HOW DO YOU JEW?
PERSONALITY AND PARTICIPATION DECISIONS AMONG AMERICAN JEWS AGES 21-35

By

Deborah N. Tuttle

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Approved By:

Advisor(s)

Director, SJCS

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Abstract

What Jewish activities do American Jews, ages 21-35, engage in? What motivation drives them to participate, and to continue participating? What role does individual personality temperament play in these decisions? This study answers these questions based on a 662-response online survey.

Reading books and listening to music with Jewish content are the activities with the highest rate of participation. These activities should be expanded to engage more young adults in group activities based on these themes. Other activities with high participation include various classes, *minyanim* or social events. These programs may not individually have high numbers, but the engagement potential is huge.

Friends and fun are clear motivating factors among this age group. If they are not going to see a lot of people they know, and engage in a well planned and enjoyable event, they will not come. Further, a large majority will not return to an event that disappoints them; this cohort gives activities one chance and, when turned off, is difficult to re-engage.

One particular personality type stood out as being less comfortable with religious aspects of Jewish life. This does not mean that they are less participatory, only that they need to be engaged differently, appealing to their enjoyment of community and expression of their values instead of only religious observance.

Nearly 15% of those surveyed in this study were unable to categorize their denominational affiliation in a broad range of choices from non-practicing to Orthodox. Instead, they filled in a range of answers from personal philosophies, to "*minyan* Jew," to interesting hybrids of Jewish practice.

All together, this research brings greater insight both into how young adults plan to participate and how their personalities affect their perception of participation. It also indicates a number of ways in which young adult programming needs to be expanded and improved. In short, this thesis increases our ability to engage young American Jews in Jewish life.

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"To put up with me is the first step to understanding me. Not that you embrace my ways as right for you, but that you are no longer irritated or disappointed with me for my seeming waywardness. And in understanding me you might come to prize my differences from you, and, far from seeking to change me, preserve and even nurture those differences."

-Different Drummers, Excerpted from David Keirsey's
Please Understand Me II, 1998.

I. Introduction

There are two brothers I know from my childhood; they continue to be friends of mine today. I became friends with them through a number of Jewish activities in my youth, from being campers, youth group board members, and eventually even camp counselors. They both participated in activities of informal education and ritual observance that have been correlated with Jewish involvement during later stages in life (Cohen & Eisen, 2000). They both spent several years in religious school, had Bar Mitzvahs, went to camp for years, went on youth group trips to Israel, worked at camp, and both even became regional presidents of our youth group. They participated in home ritual with their family for Shabbat, Passover and Chanukah. They are now young adults. The older brother, David[1], is 26, and the younger, Saul, is 23. David married his camp sweetheart at age 24; they often have large groups of Jewish friends over for Shabbat dinner, where they perform the traditional rituals. In college he went on his junior year abroad to Jerusalem, his second time in Israel. He has also created a Jewish book discussion group with a couple of friends, and a few of his early jobs were in the Jewish community. Saul has taken a different path; he finds little comfort in Jewish ritual or gatherings, although he does maintain close friendships with many Jewish friends. He is engaged to marry a woman who is not Jewish, and while their children will be aware of

[1] Names are pseudonyms.

Judaism they do not plan to keep a Jewish home. While Saul is not involved or affiliated Jewishly, his career path is rooted in social action, values that were dear to his family growing up.

I realized by observing these friends and others like them that in the vast literature on Jewish identity and expression and their correlation with childhood involvement, there has been a lack of attention to the individual personalities that make up American Jews. Personality theory and research shows that based on differences in personality people process their experiences differently, find different subjects interesting and vastly different careers rewarding. Based on all of this literature in both fields, I wanted to understand why Jews raised in similar Jewish situations take very different Jewish paths. What role do personality differences play in individuals' choice of Jewish activities, involvements and observances?

Once I began thinking about this I saw it everywhere; I realized that my older sister and I were somewhat like my two friends. She and I find very different comfort in our Jewish lives, and while we are both involved in the Jewish community she, a scientist, finds comfort in consistent ritual, and she and her husband routinely light Shabbat candles, go to synagogue, etc. I find myself immersed in Jewish communal life, most of my close friends are Jewish, and Jewish holidays are a very important part of my life, but I am often too scattered to remember ritual observance on a weekly basis. Similarly, my mother once told me, "Our synagogue is trying out this new community organization model. It's really touchy-feely. I hate it, but all my friends like it and it makes me feel guilty!" I explained to her that programs like those may only appeal to people who find spiritual meaning in that particular type of action, and it is certainly not

universal. I told her that I had even read that the majority of self-help and self-knowledge literature may come from one specific personality temperament and that for the most part, people of other temperaments take part only emptily in an attempt to act on what they "think people should want" (Keirsey, 1998). While this did not change her feeling that she was somehow "missing" the point of this new model, it did help her to stand back and think about how she processes new information and why this model does not work for her.

When Steven Cohen and Arnold Eisen wrote *The Jew Within* (2000) they reported on what they called "the Sovereign Self." They discovered that their interviewees, marginally to moderately affiliated baby-boomers (and, they believe, the general population as well), feel a greater responsibility to themselves and their personal fulfillment than previous generations. Their first responsibility is to their personal needs, and community needs or obligations are only secondary. Young adults today are for the most part the children of this first generation of Jewish journeyers. They are recipients of this new family tradition that emphasizes personal meaning and personal ritual and allows for myriad choices about what kind of Judaism they will practice, where they will go to get it and who they will do it with. Recently I heard the term "supermarket Jews" referring to this new freedom: that today being Jewish can mean looking through the aisles of not just ritual and tradition, but also cooking workshops, singles mixers and Jewish comedy nights, and pulling into your basket only those which are meaningful to you.

This new freedom of choice creates an even stronger need for quality Jewish programming options that meet the needs of the whole community. Pivotal to the success

of this programming is the needs of young adults. Today, the category of young adult is broader and more important than ever before. People are staying in school longer, taking longer to "settle down" (get married and have children), and moving often during their 20's and 30's. This has created a new programming genre that did not necessarily exist even a generation ago. In my time as a Masters student in Jewish Communal Service at Hebrew Union College, we have spent myriad hours discussing this programming gap and the ways in which different organizations are trying to address it. For UJA Federation, it is Young Leadership Division and the Ben Gurion Society, but these are funding driven groups, you have to pay to play. Many synagogues and JCCs are creating lower membership costs for "young professionals" in hopes of catching this age bracket. A whole new social networking system, "Gesher City" has been pioneered by the JCC movement, trying to organize organic social groups in cities across America for people in their 20's and 30's. However, many Jewish organizations are struggling with this new demographic: struggling to understand the needs, motivations, and interests of this new cohort, and how they can effectively provide programs that help to build Jewish connections to their institutions for the next generation.

With this in mind, I sought to increase our understanding of what activities Jews ages 21-35 are currently choosing and what motivates these choices. This thesis is also designed to bring us additional information on role personality might have in Jewish communal life. Does personality type have an impact on how young Jews choose activities and on what activities they choose? In order to program effectively for this generation, it is important for us to gain as much understanding as possible of who they are and how they make their Jewish choices. Ultimately, this thesis is designed to add to

our understanding of young adult Jewish choices and to begin a conversation about the impact that personality might have on those paths.

II. Literature Review

American Jewish Identity Research

Research on Jewish identity, affiliation and practices has been increasingly prevalent over the last 25 years. As Judaism has evolved and changed throughout the years, researchers have become more determined to try to capture exactly what it "means" to be Jewish at any given time and what implications that has for the current Jewish world and future demographic realities.

In June of 1989 a number of social researchers came together for a conference on "Jewish Identity in America." The conference, later edited into a book (Gordis and Ben Horin, 1991) described the state of research on the American Jewish community. In his contribution to this book, Bruce Phillips summarizes the ways in which the community had been quantified and studied up until that point. He denotes a dozen ritual indicators that are often used, including synagogue affiliation, Jewish education and intermarriage. Many of these indicators and questions remain relevant, but many from the first half of the 20th century that have become outdated and replaced, demonstrating the differences in what it means to be Jewish in America today. Knowing how much the "important" questions regarding Jewish identity can change in just 10 or 15 years only spotlights how difficult it can be both to pinpoint and to longitudinally track Jewish identity. Phillips notes that almost every existing study is focused on generation change, which I would say continues now, almost a generation later. This question can be broken into two

categories, either "within generation, over time" or "by generation, over time" (Gordis and Ben Horin, 1991). Both of these give us vital information, but very different. "Within generation" study helps us to understand the continuing Jewish paths or journeys undertaken by American Jews. "By generation" gives us the ability to mark where one generation was, compared to that before it, and later after, to understand the change of the face of American Judaism and its observance. The information on current young adult generations may well change the ways that Judaism can be 'measured' in the future. The face of observance and the range of ways to be Jewish has changed so drastically, that it may be much more effective to understand this cohort "within generation" rather than comparing them to generations before.

The most well known measurement tool is the National Jewish Population Survey (Kotler-Berkowitz et al., 2003), conducted by the United Jewish Communities (UJC), the umbrella organization of North American Jewish Federations. The NJPS has been conducted three times, in 1971, 1990 and 2000-1. It was originally undertaken because the U.S. census does not identify Jews or any other religious group, and the American Jewish community wanted to track accurate data about their community. The UJC lists the purpose of the NJPS as creating a "comprehensive social and demographic portrait of the American Jewish population" (www.ujc.org). In practice, the survey has been used to spur discussions on the future of American Judaism, the effects of intermarriage, success of national Jewish organizations and synagogue affiliation, among other things. Over the last 20 years in particular, many broad general surveys have been completed either nationally or by community, answering many similar questions in different ways.

All of these research undertakings have attempted to accomplish at least two things. First they try to understand the "raw material," to know the size of our national audience - how many people we think there are who are practicing Jews or have Jewish heritage. Second, they all seek to know more about exactly what Jews do and think, in terms of ritual and sense of Jewish community. What none of these have accomplished is a deep understanding of which programs young Jews choose to participate in and why, as well as the connections between who these people are and why they participate in certain ways.

How are these generations different?

Today, Judaism, as part of the private sphere, happens at home. Some would argue that it is the possibility for moments of intense personal meaning that makes Judaism something that happens primarily at home, with family and good friends (Cohen & Eisen, 2000). But even participation at home or in the private sphere can be intimidating. One of the younger interviewees in *The Jew Within* says he is less active Jewishly than he may be in the future because he equates "Judaism with commitment, not only because it is wrapped up with family... but because it demands obligation." Additionally, their research found that while many Jewish adults have some institutional affiliation, many are unsure of how useful these affiliations are in their lives. In fact, around 40% of their survey respondents agreed with the statement "I find Jewish organizations largely remote and irrelevant to me" (Cohen & Eisen, 2000). If this is a common stance in the parent generation, what attitude will we see among their children? Where will they look to find Jewish resources and community connection?

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