing on all the constructs described in the research question in Chapter 2. The themes include the following: (a) the effect of opioid substance abuse and dependence on young adult development, (b) the role of shame and guilt in treatment-as-usual effectiveness, (c) how focusing on self-compassion in a brief intervention interacts with the construct of change talk, and (d) client outcomes of treatment. Chapter 3 is the report of a research study focusing on two treatment approaches that integrated all themes identified and described in Chapter 2. The treatment approaches, MI with a focus on self-compassion or MI alone, were applied to people meeting inclusion criteria for the study. Chapter 4 includes data analysis and general conclusions and links all chapters together.

Chapter 2: A Literature Review Focusing on Self-Compassion Among Opioid-Dependent Young Adults

A Literature Review Focusing on Self-Compassion Among Opioid-Dependent Young Adults

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Abstract

Experiencing the benefits of evidence-based substance abuse and dependence relapse prevention and recovery treatments is challenging for many clients. This is especially true for young adults (ages 18–25), an age group that has seen an increase in the use of, abuse of, and dependence on opioids. Failure to meet the developmental challenges of young adulthood due to serious substance abuse and dependence creates part of this challenge. The experiences of shame and guilt resulting in increased symptoms of anxiety and depression are common with substance abusers in general, including younger clients. While effective psychosocial and medical treatments exist, engaging and retaining young adults in treatment to experience the benefits of these treatments can be challenging. The literature on self-compassion shows promise in addressing some of the common issues that younger clients with substance use disorders exhibit. Self-compassion as a contributor to substance use disorder treatment was lacking in the literature. Although identified and found to be helpful with mental health concerns, self-compassion was remarkably underrepresented in the research on substance abuse and dependency. Individuals who experience opioid addiction and other addictions often experience deep shame, guilt, and embarrassment. This often manifests as symptoms of depression and anxiety. Self-compassion has been shown to alleviate these symptoms. Thus, adding a self-compassion module to standard substance use disorder treatment offers hope to alleviate client suffering. The purpose of this paper was to review the literature on self-compassion, particularly as an addition to substance abuse treatment practices to

enhance treatment outcomes. Relevant publications concerning self-compassion published between 2000 and 2013 utilizing MEDLINE, PsyInfo, Google Scholar, EBSCO, SAMHSA, NIDA, NIAAA, and various related websites were accessed. Several key researchers' books were read to add to the examination for this paper, most notably Drs. Paul Gilbert and Kristin Neff, who have written extensively on self-compassion. Approximately 51 articles and seven books were included in the review for this paper. Of those, full reviews were performed on about half of the articles, and sections of books were also read to contribute to this paper. Partial reviews were completed on the remaining articles.

Keywords: self-compassion, change talk, opioid addiction, compassionate mind

A Literature Review Focusing on Self-Compassion Among Opioid-Dependent Young Adults

The addictions treatment community has reported a rise in the patient population of young adults (ages 18–25) addicted to opioids (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010a 2011, 2012). Many of these young adults began by experimenting with narcotic medications obtained illicitly. Some moved on to intravenous heroin use due to its easier availability and lower cost. The experience of addictions treatment providers indicates that such clients suffer unusually high levels of depression and anxiety due to physical withdrawal and high relapse rates (Witkiewitz, Marlatt, & Walker, 2005). Researchers have also found high anxiety and depression among substance abusers because of the shame, embarrassment, and guilt of living a using lifestyle (Dearing, Stuewig, & Tangney, 2005; Treeby & Bruno, 2012; Wiechelt, 2007). Depression and anxiety are also two of the most common co-occurring issues among substance-abusing clients (SAMHSA, 2010a, 2011, 2012).

In the research, the construct of self-compassion as an adjunct to traditional mental health therapy is now evolving as an improved model for clients with chronic and more severe mental health symptoms (Germer, 2009; Germer & Siegel, 2012; Gilbert, 2005, 2009, 2010a, 2010b, 2010c). Clients suffering from difficult, nonresponsive symptoms such as depression and anxiety begin to respond when self-compassion training is added to their treatment (Germer, 2009; Gilbert, 2009; Leary & Hoyle, 2009; Neff, 2012).

Young Adult Development

Arnett (2005) has described young adulthood (ages 18–25) as having five main features:

- identity explorations in love and work,
- instability,
- self-focus in life,
- feeling in-between, and
- possibilities. (Arnett, 2005, pp. 239–248)

During the age of identity explorations, young adults discover more fully who they are and what they want from a romantic partner in the long term. The same applies to issues of work—identifying what type of work they would like to pursue and their abilities and interests. As a result of exploring and defining identity during the young adult period, many changes can occur in relation to love partners, college experiences, and work and living situations. For example, at the end of the high school years, 60% of young people leave home to pursue college education. Changes in roles from being a student at home to a student living independently require a redefinition of self. Such youth learn to manage finances, make decisions about daily structure, and manage the stress of life in a new setting. This is a time of individual freedoms, where persons are on their own without any necessary obligations to others (e.g., work or family). Figuring out how to make and execute plans for their lives, experimenting with choices, and changing directions and focus are common. It can be a time of great optimism, hope, and wishes for the future (Arnett, 2005). When

substance abuse emerges during this time, most young adults will abandon any excess use by their mid-20s (Arnett, 2005; Schulenberg & Maggs, 2001).

Young adults who suffer from persistent substance abuse and dependence can find it difficult to move past the young adult developmental tasks due to risk factors such as feeling alienated from family because of a lack of support or proximity, trying to fit in with a new group, lacking adequate adult guidance and support, having difficulty making life choices, and experiencing the general stress related to transitioning from adolescence to young adulthood (Schulenberg & Maggs, 2001).

As young adults negotiate these transitions, anxiety and depression may occur, further complicating normal development. If those younger clients also use substances and tend to ruminate under stress, increases in depression and substance misuse occur (Skitch & Abela, 2008). Wei, Liao, Ku, and Shaffer (2011) studied the role of self-compassion with attachment anxiety and subjective well-being among college students and community adults. Wei et al. (2011) found that attachment-anxiety individuals are more likely to be self-critical and feel greater levels of distress, be unkind toward themselves, and feel overwhelmed by painful thoughts and feelings. In both groups, self-compassion was negatively associated with attachment anxiety and positively associated with well-being and happiness.

Because self-compassion alleviates the symptoms and severity of depression and anxiety and allows for a kinder, more realistic view of oneself in the face of life challenges, it seems practical to include self-compassion work with young adults suffering from substance abuse and dependency. In reviewing the literature, it

appears that adding a module of self-compassion to standard substance abuse treatment has yet to be established.

Some questions to consider are the following:

1. Will adding a self-compassion module to treatment-as-usual result in a higher frequency of change talk and commitment compared to treatment-as-usual?
2. What are the client's satisfaction scores and experience of the self-compassion sessions?

Compassion and Self-Compassion

The Significance of Compassion

In Latin, the word for compassion is *misericordia*, which means to suffer with. *Compassion* can be defined as "a feeling of deep sympathy and sorrow for another who is stricken by misfortune, accompanied by a strong desire to alleviate the suffering" (Compassion, n.d., para. 1). Other definitions include "deep awareness of the suffering of another coupled with the wish to relieve it" (Compassion, 2011, para. 1).

The Fourteenth Dalai Lama, named Tenzin Gyatso, stated the following:

> Genuine compassion is based not on our own projections and expectations, but rather on the needs of the other: irrespective of whether another person is a close friend or an enemy, as long as that person wishes for peace and happiness and wishes to overcome suffering, then on that basis we develop a genuine concern for his or her problems. This is genuine compassion. (Tenzin

Gyatso, n.d. p. 21)

Gilbert (2010c) defined compassion from an evolutionary neuroscience perspective as a human's ability to provide altruism and caring, further stating that altruism is a "desire to help others reach their goals and alleviate suffering" (p. 128). According to Fogel, Melson, and Mistry's (as cited in Gilbert, 2010b) model for care-nurturance, nurturance has five components: (a) noticing the need for nurturing, (b) motivation for nurturing, (c) expression of nurturing feelings, (d) understanding what needs to be nurtured, and (e) feedback on the impact of nurturing from others. Compassion includes all these components and is essential in relationships with others, including counseling relationships. Compassion consists of a range of behaviors, thoughts, and feelings, with the ultimate outcome being to benefit another. Compassionate mind therapy (CMT) aims to activate that part of the mind that will elicit compassion (Gilbert, 2009).

Compassionate Mind Therapy

When a person is highly self-critical, traditional cognitive counseling strategies are less effective in treatment (Gilbert, 2010a). For example, when using cognitive behavioral therapy (CBT) with a client, new thoughts or behaviors that would be addressed in a counseling session and would be expected to be practiced by the client tend not to be received well with the internal negative tone of the patient. Gilbert pointed out that although CBT and other behavioral therapies are effective with clients who exhibit a high level of self-critical thinking and shame experiences, inserting a CMT component into their care may help them continue to gain benefits

from more traditional treatments.

Compassionate mind therapy was originally developed to address clients exhibiting high self-criticism and shame levels and experiencing difficulty with early attachment, including the ability to self-soothe or to be compassionate toward themselves in times of stress (Gilbert & Procter, 2006). It incorporates research from both neuroscience and evolutionary research and teaches clients how to be less self-critical and more self-compassionate, while increasing their readiness to receive the benefits of traditional CBT. With accurate motivational interviewing (MI) practice, clients experience less self-judgment and greater self-acceptance during the change process, often accompanied by higher commitment toward behavioral change (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003; Martin, Christopher, Houck, & Moyers, 2011; Miller & Rollnick, 2002).

Gilbert (2009, 2010a) suggested that CMT focuses specifically on the affect regulation systems of the brain, including (a) the threat and protection system; (b) the drive, resource-seeking, and excitement system; and (c) the contentment, soothing, and safeness system.

Threat and Protection System

This system is the flight or fight system embedded in the amygdala of the brain. It is the system that is designed to alert one to any potential threat. Once alerted, the body surges with a sense of urgency to take action to protect one from perceived possible harm. The amygdala is that part of the brain that registers emotional response and makes up part of the limbic system, located in the temporal

lobe. The amygdala also stores memories. If an individual has a significant emotional reaction to an event or stimulus, there is a strong likelihood that the emotion will trigger the flight or fight reaction and also leave an impression that is stored as a memory for future reference (Gilbert, 2010b).

Some of the issues inherent in this system can be related to irrational responses. Certain triggers to a perceived threat often result in a predictable emotional response based on the individual's history. Conditioned responses such as anger, anxiety, heart rate, and racing thoughts can cause trouble for a person. The frequency and intensity of a threat-protection reaction (sometimes warranted, other times not) can pose a problem. Also problematic is the inability to calm a reaction by being able to distinguish between positive and not-so-positive responses to a perceived threat (Gilbert, 2009, 2010b; Gilbert & Procter, 2006). An example would be someone in a hostile work situation. He or she protects him or herself by becoming hypervigilant and is unable to stop thinking about the need to stay away from possible harm. He or she becomes stuck in self-reinforcing negative thoughts that take over his or her experience. As these thoughts are repeated, he or she becomes emotionally and mentally immobilized, resulting in maladaptive mechanisms.

The Drive, Resource-Seeking, and Excitement System

According to Gilbert (2010b), the function of this part of the affect system is to provide persons with pleasurable feelings and motivation. It provides the motivation for meeting basic needs such as food, shelter, sex, affiliation, and the joy

experienced when certain goals in life are attained. In the brain, dopamine is the neurotransmitter that mediates these experiences (Doidge, 2007; Siegel, 1999). Succeeding in life through achievement and reaping the rewards and recognition is an example of how this system operates. When persons do not succeed or win, the threat system is engaged to avoid rejection or feelings of inferiority. How clients react to whether or not their dreams are being fulfilled is one way that CMT works with these two systems to help clients train their minds and avoid self-critical thinking (Gilbert, 2010b).

Contentment, Soothing, and Safeness System

The final piece in the affect regulation system is the contentment, soothing, and safeness system. This system is linked to the naturally occurring opiates in the brain that allow persons to feel content and peaceful and experience a sense of well-being. Research has indicated that this sense of connection with self and others is moderated through oxytocin, a neuro-hormone associated with positive experiences of trust, caring, comfort, kindness, and bonding in relationships with others (Gilbert, 2005, 2009, 2010b).

Gilbert (2005, 2009, 2010a, 2010b) has said that persons can train their minds to be more compassionate toward themselves and others. This requires developing compassionate attributes and skills. These traits and skills help stimulate the part of the brain that allows for empathy, soothing, warmth, and affiliation.

The Role of Self-Compassion

What if clients are unable to have compassion for themselves and they are instead fearful of compassion? Gilbert described this tendency as a fear of positive emotion in his 2009 article on compassion focused therapy (CFT). He further explained that for some people, the endorphins and oxytocin that are released when experiencing kindness or warmth can elicit a fear of being vulnerable. When experiencing kindness or soothing, persons' stored memories activate the threat system in order to protect them from potential harm. In addicts, the inability to be soothed may increase relapse vulnerability (Witkiewitz et al., 2005). This concept especially makes sense for clients who have been abused. For example, if a client grew up in a substance-abusing home, the parent may have been alternately loving and kind and then hostile and aggressive after a few drinks. The client may have become conditioned to respond to the loving and kind parent with trepidation for fear of what was to follow once drinking occurred. In the same scenario, grief for the loss of a consistent, loving parent can be another reason for being afraid of experiencing loving, compassionate feelings. Lacking a mature nurturing system, or the ability to develop one, is another barrier to accepting warmth for the self; in essence, the client has a lack of practice.

When having compassion for one's self, the acceptance of kindness and understanding can alleviate symptoms of depression and anxiety (Wright, 2007). If, however, persons find comfort in depression, being self-compassionate can be upsetting. Self-compassion requires individuals to think differently about who they

are and what they are capable of being besides persons who suffer from depression and, therefore, are limited in terms of their options in life. Giving up a definition of self as depressed or anxious and allowing compassion for oneself can be upsetting for someone who is use to identifying with their depressed or anxious feelings. Redefining oneself as being worthy of forgiveness and kindness is difficult work for clients (Gilbert, 2009, 2010b).

One final consideration for clients who might have difficulty accepting compassionate feelings for themselves is the notion of *alexithymia*. Alexithymia is a term used to describe someone who has a hard time using words to express feelings. This term was developed in 1972 by Dr. Peter Sifneos, who noticed that some of his clients did not seem to have the ability to use words to define or express their feelings (Alexithymia, 2014). Thus, learning to have feelings of compassion can be difficult due to early developmental issues; typically, these clients have a hard time expressing any feelings. In CMT and other therapies that focus on developing a sense of self-compassion, it is important for the therapist to provide emotional safety. Part of the premise of CMT is to be sensitive to the reason clients may struggle with feelings of compassion for the self (e.g., protecting oneself from harmful thoughts or sad memories), and it is important to pace the counseling process appropriately (Gilbert, 2010a, 2010b).

Some of the work from Germer (2009) described preparing clients to accept self-compassion. He suggested that there are five stages to accepting pain and suffering: (a) aversion (to resist, avoid, and brood over), (b) curiosity (to turn inward

and toward pain with an attitude of inquisitiveness), (c) tolerance (to create and learn to safely sustain), (d) allowing (to let go and flow with the person's experiences), and (e) friendship (to embrace and see the "hidden" value in an individual's pain; Germer, 2009).

Germer (2009) further indicated that these stages build upon one another and naturally occur, if allowed. The stages suggest that persons progress through as they try to figure out and solve problematic feelings and experiences. If avoiding feelings does not release their pain, then perhaps trying to understand them may work. If understanding them does not work, then they can try to tolerate them until they move into allowing and later progress into acceptance as they learn the lessons of mental and emotional well-being. Self-compassion can ease the pain of anxiety and depression in clients (Germer, 2009; Gilbert, 2009, 2010a, 2010b, 2010c; Gilbert & Procter, 2006; Kelly, Zuroff, & Shapira, 2008; Leary & Hoyle, 2009; Neff, Rude, & Kirkpatrick, 2007).

How is *self-compassion* defined? Neff (2011) defined self-compassion as having three components:

- kindness toward self (self-kindness), which requires "being gentle and understanding of ourselves rather than harshly critical and judgmental";
- recognition of our common humanity, "feeling connected with others in the experience of life rather than feeling isolated and alienated by our own suffering"; and

- recognition of mindfulness, “that we hold our experience in balanced awareness, rather than ignoring our pain or exaggerating it” (p. 39).

According to Neff (2003b, 2011), it is in the combination of these three components where people experience self-compassion. She further stated that these three constructs must interact with each other and thoroughly defined each one as follows:

1. Kindness toward self is to offer warmth, acceptance, and support when persons do something that they are unhappy with or if they make a mistake or recognize a flaw in their personality. It is what being human means: that persons are all flawed, let themselves and others down, and share this experience as part of the human race.
2. Recognition of common humanity helps persons understand that they are not alone in life. They share similar joys, sorrows, and experiences with each other that connect them to each other. These are culturally shaped certainly; however, there are experiences such as the need to feel loved, accepted, nurtured, protected, and safe that all persons share as part of being human.
3. Mindfulness, different from but part of self-compassion, is to experience each moment with a heightened sense of awareness. It is experiencing each moment, noticing and letting go, and experiencing the flow of life versus holding onto negative thinking. Mindfulness allows clients to notice their life in “balanced awareness” (Neff, 2011, p. 41) so they can

> experience life more fully, including the moments of happiness they miss when ruminating on negativity. (Neff, 2011, p. 41)

It is important to distinguish self-compassion from other concepts to avoid confusion. Self-compassion is not self-pity, self-indulgence, or self-esteem (Neff, as cited in Germer & Siegel, 2012). Self-pity is described as what persons who are involved in their own problems feel to the extent that they are unable to see that others also suffer from similar issues, such as substance abuse. Self-compassion involves an ability to relate to others, to see they are human, and to share struggles with others similar to them (common humanity). Self-indulgence includes hanging on to thoughts of self-judgment or self-critical thinking and lacking the ability to be kind or to see the larger picture of one's life. Finally, self-esteem is a way to assess the self in a positive or negative way—how persons value or like who they are compared to others. In contrast, self-compassion is not about evaluation of oneself but more about developing a way to relate to, learn to value, and accept oneself without judgment.

Neff (2003a) researched and developed the Self-Compassion Scale that has been successful in establishing self-compassion as a unique construct separate from self-pity or self-esteem. There are six components: (a) self-kindness, (b) self-judgment, (c) common humanity, (d) perceived isolation, (e) mindfulness, and (f) overidentification. Research using the scale showed that individuals with a higher overall self-compassion score had better coping skills, were able to tolerate and correct negative emotional states, had lower rates of anxiety and depression, and

seemed to have more positive connections to peers and family (Leary & Hoyle, 2009; Neff, 2011).

In relationships with others, self-compassionate individuals tend to be more responsive to their partners and more forgiving, but not necessarily more empathetic. A greater sense of self-compassion has been shown in research to indicate greater relationship satisfaction and closer, more satisfying attachments. This is distinguished from enmeshment, as those with self-compassion are able to see interpersonal issues objectively (Leary & Hoyle, 2009). Gilbert (2010a, 2010b) discussed, albeit briefly, that self-compassion enhancements in therapy can repair ruptures in counseling relationships. This area of research is limited and needs further study to establish a causal relationship.

In her work, Neff (2011) has included the idea of mindful awareness of self. In the area of addictions relapse treatment, Dr. Alan Marlatt and colleagues created an aftercare program for addictions clients called mindfulness based relapse prevention (MBRP; Witkiewitz et al., 2005). This treatment combines cognitive behavioral strategies and mindfulness meditation to address cues, triggers, and discomforting thoughts, as well as unpleasant emotional and physical experiences that can lead to a return to substance use. The goal is to integrate mindfulness practice into a lifestyle that includes daily relapse-prevention and recovery strategies. The research found that those who participated in MBRP exhibited lower rates of substance use, decreased cravings, and increased acceptance and self-awareness (Witkiewitz et al., 2005).

Such success suggests a benefit to linking self-compassion with standard treatment, not just during aftercare programming. Assuming that addictions clients experience the same self-critical tone and harsh judgment for having an addiction, using a self-compassion focus with MBRP, CBT, or MI may result in similar research findings in the mental health disciplines. More research needs to be conducted to determine its importance in treating addictions clients.

Project MATCH Research

Some of the major evidence-based treatment practices for substance abuse are CBT and MI. The National Institute of Alcohol Abuse and Alcoholism (NIAAA) conducted a five-site clinical trial called Project MATCH to determine whether, if patient characteristics were matched to specific treatments, this matching of patient traits would result in better outcomes related to drinking and abstinence. The three treatments identified were CBT, motivational enhancement therapy (MET, a practice using the principles of MI), and twelve-step facilitation (TSF); all three were considered to be standard care in the addictions treatment community at the time. The results of this massive research project showed few differences among the three arms of the study. In fact, all three treatments had an effect on drinking outcomes at both 1-month and 12-month follow-ups (Project MATCH Research Group, 1997). As a result of this study, three manualized treatment products were produced for use in the study and offered to the treatment community as effective treatments for alcohol abuse. Motivational interviewing's use in addiction treatment has continued to be researched extensively. Motivational interviewing is registered as an evidence-

based best practice addictions treatment by the National Registry of Evidence-Based Practices and Programs.

Due to the sharp rise of opioid addiction in young adults, as well as the prevalence of high relapse rates, incorporating additional methods of care with a best practice such as MI is an important research agenda (SAMHSA, 2012). As part of the review of the self-compassion literature, it is conceivable to establish a link between the findings of the mental health outcomes and treatment models that serve primary substance abuse populations.

Motivational Interviewing

Change talk is client language that favors movement toward change. Significant to the practice of MI, it is essential for the therapist to access client change talk. Miller and Rollnick (2013) defined change talk as "any client speech that favors movement toward a particular change goal" (p. 406). They asserted that the amount the client talks about change and the level of commitment language serve as good predictors of the client's willingness to engage in change. In addictions treatment, the usual behavioral changes are abstinence, relapse prevention, attending treatment sessions, and completing counseling assignments. With some addictions care, such as for opioid addictions, managing medications is also an important component of change. Change talk as a focus in the research has had mixed results in terms of its component parts (Martin et al., 2011). Early research found that when clients talked about making changes, they would often speak of change as wanting to make a change (desire), thinking about whether or not they could change (ability), feeling

like there was some urgency to make a change (need), or having good reasons to change (reasons). Motivational interviewing found that when clients spoke in these ways, it was basically preparing themselves for change, also known as "preparatory change talk," that is, desire, ability, reason, and need (Miller & Rollnick, 2003). Then, as the session continued, the frequency and strength of the client commitment language was identified as a predictor of change (Amrhein et al., 2003). In a recent reexamination of initial sessions from Project MATCH using a different coding instrument, it was found that the clients' feeling that they could change (ability) combined with their level of commitment to change seemed to be the primary factors leading to change (Martin et al., 2011). In another study, increasing client change talk and elicitation of change talk by the therapist were found to be important in the reduction of substance abuse, as well as in the overall client outcomes (Glynn & Moyers, 2012; Moyers et al., 2007). Further research on change talk is important and needed in order to advance the discussion of how MI can work together to continually improve client-identified changes.

Important to the elicitation and exploration of change talk and fundamental to the practice of MI is the notion of the spirit and style of MI. Miller and Rollnick (2013) described the spirit and style of MI as "the set of heart and mind" (p. 15) that one adopts when practicing MI. These include partnership, acceptance, compassion, and evocation. *Partnership* entails being able to communicate that one is collaborative and views the counseling relationship as one that is shared between two experts toward a shared agenda for change. The components of this partnership

include eliciting the client's own world view, being aware of one's agenda for the client and being careful not to impose this onto the client, and having respect for the client and his or her own wisdom about his or her life and changes he or she needs to make to improve that life. *Acceptance* includes absolute worth (being nonjudgmental, respectful, and acknowledging a person's worth as a human being), *accurate empathy* (being able to see the other perspective through another's eyes), *autonomy support* (acknowledging and accepting the right of an individual to choose his or her own path), and *affirmation* (recognizing an individual person's strengths). *Compassion* is to work toward the welfare of clients and in their best interest. The last component of the spirit and approach of MI is evocation. *Evocation* is to pull from clients their own strengths and knowledge of themselves to draw upon their own wisdom. Much of what Miller and Rollnick described as the spirit of MI comes from the teachings of Carl Rogers. The combination of partnership, acceptance, compassion, and evocation develops over time and deepens as one develops the practice of MI. With accurate MI practice, clients experience less self-judgment and a greater self-acceptance during the change process, often accompanied with higher commitment toward behavioral change (Amrhein et al., 2003; Martin et al., 2011; Miller & Rollnick, 2013).

Measurements

For clinical practice, three measurements are useful to assist with clinical practice. For MI, two of the most common measurements used that are both for supervision and treatment fidelity are the Motivational Treatment Integrity Scale and

the Client Language EAsy Rating. Measuring and showing improvements in the clients' self-compassion can be accomplish using the Self-Compassion Scale. These measurements are described in greater detail below.

Motivational Treatment Integrity Scale. One of the most common measurements for MI treatment fidelity is the Motivational Treatment Integrity Scale v4.1 (MITI; Moyers, Martin, Manuel, Miller, & Ernst, 2010). The MITI measures clinician behaviors. Its authors suggested the main purpose of the MITI is to identify "how well or poorly . . . the practitioner is using MI" (p. 3) and to provide feedback to clinicians. The MITI has two parts: the Global scores and the Behavior counts.

In the first part, there are four scales that are measured. They are: Cultivating Change Talk, Softening Sustain Talk, Partnership, and Empathy. Part II of the MITI tallies Behavior counts. These include tallies of clinician behaviors related to the use of questions, reflective listening, giving information, offering affirmations, persuading and persuading with permission, supporting autonomy, seeking collaboration and confronting. A summary of the Global ratings and Behavior counts is then offered to the clinician, which are compared with beginning proficiency and competency standards as depicted on page 41 of the MITI manual.

The MITI is meant to be used with specific target behaviors, such as continued abstinence, treatment attendance, or completing homework assignments. There is one pass for each taped session, meaning the coder listens to tapes once for a minimum of 20 minutes.

Client Language EAsy Rating. Because the MITI does not address client

change talk or commitment language, adding another instrument that is designed to accomplish this in detail would be helpful to monitor client commitment to change. The Client Language EAsy Rating (CLEAR) instrument is used to "classify and quantify client language that is either change talk, or counter-change talk" (Glynn & Moyers, 2012, p. 2). The importance of focusing on change talk as a predictor of behavior change is discussed in the MI literature (Miller & Rollnick, 2002). The CLEAR uses only audiotapes, can be done in one pass, counts only client behavior, is designed to code the whole session versus a smaller part of a session, and requires a targeted behavior to be identified prior to coding.

As with the MITI, the CLEAR requires a minimum of two coders to establish interrater reliability. To address interrater reliability, it is suggested in the manual to have identified coders who can meet in a group for training and then posttraining to compare independent coding samples to avoid drift. The MITI and the CLEAR originated from the longer and more thorough Motivational Interviewing Skills Code (MISC; Miller et al., 2003). For practical reasons of time and cost, the other two measurements are more efficient for attending to daily clinician practice. All manuals can be found on the website http://casaa.unm.edu.

Self-Compassion Scale. The Self-Compassion Scale (SCS) was developed by Dr. Kristin Neff (2003a) from the University of Texas, Austin. The scale contains 26 items that measure and include the following:

- The degree to which a person is able to be kind and understanding toward oneself in times of stress or painful life experiences as opposed to being harshly self-critical.
- The ability for oneself to realize experiences as part of being human as opposed to feeling alone or isolated or feeling that one must be perfect or is not allowed to make mistakes.
- The degree to which one holds and is acutely aware of painful feelings and experiences instead of avoiding difficult feelings or ignoring life's difficulties.

Neff (2003a) found that having a compassionate attitude was the opposite of isolating, overidentifying with negative thinking, or being harshly self-critical or judgmental toward oneself. The primary goal of development was to create a way to measure levels of self-compassion and to identify psychological outcomes related to the different levels.

Sample items to illustrate the subscales include the following:

- Self-Kindness: "I am kind to myself when I'm experiencing suffering" (item 19).
- Self-Judgment: "I'm disapproving and judgmental about my own flaws and inadequacies" (item 1).
- Common Humanity: "I try to see my failings as part of the human condition" (item 15).

- Isolation: “When I’m really struggling, I tend to feel like other people must be having an easier time of it” (item 18).
- Mindfulness: “When I’m feeling down I try to approach my feelings with curiosity and openness” (item 22).
- Overidentification: “When I’m feeling down I tend to obsess and fixate on everything that’s wrong” (item 2).

Conclusion

Self-compassion research is an area that offers a useful way to assist substance-abusing clients to heal. It has been studied and applied in the fields of mental health, educational psychology, and education, where it offers a unique perspective on the role of self-esteem and learning. Self-compassion research attempts to shed light on improving clients’ ability to manage stress, reducing symptoms of anxiety, depression, and negative self-appraisals while offering an enhanced view of what it means to have a healthy sense of self. It builds on the work in the positive psychology movement that furthers understanding of client resiliency. Self-compassion approaches ease the pain of client shame by quieting the inner self critic. In this way, one can normalize the sensation of pain as part of life versus seeing it as pathological.

Some researchers have voiced concerns that self-compassion might be countermotivational (Neff et al., 2007). Neff’s research has shown that this is not the case. Current self-compassion research findings have indicated that those individuals with greater self-compassion show higher motivation to achieve their goals based on

the desire to improve their lives versus succeeding in order to bolster a weak ego. In educational settings, self-compassionate students tend to be motivated by their own internal goals and wants and are less motivated by a desire for social acceptance and approval. Failures toward goal achievement are treated with more kindness and compassion rather than seen as a negative indictment of the individual's sense of worth (Leary & Hoyle, 2009).

Self-compassion research has been well documented in relation to mental health issues such as depression and anxiety (Gilbert, 2009, 2010a, 2010b). Whether or not focusing on adding self-compassion tools can assist addiction clients who experience high levels of shame to benefit more fully from treatment remains to be explored. Helping clients look at how they judge themselves and assessing their ability to be more self-compassionate has many benefits. Recently, there has been more published in the substance abuse literature, but its effect with substance abusing populations may not be similar to mental health outcomes. This research is still in the early stages of study.

In conducting the literature review, two articles were identified exploring the application of self-compassion work with addiction issues. Brooks, Bowman, Kay-Lambkin, and Childs (2012) conducted a study to determine if higher levels of self-compassion would negatively correlate to depression and anxiety with participants who entered a publicly funded treatment center for alcohol abuse. The study also explored whether, if self-compassion improved over time, lower levels of depression, anxiety, and alcohol use would result. In another study, Iskender and Akin (2011)

wondered if there was a relationship between self-compassion and Internet addiction. Both studies utilized Neff's (2003a) SCS to measure their findings. Although preliminary, the findings indicated a negative correlation with higher levels of self-compassion (either on their total self-compassion score or on scores on the subscales) and decreasing symptoms of depression, anxiety, and alcohol and Internet use.

Self-compassion research in substance abuse treatment is worthy of further exploration. Early findings have suggested positive results. Infusing a self-compassion model to support current treatments can offer significant contributions to the understanding of how clients who suffer from addiction recover. Combining self-compassion with the way in which a therapist elicits change talk may improve client engagement; reduce shame, embarrassment, and guilt; manage anxiety symptoms; and improve engagement, retention, and treatment outcome effects. Helping young adults recover using evidence-based substance abuse treatments tailored to their developmental process is a research agenda worthy of pursuing.

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Chapter 3: Focusing on Self-Compassion Within Treatment-as-Usual Among Opioid-Dependent Young Adults

Focusing on Self-Compassion Within Treatment-as-Usual Among Opioid-Dependent Young Adults

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Abstract

Young adult opioid addiction is on the rise in many parts of the country. Young adults' use of opioids, in the form of illicit prescription drugs or heroin, is especially challenging for treatment engagement and retention due to high rates of relapse and debilitating shame and guilt. Normal developmental milestones of life are halted. Mental health research has found self-compassion training to be helpful; however, it is underrepresented in addiction research. Enhancing substance abuse best treatment practices such as motivational interviewing (MI) may result in fewer incidences of relapse, as well as a decrease in shame, depression, and anxiety when paired with a focus on self-compassion. The objective of this study was to determine if offering a self-compassion focus with treatment-as-usual increases the frequency of client change talk compared with treatment-as-usual alone. A secondary focus included a review of client satisfaction scores between the two study groups to determine how they would evaluate the treatment they received and their experiences participating in the study. There were 17 opioid-dependent young adults (ages 18–25) randomly assigned to one of two conditions in an outpatient substance abuse treatment clinic. Measurements of the frequency of change talk were collected at five distinct points during the intervention. At the completion of the final session, the participants evaluated their satisfaction scores using the CSQ-8 and responded to a series of open-ended questions. Results of an ANCOVA and independent *t-tests* were utilized to determine any differences between the two groups in the frequency of change talk and client satisfaction. An analysis of common themes shared by participants showed

a preference for individual counseling and a structured place to go, as well as a desire for the intervention to be longer than three sessions. The study indicated that a focus on self-compassion combined with treatment-as-usual did not differ in outcome when compared with treatment-as-usual alone. Additionally, both treatment conditions were equal in terms of client satisfaction. A final consideration was the finding of themes that could help guide treatment programs toward what would be preferred by young adults: individual counseling over groups, and activities that enhance a positive sense of self where one can learn to gain more self-acceptance, build stronger life structures, and move forward in developing one's recovery lifestyle.

Keywords: young adult opioid addiction, self-compassion, motivational interviewing, brief interventions

Focusing on Self-Compassion in Treatment-as-Usual Among Young Adult Opioid Dependents

Opioid addiction within young adult populations (ages 18–25) has increased significantly in recent years according to the 2010 National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011). Most of the increased use and abuse started with illicit prescription drug use and progressed to smoking or intravenous heroin use. Physical addiction to opioids and the subsequent painful withdrawal has resulted in increased requests in substance abuse treatment and other health care settings. According to the Treatment Episode Data Set (SAHMSA, 2010a, 2010b, 2012), 49% of outpatient admissions for opiate usage other than heroin were 20- to 29-year-olds. Another 14% of admissions were for primary heroin use, most in the same age range. Variables such as age, education, race, gender, and drug use 1 month prior to admission to treatment were analyzed to determine both admissions and discharge data.

Many substance use treatment programs, although successful for many clients, currently struggle with successfully serving young adult populations. Younger clients with opioid use, lower educational levels, and self-referral indicated shorter lengths of stay in treatment (SAHMSA, 2010b, 2011, 2012). In some settings, the treatment completion rate is under 50%, particularly for younger users (SAMHSA, 2015). Treatment practices such as motivational interviewing (MI), coupled with medication such as suboxone or methadone, can be effective for many users. However, there seems to be a subset of younger users who struggle with relapse (Germer, 2009;

Witkiewitz, Marlatt, & Walker, 2005). Conducting more research in the area of effective treatments for this younger age group has promise to address the current influx of patients at treatment centers.

When examining the literature related to self-compassion and treatment of young adult opioid dependents, four key areas of research emerge: (a) the impact of addiction on developmental processes, (b) shame among drug abusers, (c) the role of change talk in addiction treatment, and (d) the role of self-compassion in addiction treatment. After the literature related to these areas is explored, the research questions that guided this study will be detailed.

Many young people begin a progression of drug use and abuse leading to addiction in their adolescent years, seriously affecting normal developmental processes (Arnett, 2005; Arnett & Tanner, 2006). The concept of emerging adulthood is useful when addressing the young adult development issues that have been affected by substance use (Arnett, 2005). Using the emerging adulthood concept, Arnett posited that five developmental phases should be considered when thinking about drug use and abuse. These five developmental phases were: (a) the age of identity exploration, such as establishing an identity related to love relationships and work; (b) the age of instability, such as making frequent changes in housing, education, or peer affiliations; (c) the age of self-focus, when young adults make decisions about money and are free from the responsibilities of more demanding expectations and life roles; (d) the age of feeling in between, where setting and reaching self-identified goals, such as financial independence, stable

work, and committed relationships, are valued by young adults but not yet achieved and an emerging sense of self as an adult occurs; and (e) the age of possibilities, when young adults have the ability to change frequently, sometimes in big ways, often feeling optimistic about life's choices and options. Serious drug abuse in young adults increases developmental interruptions, leading to increased feelings of shame, guilt, and anxiety about the course of their lives.

Due to histories of drug abuse affecting decision making, emotional regulation, and social interactions, brain functioning is compromised as young adults attempt to manage their independence and expectations of others and themselves. In the 2005 article "The Developmental Context of Substance Use in Emerging Adulthood," Arnett suggested several areas of focus to be explored for future research on the role of substance use and abuse during these critical ages. They include identity confusion, sensation seeking, instability within the home, school or peer relationships, declines in older adult supervision and expectations, affiliation with using peers, viewing substance use as a normal part of growing up, and an either higher or lower sense of well-being about themselves.

Shame is especially prevalent among drug abusers and results in a negative appraisal of self. Guilt is also common; however, when people experience guilt, it can be a moderator for regulating behaviors such as difficult or overwhelming emotions or empathy for others (Treeby & Bruno, 2012). Research found that shame proneness was related to alcohol use to regulate negative emotions, while guilt proneness was not (Dearing, Stuewig, & Tangney, 2005; Dearing & Tangney, 2011).

Further, Wiechelt (2007) suggested that shame proneness can not only lead to substance abuse to ease the pain of negative views of the self but, if not attended to, can also impede recovery efforts.

Descriptions of shame and its relationship to how a person feels are provided in Wiechelt's (2007) article "The Specter of Shame in Substance Misuse." According to Wiechelt, internalized shame is associated with the affect system of the brain. People are hard wired to experience shame when they are surprised or startled or experience fear, terror, interest, excitement, enjoyment, distress, anguish, anger, rage, disgust, or humiliation. Shame experiences can be adapted to monitor and adjust behavior and understand personal limits. However, when shame experiences become harmful, individuals are exposed to repeated negative experiences where the experience of shame becomes a way to identify themselves as bad, thereby becoming part of who they are instead of simply being attributed as things they have done. Feeling shame is an evaluation of self as being undesirable to others; feeling guilt is defining a behavior as undesirable. Shame-prone individuals blame others and can become angry or hostile to avoid feeling the hurt and pain of the emotion of shame. Shame-free guilt has been found to motivate behavior changes, and feeling ashamed can interfere with recovery efforts. One response to experiences of shame and efforts toward recovery is for treatment programs to include a focus on healing shame experiences. This can be accomplished by using adjuncts such as self-compassion work alongside research-based treatment engagement models such as MI.

One of the key elements in the practice of MI is to acknowledge and elicit *change talk.* In the practice of MI, it is essential for the therapist to access client change talk. Miller and Rollnick (2013) defined change talk as "any client speech that favors movement toward a particular change goal" (p. 406). They asserted that the frequency of clients' talk about change and their level of commitment language serve as good predictors of their willingness to engage in making difficult behavioral changes.

Change talk as a focus in the research has had mixed results in terms of its component parts (Martin, Christopher, Houck, & Moyers, 2011). Early research found that when clients talked about making changes, they would often speak of change as wanting to make a change (desire), thinking about whether they could change (ability), feeling like there was some urgency to make a change (need), or having good reasons to change. Motivational interviewing researchers found that when clients spoke in these ways, they were preparing themselves for change defined as preparatory change talk that is, desire, ability, reason, and need. Then, as the session continued, the frequency and strength of the client commitment language was identified as a predictor of change (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003).

In a recent re-examination of initial sessions from Project MATCH using a different coding instrument, it was found that the clients' feeling that they could change (ability) combined with their level of commitment to change seemed to be the primary factors leading to change (Martin et al., 2011). In further studies, increasing

client change talk and elicitation of change talk by the therapist were found to be important in the reduction of substance abuse as well as in the overall client outcomes (Gaume, Bertholet, Faouzi, Gmel, & Daeppen, 2010; Glynn & Moyers, 2012).

In further research, the predictor of behavioral change has been tied more closely to the strength of certain aspects of change talk, namely the desire to change and having good reasons to change. In a study looking at marijuana treatment outcomes, Walker, Stephens, Rowland, and Roffman (2011) found that these two factors played a significant role in subsequent addictive behaviors. The more the clients advocated for change, the more likely they were to achieve it. In the Armhein et al. (2003) study, it was the strength of commitment language at the end of a session that seemed a strong indicator of change postsession. Whether it is commitment, intention, or confidence that is the necessary component in the client change process, what seems to be relevant is that the client, with the therapist's help, is able to enhance intrinsic motivations for change. Motivation for change is a form of self-talk externalized in the therapy context.

Obviously, if the client is not able to have positive change talk thoughts due to a poor relationship with self, eliciting motivation for change could be challenging. Enhancing one's sense of self as being worthy of kindness, compassion, and connection with others may be an important first step toward improving life-affirming motivation, reducing the experiences of shame, and helping with forming a sense of self-identity more consistent with normal developmental processes.

Although well documented in the mental health field, the role of self-compassion is not well documented in the addictions field. Neff (2011) defined *self-compassion* first as kindness toward self (self-kindness), which requires "being gentle and understanding of ourselves rather than harshly critical and judgmental" (p. 41). Further, self-kindness is about offering oneself warmth, acceptance, and support when one does something one is unhappy with, makes a mistake, or recognizes a flaw in personality. It is what being human means: that all are flawed, that persons let themselves and others down, and that this experience is shared as part of the human race. A second feature is recognition of common humanity, "feeling connected with others in the experience of life rather than feeling isolated and alienated by our own suffering" (p. 41). Recognition of common humanity brings understanding that individuals are not alone in life. They share similar joys, sorrows, and experiences with one another that connect them to each other. While these needs can be culturally shaped, there are some, such as feeling loved, accepted, nurtured, protected, and safe, that all persons share as part of being human.

A final consideration of self-compassion is recognition of mindfulness, "that we hold our experience in balanced awareness, rather than ignoring our pain or exaggerating it" (Neff, 2011, p. 41). Mindfulness, which is different from but part of self-compassion, is an awareness of each moment. It is experiencing each moment, noticing each moment, and letting go of each moment in order to experience the flow of life. Mindfulness allows clients to notice and let go of all emotions so they can experience life more fully, including the moments of happiness they miss when

ruminating on negativity. According to Neff, it is in the combination of these three components that persons experience self-compassion. The three constructs must interact with each other as self-compassion develops in each person.

Given the effectiveness of applying self-compassion tools to mental health treatment, it seems logical to ask if self-compassion tools can be helpful in engaging and treating young adult opioid abusers. Of particular interest is whether being more self-compassionate also allows for greater self-acceptance in the face of being confronted with the behaviors they engaged in while in their active addiction. Two recent studies on self-compassion focusing on alcohol abuse and Internet addiction both concluded that further research on the role of self-compassion in addictions treatment was needed (Brooks, Bowman, Kay-Lambkin, & Childs, 2012; Iskender & Akin, 2011).

The purpose of this study was to further the exploration of the role of self-compassion with a specific drug addiction (opioid addiction) within a specific age range (ages 18–25). Three research questions were defined for this purpose. The first research question was: What is the impact of TAU (treatment-as-usual) + SC (self-compassion) over TAU on frequency of change talk? The second research question considered was: What is the impact of TAU + SC over TAU in terms of client satisfaction? The third question was: What themes emerge from the participants when asking open-ended questions of the experiences of the self-compassion and/or motivational treatment interventions?

Method

Research Design

To address the first research question, a randomized pretest–posttest control group experimental design was employed (Creswell, 2009; Shadish, Cook, & Campbell, 2002). To answer the second research question, a randomized posttest only control group design was employed (Creswell, 2009; Shadish, Cook, & Campbell, 2002). These designs were chosen because they are widely used in behavioral research as a way to compare groups, as in this study; further, these designs can determine if change is a result of the experimental treatment (Dimitrov & Rumrill, 2002). For both of the first two research questions, the independent variable was a series of three individual counseling sessions using treatment-as-usual (TAU) plus self-compassion (SC) for the experimental group. The control group received TAU only. In this study, TAU was the counseling approach of MI. For the first research question, the dependent variable was the frequency of client change talk at the end of the counseling sessions. The frequency of client change talk at the beginning of the counseling sessions was used as a statistical covariate. For the second research question, the dependent variable was the level of client satisfaction at the end of the counseling sessions.

To address the third research question, a series of four open-ended questions were asked at Session 5 of the study protocol. Since all of Session 5 was transcribed for each participant, a phenomenological research approach was employed to analyze the clients' responses to the questions (Creswell, 2009). This method was chosen as

it has an emphasis on identifying common themes within text to get a general sense of the experience of the clients participating in the study. It allowed the researcher to understand the benefits of each treatment group with particular emphasis on receiving self-compassion training.

Participants

The study identified 44 young adults (ages 18–25) participating in an outpatient opioid-dependent treatment clinic to be included in the study. From the young adults screened for inclusion in the study, 23 (11 males and 12 females) were eventually enrolled and randomly assigned to one of two conditions: a set of three individual counseling sessions that added a self-compassion focus to treatment-as-usual or three individual counseling sessions with treatment-as-usual only. Of the 23 enrolled, six (three from each condition) dropped out of the study, leaving 17 who completed all five sessions. In the TAU condition there were 6 males and 3 females and in the TAU + SC condition there were 3 males and 5 females (see Figure 1).

All participants whom receive suboxone prescriptions had to have completed an alcohol and drug assessment with a primary diagnosis using the *Diagnostic and Statistical Manual of Mental Disorders,* 4th ed., text rev. (DSM-IV-TR; American Psychiatric Association, 2000). In addtion, all participants had to meet treatment level 1 severity based on the *Patient Placement Criteria* revised second edition (American Society of Addiction Medicine [ASAM], 2001). Treatment involvement was a normal requirement to receiving their medication. Patients were offered a choice of services to satisfy this expectation. Choosing to enter into the research

project which was a briefer treatment option than the other longer term care was one option offered.

Recruitment into the study was voluntary. Prior to assignment to a treatment condition, participants completed four sessions. These sessions included: (a) a medical appointment to be inducted onto suboxone; (b) completion of an individual or group orientation to suboxone treatment and signing all required paperwork; (c) completion of an ASAM-based alcohol and drug assessment concluding with a primary DSM diagnosis of opioid addiction, level of care determined as outpatient placement, and client agreement with placement and (d) completion of an intake session to confirm clients met the inclusion criteria for the study and to answer any questions they may have had about the study, including opting out of the study.

Potential clients were excluded if they met at least one of the following criteria: (a) clients were over the age of 25 or under the age of 18 prior to being enrolled in the study; (b) another treatment level of care was more appropriate; (c) once in the study, clients did not want to continue in the study; (d) once informed of the study, clients declined participation; (e) clients' primary DSM diagnosis was something other than opioid dependence; (f) clients did not want to be audiotaped; (g) clients failed to take suboxone medication as prescribed or became medically unstable, making it difficult to proceed in the study; (h) clients continued to use opioids; (i) clients refused to be randomized into the condition offered; (j) clients dropped out of treatment; (k) another condition became more severe, requiring other forms of treatment or a different level of care; and (l) clients were unable to complete

all study counseling sessions, and their overall self-compassion score was above 3.0 or lower than 2.5 on subscores.

Randomization was determined by assigning clients using the True Random Number Generator website (http://www.random.org). Clients who received a 1 went into TAU, and clients who received a 2 went into TAU + SC. After a minimum of 16 clients were enrolled into each condition while accounting for dropouts, the study enrollment ceased.

Measures

For the study three measurements were used to address the research questions. They are identified and reviewed more specifically in the following paragraphs.

Client Language EAsy Rating Coding System. The Client Language EAsy Rating Coding System (CLEAR; Glynn & Moyers, 2012) was used for coding transcribed audiotaped sessions for change talk and counterchange talk at points 1–4. Audio sessions at measurement points 1 and 4 were transcribed to protect confidentiality and for ease of coding each session. According to the *Manual for the Client Language EAsy Rating (CLEAR) Coding System*, the CLEAR is used to "classify and quantify client language that is either change talk (CT) or counter-change talk (CCT)" (Glynn & Moyers, 2012, p. 2). The formula used to define CT frequency is % CT = CT / [CT + CCT]. The CLEAR requires a target behavior. The CT and CCT focus is on the client only. CT categories include (+) and (−) tallies around the following variables: desire, ability, reason, need, commitment, and taking steps. In order for the CLEAR to be useful and reliable, coders were trained on the

instrument, which included interrater reliability. Glynn and Moyers recommended the use of intraclass correlations (ICCs) calculated in SPSS.

There were 34 sessions (18 TAU and 16 SC) coded using the CLEAR coding system (Glynn & Moyers, 2010). The CLEAR provides a simple count of the change talk and counterchange talk given by the client during the session. For this project, the coding was initiated at a preidentified point that allowed for the raters to be blinded to the intervention. Client language was evaluated for change related to both substance use and self-compassion activities. For this effort, substance use was inclusive of any identified substances (opioids, marijuana, alcohol, tobacco, etc.). It also included any behaviors that the client linked to his or her recovery or participation in the suboxone treatment (getting a job, finding new friends, establishing healthy behaviors). There were 11 sessions that were double coded and discussed during the process. While this is not enough to provide a statistical estimate of reliability, the results were compared and there was consistency and agreement between the two coders concerning what language was coded. The self-compassion activities included completing any homework, practicing skills such as meditation or journal writing, and engaging in some form of self-compassion practice.

Client Satisfaction Questionnaire. The Client Satisfaction Questionnaire (CSQ) was used to answer the second research question (Larsen, Attkisson, Hargreaves, & Nguyen, 1979). This measure was used 2 weeks after the participants' third counseling session. The CSQ's purpose is to provide a measurement of the

clients' satisfaction with behavioral health services received. The original publication date of the instrument was 1979, with the latest revisions in 2004 (see Attkisson & Greenfield, 2004). The version used for this project was the CSQ-8. The reported Cronbach's α for the CSQ-8 ranged from .83 to .93 (citations). Content validity of the survey was developed by having 248 mental health clients test on 31 items. The final eight items were chosen based on factor loadings. Those clients who completed treatment had higher satisfaction scores compared with those who did not complete treatment (Larsen et al., 1979).

The instrument is designed to be used once services conclude. It is self-administered. For the purpose of this study, an interview format was added to capture more qualitative data specific to the experiences of the self-compassion interventions and the clients' reactions to those interventions. Responses were different on each item; however, all were based on a 4-point Likert scale. Lower scores indicated lower levels of client satisfaction. Examples include the following: item (5) How satisfied are you with the amount of help you received? (1 = Quite dissatisfied, 2 = Indifferent or mildly dissatisfied, 3 = Mostly satisfied, 4 = Very satisfied) and item (2) Did you get the kind of service you wanted? (1 = No, definitely not; 2 = No, not really; 3 = Yes, generally; 4 = Yes, definitely).

Open-ended question concerning treatment experiences. Research question 3 utilized a series of 5 open questions specific to the clients' experiences of learning and practicing self-compassion (see Table 3). Seventeen transcripts of the final session of the study (Session 5) were utilized to review common themes that

presented the clients' responses to the questions and evaluation of their participation in the study. The coders were the first author and another staff member of the treatment team. The process used to determine inter-rater coder reliability required the two coders to independently rate a sample tape not used in the final study analysis to determine if they had identified similar themes. Once a baseline of understanding on how to code the transciptions was achieved, the two coders independently reviewed each transcript, looking for themes mentioned frequently by language and by the number of participants, and documented their findings in an Excel spreadsheet. Once all transcripts had been analyzed, the coders reviewed and noted their independent findings to establish a joint list of common themes. The list consisted of a majority of common themes for both study conditions.

Apparatus

A digital pocket memo speech-processing recorder was used at intake, treatment, and posttreatment sessions. Each session was professionally transcribed for analysis.

Procedures

Participants attended a total of five individual sessions for this study: (a) an intake session, (b) three individual treatment sessions, and (c) one follow-up meeting to evaluate their experience in the study. Participants randomized to the experimental condition received three specific self-compassion exercises, which were developed by the first author using material from Neff (2013) along with 14 minutes of self-compassion guided meditation (Neff, 2011). The counseling style used was a MI

counseling approach. In Session 2, those randomized to the control condition conducted a values card sort. The values card sort was retrieved from http://casaa.unm.edu/. In the following two sessions, participants typically processed their ambivalence about a particular change goal or created a change plan if they were ready to commit to a specific change plan. All counseling sessions were 45–50 minutes in length.

Finally, upon completion of all the study sessions, clients were asked to return after 2 weeks to complete a client satisfaction survey on their participation in the study and to be offered continued treatment services to be determined between the counselor and themselves. After 17 clients who were identified and found to be appropriate agreed to enter the study, the study concluded its enrollment. Clients entered into the study conditions on a first-come, first-served basis.

Treatment

The treatment interventions encompassed self-compassion skills training with a MI counseling approach in the experimental study group and an MI approach to the control group.

Self-compassion component (SC). At the beginning of each session, a self-compassion scale was completed and the previous week's homework reviewed. Further check-in included monitoring compliance with medication and other program requirements. All session exercises were obtained from http://www.selfcompassion.com/exercises. The audio meditation used (lovingkindness) was approximately 14 minutes and obtained from a CD (Neff,

2013). Three counseling sessions were conducted. The first session included the counselor-presented material defining self-compassion (SC) in general and then describing it in more specific terms. This took about 10 minutes and was followed by a brief exercise (clenched fists). Next, a discussion on SC and brain functioning occurred, followed by exercise 1 (how would I treat a friend) and exercise 2 (self-compassion break), designed to work with difficult emotions. These exercises were followed by an audiotape meditation. The homework assigned was to practice the compassionate sayings (exercise 2) throughout the week from the guided exercise. The focus of the second session was on completing exercise 3 (exploring self-compassion through writing) or exercise 5 (changing your critical self-talk), completing the lovingkindness audio meditation, and choosing from three different homework assignments (review Neff's website, redo or complete exercises 2 or 3, or something they would like to do to assist them in managing their recovery) to work on during the week. In the final session, the focus was on completing exercise 7 (identifying what we really want) and finishing the lovingkindness meditation. Clients were scheduled to return for study evaluation in 2 weeks and encouraged to continue to work on improving their SC by practicing the exercises. Pre-intervention average SCS was 2.4 and post-intervention average SCS was 3.1.

Treatment-as-usual (TAU). At the beginning of each session, a self-compassion scale was completed and the previous week's homework reviewed. Further check-in included monitoring clients' compliance with medication and other program requirements. Three counseling sessions were conducted. The first session

included assessing readiness for change toward specific change behaviors, and if clients were ambivalent, they were assisted by completing a values card sort retrieved from http://casaa.unm.edu/inst/values to help with identifying a place to focus on for potential behaviors for change. Most clients needed to complete this, as they were ambivalent about what they wanted to accomplish in treatment with the exception of being able to continue their medication. Issues such as abstinence, seeking employment, repairing damaged family relationships, finding new friends, coping with financial strain, and managing mood regulation were common areas of interest and focus. At the end of the session, homework of their choice and focus was discussed. The second session continued conversations about exploring ambivalence and determining readiness to create a change plan, if appropriate. Importance/confidence rulers were used, and identifying the type of ambivalence they were experiencing was explored (see Miller & Rollnick, 2013). The final session was devoted to highlighting any progress toward changes made, determining next steps, and developing ongoing treatment planning objectives. Pre-intervention average SCS was 2.0 and post-intervention average SCS was 2.8.

The average length of individual sessions for both conditions was 57 minutes.

Therapist training. The therapist in this study was the first author. The first author has extensive training in the practice of MI. In addition, she is a member in good standing of the Motivational Interviewing Network of Trainers (MINT). The first author has been teaching MI to clinicians, administrators, and other interested persons since 1998. She published a book through Hazelden on the use of MI with

the transtheoretical model of change for substance abuse professionals and has attended two workshops conducted by Dr. Kristin Neff.

Treatment fidelity. The Motivational Interviewing Treatment Integrity (MITI 4.2.1; Moyers, Manuel, & Ernst, 2014) coding system was used to evaluate the fidelity of both the TAU and the SC training interventions for alignment to the spirit and skills of MI. The following MITI summary scales were used: (a) global-relational, (b) global-technical, (c) reflections to question ratio, and (d) percentage of complex reflections. The purpose of the MITI is to determine clinician behaviors on two scales, global-relational and global-technical. On the global-relational scale there are 4 subscales. These include: (a) cultivating change talk, (b) softening sustain talk, (c) partnership, and (d) empathy (MITI 4.1, pp. 5–10). The global scale uses a Likert scale from 1 (low) to 5 (high) to determine an "overall impression of the clinician's use of MI" (MITI 4.1, p. 3). The global-technical behavioral scale counts specific counselor behaviors: (a) giving information, (b) persuade, (c) question, (d) simple or complex reflection, (e) affirm, (f) seeking collaboration, (g) emphasizing autonomy, and (h) confront (MITI 4.1, pp. 13–14).

For this project, six sessions (3 TAU and 3 SC) were selected randomly for review. A 20-minute segment was evaluated using the MITI. The results from the treatment fidelity examination can be found in Table 1.

Reliability is measured by having coders rate sessions against a "gold standard" (Moyers, Martin, Manuel, Miller, & Ernst, 2010, p. 27), which entails viewing and coding video segments of counseling sessions already coded by experts.

Training usually requires establishing proficiency on three levels: (a) coding for utterances (client speech), giving information, and identifying open/closed questions; (b) reflections and MI-adherent and nonadherent counselor statements; and (c) global ratings. For this project, six sessions (3 TAU and 3 SC) were randomly selected for review. A-20 minute segment of each tape was evaluated. The coding lab is involved in ongoing MITI coding, so only one session of the six was double coded. Coders were blind to group assignments. Based on criteria suggested in the application of the MITI, all six sessions met the standard of good MI in both global measures and the percentage of complex reflections. The reflection–question ratio fell between fair and good practice for the SC intervention (see Table 2).

Measurement points. Measurement occurred at two points for each dependent variable. For both dependent variables, the pretest measurement occurred at the intake session (Time 1). For the change talk dependent variable, the posttest measurement took place after Session 4 (labeled Time 2 for analysis). For the client satisfaction dependent variable, the posttest measurement took place 2 weeks after final treatment (Session 5 labeled Time 2 for analysis).

Data Analysis

To answer the first research question, a one-way analysis of covariance (ANCOVA) was conducted. The independent variable was a marker that identified whether a person was in the TAU group versus the TAU + SC group. The dependent variable was change talk at Time 2. The covariate was change talk at Time 1. In order to examine the tenents of the second resaerch question, an independent samples

t-test was used to determine if client satisfaction at Time 2 varied as a function of TAU versus TAU + SC. To address the third research question, the following four-step analysis detailed by Rovai, Baker, and Ponton (2013) was conducted: (1) all transcription was read three times to formulate a sense of the data; (2) codes were then developed, which were numbered according to emergent ideas or concepts from reading the transcriptions. Once this was completed, the categories were reduced to a list of the major categories identified; (3) a list of common themes was established, and finally; (4) all results were then discussed, identifying major themes.

Results

Means and standard deviations for all quantitative variables can be found in Table 3. For the client satisfaction questionnaire, the midpoint of the scale is 2.5. For client satisfaction, the mean is well over the midpoint.

Research Question 1

A one-way analysis of covariance (ANCOVA) was computed to investigate the tenets of the first research question. The independent variable included a treatment group and a control group. The dependent variable was change talk frequency at Time 2. The covariate was change talk frequency at Time 1. A preliminary analysis evaluating the homogeneity-of-slopes assumption indicated that the relationship between the covariate and the dependent variable did not differ significantly as a function of the independent variable, $F(1, 17) = 2.647$, $MSE = .093$, $p = .128$, partial $\eta^2 = .169$. This finding suggested no interaction effects. Levene's test for homogeneity of variance was statistically significant, $F(1, 15) = 9.740$, $p =$

.007. The ANCOVA was nonsignificant, $F(1, 17) = 1.065$ $MSE = .104$, $p = .320$. The strength of relationship between the independent variable and the dependent variable was weak, as assessed by a partial η^2, with the independent variable accounting for 7.1% of the variance in the dependent variable, holding constant change talk frequency at Time 1. The means for the treatment group and control group were adjusted for initial differences. The treatment group adjusted mean was .721, while the control group adjusted mean was .883. Follow-up tests of these means were unnecessary given the statistically nonsignificant ANCOVA results. The results of the ANCOVA showed that there was no support for the tenets of the first research question.

Research Question 2

An independent samples *t*-test was computed to see if client satisfaction varied as a function of TAU versus TAU + SC. As Ritchey (2008) noted, the independent samples *t*-test is the appropriate statistic to compute when a single continuous variable is used as a dependent variable, and a dichotomous variable is used as an independent variable. This criterion is met for the current analysis scenario. Results of the independent samples *t*-test suggest that there is no difference in client satisfaction between the TAU group ($\bar{x} = 3.65$, SD = .49) and the TAU + SC group (M = 3.81, SD = .13) ($t = 0.944$, $df = 15$, p = .369). It should be noted that the Levene's test for equality of variances was statistically significant for the independent samples *t*-test ($F = 12.979$, $p = .003$), a factor that should be taken into account when interpreting the results. It should also be noted that the independent samples *t*-test is a

parametric statistical technique, meaning that it is viable when the sample size is 30 or greater (Ritchey, 2008; Sprent, 1989). The current sample size is 17; as such, a nonparametric statistical technique is preferable. Sprent (1989) recommended using the Mann-Whitney *U* test as an alternative to the independent samples *t*-test when sample size is less than 30 but greater than 2. Results of the Mann-Whitney *U* test ($U = 32.00$, $p = .690$) are nonsignificant, suggesting that there is no difference in client satisfaction between TAU versus TAU + SC at Time 1.

These results may be due to the fact that the number of subjects was well under the threshold needed to detect statistically significant results within the data. A final sample of 17 completed surveys was obtained. An a posteriori G*Power analysis (Faul, Erdfelder, Buchner, & Lang, 2009) suggested that this sample size is inadequate. As part of the G*Power calculation, an alpha level of 0.05, a statistical power of 0.8, a medium effect size of 0.5 and a two-tailed *t*-test difference between two independent means model was assumed. The resultant G*Power calculation with these parameters suggested that the minimum sample size should be 128 respondents, with 64 being in each group. Thus the final sample of 17 respondents was well below the minimum sample size needed to detect statistically significant effects.

Research Question 3

Table 3 notes the common themes discovered as a result of coding all 17 Session 5 transcriptions. For TAU + SC, the common themes that emerged were the option for individual counseling, followed by acceptance of self, and increases in positive thinking. Additional themes mentioned by some included liking a writing

exercise, having more control of self, and a reduction of isolation, among others. As a point of interest, the two TAU common themes represented by this group were having more structure and a suggestion to increase the length of the program.

Discussion

This study had three research questions. The first question was: What is the impact of TAU (treatment-as-usual) + SC (self-compassion) over TAU on frequency of change talk? The second research question considered was: What is the impact of TAU + SC over TAU in terms of client satisfaction? The third question was: What themes emerge from the participants when asking open-ended questions of the experiences of the self-compassion and/or motivational treatment interventions? The results indicated that there was no statistical significance between the two groups for the first two questions.

There are two possible reasons for these findings of no statistical significance. First, the study was underpowered. Second, the self-compassion component does not add any value to efficacy beyond TAU. In terms of statistical power, an a posteriori G*Power analysis (Faul, Erdfelder, Buchner, & Lang, 2009) suggested that this sample size was inadequate. As part of the G*Power calculation, an alpha level of 0.05, a statistical power of 0.8, a medium effect size of 0.25, and an ANCOVA model with fixed effects, main effects, and interactions was assumed. One covariate, two groups, and only one degree of freedom in the numerator was also assumed. The resultant G*Power calculation with these parameters suggested that the minimum sample size should be 128 respondents. Thus, the final sample of 17 respondents was

well below the minimum sample size needed to detect statistically significant effects in the ANCOVA analysis.

The other possibility is that the self-compassion component does not add any value to efficacy beyond TAU. Because TAU is MI, it may be that the counseling style and approach is already conducive to enhancing and increasing SC.

Additionally, MI counseling styles would create an environment where self-efficacy is enhanced in a compassionate, accepting manner for young adults, allowing them to feel valued and heard. Feeling valued and heard would develop a sense of capability by attending to what they hope to accomplish in a treatment setting while also nurturing a relationship built on being nonjudgmental, compassionate, and focused.

When looking at treatment models for young adults, any form of treatment assistance received by the participants was seen as helpful, as noted in the coding of common themes in responses to the third question. Being able to be seen and attended to individually was valued. Counselor style and perspective was seen as important to the participants; feeling listened to, accepted, and not judged, and having patience with their early recovery issues all seemed to be helpful. Both treatment conditions had an emphasis on being compassionate during the treatment sessions, so perhaps the counselor's style was of a more significant importance than the content of the sessions. Being able to continue receiving their suboxone was a prime motivation to attend counseling such that the counseling sessions were of secondary importance to them. The duration of the intervention may not have been long enough. This was

mentioned by a few of the participants, and when they were asked how much longer they would recommend, the most frequent response was about two months total, weekly or twice per week.

Because the results showed that there was no significant advantage to adding self-compassion skills trainings to treatment-as-usual but the client satisfaction scores for both groups yielded high satisfaction scores, it may be that both treatment approaches have some value for young adults. The importance of similar satisfaction from the study participants may result in higher engagement or retention of young adults in a treatment setting. Also of note was the willingness of clients to attend more than brief interventions. Any treatment program would need to factor in the needs of young adults as found in the common themes, providing individual care options and creating treatment climates where they feel accepted and not judged and where they can eventually learn to accept themselves by experiencing positive influences.

The effect of self-determination (being ready to change and wanting to change) was mentioned by many of the patients as a significant factor in engaging and improving while in treatment. This perception could be a result of the need to see themselves as more independent and able to manage themselves without help, or could result from the severity of shame at not being able to manage their lives on their own.

In addition to the aforementioned underpower of the study, two limitations should be considered with regard to this study. First, the two treatment groups' areas

of focus were not similar enough, as one focused on skill acquisition and the other on a client-led discussion about issues related to recovery from primary substance abuse. The MI counseling style and approach can provide a counseling climate where the client is offering a change talk and commitment language; necessary components to eventual engagement in making actual changes. A skills training activity is a highly counselor-agenda driven. This is counter to the emphasis in MI of creating an agenda-sharing environment with less dependence on the counselor to lead the session with the possibility of higher engagement during counseling and more opportunity for commitment language to emerge in sessions. Clients responded differently and also valued the skills training equally, based on client satisfaction scores relating. Second, although 44 participants were screened at intake for the study, only 23 met the inclusion criteria. There were six participants who eventually dropped out of the study, most commonly due to a return to using opiates. The remaining 17 participants who completed this study did not allow for an adequate sample size to be able to generalize to the larger population.

Notwithstanding the aforementioned limitations, the results from this study do suggest implications for practice. Parts of this study could be adapted to enhance or offer additional services based on the findings, particularly within an individual counseling context. Client satisfaction was high despite the limitations of the study. For example, simply completing a CSQ upon completion of a treatment service resulted in helpful information for ongoing program development, such as learning how to integrate unmet developmental needs or skills while also managing the early

recovery issues that were present. Integrating self-compassion training into group and individual meetings can offer additional tools for patients' care. Offering a MI approach to counseling within an individual context was highly praised. Structuring treatment services was important, but the specific frequency of services was not as crucial. When participants were asked how many more sessions to add to the three sessions offered in the study, they suggested continuing treatment for about two to three months longer, which is typical in early phases of initial treatment.

The results from this study suggest two implications for research. First, the study did show some positive results when looking at the outcomes from the patient's perspective. Client satisfaction remained high for those who completed the study. It would have been interesting to redesign the study so that the two groups were more similar in structure and content. Also, it might have been advantageous to divide the 18–25 age range into two subsets, one for 18–21 and one for 22–25, to see if life differences and development made a difference in outcomes. And finally, emphasizing the role of normal developmental processes using Arnett's (2005) model to develop treatment activities and services may have been equally beneficial. Making sure there is an adequate referral pool, money, time, and focus in a medical clinic would also be advisable.

Second, a focus on how experiences of shame and its relationship to unmet development for those who have suffered from substance use dependence may also merit some attention. The life skills and resources that young adults require to navigate early recovery and the treatment models that address them are specifically

needed. Co-occurring substance use and mental health diagnoses may have a significant impact and interfere with young adults achieving the treatment gains normally seen in substance abuse treatment centers. There is value in continuing to conduct research in treatment clinics. However, more resources are needed to ensure that such research is handled in a manner that incorporates well-trained researchers, statisticians, and clinicians onto an interdisciplinary team.

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Table 1

MI Fidelity Ratings for the Experimental and Control Groups

Measure	Control (TAU)	Experimental (SC + TAU)
Relational global measures	4.2**	4.2**
Technical global measures	4.0**	3.3*
Reflections to question ratio	2.2**	1.3*
% complex reflections	66%**	69%*

* met threshold for Fair.

** met threshold for Good.

Table 2

Means and Standard Deviations, Study Variables

Variable	M	SD	Min.	Max.
Treatment versus Control Group (1 = Treatment)	0.47	0.51	0	1
Change Talk Frequency in Percentage, Time 1	0.92	0.09	0	1
Change Talk Frequency in Percentage, Time 2	0.81	0.32	0	1
Client Satisfaction Questionnaire	3.73	0.37	1	4

Note: n = 17.

Table 3

Major and Minor Themes for SC + TAU

Research 3 Questions

1. Experimental and Control Groups
    a. Describe your overall experience participating in this study.

2. Experimental Group
    a. What aspects of the self-compassion exercises did you find to be helpful?
    b. What aspects of the self-compassion exercises were challenging?
    c. What suggestions do you have for helping future clients complete the self-compassion exercises?
    d. What does self-compassion mean to you?
    e. Do you feel you have become more self-compassionate? If so, how would you describe this?
    f. Did working on self-compassion and completing the self-compassion exercises affect your recovery from substance abuse? If so, how? If not, please say more.
    g. Did you find some of the self-compassion exercises easier than others?
    h. Would you continue to use certain self-compassion exercises?

3. Experimental and Control Groups
4. Was the treatment you received helpful to you? Why or why not?
5. How did the treatment you received help you in achieving your treatment goals?

SC+ TAU	MAJOR THEMES
One-on-one counseling	1. I've never sat down with anybody to make me realize that what I did is okay. 2. It was good. I'd sit and talk to you one-on-one. It's been a nice thing. 3. I don't think a group would benefit me, due to being a pretty shy person and I wouldn't talk as much. 4. I can just open up . . . not be judged by a bunch of other people . . . (comparisons). 5. I realized I really couldn't have done it by myself. And having somebody on your team about your recovery and being able to just be in a closed space with an unbiased individual is really valuable.

(continued)

Table 3 (continued)

SC+ TAU	MAJOR THEMES
Acceptance of self	1. It really helped me realize that I'm a human being 2. Liking yourself, being nice to yourself. Taking it easy on yourself. 3. I've always been really, really hard on myself . . . I've never been nice to myself. I'm really nice to other people. So it made me not be as hard on myself. 4. I would say is just learning to cope and live with your faults in a healthy way. And just loving yourself.
Positive thinking	1. Basically thinking about using different words rather than focusing on that . . . trying to just think what you could do better next time . . . nicer to yourself. 2. The self talk . . . working on that was helpful or me. 3. Being nice and kind to myself. . . . Realizing that I'm being mean to myself, cause then I'm gonna be able to talk myself out of being mean to myself.
	MINOR THEMES
Writing	1. I liked the one where he had to write something like in my own words about myself that I didn't like, and then switching it to help me. 2. Using something that I was writing that I completely hated about myself and I switched it to completely. 3. Writing the letter . . . it was nice because I asked my best friend to help me out . . . just nice to hear from him.
Structure	1. I like coming to the meetings; the structure of these settings, so just having the structure of having to come every week. 2. Coming to sessions weekly, more than drug abuse, figure out what causes drug abuse, better about self, hope

(continued)

Table 3 (continued)

Control of self	1. I feel like I have better control over my feelings and my emotions. 2. Being able to give myself those timeouts before I escalate
Mindfulness/meditation	1. The meditation . . . cause I liked it . . . things that you enjoy doing I feel like they're easier. 2. I really like the meditation one.
Mindfulness/meditation	3. The meditation . . . cause I liked it . . . things that you enjoy doing I feel like they're easier. 4. I really like the meditation one.
Reduction in isolation	1. Understanding . . . knowing what you can do and realize everyone has got their own issues and you got yours. 2. Like . . . those questions . . . where do you feel separated from other people . . . I don't feel different from other people . . . this helped me to realize that.
Increase in the frequency of program	1. Maybe longer in the amount of weeks . . . it might take a little bit longer for people. 2. I think the program does need to be longer.

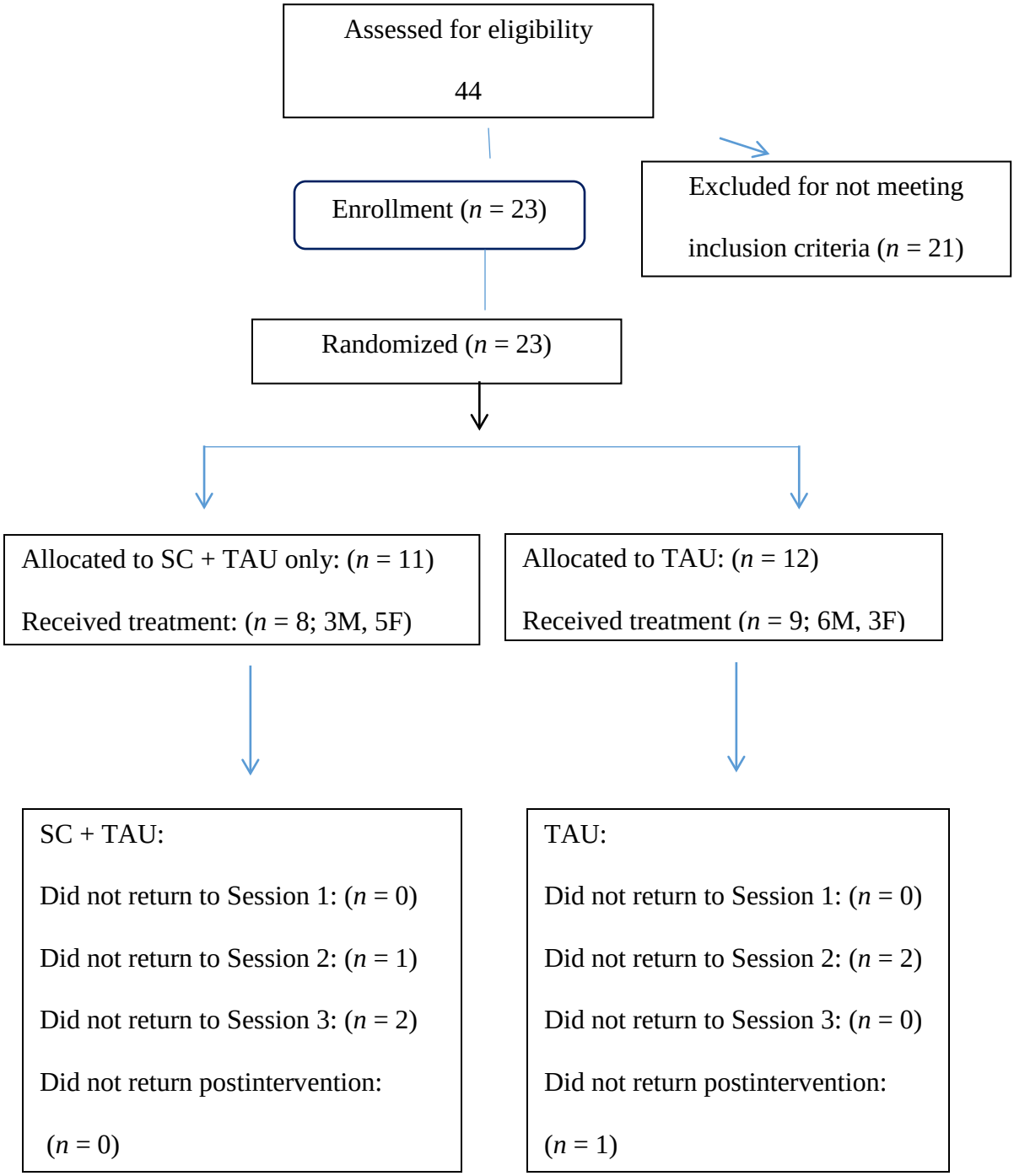

Figure 1. Study participants flow chart.

Chapter 4: General Conclusions

The intent of this chapter is to provide a summary of the findings of the literature review (Chapter 2) and the results of the report of original research (Chapter 3). This chapter therefore discusses the combined findings, identifies common themes between chapters, and draws final conclusions. Included in this discussion is an identification of significant results, knowledge gaps, and future research directions that will inform the area of young adults and opioid addiction.

Chapter 2 Summary

The literature review presented in Chapter 2 was related to the concept of self-compassion among young adults with opioid addiction. The findings of the literature review are summarized below, followed by an overview of the motivational interviewing (MI) counseling approach, the limitations of the literature review, a discussion of the findings, and recommendations for additional research.

Findings

Several themes emerged in the literature review, including a rise in opioid addiction among 18- to 25-year-olds, a model for young adult developmental needs, and the potential role of self-compassion in addictions treatment.

Opioid addiction among 18- to 25-year-olds. The addictions treatment community has reported a rise in the patient population of young adults (ages 18–25) addicted to opioids (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010a, 2011, 2012). This rise in opioid-addicted young adults is likely

due to their increased access to illicit pain medications. As the addiction worsens and the associated costs increase, it is not uncommon for this population to start using heroin, either by smoking or intravenously. Moreover, as young adults present to addictions treatment centers, it has become a challenge to offer treatment services relevant to the needs of these young people.

Young adult developmental needs. Arnett (2005) proposed a model highlighting the five main areas in the normal developmental process of young adults which can be affected by substance abuse. These areas include: (a) an age of identity exploration in relation to love and work that involves learning who they are more fully and determining what would work for them in a romantic partner and in their career path; (b) an age of instability resulting from various transitions, including moving from their parents' home to college (for many young adults) and/or experiencing more independence from family, and establishing new friendships; (c) an age of self-focus in life as they attempt to establish themselves as more independent persons by exercising and trying out new experiences and activities to build greater confidence; (d) an age of feeling in between as they assume more responsibility for daily life tasks such as keeping a budget, establishing their own home, and developing their individual lifestyles, and they deal with less supervision from older adults like teachers and parents; and (e) an age of possibilities and feeling optimistic about life's opportunities. The main concern is that, when substance abuse affects young adults, their developmental needs can remain unmet. Often, they also feel alone due to a loss of ties to family and sober friends as a result of their

addiction, and a sense of shame and guilt that they have not progressed in life more predictably; these experiences in turn can lead to feelings of depression and anxiety.

The role of self-compassion. Researchers have found that incorporating self-compassion into a person's life can help ease anxiety and depression (Gilbert & Procter, 2006; Neff, 2011). Because depression and anxiety often coexist with substance use disorders and shame from the experiences of living an addiction lifestyle, incorporating self-compassion into treatment can assist individuals with re-establishing a normally functioning life. A primary focus of self-compassion, in part, is to teach people how to accept being kinder to themselves and offer understanding instead of judging themselves harshly.

Neff (2011) has built on the work of other researchers and practitioners of compassion and self-compassion practices to create a useful definition of the concept and activities that allow individuals to easily apply it in their daily lives. How is self-compassion defined? Neff (2011) has defined self-compassion as having three components:

- kindness toward self (self-kindness), which requires "being gentle and understanding of ourselves rather than harshly critical and judgmental";
- recognition of our common humanity, which involves "feeling connected with others in the experience of life rather than feeling isolated and alienated by our own suffering"; and

- recognition of mindfulness, which entails “that we hold our experience in balanced awareness, rather than ignoring our pain or exaggerating it” (p. 39).

Motivational Interviewing

Motivational interviewing is a counseling approach designed to elicit change talk. Change talk is client language that encourages individuals to begin to implement change in their lives. Miller and Rollnick (2013) defined change talk as “any client speech that favors movement toward a particular change goal” (p. 406). Significant to the practice of MI, it is essential for the therapist to access client change talk. Miller and Rollnick asserted that the amount the client talks about change and the level of commitment language used serve as good predictors of the client’s willingness to engage in change.

In addictions treatment, the usual behavioral changes of focus are abstinence, relapse prevention, attending treatment sessions, and completing counseling assignments. With some addictions care, such as with opioid addictions, managing medications and engagement in behavioral treatments that support a medication-assisted form of care are also important components of change. The objective of this literature review was to identify treatment for young-adult addiction that would easily combine with existing treatments using self-compassion skills training—the target outcome of such treatment being to increase patients’ change talk language leading to committment to changes from behaviors that damage the quality of their lives.

Limitations

There were several limitations to the literature review. First, at the time that the review was conducted, there were very few articles that addressed addiction-related treatments, particularly related to opiate addiction. Second, there were very few findings in the literature that would provide guidance to the practitioner on how to combine self-compassion with substance use treatments. Third, another gap in the available literature for review was research addressing the relationship between shame and self-judgment among young adults.

Finally, there was a dearth of literature addressing delayed development when designing treatment models for younger adults, as well as examining what happens when young adults with addiction issues that have altered the course of their development struggle with moving forward with adulthood.

Discussion

The literature review identified a gap in the research related to young adult opioid addiction and the application of self-compassion in the treatment of this population. Another gap identified was how effective treatments could be adapted to serve the young adult client. Given that the issues of shame and not moving forward in life are prominent among this population, many adult treatment models that assume capability and skill may not be effective in treating these young adults with opiate and other serious drug addictions who are lacking in maturity, confidence, and self-efficacy. An additional concern is the effect of delayed development due to living with addiction. For example, completing education or career training programs,

forming positive peer affiliations, and living independently were struggles for those who had experienced drug addiction; these challenges in turn caused stress, anxiety, and concerns about how to make up for those losses. Some clients also experienced criminal charges such as felonies, which further complicated and compromised their options in these important areas of development.

Recommendations

Based on the findings of the literature review, it was determined that continued research needs to be conducted to identify strategies for assisting young people within a treatment environment to develop the skills, hope, resilience, and calming perspectives needed to thrive in the early recovery process and beyond. Further exploration is also needed into questions of young adult development and how substance use disorders interfere with that development. Additionally, future reviews might examine research on how unmet life milestones related to the abuse of opioids affect a person's feelings of shame and what guidance the literature provides to address this issue. It is imperative that we identify effective solutions to these problems to help safeguard the futures of these young adults.

Chapter 3 Summary

Chapter 3 discussed the outcome of a study focusing on the impact of self-compassion training with treatment-as-usual. The study compared two groups that presented with a specific drug addiction (opioid addiction) within a specific age range (ages 18–25). The research questions were the following:

1. What is the impact of TAU (treatment-as-usual) + SC (self-compassion)

over TAU on frequency of change talk?

$H_{0:}$ TAU + SC *does not impact* the frequency of change talk over TAU.

$H_{1:}$ TAU + SC *does impact* the frequency of change talk over TAU.

2. What is the impact of TAU + SC over TAU in terms of client satisfaction?

   $H_{0:}$ TAU + SC *does not impact* client satisfaction.

   $H_{1:}$ TAU + SC *does impact* client satisfaction.

3. What themes emerge from the participants when asking open-ended questions of the experiences of the self-compassion and/or motivational treatment interventions?

A randomized pretest–posttest design was employed to answer research question 1, and a randomized posttest design was used to answer research question 2. Research question 3 utilized a phenomological design to explore study participants' experiences with the study. Measurements consisted of the Motivational Treatment Integrity Scale (MITI; Moyers, Martin, Manuel, Miller, & Ernst, 2010), the Client Language EAsy Rating (CLEAR; Glynn & Moyers, 2012), and the Self-Compassion Scale (SCS; Neff, 2003a).

Findings

Independent *t*-tests analyzed the data related to the first two research questions. Results of the analyses found no statistically significant differences in frequency of change talk or client satisfaction between the two study groups. An ANCOVA accounted for any changes between the two groups over time from intake

to Session 4, Time 1 and Time 2. Qualitative data collected to address the third research question yielded several common themes among those who received self-compassion skills training. The top three themes discovered based on being mentioned by 65% or more of the participants was a higher acceptance of self, thinking more positively about themselves, and a strong preference for one-to-one counseling over other treatment activities such as groups.

Limitations

Perhaps the biggest limitation of this study was the sample size of 17. It is likely that a much larger sample size would have yielded more definitive and reliable results. Conducting unfunded research of this nature poses challenges for any researcher, including the significant amount of time and effort required to recruit greater numbers of clients. Moreover, the study was constrained by the inability to establish a focused research track within a treatment program, as well as the inability for other research professionals, such as behavioral health statisticians, to work in concert with the treatment professionals conducting this real-world research. Additional issues are the need for the treatment professionals involved in the study to be trained in and well-versed with young adult issues in order to more effectively engage with and retain these clients in their treatment programs. There are very limited treatment options for this population at all levels of care. Many programs available for young adult treatment do not have staff members who would meet the practice requirements to use evidence-based treatment models such as MI, and this would also pose a limitation, especially if not used with fidelity. A final

consideration is the limited availability of clinical supervisors who can effectively focus, direct, and collaborate with other entities such as job training programs, educational institutions, financial institutions, nutritionists, and other medical and behavioral health professionals to assist young adults in their early recovery efforts.

Discussion

Despite its limitations, this study was able to shine a light on a particular model to address what young adults with opioid addictions can teach us about the frequency, intensity, and type of treatment models needed to engage and retain them and therefore provide relief from the debilitating effects of addiction. This type of research would require a much larger sample size to generate any broad conclusions related to whether or not self-compassion would increase change talk towards specific behavioral targets. It may also be true that those who continue in treatment will need more than a few sesssions for the practice of self-compassion to bear any fruit. Nevertheless, this study yielded insightful information regarding client preferences and experiences such as improved self-efficacy, thinking more positively, and the types of treatment services that they found most effective (individual counseling over group counseling).

Recommendations

Further research needs to be conducted to assist the treatment community by identifying the essential components necessary to meet the needs of this young adult population. Models could address unmet developmental needs such as assistance with managing finances, how to get back on a career path, meeting and developing

sober friends, and reuniting with healthy significant family members and other social supports. Utilizing the research on healing from shame experiences with a self-compassion focus and modifying concepts to fit younger age groups might also be helpful. For opioid addiction specifically, additional investigation is needed into treatment approaches that combine medication with other types of treatment activities like skills training, family therapy, and other models that would serve young adults more effectively.

Combined Discussion

Chapters 2 and 3 both identified the rise in young adult opiate dependence. Chapter 2 identified the trends in the literature regarding this increase in addiction, while Chapter 3 focused on the struggle within treatment agencies serving young adults with inadequate models of care. In particular, the literature review highlighted the importance of creating models of care that also address the developmental issues of this age group (Arnett, 2005), and the significant role that SC and MI can play in addressing the shame and guilt associated with chronic opiate dependence (Neff, 2011; Miller & Rollnick, 2013).

A brief individual counseling model was utilized in the research study presented in Chapter 3 to treat young adults with opioid addiction in an effort to address the issues of shame, developmental delays, and motivation. The aim of this dissertation project was thus to determine whether applying a SC component within a MI counseling style of treatment would increase movement toward change. It was hypothesized that adding a practice that would enhance addiction treatment (SC)

might reduce shame and guilt and thus allow more traditional care, such as MI, to lead to increasing change talk.

The research yielded several findings of interest. First, SC + MI and MI treatments were evaluated as equally desirable based on client satisfaction scores. Second, the SC + MI arm of the study found three common themes when asking open-ended questions: (a) acceptance of self, (b) positive thinking, and (c) preference for individual counseling. Third, when the MI results were combined with the SC + MI results, the following additional themes emerged: (a) a desire to develop greater self-control, (b) a preference for more structure, and (c) a desire to increase the length of treatment.

In this study, feeling accepted was related to reduced shame, while participants mentioned improved self-control in the context of greater mood regulation. Furthermore, participants indicated that having a place to go weekly was helpful. However, the frequency of the treatment was not as important. Interestingly, attending a group was not the first choice of participants given the stigma often associated with heroin addiction. However, for some participants, reducing that stigma through an individual MI counseling approach allowed other treatment options such as group therapy to become more acceptable.

Future Research Agenda

Following are some suggestions to further the research agenda of contributing to improving the early recovery efforts of opioid-dependent young adults. Several qualitative approaches could be taken as part of future research studies, including:

- Semistructured interviews with patients to determine their lived treatment experiences regarding what was most to least helpful.
- Semistructured interviews with patients who attended only group counseling and those who attended only individual counseling to investigate any differences that emerge between the two groups.
- A series of case studies following two or three patients over the course of their care. Each case would ideally be receiving different treatment services of their choice, such as group or individual, or individual with family involvement. Each person studied would complete a series of self-compassion skills trainings and would evaluate their satisfaction with the care received upon the conclusion of the study.

Quantitative approaches that may be useful to further this research agenda include:

- Comparing the outcomes of patients undergoing the same treatment who received medication to those who did not receive medication.
- Identifying and comparing patients who presented as more stable with housing, work, and sober support in an episode of care to those who did not have predetermined stable markers.
- Further investigating whether adding a single session of self-compassion to TAU in a group setting differs from an individual setting.
- Exploring which variations in structure and frequency improve overall outcomes within the young adult population.

- Measuring the outcomes of treatments that focus on the significant developmental needs identified by Arnett (2005).

The research conducted for this dissertation may inform those in the treatment community who are interested in providing assistance to young adults. This study expanded on the findings of other studies by its specific focus on young adults with addiction histories. The study highlighted the importance of maintaining an accepting and nonjudgmental counseling attitude—which includes active listening and providing assistance for developing skills—since such an approach helps to improve an overall sense of self-compassion and leads to less shame and more self-acceptance. What is also clear from this study is that utilizing flexible models of treatment, being flexible within those models, and treating opioid patients who are medically stable are all imperative elements in order for clients to benefit from behavioral treatments.

Perhaps the best way to sum up what was most important to the patients in this study is to share a comment made by one of the participants:

> I just feel like if you guys were to just starting the program and you guys are trying to mold this better program . . . that should be a huge thing that you guys should discuss between you. . . . It's the listening that is one of the key points. You just have to listen to what the person is saying, and what really hurts them so that you guys can take it from there. Because those are the things what are going to really change a person or really gonna make a difference, you know.

The two approaches of self-compassion and motivational interviewing—whether

employed separately or integrated—were clearly shown to be helpful to patients. Both of these approaches require creating an environment where the client and his or her needs are primary that involves a practitioner who listens to and hears the client accurately while demonstrating a kind, accepting, and nonjudgmental attitude in session. Given that providers are likely to see the need for increased treatment of this nature, it is therefore a worthy undertaking to be continued beyond this dissertation project.

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APPENDICES

Appendix A: Copy of IRB Approval Letter From Kaiser Permanente

KAISER PERMANENTE®

NOTIFICATION OF INITIAL APPROVAL (contingencies met)

November 27, 2013

To: Kathyleen Tomlin

CC:

Barbara Bachman
Gail Morgan
David Mosen

No further contacts were listed on this study.

Re: Study ID: Pro00004024
Study Title: FOCUSING ON SELF COMPASSION WITH YOUNG ADULT OPIOID DEPENDENTS

As you know, the study referenced above was reviewed and given contingent approval by the Kaiser Permanente Northwest Institutional Review Board (KPNW IRB) on 11/20/2013. The contingencies have been satisfied. Therefore, this study now has final approval. The approval expires on **11/20/2014**.

A final consent form with the IRB approval date is now available in the eIRB system for your use with participants. Please send a copy to the appropriate organization or individual (e.g., study sponsor, coordinating center).

NOTE: Only KPNW IRB approved consent forms with the IRB approval date are to be used with study participants. If you have any revisions or edits to the consent form, it must be sent to the Research Subjects Protection Office (RSPO) via a study modification through the eIRB for processing. Use of an unapproved consent form or use of a previous version of a consent form constitutes a protocol violation and must be reported to the IRB as a reportable event through the eIRB system.

The IRB also approved a Privacy Rule authorization. Use this URL/link to find instructions for your compliance with Privacy Rule provisions relating to research participant authorization:

http://www.kpchr.org/rspopublic/public/common/getdocbyname.aspx?filename=PRIVACY RULE INSTRUCTION SHEET.pdf

The IRB waived the Privacy Rule authorization requirement for the purposes of, and only for the purposes of, recruitment. This waiver was granted to allow the research team to access protected health information prior to obtaining written authorization.

Please contact Gary Ansell (503-335-6735) in the CHR Compliance Office within the next two weeks to schedule a data review for your project. This review determines if any compliance documents or Risk Assessment and Mitigation Process calls are needed prior to disclosing data/samples. Please note that no data transfer may occur for this project until all compliance documents are on file with the CHR Compliance Office.

If your study or study-related documents require modification, you must seek IRB approval for these changes before they are implemented. If, during the course of your study, you need to make a modification in order to protect the rights, safety, or welfare of a participant prior to obtaining IRB approval, you are required to notify the IRB within five business (5) days of this action. In addition, you must promptly notify the IRB of any unanticipated problems associated with this study.

Federal regulations require that all studies be reviewed at least annually. It is your responsibility to ensure that you reapply for approval at least one month prior to the study approval expiration date.

Please use this notification of approval should the funding agency require documentation of IRB approval. Our Federalwide Assurance number is FWA 00002344 – IRB 00000405.

Sandy Heintz

Sandy Heintz, CIP
Administrator
Research Subjects Protection Office
3800 N Interstate Avenue
Portland, OR 97227
(503) 335-6357

Appendix B: Ceding Letter From Oregon State University Institutional Review Board

Institutional Review Board
Office of Research Integrity | Oregon State University
B308 Kerr Administration Building, Corvallis, OR 97331-2140
Telephone (541) 737-8008
irb@oregonstate.edu | http://research.oregonstate.edu/irb

Submission Acknowledged

Date of Notification	09/16/2015		
Study ID	5977		
Study Title	Focusing on self compassion with young adult opioid dependents		
Principal Investigator	Cass Dykeman		
Study Team Members	Kathyleen Tomlin		
Submission Type	Continuing Review	Date Deferred	01/16/2014
Funding Source	None	Proposal #	N/A
PI on Grant or Contract	N/A	Cayuse #	N/A
External Approval Date	08/04/2015	External Expiration Date	08/04/2016
Status	Approved at external institution		

The IRB has reviewed your submission of external IRB Documents dated 09/05/2015. No further action is required at this time.

The agreement which permits OSU's IRB to rely on Kaiser Permanente IRB for oversight of this study remains in place. You may proceed with the project without further OSU IRB review.

It is the responsibility of the OSU investigator to ensure that the OSU IRB file for this study matches the external IRB file. Please provide OSU's IRB with pdf versions of all approval documents issued by Kaiser Permanente and all study documents approved by Kaiser Permanente within 30 days of approval for all submission types (i.e., initial, revisions, annual reviews, adverse events).

Please note that revisions to this project may impact this determination.

Principal Investigator Responsibilities for OSU and IRB of Record:

Oregon State University (OSU) has agreed to cede oversight for a study that engages one or more external institutions in research. This document is intended to outline the responsibilities for the investigators at each institution to ensure compliance with all applicable regulations and policies.

The IRB of Record PI will:

1) Identify OSU as a collaborating institution in the documents to be submitted to the IRB of Record and indicate the role of the OSU researcher(s).

2) Promptly provide the OSU PI with:
   a. All approval Notice(s), including those issued for initial applications, continuing project reviews, and revisions;
   b. Documents approved by the IRB of Record, including, protocol, recruitment materials, test instruments, and informed consent documents, etc.

3) Notify the OSU PI of the standards and guidelines of the IRB of Record for the reporting of any post-approval events, such as (i) proposed changes in study activities, (ii) adverse events or

Institutional Review Board
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unanticipated problems, and (iii) protocol deviations. Collect related reports and provide them to IRB of Record within required reporting timeframe.

4) Notify the OSU PI immediately if there is a lapse in IRB approval.

Oregon State University's (OSU) PI will:

1) Notify the IRB of Record PI about any special local considerations that should be taken into account by the IRB of Record.

2) Provide the IRB of Record PI with any information needed to complete the initial and continuing review of the study.

3) Assure that research activities at OSU are not initiated until all IRB of Record and OSU requirements for the study are finalized.

4) Adhere to the protocol as approved by the IRB of Record.

5) If at any time study approval lapses, cease all human subjects research activities related to the protocol at OSU, including data analysis and receipt of new samples or data. If the OSU PI determines that subjects on the study may be harmed if the research is stopped, notify the OSU IRB and the IRB of Record PI and provide justification for continuing study activities. The OSU IRB will contact the IRB of Record.

6) Promptly report all post-approval events to the IRB of Record PI. Review IRB of Record requirements regarding reportable event and cooperate with any IRB of Record or OSU investigation regarding serious or continuing noncompliance or an unanticipated problem.

7) Cooperate with any IRB of Record or OSU quality assurance / quality improvement or monitoring of the study protocol.

8) In the event of an audit, allow the institutional officials at the IRB of Record access to research and related records.

9) Maintain records for all research and related activities conducted under this agreement for at least 3 years post-study termination, and longer if required by regulations, study sponsor, or external site.

10) Respond promptly to all requests for information from the IRB of Record PI or OSU IRB, including but not limited to, the information set forth in this agreement.

Appendix C: Letter of Invitation

Flyer: **WEST INTERSTATE CLINIC**

Department of Addiction Medicine

NEW RESEARCH STUDY OPPORTUNITY

FOCUSING ON SELF-COMPASSION TO ENHANCE TREATMENT AND RECOVERY

FOR YOUNG ADULTS WITH OPIOID DEPENDENCE

Hello;

Thank you for taking the time to read this flyer. I am a student researcher who is studying how increasing one's self-compassion can help people improve their lives. Having more self-compassion can help you to eliminate negative thinking and judging yourself harshly as a result of struggling with addiction. I am particularly interested in young adults between the ages of 18-25.

As part of the work for my degree, I am required to complete a research study. As a counselor who has worked with many young people, I have noticed the devastation that addiction, particularly tP opiates, can cause. Many of the patients I work with often tell me that they feel sad, shame and embarrassment, and experience anxiety and depression from their addiction lifestyle.

Since you are required to attend treatment, I am offering an alternative treatment service that will meet the requirement for continuing in the program. Instead of attending treatment groups, you will have some brief individual sessions with me which will address your treatment needs. If you are chosen, the sessions may also focus on enhancing your own self-compassion and how this affects your life and recovery.

If you are interested in receiving individual sessions instead of starting groups as part of your treatment at our clinic, please contact me at the numbers below. I will set up an intake appointment, at no charge, to discuss this research study to determine if you qualify.

You can reach me at: ***503-331-5020*** for an intake appointment. Further information will be given at this appointment, including study forms to sign to begin your treatment requirement.

Sincerely,

Kathy Tomlin, Clinical Services Manager

Appendix D: Study Inclusion/Exclusion Criteria

Participants considered for inclusion in the study met all the following criteria:	YES	NO
1. Clients must be between the ages of 18 and 25.		
2. Clients must have completed an ASAM-based alcohol and drug assessment.		
3. Clients must agree to random assignment to one of two treatment conditions.		
4. Clients must be assessed for treatment at an outpatient level of care.		
5. Client's primary DSM diagnosis met all the criteria for opioid dependence.		
6. Clients must be physically stable and in compliance with all medications administered for their care.		
7. Clients must agree to commit to attendance at all study sessions.		
8. Client must give signed permission to be audiotaped.		
9. Clients must have a self-compassion score out of the normal range for overall or for any subscales.		

Potential clients were excluded if they met at least one of the following criteria:	YES	NO
1. Over or under the ages of 18–25, respectively.		
2. Another treatment level of care is more appropriate.		
3. Does not want to continue in the study, once started.		
4. Once informed of the study, declines to participate.		
5. Primary DSM diagnosis is something other than opioid dependence.		
6. Does not want to be audiotaped.		
7. Failure to take suboxone medication as prescribed or becomes medically unstable, rendering it difficult to proceed in the study.		
8. Client continues to use opioids.		
9. Refuses to be randomized into condition offered.		
10. Drops out of treatment.		
11. Another condition becomes more severe, requiring other forms of treatment or a different level of care.		
12. Inability to complete all study counseling sessions.		
13. Self-compassion score is within normal ranges for subscales and overall score.		
14. Client is already enrolled in another research study.		

Appendix E: Self-Compassion + Treatment-As-Usual Session Details

Session 1 Steps (55")

First 10"

1. Complete Self-Compassion Scale (SCS)
2. Review any medication management issues and recent urine drug screen results
3. General check-in

Next 30"

4. Present and define self-compassion:
    a. Self-kindness vs self-judgment
    b. Common humanity vs isolation
    c. Mindfulness vs overidentification
5. Complete "clenched fist" exercise
6. Briefly review brain functioning as it related to negative emotions and care giving systems
7. Complete exercise #2 *(self-compassion break)* from Neff website (www.self-compassion.com)
8. Handout out sayings from the exercise to fold up and carry with them to practice throughout the week

Final 15"

9. Invite participants to meditate using lovingkindness meditation from Neff CD, tape 5, track 3

Session 2 Steps (55")

First 5"

1. Complete Self-Compassion Scale (SCS)
2. Review any medication management issues and recent urine drug screen results
3. General check-in-including homework experience

Next 35"

4. Present and complete exercises #1, (*how would you treat a friend)* followed by exercise #3 (*exploring self-compassion through writing)* in session
5. Process writing experience

Final 15”

6. Invite participants to meditate using lovingkindness meditation from Neff CD, tape 5, track 3

Session 3 Steps (55”)

First 5”

1. Complete Self-Compassion Scale (SCS)
2. Review any medication management issues and recent urine drug screen results
3. General check-in-including homework experience

Next 35”

4. Present and complete exercises #7, *(identifying what we really want)*
5. Process exercise
6. Discuss how continuing to use self-compassion practices can aid them in their recovery by helping them to meet their current and long term goals.
7. Handout all seven exercises from the website for ongoing practice

Final 15”

8. Invite participants to meditate using lovingkindness meditation from Neff CD, tape 5, track 3

Treatment-As-Usual Session Details

Session 1 Steps (55")

First 10"

1. Complete Self-Compassion Scale (SCS)
2. Review any medication management issues and recent urine drug screen results
3. General check-in

Next 35"

1. Invite participants to engage in treatment planning for specific behavioral goals using standard initial treatment plan form (see attached)
    a. For the first 10", using a MI counseling approach explore different target behaviors
    b. Conduct values card sort from (http://casaa.unm.edu/inst/Personal Values Card Sort.pdf)
    c. If there is low ambivalence and clear target goals for the patient, conduct readiness assessment to see if they are ready to write a plan for change (see attached)

Final 10"

2. Summarize session and homework next steps
    a. Print out copy of values from the exercise for homework to look at throughout the week or
    b. Ask the patient to think about specific plans for change or
    c. Explore other options for them to focus on based on their treatment goals

Session 2 Steps (55")

First 10"

1. Complete Self-Compassion Scale (SCS)
2. Review any medication management issues and recent urine drug screen results
3. General check-in

Next 35"

4. Invite participants to discuss homework done and questions that might have come up from last week.

5. Identify areas of concern from their treatment plan they would like to work on during this session
    a. Determine agenda for the session by asking open questions and reflect their responses about their treatment goals
    b. Review any specific target behaviors and process ambivalence using ambivalence chart from Miller & Rollnick (2013), p. 158
    c. Tie identified goals to expectations for being in the suboxone program and process any issues they may have such as; struggles with early recovery issues, abstinence, finishing school, employment, repairing family and/or peer relationships, managing their time and daily structure or anything that is unique to the patient OR
    d. If they are ready to create a change plan, using change plan form, write out specifics during session time (see planning for behavioral change form)

Final 10”

6. Summarize session and homework next steps
    a. Ask the patient to think about specific plans for change based on treatment plan goals and objectives OR
    b. Continue to explore other options for them to focus on based on what their experiences are in between sessions that can be added to their treatment goals
    c. Offer homework options based on their responses
        i. Keeping a weekly mood log
        ii. Reviewing and thinking about their “type of ambivalence” and how it matches with their top five values and/or goals
        iii. Trying a new or practicing a behavior they are interested in, such as going to a support group meeting, monitoring nutrition, searching for assistance for managing money issues, meeting new sober people, etc.

Session 3 Steps (55”)

First 10”

7. Complete Self-Compassion Scale (SCS)
8. Review any medication management issues and recent urine drug screen results
9. General check-in

Next 35”

10. Invite participants to discuss homework done and questions that might have come up from last week.
11. Identify areas of concern from their treatment plan they would like to work on during this session
    a. Determine agenda for the session by asking open questions and reflect their responses about their treatment goals
    b. Continue to review and process any specific target behaviors and process ambivalence using ambivalence chart from Miller & Rollnick (2013), p. 158
    c. Tie identified goals to expectations for being in the suboxone program and process any issues they may have such as; struggles with early recovery issues such as abstinence, finishing school, employment, repairing family and/or peer issues, managing their time and daily structure or anything that is unique to the patient OR
    d. If they are ready to create a change plan, using change plan form, write out specifics during session time (see planning for change form)

Final 10”

12. Summarize session and next steps
    a. Ask the patient to think about specific plans for change based on treatment plan goals and objectives and identify and reinforce any commitments to change and/or
    b. Offer options to continue their care if desired and set next appointment for continued monitoring of medication OR
    c. Summarize their gains while attending the three sessions
        i. How they can continue to process any ongoing ambivalence and/or
        ii. What steps they have made towards accomplishing their goals
        iii. Anything else that they would see as helpful

Initial Treatment Plan

_____ / HRN: _____
Patient Name Health Record #

Patient Strengths/Abilities:

1.

2.

3.

Primary Issues: (CIRCLE ALL RELEVANT ASAM DIMENSIONS)

1. _____(D: 1 2 3 4 5 6)

2. _____(D: 1 2 3 4 5 6)

3. _____(D: 1 2 3 4 5 6)

Objectives/Treatment Services: *(CIRCLE ALL RELEVANT ASAM DIMENSIONS)*

1. _____(D: 1 2 3 4 5 6)

2. _____(D: 1 2 3 4 5 6)

3. _____(D: 1 2 3 4 5 6)

ASAM Level of Care (LOC) Placement: *(1, 2.1, 2.5, 3.1, 3.3, 3.5, 3.7, 4)*

Treatment Services/Activities: *(to match to treatment objectives)*

1. (status: to include time frame, who's involved, frequency and intensity)
2. (status: to include time frame, who's involved, frequency and intensity)
3. (status: to include time frame, who's involved, frequency and intensity), etc.

Patient Signature: _____ Date:

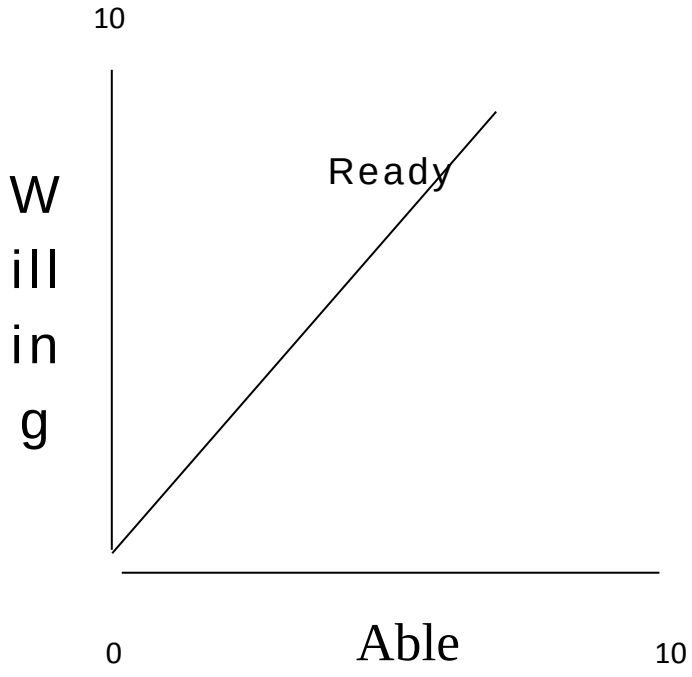
Clinician Signature: _____ Date:

Significant Other(s) Signature(s): _____ Date:

Processing Ambivalence

1. Describe what ambivalence means using definitions provided by Miller & Rollnick.
2. Using Miller, W., & Rollnick, S. (2013). *Motivational Interviewing: Helping People Change* (3rd ed.) on page 158, introduce the four different types of ambivalence grid.
3. Ask the client what behaviors do they struggle the most with as it relates to desire, ability, reasons and need to change and what type of ambivalent struggles are they encountering.
4. Using an MI counseling approach and process, assist the person to help toward resolving significant ambivalence and reinforce any change talk and commitment language.
5. Check-in along the way to determine if any readiness to move forward with their change goal(s) arises.
6. Summarize the process, as needed and at the end.
7. Repeat the process as needed.

Readiness Assessment



Barriers to Change	Solutions to Barriers
_____	_____
_____	_____
_____	_____
_____	_____

My Values	My Strengths
_____	_____
_____	_____
_____	_____

Planning for Behavior Change

1. Behavior that I would like to modify or change: *(be specific)*

_____

2. List the top three reasons for wanting to make the change(s) identified above.

_____

_____

_____

3. Identify the specific steps that will help me accomplish the change(s) I want to make:

1. _____
2. _____
3. _____

4. Identify four to five barriers that may get in the way with my ability to accomplish the desired change(s).

1. _____
2. _____
3. _____
4. _____

5. List the supportive people in my life who will assist in my desired change (s) including how they can be helpful.

Person: _____can help me by:

_____

Person: _____can help me by:

_____

Person: _____can help me by:

_____

6. By making the desired change, I am hoping I will have the following effects:

a._____

_____

b._____

_____

c._____

_____