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New York School
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Doctor of Ministry Project Final Approval

To: The Members of the Doctor of Ministry Faculty

I hereby submit the signatures of approval from my advisors and Dr. Carol Ochs for my completed Doctor of Ministry Project.

The title of the completed Project is: MEDITATION: A Coping Tool For the Addicted in a MICA Therapeutic Community Residence

I have submitted one unbound copy on 25% cotton paper to the HUC-JIR library for binding.

I have submitted velo or spiral bound copies to my mentors and Dr. Carol Ochs.

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MEDITATION

A COPING TOOL FOR THE ADDICTED IN A MICA THERAPEUTIC COMMUNITY RESIDENCE

BY

Benet Obinna Ugwu

Being the Project Submitted in Partial Fulfillment of the requirements for the Award of Doctor of Ministry Degree (D.Min) in pastoral Counseling and Care

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Dedication:

To the dead members of my family: My father Gilbert Oyiagu Ugwu, uncle Epiphanus Onyeneje Ugwu and aunt Angela Ani, My sisters Eugenia Chinyere Uzodi, and Maureen Ifeoma Ugwu. My Cousins Epiphanus Ogbonna Ugwu, and Blessing Uju Ugwu.

Appreciation:

I thank God whose grace and providence made it possible for me to undertake this study successfully. I am grateful to my mother Patricia Nneze Ugwu, and the rest of my family members for their continuous support and encouragement. I appreciate the good works of Hebrew Union College and Postgraduate Center for Mental Health faculty members. In a very special way, I thank Carol Ochs Ph.D, and Marianne Wickel, MS., LCSW for accepting to be my mentors and for their contribution to the success of this project. I am grateful to Geoffrey Lindenauer and Cari Besserman for their clinical support. I appreciate the help of Fr. Andy Struzzieri, D. Min., Kyle John, Lorna Fyffe, Donya Bobrowsky, and the host of other friends. Thank you all and God bless you.

Introduction:

In my home country, Nigeria, addicts are condemned to be laughed at, blamed for not taking charge of their lives, or even killed for being useless in society. To the best of my knowledge, there is no treatment center for alcoholics and drug abusers. They are often advised to quit, but nothing is done to help them quit. Addiction is still a blame game in which shame and guilt play a major role. To do something about this ugly situation is the reason why I work in the field of addiction.

Contrary to the above picture, addiction receives a lot of attention in the United States of America. There are many models of treatment in this country. I work in a Phoenix House MICA (Mentally Ill Chemical Abusers') community residence. The residents are affected by what goes on in their minds. They come from different backgrounds, too. Some voluntarily sign themselves in for treatment. Others are court mandated. My observation is that the residents' mental illness and medications impact their behavior. Their mood swing and their attitude change from time to time. And in addition to what the agency through the program is doing to help the residents, I am proposing, "Meditation: A Coping Tool for the Addicted."

I recognize that spirituality understood as a personal relationship to the Higher Power is a major component in addiction treatment. This important component is unfortunately neglected often in treatment programs. Spirituality is typically left to self-help programs. But healing should be for the whole person.

It is therefore this spiritual component that I want to address through my project. Spirituality is a huge area of study. I have decided to narrow my topic to an aspect of spirituality that I think will be helpful to the residents: Meditation.

In Chapter One, I intend to discuss the evolution, concepts and theories of the Therapeutic Community (TC). Therapeutic community refers to "a powerful treatment approach," that is fundamentally a self-help method developed outside of "the mainstream psychiatry, psychology and medicine (De Leon 2000, p.3)." Therapeutic Community implies the notion of empowerment by which clients are seen as actively involved in their own treatment and recovery.

I intend to show the nature of the Therapeutic Community from an historical point of view by looking at its origin in two English hospitals, namely Northfield Military Hospital in Birmingham through the effort of Rickman, Bion, Foulkes, and Main; and Mill Hill under Maxwell Jones. I will highlight the development of TC in the US as it is seen in Synanon and Phoenix House. I will emphasize the significance of the integrated model of treatment that utilizes the principles of stages of change in TC residence for mentally ill chemical abusers. The concept of "Stages of change" is a tool for matching treatment interventions to the particular stage of an individual's readiness for change.

Meditation, defined by Eknath Easwaran, is "a systematic technique for taking hold of and concentrating to the utmost degree our latent mental power." It consists in training the mind, especially in the ability to pay attention, and the will to autonomy. I intend to introduce Meditation as a coping tool that increases the propensity of thinking or reflection before action. In doing this, residents will achieve greater mastery over negative behaviors. This will be relevant to my

future ministry of beginning an addiction treatment program in my country that will include the spiritual component. It will bear the characteristics of ministry to the needy, in this case, the addicted individuals.

In Chapter Two, I will discuss the Psychological and the Theological principles that guide my project. The two psychological models/theories at my disposal are: Psychodynamic Principles and Behavior Modification Theory. It is my intention to see how certain dynamic principles inform and shape my project. With Drive Theory for instance, I will show how the behavior of our residents are biologically and psychologically determined. I will demonstrate how such behaviors are simply, either, regression, understood as a return to the earlier stages of functioning, or, signs of fixation, that is, getting stuck at a particular stage of psychosexual development. The practice of meditation will bring such behaviors to the awareness of the participants and provide them with the directives for transformation of such behaviors.

Structural Theory discusses the relationships between the structures of the mind, namely, the id, the ego and the superego. With Structural Theory, I will demonstrate how depression, anxiety, low self-esteem and other emotional problems our residents struggle with are consequences of the internal and unconscious conflicts between the "id" (center of the unconscious instinctual gratifications) and the "superego" (the arbitrary moral commander). The teachings on meditation will supply the necessary tools that will enable the "ego" (the agent of cohesion) to organize, synthesize and integrate mental processes in a balanced and healthy fashion.

Ego Psychology pays attention to the conscious adaptive and controlling function of the ego and discusses, among other things, issues surrounding intimacy, identity and integrity. Here, I will simply show how the truncated ego functions of the participants will be helped by meditation which will build up an observing ego in them. The realization of the observing ego will help participants to acknowledge reality without resorting to more primitive defenses such as, denial or projection.

Object Relations Theory states that the human psyche takes in what it experiences with its primary caregiver making it part of itself. The quality of attachment and separation- individuation (being together and at the same time being separate and unique) is important according to this theory. The disturbing impact of weak "object permanence" (the capacity to maintain a mental representation of an object even when the object is not present, according to Piaget) and wavering "object constancy" (the capacity to retain belief in the goodness of an object even when the object is not being gratifying according to Mahler) will be resolved by the use of Mantra as a "transitional object" (literally, the thing that somebody carries as a reminder of the possibility that a person, especially a care giver, continues to exist even if absent) by the participants.

Self Psychology discusses the development of the true self in a nurturing and stable environment in contrast to the false self manufactured in an emotionally deprived environment. The true self will be able to be in mature relationships. This project will provide a "good enough" psychological and spiritual environment that will aid the development of a true self.

Another psychological principle at my disposal in the course of this project is the Behavior Modification Theory with its utilization of the consequential process of reward or denial of privileges. Behavior Modification is the term given to any process derived from the learning theory, where the goal is to change a person's behavior or the way the person interacts with his/her environment. My aim is to utilize these principles in dealing with the residents who will accept participation in my project.

My theological principles include the use of some biblical images of God as Potter, Love and Lover and Liberator, as I undertake a discussion of the miracle of creation. The miracle of creation emphasizes the Trinitarian role in the coming into being of all things and the empowerment of human beings to be engaged in creative acts. This empowerment of human beings to be involved in creative acts becomes a goal for my project. The residents are to be gradually led into having a reconnection to the inner power of creativity through meditation. This will be done, for instance, by the use of the Mantra, training the senses and reading the mystics, during the execution of the project. Constant use of their creative acts will destabilize the power of addiction in their lives.

The second theological principle I hope to use is the wonder of honoring the Holy Ground in which the encounter takes place during the execution of the project. This principle is a constant reminder that I am in the realm of Mystery. I am only a witness to God's work in the life of the participants. This principle encourages respect and constant attention to the ethical issues of confidentiality.

In Chapter Three, I will discuss the actual execution of the project following Eknath Easwaran's teaching on Meditation which I find practical and

easy to adapt to a population that is not purely academic. The themes revolve around the values that are upheld by the therapeutic community as understood by my agency. The project will be carried out once a week for nine sessions. The first eight weeks will follow the 8-Point steps in Easwaran's teaching, namely: Meditation, Mantram, Slowing down, Giving one-pointed attention, Training the senses, Putting the welfare of others first, Spiritual companionship, and Reading from the scriptures and mystics of all religions. The last week will be devoted to sharing and a ritual for a closure of the group. I will be able to assess the outcome of the project from the participants' attendance, their ability to understand the material and their readiness to share and learn from each other.

In Chapter Four, I will describe the outcome and give a synopsis of unexpected outcomes in an analysis and evaluation format. This will enable me to move the project towards conclusions which will be discussed in Chapter Five. This last chapter will basically synthesize the implications of the project in terms of my contribution to psychological and theological principles and ministry in a wider context.

CHAPTER 1: EVOLUTION, CONCEPTS AND THEORY

1.1 Therapeutic Community:

David Kennard (1998) noted that the term "Therapeutic Community" specifically refers to "a particular set of principles and methods used to help people with particular kinds of problems and disorders." Its structure and daily activities are designed to help its members to grow and change. The English psychiatrist and psychotherapist Tom Main first used this term in 1946. He was at the time using the term in a general way in which any institution that sought the welfare of its residents was called therapeutic. It meant that the institution was offering the residents the opportunities to develop their interests and talents, to be productive and responsible as the residents participated in the daily running of the institution. My aim in this section is to highlight the development of the Therapeutic Community (TC), in reference to mental illness, discussed in the subsection called English Origin, and substance abuse as shown in its history in the U.S.

English Origin

A new approach to psychiatry and psychiatric treatment was introduced in two separate hospitals in the early forties. In the Northfield Military Hospital in Birmingham, J.R. Rickman, W.R. Bion, S.H. Foulkes and Tom Main became the widely recognized pioneers of this new approach. It was Tom Marin who referred to it as "Therapeutic Community" (Kennard, 1998).

Rickman came to Northfield in July 1942. He was in charge of the acute psychiatric ward of 14 to 16 beds (Harrison, 2000). Here the patients spent about six to eight weeks before moving to the Training Wing. From this training unit, soldiers would either move to

their units or be discharged from active service. Rickman treated patients individually and in groups. There was a story of a solider wounded in Northern France who had been treated successfully for his physical trauma. But as soon as he returned to his unit, his arm became paralyzed. Medical solutions were employed to no avail. He became "morose and dejected." In a brief discussion, he stated that he lost a friend for whom he "would have given his right arm," in the same battle he himself was wounded. He was at the same time preoccupied with nursing his wounded arm. Rickman let him see the connection between the arm and his loss: the arm represented his loss that had not been sufficiently mourned. He rejected Rickman's interpretation but continued to talk about his bereavement following Rickman's persuasion. As he talked, he became depressed, eventually, emotional and then he experienced gradual sensation in his limb. He recovered to the point of enjoying taking up rifle drill again (Rickman, 1941).

In his one-on-one encounter, however, Rickman's therapeutic task was clearly identified as "developing group membership skills," which would enable patients adapt to any community afterwards. The focus was thus on what actions strengthen the group and not necessarily an individual need and emotional status. Therapy was embedded in the soldier's real situation underlined by the statement, "Although you are a patient, you are, a soldier as well (Rickman, 1943)."

Bion was posted to Northfield in 1943 to take charge of the training unit. This housed more than half the soldiers receiving care at the hospital. On assumption of duty, Bion discovered the elephant in the room: "Indiscipline." Patients numbering between 100 and 200 soldiers, were absent without leave, requested leave on various pretexts and overstayed the leave they had. Officers themselves were confused and uncertain in terms of their duties and responsibilities (Kennard, 1998). The atmosphere was in such a mess that Bion referred

to the community as "a rather scallywag battalion (Bion and Rickman, 1943)." Bion felt that the lack of discipline should be seen as a common enemy to be studied and fought by all in the training wing as they would an external enemy (Bion 1961). For this reason, he came up with a framework of various activities that the soldiers should take part in.

First, Bion brought together into small groups "those patients who are not already too far gone to be studied." Two things stand out in practical terms in Bion's group. There is a passivity through which Bion did "not steer the discourse when handling the group" and an active participation by which Bion drew the attention of other participants to what is happening at the moment in the group." Bion built up "group mentality" through his exploration of transferences and counter- transferences. Bion emphasized the importance of elucidating in groups "one aspect or another of these three things – the group mentality, the attempt of the individual to achieve a full life in the group, and the culture of the group – and, if possible, to demonstrate their interplay (Bion 1948, p.110)." It was also important to substantiate interpretation with evidence. The purpose was not to provide the person with a solution but to develop the ability in participants to seek for solutions to their own problems (ibid). In addition, Bion instituted a daily "parade" which lasted for 30 minutes for the whole unit. The purpose was to make announcements and conduct the business of the unit; rules outlining the duties of each person were laid down. The activities of this daily parade led to the development of setting contracts and the emerging ego in Therapeutic Communities.

Bion achieved two things by his experiment: the soldiers enjoyed their freedom and their behaviors were put in check. The result was that changes had taken place within a month of the inception of Bion's scheme. But this experiment died prematurely, after six weeks, in the row between Bion and the military staff in which Bion and the commanding officer, Lt. Col. J.D.W. Pearce, were ousted from Northfield (Kennard, 1998).

However, a "second experiment" in creating Therapeutic Community in Northfield, began slowly and more securely, sanctioned by the coming of Foulkes two months after Bion left. Foulkes' major contribution to the development of Therapeutic Community was in his initiating and sustaining of good team work. For instance, Dennis Carroll who was very active in assisting the work of D.W. Wills in the Hawkspur Experiment, a Therapeutic Community for young men, gave a tacit support to Foulkes and others in his position as a commanding officer. Joshua Bierer was at this phase the expert in recreational therapy in the hospital. Lawrence Bradbury was the Art therapist; Martin James was very supportive of Foulkes, and Harold Bridges, was the officer in charge of the training wing, who made remarkable advances with his skill in "leaderless group" and "social therapy."

In addition, when in September 1945, Tom Main assigned him the role of group Therapy Coordinator and ad-hoc trouble-shooting Consultant, Foulkes, rose up to the challenges of the time becoming a roving group therapist that went wherever a crisis had arisen. He, with the group-art, work team and other gangs of patients would work out what the problem was and how best to resolve it. He founded a coordination group and issued communiqués to function effectively in this role. Despite its noted problems (troubles, inefficiency, quarrels, arguments, sulks and walkouts), this phase experienced a good deal of patient-staff interactions. Patients shared in hospital management and there was active contact between patients, nurses, doctors and other staff in the meetings and common work in which they were all involved.

Kennard (1998) summarized the key ideas developed in Northfield by Bion, Foulkes and Main:

1. The problem of disruptive behavior in the ward is defined as a shared and common problem rather than the leader's problem.

2. A clear program of events, activities, etc. is set up through which patients are free to move as they choose rather than having an agenda imposed on them. In this way individuals' true intentions are revealed, to be contrasted with their professed ones. Their behavior and responses are then reviewed in regular meetings at which attendance is required.
3. Groups are set up with various tasks to perform. This leads the members to have mutual expectations of one another and communicate and cooperate with others.
4. Leadership is used not as an end in itself but as a stepping-stone towards patients taking it over. Leadership needs to be securely established by staff and given up as patients grow to assume it themselves.
5. A 'culture of enquiry" is established. This especially includes the relationships among staff members whose frustrations are otherwise directed towards heads of departments who get into repetitive conflicts with one another.
6. It is recognized that innovation in one part of an organization always affects other parts, and that it is vital to work with all the affected parts of the organization if the innovation is not to be attacked by them.
7. The term "Therapeutic Community" is used by Main as a general label for these new ideas.

Mill Hill Hospital

In 1935, a young graduate of medical school at Edinburgh University became the assistant to Sir Aubrey Lewis at Maudsley, London's leading teaching hospital. His name was Maxwell Jones. This young psychiatrist was exposed to psychoanalytic therapy in Maudsley. The hospital was closed during the World War 11 and Maxwell Jones moved to Mill Hill, a

temporarily converted public school on the outskirts of London, where he became in charge of a research project and worked with soldiers suffering from neurocirculatory asthenia, known as "effort syndrome." This psychosomatic disorder was a condition in which physical exercise caused people to become breathless and giddy, as they suffered from palpitations and chest pains, which made them believe that they had "serious heart disease (Kennard, 1998)." It was while working with these soldiers at Mill Hill, that Maxwell Jones enthusiastically developed the concepts of "Therapeutic Community" that spread both in Britain, the United States, and especially to institutions outside of the formal psychiatric system.

Maxwell Jones enhanced therapeutic treatments in three ways, namely: education, modifications of the general organization of the unit, and incorporation of the social projection method (Harrison, 2000). Jones thought that if patients understood for themselves the cause of their symptoms, they might stop worrying about their hearts and that this would, in turn, have a positive impact on their attitudes. In 1941, Jones started a series of lectures to educate the patients about human physiology. This didactic consisted of a course of twelve sessions of an hour each over a period of four weeks. In providing general information in normal and abnormal psychology, the soldiers were given the opportunity to evaluate their own problems more objectively. Soldiers thought of their symptoms as merely physical and saw it as their "ticket out" of the army. Jones then explained their disorders to them in a group, using simplified physiological concepts, to educate them on parasympathetic and sympathetic nervous systems and their internal harmony, the physiological basis of fear and its "normality" among other topics. Three times a week, 100 patients gathered to listen to these lectures and discuss their symptoms.

Then, an unexpected thing began to happen (Kennard, 1998). Soldiers who had completed the "course" of lectures and had not left the hospital began to help. They explained

things to new comers with enthusiasm and a high degree of articulation. Jones recognized the benefit of this patients' activity. Helping one another brought out a lot of what was well and healthy in them and subsequently increased their morale and self-esteem. It generated the "group or communal atmosphere" imbued with mutual responsibility characterized be general feeling of support. Through this a lot of the soldiers were encouraged to go back to active service (Jones, 1942).

Treatment for Maxwell Jones was no longer confined to a therapeutic hour. It became a continuous process operating all the time in the waking life of the patients. To accomplish this, Jones reordered hospital society by leveling up the traditional hierarchical pyramid of authority, thus promoting more interactions between patients, nurses and doctors. The first inklings of the therapeutic community approach developed by Jones were evident in the weekly ward meetings, in which both staff and patients participated in issues such as improvements; decorations and criticisms of both the ward and the organization were considered. Years later, these weekly meetings progressed into daily meetings in a ward of 70 patients (Jones, 1947).

The demolition of traditional distinctions between the "well" and "professional" and the "patients" and "disordered" encourages a democratic way of working. Each week, the patients and staff, that is, nurses who were mostly conscripted and lacking traditional training, from different wards would present prepared playlets. This would form the basis for discussion between patients and staff. The doctor would then sum up (Harrison, 2000), enlightening participants on the various views expressed to "illustrate the advantages of intelligent assessment of a problem (Jones, 1944)." By the end of 1946, Jones' approach was modified to allow free expression and more opportunity for the patients to take the lead (Jones, 1947). There was a small group in which the sessions began with open discussion of

any issue of concern for the soldiers. Once members gain a degree of mutual trust, a session turns into a role-play with its two-fold functions of re- education and emotional catharsis. On the one hand, there would be recreation of social situations which had caused some, minor psychological discomfort for the individual. Members would discuss how such behavior might be modified to improve the outcome. And, on the other hand, there would be a re-enactment of traumatic events that allowed the soldiers to relive the experience as much as possible. The soldier would be distressed as he went through the pain similar to the original circumstance. Again, others would discuss what had happened and provided their peer alternative explanations, reassurance and emotional support (Jones, 1947). Looking back at what took place in Mill Hill, Maxwell Jones noted that it was in order to make the most use of this new approach that he evolved a new hospital structure that included "more open communication; less rigid hierarchy of doctors, nurses, and patients, daily structured discussions of the whole unit, and various sub-groups (Jones, 1968)." Jones succeeded in involving all the clinical staff in his approach, and, together, they established an atmosphere of creativity, activity and optimism that engendered a similar attitude in the soldiers who were patients in Mill Hill Hospital (Harrison, 2000).

The second phase of Maxwell Jones' contributions to the origins of therapeutic community took place in Henderson Hospital. After the Second World War, Jones developed a program for ex-prisoners of war and continued his experiment using discussion groups and educational films. This work with people with social; and interpersonal problems was so successful that he was made the Director of a new unit set up to tackle the problems of the unemployed "drifter" at Belmont Hospital in Surrey. The unit was called the Industrial Neurosis Unit, later, the Social Rehabilitation unit, and, finally, renamed, Henderson Hospital (Kennard, 1998). Patients, admitted at the time, were those considered to be

unsuitable for psychotherapy or physical methods of treatment. Three major procedures and several principles are delineated from Henderson under Jones.

The first of these procedures was the daily community meeting at which all staff and patients met in a large circle to discuss whatever has been going on in the community for the past twenty four hours and to examine any problem that may have come up. This is the hub into which events, in the other groups and activities, were fed back, and in which ideas and discussions were debated freely. Two things were achieved. In the first place; being responsible participants in the community affairs helped patients to overcome their lack of confidence and increased their self-esteem. Second, discussions of particular incidents enabled patients learn what feelings and perceptions lay behind the behavior and helped them to test distorted perception against common concessions (Kennard, 1998).

A staff review meeting followed every community meeting. Here, the interactions in the community meeting were discussed and it's aimed at examined the relationships among the staff. This helped the staff to settle problems in the relationships between the different disciplines. New staff members, especially, were able to learn more about their roles in the overlapping and presumably conflicting responsibilities.

The third procedure introduced by Jones and his Henderson staff was the "living - learning situation", designed to handle crises in the community. A crisis meeting is called whenever there is a crisis between individuals or all members of the community. This is a "face –to-face confrontation and a joint analysis of the current interpersonal difficulty, (Jones, 1967)." Through this meeting those involved are helped to be aware of the thinking and feelings of the others, thus enabling all to have a more objective and comprehensive view of the situation. The goal of this meeting is for personal growth and maturation.

The other activities of Jones' Henderson heritage include: work groups followed by discussions of the members, centered on their responses to doing the work; role-play of situations residents might face outside the community; and a selection committee for new patients, made up of staff and patients in equal proportion and with equal voting rights. Besides, wide ranges of posts were created, to which residents could be elected. There was a constant use of the terms "role blurring" and "feed back." 'Role blurring' meant the flexibility of roles, without confusion, if proper discussions were held about it. 'Feedback' refers to the practice of reporting back, in a meeting something of therapeutic value that happened outside. This may sometimes breach the ethics of confidentiality, but since the community, as a whole trusts the individual, the principle of confidentiality extends to the whole community, at least in theory (Kennard, 1998).

Maxwell Jones was very influential in therapeutic communities in the US and other nations of the world. These activities in those places are beyond the scope of this project. Suffice it to say that Jones and his colleagues performed follow-up studies and found out that six months after leaving the hospital, two thirds of the patients they were able to trace, had made a fair adjustment or better. Over one half have worked full time since leaving. Psychiatry "had met World War 11 and made creative use of the encounter" (Kennard, 1998) and is moving on.

Charles Dederich and Synanon

In 1958, a new kind of therapeutic community, Synanon, was created in the United States of America by a group of ex-addicts. Charles E. Dederich Sr., was born in March 22, 1913 into a German Catholic family in Toledo, Ohio. Alcoholism pushed this former oil company executive through two failed marriages, and lost jobs, and to the doorsteps of

Alcoholics Anonymous. He became a committed believer. Dederich felt, however, that AA was limiting. He then began holding meetings with his AA circle of friends in his own apartment in Ocean Park, a "slum" district of California. Several months later, he used his thirty-three dollars unemployment check to rent a storefront for their meetings. The group named the club Tender Loving Care (TLC).

Dederich integrated his AA experiences with other philosophical, pragmatic and psychological influences in his development of the Synanon program. In a humble beginning, he initiated weekly "free association" that evolved into a unique encounter group process he called "the game," which brought therapeutic changes in the lives of participants. Some members brought their other suffering friends who were interested in "kicking" the bad habit. Dederich told an incorrigible addict to move in and live in the clubhouse. The addict moved in and stayed off drugs (Kennard, 1998). Other people who had nowhere to go stayed in the clubhouse. Subsequently, the weekly meetings became a residential community, and, in August 1959, the organization was officially launched to treat any substance abuser (De Leon, 2000).

The history of Synanon, a word derived from a newly arrived addict's attempt to pronounce the unfamiliar words, "Symposium and seminar," during his request to go to another of those "Sym...sim....syannons," can be broken into three eras: 1958-1968 (it served as a therapeutic community); 1969-1975 (it became a social movement and an alternate society); and from 1975 to the present (when the group is serving religious purposes). The concentration of this paper is however the era of its therapeutic orientation.

In 1959, Synanon moved from the TLC club in Ocean Park into an old National Guard armory in Santa Monica. Using his business knowledge, Dederich registered the club as a non-profit organization called, "The Synanon Foundation." He then began to formulate ideas

about how it worked. The program established at Synanon was a two year recovery process aimed at returning ex-addicts to a society in which they had been hitherto, unable to live.

It was organized into a more or less autocratic family structure, which Dederich thought was necessary to buy some time for their recovering addict. The patients began their therapeutic journey through detoxification by quitting "cold Turkey" and slowly gained more responsibility until the ultimate goal, their rehabilitation (having an outside residence and a job) or absorption (gaining a position within the organization) was realized.

While in the residence, patients were administered "doses" of inner-directed philosophies. Those philosophical and moral values became "concepts" in the language of Therapeutic Communities. At the same time, a daily routine took shape at Synanon. It included daily job assignments, regular "Synanons", that is the "attack" therapy groups, and daily discussions around philosophical readings. During this time too, there was a shift from residents still using a limited amount of drugs to those completely "clean", that is, drug-free. The latter were "role-models", to whom new arrivals could look as examples to follow. They were the older brothers/sisters in the family (Kennard, 1998).

At the time, Synanon reconfigured a variety of influences into a prototypical addiction therapeutic community. It inherited moral and spiritual values from the Oxford Group and AA along with other social, psychological, economical and philosophical elements that Synanon integrated into its goal of changing personalities and lifestyles. In the Synanon twenty-four hour residential setting, a social learning technology was evolved that utilized the whole community life to achieve complex goals. Synanon was thus evolutionary (in building upon the foundation of those influences) and revolutionary in its innovation of a new approach to the treatment of addiction (De Leon, 2000).

From its development, the state and Federal committees that assessed Synanon reported that Synanon is "a most promising effort to rehabilitate narcotic addicts," and "a man made miracle on the beach of Santa Monica." The media orchestrated the success of Synanon, which eventually led to the beginning of similar communities in New York, the city with largest problem of addiction in the U.S. Among these were Day top Village (1963) and Phoenix House (1968).

Phoenix House

Five heroin addicts were together in a detox unit in a New York Hospital. They had a discussion about their struggles and difficulties in maintaining a drug free life style. They agreed to help one another. On May 2, 1967 they moved into a few furnished rooms on the top floor of 205 West 85th Street in Manhattan, New York. They vowed to remain drug free with each other's help. These men namely, Ron Williams, Carlos Pagan, Julio Martinez, Julio Vasquez and Ray Colon put their welfare checks together and began to live as a community committed to help each other change their lives. This marked the birth of Phoenix House, named after the Egyptian mythological bird that rose from its own ashes.

The effort of those men were complimented and advanced by a Synanon experienced psychiatrist, Dr. Mitchell S. Rosenthal who was at the time Deputy Commissioner of New York City's Addiction Services Agency and his counselors. In his position, Dr. Rosenthal made Phoenix House the model for a citywide treatment network. The mission of Phoenix House metamorphosed into: reclaiming disordered lives, encouraging individual responsibility, positive behavior; and personal growth, strengthening families and communities, safeguarding public health, and promoting a drug free society through prevention, treatment, education, training, research and advocacy. This mission is supported

by Phoenix House adhering to the concept of self-help, sustaining excellence in programming and service delivery, seeking innovative solutions to emerging social problems, and honoring the dignity of the individual (Phoenix House Orientation Package-COP p.5)

In so doing, Phoenix House has become America's leading provider of drug and alcohol abuse treatment and prevention services operating more than one hundred treatment programs in nine states including New England, Florida, Texas and California. These programs include twelve to twenty-four months residential programs, shorter residential programs, prison-based programs, ambulatory treatment programs, education, and prevention programs. A variety of populations are targets of Phoenix House programs. These include adults, adolescents, women and children, mentally diagnosed (Mentally Ill and Substance Abusers), homeless and others of varied socioeconomic, racial and ethnic backgrounds (COP p.5)

In Phoenix House, the concept of therapeutic community embraces the structure and daily activities designed to help members grow and change. It is based on the understanding that the "community is the healer" and members are helping each other develop the skills needed to negotiate "success in life and recovery." Today, Phoenix House uses self-help therapeutic community as its treatment modality. A major part of this paper will be focusing on the understanding and practice of these concepts in Phoenix House MICA population community residence.

1.2 MICA (Mentally Ill Chemical Abusers).

MICA is an acronym for Mentally Ill Chemical Abusers. This stands for a group of individuals that are dually diagnosed of any chemical disorder, that is, addictions to alcohol

or drugs and mental illness such as depression, schizophrenia or a personality disorder. Dual disorders are common today. Approximately 25% of American adults have a mental disorder at some point in their lives and about one-third of individuals, with mental disorder have an addiction. Again, 16% of American adults have an addiction at some point in their lives. Many of those with alcohol or other drug problems will experience a mental disorder at some point in their lives (Daley 2003).

There is no simple explanation to the cause of dual disorder. It ranges, however, from genetic and biological factors encompassing heredity, brain chemistry and medical conditions to psychological (e.g. the way one thinks and reacts and manages stress and one's beliefs of oneself and the world) and social or environmental (i.e. influences of family, friends and society) factors. It is clear that having a mental disorder increases one's risk of having an addiction. People with mental illness sometimes turn to drugs to mask uncomfortable feelings in their lives. Having an addiction on the other hand raises the risk of activating a mental disorder. Drugs could interfere with effectiveness of psychotic medication or interact with them in a dangerous manner (Daley 2003). This section deals with the treatment of the dually diagnosed in a Therapeutic Community. Therapeutic Communities were first created for maladjusted children in the early part of the 20th century. The principles were carried out in a detailed form in psychiatric units to deal with neurotic or personality disorders, the exercise that led to the coinage of the term "Therapeutic Community." The principles and methods discovered and elaborated in these places were taken up and further applied to the treatment of individuals who are substance abusers and persons in other settings at different places. Our concern at this point is to discuss how these principles and methods were applied in the treatment of comorbidity.

J. Anderson (1997) noted that patients diagnosed with severe mental illness, who suffer also from substance use or addiction disorders present a variety of individual, social, fiscal and political challenges that stretch the ability of traditional Therapeutic Community programs to deliver adequate services effective enough to meet the patient's multiple treatment needs. Their needs range from histories of homelessness and housing instability to increased rate of acute hospitalization, criminality and homicidal/suicidal behavior and poor response to treatment, services and medication compliance. The fact is that traditional mental health programs are often ill equipped to effectively handle dependency and recovery needs that is ongoing for MICA patients. In the same way purely addiction programs are handicapped in dealing with psychotic symptoms of patients who may require medication and psychotherapy to resolve various mental issues.

Epidemiological studies have established that co-occurring disorders are the norm among individuals with substance use disorders. Substance use can exacerbate or obscure symptoms or enhance premature termination or failure to progress in treatment. Treatment for substance use disorders must address these co-occurring problems and vice versa (Washton & Zweben, 2006). A historical mistake was to see substance abuse problems as manifestations of an "underlying" disorder, which dissolves when the "primary" disorder was treated. Overall treatment failed; patients were embittered and recovering communities developed an intense distrust of professionals. Another mistake was to treat substance use disorder while other issues are on hold until abstinence is firmly achieved. Many patients never achieved complete sobriety, and, as such, their treatment was ineffective (p. 31).

Given the complex treatment needs of the population that is dually diagnosed, a variety of hybrid program models emerged to address those needs. These models generally

fall into one of three categories, namely, disease specific models with modifications, linkage or integrated programs (Anderson 1997).

In programs using the disease specific model, the multiple symptoms of MICA patients are addressed by incorporation of mental health or addiction counseling into a spectrum of services while the primary clinical focus remains the principal diagnosis of mental illness or substance abuse. Most of the programs using this model for MICA patients emphasize sequential program modeling whereby patients attend collateral treatment after attaining current treatment goals in mental health or substance abuse. In other words they first treat diagnosed mental illness or substance abuse, and refer out the patient to another program to work on the remaining symptomatology (Minkoff, 1991; Anderson 1997).

Linkage programs take a more strategic position. These ones generally emphasize the parallel treatment model by which patients attend collateral treatment in another program for the mental illness or addiction problem that are not addressed in their current program. Linkage programs thus attempt to deal with both addiction and mental illness simultaneously. The shared problems of these two models as earlier seen is that the programs generally see mental illness and underlying pathology as secondary to substance abuse and their primary treatment phases and components generally mirror that of traditional substance abuse treatment program (Osher & Kofoed, 1989). Any one-sided treatment of MICA patients is doomed to failure.

Effective treatment of MICA population adheres to the integrated program model. Here, programs incorporate clinical resources and systems necessary to meet the multiple clinical needs of MICA patients within a single program. Besides, treatment in this model is individualized. That is, customizing treatment planning and services to meet the needs of individual MICA patients.

In reviewing the historical development, theoretical or philosophical assumptions, model components and efficiency of MICA treatment models, A. Anderson (1997) clearly demonstrated that an integrative model is advantageous on two fronts – theoretical and clinical. The model which emphasizes the individualized "mix" of treatment options produces greater patient satisfaction, yields a higher level of efficiency, reduces costs and duplication of efforts and generally meets the needs of the individual MICA patients, instead of matching patients to rigidly structured, generic programs that may or may not meet treatment needs (Jolivet, 1993).

The integrated model of treatment emphasizes a process by which treatment interventions are matched to the particular stage of an individual patients' readiness to change. The stage of change (SOC) tool "informs and guides the process of finding the 'best fit' between where the patient is and what the therapist should be doing to engender positive change at each stage of the process" (Washton and Zweben, 2006).

The "stages of change" tool was developed by James Prochaska and Carlo DiClemnte in the late 1970s and early 1980s at the University of Rhode Island while studying how smokers were able to give up their habits. Behavior change does not happen in a flash. Steps to successful change take different stages and each patient progresses at his/her own pace, takes a decision for himself/herself when a stage is completed and when it's time to move on to the next stage and be prepared to grapple with different set of issues and tasks associated with the particular stage of change (Kern, 2005). The five stages of change are: pre-contemplation, contemplation, preparation, action and maintenance.

Pre-contemplation: Kevin came into the Phoenix House Springfield Garden Community Residence for MICA populations. He was barely three weeks into the program and had eloped for the second time to use marijuana, his drug of choice. During an encounter

with him, Kevin stated "Everybody smokes weed... musicians... business men... they all smoke. It is grown everywhere and it generates money. I don't see the problem in smoking weed. I don't think I will stop smoking weed...." Pre-contemplation is the stage in which the problem is evident to others but not to the individual with the problem. I remember a crazy man walking around naked in the street. When he came to a group of kids looking at him he asked, "What are you mad people looking at?" For him, the kids were mad and he was sane. Patients in this stage are generally unaware or under aware of their problems and do not understand why others are worried about it. And the more they are confronted, the more defensive they become and they either deny the existence of the problem or they argue that the problem is not serious enough to warrant doing anything about it. Typical of somebody in this stage, Kevin came into the program because he was mandated. And instead of investing in the process of change, he spent his first ninety days trying to beat the system that mandated him into the program.

Contemplation: This stage is marked by ambivalence in the mind of the patient. They are aware of consequences from their bad habit and they spend time thinking about their problem – their behavior at this point is perceived as a possible problem. The patients at this stage vacillate thinking about whether or not to do something about the problem. They weigh the difficulties of living with the problem against the challenges of change. When Kevin was at this stage in his treatment at Phoenix house, he came to speak privately with me at the end of a group. He heard people speak about the number of years they have been sober. Kevin stated that he has been thinking much about his situation. The peers may not understand him; they were older than Kevin. He recalled that he used to be smart and was doing well in school. But since he started using drugs his life changed for the worse. He enjoys using it; but he has always been in trouble. He would not be taking psychotropic medications but for

the drugs. Is it possible to have his life back that is, living a drug free lifestyle, go back to school and achieve his life goals even without medications? At this stage, Kevin was able to receive more information about his problems. Patients might take a couple of weeks or as long as life time to get through this stage (Kern, 2005) or even return to it on the heels of a relapse after periods of extended abstinence (Washton & Zweben).

Preparation: In this third stage, the "balance tips in favor of change," as patients makes some initial commitment to change. This stage is characterized by the patients' quest for method. This is a warm-up stage. Behavior changes are in the making. The concern is how these changes are going to be effected. Most patients at this stage hope to find the easiest, fastest and most painless way to achieve the desired change. Such people move almost from contemplation to action. They fall flat on their faces and feel frustrated and disappointed when they discover that there is no "short cut' to change. It should be remembered that this stage is a research stage. It is a time for gathering information about what the patients need to do to change their behavior, and for finding out strategies and resources that are available to assist patients in their determination to change. Residents in Phoenix House at this stage begin to ask so many questions to gather information about their options in the course of the treatment program.

Action: This is the fourth stage and is marked by patients' commitment to specific goals as patients begin to really do something about their problems using definitive methods. They are actively involved in taking steps to change their bad behavior by using varieties of different techniques. At this stage, patients make significant changes to reach clearly defined goals such as abstinence or notable reduction in drug use. In this stage, patients take definitive action to break their bad habits. They depend on their Will Power and could begin to avoid people, places and things associated with prior negative behavior. Two things

happen at this stage in the patients' life. One, the change in their life is visible to others and this elicits considerable support from others (Washton & Zweban, 2006). And, two, patients at this stage are more open to seeking support from others (Kerr, 2005). Kevin at a point started avoiding the company of peers that were a negative influence for him. He was often seen in the company of elderly and more stabilized peers. He became open and often shared in the group his feelings and thoughts. His entire attitude in the program changed. He went into VESID, acted as a peer escort and will soon be discharged for successful completion of program.

Maintenance: The fifth stage in which patients' goal is relapse prevention, which is, maintaining progress by successfully avoiding temptations to return to the bad habit. The aim of this stage is to maintain the new status quo; it is a solidification phase in which patients' extensive progress is noted and patients learn new coping tools for emotions and relationships. A wider range of relapse prevention techniques, such as, meditation are useful to enable patients in this stage maintain what they realize as a worthwhile and meaningful goal.

Relapse is a factor that is recognized in the process of change. This is a return to the former pattern of mental illness or substance abuse behavior. It is understood generally in terms of regression, that is, a movement from a higher level of change to a lower one. For example, when Kevin was denied graduation from the program, he attempted suicide by overdosing. He was rushed to the hospital and spent sometime in the psychiatric ward before coming back to the residence. Relapse can be a by-product of success. On one occasion, Kevin had become a role model. He stopped using drugs for a couple of months. Staff and peers relied on him and kept giving Kevin positive feed back. And suddenly he relapsed. When asked to write an essay on what happened to him, Kevin stated that he lost confidence

in himself because he thought he could not live up to the expectations of staff and peers. He could not deal with the "other people's high expectation" born out of his earlier success. Relapse can also occur when patients disregard the power of relapse triggers. For example, a depressed patient who has attained mental stability stops taking his medications against the psychiatrists' advice may sooner or later find him self in a psychiatric emergency room. No matter how successful MICA patients are in the treatment program, motivations wane and relapse is unavoidable. People who relapse may experience an immediate sense of failure and fall back to a low sense of self-esteem. The MICA program that has an integral approach is open to helping such patients get back on track. There was a time when Kevin packed his stuff to leave the residence. Every approach was utilized to keep him. But he self-discharged against staff advice. He simply went on the street and back to his old negative behavior with drugs and alcohol. He came back four days later, was accepted and allowed to continue with his treatment. Relapse can be a wonderful opportunity to learn from one's mistakes.

When patients learn from their various experiences of success and relapse and then grow to the point of staying long enough in the "maintenance stage," the expectation is the ability to work with their emotions, understand their behavior and see their life in a new light, termed, Transcendence (Kern, 2005). At this stage, mental instability and drug abuse cease to be an integral part of the patients' life and return to it would be atypical, abnormal and even weird to patients. They don't need the old habit to sustain them in life. Kevin eventually came to the point where he wanted to be integrated into the wider society, be involved in giving back to society through work, instead of taking away from the society, by being paid couple of dollars for doing drugs.

The stages of change offer a framework through which programs using an integrated model are able to match treatment interventions to the particular stage of change process the

MICA patients happen to be in. Treatment techniques must be chosen to suit a particular stage of change or they become ineffective, counter therapeutic or even harmful. Knowing in which stage patients are, offers the clues necessary to determine what will work or what will not work (Washton & Zweben, 2006).

1.3 Meditation

We read from the wikipedia that the term meditation stands for a variety of practices with a variety of goals. It involves turning one's attention inward to the mind itself. Meditation cuts across different cultures and religions. In all, it is a spiritual exercise that encompasses mental activity. While some engage in meditation to achieve eternal peace, others simply utilize it for personal health, growth and development. The term "meditation" comes from the Latin "meditatio" which originally referred to physical or intellectual exercise and evolved to more specific meaning of contemplation. In this paper, however, meditation involves a set of practical activities that impacts the mental wellbeing of those involved. It aims at the integration of mind, body and spirit that hopefully leads to positive changes in life and attitudes.

Common postures delineated from different religions and practices include seated, cross legged, kneeling and lying down postures. In the seated posture, people use any chair, stool, bench and anything with a horizontal top that one can sit on. The person sits up with back straight, and holds his/her head and spine in alignment. Hands are comfortably laid on the knees or arms of the chair; thighs are parallel to the floor and the back does not lean against anything. In the cross-legged posture, the individual crosses legs while seated on the floor or a cushion. The person still sits upright, with back straight and head and spine also in

alignment. Hands may rest in any position. In a kneeling posture, the individual bring their knees together on the floor, buttocks resting on their knees and toes almost touching. In this posture too, the back is straight, head and spine in alignment and hands are rested on the thigh. Finally, in the lying down posture, the individual lies down on a carpet making sure that the legs are straight and relaxed. This posture is more of a stress reducer than a meditation process. It makes it easy to sleep rather than to meditate.

Frequency and duration vary greatly. Twenty to thirty minutes is typically accepted and continual practice strengthens concentration and increases focus. This may be the reason why meditation has entered the mainstream of health care as a method of stress and pain reduction. Dr. Herbert Benson reports that meditation induces a host of biochemical and physical changes in the body that includes metabolism, heart rate, respiration, blood pressure, and brain chemistry. These changes are collectively called "relaxation response (Lazar, et.al. 2003)."

Considering the relationship in the role of the amygdale, the part of the brain that decides if one should get angry, anxious, etc., and the pre-frontal cortex, the part of the brain that enables one to stop and think, called, the inhibitory center to human behavior and attitude, some studies of meditation have linked the practice to increased activity in the left pre-frontal cortex associated with concentration, planning, meta-cognition (thinking about thinking) and positive affect. Depression and anxiety are associated with decreased activity in same region and /or with dominant activity in the right pre-frontal cortex.

In the field of addiction, Ronald A. Ruden with Marcia Byalick (2003) see the brain as a "most formidable enemy." The brain is the seat of craving. A way to win the battle over the craving response was discovered by Siddhartha Gautama, the founder of Buddhism through meditation. The origin of suffering was craving and the solution was to follow the "Eightfold

Path" of right understanding, right intentions, right speech, right conduct, right means of livelihood, right endeavor, right mindfulness, and right contemplation. All of these require a mental discipline that is available through the practice of meditation.

The goal of this project is to enable residents to utilize meditation as a tool that creates within their hearts a "flexible space of resonance (Magrassi, 1997)," that has a transforming effect in the behavior of the addict. This goal will be attained through recollection and rumination over values that will last. But for the method to be adapted to the mentally ill chemical abusers, it will be as practical as the Ignatian "examen of consciousness." It has to have the quality of universality. The teaching that fulfills these dual requirements is Eknath Easwaran's meditation (1991).

1.4 Background to the Project

I came to work in Phoenix House MICA Community residence through Geoffrey Lindenauer (Director of Case Management and Continuum of Care). He kept saying that our meeting each other was not by chance. There had to be a reason. We have been working together to realize the design of that meeting. Sr. Julie Houser (my supervisor during the Clinical Pastoral Education Program) introduced me to Geoffrey as a Catholic priest from Nigeria who is interested in working in the addiction field. We spoke about what was available and what I might want to do with the options set before me. Once I decided to work with the population, I was made to go through the admitting process interview with Geoffrey and Carrie Besserman (the Regional Director). After these, I was scheduled to start on September 1, 2005.

The task facing me at the time was to help residents be firmly grounded while they got connected to their inner strength. This meant bringing the spiritual component into the

treatment program. I quickly called my colleague, Fr. Ifunanya Aneke. He suggested my reading the Easwaran's books.

I came into work in Phoenix House MICA Community Residence at a difficult time. The facility was under staffed and clients had taken over the control of the place to the detriment of the structures of a Therapeutic Community. We had clients who came from the prison and were operating with a "jail mentality." They had formed a clique that jeopardized the stay of their peers and boasted to be in charge of the place. And they seemed to be really in charge. I know that it was a good thing for residents to be in charge, but the problem at the time was that our own residents were in charge by the use of intimidation rather than by means of cooperation and collaboration. Things could be done only when it would serve the selfish interests of the few numbers of the clique. And when it fails to serve their interests, the other values of a Therapeutic Community would be disrupted. The clique members fought a new resident who in turn wanted to leave the place. One of them struck a staff member and three of them in another incident threatened a male staff member.

It was a period when the facility had to deal with many incidents. Residents were impulsively leaving the program to go and use drugs. They knew they had to face the consequences of their negative behaviors. Yet they would not stop going out to get "high." We had about three who said in a group that they would never stop using illegal drugs. For them, "everybody", businessmen, government officials and celebrities are abusing substances. Drugs are cultivated and approved by some countries." Why should they even contemplate living "clean lives?" But they typically forgot that they were taking psychotropic medications and these would have an adverse effect when taken together with illegal substances.

Being in possession of money was an issue for some of the residents. The Office of Mental Health puts some cash in the hands of these residents every month.

The intention for doing this is clearly understandable and praiseworthy. But it is a trigger for our residents. As soon as you put cash into the hands of some of them, they move into the street to do drugs or drink alcohol. They would come back full of confusion, shame and guilt.

Again, we had residents who felt they should not be in treatment. They were there because they were mandated to be in treatment. These ones knew everything about the patients' rights but nothing about patients' responsibilities. They would walk on peoples' toes and act out in many ways. Several case conferences were held to help encourage these residents to buy into the values of their treatment program. They would refuse to abide by the terms of the agreement.

The challenge was therefore to recognize these abnormalities and do something positive. Insanity has been described as doing the same thing and expecting different results. What could we do differently to achieve the goals of the therapeutic community? How would I help the residents look into their negative behavior, recognize it as such and be able to take healthy decisions? This is the challenge and I thought of getting them to reflect and meditate as far as they possibly could.

1.5 Increase the Propensity of Thinking/Reflection before action: A Special Need in a MICA Population Treatment Program.

Let me begin this section with a brief summary of the psychosocial history of some participants. Reginald is a 48 year old Hispanic male. He is 5' 7" in height and weighs 200 lbs. He is neatly dressed and speaks English and Spanish. Reginald was admitted to Elmhurst Hospital for alcohol withdrawal. He was later transferred to an inpatient psychiatric unit for depressed mood, hopelessness, and suicidal thought with plans to jump in front of a car, paranoid ideation, auditory hallucinations, and on/off command type to kill

himself. Reginald has a history of polysubstance abuse. His drugs of choice were marijuana, alcohol and cocaine. Reginald spent a year in the military service in his home country. The longest he has held a job was five years. Reginald recalls having a happy childhood. He played around with seventy-two cousins on his mother's side. He completed his high school education as "an honor student." His cousin introduced him to marijuana and alcohol at the age of 11. Reginald is diagnosed with Major Depressive Disorder (Recurrent), Alcohol Dependence and Cannabis Abuse. At the time of this writing, Reginald has stayed fifteen months in the residence. He is high functional. His psychotropic medications are Paxil and Trazodone, antidepressants. Reginald enjoys reading, writing, painting, listening to music and playing guitar. He is working on his quick temper.

A second resident Nora is a 30-year-old Caucasian female who is a mother of two children, a sixteen year old and a two year old conceived with different men. Both fathers have custody of the children and an order of Protection against Nora. She has a history of physical abuse and was raped while in prison. Nora started abusing alcohol at the age of 13. She experienced blackouts at the same age and began using marijuana at the age of 13. The resident tried cocaine when she turned 21. Her first hospitalization for mental illness was at the age of 9 when she attempted suicide. She has had multiple hospitalizations since then.

Nora is diagnosed with Schizoaffective Disorder-Bi-Polar type, Cocaine Abuse and Alcohol Abuse. Nora is sexually active and has had unprotected sex several times in the facility. Every other thing is boring for Nora. Her psychotropic medications include: Trazodone, Ability, Inderil, Topamax, Vistaril and Zoloft.

While the above residents are described as high functional and are ready or almost ready for graduation we have clients who have need for particular attention. Melba is a 30-year-old African American. Her biological mother was a drug addict who left Melba and her

twin sister on the street at Kings County Hospital. A staff member of the hospital adopted them when they were a few months old. Melba has a long history of drug abuse and mental illness. She is diagnosed with Schizoaffective Disorder, Cannabis Dependence and Alcohol Abuse. On April 7, 2006 Melba left the company of her peers as they traveled to a Continuing Day Treatment (CDT) program. She returned to the residence in the middle of the night and admitted smoking crack and drinking alcohol. She was sent to the hospital, and discharged after evaluations on April 8, 2006. Three days later, Melba left the community residence to smoke crack. On April 24, 2006, Melba left again on her way to CDT with her peers. She admitted smoking crack and drinking alcohol. A decision was made to send Melba to a drug rehabilitation center. She spent twenty-one days in rehab from May 9, 2006 to May 30, 2006. Melba was in high spirits when she came back. She was "determined to make it through" in the program.

On July 17, 2006, Melba left the program. She did the same things, smoked crack and drank alcohol. She would still leave on August 01, 2006 and on September 14, 2006. Each time, Melba smoked crack and drank alcohol. She left the community residence on October 14, 2006 and spent two days on the street smoking crack and drinking alcohol.

Melba was also sexually acting out. She admitted having sex several times with a male staff member who lost his job as a result of that accusation. She gave oral sex to many of her male peers in the community residence and at CDT just for a few dollars.

Melba was taking the following psychotropic medications Trazodone (150mg), Fluoxetine (20mg), Haldol (10mg) Benztropine Mesylate (1mg) and Vistaril (50mg). The resident was always complaining of not sleeping well, and could hardly keep her eyes open during groups. Melba is a mother of five beautiful children. She recently signed them out for adoption. She complains often of her own nagging mother. Her mother had never told her

and her twin sister that they were adopted. The twin sisters discovered the documents themselves while searching for money to steal. Melba once stole two thousand US dollars from her mother and used all of it in drugs and alcohol.

Having a picture of the population I intend to work with, the basic question is what do these individuals have in common despite their varied diagnosis, medical conditions and medications? Basically, one thing that stands out among our residents is their impulsivity. David Shapiro (1999) sees their "mode of experience" and other aspects of their functioning as deficient in terms of active organizing and integrative mental functions. Their action is speedy, abnormal and unplanned. Melba was not allowed to leave the facility for a couple of weeks because of her frequent disappearances. She asked to be given another chance with promises never to disappear again. She was allowed to go to CDT. I remember meeting her on a Tuesday when I had to be at CDT for a clinical meeting. I encouraged her to come straight back. She insisted she would be back. She spoke to a couple of other staff members showing how happy she was in being allowed to go to CDT. She would not mess it up. But Melba got off the bus on the way back to the facility and left to use drugs and drink alcohol.

Another residence, Ron, wanted to self-discharge from the facility. We had no reason to compel him to stay. He voluntarily came into the program and was free to leave any time he would decide. Nevertheless, efforts were made to convince him to stay. Staff members, the peers and his brother spoke with him. He would not listen to anyone. He claimed to have gotten an apartment for himself and would be able to manage his life. When all our options were exhausted, we let him self-discharge against clinical advice. Four days later, Ron came in front to the door pleading to be given a second chance. He had been sleeping on the streets since he left the facility.

In normal people, a whim is the beginning of a complex process that touching on an existing direction of interest modified by that existing direction as it becomes integrated into the fabric of current aims and interests. This will lead to an experience of active, intended and deliberate want, a choice of decisions, a sustained desire at the base of planning. On the other hand, the impulsive persons by "short-circumventing" these integrative processes are deficient in terms of the end point of the integrative processes mentioned above. Their interest is in their immediate satisfaction, and because of this, their interests tend to be labile and erratic, making it difficult for them to resist their impulses. Again, forbearance or tolerance is unthinkable because they lack extended aims, interests, goals and values (Shapiro, 1999). Nora kept complaining about how it "sucks" to be here, because there is nothing to do. In the course of our session, Nora pointed out that she prefers being in the hospital because it would be easy to have sex. Besides, Nora had claimed that her class of people is not in the facility. Yet she had sexual intercourse with a resident a number of times. Immediate satisfaction impels our residents into acting out in so many ways.

Shapiro (1999) posits that the impulsive mode of cognition and thinking shows not only lack of the ability to plan but also a deficiency in concentration, logical objectivity, capacity for abstraction and generalization and reflectiveness. Their judgment is poor, arbitrary and even reckless. Judgment understood as an active, searching and critical process is either circumvented or completely eliminated by impulsive people. His initial impression, without further development, becomes in a way, his conclusions. Their cognition is dominated by the present and, as in impaired planning, the importance of the distant future dwindles. Concentration understood as focused and sustained attention, and examination is jeopardized because the next thing that comes along distracts the impulsive person. And because the impulsive person lacks reflection (turning over a situation in one's mind) their

mode of cognition is, on the whole, egocentric. There is no room for what is significant in a general or more permanent way (pp147-182).

These are some examples of how the mode of cognition described above played out in our residents. Melba gives oral sex and has unprotected sex with her male peers. Another female resident gave her thirteen-year-old daughter money. The daughter spent all the money on sneakers. Two days later, the resident called to find out how the daughter was doing. The thirteen year old explained that she had no money left. The resident reminded the daughter of the fact that she too had no money. Nevertheless, impulsively, she promised to borrow money for her daughter's desires. A male resident impulsively insisted he could handle two full time jobs while attending two different treatment programs, because he "needs the money." Another male resident suffering from high cholesterol sees nothing wrong in feeding himself with over eight eggs constantly.

These impulsive behaviors are a major reason why our residents are in treatment. If they are able to be constantly aware of their action in terms of reflection, planning and objectivity, they will be able to maintain mental stability. I propose that Mediation would be a good tool to enable them to be grounded, without guilt or threat, and effectively centered, focused and organized in life. Easwaran's type of meditation would be a suitable tool for this population. I hope that the practice of meditation that is practical and encompassing will increase the propensity of thinking through or reflection before action, because it involves a typical training of the mind.

1.6 Relevance of Meditation to Ministry

Groeschel (1986) stated rightly that human beings are constantly in "process of becoming." The appropriate way of becoming embraces growth understood as creativity and

productivity. And a negative process of becoming entails declines. The child is becoming old; the old never loose the child and may regress occasionally to the stage of childhood as a result of pressure in life. The reflecting person has the ability, in the present, to become both what his past has made him and what he is determined to become within the "potential of his given situation" (pp.41). This is why meditation is valuable in the teaching and practice of religion through out the world.

Meditation associated with the "asceticism of the medieval saints and of the yogis of India, the Hellenistic mystery initiations, the ancient philosophies of the East and of the West", is a technique for the "shifting of the emphasis of individual consciousness away from the garments (Campbell, 1949, p. 385)." The goal of meditation is thus to enable practitioners to detach their minds and sentiments from the accidents of life symbolized by the "garments," and thus enable them embrace the core of their being. In meditation, there is a breakthrough to an individual's profound depth where the person reaches a point of realization of the oneness of the essence of the world and the essence of oneself. This is the point where there is no room for both selfishness and altruism (pp. 386).

Therefore, putting the above ideas together, we can confidently say without equivocation that meditation enables the practitioner to be a "whole" person. He would be an "adult self," who, in touch with his life, is responsible and productive. Through meditation, he can be in relations with others without, loosing himself. Differences in opinion, teaching and doctrine will not suffocate this person because through meditation, he/she is able to be open, objective and real. The person becomes a spiritual guru able to impact others with spiritual values by words and especially by actions. The individual is simply at home with the tenets of peace, and justice, as he/she becomes an embodiment of genuine love.

Ministry is about creating a whole person. Pastoral ministry addresses this issue in its five traditional roles of: healing through "depth pastoral counseling" or "pastoral psychotherapy," by which it helps those with major psychological and spiritual problems to be restored to a condition of wholeness; a sustaining role in enabling a hurting person to endure through, crisis supportive or bereavement counseling; a guiding role as in educative counseling, ethical guidance and spiritual directions aimed at helping confused people find their confident choices; a reconciling role that re-establishes broken relationships, resolving interpersonal conflicts and increasing the quality of relationships expressed through marriage and family counseling; and a growth nurturing role that helps people enhance their lives as they deal in a creative fashion, with their developmental crises in a variety of individual and group counseling (Estadt, 1984, Campbell, 1987, Ugwu, 2004).

This unique way of ministry through pastoral counseling demands practitioners to be in touch with themselves through training, acquisition of skills, psychotherapy, supervision refection and meditation. Meditation opens the gate for the grace of ministry.

Meditation is particularly important in Christian ministry. Thelma Hall (1988), states that, it plays an important role in forming us as Christians by enabling us to grow in the knowledge of God's constant work of love in creation and especially in our individual lives. It increases and enriches our familiarity with the life and teaching of Jesus and helps us reflect on how to reciprocate in love and service. In a word, meditation helps to establish the essential foundation of faith and conviction for our Christian life. For instance, when faced with "another language" not yet learned, the finite human intellect finds it incomprehensible. Meditating on the life and deeds of Jesus the Word of God, allows one to get into the depth of God giving the person a clue to making the necessary connection to the meaning of this "foreign language," that is, God.

In 'A letter from Guigo 11, prior of the Grand Chartreuse to his friend Gervase", reading, meditation, prayer and contemplation are seen as a ladder by which Christians are lifted up from earth to heaven. This blessed life is sought through reading, perceived by meditation, asked for through prayer and tasted by contemplation. Reading puts a chunk of food in the mouth, meditation chews it and breaks it up; prayer extracts the flavor and contemplation gladdens and refreshes this sweetness (Bianch, 1998). Seen in this light, the relevance of meditation is obvious. The worst curse offered to man in my culture is for him to die of hunger in the midst of plenty of food. And one could definitely "die" if food is not eaten. Without meditation the Christian life would be arid, dry and dead. With the practice of meditation, ministry is productive and the minister will be able to bear fruit, the kind of fruit that will last (Jn.15: 5).

CHAPTER 2: PSYCHOLOGICAL AND THEOLOGICAL PRINCIPLES

2.1 Psychodynamic Principles

My attempt in communicating to MICA residents my wish to understand and help is informed by my integration of psychodynamic principles. Freud's Drive Theory "stressed the centrality of instinctual processes and constructed human beings as passing through an orderly progression of bodily preoccupations from oral to anal to phallic and genital concerns" (McWilliams 1994, p.21). This biologically informed theory held that survival was important in infancy and early childhood. This, at first, is experienced in a deeply sensual way through the nursing and other activities of the mother in relation to the infant's body, and later in his/her fantasy life about life and death and through the sensual tie the child has with the parents.

Infantile aspects of life are seen in the MICA population as uninhabited seekers of instinctual gratification. Often, their stories are those of people operating with the pleasure principle: I want sex now! I want drug now! The struggle for the program would be to enable our residents to replace this pleasure principal with reality principle, and thus enable them to realize that some gratifications are problematic. Some might go free of their abuse of drugs. A mentally ill person, taking psychotropic medications, increases the chances of harming himself /herself and/or other people if he/she decides to abuse drugs or drink alcohol.

Freud with his "drive theory" saw that parental failures involved either excessive gratification of drives that jeopardized development or excessive deprivation of them that forces the child to loose the capacity to absorb frustrating realities. If a child was over frustrated, or over gratified at an early psychosexual stage, the child would become "fixated" on the issues of that stage. Thus a depressed adult was seen as having been either neglected

or overindulged in the first year and half, that is, the first oral stage of development. Nora recalled her mother always trying to "do stuff" for her. Her mother would leave some alcoholic beverages on Nora's desk and when Nora asked who left it, the mother would quickly state: "I left it there for you honey." Nora noted that her mother would do something like that whenever Nora was frustrated. Nora had relapsed several times in the facility because that is her easy way of dealing with stress and frustration. In Freudian terms, Nora regresses to her early stage of functioning.

Freud's idea was that any unresolved issues in various stages of the child's development show up in adult problems. The oral needs include: to be loved, to be satisfied or to be appropriately gratified "at the most basic level." When these are not met, the individual may have a difficult time with empathy, mutuality and love and as a result exhibit the character traits of narcissism, dependency, envy and rage (Berzoff et.al. 2002). Edwin spoke of being jealous of the staff that can go home after work is over. One day a staff member told Edwin to wait for the cook to come in and prepare some dinner. Edwin said he was too hungry to wait. But the staff member insisted that Edwin should not cook because the last time he was permitted to cook, Edwin almost set the facility ablaze. Edwin went into a rage. Edwin has been in the program for four years and is still working on his anger management. He has been living a drug free life style for over three years. Edwin however is finding it difficult to do things for himself, his hygiene is still poor and he is afraid of traveling alone.

The Psychosexual tasks associated to the Anal Stage are internal control. The child is constantly testing the boundaries of what is acceptable and what is not. When the child fails to internalize what is prohibited, he will have issues with control and tends to exhibit the character trait of dominance, excessive cleanliness, hoarding, or frugality. Denis came into

the facility with lots of clothing and jewelry. The staff members reminded Denis of the policy in the facility in reference to properties. He was supposed to come in with specified items. He had too much with him already and is asking to go and get his bicycle, TV, etc. Each time Denis went out, he came in with other things; his room is filled to the brim. His closet is full, underneath the bed is jam packed and there is no space around the bed, sometimes, things are left neatly on the bed itself. He has five bags of clothing in the store. Yet he would be wearing the same pant and the same shirt for a whole week, wash and use them the next week. He hoards food items and spends over an hour in the bathroom. He seems to be delighted when his peers complain of his occupying the bathroom too long and making life difficult for them.

Denis gets on peoples nerves, and has a way of controlling other peers' happiness and joy. He kept John miserable until the latter was discharged from the program. When Denis wants something, he pesters everybody until he gets what he wants. He sees everything and everybody as a game of control.

Around ages 3 to 5, children enter the exciting world of fantasy, imagination and budding romance (Berzoff, et al 2002). They are beginning to discover their own genitals identified by Freud as the erogenous zone of the phallic stage. They become aware of sex roles and play out games of home and marriage. The world of a child at this stage involves a triadic relationship of the child, the mother and the father, or parent substitute. "Drive theory" postulates that the child's sexual feelings are directed towards the parent of the opposite sex while the child's aggressive feelings are directed toward the same sex parent or parent substitute. This stage is marked by the oedipal conflict. Sexual feelings ought to be renounced and repressed, on the one hand, while, on the other hand, the child loves the object of his aggression (same sex- parent). Freud taught that these conflicts are resolved by

castration anxiety (fear of retribution by physical harm from the same sex-parent) or by identification (the child's taking in of values, attributes and ideals of the same sex-parent).

Successful resolution of the oedipal conflict results in the child's gender role being solidified. And the child's internalization of parental values and sense of right and wrong at this stage is the beginning of the development of "conscience." But the violation of this internal code and social prohibition exposes the child to the unpleasant feeling of guilt.

An understanding of Freud's teaching about this phase is important for me given the population I chose to work with. Many kinds of neurotic disturbances derive from fixations at the oedipal stage: excessive competitiveness, emotionality, over- sexualization, inhibition, and a sense of inadequacy or inferiority (Berzoff, p. 36). Working in a MICA residence is energy draining. Emotionality is intense; a female resident had unprotected sex with a male peer on five different occasions and the same female resident prefers being in the hospital because it is easier to engage in "sexual intercourse in the hospital." It is a common saying among the staff that "Albert is not yet in treatment." Albert has a history of violence, and has not been communicating with his family members for over fifteen years and has refused to attend his graduation ceremony. Getting Albert to talk about any of these things has never worked. However, the good news is that the exposure of this unconscious patricidal and incestuous desire to the conscious awareness of the mind protects the residents from the oedipal consequences.

Sexual and aggressive drives are relatively quiescent during latency stage which is placed by Freud between the ages 6 to 11. At this school age, one's energies are expressed as a drive "to gain mastery of physical skills and cognitive learning (Berzoff, p. 39)." It is an age of socialization into the culture's sex role through identification with peers. Myths, legends and mysteries are attractive to the literacy imaginations of children during the latency stage.

Aggression is expressed through competition with peers; parents of the same sex are idealized at this stage. Exploration, skill building, learning and socialization mark this stage. It is an age of sorting activity and modesty. The body becomes a means of achievement in sports, acquiring skills and developing muscles for games. Inability to negotiate this stage successfully leads to the character traits of inferiority, failure, defeat and rigidity in thought and behavior (Berzoff, p. 40).

John kept struggling with his inferiority complex in the residence. When he was expected to lead because of his high level in the residence, John found it difficult to command. He preferred to do the work he should have asked a peer to do because "they don't obey me." John does not know how to negotiate with people. People either do things as he expects or he simply walks away. John went to his day treatment program one day and felt that everybody was disrespectful towards him. He greeted them and no one responded. John left the group and walked back to the residence. On another occasion, John challenged a staff member in his day treatment. The staff member responded. While they were still arguing back and forth, John left and walked back to the facility. That entails walking seven miles in a hot summer day when the temperature outside was ninety-five degrees. John would express his frustration later: "they allowed me to walk in the hot weather."

The last stage in Freud's drive theory is the Genital or Adolescence stage. There is a revitalization of sexual and aggressive energies. Biological changes of the rise in sex hormones and physical maturation make this stage tumultuous. The physical change affects the cognition, emotion and fantasy of the adolescent. The goal of this stage is separation from family of origin. The sexual and aggressive drives serve the adolescent goal. The adolescent experiences grandiosity and invulnerability in his/her thinking and judgment. S/he believes that s/he has all the answers where the parents and people with authority over them do not.

They act out, become rebellious and constantly devalue authority figures. Successful negotiation of this stage enriches the curiosity and creativity of adolescents. Fixation at this stage will lead to pathological traits that we contend with in the MICA residential community. These include violation of social norms through the acting out of unacceptable behaviors, the lack of neutralized aggressive and individual drives and a lack of age-appropriate identifications (Berzoff, pp. 40-42).

Patrick is a thirty-nine year old African American in treatment. He has a history of sexual inappropriateness. Patrick once stood at the door of a female staff, held his penis and was masturbating while the female staff was busy working on the computer. The female staff suddenly turned around and was scared to death when she saw what Patrick was doing. Another resident, Val still holds his pants down below his butt. Val is a 55 year old man who walks around dressed like a teenager.

From the Drive theory, therefore, we learn that each stage is biologically and psychologically determined. The first thirteen to fifteen years are the bedrock of human personality and behavior. The notions of regression or return to earlier stages of functioning and fixation or getting stuck at a particular stage of the psychosexual development enables me to have a clearer perspective of where the residents are coming from. This understanding of their behaviors incites my desire to help reshape their behavior.

However, human personality is not just biologically and psychologically determined. There could be cultural and social determinants too. The environment advances or frustrates personality developments as well. Erik Erikson (1950) considered the interpersonal and intra psychic tasks of each stage and reconfigured Freud's biologism into his psychosocial personality development.

Before Erikson, Freud established structural theory as another way of understanding the conflict between wishes (sexual or aggression), reality, and ideals (or internal moral prohibitions). These internal and unconscious conflicts lead to depression, anxiety, low self-esteem, diminished psychological capacity to function freely and breaks with reality (Berzoff et. al., 2002). According to structural theory, the mind is organized into three agencies: the id, the ego and the super ego.

The id is the part of the mind made up of primitive drives, impulses, pre-rational strivings, wish-fear combinations and fantasies which operate according to the pleasure principle. It constantly seeks immediate gratification. It is conjunctively preverbal and pre-logical. On the one hand, the id expresses itself in images and symbols. And it has no concept of time, mortality, limitation and does not allow for the co-existence of opposites (McWilliams, 1994). The id is engaged in primary process thought surviving in the language of dreams, jokes and hallucinations. Rooted in the unconscious, the effect of the id is known through derivatives, such as, thoughts, acts and emotions.

The Superego is the moral watchdog. It is the compendium of moral beliefs and prohibitions. It is often referred to as the conscience. It is also the embodiment of "developmentally early, punitive and persecutory tendencies (Berzoff, p. 56)." The superego is seen as the internal authority or judge that dictates how to think and act and how not to think and act. It congratulates the person when she/he lives up to the superego's standard and criticizes the person when she/he falls short of the superego's standard.

The superego is constantly in conflict with the id. The Ego operating from reality principle mediates between the id and the superego. The Ego also mediates between the demands of the id and the constraints of external reality and ethics. The ego is the bedrock of secondary thought process, that is, sequential, logical, reality-oriented type of cognition

(McWilliams, p. 26). It maintains psychological cohesion and stability by its ability to organize, synthesize and integrate mental processes (Berzoff, p. 59). Because the ego is both conscious and unconscious, it must be sensitive to the demands of the id, the superego, the physical world and the social reality.

A simple understanding of structural theory enables me to understand the residents' struggles and equips me to be helpful. James came into the office and wanted to share a "disturbing incident" with me. It turned out that James had a dream in which he saw "my sister's girlfriend." After exchanging pleasantries, James had sexual intercourse with the girl. He woke up and found out he actually discharged on himself. He was angry, ashamed and depressed. Working with James on this dream, in the light of structural theory, we realized that while James was in prison, he would masturbate "once in a while" which he "knew to be wrong." He used to have sex with the sister's girl friend, a fact both had hidden from the sister. The conflict between the demands of the id and those of the superego and social reality with its consequent effect on the ego was prominent. Thus, when James woke up, he felt "angry, ashamed and depressed."

Another psychodynamic principle at our disposal in working with MICA population is Ego Psychology. While structural theory emphasized the power of the id in the psychological understanding of the clients' mental processes, ego psychology shifts the concentration to the power and efficiency of the ego. The ego is now understood as having an organizing and synthesizing function, and is, thus seen as a preeminent psychic agency. The ego strength/weakness is understood in terms of the ego functions and defenses.

Jane came to speak to me. Jane is an African American single mother of two kids. At five feet seven inches, Jane weighs four hundred and ten pounds. Jane eats a lot of junk food, drinks a lot of soda and could sleep all day long. And everyday Jane thinks she lost some

weight. When Jane came into the office, she stated that Debbie a female staff member hated her. Jane claimed that Debbie was instigating other female residents to fight her. She stated that Debbie thought Jane was sleeping, "but I wasn't sleeping. I was upstairs in the female lounge with my eyes closed. Debbie was telling the female residents to make life miserable for me and even to fight me." It turned out that Debbie did not even come to work the day Jane said this event took place. Besides, the female peers of Jane denied ever having a meeting with Debbie to plan on how to hurt Jane. It was obvious that Jane's ego function of reality testing was at this time jeopardized.

My reason for introducing Meditation as a tool for recovery for our residents is that Ego strength deals with the basic role of perceiving and adapting to reality, that is the capacity to acknowledge reality without resorting to more primitive defenses (McWilliams), such as denial and projection (Berzoff). Meditation can hopefully build up in the participants an observing ego. This is the part of the ego that is rational, conscious and able to comment on its own emotional experiences. Treatment would then be easier because the distinction between problems/symptoms that are ego Dystonic (alien to the observing ego) and those that are ego Syntonic would be clearly defined and handled adequately.

Another psychodynamic principle that is prominent in my work with the MICA population is Object Relations Theory. The human psyche, according to this theory, takes in what it experiences with others and makes it part of itself. Here, the sense of self esteem exhibited by our residents is considered in the light of their internalized experiences with their primary care givers. The quality of their attachment to those primary care givers is reviewed in terms of the process of separation-individuation (separate/distinct and unique/individual person) attested to by the degree of internalization. The three main levels of internalization are incorporation, introjection and idealization. In incorporation, the entire

aspect of the other is taken in and made part of the self. In introjections, aspects of the other are taken in, while values of the other are taken in idealization.

Their biological and addicted mother abandoned Melba on the street with her twin sister. A hospital staff member adopted them. Melba stated that she hated the way the adopted mother speaks to her and Melba feels like a zombie in her presence. All effort to empower Melba to be independent proved abortive because Melba would relate everything said or done to the mother she "loves" dearly. And the mother believes that Melba would "never" be independent as such.

The use of Mantra in meditation will serve as Winnicott's transitional objects for the residents struggling with weak object permanence (Piaget, 1939) and wavering object constancy (Mahler, 1975). "Object permanence" is a purely cognitive achievement while "object constancy" has an affective dimension. The achievements of both are worthwhile and attainable goals (Berzoff et al 2002). The participants would achieve the capacity to have a mental representation of the goodness of the object even when it is not gratifying. And this will impact their thoughts and behaviors in a positive way.

Another psychodynamic principle I want to use in the project is self-psychology. The goal is the achievement of a cohesive, empathic, well-regulated and vigorous self in the psychological development of the participants in my project. The method will be my ability to create an empathic environment which is a way of knowing in the self-psychology of Kohut. The self is understood as tripolar, and each of the tripartite self has specific self-object needs. The "grandiose" part of the self, described as "I am wonderful and you know it," needs mirroring self-objects. This means people who will identify and reflect the unique capacities, talents and characteristics of the self thereby making it feel special and alive. Ambition,

understood as the power to complete maturational tasks, is the force that propels the grandiose part of the self.

The `second part of the self is the "idealized parent imago." It is described as: "You are wonderful and I am part of you." It is the part that idealizes the other. Its need is the strength and wonder in others that this part of the self could merge with so that one can feel secure. There ought to be something or somebody wonderful outside of the self, otherwise, we suffer in a scary world. The idealization of families, loved ones and culture expressed as strongly held ideals and values are the basis of intimacy, sharing and empathy. The energy at its service is the "pull" of ideals. The successful implication is that the qualities of the idealized self-object are taken into the self as a result of the merger experiences. The danger here is potential loss of self or too much idealization of the other that leaves the self devalued, feeling little, worthless and ashamed (Berzoff pp. 178-179).

The third pole is the pole of twinship described as: "You are wonderful and I am like you." The self-object need of this part is experiencing others as similar to the self. The feeling of soul mate sameness is comforting to the self and enables it to develop its vigorous cohesiveness. The energy motivation for this part of the self is the need not to be different or isolated (Berzoff). One of the strengths of our community residence is the emphasis on the sameness of the residents. Their diagnoses might be different, but they have a lot in common. The mature qualities emerging from the satisfaction of this need are security and a sense of belonging and legitimacy.

This theory emphasizes, how the "outside" affects the "inside" and how the latter grows into mature selfhood (Berzoff p. 197). My goal, therefore, is to use this project to provide a good enough psychological and spiritual environment where the "qualities and functions" of self-objects are taken in by the process of "transmuting internalizations" that will transform

participants into strong and whole individuals able to enjoy a deep sense of genuineness, authenticity and individuality by bringing out the best that is already in them.

2.2 Behavior Modification Theory

This theory is influenced by the rise of behaviorism and the development of the experimental method in psychology. Behaviorism is a natural philosophy that assumes the world is exclusively composed of matter and energy. Human qualities such as "mind", "soul," "will" or the "unconscious' are either denied existence or understood in terms of the same physical laws that explain the rest of existence. All behaviors are seen as caused by events in the environment.

Experimental psychology developed out of logical positivism which explains that everything that exists is empirically verifiable. Human beings are seen as material beings explainable by natural laws. Thus, the experimental method is putting philosophical behaviorism into practice (Parrott, 2003). Prominent exponents of this theory included John Watson who discovered that phobia could be induced by scaring infants. Watson knew that children reacted in fear whenever they heard a loud noise (Wikippedia). In 1920, John, with his the assistant and future wife, Rosalie Rayner, experimented on an 11 month old Albert to show that the latter could be conditioned to fear a distinctive stimulus in which Albert showed no fear prior to the experiment. The experiment began by placing the little Albert on a rug on the floor in the middle of the room. A white rat was presented to the child who reached out to the rat and gurgled as the rat roamed around him. Later Watson and Rayner made a loud sound behind Albert's back by striking a hammer suspended on a steel bar when the rat was presented to him. Albert cried and showed fear as he heard the noise. After several pairings of the noise with the rat, Albert was again presented with the rat alone. He

became very distressed as the rat appeared in the room. He cried, turned and tried to move away from the rat. Apparently, then little Albert had associated the white rat (original natural stimulus now a conditioned stimulus) with the loud noise (unconditioned stimulus) and was producing the fearful or emotional response of crying (originally the unconditioned response to the noise and now the conditioned response to the rat).

Loud sound (US) > Fear (UR) Natural Response

Loud sound (US) + Rat (CS) > Fear (UR) after pairing them

Rat (CS) > Fear (CR) Learning occurs.

Along the line of classical conditioning was the work of Ivan Pavlov with his salivating dog, based on his Stimulus- Response model of explanation. On the other end of the spectrum was Edward Throndike who, in 1911, developed his famous "law of effect" in which he described how behavior was learned according to the principles of reward and punishment. Rewarded responses tend to be reinforced and punished responses eliminated. His methodological innovations, especially, his "puzzle-box" facilitated objective quantitative data collection and influenced subsequent research methods of behaviorists. Other eminent contributors to the behavior modification theory were B.F Skinner who taught pigeons to play ping-pong and Joseph Wolpe who translated the early behaviorists' research effort into action techniques for promoting systematic client change (Parrott, p. 271).

Human nature according to this theory is neutral. People are neither good nor bad. They are simply the product of their experiences in their environments. Human beings are hedonistic in nature responding to pleasure and enjoyment in life and avoiding personal suffering. Psychopathology from this perspective is seen as behavior that is dangerous or disadvantageous to the individual and/or to the other people. Maladaptive behaviors can

result from insufficient clues to predict consequences, inadequate reinforcement or an early severe set of self-standards with resulting excessive self-criticisms.

Behaviorists focus on changing only behavior. Behavior modification is the term given to any process derived from a learning theory where the goal is to change a person's behavior or the way the person interacts with his/her environment. Changing complex behaviors requires complex behavioral modification. Behaviorists apply the concept of "shaping" which refers to the reinforcement of behavior that approximates or comes close to the desired new behavior. The steps taken are called successive approximations because they successively get closer and closer to the desired behavior.

Shaping works well for phobias and anxiety related disorders. Phobia goes with an irrational fear that is not justified by current outcome and significant distress or negative consequences resulting from such an irrational fear. The process of shaping involves creation of a hierarchy ranging from the least feared situation to the most feared situation. For example in treating the fear of a spider we construct the following hierarchy:

- Handling a stuffed animal shaped like a spider.
- Handling a realistic rubber spider.
- Observing a live spider in a cage.
- Observing someone else hold a live spider.
- Holding a live spider.

We would then start from the least feared (touching and holding the stuffed animal shaped like a spider) and reinforce the person for engaging in this behavior. Once this is mastered we move into the next level repeating the same process until the person is

ultimately cured of the specific disorder. Shaping uses the principle of operant conditioning, which means that a desired behavior could be repeated when it is rewarded.

A similar process is involved in the behaviorist technique of systematic desensitization. A concept described by Joseph Wolpe that takes three basic steps; training in deep muscle relaxations (which is itself another technique), constructing a hierarchy of emotionally provoking situations, and progressively paring the items on the hierarchy with a state of relaxation in the client (Parrott, 2003). Often this technique employs imagination such as imagining a spider crawling gradually towards you as immediate steps. The client indicates by sign e.g. the raising of an index finger when anxiety is experienced during the paring. The process continues until the client can imagine the situation without experiencing anxiety. This process uses classical conditioning in which the object (unconditioned stimulus) originally paired with fear (unconditioned response) is altered so that the object (conditioned stimulus) becomes paired with relaxation (conditioned response) and hence a relearning of a conditioned response. This again works well with fear and anxiety related disorders.

In utilizing some of the tenets of this theory in my project my goal is to extinguish the participants' identified maladaptive behaviors and introduce or strengthen adaptive behaviors that would serve as a replacement to enable them to live productive lives.

2.3 *The Miracle of Creation*

The first theological principle at my disposal in the actual execution of this project is the miracle of creation. In both philosophical and theological understanding creation means the "production of a thing out of nothing (Ott, 1960)." Thomas Aquinas made a distinction between "creatio prima', that is creation mentioned above in the proper and strict sense by which is understood that prior to the act of creation, neither the thing as such,

nor any material substratum, from which the thing is produced existed; and "creatio secunda", by which is understood the modeling of formless material and the bestowal of life upon it.

The creation of the world out of nothing from the Judeo-Christian perspective is explicitly expressed in the Holy Bible: "In the beginning, when God created the heavens and the earth (Gen 1:1)." "In the beginning" means the absolute time before which there was nothing side by side with God. No substratum of creation and no "materia ex qua" (material out of which something is made). The term "in the beginning" refers therefore to the time at which point the things external to God began to exist. The conviction concerning creation in this strict sense is attested to by the wise Maccabean mother when adjuring her youngest son to accept martyrdom: "I beg you, child, to look at the heavens and the earth and see all that is in them; then you will know that God did not make them out of existing things... (2 Mac 7: 28)," and by Paul writing of God who "calls into being what does not exist (Rm 4: 17)."

The secondary understanding of creation- "creatio secunda," is attested to by the second story of the creation of man: "the Lord God formed man out of the clay of the ground and blew into his nostrils the breath of life, and so man became a living being (Gen 2:7)," and woman: "The Lord God then built up into a woman the rib that he had taken from the man (Gen 2: 22)." And the author of the letter to the Hebrews writes of "what is visible coming into being through the invisible (Heb 11:3)." In this latter understanding of the term creation, the image of God is that of a potter molding man's body out of clay. In this perspective, we see that the motive of God's creation is his absolute goodness and the purpose is the revelation of divine perfection.

A closer look at both creation narratives, in Genesis 1 and 2, alludes to the following facts: the intimate life of God (ad intra) is relational, signifying the relationships of

communion among the three divine persons of the Most Holy Trinity- Father, Son and Holy Spirit; Creation is in itself an external expression (ad extra) of this relational life extended to God's creatures out of God's benevolence; and God takes delight in his creatures identified as "good (Keenan, 2000)."

Creation of the world by the Trinity is understood in theology by two main tendencies. The first states that creation is from the free exercise of the Divine Will. God is omnipotent and absolutely free to create what he wants without any internal or external coercion. In this view creation is something "ad extra" in reference to God. It is the overflowing glory of the eternal being. The second view begins from the "mystery of love and perichoretic communion" between the three persons of the Trinity and states that temporal creation is just the manifestation of Trinitarian love and communion for the utterly other than God, that is, creatures. Creation is "ad intra" when it's still an idea dwelling within the Trinity and "ad extra" once that idea is embodied in the image of the Trinity (Boff, 1988).

In the light of the Trinity, creation could be seen in three moments. The moment of the Father emphasizes creation in its aspect of open system where God provides for his creation and watches over all created beings and protecting them from falling into contrary forces while directing them to a future full of hope. The moment of the Son emphasizes the time of freedom corrupted by abuse that obstructs the achievement of humanity's first calling, that is, giving glory to the Trinity. And the moment of the Holy Spirit that continues and interiorizes the new life won by the Son (Boff, 1988).

In my project, therefore, I am looking forward to the realization of these moments of providence/protection, liberation and empowerment against the forces of drug abuse and mental illness for the participants. Though, the participants are dually diagnosed with mental

illness and substance use disorder, they are still men and women created in the image and likeness of God with the authority of dominion over other creatures (Gen 1:27-28).

Created in the image and likeness of God, the participants have an inborn creative power. The purpose of God's creation is the glorification of God. A distinction is made however between 'objective glory" (gloria objectiva) given to God by all creation without exception, by their mere existence, which mirrors the Divine Perfection; and "formal glory" (gloria formalis) rendered to God with knowledge and will by rational creatures (Ott, 1960), through their creative acts. The inborn creative power has been jeopardized in the lives of our residents by substance abuse/dependence and mental illness. But it is still there.

By the grace of God, meditation will help reconnecting them to this inner power of creativity. The Almighty finger of God is there waiting for them in the depth of their being. Meditation will provide a fertile ground for a reconnection to the power of transformation and recovery will be a joyful work: "Many of the answers for our lives are already inside of us if we will just listen...listening to the inner voice, the source of one's creativity is the smart choice (Blaney, 2003, p. 41)." Meditation is a way of listening to that inner voice where solutions to our problems are sought and found.

2.4 Honoring the Holy Ground

The story of the call of Moses in Exodus, chapter 3, supplies another theological principle that I want to use in this project – Honoring the Holy Ground. In reference to pastoral counseling, James E. Dittes (1999) asked the question: "what brings someone to this strenuous, awkward, hopeful moment?" In the same light the question that came up for me is: what draws participants into this project? My mentor/supervisor, Mr. Geoffrey Lindenauer, always says: "Our meeting together is not by chance." This is the picture we get

from the reading of Ex 3: 1-3. Moses was about his ordinary task of shepherding the flock in the desert. He was drawn to mount Horeb – the mountain of God. He saw a bush in unusual flames of fire. Attracted by this wonder, Moses decided: "I must go over to look at this remarkable sight, and see why the bush is not consumed."

As a pastoral counselor, something is pulling me to work with the mentally ill chemical abusers. Robert J. Wicks and Thomas E. Rodgerson (1998) recognized the fact that our attention is often caught by burning issues in the life of other people. These burning issues urge us to draw near. In my case, the population I work with are men and women who are no longer themselves. They are people filled with a sense of self- depletion and insufficiency. They see themselves as not being as they were created to be. They take themselves to be "misfits (Dittes, p. 18)." These men and women are in the flames of mental illness. They hear voices others are not hearing and see things others are not seeing. They are hurting; but they are still alive, not consumed.

In my project, I go with the mentality of Moses: "to look at this remarkable sight." The art of looking involves a pastoral discipline that is content with being a witness and not a player. It means being intensely present, as a witness, without craving to have an impact, to make a difference (usually a result of a need) on the participants. This art of witnessing is an affirmation that both the participants and I are in God's world, and as such, in God's care. Here, I don't need to intervene and take control of the participants' lives. I don't need to take responsibility for resolution and remedy. I don't even need to guarantee a positive outcome. Their well-being is not dependent upon my performance. They are in God's hands. I am there to wonder and marvel at God's endlessly resourceful power to create afresh in a surprising manner a personality that is whole out of the debris and casualties of mental illness

and addiction. This theological position calls me to stand as a witness to what God can do (Dittes, 1999).

When Moses drew near, he experienced that the place was a "Holy Ground." My theological principle is that the place of our encounter is Holy Ground. Meeting participants on Holy Ground involves conveying an atmosphere of trust, understanding of their frame of reference, recognizing their non-verbal signals, evaluating my own reactions, and keeping the focus on the participants (Wicks & Rodgerson, 1998).

It is important to honor the Holy Ground by conveying an atmosphere of trust. If there is no trust, nothing sacred will be revealed; and if this trust is first given and later betrayed, nothing else sacred will be revealed. Confidentiality understood as "an explicit promise or contract to reveal nothing about a person except under conditions mutually agreed upon," is the major key to trust (p. 19). Without confidentiality, participants will not share deeply and personally. Honoring the Holy Ground means respecting the demands of trust based on ethical and legal fulfillment of the confidentiality demands. Again, trust is conveyed by a caring and active listening, that is, nonanxious presence of one who is not afraid of silence, emotions or ambiguity (ibid).

Honoring the Holy Ground means understanding what the participants say from their own point of view. It is grasping his/ her frame of reference in a totally empathic manner. This asks for the use of the other senses as well as the ears. While listening to what is being said, it is important to pay attention to how it is being said. Honoring the Holy Ground calls for the evaluation of our own reactions in what is being said and how it is being said. It calls also for the criticism of our own negative or positive biases. It finally calls for recognition of the defenses of the participants – a fact that makes it easier for all of us to be comfortable on

the "holy dance floor" without moving away from it or bumping into each other (Wicks & Rodgerson, 1998).

Honoring the Holy Ground is recognition of the Divine Presence. God is present in the world. William A. Barry, SJ (2004) argues that "God is present in the one action that is the universe in an analogous manner to the way we are present in our actions. Yet God is immanent in the one action God is doing, just as, analogously, we are immanent in our actions as we do them (p.18)." The implication of this is that we encounter God on Holy Ground. We are in the presence of a mystery when standing on Holy Ground. During the execution of the project, we will acknowledge the inner powerful voice that speaks to/ and in our hearts.

Honoring the Holy Ground implies accepting the directives and directions of the Mysterious Being. Each participant will identify the Divine Being with a name unique to the participant. This theological principle emphasizes that God will be present to every participant as to the entire community. God has witnessed the affliction of the participants, heard their cry, and knows well their suffering. God is present to speak, to help and to save. Honoring the Holy Ground implies an acceptance of what God is willing to offer.

Besides, honoring the Holy Ground involves respecting the space of each other. God respects the freedom of human beings. Participation in the project is by choice and not by coercion. Everything we do during the project will be guided by this theological principle that respects human freedom. Sharing, for example, will be by choice. It is a matter of the quality of being in the presence of the Divine Being than the quantity of the time spent in meditation (Dreyer, 1994).

CHAPTER 3: EIGHT WEEKS ENGAEMENT OF PARTICIPATING RESIDENTS

3.1 Eknath Easwaran's 8-Point Steps

I. Meditation

Once everybody sat down in their seats, I gave out typed copies of the Prayer of Saint Francis of Assisi. Easwaran recommended that we begin with this because of its universal appeal and because it is the fruit of one man's efforts to transform character, conduct and consciousness. This transformation of character, conduct and consciousness is the reason for introducing meditation to our residents. The Prayer reads:

Lord make me an instrument of thy peace,

Where there is hatred, let me sow love;

Where there is injury, pardon;

Where there is doubt, faith;

Where there is despair, hope;

Where there is darkness, light;

Where there is sadness, joy.

O divine Master, grant that I may not so much seek

To be consoled as to console,

To be understood as to understand,

To be loved as to love;

For it is in giving that we receive;

It is in pardoning that we are pardoned;

It is in dying to self that we are born to eternal life.

I allowed everybody to read silently for some minutes. Then one person read it aloud while others listened. I mentioned the two principles they have to remember all the time: "You are what you think," and "Meditation is an interior discipline." You are what you think because in meditation, you focus on words that embody your highest values and ideals. Focusing on such words drives them deep into your consciousness and begins to create wonderful changes – changes people generally desire but have no clue how to effect in their lives. Secondly, meditation as interior discipline requires strenuous effort. It is not an easy task. Meditation is not a relaxation technique, it is work.

I then put the participants into a practical meditation mood. I asked them to pick a word that struck them during the reading of the text. I instructed them: "close your eyes, gradually, like a baby falling asleep. Be aware of the seat holding you from falling. Be aware of where your legs are. Straighten up your back and be aware of your breathing. Concentrate on your breathing and be relaxed. Pull out the plugs to disconnect your senses from distractions. Don't go on the bus or train. Rather, let the words follow the direction of your breathing. Stay with this word and let it be part of your veins, arteries, and the blood flowing all over you. Stay with the word... (Then after some minutes), now open your eyes gradually." Easwaran (1978) defined meditation as the regular, systematic training of attention to turn inward and to dwell continuously on a single focus, with consciousness until one is absorbed in the object of contemplation. It means, then, that meditation requires some degree of work. Now that the participants are disposed to learn, I summarized Easwaran's form of meditation:

- Choose a place, time and an inspirational passage. The place should be calm, clean and cool. The place of your choice should be

simple and recognized as your own Holy Ground – the meeting place with the Divine. In the choice of time, remember that early morning is the best time. Have thirty uninterrupted minutes for your meditation and stick to the same time everyday. Finally use an inspirational passage that is able to transform your thought, feeling, words and deeds bearing in mind the words of Buddha: "All that we are is the result of what we have thought." Use the Scripture and the writings of the great mystics of the world as your meditation text.

- For your posture, wear comfortable clothes and endeavor to sit erect/ upright with the spinal column, the nape of the neck and the head in a straight line. Close your eyes and begin to go slowly in your mind through the words of your simple, positive and inspirational passage which you have chosen. Remember the words of a modern mystic of India, Meher Baba: "A mind that is fast is sick. A mind that is slow is sound. A mind that is still is divine." Concentrate on the words and let them sink deep in you until you experience "the peace that passeth understanding."
- Be aware of distraction, drowsiness and emotional disturbance (DDE). Your mind can wander away in absurd dialogue, that is, question and answer type of discussion, or sleep might invade your space. You may also find yourself going deeper to the level where you experience emotional dangers such as extreme fear, or extreme happiness. When any of these happens, wake up and bring your mind back to the word you decided to use for your meditation. You could be

distracted by physical sensations such as nausea, itching or salivation. Therefore, before meditation, have good food, good exercise and good enough sleep.

- Lastly, renew your commitment: meditation should not be missed. Put it first and everything else second. Resolve to have your meditation everyday – even though your schedule might be overloaded and despite your regular interruptions.

On this first day, I had only four people in the group. Nora opened her eyes when she was asked to close her eyes and she seemed so much distracted. Val looked completely lost. These two had nothing to say during the sharing at the end of the day. Edwin expressed his surprise: "This is not what I expected." And Reginald stated that "this is the first time I relaxed."

II. The Mantram

We discussed the Mantram in the second week. The evening started with a jumping exercise. The participants were asked to stand in a circle. We were to jump as high as possible and land as soft as possible. We were, however, expected to jump and land together without being directed. This exercise is training in sensitivity, listening skills and cooperation. At the beginning, some jumped and landed before others. After some trial and error we were able to jump and land together a few times.

As a facilitator, I checked in on the participants to see how they did since our last meeting. Reginald tried to meditate everyday. He stated that he lacked focus at the beginning, but realized that he was energized throughout the day as a result of the morning meditation. He stated that he spent an hour engaging in meditation. I acknowledged his

effort, praised his honesty and reminded him to keep his meditation time to thirty minutes. Nora requested to withdraw just prior to us starting because, according to her, she was meditating at her day program and it was "boring." Val forgot to meditate; and Edwin tried once at night, lacked concentration and gave up. Val and Edwin were praised for their honesty as well. Val was challenged to practice what he learned and Edwin was advised to change his time for meditation. The morning period would be better for him because he would be tired by the time got home at night from the day program and place of work.

We then discussed the topic for the day: The Mantram. The human mind according to Easwaran is like the trunk of an elephant- restless and always moving through sensations, images, thoughts, hopes, regrets, impulses and so on. According to Easwaran, the wandering mind can be controlled by the systematic repetition of the Mantram. The popular etymology links the word Mantram to the roots- "man", i.e. "the mind" and tri- meaning "to cross." The mind is looked at as resembling a sea, ever-changing; placid one day and turbulent the next. It is filled with animosities, desires and conflicts. The Mantram repeated regularly, enables us to cross the sea of the mind.

The Mantram is a powerful spiritual formula that transforms the mind and consciousness. The Mantram strengthens the body and toughens the will to contain addiction. Internal conflicts are settled, human purpose unified and the individual becomes a beneficent force in life and not, as chemical abusers have sometimes been, a burden on the earth. The repetition of the Mantram is like every step we take, that is, superficially alike, but each takes us "deeper into consciousness and closer to the goal of love and joyful awareness (p. 62)." Easwaran referred to Mahatma Gandhi's statement: "For each repetition has a new meaning, carrying you nearer and nearer to God (ibid)."

The Mantram is connected to meditation. The Mantram stabilizes the mind so that it could be profitably engaged in meditation. Unlike meditation, however, the Mantram can be used anywhere and at anytime. Meditation requires discipline and will, the Mantram requires just the effort to start and continue going. The Mantram suits everyone no matter where you live, what you do or how old you are, whatever level of education you have, whether you are rich or poor and regardless of your health condition, you can use the Mantram.

In choosing a Mantram, Easwaran urges us to use a formula that has been sanctified by centuries of devout tradition- one of proven power, which has enabled many men and women to realize unity of life. Examples are the Christian "Jesus", the Catholic Mary" or "Ave Maria", the Jewish "Barrukh Attah Adonai", the Muslims "Allah", or "Allahu Akbar", the Buddhist "Om mani padme hum", and the "Rama Rama" in Hinduism. Easwaran advised that a Mantram should not be changed once chosen. Changing a Mantram is compared to digging shallow holes in many places and so the person that does that will never go deep enough to find water. The Mantram is most effective when repeated silently and with concentration. Use it whenever you get the chance: walking, waiting, doing chores, when falling asleep. Use it in dealing with difficult emotions (such as anger or fear); when excited or depressed, and at times of crisis. For example, when you are nervous or hurried or resentful, repeat the Holy Name until agitation in your mind subsides. Avoid counting or synchronizing your Mantram with physiological processes like breathing and using the Mantram when doing other things that require concentration, such as listening to music, or lectures, reading, writing, studying or conversing. It would be counterproductive to do that. Remember that the effort is to drive the Mantram to the "deepest levels of consciousness where it operates not as words, but as a healing power (p. 71)."

At the end of the day, participants chose their own specific Mantram. For Reginald, it is "Divino Spirito", for Val, it is "Jesus Christ", and for Edwin it is "I am God." They were reminded to use the Mantram as often as possible within the week. All went away silently.

III. Slowing Down

This session began with mirroring exercise. The participants were paired up. One person was asked to express himself/herself through physical gesture. The second person will mirror the first person. After a while, they were asked to change roles and the second person does something leaving the first participant to do the mirroring. They were free to do whatever they chose to do.

The exercise was followed by Easwaran's teaching on Slowing Down: Speeded ways of working and living leads to human beings becoming automatic beings without freedom and choices- only compulsions. The capacity of reflection is lost in speed and there is no change without this capacity to reflect. Paradoxically, people are stuck in the same place when they hurry (p. 90).

- Sensitivity to human need and relationship is lost in speed. Under the goal of speed, we act as if others are not there- those around us seem "to be blurs, like statues glimpsed through the fog (ibid)." Besides, hurry is contagious just as collectedness is contagious.
- Speed begets many physical disorders referred to as "hurry sickness." People who hurry experience digestive, breathing and nervous problems. The way we live, think, speak and act has to be put into perspective. A heart attack is a stop sign for hurry when hurry is understood as aggressive involvement in chronic incessant struggle "to

achieve more in less time." This could even include people who hurry while eating, moving and walking.

We also did a little check-in before the session. Reginald used his Mantram "Divino Espiritu" several times and refers to it as a source of strength. Val forgot to use his Mantram "Jesus Christ." Edwin used his "I am God" one time and forgot to do it again.

- Speed is encouraged by competition and drive enslaving men and women of our generation. People are aggressive in making money and in winning in various life competitions. Such people might win and be wealthy without the least enjoyment of the honor or health. Remember that true achievement goes to the wise and the not the hasty, to those tactful and not the hostile, to the creative rather than the person who is agile in competitive strife (p. 98).
- If we want freedom of action, good relationships, stability of mind, health and ability to grow, we have to learn to slow down. The words of Thoreau should be our motto: "I have no time to be in a hurry."
- Practical steps would be to set the pace up for the day by getting up early in the morning. Begin our meditation as early as possible, don't skip breakfast, and allow enough time to get to work. People forget important things when they hurry out of the house.
- Eliminate activities outside of the job and family responsibilities which do not add to your growth. At work, practice "no postponement of essential things." Slowing down makes one efficient at work; eliminates mistakes and accidents and essentially encourages more creativity at work.

- Encourage others to slow down. Even in an emergency situation, be able to have a clear vision of how to respond. When the work day is over, endeavor to drop it mentally.

In the end, we allowed participants to share their understanding of the topic. Reginald stated that his grandfather was good at slowing down. He was Reginald's first teacher on this topic. As kids, they messed up coffee when hurrying to make more money. The grandfather taught them not to hurry with anything in life if they want peace, joy and happiness. Reginald remembers his grandfather taking his time to dress for work.

IV. One-Pointed Attention

The session began with a physical warm up that we call the ball bearing exercise. We formed a circle. One person was established as having an imaginary ball. The person having the ball will use his/her hands to describe the type of ball s/he has by indicating the shape and size. The other participants will be watching intently. Then, the bearer will throw the ball to any person of his/her choice. The person to whom the ball is thrown is expected to catch it as if s/he would for the exact type of ball that has been demonstrated.

Today, we had two more members in the group. They were briefed on what the group was about. They were also updated on what had been happening in the group. The two new members were asked to choose their Mantram if they wished to continue attending the group. James chose "God" for his Mantram and Sam chose "God of Mercy" for his own. We checked-in on how others have been doing since the last meeting. Val remembered to use his Mantram, "Jesus Christ," occasionally. Reginald was upset at work, but practices slowing down and enjoyed the peace of mind he had as a result of the practice. Edwin forgot to do anything with what we had learned so far.

We then moved into teaching the topic of the day: One Pointed Attention. This is another powerful aid to meditation. Easwaran teaches that everything one does should be worthy of the person's full attention. Doing many things at the same time divides attention and fragments consciousness. There is a saying in my language which states that the person cooking and climbing the palm tree at the same time will either fall from the tree or the food will burn. Doing one thing at a time helps to unify consciousness and deepen concentration. One Pointed Attention is about mastery of our thought. Some thoughts intrude without permission. One Pointed Attention is seen in clear thinking and smooth functioning. The mind is effective when it is one-pointed and focused, but if it is scattered, diffused and filled with holes and cracks, it is hence less effective.

Secondly, training the mind is possible. Though the mind is a million- pointed at the moment, it can be trained to be one-pointed in meditation. Until it is trained, the mind will continue to do its own thing and go its own way because it is the nature of the untrained mind to wander. A disciplined mind obeys the command of the owner.

Again, the skill to direct one's attention at will is very beneficial. The mind that is trained is loyal and steadfast, pleasant and imbedded with an invigorating energy capable of opening doors of great opportunities. If you train your mind to give full attention to one thing at a time, you can achieve your goal in any walk of life. Concentration is a basic requirement in each type of human endeavor: arts, sciences, sports or any profession. The greatest benefit of a trained mind is the emotional stability it provides. In order for one to be angry, upset or afraid, for instance, concentration would have to be broken and the mind would have to change lanes. When the mind is one-pointed, it will be secure, free from tension and then able to concentrate. The capacity to concentrate on what one is doing is the mark of genius in any field.

The secret of training the mind is developing some form of voluntary control over our attention (p. 22). Divided attention can lead to physical exhaustion. It matters a lot what we do with our attention because on whatever we place our attention, good or ill is encouraged to flourish. In meditation we learn to control our desire and gradually become able to direct our attention to wherever we want. In meditation, also, we strengthen our discrimination and will so as to know where to put our attention and how to shift it when necessary (p.127) to avoid involuntary actions.

Splitting our attention is capable of destroying our goals in life. One-pointed attention enhances our studies, our enjoyment and our safety. We achieve the art of one-pointedness by avoiding doing several things at the same time. Developing one-pointed skills enriches our lives moment to moment – the senses become keener, emotions more stable, the intellect more lucid and sensitivity to others heightened. Being one –pointed can lead to consecration understood as the ability to discover that only love and wisdom can truly satisfy.

V. Training the Senses

We began this session with the exercise called "Simon says." Participants took turns in being the Simon that commands others to walk, stop, jump, crawl, laugh, sing and dance, etc. When the Simon gives orders, every person obeys by doing whatever he has asked us to do. This exercise is intended to help participants have a taste of what it means to either be in charge or accept being pushed around by others, especially, by our own senses.

There was also a check-in on the participants to see where each person is at in reference to the lessons given. Reginald expressed his happiness for being able to be punctual at his place of work. Val was happy for doing what he has to do. Sam accepted his sickness and feels better "not hurrying in life."

Then follows Easwaran's teaching on Training the Senses. Admirers of excellence train their body, judgment and endurance. As the body can be trained for virtuoso skills in sports, so can the senses be trained to benefit us and those around us. Trained senses are trusted servants. Untrained senses are hard masters. Training the senses means to enjoy food or entertainment that is beneficial and ignoring indulgencies one will likely regret latter. It means educating the senses not to demand things that will be detrimental to our health, security and freedom.

In training the senses we need to bear the following in mind:

- Freedom from the tyranny of likes and dislikes begins with training our senses to do what we approve of and to obey when our judgment say "no."
- The senses are the secretaries of the mind; to get the mind to listen to us, we need to bring them over to our side.
- In everything we do, we are subject to the dictatorship of rigid likes and dislikes. To be free from this conditioning, we need to change our likes and dislikes freely to serve the best interest of those around us or ourselves.

The best place to start changing the conditioning of our likes and dislikes is the senses. In a practical way, we begin by denying the body whatever injures the body. We give the body only what nourishes it. For example, eat only when hungry, skip the next meal after overeating and know when to stop eating. Training the senses requires a certain artistry, that is, knowing when to be strict, when to negotiate with the senses and when to allow them to be frisky a bit.

In all, however, we still have the power of choice. We can not only choose what to eat, but are capable of selecting our own entertainment. We can also train our sense of speech by insisting that whatever word comes out of our mouth has to pass through the Sufis' three

gates of what is true, necessary and kind. If what we want to say is not true, stop. If it is, ask the next question: is it necessary? If not, deny it an exit visa. And if it is necessary find out if it is kind, that is, supportive and loving. If the word will wound another person in any way, then keep your mouth shut.

Thought affects our mind. Buddha says: "All that we are is the result of what we have thought." For instance, mental violence gives rise to physical violence. The goal of training the senses is twofold: to conserve energy and to discover our real identity. Vitality flows out through the senses leaving us physically, emotionally and spiritually drained. Trained senses conserve vital energy – the very stuff of life. And when the senses are trained, one experiences the stillness of the mind: "Be still and know that I am God (Is 41)."

VI. Putting Others First

The session began with an exercise called "pastiques," that is, "writing in the air." Participants were asked to draw a triangle in the air. From the end of the initial triangle, they were to continue to draw a second one. They were to move around as they kept drawing. The drawing soon incorporated a circle and a square. People were coming close to each other, as participants were drawing and moving around the room; but nobody ever bumped into another person.

We had our usual check-in to find out how the week was for the participants. Reginald tried to train his sense of hearing by turning off his radio when he wanted to sleep and by lowering the volume when he had to listen to it. Edwin was angry that his pass request (i.e. permission to go out of the residence on the weekend) was denied and refused to come to the group. Sam found it difficult to train his senses and Abel spoke of his inability to practice what he learned due to the side effect of his medication.

I gave out a hand out containing three readings from Saint Paul, Hindu Scripture and John Donne as quoted by Easwaran.

Love is patience; love is kind and envies no one.
Love is never boastful, nor conceited, nor rude;
Never selfish, nor quick to take offence.
Love keeps no score of wrongs; does not gloat over other's sins,
But delights in the truth. There is nothing love cannot face;
There is no limit to its faith, its hope, its endurance.
Love will never come to an end (St Paul).

When a man loves his wife more than himself,
He is loving the Lord in her.
When a woman loves her husband more than herself,
She is loving the Lord in him.
When parents love their children more than themselves,
They are loving the Lord in them (Hindu Scripture).

No man is an island, entire of itself; every man is a piece of the continent,
A part of the main.... Any man's death diminishes me, because I am
Involved in mankind. And therefore never send to know for whom the bell
Tolls: it tolls for thee (John Donne).

That was a way of beginning the teaching on Putting Others First. It is our nature as human beings to be part of a whole. We want to live in a supportive environment. Easwaran

stated that some people suffer from the "elephantiasis of the ego," understood as, swollen concern for the self. This is a disease of self aggrandizement is which all that matters is "me," "my" and "mine." This constant dwelling on oneself builds a wall against interpersonal relationships. It keeps us from sympathy, understanding and accepting others because we see them from the point of view of our likes/dislikes, hopes/fears, opinions and judgment. Self will denies us of the happiness we are looking for and leads to increased frustrations, loneliness, insecurity and pain.

The remedy is eventually learning to lose ourselves to find others. Putting others first means that their welfare is a priority. It means paying attention to others and being sensitive to their needs. It means completing one another instead of competing with one another. When Gandhi was challenged as having no ambition, he replied: "Oh, no, I have the greatest ambition imaginable; I want to make myself a zero (qtd. in p.173)."

Putting others first removes the barriers of the ego- prison and deepens our relationship with one another. It encourages a spiritual union marked by love, patience and forgiveness as opposed to mere "attraction relationship" marked by manipulation, self-assertion and pride. Putting others first then sets us afire with love that recognizes the other. It's simply saying: "your welfare before my desires."

VII. Spiritual Companionship.

This session began with an exercise we called "zip-zap-zop." Participants were in a circle. A participant was to say "zip" while demonstratively directing the word to a second person. The latter would respond and redirect it to a third person with the word "zap." And the third person does the same with the word "zop." So it goes "zip-zap-zop" and begins with

"zip" again. Sometimes, the participants miss the trend. But it was fun enough to bond with each other.

We again checked-in on how people did for the week. Sam recalled giving a peer chance to go for food before him. Reginald gave a peer some money for use. According to Reginald, "I am working and making some money while my peer is in need of money. I felt I should support him." Besides, Reginald considered getting back with his divorced wife who always "loved me."

We then had the teaching on Spiritual Companionship. Spiritual friends are what Buddha, according to Easwaran, would call "right companionship." Everything we do either adds or subtracts from our own image as human beings. What we give our attention to, what we talk about, what we read about and the people we are close to contribute to either a higher or lower image of ourselves.

At this point, the participants are seen as spiritual seedlings. They need to be supported and protected. It is therefore necessary to join with those who want to promote our growth and who want us to promote theirs. It is advisable to cultivate friendship with those whose loyal companionship elevates you. When friendship is based on the goodness and nobility of those who share the same spiritual values, burdens are shared easing them and joys are shared multiplying them.

Participants are advised to avoid isolating themselves and to take advantage of the presence of people in the same meditation program with them. They could get together regularly to share a meal, meditate and perhaps read and discuss spiritual reading. And because recreation is an important component of healthy and spiritual living, they are asked to share moments of entertainment, too.

The power of spiritual companionship is marked by the augmentation and enhancement of individual capacities. The bonding and working together unleashes an irresistible force able to change the world. Therefore, there is a need to emphasize building deep relationships in our lives, with those who welcome the changes we are trying to make and those who will help us make them.

At this point, Edwin shared in the group what he has never told anybody before. At the age of 14, Edwin admired and followed the footsteps of his two elder brothers in football and wrestling. He became a county champion. Edwin had a group of friends at the age of 17. The members had different values in life. They happened to be the wrong values. They were drug abusers. Edwin later fell out with the law for abusing drugs. He consequently was imprisoned. Edwin's coach visited him in prison and told him about a scholarship Edwin had ruined for himself because of his current situation. Edwin knows better now and experience has taught him to "hang out" with positive people who can give Edwin feedback in reference to his effort in working for his recovery.

VIII. Reading the Mystics

This session began with an organized movement for pleasure. The process begins with everybody forming a circle. Then each person will have to bear two other people in mind and try to form a triangle with them. Nobody tells the two people s/he has in mind until everybody has formed the triangles. Participants were moving all over the place till each person was able to be in the same triangle with the two people in his/her mind.

During the check-in, Reginald shared his recent experience with the group. Reginald had a dream in which he saw himself as a surgeon performing surgery on a patient. It happened that when he got to his job the next day, the patient he was looking after became

seriously sick. He remembered the treatment he had administered to the patient in his dream, thought that it was meant for his own patient and requested that it be given to the patient. The patient had a quick recovery. Reginald stated also that he is being more in control over his anger problem.

The dream was acknowledged but not analyzed. Reginald was also praised for his courage to bring it up in the group. We quickly moved into the teaching of the day – Reading the Mystics. The journey of recovery and spirituality are arduous tasks. Reading the mystics and about their trials puts ours in perspective and the stories of their victories give us the courage we need to carry on.

The nature of spiritual reading is that it is continuously inspiring, prompts us to change, shows us how to change and encourages us to practice the ways of change. They remind us that the spark of divinity in all of us can be released through meditation, prayer and daily spiritual practice. Easwaran advises that we read directly from the mystics instead of the commentaries on them. We also need to read for understanding and inspiration as opposed to reading for information.

Spiritual reading should be thirty minutes following evening meditation because the thought we fall asleep in, will somehow be with us throughout the night. So, the sequence of the bedtime ritual would be: meditation – Spiritual Reading – Mantram. Having this scheme will help us not to jeopardize our work, family responsibilities and other obligations. We need to read widely and carefully to assimilate the good instructions in them. Reading materials from Tai Chi, Mandalas, Tantara Yoga, Works of Theresa of Avila (such as The Interior Castle), works of Theresa of Lisieux (such as The Story of a Soul), Thomas a Kempis' Imitation of Christ, Hindu's Upanishad, the Gospel of Sri Rama Krishna, Bhagavad-Gita,

among others, enables us to have a grasp of what we can be as human beings. We will see our capacity to choose, to change, to endure, to know, and to radiate spiritual glory.

3.2 Group Sharing

This ninth session is our last. I intend to make it an exercise of a closing ritual. In preparation, I gave the participants an assignment sheet the week before. The closing ritual began with silence that lasted for a period of six minutes. During the silence, we all acknowledged the Divine Presence in our Holy Ground. Our eyes were closed but it seemed that our hearts were, at that time connected to one another.

The participants were asked to address the issues in their assignment sheet by way of sharing. Sam volunteered to open it up. He spoke of allowing Roderick to use Sam's walkman and gave out cigarettes to few of his peers. In reference to alcohol, Sam spent quality time thinking about the humiliation he had to suffer as a result of his drinking and the betrayal of people's trust in him. He shared with the group the dreams he had about alcohol, drugs, toiling and work. Sam abstained from touching a woman even when the instinct said, "grab her." In addition, he went to see his psychiatrist for medication adjustment because he does not want to be sleeping in the program any more. While meditation has made Sam submissive and takes away his stress, Sam also uses the Mantram to offer himself to the Divine and the Mantram enables him to pray for others, especially, those he does not like.

Reginald whose Mantram is Divino Espiritu recites it repeatedly before going to bed and is able to sleep seven hours now. He stayed an extra forty-five minutes at work taking care of an elderly person – feeding and shaving him. He bought soda for his peers and shared with many of them what he learned in the meditation group. Although the texts strengthened

his faith, Reginald has wondered how a Catholic priest could be giving out material of other religions and actually encouraging people to utilize the content of such texts. During his meditation, time stops and Reginald is able to travel beyond his feelings. He finds himself at peace with his soul. Reginald is relaxing more and is peaceful. He gave out gum to all participants at this point.

Val shared that he is becoming social and relating better with his peers. For Val, the Mantram protects and delivers him from mental and physical troubles. The exercises help in group building and the selection of the exercises made the lessons clearer just as it brought body and soul together.

For Edwin, the Mantram brings in energy that motivates him and helps him deal with depression. He is now ready to move on to the next level of care. Besides, meditation enabled him to stop watching movies that have a negative influence on him. At the end, the participants agreed to help Edwin pack his properties to get ready for his moving. They also agreed to go out together to "hang out" and watch movies.

I ended this part by words of encouragement. I said something good and positive about each participant. I recognized the effort of those who wanted but could not join the group. I appreciated the effort of those who could not follow through. And I encouraged them to share whatever they have learned with their peers and every human being. I shared the lessons of transformation taken from Jean-Dominique Bauby's "The Diving Bell and the Butterfly." Jean- Do, as they called the author in the hospital, suffered from "locked-in syndrome," an ailment that leaves the body inert. He was able to compose a memoir that was published two days before his death. I finally urged them to continue the practice of meditation for the rest of their lives.

We then moved into the third and final part of this ritual – the closing proper. The first part is my articulated prayer for the participants: "Dear fundamental Source of energy and life identified as 'I AM' by Edwin, 'Divino Espiritu' by Reginald, 'Jesus Christ' by Val and 'God of Mercy' by Sam; we come before you with one heart, one mind and one soul. We are in your presence all the time and especially, now. We acknowledge your assistance and we thank you. O source of life, it has been eight successful weeks and we thank you. We still have more seconds, minutes, hours, days, weeks, months and years ahead. We entrust those into your hands for guidance. Through the use of meditation, keep us mentally stable and help our sobriety. We will be creative, productive, fulfilled and happy for ever. Amen."

The second part of this aspect of our ritual followed immediately. I urged everybody to say a word to the group and requested that the participants take these final words personally. One after another, the final words from participants were: "You made it," "Be Strong," "We are always here for you," and "Don't give up." Finally, we had everybody give each person African-American handshakes and hugs.

3.3 Assessments Tools.

I will utilize the following tools to assess the outcome of my project.

* Attendance Sheet: Participation in the project is voluntary and open. That is to say that people are free to join or withdraw at will. For this reason, therefore, I intend to use attendance sheet to find out how serious participants took the project. This will demonstrate the participants' consistency.

* Simple Survey/ Questioner: I intend to present the participants with a set of very simple questions. Answers to these questions will help me to find out the actual impact of the project on the participants.

* Observation/ verbatim: I will utilize a subjective discussion on the outcome and a verbatim account that will enable a participant to say what happened in their own estimation.

CHAPTER 4: ANALYSIS AND EVALUATION

4.1 Description and Discussion of Attendance

Attendance Sheet

	Dates	10/19/06	10/26/06	11/11/06	11/18/06	11/22/06	12/02/06	12/07/06	2/09/06
Names									
Reginald		√	√	√	√	√	√	√	√
Nora		√	∅	∅	∅	∅	∅	∅	∅
Val		√	√	√	√	√	√	√	√
Melba		∅	∅	∅	∅	∅	∅	∅	∅
Edwin		√	√	√	√	∅	√	√	√
Kevin		∅	∅	∅	∅	∅	∅	∅	∅
Ron		∅	∅	∅	∅	∅	∅	∅	∅
James		∅	∅	√	∅	∅	∅	√	∅
Sam		∅	∅	√	√	√	√	√	√
Roderick		∅	∅	∅	√	√	∅	∅	∅

Key

√- Attended

∅- Didn't Attend

In the beginning of this project, seven residents volunteered to participate. We met briefly and agreed to meet once per week for nine weeks. The schedule would be flexible considering the nature of the population and the kind of work we do. Two other people joined in later due to being newly admitted to the program. One resident was convinced to join by a peer who is a Home Health Aide and is reaping the benefits of mediation just after three weeks.

Before the first meeting, one resident was hospitalized and soon after was discharged from the program, hence never participated in the project. Another resident was sick and refused to attend after he recovered. A third resident self discharged from the program. One resident withdrew after the first week stating that meditation was boring and it is done everyday in the day program this resident attends. For some time, there were basically four residents that attended consistently throughout.

Of the last three residents, one showed up two random times, another attended twice just prior to being hospitalized for decompensation (mental relapse). The resident that came because a peer convinced him ended up continuing until the end. In all, five residents were constantly present for the project.

Overall, the meditation seemed to be a beneficial enhancement to therapy for those that diligently practiced it. Often times, people are resistant to try new things and some take longer than others to realize the benefits and therapeutic goals of a certain task. Even when an individual enters treatment, there are many aspects (of treatment) in which they are reluctant to fully surrender to. Unfortunately, an individual, especially in this complex population, will often fail several times before they become fully aware of the steps needed to make life changes to be made in order to become an esteemed human being.

Even those individuals that did not embrace mediation at this time still have experienced the introduction and knowledge of this journey to a greater awareness. This can assist the individual later on in life if they choose to come back to seeking an alternative treatment method. The more tools a person has to become aware of themselves and their illnesses, the greater the chances of that person gaining enough insight to make a positive and productive recovery.

4.2 Explanation of Outcome of the Survey

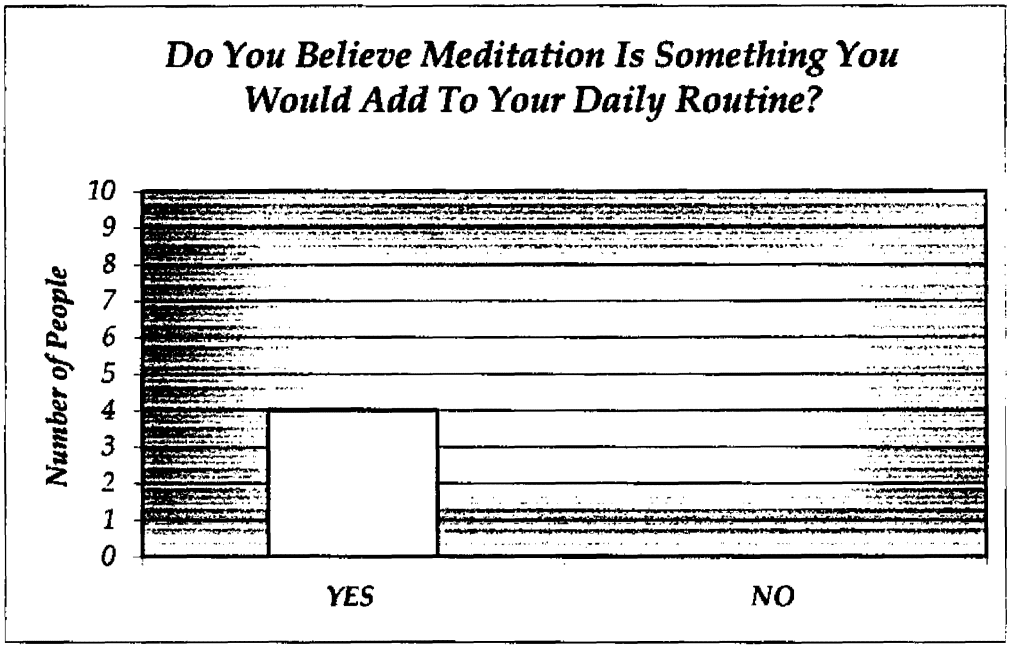

Figure 1

According to figure 1, all participants that persevered to the conclusion of the group stated that they would include meditation in their daily routine. The four participants who completed the survey were pleased with the group and believe it had a positive impact on their road to recovery as evidenced by the results of this survey question.

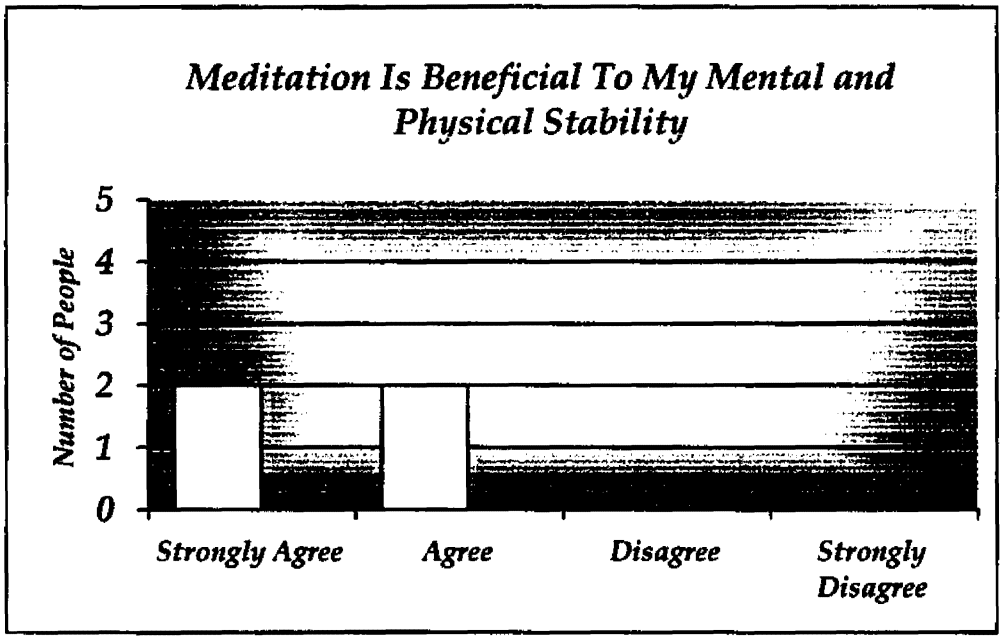

Figure 2

According to figure 2, all participants surveyed believe that mediation has a positive impact on their well being. Of the four individuals surveyed, two stated that they "strongly agree" and the other two "agreed" with the statement in question. It is interesting to note that one of the individuals who completed this survey was hesitant at first to believe that meditation would have any impact on his mental stability. Due to the confidentiality of the survey, it is unable to be determined which answer this individual chose. One of the participants had stated that meditation is calming and assists in controlling angry outbursts.

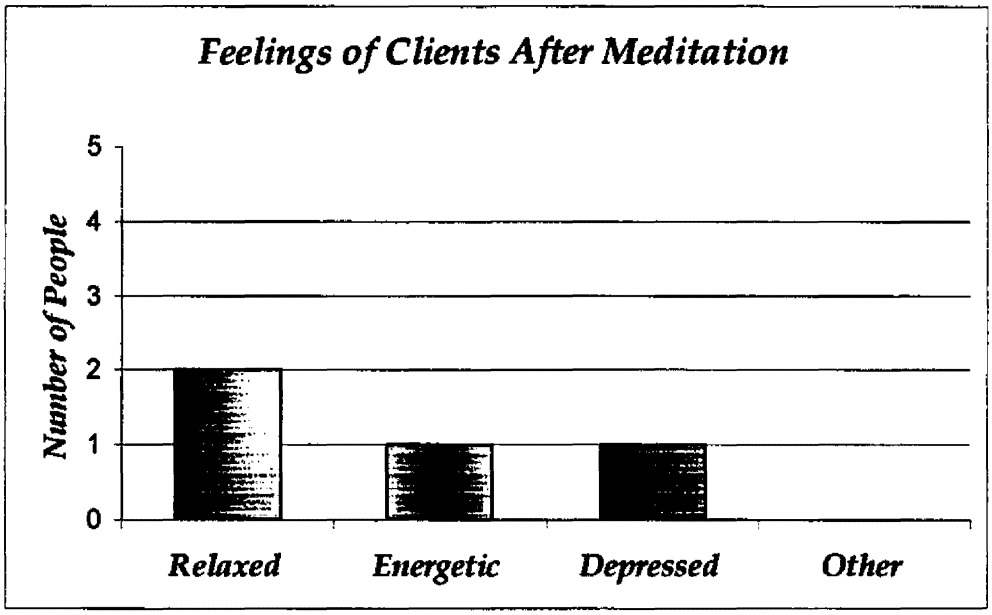

Figure 3

There is a clear representation in figure 3 that most clients are able to experience an encouraging feeling due to meditation. Although one client did report feeling depressed following meditation, it is essential to note that many times client's mistake feelings of boredom or calmness for depressed feelings. One of the clients reported feeling more energetic and stated that meditation enables them to be more proactive in the morning, which hence leads to a day focused on goals and productivity. Due to these results, this client believes meditation is most beneficial when practiced in the morning. On the contrary, those clients reporting a relaxed feeling prefer meditation in the evening or when emotions are high. They find it easier falling asleep and remaining in a restful state for the entire night or they use meditation as a relaxation technique against stress or frustration.

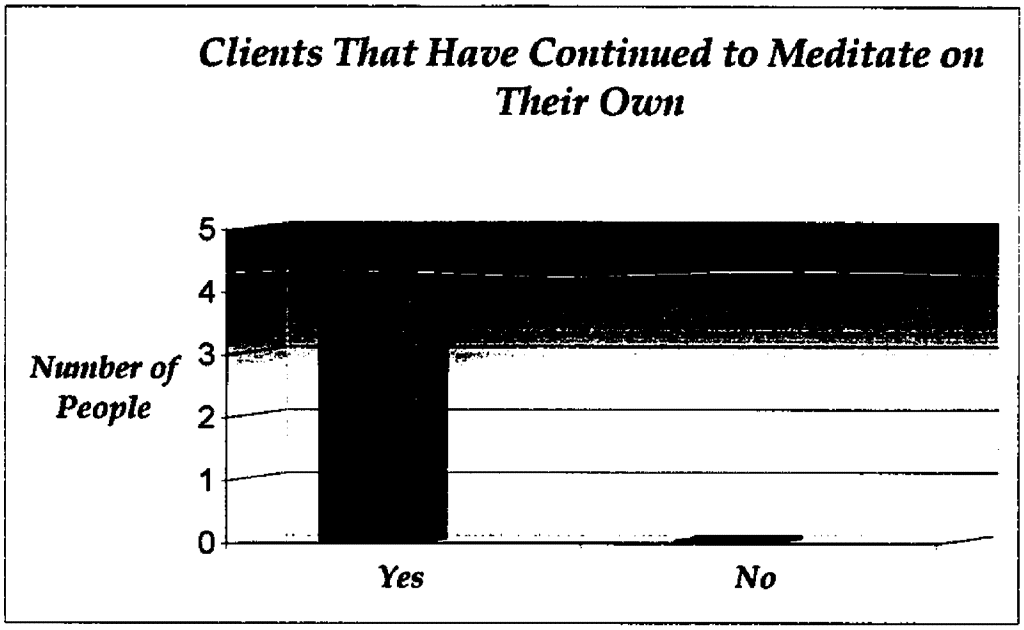

Figure 4

It is interesting to be aware of the fact that all the clients who participated in the entire group cycle have continued meditation on their own time. Historically, this population of clients is very resistant to trying new things and remaining consistent with it. All four clients have reported to use meditation at various parts of the day. One client has even stated that meditation is a useful coping mechanism for dealing with stressful situations.

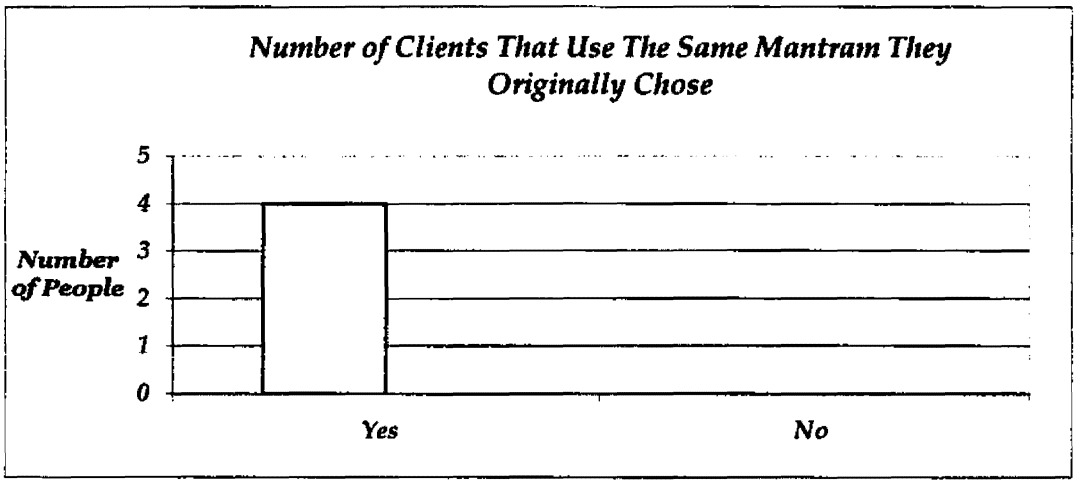

Figure 5

At the beginning of the group, the clients were informed what a mantram is and how it is used. The clients were asked to pick a mantram of their own liking that they believed would help guide them spiritually. Meditation is used many times to realize the inspiration within all of us. It also produces a stillness of the mind that in turn allows a clearer thought process and a greater ability of awareness. The mantram is instrumental in allowing this process to be achieved to its optimum ability. This gives way to the fact all clients stated that they kept the same mantram throughout the group.

4.3 Verbatim Account

Edwin was one of the participants in my project on "Meditation as a coping tool" for mentally ill chemical abusers' recovery. He only missed one week. He refused to come because he was angry that his pass request (that is permission to go on visit for the weekend) was denied. The group barely ended when Edwin was discharged for successful completion of the program. He lives with a roommate in an apartment, goes to work and meets occasionally with his Intensive Case Manage (ICM). We met at the Continuous Day Treatment building.

E stands for Edwin.

B stands for Benet.

E1: Hi, Mr. Benet (gave me a hug).

B1: Hi Edwin. You are full of smiles, how are you?

E2: I am doing well. I have an appointment with my ICM.

B2: You look terrific. How have you been doing?

E3: Thank you Mr. Benet. I am doing okay. Did they tell you...ohm...ohm... that I came to the residence?

B3: you did?

EG4: I did. I meant to ask you something about the meditation group.

B4: Okay

E5: Are you still doing it? I want to come for that group.

B5: Tell me more.

E6: Meditation group helped me, Mr. Benet. I am still meditating. My roommate is doing it with me too. I told him about it and he wants to come with me to the group.

B6: This is amazing. How do you feel?

E7: I am happy. See how I look. I even stopped taking eggs. My cholesterol is fair now, and I do my best to do one thing at a time, thanks to the meditation group.

B7: You learned a lot from the group and you have even become an apostle of meditation.

E8: I am excited about it Mr. Benet. It helped and I know it can help others.

B8: Good to hear that Edwin. The group is ended now. I hope to do it again. Have you a number I can reach you with, just in case?

E9: Yea (giving me the number), here it is.

B9: Thanks Edwin, I have to go to our meeting now

E10: Thanks Mr. Benet. It was nice meeting you, again. Please let me know when you begin the meditation group again.

B10: I will (we shook hands, hugged each other and left).

CHAPTER 5: TOWARDS CONCLUSION

5.1 *Implication of Anticipated Results*

In this section, I want to discuss the outcome of my project in the light of the psychological and theological principles outlined in the second chapter. The attendance sheet presented in Chapter Four indicated that three prospective volunteer participants never made it to the group. One of them self-discharged from the program, that is, left against clinical advice. In the psychodynamic principle of ego psychology, we noted that reality testing is a way of determining the ego strength or weakness of the person we are working with in counseling. Ron had very poor results in reality testing. The first time I spoke about my project and its expected advantages, Ron was among the first people to volunteer. He often sang and spoke of Jesus who has "never failed me yet."

Ron thought that meditation would be helpful to him. Days before the project started, Ron self-discharged against clinical advice. That was his second time of self-discharging from the program. Interventions were set up to stop him. But Ron insisted, then, that he was in the program voluntarily and had the right to leave whenever he would want. He stated that he had an apartment already in place and everything would be fine with him. Ron left and was on the street for a couple of days and later hospitalized.

A second prospective volunteer participant, Melba, was administratively discharged for non compliance and inability to invest in her recovery. Melba's situation would be understood in the light of biologically determined behavior as delineated from the Drive Theory. Melba's biological and addicted mother abandoned her on the street with Melba's twin sister. Her adopted mother smothered Melba. While in the program, Melba was sexually acting out and constantly missing from the residence. It came to a point where she

became such a negative influence on the community that she had to be discharged for administrative reasons.

A third prospective volunteer, Kevin, never showed up because he developed a skin disease. He was advised medically to isolate himself from the rest of the members of the community pending the result of his laboratory test. With the result indicating that the disease was not infectious, Kevin was free to mix with the rest of the members. The effect of isolation and shame prevented him from joining the group.

Again the attendance sheet indicates that one of the participants withdrew from the project after the first session. Nora had stated that meditation was boring while claiming to be participating in it in her day program. Nora was presented as an example in Freud's Drive Theory, discussed in Chapter Two, as someone who regressed to her earlier stage of functioning whenever she was frustrated. Her withdrawal from the group happened to be one of those decisions she took while she was frustrated by some other event in her life.

The attendance sheet also indicated infrequent attendance by a particular participant. James joined the group late because he was admitted into the residence weeks after we started the project. But the group was open and people were free to join or leave at any time. However, James was highly infrequent in attendance. At that time, he was experiencing inner conflict between the id and the superego. We saw this in Structural Theory. His attendance depended on which of those overpowered the other in his life at the moment for the group. He did not last long enough to develop a strong ego through meditation. That would have put a check to the conflict he was experiencing.

A major expected outcome of the project is the transformation in the lives and behaviors of the participants who stayed to the end. From the result of the survey, we delineate that participants experienced the project as having a positive impact on their mental

and physical stability. They are beginning to have good feelings to counteract the feelings of shame, guilt and worthlessness. They see meditation as a coping mechanism for handling stressful situations. The consistent use of the mantram especially in stressful and depressive situations is a sign that participants are beginning to think before they act.

Sam joined the group late. He had stated that meditation contributed to his mental illness. For that reason, Sam had declined from joining the group. The discussed the effect of "twinning" in the psychodynamic principle of self-psychology. Reginald is a buddy to Sam. They played the guitar and sang together often during morning meetings. Reginald always spoke to Sam about the group at the end of each meeting. When Sam joined, the system used in the project became a behavioral modification tool for Sam. He overcame his fears and made considerable progress through meditation. He is ready now to add meditation in his daily activity. In addition, Sam who abused alcohol daily, by mixing alcohol with tea, has stopped "drinking" and is committed to his "sobriety."

Before the project, some residents would not want to be escorted by Val. He was such a "dumb escort." Through the group, however, Val has developed his socialization skills: he now participates actively in house meetings, facilitates the meetings sometimes and plays in skits (mini drama) during the morning meetings. A lot of the residents want Val to be their escort to various appointments now.

Another participant, Edwin whose verbatim is presented in the previous chapter has benefited from the project. Idealization discussed in the Object Relations Theory and Self-Psychology is a major help for Edwin's mental stability. The teaching, understanding and use of a mantram offered Edwin the tool for idealization. In the end, Edwin who had not been good at handling frustrations developed an observing ego through meditation and is appreciative of such help as seen in the verbatim account in Chapter Four.

For Reginald, the discussion on "Putting Others First," had a wonderful effect on him. It was presented as a behavior modification tool. Reginald benefited from this because it addressed his anxiety and offered him help in facing depressing moments. Reginald was an active participant in the group. Prior to this project, Reginald would not discuss his relationship with his ex-wife. At the moment of writing, Reginald has started dating her. It is his intention to get back together again with her, as a wedding gift to his first daughter, who unsuccessfully had worked so hard at keeping her parents together.

In all the stories of success, I see the influence of God who watched and directed every participant in the project. The project enabled the participants to be reconnected to the power of transformation one way or another. In the group we created an atmosphere of trust (in honoring the Holy Ground) that a participant, Edwin, was able to share what he had never told any person. Most importantly, I admire the four participants who have accepted what God was willing to offer them and they are ready to meditate often on their own. The transformation in their individual lives is an encouragement to me.

5.2 Discussion of the Unexpected Outcome.

The unexpected outcome in reference to attendance was discouraging to me in the beginning of the project. Seven residents volunteered to participate. I had wanted more people to volunteer. Having just seven out of eighteen residents volunteering was discouraging. Then before we even started, one was hospitalized because of her relapse in substance abuse. A second person had rashes suspected to be infectious all over his skin and he had been advised to stay away from everyone until he got the results of his skin test. When eventually the result was released and he was declared free to mingle with others, he decided

not to come because his "skin is itching." A third person self-discharged, that is, he left the program against clinical advice.

It was then that it dawned on me that I had just four residents to begin the project. I was sad and confused. Should I continue with this or change my audience? I knew I could do an easier job talking about "Meditation" with the Intercessory Ministry, Teaching Ministry, Praying Ministry or the Singing Ministry in my Parish Prayer Group. I am sure they would appreciate it and be more consistent in the course of the execution of the project. I wondered, at this point, if I could go back to my lecturers and tell them how difficult it would be to carry out this project with my chosen population. Would it have been possible to just do a thesis instead of this project?

At this point, I thought that our residents are fixated in their early developmental stages. They are, as discussed in Chapter One, impulsive in their behavior. Instant satisfaction of their impulsive desires was all their concern. This initial attendance outcome shows how difficult it was for our residents to do something to better their condition by themselves. Those who volunteered and could later not attend simply regressed to their comfort zone and preferred not to be bothered with meditation. After thorough reflection, I decided to give the project a trial. For one reason, I decided I would avoid falling into the same problem of acting impulsively. Again, I still had four prospective participants who seemed eager to proceed with the project.

Another unexpected outcome from the census/attendance sheet was the presence of absenteeism. Edwin who has been showing up for meditation group was absent on the fifth session. When asked the next time he showed up, Edwin stated that he was angry because his pass request (i.e. permission to go out of the facility during the weekend) had been denied. He stated also that he struggled in his mind whether to come or not. Edwin has been in the

program for over three years. Each time he is frustrated, he takes it out on himself by attempting suicide. This time, as a result of his participation in the group, Edwin is beginning to think before acting. The struggle going on in his head might have been the conflict between the id and the superego. Edwin regressed to a similar and more familiar stage of development where he takes his anger out on himself, thinking that he is punishing other people, by his absence from the group.

From the survey, we got some participants who felt relaxed after meditation. Meditation as was presented is not a relaxation technique. Meditation is work and is expected to set the pace for the practitioner's day. That relaxation could sometimes be an effect of meditation does not mean that there are no demands attached. Sometimes, the demands are not relaxing at all. It is possible that the participants who see it as relaxing incorporated in themselves the teaching on "Slowing Down," in Object Relations Theory's terminology. But Slowing Down, which requires some effort to maintain, is at the service of meditation. When we practice taking things easier in life, we are better prepared for a fruitful meditation exercise.

In the same survey, one person expressed that meditation left him depressed. I believe that the participant is confusing depression with something else. All the participants either agreed or strongly agreed that meditation is beneficial to their mental and physical stability. Again, all of them indicated their readiness to add meditation to their daily routine. If meditation left this anonymous participant actually depressed, the participant would have answered differently to the two questions preceding that of depression. If the participant's feeling of depression is a constant thing, however, it needs to be addressed in subsequent one-on-one counseling sessions to see how the participant could be helped with the issue.

5.3 Personal Contribution to Ministry in Wider Context

My aim in this section is to discuss the extent to which my initial goals for conducting this project are realized. Despite my initial disappointment over poor numbers of volunteers, and the subsequent disappearance of some of them, I recall the fact that I have been thinking of this project constantly. I discussed my aims with several people. Every discussion around the project throws more light into what I was conceptualizing. I also spoke to the residents about meditation and how helpful I thought it would be for them. Having seven people volunteer to participate in the project was a huge success, considering the nature of our population.

The initial challenge was to adapt an integrated approach that meets residents where they are, during my project, as opposed to the strictly Therapeutic Community model of treatment. This integrated approach will hopefully produce greater participants' satisfaction and a higher level of efficiency as it meets the individual needs of participants. This approach will also emphasize the integration of mind, body and spirit, in such a way, that positive changes in attitudes and behaviors can be realized. This goal was realized by my flexibility. For example, membership was open, that is, people were free to join or withdraw at will, and our time of meeting could be changed to meet the needs of participants.

Again, I aimed at bringing a spiritual component into the program. This spiritual component was to help in grounding participants while they get reconnected to their inner strength. It would mean empowering them to be in charge of their lives, not in an intimidating or selfish way, but rather in a way that is useful for themselves and for others around them. By the end of our project, participants were conscious of the needs of others and became readily available to the needs of others. They became more social, more caring

and more lovable. Broken relationships were mended as a result of their participation in the project.

Moreover, I believe that meditation will enable the participants to begin to accept responsibility for their actions as they battle with selfishness inherent in the substance abuse lifestyle. Meditation would carefully overcome their impulsivity by increasing in the participants the propensity of thinking or reflection before action. Before this project, three participants were finding it extremely difficult to manage their frequent outbursts of anger. Two of them would actually turn their anger against themselves and engage in self mutilation or attempt suicide by overdosing on their medication. They are the ones that demonstrated dramatic change in their behavior in the course of the project. For example, Edwin can talk about his anger and is able to apologize if necessary for an initial emotional outburst instead of harming himself. Sam is no longer self mutilating and he is committed to his sobriety in a way he was unable to prior to joining in the project. Reginald has a map for complete reconciliation with his ex-wife scheduled to happen before the wedding of his first daughter.

Finally, my aim for engaging our residents in this project is to recreate a whole person, an adult self ready to help others with the help they received. Therapeutic Community emphasizes being one's brother/sister's keeper. It means looking out for the welfare of those around you. It means, in this case, sharing the fruit of meditation with others who might as well need it for their own growth into being mature human beings. From the first day, Reginald became an apostle of meditation. He brought Sam in and both have made tremendous progress in their recovery through meditation. Edwin has been discharged for successful completion of the program; and Edwin has taken the fruit of meditation to his new place as indicated in the verbatim account. Val has been transformed. He has become the

most sort after escort for the peers in lower levels. Thus, this project has opened the gate for ministry in the lives of the participants.

5.4 Implication for Future Ministry

Let me, at this point, reiterate a few things I stated in my project proposal. In my country, Nigeria, addicts are objects of public laughter and blame. They are even murdered sometimes for being "useless" to the society. There is no treatment center, to my knowledge, for alcoholics and/or drug abusers. Addiction is still a blame game in which shame and guilt play a major role.

Mental illness and wellbeing are being addressed in many countries of the world. But there are still countries where treatment of the mentally ill is either not being addressed or is addressed in an improper way. People who are mentally ill are seen completely naked as they travel from village to village, town to town, city to city and even state to state. Sometimes they are seen dressed in dirty rags, picking food from garbage on the street and drinking water from the gutter. In some countries, overwhelmed by the influence of the mentally ill, and experiencing a lack of treatment, they have them tied up or permanently locked up in a dark room.

In countries, such as the US, where treatment is being offered and the government is taking proper care of recipients in different programs, we still find that mental illness and medication impact the behavior of the residents. Their mood swings, and their attitude changes from time to time. Addicted individuals are often impulsive. I stated that if they learned the value of thinking and are able to think before acting, there will be a lot of improvement in their recovery from addiction and mental illness. It was for this reason – the

increase of the propensity of thinking or reflection before acting – that I introduced meditation as a coping tool for the addicted and mentally ill residents. It worked.

There were, however, challenges during the execution of my project that were not addressed in this paper. For instance, when will it be best to introduce meditation to people receiving treatment for addiction or mental illness or both? My participants are mixed up. Some have been in the residence over a year and were getting prepared to leave, others were recently admitted. At what time will meditation be beneficial for recipients of services – during their orientation into the program, in the middle of it or towards the end of their treatment program? Though I want to leave the answer to this particular question to future research/or a future project, I still think that meditation, like any other valued tool should be introduced on need basis in the light of the integrated model of treatment. It has to be channeled to the individual needs of the recipients.

Again, how would meditation be effective for people presently experiencing psychotic episodes? One of the participants could not complete the project he was interested in (although he was newly admitted into the program) because he was hospitalized as a result of a psychotic episode. He had a manic attack and became a danger to himself and to others. I was not present when the incident took place; but even if I were present, the situation would still be beyond my control and I doubt if, at that point, my teaching on meditation would have any effect.

Moreover, I had participants who seemed less interested and apparently lacked understanding. They would forget their assignment and would not participate in the sharing. When encouraged to speak, they would say something outside the topic being discussed. All they did was come in when it was group time, grab a seat and join in whatever is happening at the moment. It was therefore surprising to observe the changes and transformations in

various levels among such participants. I know that the grace of God has been wonderful in the group by what such participants were able to achieve within a few weeks. When all is said and done, Eknath Easwaran's type of meditation is simple, practical and adaptable to any group or population in life. And it works!

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