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Positive Recovery

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Positive Recovery

Abstract

Addiction is a chronic, progressive, and self-perpetuating disease that profoundly diminishes individual, family, and community well-being. Every year in the U.S., drugs (including alcohol and tobacco) are responsible for 25% of hospital admissions, 25% of deaths, and hundreds of billions of dollars in lost productivity, healthcare costs, and criminal justice costs. Addiction adversely impacts every arena of life ranging from hedonistic pursuits, occupational success, familial and other supportive relationships, to a sense of meaning, physical health, and overall fulfillment of individual potential. Addiction is amenable to treatment, but our medical-model approach to addiction is merely effective for initiating abstinence and reducing symptoms. Interrupting addiction in the short term breaks its self-perpetuation and restores individual free will, but it does not build "recovery." Recovery is a rich and full lifestyle that makes abstinence sustainable because it is accompanied by a rewarding and meaningful life. The medical model has limitations and offers myriad opportunities for improvement, as relapse rates during and soon after treatment remain high. Insights from positive psychology can increase the efficacy and effectiveness of addiction treatment by nurturing recovery. The Positive Recovery construct and curriculum applies positive psychology insights to help recovering addicts establish lifelong skills to pursue happier, more meaningful lives so that addiction is less tempting and relapse is less likely. This capstone discusses the rationale and evidence for an addiction curriculum that integrates existing effective approaches with interventions that enhance wellbeing through positive emotions, engagement, relationships, meaning, and achievement.

Keywords

positive recovery, addiction, rehab, drug treatment, AA, alcoholics anonymous, alcohol, alcoholism, drugs, alcohol treatment, sex addiction, food addiction

Disciplines

Applied Behavior Analysis | Behavior and Behavior Mechanisms | Biological Psychology | Clinical Psychology | Cognitive Behavioral Therapy | Community Health and Preventive Medicine | Counseling Psychology | Counselor Education | Health Psychology | Industrial and Organizational Psychology | Medical Education | Medical Humanities | Mental Disorders | Neurosciences | Organization Development | Other Mental and Social Health | Other Psychiatry and Psychology | Other Psychology | Other Public Health | Other Rehabilitation and Therapy | Other Social and Behavioral Sciences | Primary Care | Psychiatric and Mental Health | Psychiatry | Psychological Phenomena and Processes | Substance Abuse and Addiction | Translational Medical Research

Positive Recovery

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University of Pennsylvania

A Capstone Project Submitted

In Partial Fulfillment of the Requirements for the Degree of

Master of Applied Positive Psychology

Advisor: Leona Brandwene

August 1, 2013

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Addiction is a chronic, progressive, and self-perpetuating disease that profoundly diminishes individual, family, and community well-being. Every year in the U.S., drugs (including alcohol and tobacco) are responsible for 25% of hospital admissions, 25% of deaths, and hundreds of billions of dollars in lost productivity, healthcare costs, and criminal justice costs. Addiction adversely impacts every arena of life ranging from hedonistic pursuits, occupational success, familial and other supportive relationships, to a sense of meaning, physical health, and overall fulfillment of individual potential. Addiction is amenable to treatment, but our medical-model approach to addiction is merely effective for initiating abstinence and reducing symptoms. Interrupting addiction in the short term breaks its self-perpetuation and restores individual free will, but it does not build "recovery." Recovery is a rich and full lifestyle that makes abstinence sustainable because it is accompanied by a rewarding and meaningful life. The medical model has limitations and offers myriad opportunities for improvement, as relapse rates during and soon after treatment remain high. Insights from positive psychology can increase the efficacy and effectiveness of addiction treatment by nurturing recovery. The Positive Recovery construct and curriculum applies positive psychology insights to help recovering addicts establish lifelong skills to pursue happier, more meaningful lives so that addiction is less tempting and relapse is less likely. This capstone discusses the rationale and evidence for an addiction curriculum that integrates existing effective approaches with interventions that enhance well-being through positive emotions, engagement, relationships, meaning, and achievement.

Introduction

In the United States, drug use and abuse is a critical issue that calls us to improve

treatment strategies. Roughly 10% of Americans meet the criteria for a substance use disorder,

which we henceforth refer to as "addiction" for efficiency (Substance Abuse and Mental Health

Services Administration, 2010), defined simply as a chronic and progressive harmful disease

(Carroll & Miller, 2006). However, addiction is far from simple: addiction robs its host of

agency, and involves and disrupts the brain's reward, motivation, memory, and interrelated

circuitry (Yücel, Lubman, Solowij, & Brewer, 2007). Addiction is also malignant: it adversely

affects mental and physical health, family health, and public health (Erickson, 2007; Room,

Babor, & Rehm, 2005). Furthermore, relapse is the norm and the majority of addicts have a co-

occurring illness, which refers to the coexistence of two or more mental illnesses, further

compounding an already complex and malignant issue (Emmelkamp & Vedel, 2012).

Recent developments in genetic, pharmacology and neurophysiology research helped (a)

establish that addiction is a brain disease (instead of a moral failing), (b) develop several

treatment options, and (c) create the nation's first medical specialty board, The American

Board of Addiction Medicine (Miller, 2010; Erickson, 2007; Yücel et al., 2007). In short, we

have made progress, but we have not evolved far enough.

Most treatments are too short and narrow in scope, relapse prevention plans are too

avoidant, research-to-application gaps are too wide, few validated treatments exist, and fewer

of those are even implemented (Sellman, 2010; Miller, Zweben, & Johnson, 2005; Welberg,

2011). These shortcomings combined with high relapse rates both during and soon after

treatment, cast doubts on whether our current system of care is viable (Doweiko, 2002; Miller

et al., 2005; McLellan, 2006). Quite simply, we designed the Positive Recovery Curriculum

("PRC") to help fill these shortcomings and to address the call for a major overhaul in addiction treatment approaches (Dennis, Foss, & Scott, 2007).

PRC expands treatment length and depth. Short episodes of care do not predict successful management in any chronic (aka 'long-term') disease, and addiction is not an exception to the rule (McLellan, Lewis, O'Brien, & Kleber, 2000). Like other chronic diseases, addiction should be managed on a long-term basis (McLellan, McKay, Forman, Cacciola, & Kemp, 2005). In addition, a narrow orientation, or one that is only influenced by the disease model, ignores those elements that contribute to well-being. Too many treatments use a one-size-fits-all approach that fails to account for individual differences and appreciate deeply meaningful individual values and beliefs (Heyman, 2013, Carroll & Miller, 2006). The current system successfully stabilizes crises and facilitates abstinence, but it is not designed to do so sustainably, and needs improvement. Once addiction is interrupted, even for a short period of time that science cannot yet quantify, agency is restored. Optimal treatment must account for agency because extrinsic forces that make the disease self-perpetuating very quickly disappear; therefore, individuals resume making lifestyle choices. Without options to enrich their lives, too many people return to addiction too quickly.

Another major shortcoming that we aim to improve upon involves the issue of relapse. Most treatments offer at least some form of relapse prevention (National Institute on Drug Abuse, 2009), but most of these avoid specifically mapping out pathways for clients to take (if and) when they relapse. Since relapse is the *norm* in addiction, clients who prepare specific strategies to manage it can decrease the severity of a likely relapse and will strengthen plans that simply aim at prevention. We address this by including relapse-specific goals, pathways,

negative and positive contingency plans, and accountability partners, all of which we outline in

Maintenance Phase (p. 36). Furthermore recovery is a long process, not a destination, one that

creates a full and rich life above and beyond abstinence (Carroll & Miller, 2006). Therefore,

treatment must help people discover the self-directed motivation necessary to persist long

enough to develop recovery habits.

In sum, optimal treatment accounts for, and appreciates, each individual's values and

beliefs; balances problem resolution with resource building, is extended over the course of

years, not days or weeks; and explicitly addresses relapse. These elements underlie Positive

Recovery.

Positive Recovery

This segment of Capstone is divided into five parts. First, we provide a cursory overview

of addiction's etiology, nature, and treatment delivery system. Then, we introduce positive

psychology and present its applied value in treatment. Afterwards, we review metrics for

making course corrections and measuring success of PRC. Finally, we review the curriculum's

design and outline, providing brief descriptions of the first six phases (Habit, Resilience,

Strength, Relationship, Addiction, and What Do I Stand For) and a more in depth description

of the last phase (Maintenance). This segment concludes with the evidence base underlying our

model.

Addiction: A Misguided Pursuit of Happiness

What are the sources of human happiness? Philosophers and religious thought leaders

have pondered this question for centuries. One enduringly popular idea argues that the ultimate

source for human happiness is described in the following simple formula (Linley, Maltby,

Wood, Osborne, & Hurling, 2009):

<div align="center">More Pleasure + Less Pain = Happiness</div>

This approach, also known as 'hedonism,' is generally held to be the most widely pursued form of happiness in America today. In 1974, philosopher Robert Nozick constructed a thought experiment to expose flaws in this argument. He challenges us to consider the following:

Suppose there were an experience machine that would give you any experience you desired. Superduper neuropsychologists could stimulate your brain so that you would think and feel you were writing a great novel, or making a friend, or reading an interesting book. All the time you would be floating in a tank, with electrodes attached to your brain. Should you plug into this machine for life, preprogramming your life experiences? [...] Of course, while in the tank you won't know that you're there; you'll think that it's all actually happening [...] Would you plug in? (Nozick, 1974, pp. 42-43).

Nozick (1974) notes that there are three primary reasons why people would reject the option of trading in life for the machine: 1) people intrinsically wish to act and create - to have an influence on the world around them; 2) the experiences of pleasure comes with this, but pleasure alone quickly becomes hollow; and 3) people wish to function like people, not just a collection of cells.

On its surface, substance abuse would seem akin to Nozick's machine: the desire to engage in something that offers pleasure reliably and easily. However, addiction is not a pleasure-only disease. In fact, by the time addiction is activated, pleasure is often absent, replaced by profound adverse consequences such as unemployment, incarceration, and death

(Erickson, 2007). But like the machine, addiction leaves little room to fulfill basic psychological needs to connect with others and to act and create (Brown & Ryan, 2004).

Moreover, addiction is not simply hedonistic pursuits gone wrong. Addicts use substances and act out for many reasons: to feel pleasure, to fit in, to self-medicate, and to relieve unwanted affective states (such as anxiety or depression) (Miller & Brown, 1997). Exactly how and when addiction develops remains unclear (Carroll & Miller, 2006). Some suggest that addiction results from a misguided search for pleasure (Esch & Stefano, 2004), to experience flow-like states (Chou & Ting, 2003; Wu, Scott, & Yang, 2013), in a desire for intimacy, love, and relationships (Vaillant, 2008; Mellody, 1988), to find meaning (Burrell, 1999; Klion, 1993), to bolster spirituality (Jung, 1969), or seek achievement (Weiner, 1985; Snir & Harpaz, 2012). However, addiction does not simply develop because people are misguided in pursuing any <u>one</u> of these in isolation. Instead, these frequently overlap and interact. We arrive at a more precise etiology only by recognizing all of these together: pleasure, engagement, relationships, meaning, and achievement, define psychological well-being, a nuanced and complex construct of human happiness (Seligman, 2011). In turn, we discover that addiction develops from a misguided pursuit of happiness.

Organizations and clinicians that wish to assist clients to maintain recovery will help them establish self-reinforcing behaviors that ultimately create a happier life without addiction. This defines positive psychology's scientific inquiry, and illuminates our motivation to build the Positive Recovery Curriculum.

Addiction: Current Treatment

Addiction is complex. It is a primary, chronic, and progressive disease involving and disrupting the brain's reward, motivation, memory, and interrelated circuitry (American Society of Addiction Medicine, 2011; Yücel et al., 2007). Dysfunction in these brain circuits appears to cause the distinctive negative biological, psychological, social, and spiritual consequences which both define and reflect poor self-regulation, dysfunctional emotional responses, and a pathological behavioral pursuit of reward and/or relief by using drugs and/or addictive behaviors (Miller & Brown, 1997). Addiction is also uniquely characterized by craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and an inability to consistently control the use of drugs and/or engagement in addictive behaviors (Miller & Brown, 1997; American Society of Addiction Medicine, 2011).

Addiction is a increasingly prevalent public health problem. Between 1993 and 2003, the number of admissions for addiction increased from 1.62 million to 1.84 million treatment admissions, reflecting nearly a 14% increase (Wells, Lemak, & D'Aunno, (2006), yet only 6% of addicts receive evidence-based treatment (McGlynn et al., 2003). Every year in the United States, treatment of patients with alcohol problems accounts for approximately 15% of our national healthcare budget (nearly $360 million according to 2003 data) and 25% of hospital admissions and deaths are attributed to drugs and tobacco (Wells et al., 2006).

While the prevalence of substance abuse is increasing, the question of whether we are able to effectively treat addiction is difficult to parse because addiction is often inaccurately framed (McLellan et al. 2000). Addiction is not an acute disease, like the common cold or even appendicitis, and therefore it does not respond to short episodes of treatment (McLellan et al. 2000). Rather, it is a chronic disease that requires ongoing management. Chronic diseases, such

as high blood pressure or diabetes, require repeated and often life-long treatments. Short-term

treatment for any chronic disease is inappropriate, and inappropriate treatments are ineffective.

For example, when a patient with high blood pressure is treated appropriately, they receive life-

long treatments which include multiple interactions with treating professionals, education, and

so forth. If that same patient were inappropriately treated (e.g., for only three days, three

months, or even three years), then the symptoms and signs of high blood pressure would recur

(McLellan et al. 2000).

In fact, relapse rates for drug addiction are similar to those of other well-established

chronic illness like high blood pressure, diabetes, and asthma. Relapse is very common across

addiction, high blood pressure, asthma, and diabetes. The reason is simple. We do not cure

most diseases: we manage them. And, we are not perfect at it most of the time. Like every

other chronic disease, addiction has behavioral and biologic aspects, and both of these must be

addressed during long-term treatment. Recovery from addiction is a long-term process and

may require repeated attempts and episodes of treatment—which is no different from other

chronic diseases. Rarely does a diabetic or high blood pressure patient achieve 100% control of

their blood sugar and blood pressure from the first moment they are diagnosed (McLellan et

al., 2000).

Long-term management of chronic diseases involves trial and error, adaptation, and

repeated attempts to achieve the desired outcome. Changes throughout the course of treatment

and multiple attempts at consistent management are the norm, not the exception in most

chronic diseases. Relapses, or deviations from perfect management, can occur during the

course of treatment for any chronic illness, and are a sign that treatment adjustments should be

made. Note that while relapse is common, it is not mandatory. One can find addicts in stable

recovery who have never relapsed (Powers, 2012). Some addiction treatments are effective

(NIDA, 2009), but inappropriate treatments including short episodic care, are nearly always

ineffective.

The need to make changes is particularly urgent because addiction is frequently

accompanied by other problems. The National Comorbidity Study estimated that 41-65% of

people with addiction also have at least one other psychiatric health disorder (Kessler et al.,

1996). The toll of multiple illnesses impedes the ability to sustain a lifestyle in recovery and

compounds the individual suffering and social woes that may have served as the very catalyst

for the addiction, especially when we offer nothing more than short-term crisis stabilization.

Addiction is also difficult to treat. Research demonstrates that it takes, on average, seven

quit attempts to remain abstinent from all drugs, such as cigarettes, alcohol, cocaine, and

heroin (Best et al., 2008; Norcross, Krebs & Prochaska, 2011; Price, Risk, & Spitznagel,

2001). The progress of most patients is marked by cycles of recovery, relapse, and repeated

treatments over many years before few even reach stable recovery (McLellan, 2006; Dennis et

al., 2007). Relapse and frequent quit attempts are the norm, and addicts are formally treated, on

average, four times before remaining abstinent (Scott et al., 2007).

These figures are disheartening but this same data also suggest a real opportunity for

improvement. However, recent efforts to improve treatment outcomes reveal limited success:

they attempt to improve a delivery system that is broken (McLellan et al., 2005; Miller &

Miller, 2009). While noble, these efforts aim to improve episodes of care that are too short

(Miller et al., 2005), unidimensionally strive to eliminate negatives (Seligman, 2011), and fail

to account for addiction's chronicity (Miller & Miller, 2009) and the return of agency (Carroll & Miller, 2006).

To summarize the challenges, addiction treatments are too short and narrow in scope (Sellman, 2010; Miller et al., 2005), relapse prevention plans emphasize avoidant strategies to the exclusion of other useful approaches, research-to-application gaps are wide and rarely connected (McGlynn et al., 2003), few validated treatments exist, and even fewer of those are even implemented (Miller et al., 2005; Welberg, 2011). Moreover, outcomes of specific addiction treatments vary extensively, some treatments consistently fail to demonstrate any benefit (Miller et al., 2005), treatment effects vary substantially among different sites, we lack consensus regarding what constitutes an evidence-based therapy, and few clinical trials are even conducted on evidence based therapies under natural conditions (Carroll & Miller, 2006; Miller & Miller, 2009).

At least a few bright spots of effective approaches exist. When we compare outcomes of addiction treatment to other chronic diseases, such as asthma, diabetes, and hypertension, we discover that treatments are generally equally effective (McLellan et al., 2000). We know that people are better off in treatment than not (Sellman, 2010). Indeed, several meta-analyses of drug abuse treatments clearly demonstrate that treatment is effective in decreasing drug use, reducing addiction-related problems, and improving positive life indicators (Prendergast, Podus, Chang, & Urada, 2002; Miller et al., 2005). Validated studies demonstrate the following aspects of addiction care produce positive outcomes: (a) aftercare monitoring, (b) individualized treatment, (c) identification and treatment of co-occurring illnesses, (d) the presence of an empathic and supportive staff, (e) positive therapeutic inpatient treatment

experience ("therapeutic milieu"), (f) patient engagement in recovery fellowships (e.g., A.A),

and (g) engagement of family and other support (Carter & Hall, 2011; Prendergast et al., 2002;

Miller et al., 2005; Powers, 2012; Vaillant, 2008).

Given this state of affairs, clinicians and treatment providers that strive to *both* prevent

relapse and improve clients' well-being must implement empirically-validated and effective

methods that concurrently improve those elements that lead to well-being and sobriety.

Where We Went Wrong

The medical model of disease has been the dominant model of approaching physical and

mental wellness in the Western world for over two centuries (Seligman, 1991). According to

the medical model, disease is defined as a departure from normal functioning, or a neutral state

corresponding to zero on a metaphorical wellness continuum that spans from minus ten to

positive ten. U.S.-trained physicians, psychologists, and other clinicians are exposed to and

trained almost exclusively to focus on this pathological orientation. As a result, our healthcare

system overwhelmingly searches for problem areas to remove disproportionately more than

identifying positives (e.g., strengths) to build and nurture (Seligman, 2011).

The medical model approach has spawned an enormous amount of understanding and

advancement in health care. For example, we now have effective treatments to alleviate

depressive symptoms, curb drug cravings, and minimize adverse problems of addiction

(Seligman, 1991; Erickson, 2007; McLellan, 2006). Nonetheless, an obsession with the "what

is wrong?" approach fails to consider the "what is right?" one (Seligman, 1991). Normal, or

zero on the metaphorical scale, is not equivalent to wellness: removing depression does not

create happiness, as the skills necessary to build what is flourishing in life are much different

than the skills necessary to remediate that which is broken (Seligman, 2011).

Positive Psychology

Throughout the world and over the ages, human beings have sought to discover and outline strategies to increase human happiness (Haybron, 2008). What's exciting about positive psychology is that, for the first time, researchers are applying empirical research methods to identify and measure the specific benefits of certain behaviors; deepen our understanding of why these benefits occur; and develop evidence-based applications of their research in health, education, and other domains (Seligman & Csikszentmihalyi, 2000).

Positive psychology describes the scientific endeavor to discover ways that individuals and groups can to flourish. This separates positive psychology from self-help approaches and methods whose claims are similar but lacking evidence of their effectiveness. 'Evidence-based' describes theoretical (theory-based), experimental (lab-tested), or evaluative (real-world conditions) methods (J. Pawelski, personal communication, September 6, 2012). Using scientific method, positive psychology collects and analyzes empirical evidence in controlled experiments designed to discover interventions that effectively increase well-being. As is the case for rigorous scientific studies, positive psychology's research findings are reviewed by other scientists (peer review). In fact, positive psychology's "notable strength is its continuity with tried-and-true psychological research methods and its belief that these can be used productively to study new topics—those that make life most worth living" (Peterson, 2006, p. 18).

Positive psychology uses evidence-based interventions, or positive interventions (PIs) to filter effective strategies from those that may sound pleasing but fail to enhance well-being. A

positive intervention is an evidence-based, intentional act, designed to increase well-being,

primarily (but not strictly) in non-clinical populations (J. Pawelski, personal communication,

September 6). PIs are also considered as simple (and often self-administered) cognitive and

behavioral strategies intended to increase individual and/or group well-being.

Positive psychology emphasizes the development of positive human qualities and the

facilitation of psychological health and happiness, but does not deny the value in ameliorating

negative human qualities and human misery (Maddux, 2009). Positive psychology expanded

the orientation and research emphasis of traditional psychology to focus on both the positive

(e.g., joy) and the negative (e.g., stress) sides of life. Even though positive psychology focuses

on building happiness, positive psychology does not pretend that flourishing results from being

unidimensionally optimistic, either (Seligman, 2011).

Positive psychology can also be defined as a 'positive' tool that individuals, clinicians,

organizations, and institutions can use when appropriate; when added to effective traditional

treatments, it adds balance and depth. 'Positive' refers to the better aspects of human nature,

such as growth, confidence, resilience, honesty, and integrity (Jarden, 2012). In addition,

positive refers to what human beings do right that contributes to well-being. In short, positive

in positive psychology is the study of that which leads to experiencing life north of zero.

Embracing positive psychology and embracing a life in recovery share some similar

attributes. Recovery often involves a transformational change as people discover new meaning,

purpose, and hope in life (Powers, 2012). Begbie (1909) argued that alcoholics who recovered

did so, not because they changed their behavior, but because they experienced a 'revolution in

character,' more descriptive of someone who has had a transformational experience that led to

flourishing in recovery than simply being 'on the wagon.' Sellman, Baker, Adamson, and

Geering (2007) similarly describe how recovery catalyzes a 're-orientation' from a negative to

a positive perspective, which, like Begbie's idea of a character revolution, at least qualitatively

supports the idea that recovery is a full lifestyle.

Choice is a large part in developing addiction, but choice disappears with the onset of

addiction (Erickson, 2007). In other words, individuals chose to use drugs and/or engage in

addictive behaviors until addiction is active, at which point addiction is self-perpetuating.

Despite losing volition in active addiction, once drugs and/or behaviors are extinguished for a

short time, volition is restored (Powers, 2012). Addiction is associated with brain circuitry and

functional changes that impedes the pursuit of happiness (Goldstein & Volkow, 2002; Yücel et

al., 2007; Laudet, Becker, & White, 2009). However, these changes do not prevent addicts

from either quitting using addictive substances, engaging in addictive behaviors, or desiring to

maximize their well-being (Heyman, 2013). Addicts are motivated to quit by the very same

moral and pragmatic, or well-being enhancing, elements that catalyzed their engagement with

the disease. Addicts don't quit to minimize their "multifaceted dysfunction," they quit to pursue

happiness (Heyman, 2013).

Positive psychology teaches that happiness often requires intentional self-regulation and

grit in developing good habits (Duckworth, Peterson, Matthews, & Kelly, 2007; James, 1890).

Similarly, research consistently supports the idea that personal commitment is an essential

ingredient for recovery (White, 1996; DiClemente, 2006). PRC uses this idea to approach

clients as capable and responsible agents (Bandura, 1997; Ryan & Deci, 2000) who are

collaborators, and not helpless victims in their treatment experience. Positive psychology

encourages a "metaphysical orientation towards the positive" (Csikszentmihalyi, 2002),

defined as a deep and complete appreciation that the positive is just as real as the negative, and

offers addiction treatment several validated interventions that can help clients flourish in

recovery. However, the current addiction treatment model has grown out of the medical model,

a point illustrated in the following two nonfictional narratives:

Mr. Impatient

When "Steve" was five years old, his preschool teacher, Mrs. Lewis, gave him the snide

nickname, 'Mr. Impatient.' She identified Steve from amongst a group of five year-olds, who

are generally all as self-regulated as Chihuahuas on crack, which reflects how severe his

behavior was. Today, the same five year old Steve would most likely be diagnosed with ADHD

and medicated. Even today, he continues to exhibit nearly every single criterion for ADHD as

listed in the Diagnostic and Statistical Manual (DSM) (American Psychiatric Association,

2013).

However, he was offered neither diagnostic label nor drug. The 'Mr. and Ms. Impatients'

of the world had to simply make the most of what they had if they wished to achieve success.

Again, Steve continues to frequently misplace things, interrupts people (this one bothers him

the most), and gets distracted by shiny objects (the bothersome factor is correlated with the

object's shininess). Nonetheless, Steve was still somehow able to complete medical school and

residency training without using ADHD (or any other) medication, which are not easy tasks

even for those without ADHD.

While we do not deny the existence of mental disorders (Steve is certifiable) nor wish to

replace effective psychotherapeutic medications with shame (e.g., calling children by

derogatory names), we do wish to point out that Steve did very well making the most of what

he had. Seligman (2011) suggests that sometimes, people are quite capable of mustering the

necessary strength and resource to just *deal with it* (where 'it' refers to challenges and

hardships). Too often, we simply don't give them the chance, or shove, to do just that.

The current approach to diagnose and medicate ADHD (amongst many other diagnoses)

may not always be appropriate, but we are not arguing that current practices are immoral, or

worse, or useless. Instead, we suggest that for too long we have overlooked a positive

metaphysical orientation and the success that constructing the positive in life can yield.

Sometimes, working with good enough (that is, working with what you've got) is more than

good enough. Steve is nonfictional, not medicated, and doing well today.

Dr. Open Minded

A modern physician comes across a patient that claims his room became filled with light

and filled with God's Presence. He then envisioned that he was standing on a mountain peak

where Spirit winds flowed through his body, leaving the thought: *You are a free man*. The

doctor checks the chart and sure enough, the patient told the staff nurse, the charge nurse, and

even the janitor the same story. The disease model of health care is ingrained in our modern

"scientific approach" (that is scientific largely in name and not in practice) (Engel, 1977). In

modern behavioral and physical medicine, if the doctor decides and charts that what the patient

was describing was actually perfectly healthy and spiritual in nature, then the doctor would put

his hospital staff privileges and medical license in serious jeopardy.

Dr. Open Minded lived prior to the Diagnostic and Statistical Manual (DSM) (American

Psychiatric Association, 2013) era, which places him pre-1952, the year DSM was first

published. In addition, he is not a fictional character. His name is Dr. William Silkworth and he is the last treating physician to detoxify Bill Wilson (1895-1971) in what was his fourth hospitalization for alcohol detoxification. Wilson was not pleased that he was, yet again, detoxing. Perhaps he was desperate because the hospital he was in at the time was performing frontal lobotomies on their alcoholic patients, or perhaps he was just *sick and tired of being sick and tired* (a common recovery phrase used to describe the common experience of scraping by through life, dreadfully, while addiction is active). In any case, Bill cried out, "If there is a God, let Him show Himself!"

The next thing he knew, his room became ablaze with light and he was overwhelmed by a Presence and a vision of being on a mountaintop where a spirit wind blew through him, leaving the thought, "You are a free man." Wilson never took another drink again. Wilson later cofounded Alcoholics Anonymous, was named by TIME Magazine as one of the most 100 influential people in the 20th Century, and is a household name amongst millions of worldwide 12-Step fellowship members, who refer to themselves and other members as *'Friends of Bill'* (AA Services, 2001; Powers, 2012).

These two narratives are not meant to suggest that modern physicians, psychologists, or others ignore or simply reframe hallucinations, messianic callings, or minimize other disease, disorder, or dysfunctions. Mental illness does exist and pharmacology and cognitive behavioral therapy, or negative mitigation approaches, can and often do help, the same view supported by positive psychology (Seligman, 2011). Instead, we offer these narratives as testament that a pathology-oriented approach can be terribly misguided at times.

Balance & Depth

Positive Recovery Curriculum can 'balance' such a misguided system. PRC includes

strategies to remove the undesirable aspects of life and to build what makes life most worth

living. PRC applies findings from positive psychology to enable clients to live his or her life

within the "upper reaches" of what is possible in the human experience (Seligman, 2011).

Moreover, PRC adds depth by appreciating and accounting for each client's deeply held values,

beliefs, and goals, thereby individualizing treatment, which improves outcomes (Magura,

Staines, Blankertz, & Madison, 2004; McLellan, Arndt, Metzger, Woody, & O'Brlen, 1993).

The benefits of building the positive is clear: happier people have healthier relationships, live

longer, are more resilient, more successful at work and earn more money, have stronger

immune systems, require less medical care, and are more likely to engage in prosocial

behaviors (Lyubomirsky, King, & Diener, 2005; Seligman, 2011).

Positive Psychology and Clinical Populations

Positive psychology is not just for happy (nonclinical) people. While most positive

intervention (PI) studies have been conducted with nonclinical individuals, validated studies in

clinical (e.g., depressed) patients are promising (Layous, Chancellor, Lyubomirsky, Wang, &

Doraiswamy, 2011). Similarly, positive psychotherapy (PPT), a psychotherapeutic technique

that searches for ways to decrease symptoms and improve lives in clinical populations, also

appears applicable to our clinical population (Seligman, Rashid, & Parks, 2006). One study of

severely depressed patients demonstrated that PPT removed symptoms of depression better

than treatment as usual and better than antidepressant medications. In another randomized

controlled trial, PTT demonstrated that both mild-to-moderately depressed students and

severely depressed mental health patients experienced increases in happiness and decreases in

depressive symptoms - with moderate to large improvements persisted at a one-year follow-up, too (Seligman et al., 2006). These suggest that both PIs and PPT may improve efficacy and effectiveness of addiction treatment for clients with or without co-occurring psychiatric disorders.

Some PIs not only have persistent effects, they also work quickly. One study (Duckworth, Steen, & Seligman, 2005) showed significant decreases in some of the study participant's depressive symptoms in less than one week. In another study, Seligman instructed severely depressed individuals to engage in *Three Good Things* daily, a positive intervention that asks people to write about three positive events that happened that day. In about two weeks (within 15 days), nearly every participant experienced relief (94%) (Layous et al., 2011). Carroll and Miller (2006) recommend quick-acting interventions: addicts struggle with delayed gratification and the current system of care only provides brief treatments spans.

Positive interventions and positive psychotherapy appear promising, yet only a few clinicians and researchers support the view that positive psychology has worthwhile insights for treating addiction (Miller & Miller, 2009; Krentzman, 2013; Akhtar & Boniwell, 2010). In one such study, researchers hypothesized that patients would be more successful at quitting if they were primed with positive emotions prior to the quit date because positive emotions can improve learning, problem-solving, social bonding, and self-esteem (Fredrickson, 2009). Participants who were primed to experience positive emotions reported greater smoking abstinence and a greater reduction in depressive symptoms than did those in the standard smoking cessation therapy group (MacPherson et al., 2010).

The closest scientific evidence that supports the common-sense idea that higher well-

being helps clients maintain recovery can only be inferred at this point by higher reported

levels of wellness (Hattie, Myers, & Sweeney, 2004), a construct similar to quality of life,

which is predictive for lower rates of relapse (Laudet et al., 2009). However, there are only a

few validated interventions which might effectively enhance well-being or build the 'positive'

for addicts (e.g., autonomy, mastery, connectedness, supportive relationships, character

strengths, self efficacy, hope, etc.).

In another study, Akhtar and Boniwell (2010) investigated outcomes of a positive

psychology intervention on 10 adolescents over eight weeks in the U.K. This study, albeit for a

small sample size, also supports applying positive psychology in addiction treatment. Study

participants experienced more well-being, more positive affect, developed a future goal

orientation, an escalation of change amounting to transformation, less drug use, significant

increases in happiness, optimism, and positive emotions, and a significant decline in alcohol

dependence (Akhtar & Boniwell, 2010).

Boldly Explicit

'Bold' describes our straightforward approach to the relapse issue. Many addicts maintain

stable recovery from their first treatment episode and relapse is not mandatory, yet relapse is

still more likely than not (Sellman, 2010). This point deserves a more explicit and direct, or

"bold" approach, for several reasons.

First, if clients suspect that a relapse is not just possible but likely, they may then be

motivated to be even *more* vigilant and less complacent in their lives. This may enhance their

mindfulness, with its associated benefits, such as relapse prevention (Marlatt & Gordon, 2005),

behavioral regulation, and emotional control (Breslin, Zack & McMain, 2002), undo the effects

of stress (Fredrickson, Mancuso, Branigan, & Tugade, 2000; Benson & Stuart, 1992), and

enhance well-being (Csikzentmihalyi, 1990).

Second, if clients plan for the most likely event (relapse) they can then have clear

contingency plans, which may decrease the intensity of the relapse. Third, if clients understand

that relapse is part of every chronic disease (McLellan et al., 2005), then they may adopt a

favorable mindset that fosters resilience. For instance, clients that appreciate addiction is a

chronic illness that often (but not necessarily) includes relapse, then feelings of helplessness,

hopelessness, and isolation are less likely to overwhelm them when and if they relapse. In

short, relapses are simply challenges, like any other - such as unexpected unemployment -

which can and will be overcome by making course corrections as people pursue meaningful

goals in recovery.

Recovery & Flourishing

The Betty Ford Institute Consensus Panel defines recovery as "a voluntarily maintained

lifestyle characterized by sobriety, personal health, and citizenship" (White, 2007, p.236) and

The American Society of Addiction Medicine defines recovery as a "process of overcoming

both physical and psychological dependence on a psychoactive drug with a commitment to

abstinence-based sobriety in order to achieve overall health and well-being" (ASAM, n.d.).

Notable points in both of these definitions are the robust description of recovery and the

emphasis on well-being as an end-goal.

Seligman (1991) learned that once he removed depression, all he saw were empty

patients, not happy patients. So he began searching for ways to take these empty patients and

fill them up with well-being. He discovered 1) teaching optimism and resilience were possible

(his clients moved their lives in the positive direction), and 2) shifting from depression to emptiness is neither the same nor includes the same skill set as the shift from emptiness to flourishing (Seligman, 1991). Notably, an analogous relationship exists between abstinence and recovery (Teresi & Haroutunian, 2012; Vaillant, 2008). In other words, recovery transforms an otherwise empty abstinent life into a robust one. Recovery is to abstinence what flourishing is to the absence of disease: you can remove the negative but all you are left with is nothing.

Abstinence does not create healthy and adaptive coping skills, supportive relationships, positive emotions, or other elements that contribute to well-being. Abstinence simply refers to a state without drugs and/or addictive behaviors. Organizations and clinicians that wish to assist their clients to successfully prevent relapse will help them establish self-reinforcing behaviors that ultimately create a happier life without addiction. This defines positive psychology's scientific inquiry; this is why we aim to help clients flourish; this is Positive Recovery.

So far, we covered several crucial ideas in our model. To summarize: addiction is a chronic, harmful, and self-perpetuating disease that results from misguided pursuits; positive psychology and psychotherapy demonstrate effectiveness, speed, and long-lasting effects in clinical populations; adopting a positive orientation adds balance to the disease-model approach; and treatment should be individualized: each client holds their own set of deep and meaningful values, beliefs, and preferences that will ultimately motivate them to establish happier lives in recovery. Next, we outline our plan for making process adjustments and measuring success.

Metrics

We may positively influence success in implementing PRC by tracking specific outcomes. Although the measurement-improvement correlation, or "Hawthorne Effect," was initially presented in business research, it may also apply to clinical practice: since there is a noticeable advantage from engaging in clinical research, then this has ramifications for best clinical practices and for improving outcomes (Braunholtz, Edwards, & Lilford, 2001; Peppercorn, Weeks, Cook, & Joffe, 2004). We plan to implement and measure PRC in two (of four) co-managed inpatient rehabilitation treatment facilities, while the other two will serve as waitlisted control groups. Both process and outcome metrics will help us ensure that the time and resources that we invest are advancing us toward the desired outcomes of the program in the most efficient manner possible.

Program outcomes are lagging indicators of overall program success. The first outcome metric we will measure is the completion rate (CR). Treatment completion is predictive of better outcomes (Emmelkamp & Vedel, 2012; Messina, Wish, & Nemes, 2000) and adds value to the company's bottom line. In addition to completion rate, we will monitor post-treatment length of continuous sobriety (measured in days), length of relapse (measured in days), and patient satisfaction (measured using surveys). In addition, to track impact of implementation on program staff, we will use the Gallup Well-being for the Workplace Survey (Gallup, 2006) to measure staff engagement, which also positively correlates with productivity and business success. As mentioned earlier, PRC will be initiated at two of four facilities in an inpatient treatment group to start; the waitlisted control groups will be rolled out subsequent to full implementation in the first two facilities.

Process outcome measurement will focus on interim metrics of well-being for participating patients; five assessment tools will be used and based upon the elements that constitute well-being in Seligman's (2011) model of PERMA: positive emotions, engagement, relationships, meaning, and accomplishment. We intend to continue measuring these among clients after discharge (for as long as they are willing). To facilitate this, those clients that participate in the Positive Recovery Online Forum (PRF) will automatically receive these assessments, and that data will automatically be entered into our data set.

Positivity: The Positive and Negative Affect Schedule (PANAS) (Watson, Clark, & Tellegen, 1988) is a 20-item self-report measure consisting of two 10-item subscales (positive affect and negative affect). PANAS treats both variables as separate dimensions rather than polar ends of the same scale and is generally seen as a reliable, valid, and efficient means of measuring positive and negative affect emotions (Watson et al., 1988).

Engagement: The Short Grit Scale (Grit-S) (Duckworth & Quinn, 2009) is the questionnaire we will use as a proxy measure for engagement because it is more economical and feasible than the Flow Scale (Jackson & Marsh, 1996). Grit-S is a validated measure of perseverance and passion for long-term goals (Duckworth & Quinn, 2009).

Relationship: The Medical Outcomes Study Social Support Survey (MOS) (Sherbourne & Stewart, 1991) is a relatively short 19-item survey. MOS measures multiple dimensions of support (affectionate, emotional, informational, positive social interaction, and tangible) that have high reliability and are stable over a 12-month period.

Meaning: The Meaning in Life Questionnaire (MLQ) (Steger, Frazier, Oishi, & Kaler, 2006) is a validated survey that measures perceived meaning in life. MLQ consists of two 5-

item subscales that are rated on a 7-point scale ranging from 1 (absolutely untrue) to 7

(absolutely true). Higher scores indicate greater levels of perceived meaning in life.

Achievement: The Hope Scale, which is frequently called The Goals Scale in practice

(Lopez et al., 2004), is the survey we will use as a proxy for achievement. This survey is a

validated dispositional survey of hope (Snyder et al., 1991). We do not plan to use this in

clients that are just starting their recovery because early recovery is generally awful - people

usually enter treatment after hitting some type of bottom – but we will use the hope scale after

treatment (e.g., during the maintenance phase).

Curriculum Design

Positive Recovery Curriculum is divided in 7 phases:

1) Habit

2) Resilience

3) Strengths

4) Relationship

5) Addiction

6) What Do I Stand For

7) Maintenance

Each of these seven phases are divided into several sessions, at least one of which involves a

relapse prevention activity. The sessions within each phase follow a strategic order but several

phases cover overlapping ideas or skills, and many sessions are designed for individualized use

in any order. In addition, we will provide our staff with a training manual prepared for the

curriculum rollout that will include literature reviews, in-depth session descriptions, metrics we

will be using, and checklists that our clinicians can use to ensure major ideas are covered and

understood.

Most sessions follow the following format:

1) Opening brief meditation   (5-10 minutes)

2) Review of key teaching points   (5-10 minutes)

3) Activity designed to enhance a specific skill(s)   (30-50 minutes)

4) Short de-brief period   (5-10 minutes)

5) Post-module assignment explanation and close   (5 minutes)

Curriculum Outline

Habit Phase

This phase is mostly didactic and introduces clients to key terms and ideas such as self-

regulation (Baumeister, Gailliot, DeWall, & Oaten, 2006), positive psychology (Seligman,

2011), positive metaphysical orientation to the positive and optimal health (Pawelski, 2003;

Csikzentmihalyi, 1990), Broaden and Build Theory (Fredrickson, 2001), social networks

(Fowler & Christakis, 2008), neuroplasticity (Dobkin, 1993), physical exercise, diet, and sleep.

In this phase we also stress personal responsibility. Staff will reinforce the key idea that

clients have control over themselves, beginning with the power to choose their perspective by

intentionally directing their attention, and when they regulate that limited resource optimally

(through positive thoughts and behaviors), they form good habits, create good character, and

forge their destiny. 'There is no skill in a pill' is a cliché that communicates the idea that

change and growth require effort. For instance, medications may help relieve unwanted

feelings (e.g., anxiety or depression), but medication does not do the heavy lifting or remove

personal responsibility. These points are crucial to reinforce because happiness generally

requires individual grit (Duckworth et al., 2007), self-regulation (Baumeister, DeWall,

Ciarocco, & Twenge, 2005), autonomy (Ryan & Deci, 2000) and personal responsibility

(Peterson, 2012) to name just a few.

Habit phase includes the following six sessions: (1) PERMA & Positive Orientation; (2)

Habit, Attention & Self-regulation; (3) Positivity; (4) Diet; (5) Exercise; and (6) Sleep.

Resilience Phase

This phase is mainly experiential and is based on (1) the pivotal work of Seligman

spanning from "learned helplessness" (Abramson, Seligman, & Teasdale, 1978) through

Learned Optimism (1991), to his more recent work in *Flourish* (2011), (2) Reivich and Shatte's

(2002) cognitive behavioral strategies, (3) Schneider's (2001) argument for "realistic

optimism," (4) Gable, Reis, Impett & Asher's (2004) work in positive communication styles,

(5) *Emotional Intelligence* (Goleman, 1995), (6) hope theory (Snyder, Feldman, Taylor,

Schroeder, & Adams, 2000), and (7) goal-setting theory (Brown & Ryan, 2004; Locke, 1996).

Resilience can help clients maintain recovery (Carroll & Onken, 2005) but if and when

relapse does occur, resilience also helps prevent the relapse from spinning out of control

(Larimer, Palmer, & Marlatt, 1999). When our clients experience the way we approach relapse,

as a normal symptom of their chronic disease, we hope they view their own relapse as having

the same significance that a diabetic would with high blood sugar readings. Without the

negativity surrounding guilt and shame, they also may be better equipped to see more clearly

the causal variables that led up to the relapse. Whether factors leading up to the relapse were

visual or emotional cues, maladaptive behavioral patterns that resulted from stress or ego-

depletion, noncompliance with the proper medications or their positive recovery prevention

plan, using improper medications or other substances, or denial – they may be able to get a

broader view of the facts and learn from their mistakes when negativity is not constricting their

attention (Fredrickson & Branigan, 2005).

Staff will emphasize that each client's past, habits, or even genes do not imprison them,

that what defined their lifestyle prior to now (each present moment), does not have to define it

today or tomorrow. To that end, we will teach clients that they *can* learn to recognize and

change catastrophic thinking and increase the accuracy of appraisals about activating events

and implications for the future (Seligman, 1991; Reivich & Shatte, 2002). In addition, clients

will have opportunities to practice building these resilience skills in several sessions (e.g.,

"Recognizing Emotions in Others" and "Explanatory Style").

Resilience phase includes the following five sessions: (1) Emotional Intelligence; (2)

Explanatory Style; (3) Hope; (4) SMART Goals; and (5) Pathways.

Strengths Phase

The strengths phase of the curriculum is based on *Character Strengths and Virtues*

(CSV) (Peterson & Seligman, 2004), existing strength research (Gillham, Abenavoli,

Brunwasser, Reivich, & Seligman, 2012; Park & Peterson, 2009) and curricula such as Master

Resilience Training (Reivich, Seligman, & McBride, 2011). This phase strives to boost clients'

strengths signature strengths (e.g.,, gratitude, courage, prudence, wisdom), spot strengths in

others, and help them use these positive traits to their fullest extent on a daily basis while at

work, home, school, or leisure.

We believe that teaching clients the foundations of good character can help prevent relapse and enhance well-being. Research has shown that character strengths contribute to optimal human development and well-being (Park & Peterson, 2009; Peterson & Seligman, 2004) and that specific strengths of character, such as hope, kindness, social intelligence, self-control, and perspective, can help buffer people against the negative outcomes caused by stress and trauma in peoples' lives (Park & Peterson, 2009). The life satisfaction gains that result from increased character strengths can serve to build long-term personal resources that enable clients to enjoy a flourishing life (Gillham, et al., 2012; Park & Peterson, 2009; Peterson & Seligman, 2004).

Strengths phase offers clients opportunities to build a strength-based foundation through discovering their own strengths, spotting others' strengths, and speaking in a strength-infused vernacular within the therapeutic milieu. Starting from the first encounter and persisting throughout treatment, our staff will be trained to view clients' strengths in action and to capitalize on opportunities to verbally identify times when clients use them, thereby reinforcing the concepts to help clients better absorb the material. For example, during the first intake experience (live or via the call center) clients (or family members) will hear how courageous they are by simply reaching out for help and/or coming in for a professional assessment. Then, in treatment, as clients achieve meaningful goals, staff will praise their effort (Dweck, 2007) and success, which may increase their future efforts (Dweck, 2007), self-efficacy (Bandura, 1997) and hope (Snyder et al., 2000).

Strengths phase consists of the following seven sessions: (1) Foundations of Character;

(2) What Are Character Strengths; (3) One's Own Character Strengths; (4) Strength Spotting;

(5) Benefits of Utilizing Character Strengths; (6) Character Strengths in Action; and (7) 'How

True!' Personal Relic.

Relationship Phase

This mostly experiential phase is based on the work of communication styles (Gable et

al., 2004), social networks (Fowler & Christakis, 2008), prosocial behavior (Grant, 2013),

relationships (Cohen & Wills, 1985), positivity (Fredrickson, 2009), recovery fellowships

(Humphreys & Moos, 2004) and more. Activities here are designed to build client's awareness

of the value of relationships and to enhance relationship-building skills such as active-

constructive response styles (Gable et al., 2004, p. 233). In addition, this phase introduces

clients to recovery fellowships because these reliably help members to maintain recovery

(McLellan, 2006).

Feelings of support are positively correlated with well-being when individuals are

integrated with, and perceive support from, their social networks (Cohen & Wills, 1985).

Indeed, many research studies "document the link between society and psyche: people who

have close friends and confidants, friendly neighbors, and supportive coworkers are less likely

to experience sadness, loneliness, low self-esteem, and problems with eating and

sleeping" (Putnam, 2001, p. 332).

Relationships phase consists of the following six sessions: (1) Value of Relationships;

(2) Being a Good Friend; (3) 12 Steps & Recovery Fellowships; (4) Trust; (5) Forgiveness; and

(6) Positive Relapse Prevention Plan.

Addiction Phase

This mostly didactic phase covers topics that are generally included in most addiction treatment curricula, such as the science of addiction, medical consequences, process addictions, relapse prevention strategies, aftercare planning, family dynamics, process addictions (Blumenthal & Gold, 2010; Yücel et al., 2007; Carnes, 2001; Mellody, 1988; Bechara et al., 2001; Fillmore, 2003; Goldstein & Volkow, 2002; Marlatt & Gordon, 1985), and other (often regulatory-mandated) didactic sessions that cover topics such as infectious and communicable diseases.

Addiction Phase includes the following nine sessions, many of which explicitly include relapse prevention strategies: (1) Definition & Concepts; (2) The Science of Addiction; (3) Post Acute Withdrawal Syndrome; (4) Cross Addiction; (5) Process Addictions; (6) Medical Consequences; (7) Infectious Disease; and (8) Mind Body Medicine & Addiction.

What Do I Stand For Phase

This mostly experiential phase provides clients with several opportunities to conceptualize and organize their values, purpose, meaning, and goals in order to help them think about what they stand for, how they fit in and serve the world, and where they are heading. What Do I Stand For phase includes many activities that draw from and reinforce other phases, but includes a session on spirituality that draws from general spirituality research (Pargament, 2002 & 2007) and spirituality in addiction (D'Souza & Rodrigo, 2004; Richards, Berrett, Hardman, & Eggett, 2006).

Some (Burrell, 1999 & Klion, 1993) suggest that addiction results from a misguided search for meaning and purpose in life while others (Galanter, 2007) suggest that success in

recovery is mediated by discovering new meaning. Today, we know that meaning in life is correlated with several mental and physical benefits (Baumeister & Vohs, 2005) but addicts are an especially vulnerable population that appears to need specific interventions aimed at increasing their meaning and purpose. Indeed, addicts have less meaning and purpose than age matched controls (Nicholson et al., 1994; Klion, 1993), and lack of purpose is a mediating factor in both substance abuse and suicide (Harlow, Newcomb, & Bentler, 1986; Heisel & Flett, 2004).

PRC includes several sessions on these topics because meaning and purpose can make human lives better. Meaning can increase happiness, control, and engagement at work and decrease depression, anxiety, substance abuse, suicidality, and need for therapy (Steger, 2009); and purpose contributes to well-being when it is aligned in the pursuit of the good life (Steger, 2009), is a strong predictor of life satisfaction (Diener, Fujita, Tay, & Biswas-Diener, 2012), improves our overall well-being, physical and mental health (Reker, Peacock, & Wong, 1987), resiliency (Steger & Park, 2012), optimism (Comptom, 2004), self-esteem (Steger, 2009), decreases depression and anxiety (Steger, 2009), and increases vocational commitment and well-being at work (Steger, Dik, & Duffy, 2012).

What Do I Stand For phase is comprised of the following sessions: (1) Valued Psychological Growth and Physical Health Goals, (2) SMART goals for one, three, six, and 12 months, (3) A Higher Purpose, (4) Values, (5) Spirituality: Search for the Sacred in Connecting With Something Larger Than the Self, and (6) Formulating a Comprehensive Positive Relapse Prevention Plan.

Maintenance Phase

Addiction is a self-sustaining, relapsing, progressive disease that is never cured (Erickson, 2007; McLellan et al., 2000). In addition, addiction requires that treatment to be delivered over years, even over a lifetime, rather than in short episodes that defines our current delivery system (Dennis et al., 2007). Again, relapse rates are high during and soon after treatment, which spoils the effectiveness of treatment, predicts continued relapse, and prevents people from living full, rich lives. Addiction is only temporarily self-perpetuating, and soon after abstinence is established, agency is restored (Carroll & Miller, 2006). Treatments must be long enough to provide the training in, and offer adequate opportunities to, develop self-sustained cognitive, behavioral, emotional, relationship, and spiritual resources (McLellan et al., 2000; Marlatt & Gordon, 1985), or "recovery habits," that ultimately make recovery more fulfilling and attractive than addiction.

The current system has strengths: treatment has demonstrated efficacy and effectiveness at helping people maintain recovery and for reducing addiction-related problems (McLellan et al., 2000; Sellman, 2010). In addition, many treatment providers support positive psychology's idea that treatments for mental illness (e.g., addiction) should not end once negative symptoms disappear and frequently recommend aftercare for their clients. However, rehabs and clinicians are powerless to enforce compliance in most cases. Participation in post treatment recommendations (e.g., group, individual, or fellowship) depends upon several factors, such as an individual's level of motivation, ability to attend, or work conflicts. We address this shortcoming by designing the Maintenance Phase to be self-guided, allowing for schedule variations, and to be familiar: many of the concepts and activities are similar, or identical, to

those experienced in treatment. Our goals here are for clients to prevent relapse and (when applicable) decrease the acuity of relapse as well as to continue developing recovery habits in a guided pursuit of happiness.

Maintenance Phase consists of three main parts: Positive Recovery Daily Meditation Guide (a daily positive intervention guide), Positive Recovery Online Forum (an online positive recovery support group, host for journaling assignments, and automated program that offers reminders of goals, rewards for accomplishments, and triggers contingency plans in case of relapse), and Aftercare Monitoring (an extended therapeutic contact with clients).

Positive Recovery Daily Meditation Guide & Positive Recovery Forum

The Positive Recovery Daily Meditation Guide (PRMG) is a daily positive intervention guide that provides clients with options to intentionally direct their behavior while forming recovery habits. PRMG is based on the idea that treatment for addiction should be a long process, involving years and often entire lifetimes rather than 30, 60, or 90 days. This guide is a recurring exercise meditation book that clients can use every day for the rest of their lives. It consists of relapse prevention strategies, PIs, and other activities that incorporate correlated ideas (e.g., good relapse prevention strategies involve nurturing one's healthy relationships). Furthermore, many activities are strategically placed to coincide with seasons and holidays. For instance, the Good Consumerism positive intervention (J. Pawelski, personal communication, December 2, 2012), which encourages more meaningful gift giving than the usual materialism that defines holiday gift-giving, is placed in early December where many people will be preparing for holiday season. Thus, PRMG will reminded users to focus on spending time with the people they love and spending money on altruistic, in addition to only

materialistic ends.

We strongly encourage that clients comply with treatment team suggestions for aftercare, such as counseling, medication management, or testing. PRMG is not meant to substitute for an aftercare plan whether it may include individual therapy, outpatient treatment (after inpatient treatment), or attending recovery fellowships. The day's activities will expose clients to a wide array of activities, improving the chances of finding a person-activity fit (Lyubomirsky, 2008).

Positive Recovery Online Forum (PRF) is one option where clients can connect with other like-minded people. PRF enables clients to join a supportive online community at no cost where they can exchange ideas, experience, strength, and hope with other members. Many PRMG days include written assignments and offer readers the option to post them on the forum and comment on other's posts. We encourage journaling as a means to enhance mental and physical health, goal attainment, and learning (King, 2001). While digital community support is not meant to replace offline interpersonal dynamics, recent developments in, and studies of, web-based interventions for a wide array of mental health issues (e.g., smoking cessation, substance abuse, etc.) supports the efficacy of using online formats (Bennett & Glasgow, 2009).

PRMG is not a daily "meditation" guide in the strict sense. While a few specific days include meditation exercises, these books are called "meditation guides" in the recovery genre. Recovery fellowships use meditation books like PRMG to discover interesting topics as discuss starters for fellowships meetings. With that in mind, PRMG begins with an inspirational quote followed by a brief discussion of how the passage relates to positive

recovery. Each day provides the instructions for that day's activity, one of any variety of

activities that frequently include written assignments that can be submitted at the participant's

discretion to the community forum. On the forum, members can provide feedback for others

and read feedback others provide. A licensed therapist will moderate the site and any improper

or unhealthy posts will quickly be removed.

Aftercare Monitoring

Again, many people with addiction receive multiple, short, and disconnected episodes of

treatment. While routine monitoring of symptoms over long periods of time by health care

providers or patients is considered the gold standard of care for chronic disorders (e.g., diabetes,

asthma, etc.) (McLellan et al. 2000), people with addiction do not receive the same level of care.

Instead, they generally receive disjointed, short episodic treatments. We address this shortcoming

for our clients by providing routine and integrated services through aftercare monitoring.

Whether it is due to stress, biological vulnerability, or waning motivating, countless studies

indicate that continued and integrated contact with patients increases lengths of sobriety and

decreases substance abuse-related problems (Wagner et al. 2001; McLellan et al. 2005).

Moreover, regularly recording symptoms and behaviors can motivate people to persist in efforts

at behavioral change and is associated with health benefits (Pelletier, Dion, Slovinec-D'Angelo,

& Reid, 2004; Febbraro & Clum 1998; Bandura 1991). One study demonstrated that aftercare

monitoring reduced sick days, hospital lengths of stay, and mortality rates at 6-16 years

compared to control group participants (Kristenson, Ohlin, Hulten-Nosslin, Trell, & Hood, 1983;

Kristenson, Osterling, Nilsson, & Lindgarde, 2002).

Positive Recovery Evidence Base

In this section, we will provide a limited literature review of the evidence based regarding the major conceptual elements of the positive recovery curriculum, including habit, attention, self-regulation theory, positive and negative emotions, optimism, positive interventions and positive psychotherapy, positive psychology & addiction, the body (exercise, diet, and sleep), emotional intelligence theory, goal setting theory, hope theory, self-determination theory, character strengths, relationships & social connections, recovery fellowships, meaning & purpose, spirituality, journaling, and business value.

Habit

James (1890) is credited as the first person who claimed habits are responsible for forming neural pathways, which is a genuine physiological process modern scientists call "neuroplasticity." Repetition leads to learning, mastery, and eventually habits that change us physically (Dobkin, 1993). Nearly half of our daily behavior is automatic, habitual, and unconscious (Wood, Quinn, & Kashy 2002). Habits are powerful, and like double-edged swords, habits can help and harm. We teach that addiction is a BAD habit in need of breaking, and that recovery is a GOOD habit in need of forming. Resolutions take little effort to say but are very difficult to carry it out: good habits are difficult to create but easy to break while bad habits are easy to form but hard to break (James, 1890).

Addiction is a *habitual* process more than an isolated event (Dennis et al., 2007; Larimer et al., 1999), which is associated with specific structural and functional brain changes (Goldstein & Volkow, 2002). Fortunately, abstinence is also associated with neuroplastic changes (e.g., white and grey matter volume and synaptic activity) (Demirakca et al., 2011).

Similarly, happiness is also more like a *habitual* process than an isolated event (Peterson, 2012; James, 1890). However, bad habits, like addiction, are hard to break and good habits, like recovery are not (Duhigg, 2012; James, 1890). If recovery is not ultimately more fulfilling, though, most people will probably relapse.

Habit requires repetition, repetition takes time, and time passes slowly. PRC reinforces the idea that habit changes the self, that human attention and will power are finite resources, and that self-regulation (or 'willpower') helps direct attention in the formation of habits and in the pursuit of happiness. Habits (both healthy and harmful) allow individuals to conserve attention and energy (James, 1890; Duhigg, 2012). Habits lead to mastery and help the novice to become the master. Long-term recovery, which results from repeatedly performing recovery behaviors in the formation of recovery habits, predicts further recovery: studies show that some sobriety is predictive of more sobriety (Maddux & Desmund, 1986; Vaillant, 1995; Duvall, Locke, & Brill, 1963).

Attention

Every day, we are exposed to a nearly infinite amount of noise. Thoughts, feelings, interactions, and impulses constantly bombard the mind (Csikszentmihalyi, 1990) to such a large extent that Seligman proclaimed, 'the mind is a mess!' (M. Seligman, personal communication, November 3, 2012). Which personal resources, if any, can clean this mess? Voluntary control of attention does: it regulates the mind and determines experiences, shapes judgment, builds character, and affects well-being (Csikszentmihalyi, 1990; James, 1890). However, we only have a limited bandwidth of attention. Therefore we must direct our attention wisely on those thoughts and impulses that help us forge good habits and avoid

attending to those which erode them (Csikszentmihalyi, 1990).

Self-regulation

Self-regulation, or "willpower," is defined as the strength that controls our limited supply of attentional bandwidth (Baumeister et al., 2006). In addition, self-regulation is a character strength every human possesses, albeit on a continuum – some of us have more than others (Baumeister, 2002). Self-regulation manages behavior, resists temptation (e.g., cravings), controls impulses, delays gratification, and pursues long-term goals (Baumeister et al., 2005). High amounts of self-regulation predict better health, life and work satisfaction, success, and popularity (Baumeister et al., 2006).

Self-regulation is a limited strength: under stressful situations, self-regulation can fatigue, a state which Baumeister (2002) calls "ego depletion." Like a muscle, the more we use self-regulation, the more ego depleted we become. Hungry participants in one study that had to use their willpower to not eat chocolate chip cookies, became ego depleted by not eating the cookies and quit a puzzle-solving task more quickly than the control group (Baumeister, Bratslavsky, Muraven, & Tice, 1998). In addition, participants in another study, who were told not to think of a *white bear,* drank more beer than the control group (in a 'taste test' ruse), despite knowing they would subsequently be taking a driving test (Muraven, Collins, & Nienhaus, 2002).

Studies prove the wisdom of an oft-repeated cliché in recovery fellowships, "don't let yourself get too hungry, angry, lonely, or tired." When self-regulation becomes worn-out, people are less able to inhibit certain socially undesirable behaviors, which are usually kept under strict control. For instance, low self-regulation can lead to immoral, unlawful, or

inappropriate behavior (Baumeister et al., 2006). In addition, self-regulation also helps prevent

relapse. Studies show that when triggers (i.e., high-risk situations) activate physiological

cravings, low self-regulation predicts relapse (Bandura, 1982).

Self-regulation is a precious, limited resource that can be strengthened. In addition, self-

regulation is not limited by specific contexts or tasks. Self-regulation in one arena of life, like

physical exercise, leads to better self-regulation and improvements in other, even unrelated

spheres of life, too, such as money management or study habits (Baumeister & Vohs, 2005).

Just as habitual weight lifting over time builds strength, using self-regulation can also slowly

increase endurance against ego depletion (Baumeister & Vohs, 2005). For instance, research

participants in one study who engaged in a fitness program for two months reported greater

discipline across apparently unrelated areas of their life: they watched less television and spent

less money impulsively (Baumeister et al., 2006).

Self-regulation may be the single most crucial strength human beings have at our

disposal (Baumeister et al., 2006). Indeed, how we override and alter our reactions to people,

places, and things and how we manage our limited attention bandwidth does result in more

positive outcomes across a broader range of well-being pursuits than result from using any

other strength (Baumeister et al., 2006). Furthermore, much of life is under personal control:

we can either regulate our attention to embrace beliefs of self-doubt and pessimism, or

embrace those that are more beneficial and helpful in improving well-being, achieving success,

and building character (Peterson, 2006).

Addiction strips the addict of volition, thereby removing intentionally-directed attention

(self-regulation) (Erickson, 2007). However, addicts do not lose self-regulation forever

(Schneider et al., 1993), which is fortunate because self-regulation is required to maintain recovery (Robinson & Berridge, 1993; Noël et al., 2007; Tiffany, 1990).

Negative Emotions

Negative emotions can, at times, contribute to human flourishing. For example, engaging in conflicts may be productive and healthy within relationships, provided that both partners communicate both verbally and nonverbally with respect (Gottman, 1994). Other negative emotions, such as guilt and shame, can alert individuals to recognize when their own behaviors impede on others' rights, which lead them to admit fault or adjust their behavior, thereby letting others know that they are valued and respected (P. Rozin, personal communication, November 11, 2012).

Negative emotions can also be appropriate in therapeutic settings. For example, Feudtner (2009) demonstrates that within profoundly sad pediatric hospice scenarios, using negative emotions can help motivate families to act on positive emotions such as hope. Furthermore, when individuals are in the midst of a major personal growth phase, which often accompanies the metamorphosis from addiction to recovery, negative emotions frequently accompany these periods of personal growth. In such cases, negative emotions would not indicate a 'negative' process in need of professional amelioration. Instead, as James (1902, p. 187) notes, "[w]hen the new centre of personal energy has been subconsciously incubated so long as to be just ready to open into flower, 'hands off' is the only word for us, it must burst forth unaided!" Clearly, there are times when negative emotions are useful and PRC supports the adaptive value of negative emotions that are context-appropriate. However, we also hold that constructing the positive is at least as valuable as mitigating the negative (Peterson, 2006).

Negative emotions are often adaptive, and not always "bad," however when they become self-propagating and prolonged without an adaptive outcome, they can adversely impact health. Stress and anxiety damage the cardiovascular-pulmonary system, immune system, decrease longevity (Black & Garbutt, 2002; Davidson et al., 2003), alters executive functioning by impairing speed and accuracy of cognitive processes (Ciesla & Roberts, 2007; Cabeza & Nyberg, 2000), and predicts relapse (Sinha, 2001). Indeed, addicts report that stress and negative affect are major reasons why they relapse (Marlatt & Gordon, 1985; Lowman, Allen, & Stout, 1996). Negative emotions elicit conditioned behaviors that increase the likelihood of relapsing (Ludwig, 1986) and anxiety is positively correlated with alcohol consumption (Anton & Miller, 2005). Empirical evidence demonstrates that stress increases the vulnerability to relapse and while addiction alters the stress response and coping, thereby increasing the likelihood of drug seeking and relapse (Sinha, 2001). The intensity of negative affect prior to relapse predicts the duration of relapse (Zywiak, Connors, Maisto, & Westerberg, 1996). These findings strongly suggest that optimal treatments must include ways to undo the detrimental effects of maladaptive amounts of negativity and/or increase positivity.

Positive Emotions

Fortunately*,* positive emotions can reverse the effects of stress (Fredrickson et al., 2000), and help protect against cravings (McHugh, Kaufman, Frost, Fitzmaurice, & Weiss, 2013), both of which are especially prevalent in addiction. In one study, Fredrickson and colleagues (2000) studied volunteers who were subjected to high stress situations and then exposed to view one of four films with themes of: joy, contentment, neutrality, or sadness. In three independent samples, participants in the two positive emotion conditions (joy and

contentment) predictably demonstrated faster physiologic recovery from the effects of stress (e.g., elevated heart rate) than those in the neutral and sadness conditions. This study also points to how bad unopposed negativity can be: those who were exposed to the sadness condition exhibited the slowest return to baseline.

Negativity and positivity are not equipotent: 'bad is stronger than good' (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001; Rozin & Royzman, 2001). In other words, negativity trumps positivity: equivalent financial gains are not as strongly pleasing as equivalent financial losses hurt (Schwartz, 2009), and our brains react more quickly and powerfully to threatening images than it reacts to positive ones (Öhman, Lundqvist, & Esteves, 2001). 'Bad is stronger than good' implies that equal amounts of positivity and negativity do not balance one another; we must cultivate positive experiences more frequently to balance the dose of negativity. Cultivating positivity may improve completion rates and compliance because depressed patients are less likely to adhere to medical treatment recommendations (Chwastiak et al., 2002). Indeed, recovery fellowships may be effective in relapse prevention precisely because they induce positive emotions in members (Galanter, 2007; Vaillant, 2008).

There are more reasons to care about positive emotions than feeling better and managing stress. Interventions that increase positivity can provide the positive reinforcements that distract us from the lure of addictive substances and/or behaviors (Carroll & Miller, 2006). In addition, positive emotions can improve resilience to adversity (Fredrickson, Tugade, Waugh, & Larkin, 2003), enhance overall well-being (Fredrickson & Joiner, 2002), nurture psychological growth (Fredrickson et al., 2003), and is associated with increased longevity (Levy, Slade, Kunkel & Kasl, 2002; Danner, Snowdon, & Friesen, 2001). Positive emotions

also are associated with reduced levels of cortisol in response to everyday stress (Steptoe,

Wardle, & Marmot, 2005), reduced susceptibility to the common cold (Cohen, Doyle, Alper,

Janicki-Deverts, & Turner 2009), and inflammatory responses to stress (Steptoe et al., 2005).

Furthermore, beyond making us feel good as individuals, the experience of positive emotions

(e.g., joy, happiness, and contentment) can improve our relationships (Lyubomirsky et al.,

2005), widen the scope of attention, and broaden behavioral repertoires (Fredrickson &

Branigan, 2005).

One session in PRC designed to increase positivity in clients is 'savoring,' a strategy

with three separate time-based perspectives: anticipation, online hedonic enjoyment, and

reminiscence (Bryant, 2003). Life can be full of positive emotions, but experiencing these does

not guarantee that individuals will make the most of them - some individuals do not feel

capable of intentionally "generating, intensifying, and prolonging enjoyment" (Bryant, 2003,

p. 176). A fundamental assumption of savoring is based on an individual's sense that they can

savor, which is a form of perceived control. This control is distinct from the control one would

perceive when mitigating negative events, thereby making savoring a strategy in need of

specific cultivation (Bryant, 2003). Therefore savoring may help clients discover that they *can*

experience more positive affect than they previously imagined.

Happiness is Changeable

Lyubomirsky (2008) devised a largely symbolic, though easy to remember, range of

happiness that explains how roughly 40% of our happiness is under individual control. Genes

influence approximately 50% of our happiness, external factors contribute but 10%, and 40%

is under individual control. These broad percentages, while symbolic, support the idea that

individuals are in control of at least some of their well-being (Lykken & Tellegen, 1996).

Furthermore, this indicates that individuals are not helpless victims of fate; rather, we are

responsible for at least those things that we can change. Lyubomirsky (2008) reminds us that

while 40 per cent is not 100 per cent, it remains substantial. The take away message for clients

will not be whether this happiness range is a valid construct, but that each individual is an

active agent participating, at least in some degree, in creating personal well-being.

Optimism

Seligman (1991) posits that anyone, both pessimists and optimists alike, can learn

optimism and improve responses to both big and small adversities. PRC aims to facilitate this

type of resilience by teaching clients to develop, or strengthen, an optimistic explanatory style.

Explanatory style, or the way we habitually explain stressful and adverse events, is crucial in

developing resilience and optimism (Seligman, Reivich, Jaycox, & Gillham, 1995). When any

event happens, individuals explain or interpret them according to three main components:

- 'Personalization'- is the event is personal (who is to blame?)

- 'Permanence'- how long will it last (will it last forever?)

- 'Pervasiveness'- what are all the implications (is my whole world affected or just a

   portion of it?)

Clients will learn that optimism or pessimism can be viewed as choices of explaining

why certain events happen. Since realism and optimism are not mutually exclusive, the finite

amount of certainty in the world enables the freedom to choose the best possible realistic

interpretation (Schneider, 2001). This perspective implies that flourishing is not something that

we mine or pick but we create (J. Pawelski, personal communication, February 2, 2013). In

other words, people do not need to feel limited by certain epistemological notions of what they can and cannot do; instead, we are co-creators of reality, and we have a role in crafting rich, full lives in recovery.

Optimistic explanatory style may help people maintain recovery because emotional and explanatory responses to events are more important in maintaining recovery than the specific events (Larimer et al., 1999; Reivich & Shattè, 2002). In addition, optimistic explanatory style appears to exert protective health benefits independent from risky health behaviors frequently seen in addicts (e.g., smoking) (Kubzansky, Sparrow, Vokonas, & Kawachi, 2001).

On the other hand, a pessimistic explanatory style generally explains positive events as temporary, context-specific, and external but explains negative events as permanent, pervasive, and personal (Seligman, 1991). A pessimistic explanatory style does not simply refer to overall pessimism. Instead, a pessimistic explanatory style is a specific, dispositional, and rather automatic form of self-talk which explains both negative and positive life events in a self deprecating, catastrophic, and gloomy manner (Seligman, 1991). Pessimistic explanatory style is associated with low amounts of resilience (Reivich & Shatte, 2002; Seligman, 1991), poor mental and physical health, diminished work production (Peterson & Barrett, 1987; Peterson & Seligman, 1984; Kubzansky et al., 2001; Sweeney, Anderson, & Bailey, 1986), poor treatment outcomes (Carroll & Onken, 2005), and depression (Peterson & Seligman, 1984; Sweeney et al., 1986).

Addicts are especially vulnerable to threatening and stressful events: they generally exhibit low self-regulation, self-efficacy, and emotional intelligence that compound their ability to effectively manage emotional states (Marlatt & Gordon, 1985). Additionally, people

who frequently relapse report that they view their relapse as permanent, pervasive, and

personal proof that they will *always* fail at maintaining recovery (Larimer et al., 1999), which

erodes self-esteem and well-being (Seligman, 1991).

A shift toward optimism is a shift away from depression. According to Beck (2005),

depressed patients explain the world to themselves through a self-deprecating and catastrophic

lens (pessimism). PRC teaches clients that they *can* control how they respond to adversity, that

they can learn optimism. Clients will learn to explain negative events as temporary, context-

specific, and external and, when appropriate, explain positive events as permanent, pervasive,

and personal; using this style protects against feeling helpless and overwhelmed (Seligman,

1991). Optimism is often more accurate, flexible, and certainly are more helpful interpretations

on events (Schneider, 2001). Indeed, when things go bad for us, probability suggests that we

are rarely the only ones to blame (personalization), things are hardly messed up forever

(permanence), and problems rarely extend to the entirety of our existence (pervasiveness).

Clients who develop more levels of optimism can experience a decrease in depressive

symptoms (Seligman, 1991), enhanced coping skills (Peterson & Seligman, 2004; Reivich &

Shatte, 2002), better social relationships (Peterson, 2012), and (potentially) higher salaries

(Schulman, 1999).

Positive Interventions and Positive Psychotherapy

Simply stated, both positive interventions (PIs) and positive psychotherapy (PPT) can

improve efficacy and effectiveness of addiction treatment for clients with or without co-

occurring psychiatric disorders. While most PI studies have been conducted with nonclinical

individuals, "two randomized controlled studies in patients with mild clinical depression have

reported promising initial findings" (Layous et al., 2011, p. 11). The application of this approach to addiction has not gone unnoticed (Slade, 2010; Miller & Miller, 2009; Krentzman, 2013; Layous et al., 2011).

In a study of mildly depressed volunteers who were randomly assigned to engage for one week in one of five well-being-enhancing activities (involving practicing gratitude, positive thinking, and one's strengths) versus a placebo control activity (involving writing one's early experiences), participants in the well-being-enhancing activities experienced a boost in well-being and a decline in depressive symptoms both during and after the intervention ended (Layous et al., 2011). In fact, the boost in well-being and decline in depressive symptoms lasted for six months in those participants who wrote about three good things in their life and used their signature strengths in a new way (Layous et al., 2011).

Some PIs not only have persistent effects, they also have quite rapid onsets of action. In one study (Seligman, Steen, Park, & Peterson, 2005) severely depressed individuals were instructed to engage in the Three Good Things PI every day, and in about two weeks (within 15 days), nearly every participant experienced relief (94%). These results indicate that not only can PIs be effective in reducing depressive symptoms, but that they can also work quickly. This latter point makes PIs especially valuable in our population for two reasons: first, the addicted population often has trouble with delaying gratification, and secondly, the current system of care grants brief treatments spans and short lengths of stay.

A widely used and especially powerful strengths intervention we include in PRC is to use their 'signature strengths' in a new and unique way daily for a week (Niemeic, 2013; Seligman et al., 2005). Signature strengths are defined as the top 5 VIA character strengths as signature

strengths (note: a validated set of signature strengths does not yet exist and the construct is merely used as a general rule, though research is underway). In one study, which was a large, randomized, and controlled trial on the Internet, using a signature strength in a new and unique way each day for a week boosted happiness levels and decreased depression levels at one week and even 6 months later (Seligman et al., 2005). In another study, groups assigned to using strengths also experienced significant gains in life satisfaction (Rust, Diessner, & Reade, 2009). *The Best Possible Self* PI is another validated positive intervention we use in PRC that can lead to significant health benefits, significantly increases positive affect (PA), improves levels of intrinsic motivation (Sheldon & Lyubomirsky, 2006; King, 2001), self-regulation, mental health, and physical health (Sexton & Pennebaker, 2009). In addition, we believe this PI will usher in many other benefits of positive thinking such as positive affect and optimism (Taylor & Brown, 1988).

PPT is a psychotherapeutic technique that searches for ways to decrease symptoms and improve lives in clinical populations by enhancing positive emotion, engagement, and meaning in life (Seligman, 2011; Seligman et al., 2006). In one study of severely depressed patients, PPT "relieved depressive symptoms on all outcome measures better than treatment as usual and better than antidepressant medications" (Seligman, 2011, p. 43). In another randomized controlled trial using PPT in clinical groups, happiness increased and depressive symptoms decreased - with persistent (12-month) moderate to large improvements (Seligman et al., 2006). These two studies do not constitute a robust set of findings, instead these demonstrate that balanced interventions can be effective and also suggest that similar approaches (e.g., PRC) may have positive effects on treatment outcomes (e.g., completion rates and continuous

sobriety) and well-being.

Positive Psychology & Addiction

Only a few clinicians and researchers support the view that positive psychology has worthwhile insights for treating addiction (Slade, 2010; Miller & Miller, 2009; Krentzman, 2013). Although the limited number of studies does not reflect a robust interest in addiction treatment thus far, aspects of positive psychology have demonstrated positive effects in medicine. For example, one study demonstrated that inducing positive affect in physicians can improved their clinical decision-making skills (Estrada, Isen, & Young, 1994). We believe that positive psychology can enhance treatments for addictive disorders but we need more studies. The two studies that directly applied positive psychology to addiction medicine are reviewed next.

Smoking tobacco is one of the hardest habits to quit (Powers, 2012). Mark Twain claimed that, 'Quitting smoking is easy, I've done it thousands of times!'(as cited in Powers, 2012). Perhaps Twain could have stayed abstinent had he received positive psychotherapy, which MacPherson et al. (2010) used successfully on smokers. In the study, researchers hypothesized that patients would be more successful at quitting if they were primed with positive emotions prior to the quit date because they could have more resources at their disposal: positive emotions can improve learning, problem-solving, social bonding, and self-esteem (Fredrickson, 2009). Consequently, researchers found that participants who were primed to experience positive emotions reported greater smoking abstinence than did those in the standard smoking cessation therapy group and reported a greater reduction in depressive symptoms than did those in the standard smoking cessation therapy group (MacPherson et al.,

2010).

In another study discussed earlier, Akhtar and Boniwell (2010) investigated outcomes of a positive psychology intervention on 10 adolescents over 8 weeks in the U.K. This study, albeit for a small sample size, also supports applying positive psychology in addiction treatment. Study participants experienced more well-being, more positive affect, developed a future goal orientation, an escalation of change amounting to transformation, less drug use, significant increases in happiness, optimism, and positive emotions, and a significant decline in alcohol dependence (Akhtar & Boniwell, 2010).

The Body

A technique we teach our clients to try when they feel sad is to "fake it till you make it." When individuals imitate how the body naturally behaves when experiencing a certain emotion, they can powerfully influence the very same thoughts and feelings that usually accompany or result from that emotion (Levenson, Ekman, & Friesen, 1990; Larsen & Sinnett, 1991; Kim & Kim, 2007). Bodies can be utilized to feel better simply by flexing certain facial muscles: if individuals smile and laugh, they may end up feeling better because the act of smiling can lead to experiencing positive emotion (Levenson et al., 1990). Or, many people slouch while standing or sitting because they may be tired, bored, or simply wish to relax, but slouching can cause people to feel tired, bored, or even powerless. In contrast, standing and sitting upright takes effort and focus, especially when individuals feel bored or tired, but standing and sitting upright can elicit individuals to feel powerful (J. Pawelski, personal communication, August 20, 2012). Simply stated: the human body can significantly affect emotional health, cognition, and well-being (Mutrie & Faulkner, 2004).

Habit Phase includes three sessions on the body (diet, exercise, and sleep) because we are what we repeatedly do. That is, habits create tangible, physical changes in our bodies (James, 1890; Cramer et al., 2011). Since our bodies are malleable, repeated actions create advantageous neural pathways that increase competence and decrease future effort (James, 1890). Our bodies reflect and direct how we regulate attention and behavior. In other words, habits can build personal resources if we repeatedly act in healthy ways. Time and practice can make even challenging acts nearly automatic, which allows for attention to be directed in other ways. Master professional basketball players, for example, are so automatic that they get nicknames like *The Mailman* (because mailmen always deliver the mail) and *Magic* (self-explanatory).

Strategically applied attention in habit formation, makes an ally of one's nervous system and is the means by which individuals shape their character, forge their destiny, and thrive (James, 1890). We cannot afford to be complacent in this process: good habits are difficult and slow to form while easy to break, and bad habits are quick to form and difficult to break (James, 1890). Therefore, we must be forever diligent in directing our attention to our growth (Peterson, 2012). James suggests we SNAP: Start strong, No exceptions (be consistent), Always act (take advantage of every opportunity), and Practice exercising the will.

Modern scientists can prove that habit rewires our brain at even the most microscopic, genetic level (Miller, 2010). Similarly, addiction causes specific genetic (Rhodes & Crabbe, 2005) changes that can drive and control further brain circuitry changes (Blednov et al., 2012). Fortunately, human beings do not become forever trapped by even bad habits from the past. Diet, exercise, and sleep all can alter how hundreds of genes are expressed, from increasing the

activity of disease-preventing genes to lowering the activity of disease-promoting genes (Miller, 2010). Behaviors alter genes in both positive and negative directions, so we must be careful what we do, or don't do, and genetic influences (predispositions) make it easier to become addicted, but genes do not prevent one from choosing to behave and think in optimal ways from now on.

While a complete discussion about all things exercise, diet, and sleep are beyond the scope of this work, we will discuss findings pertinent to addiction that will guide physical fitness groups, food service for inpatients, sleep strategies, and educational processes.

Exercise

We support exercise as a pathway to improve overall health and prevent relapse. Exercise reduces the risk of cancer, heart disease, high blood pressure, obesity, and depression; and exercise slows aging (Rath, 2013). The key to health is exercise: the fitter one is, the lower the mortality risk for any cause, even when one is overweight (Blair et al., 1995). However, if one wants to lose weight, exercise cannot be the only tool: exercise without healthy dietary habits may actually cause weight gain because exercise can increase appetites (Bailey, 1991). While the food one consumes is crucial for overall health, it is one's fitness level that is most important for extending lifespan (Lee et al., 2011). In addition, exercise appears to prevent relapse: a12-week exercise intervention study of alcohol dependent patients revealed significant increases in percent days abstinence and decreases in drinks per drinking day at follow up visits (Brown et al., 2009).

Physical activity is strongly correlated with psychological well-being for all ages in both clinical and nonclinical populations (Moses, Steptoe, Mathews, & Edwards, 1989; Park, 2005).

Exercise may be especially useful for our clientele. A study of trauma-exposed alcoholics demonstrated that vigorous exercise can decrease coping-oriented alcohol use (Medina et al., 2011). And in another study, just one session of moderate intensity exercise was enough to reduce cravings for alcohol (Ussher, Taylor, & Faulkner, 2012). Zschucke, Heinz, & Ströhle (2012) conclude from their literature review that exercise is an effective option to help smokers quit.

One strategy to improve the health of our clients is by using pedometers and counting daily steps totals. Research suggests that when individuals wear pedometers, they walk over a mile longer per day than when they don't, overall activity increases 27%, body mass index (BMI) decreases, and blood pressure decreases (Dwyer et al., 2011; Tudor-Locke, 2002). Current research supports setting a goal to walk at least 10,000 steps a day to prevent diabetes and improve weight loss (Dwyer et al., 2011; Tudor-Locke, 2002). We could also apply this principle to other pro-positive recovery behaviors, such as continuous sobriety and weight goals, because measurement itself creates improvement – simply asking people to track specific outcomes makes them more likely to engage in those behaviors (Rath, 2013).

We can maximize the benefits of each workout by turning up the intensity: the more intense each workout is, the more calories are burned throughout the next 14 hours (Knab et al., 2011). Additionally, morning workouts can increase our mood for up to 12 hours throughout the rest of the day (Sibold & Berg, 2010). Exercise also improves brain function: multiple studies demonstrate that aerobic exercise increases critical brain structure size and improves cognition, and even one 20-minute yoga session can significantly enhance the speed and accuracy on tests of working memory and inhibitory control (Goethe, Pontifex, Hillman, &

McAuley, 2013).

In an open study of 156 adult volunteers with major depressive disorder, Babyak and colleagues (2000) discovered that exercise could help mitigate undesirable moods more powerfully than antidepressants. The volunteers were divided into three groups: an aerobic exercise-only group, an antidepressant-only group, and an exercise + antidepressant group. After 4 months patients in all three groups exhibited significant improvement; but after 10 months, volunteers in the exercise-only group had significantly lower relapse rates than subjects in both the medication-only and medication + exercise groups. Puterman and colleagues (2011) measured the effects of exercise on chronic stress, and found that compared to sedentary participants, those who exercised experienced less rumination and produced lower levels of stress hormones.

Diet

Nutrition education should be part of any addiction treatment since poor diets can cause or exacerbate many medical consequences of addiction (Cala et al, 1983; Estruch, Nicolás, Villegas, Junqué, & Urbano-Márquez, 1993). Moreover, nutrition education is positively associated with addiction treatment outcomes. Grant, Haughton, & Sachan (2004) discovered that individual nutrition/substance abuse education was associated with significant (99%) decreases in addiction-related family/social problems.

Alcoholics who stop drinking frequently crave sweets because sugar alcohols are no longer in their diet (Erickson, 2007), and many clients who stop one addiction (e.g., drugs or sex) run the risk of acting out with another specific substance or behavior (Blumenthal & Gold, 2010; Carnes, 2001). Drug cues that elicit drug-seeking behavior activate reward and

deactivate inhibitory pathways in the same brain regions in which food cues elicit food intake

(Childress et al., 1993; Gearhardt et al., 2011). While food cues trigger hunger and feeding

behavior (Jansen, 1998), drug cues trigger craving and relapse (Shiffman et al., 2002). The

neural response to cues as measured by functional magnetic resonance imaging (fMRI)

predicts weight gain (for food cues), relapse for drug cues (Payne, Smith, Adams, &

Diefenbach, 2006; Janes et al., 2010), and persistent smoking for cigarette cues (Janes et al.,

2010; Le Foll & Goldberg, 2005). MRI studies also demonstrate that when we are hungry we

eat worse than when we snack regularly throughout the day: those parts of our brain that light

up indicate our brain craves calorie-rich foods (Führer, Zysset, & Stumvoll, 2008). Thus, we

hope to prevent this effect by keeping nutrition-dense foods (e.g., bowls of raw almonds)

available in high visibility in between meal times.

For meal times, we will implement the following cost effective and easy to implement

strategies that can improve client health: a strategic use of plate color, plate size, and allowing

for adequate meal times. We can help clients to eat less unwanted food without feeling hungry

while decreasing food waste costs. Smaller serving plates decrease the amount of food people

eat (Wansink, 2012) and when the plate's color contrasts with the foods on it, people eat less

than if the plate is the same color as the food (Van Ittersum & Wansink, 2012). The goal is not

to shrink client's waists along with overhead expenses. Instead, the participants in these studies

ate less amounts of (unwanted food) but did not feel hungrier (Van Ittersum & Wansink, 2012;

Wansink, 2012). Furthermore, we will educate staff and clients to slow down when they eat.

Eating slowly, at least over a 20 minute time span, is ideal since that is the time required for

stomachs to tell brains how full they are getting (Andrade, Greene, & Melanson, 2008), which

is better than shoveling in food quickly and later discovering that one's clothes have atrophied.

Again, addiction causes innumerable health consequences. We use one major common consequence of addiction, heart disease, to demonstrate how healthy diets (e.g., more fruits and vegetables) can benefit our clients in more ways than enhancing their well-being. It appears that high raw vegetable and fruit consumption nearly negates the effect of even the most powerful known genetic mutation for heart disease that predisposes human beings to develop cardiovascular disease (Do et al., 2011). Heart attacks and other cardiovascular diseases (e.g., stroke) may be modified by a sensible diet high in raw vegetables and fruits.

PRC nutrition sessions also present various other current and scientifically accurate dietary information. For example, sugar is now identified as a causative agent for several health problems. Sugar is a toxic, inflammatory agent that causes brain atrophy, speeds up aging rates, and increases the prevalence of non-communicable disease (Lustig, Schmidt, & Brindis, 2012). In fact, some experts now refer to sugar as 'candy for cancer cells' (Rath, 2013) since it presents a clear and present danger for public health. Sugar is recognized by many experts as an addictive drug, and compulsive overeating as an addiction (for a review, see Blumenthal & Gold, 2010) and according to this position, sugar is a legal drug that deserves as much scrutiny as tobacco and alcohol. Fortunately, cutting back on carbohydrates (sugars) can decrease cancer growth rates by 50% (Ho et al., 2011), and one study of over 800,000 people demonstrated that "each additional serving of fruits or vegetables, all the way up to seven servings, continues to improve well-being" (Rath, 2013).

Sleep

Sleep disturbances are common among addicts in early recovery (Brower, 2001;

Schierenbeck, Riemann, Berger, & Hornyak, 2008) and poor sleep increases relapse rates for all psychoactive substances (Brower & Perron, 2010). Our clients are not alone: approximately 50–70 million adults in the United States have sleep problems and any number of associated of physiologic consequences of sleep problems such as obesity, diabetes, and cardiovascular disease (Orzeł-Gryglewska, 2010). Poor sleep also predicts mental, emotional and physical fatigue, poor performance on cognitive tasks (Li et al., 2008), and decreases physical health (Cohen, et al., 2009; Orzeł-Gryglewska, 2010).

Our literature review and situation analysis leads us to make the following low-cost and easy to implement recommendations that can help improve sleep, help prevent relapse, and improve physical, emotional, and cognitive health and performance including engagement in treatment: (a) use specific light bulbs around bedtime, (b) limit exposure to specific forms of light around bedtime, (c) maintain a low ambient room temperature around bedtime, and (d) sleeping for approximately eight hours per night.

In one study, light bulbs with wavelengths of 6500K were more effective than light at both 2500K and 3000K wavelengths for decreasing subjective sleepiness and increasing cognitive performance (Chellappa et al., 2011). This effect, which is explained by 6500K light exposure's suppressive effect on melatonin levels that decreases sleep efficiency (Rath, 2013), can easily be addressed by 1) minimizing client exposure to all light starting every evening and 2) when lights must be on, we will use only 2500K and 3000K wavelength light.

Individuals sleep better and longer when ambient room temperatures are lowered at bedtime: optimal temperature range for sleep appears to be between 65 and 72 degrees (Van Someren, 2004). Strategically closing off vents in rooms that are not utilized can help divert air

and keep electricity costs down (Rath, 2013). Furthermore, duration of sleep is a crucial

variable we plan to address and teach about in treatment. One study showed that sleeping 8.6

hours on average per night helps individuals to perform at their peak while negotiating

motivational and external constraints (Ericsson, Krampe, & Tesch-Römer, 1993).

Emotional Intelligence

Emotional intelligence (EI) is defined as the capacity to synchronize reason and emotion

together in order to do the next right thing (Salovey, Caruso, & Mayer, 2004). Emotional

intelligence aligns cognitions and emotions to make optimal situation-specific decisions and

behaviors. Emotional intelligence is not only directed inwards, EI also includes the ability to

recognize and shape emotions in others (Salovey et al., 2004).

In order to sustainably recover, addicts must have chronic, extended treatment options

that not only address their addiction, but also enable them to sustainably build elements of

well-being. Most addicts in early recovery have poor coping skills, poor impulse control,

arrested emotional development, uncontrolled and unmanageable lives, and low self-esteem

(Carnes, 2001; Erickson, 2007), and preventing relapse is extremely difficult for even the most

stable and resourceful individual. Adverse consequences lead many addicts to feel helpless and

hopeless, especially after several repeated unsuccessful quit attempts (Erickson, 2007), and

many addicts simply just give up (Larimer et al., 1999).

Research show us that individuals in crises can learn to overcome unwanted affective

states, strengthen their relationships with others, and appreciate life more deeply (Fredrickson,

2008; Seligman, 2011). This implies that even addicts that are early in their recovery can

develop emotional intelligence, improve decision-making, enhance relationships, and decrease

substance abuse (Goleman, 1995; Larimer et al., 1999). In addition, EI appears to protect

against destructive behaviors (e.g., drug use) and improve social relationships (Salovey et al.,

2004).

Sessions in PRC designed to help clients improve their EI include such activities as

identifying emotions in others through movie clips and identifying their own emotions through

frequent journaling assignments and biweekly individual therapy sessions.

Goal Setting Theory

Throughout PRC, staff and clients work collaboratively in constructing a list of

goals. Based on goals research about, we utilize the SMART (Specific, Measurable, Aligned

with values, Realistic yet challenging, and Timely) goal model as a general construct and with

special emphasis on subgoals. SMART goals are those goals associated with highest goal

attainment (Brown & Ryan, 2004; Locke, 1996). Challenging goals lead to a better sense of

achievement, but even highly meaningful stretch goals (e.g., "flourish in recovery") are hard to

achieve if they are too broad and nebulous to be useful (Locke, 1996).

Specific goals that are broken down into an incremental hierarchy ("subgoals') also

improve performance (Locke, 1996). For example, "staying sober forever" is a daunting and

depleting goal – no one can live his or her life in one day. When people are depleted, they

abandon goals and standards, focus more on their fatigue, and give up more easily (Baumeister

2002; Baumeister & Vohs 2007). Perhaps this explains the sage Alcoholics Anonymous cliché,

one day at a time, which encourages members to focus on the present and set short-term,

attainable subgoals. No one can stay sober forever, but anyone can stay sober today.

The goal- and hope-related sessions in PRC provide clients with other useful instructions,

such as setting subgoals (Locke, 1996), formulating several pathways to achieve their goals

(Brown & Ryan, 2004), setting challenging, yet realistic goals (Locke, 1996), and the wisdom

of when to let goals go (e.g., when they are no longer healthy) and set new ones. Furthermore,

PRC incorporates both positive and negative contingency management relapse prevention

planning. Positive contingencies are positive reinforcers that each client will include in the

relapse prevention plan. For example, a client may plan to reward herself with a mani-pedi

when she reaches the 90-day mark in recovery. Negative contingencies are aspects of the

relapse prevention plan that activate if a relapse occurs. For example, if "Joe" begins to behave

in "risky" ways (e.g., stops therapy, medications, or spending time with family and friends), his

therapist, physician, friends, family, and work manager all have permission to intervene.

      Treatment plan goals are not concrete or fixed. Instead, they are dynamic and adaptive

through staff and client collaboration based on current variables (e.g., client progress, input,

circumstances, feedback, etc.). In this way, clients experience what it feels like to attain goals

by adjusting and collaborating (Locke & Latham, 2002). Staff can increase clients'

commitment to their goals through other effective techniques, such as inspirational and

supportive communication, role modeling, helping them set high standards, and resilience

(Locke & Latham, 2002). In fact, the simple act of collaboration between staff and clients itself

can increase client's self-confidence (Locke, Alavi, Wagner, & Ferris, 1997).

      One session aims to use hope's ability to help individuals generate more pathways and

persist more in maintaining their recovery, even when faced with roadblocks (Snyder et al.,

2000). Hope is associated with adaptive coping and positive adjustment across several

domains, including school, work, and health (Snyder, Cheavens, & Michael, 1999) and helps

people formulate several alternate pathways and persist more in achieving goals, even when

confronted with difficulties and blockages (Snyder et al., 2000).

Hope Theory

In PRC we use findings from research on hope theory to specifically cultivate hope,

which we believe ranks among the most powerful motivating constructs for our clients. Hope

is "goal-directed thinking" in which individuals assess their competency of constructing viable

ways to attain goals ('pathways') and their potential to start and continue following those

pathways ('agency') (Lopez et al., 2000). In other words, hope helps clients to set meaningful

goals (e.g., flourish in recovery), figure out how to achieve them (maintain recovery and

regulate attention and behavior), and be self-motivated enough to succeed. Individuals with

high levels of hope persist and succeed more often in attaining their goals (Snyder et al., 2000);

higher levels of hope increase life satisfaction, self-esteem, perceived competence, mental

health (Valle, Huebner, & Suldo, 2006), positive coping skills (Compton, 2005), physical and

psychological health (Lopez et al., 2004), and with balance, interventions based on this model

simultaneously increase hope and decrease psychopathology (Cheavens, Gum, Feldman,

Michael, & Snyder, 2001).

While maintaining uninterrupted, stable recovery is a realistic goal that we will

encourage: relapse is still the norm in addiction. Hope also appears to mediate how resilient

individuals are during a relapse. Individuals with high hope appear to ruminate unproductively

about a problem less than peers with low levels of hope (Snyder et al., 1999), which may

protect them against negative and narrow thinking and enable them to apply lessons learned

from their own, or others, experience to manage their current problems (Snyder et al., 2000).

Operationally, this suggests that clients who have low levels of hope will be more likely to experience more severe relapse episodes than clients with high levels of hope, since they would be more likely to ruminate unproductively (Snyder et al., 1999), believe that they would have more limited choices (Fredrickson, 2009), and fail to learn lessons from their own history or from lessons about which they have seen, read, or heard (Snyder et al., 2000).

Self-Determination Theory

Hopes and goals, and how intensely they are valued, predict how persistently individuals pursue those goals (Ryan, Sheldon, Kasser, & Deci, 1996). Self-determination theory (Ryan & Deci, 2000) supports the idea that people will naturally value, and are motivated to nourish, their psychological growth and physical health (Ryan & Deci, 2000). Indeed, nourishing one's physical health through personal growth and supportive relationships is aligned with intrinsic life goals (Deci & Ryan, 2000; Ryan & Deci, 2000). Neimiec, Ryan, Deci, and Williams (2009) found that an SDT-based intervention helped smokers to facilitate autonomous self-regulation for quitting, to maintain abstinence from smoking, and to maintain the value they placed on their physical health. Therefore, PRC includes several sessions where staff will elicit and discuss intrinsically valuable recovery-related hopes and goals, which may enhance client motivation to achieve them, thereby preventing relapse whilst forming good habits on the road of happiness in recovery.

Character Strengths

The strengths phase of PRC is based on the 24 character strengths that have been universally valued across cultures, religions, and philosophies over the past 2000 years (Peterson & Seligman, 2004). The PRC strengths exercises are modeled after existing research

on these strengths (Niemeic, 2013) as well as curricula (Harms, Herian, Krasikova, Vanhove, & Lester, 2013). The goals of the strengths phase are to boost clients' well-being by assessing their character strengths (e.g., gratitude, courage, prudence, wisdom), helping them to recognize strengths in others, and helping them to use their positive traits in a context-appropriate manner on a daily basis while at work, home, school, or leisure. Knowing one's strengths positively affects intrinsically-valued goal pursuit, strength-focused therapy increases therapy outcomes and trust, and strengths help mitigate the effects of negative traits such as perfectionism and learned helplessness (Niemeic, 2013).

Character strengths are stable personality traits but they can be changed, developed, and are expressed in different amounts in different contexts (Niemeic, 2013). In that way, character strengths are formed from who we are and what we do, but are different from our raw talents. Raw talent is what comes naturally to us and is an innate capability that we are born with and build easily, while character strengths are something we can practice and nurture to improve over time (Peterson, 2006). In other words, character strengths help determine how individuals think, feel, and behave (Park & Peterson, 2009). Hence, a client's character is a valuable resource to flourish in recovery. Niemeic (2013) argues that one's character helps determine how one reacts in certain situations and whether they will make an appropriate decision in that specific situation, which suggests that clients who invest time and energy into developing their character strengths may be less likely to relapse.

Character Strengths and Virtues (CSV), or "the manual of the sanities" (Peterson & Seligman, 2004, p. 4) is a classification system of what's right in people (a positive construction orientation), in contrast to the Diagnostic & Statistical Manual (DSM) (American

Psychiatric Association, 2013), which catalogs only disorders (a negative ameliorative

orientation). Strengths building can help restore some balance to our approach to optimal

wellness that has disproportionately relied on the negative approach. There is good empirical

evidence that the balanced use of character strengths in life leads to improvements in well-

being (Seligman et al., 2005). In addition, the more intensely individuals endorse any one

particular strength, the higher the boost on well-being (Seligman, et al., 2006).

Lambert (1992) discovered that approximately 40% of improvement that happens in

therapy is due to patient factors, such as self-efficacy, which suggests that a therapy designed

to maximize patient factors may improve treatment outcomes. Research demonstrates that

character strengths contribute to optimal human development and well-being (Park & Peterson,

2009; Peterson & Seligman, 2004) and that specific strengths of character (hope, kindness,

social intelligence, self-control, and perspective) help to buffer people against the negative

outcomes caused by stress and trauma in their lives (Park & Peterson, 2009). In addition, using

one's strengths in novel ways can increase happiness and decrease depression for six months

(Niemeic, 2013), and using one's most valued strength at work) increases work satisfaction,

well-being, and meaning in life (Niemeic, 2013). Using strengths also makes it possible to

enter the state of flow, which could also improve outcomes: flow can increase self-efficacy

(Csikszentmihalyi, 1990), thereby helping prevent relapse (Condiotte & Lichtenstein, 1981;

Shiffman et al., 2000) since self-efficacy mediates goal-attainment (Deci & Ryan, 2000). The

life satisfaction gains that result from increased character strengths may serve to build long-

term personal resources that enhance our clients' abilities to enjoy a flourishing life (Gillham,

et al., 2012; Park & Peterson, 2009; Peterson & Seligman, 2004).

The Values In Action Classification of Strengths (VIA) (Peterson & Seligman, 2004)**,** a

validated categorization of strengths, was developed to unearth the best thinking on virtue and

positive human qualities by researchers that reviewed and analyzed various tenets and works

from major world religions, Aristotle, Benjamin Franklin, and Dr. Seuss, just to name a few.

VIA quantifies strengths, serving as a foundation for a positive approach to health, and

provides a meaningful and scientific resource for well-being application and research. Thus far,

VIA-inspired interventions helped individuals meet psychological needs, improve well-being,

decrease depression, increase job satisfaction, and enhance life meaning (Peterson, 2012).

The final 24 universal strengths, which are the most general and easily recognized, used

the following criteria: the strength: 1) contributes to the good life above and beyond mitigating

weakness or problems; 2) is intrinsically good; 3) is not zero-sum (the strength can help others

in their strength); 4) is not simply the opposite of a weakness; 5) is stable across situations,

domains, and time; 6) is distinct and not a derivative of combination of other strengths; 7) is

embodied in paragons; 8) might have prodigies; 9) might have imbeciles; 10) or has

reinforcing societal institutions. Additionally, VIA divides the 24 main human character

strengths into six chief virtues: wisdom and knowledge, courage, humanity, justice, temperance

and transcendence (Niemeic, 2013).

Relationships & Social Connections

Peterson's (2012) well-known signature phrase "other people matter" (p. 127)

symbolizes how crucial relationships are in human happiness. Indeed, findings from research

consistently demonstrate that supportive relationships (e.g., friends, neighbors, coworkers, etc.)

can decrease sorrow and loneliness, elevate self-esteem (Cohen & Wills, 1985), improve

resilience, and contribute to overall well-being (Seligman, 2011). In addition, when people

perceive others are there for them in times of stress, and when emotional support is given,

people are buffered against the harmful effects of stress and relationships function better

(Cohen & Wills, 1985; Reis & Franks, 1994; Uchino, Cacioppo, & Kiecolt-Glaser, 1996).

People also matter in recovery: supportive relationships help prevent relapse (Brown &

Riley, 2005; Barrera, 2000). However, many addicts have less than optimal social support,

which correlates with low self-regulation (Baumeister et al., 2005), psychological distress,

morbidity, mortality, loneliness, and poor well-being (Phillipson, Allan, & Morgan, 2004; Veiel

& Baumann, 1992). Even when clients do feel supported by others, they may also benefit:

addicts who feel supported often perceive a smaller amount of support from their community

than non-addicts (Brown & Riley, 2005).

The Relationships Phase stresses supportive relationships and helps clients develop skills

that can help them be better friends and to place more trust in others. Life satisfaction gains

that result from supportive relationships (Gillham et al., 2012; Park & Peterson, 2009) also

may serve to build long-term personal resources to enable clients to enjoy a flourishing life

(Peterson & Seligman, 2004). In addition to holding multi-family groups (in which patients

and families receive education and have the opportunity to process some of their problems),

PRC includes specific 'positive' elements that can foster skills to nurture better relationships.

For example, clients explore what being "friendly" means, and learn listening skills through

Active Constructive Responding (ACR) (Reivich & Shatte, 2002). Research on the subject of

how we respond to other's success indicates that people feel more supported, closer, more

intimate, validated, and happy with relationships when their relations respond actively and

constructively to good news (Gable et al., 2004; Gable, Gonzaga, and Strachman, 2006). Four

main types of response styles are:

1. **Active-Constructive** – enthusiastic support, positive and engaging body language,

   vibrant tone (Wow! Great! Tell me more! I bet you felt wonderful!)

2. **Passive-Constructive** – quiet, understated support, flat body language, quiet and

   dismissive delivery (mmm, that's nice. Good job.)

3. **Active-Destructive** – demeaning the event, pointing out the negative, engaged but

   dismissive (that's going to be very challenging. How are you going to manage

   everything? I bet it's a political thing. Anyone can win that.)

4. **Passive-Destructive** – ignoring the event, self-absorbed turning conversation

   towards themselves or unrelated topic (look, I broke a nail. Did I tell you what the

   dog did?)

Only one of these response styles, Active-Constructive, is beneficial. Active constructive

responses increase intimacy, trust, relationship satisfaction, and relationship well-being (Gable

et al., 2004) by demonstrating a mutual belief that the news is indeed good and valuable, that

partners are indeed interested in each other's life, which increases familiarity and intimacy.

By examining the effects of social connectedness in over 12,000 individuals spanning

over 30 years, Fowler and Christakis (2008) discovered that not only is happiness contagious,

happiness is highly contagious: happiness is infectious up to three degrees of separation

(Christakis & Fowler, 2012). Remarkably, an individual's emotional experience extends out

and back from as far out in their social network as the friends of their friends' friends. These

findings demonstrate that humans are interconnected in profound ways. Humans are social

organisms, not islands: individual happiness does not appear to result solely from one's

personal experience (Fowler & Christakis, 2008; Smith & Christakis, 2008), which confirm:

"happiness is best predicated by the breadth and depth of one's social connection" (Putnam,

2001, p. 332).

Recovery Fellowships

We support 12-Step fellowships , such as Alcoholics Anonymous (AA), simply because

they are effective treatment options. Among six identified factors that predicted the pathway

from relapse to abstinence, the only factor that consistently predicted a transition to and staying

in abstinence was sober friends (Scott, Foss, & Dennis, 2005). Enough valid research

consistently points out AA works, although how it works, remains elusive (Vaillant, 2008).

Nonetheless, despite hundreds of published studies (many in top scientific journals) that reveal

AA's benefits (Emrick, Tonigan, Montgomery, & Little, 1993; Humphreys et al., 2004;

Kaskutas, 2009; White, 2007), 12-Step groups continue to earn considerable amounts of public

and scientific scrutiny (Ferri, Amato, & Davoli, 2006; McCrady & Miller, 1993).

Mutual self-help groups facilitate the same constructive behavior changes, such as

increasing self-efficacy (Bogenschutz, Geppert, & George, 2006), that help people maintain

recovery as treatments that are led by trained professionals (Humphreys & Moos, 2007; Timko,

Moos, Finney, & Lesar, 2000; Timko, Sempel, & Moos, 2003). For example, addicts who used

12-Step recovery fellowships were more likely to have achieved abstinence and were 70% less

likely to use mental health services, resulting in 64% lowered mental health care costs than

addicts who used CBT (Humphreys & Moos, 2007).

Furthermore, AA members who serve as mentors for new members protect themselves

from relapse (Zemore & Kaskutas, 2004; Pagano, Friend, Tonigan, & Stout, 2004). This

finding is consistent with other research demonstrating that giving help can be more

significantly associated with better mental health than receiving help (Post, 2005) and is

"associated with higher levels of mental health, above and beyond the benefits of receiving

help and other known psychospiritual, stress, and demographic factors" (Schwartz,

Meisenhelder, & Reed, 2003, p.782). AA itself is clear on this subject, "[o]ur very lives, as ex-

problem drinkers, depend upon our constant thought of others and how we may help meet their

needs" (AA Services, 2001, p 20).

These points clearly show that in recovery, other people really do matter. However,

addiction makes it very challenging for addicts to reap the benefits of social resources because

addiction leads to isolation (Carroll & Miller, 2006), which can increase rates of mental illness

(Uchino et al., 1996) and lower levels of self-regulation (Baumeister et al., 2005). Therefore,

instead of stimulating the seemingly adaptive and socially desirable response of better self-

regulation, social isolation seems to elicit the opposite (Baumeister et al, 2005). Recovery

fellowships are safe social groups where members interact (Magura et al., 2004) that may

prevent the negative effects social isolation cause on self-regulation and mental illness

(Baumeister et al, 2005).

In addition, fellowships are also strong social communities that can help addicts maintain

recovery, experience elements of PERMA, and increase well-being (Vaillant, 2008). Members

do not encounter shame or contingencies: the only requirement for membership is the desire to

stop using and acting out (AA Services, 2001). Everyone is welcome: 12-Step groups are not

aligned with any political group or religious affiliation, holds no opinions on outside issues,

and place principles before personalities (AA Services, 2001). Indeed, *we*, not *I*, describe how members work through the steps; *we*, not *I*, are how members participate together, united in a common altruistic purpose that includes joy (Vaillant, 2008). As AA boasts, '…we aren't a glum lot… We absolutely insist on enjoying life' (AA Services, 2001, p.132), and "[l]ife will take on new meaning. To watch people recover, to see them help others, to watch loneliness vanish, to see a fellowship grow up about you, to have a host of friends—this is an experience you must not miss. We know you will not want to miss it. Frequent contact with newcomers and with each other is the bright spot of our lives" (p. 89).

Meaning & Purpose

Some suggest that addiction results from a misguided search for meaning and purpose in life (Burrell, 1999; Klion, 1993) and that success in recovery is mediated by discovering new meaning (Galanter, 2007). Today, we know that meaning in life is correlated with several mental and physical benefits (Baumeister & Vohs, 2005) but unfortunately addicts are an especially vulnerable population. Addicts have less meaning and purpose than age matched controls (Nicholson et al., 1994; Klion, 1993). Lack of purpose is similarly detrimental, serving as a mediating factor in both substance abuse and suicide (Harlow et al., 1986; Heisel & Flett, 2004). Again, addicts are an especially vulnerable population here, too: suicide rates in addicts can be up to 200 times greater than that of the general population (Murphy & Wetzel, 1990). Among other reasons, interventions that mitigate suicidal behaviors, such as helping to discover meaning, are therefore crucial to specifically address in treatment (Sher, 2012).

Leading modern researchers define meaning in two main parts: *purpose* – motivating us to discover connections and stability in rapidly changing conditions of life and between past

and *comprehension* – making sense of the self and the world coherently (Ryff & Singer, 1998; Baumeister & Vohs, 2005; Emmons, 2003). Comprehension and motivation contribute to well-being when they are aligned in the pursuit of the good life and effectively integrate personal, environmental, and temporal ideas, interactions, and values in rewarding ways (Steger, 2009).

Simply stated, meaning and purpose can make human lives better. Meaning can increase happiness, control, and engagement at work; and meaning can decrease depression, anxiety, substance abuse, suicidality, and need for therapy (Steger, 2009). Purpose is strong predictor of life satisfaction (Diener, et al., 2012), improves our overall well-being, physical and mental health (Reker et al., 1987), resiliency (Steger & Park, 2012), optimism (Comptom, 2004), self-esteem (Steger, 2009), decreases depression and anxiety (Steger, 2009), and increases vocational commitment and well-being at work (Steger et al., 2012).

Paths to Meaning & Purpose: Spirituality/Religion

Alcoholics Anonymous was created because a famous European psychiatrist, Carl Jung, concluded that the best, and perhaps only, remedy for hopeless alcoholics was for them to have a spiritual experience (AA Services, 2001; Finlay, 2000). Jung attracted patients from all over the world, such as Rowland Hazard, a former Rhode Island state senator.

> Some time during 1930, Hazard…found himself slipping ever deeper into despair over problems associated with his uncontrollable drinking (Pittman, 1988). Having tried several methods to overcome his problem with no success, Hazard…placed himself under the care of…Carl Jung. Jung worked with Hazard for more than a year during which Hazard came to believe he was cured of his obsession. Hazard left Zurich and returned to the United States, but within a few weeks he had relapsed into his old

destructive patterns of drinking. On his return to Zurich, Hazard was told by Jung that

there was nothing more that psychiatry or medicine could do for him. The only hope that

Jung gave him was telling him that he had occasionally seen alcoholics recover after

experiencing some type of religious conversion, but he cautioned that these recoveries

were relatively rare (Finlay, 2000, p. 3).

Spirituality

Spirituality (including religion) is likely the most common means by way of which

people discover meaning in their lives. Religion can be a divisive topic among the typical

heterogeneous groups that are found in most treatments; we explore religion in as broad a way

as possible with the hopes of minimizing conflict over the beliefs that underpin various

religions, and focusing on the benefits of spiritual practice that individuals may realize. This

session will require leaders who possess a high degree of emotional intelligence and verbal

skills.

Despite criticisms comparing AA to cults that rely on God, AA offers its members a

broad and minimally divisive spiritual option (Kaskutas, 2009). AA encourages that each

member define God in his or her own way, *sans* dogma or cultishness. Recovery fellowships

are not religions but they are spiritual (Kaskutas, 2009) groups, and 12-step programs are

frequently called 'spiritual fellowships' (Galanter, 2007). *The Big Book of Alcoholics*

Anonymous (A.a., 1948) adorns recovery with such terms as 'spiritual experiences' and

'spiritual awakenings,' and God is mentioned in four of the twelve steps (Galanter, 2007;

Powers, 2012). Recovery fellowships encourage a noncompetitive approach to life that

promotes well-being in its members bound by a common purpose and unified in altruism.

Here, God, referred to as the *Higher Power*, is democratic, all-accepting, and guided by the same noncompetitive approach to life as the program of recovery itself (Bateson, 2000). Indeed, *"AA provides a concrete example of spirituality being made safe for human consumption"* (Vaillant, 2008, p.194).

Science-based approaches to wellness have traditionally excluded spirituality even though many scientists and therapists are often as emotional about religion and spirituality as everyone else (Pargament, 2002). For instance, Freud derisively describes religion as an infantile delusion (Segal, 2005), but Jung feels strongly "that the evil principle prevailing in this world leads the unrecognized spiritual need into perdition, if it is not counteracted either by a real religious insight or by the protective wall of human community" (Finlay, 2000, p.8).

Science's inability to detect the afterlife, measure faith, or prove god's existence may simply indicate that such issues are outside of the scope of science (Pargament, 2002). Pargament notes that although we can't measure god or faith ('roots'), we can measure how such issues contribute to elements of well-being and other outcomes ('fruits'). According to Pargament's extensive literature review on the subject (2002), internalized and intrinsically motivated religious beliefs that are based upon a greater meaning in life, feelings of spiritual connections with others, and secure relationships with God are positively correlated with well-being. On the other hand, unexamined, extrinsically motivated, and tenuous relationships with God can diminish well-being. Furthermore, religious beliefs can also help buffer against stress, especially when personal and social resources are scarce or exhausted.

Findings suggest that therapy augmented with spirituality may be more effective than CBT in activating feelings of hope and life satisfaction (D'Souza & Rodrigo, 2004; Frankl,

1978). In addition, randomized controlled trials demonstrate that spirituality may reduce

relapse rates and enhance the quality of recovery (D'Souza & Rodrigo, 2004). In one study of

recovering addicts, strength from religion and spirituality was cited as a cause of highly

favorable outcomes, such as negative urine and hair toxicology results, no self-reported drug

use, less than daily alcohol use, and no illegal activity or arrests during the past year (Flynn,

Joe, Broome, Simpson, & Brown, 2003).

Reductionist views of the material world necessarily exclude what it cannot measure. Yet,

in my view, refusing to acknowledge an arena of life that is so integral to human experience

and well-being is a grave error - albeit not as extreme a mistake as to call it a form of perdition,

as Jung claimed (Finlay, 2000). Indeed, human beings are more often spiritual than physical,

even reproducing: humans spend more time in prayer or meditation than they do fornicating

(Gallup, 2006).

Richards and colleagues' (2006) study on spiritual group interventions for inpatients with

eating disorders (a process addiction) is also promising. Spirituality group participants

demonstrated significant improvements more quickly on weekly outcome measures (lower

psychological disturbance and eating disorder symptoms, and higher spiritual well-being)

during the first four weeks of treatment. Considering again how much stress and unwanted

emotional states trigger relapse and interpersonal conflicts, this study implies spiritual

components in addiction (inpatient) treatment have the potential to reduce unwanted emotional

states, decrease social conflict and relationship stress, and help prevent relapse.

Alcoholics Anonymous, Rowland Hazard, and Carl Jung Continues…

Jung did not become aware of his connection to AA until just months before his death,

when Wilson wrote him on January 23,1961. Portions of Wilson's long letter follow. 'I

doubt if you are aware that a conversation you once had with one of your patients, a Mr.

Roland [sic] H___, did play a crucial role in the founding of our fellowship. Having

exhausted other means of recovery from his alcoholism, it was about 1931 that he

became your patient. I believe he remained under your care for perhaps a year. His

admiration for you was boundless, and he left you with a feeling of much confidence. To

his great consternation, he soon relapsed into intoxication. Certain that you were the

"court of his last resort," he again returned to your care. Then followed the conversation

between you that was to become the first link in the chain of events that led to the

founding of Alcoholics Anonymous (Finlay, 2000, p. 7).'

Wilson went on to tell Jung the subsequent events that led to the founding of AA. Jung

replied to Wilson's letter promptly. In his reply, dated January 30, 1961, Jung wrote,

'His craving for alcohol was the equivalent on a low level of the spiritual thirst of our being for

wholeness, expressed in medieval language: the union with God…. alcohol in Latin is *spiritus*

and you use the same word for the highest religious experience as well as for the most

depraving poison. The helpful formula here is: *spiritus contra spiritum*. [Thank] you again for

your kind letter'" (Finlay, 2000, p. 8).

Journaling

Writing is simply an effective tool for expressing and processing the full range of

emotions. Multiple studies prove that disclosing emotions through journaling is beneficial

(Smyth, 1998). Journaling is a healthy exercise that can improve physical health and emotional

adjustment (King, 2001), and enhance positive affect and optimism (Taylor & Brown, 1988).

Journaling about past negative events can create positive outcomes for many populations with some exceptions (Sbarra, Boals, Mason, Larson, & Mehl, 2013); overall, journaling improves immune system function, reduces health problems, improves college students' adjustment to a new environment and workload, and helps find employment faster after losing one's job (King, 2001). Journaling appears to increase self-regulation when journaling increases self-awareness (King, 2001). We aim to capitalize on this possibility by including pre- and post-assignment journaling activities that prompt clients to spend time in reflection, dig deeper, think about topics on their own and in new ways, and reflect about what has been most meaningful to them. In addition, journaling enhances learning when writing prompts ask reflective questions about participant's learning progress, rather than asking about course content (Bangert-Drowns, Hurley, & Wilkinson, 2004).

Journaling is an inexpensive and easily disseminated activity with a favorable risk-benefit ratio. Clients already receive pens, workbooks, and notebooks and journaling is arguably a very safe activity. In the event that a particular client toils with literacy, we can discreetly intervene. In addition, we will not suggest that any assignments which involve journaling have specific ends, such as to discover meaning from past traumatic events or to enhance learning. Sbarra and colleagues' (2013) study suggests that when people are actively engaged in a search for meaning, expressing writing may have unintended harmful consequences. Clients will write for their *own* benefit and consumption: sharing is voluntary, their work will not be critiqued on either writing style or content, staff will reinforce the idea that journaling assignments are not intended to "fix" a problem or to "discover meaning."

Business Value

Implementing PRC, with its comprehensive and diverse material, staff training, and so forth will certainly be a massive and challenging project that requires a high degree of commitment in order to ensure its operational success. The return on investment should be worthwhile: well-being in the workplace can positively forecast a company's bottom line (Rath & Conchie, 2009). Several outcomes, including employee engagement and financial success are associated with higher employee well-being (Diener & Seligman, 2004). Moreover, by leading and training staff in the same processes we will use for our clients, we hope to improve the overall well-being of our staff. Perhaps then the contagion effect (Fowler & Christakis, 2008) may facilitate the spread of happiness and other positive emotions and behaviors throughout both staff and clients.

Engagement is essential to every company's customer satisfaction, employee productivity and helpfulness, and organizational profitability (Sorensen & Garman, 2013). Exceptional companies enjoy more than 63% engaged employees and earn nearly four times as much as most other companies, who languish with a 30% employee engagement level. Gallup (2006) also quantifies the degree to which actively disengaged employees lose companies billions of dollars per year due to lost productivity: companies lose approximately $30,000 in lost productivity for each worker, with the lowest well-being scores due to sick days alone each year. In comparison, companies lose only $840 in lost productivity for sick days for workers with the highest well-being scores. These numbers do not account for lost productivity while at work.

Most adults spend most waking hours at work, laboring under a structure designed

strictly to maximize financial well-being. Employers generally are amenable to structural additions that align employee well-being with the company's financial well-being (Diener & Seligman, 2004). Job crafting, a process of aligning and grouping work tasks with personal strengths and values, can boost engagement, reward, and meaning at work (Wrzesniewski, Berg, & Dutton, 2010). Using signature strengths improves well-being, engagement, work satisfaction, and finding higher meaning in life (Harter, Schmidt, & Hayes, 2002; Peterson, Stephens, Park, Lee, & Seligman, 2009). Although companies often dismiss policies that are not primarily directed at financial ROI, it is difficult to deny the correlations between worker well-being and the bottom-line.

Positive interventions are also valuable for treatment administrators, institutions, and owners. In general, they are efficient, inexpensive, and effective. Many validated PIs are self-directed (Lyubomirsky et al., 2005) and many validated studies were conducted over the Internet (Seligman et al., 2005), indicating that the PIs themselves, rather than intense face-to-face sessions, are valuable. Validated research demonstrates that these intentional activities effectively enhance well-being and decrease depressive symptoms (Boehm & Lyubomirsky, 2009). Without undervaluing the crucial role of clinical staff, PIs are cost-effective methods for clients to use both in conjunction with professionally-guided treatment as well as during the self-guided Maintenance Phase. Positive activities such as the regular practice of gratitude, optimism, kindness, and meditation are but a few examples of positive activities throughout PRC, which are all relatively brief, nonstigmatizing, and self-administered activities that foster positive feelings, thoughts, and/or behaviors.

Conclusion

Addiction is a complex, chronic, and harmful disease that robs individuals of agency. It is amenable to treatment, but relapse rates during and soon after treatment remain high. Additionally, our medical-model short-term approach is inappropriate. It is effective for initiating abstinence and reducing symptoms in the short-term, but it does not promote 'recovery,' which is a rich and full lifestyle that includes abstinence but is not limited to it. Interrupting addiction in the short term breaks its self-perpetuation and restores individual free will, but it leaves people void by focusing solely on crisis stabilization instead of adding resource building as well. Moreover, relapse rates during and soon after treatment remain high.

Insights from positive psychology can fill these gaps, possibly increasing completion rates, efficacy, and effectiveness of addiction treatment by helping people to establish lifelong skills to pursue happier, more meaningful lives so that addiction is less tempting and relapse is less likely. For the purposes of this Capstone, we have highlighted more strength-centric ideas (e.g., optimistic explanatory style, resilience, healthy physical habits, etc.) than illness-focused ones. However, we will continue those effective practices (e.g., identifying and treating co-occurring disorders, assisting with trauma resolution, using psychotropic medications, etc.) that enable clients to also live full, rich lives in recovery because both approaches are necessary to create a balanced program. Currently, research that specifically applies positive psychology in addiction treatment is scarce. PRC is not the first attempt to apply positive psychology to addiction treatment; however only a handful of studies doing so have been published and thus far, this is the first comprehensive academic argument and structured curriculum of its kind.

This capstone discusses the rationale and evidence for a balanced addiction curriculum

that integrates existing effective approaches with interventions that account for individual differences and values to enhance well-being through positive emotions, engagement, relationships, meaning, and achievement. We plan to continue hiring and training staff with authentic and accurate empathic styles who will foster positive expectations that clients will (eventually) thrive in recovery. Furthermore, we use extended and explicit relapse prevention strategies; encourage personal responsibility in the formation of habit, character, and destiny; strive to create a positive institution and add value to our business.

Addiction results when people try (a) to feel better (increase positive emotions), (b) to generate flow-like experiences (increase engagement), (c) to be accepted and connect with others (improve relationships), (d) to discover meaning in life (find a sense of meaning and purpose), and (e) to achieve more (increase accomplishment). Addicts are chasing the elements of the PERMA model of well-being. Positive Recovery is designed to guide clients in pursuing happiness along the right pathways: building people's abilities to not just abstain from addictive substances and/or behaviors, but to also use positive, evidence-based interventions to enhance well-being. This is the foundation of the Positive Recovery Curriculum.

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Gratitude

*First and foremost this Capstone is dedicated to the memory of **Anahiid Rice**.* "**Ana,**" my Nurse Practitioner, a mother and wife, friend, and as good a clinician as they come. Quite simply, without her – no MAPP8 – she made this possible but she passed away during the last days of writing this, and her memory will live on through our work.

Amy, my first and last wife, thank you for enduring the strain of this year like a champion. Ironically having the exact but polar opposite experience that I did (her PANAS tanked), I also could not have done this without you. I love you.

Leona, you deserve more praise than God. **LB**, if I was God and I had to create the perfect MAPP professor, assistant, or just presence, I would make a **Leona Brandwene**. Thank you, thank you, and thank you. I knew as early as the second onsite that I wanted YOU to be my advisor even though your addiction experience, gratefully, is limited. Thanks for saying yes, for helping me with my daughter, and putting up with the way I start writing by throwing everything but the sink in a paper before reducing it. You are a blessing to MAPP and the world, a rock star in the truest sense of the word. Soup for you!!! More soup!!!

Judy & James - I came to MAPP because, as I joked, I loved Marty and wanted to have his baby. After arriving, I quickly realized that you two are at least his equals in excellence - and now I realize that I want to mother your children, too. I use humor (I hope) to hide my feelings. Truth is, I am very sad that I'm done, however, I stand in admiration of two leaders Marty can't possibly replace or improve upon. **Judy**, you are a walking high set point wrapped around a brilliant clinician. If I could just breathe next to you, I would improve by osmosis. Thanks for being part of this process. Pine Forest & Wicked rule! (**James** already saw his part.)

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This is the true joy in life, the being used for a purpose recognized by yourself as a mighty one; the being thoroughly worn out before you are thrown on the scrap heap; the being a force of Nature instead of a feverish selfish little clod of ailments and grievances complaining that the world will not devote itself to making you happy. And also the only real tragedy in life is the being used by personally minded men for purposes which you recognize to be base. All the rest is at worst mere misfortune or mortality: this alone is misery, slavery, hell on earth - George Bernard Shaw