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Review

The Role of Self-Compassion in Recovery from Substance Use Disorders

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Abstract

***Background*:** A large body of empirical evidence has supported the notion that individuals with substance use disorders (SUDs) have difficulty regulating their negative emotions and employing emotion-regulation strategies. The aim of this article is to (a) explore the role of self-compassion in providing an emotion-regulation strategy for initiating a process of recovery from SUDs; (b) examine the role of self-compassion in building recovery capital (RC) to promote long-term recovery; and (c) examine the practice of self-compassion in the Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) programs.

***Methods*:** This narrative review assesses the role of self-compassion in providing an emotion-regulation strategy and in building RC to initiate and promote long-term recovery.

***Results*:** Empirical evidence has shown self-compassion to be an emotion-regulation strategy in which negative feelings are accepted and held with awareness, kindness, understanding, and a sense of common humanity. Based on the broaden-and-build theory, I posit that self-

compassion as a positive emotional stance towards oneself enables the development of personal and social resources. The prospects for successful recovery from SUDs are dependent upon the individual's resources, which Granfield and Cloud referred to as RC.

***Conclusions*:** This article may contribute to the field by presenting the role of self-compassion in building RC to initiate and promote long-term recovery from SUDs and by discussing the practice of self-compassion in the AA and NA programs.

Keywords

Self-compassion; emotion regulation; recovery capital; recovery; substance use disorders

1. Introduction

A large body of empirical evidence has supported the notion that individuals with substance use disorders (SUDs) have difficulty regulating their emotions, and that negative emotional states precipitate SUDs [1, 2]. Moreover, findings have shown that it is more difficult for individuals with SUDs to understand and identify their emotions [3, 4] and to employ emotion-regulation (ER) strategies [1, 5]. Furthermore, there is also evidence that positive emotions help with self-regulation deficits [6].

Self-compassion is a positive emotional stance towards oneself [7]. Numerous studies have found self-compassion to correlate positively with positive affect and negatively with negative affect [8-10]. Moreover, Neff [7, 11] posited that self-compassion is an ER strategy in which the individual accepts negative feelings with awareness, kindness, understanding, and a sense of common humanity. Thus, in times of suffering and distress, self-compassion helps transform negative emotions into more positive ones [12]. In a similar vein, according to the broaden-and-build theory, positive emotions have the ability to amend the effects of negative emotions, broaden one's thought–action repertoires, and build personal resources over time [13, 14]. Therefore, it is reasonable to suggest that self-compassion enables individuals to build personal and social resources, such as recovery capital (RC), and, in turn, to initiate and sustain long-term recovery from SUDs.

In light of the above, the present article is devoted to (a) exploration of the role of self-compassion in providing an ER strategy to initiate a process of long-term recovery from SUDs; (b) investigation of the role of self-compassion in building RC to initiate and promote long-term recovery; and (c) examination of the practice of self-compassion in the Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) programs. This article is divided into four sections. The first is a survey of the existing empirical research on ER and SUDs. The second provides a narrative review of the literature on self-compassion as an ER strategy and an emotionally positive self-attitude that builds RC as a means of initiation and promoting long-term recovery from SUDs. The third section offers an examination of the practice of self-compassion by members of NA and AA programs as a means to build RC that enables long-term recovery, and the final section presents the conceptual model of the current article.

1.1 Emotion Regulation and SUDs

Emotion regulation (ER) has become a central concept in psychophysiology and modern psychotherapy. ER is regarded as an essential psychological capacity, consisting of three primary cognitive, emotional, and behavioral dimensions: the ability to exhibit self-control, the ability to tolerate distress, and the ability to self-monitor and integrate awareness of emotions [15]. ER represents the processes of individual emotion management [16], subjective expression of experiences [17], and adaptive coping with negative emotional states [18]. ER skills are essential for a range of related capacities, including stress management, interpersonal functioning, development of cognitive problem solving, and communication skills. Expressions of deficits in ER include mood and anxiety disorders, maladaptive strategies to regulate negative emotions (e.g., avoidance or substance use), behavioral impulsivity, difficulty in delaying gratification, instability of behavioral control, and affective liability, each of which is further perpetuated by negative life events [4].

Theoretical models of ER difficulties among individuals with maladaptive behaviors, such as SUDs, violent crimes, or eating disorders, have indicated childhood maltreatment as a significant factor that could predispose or intensify emotion dysregulation, which is associated with other mental health problems later in life [19-22]. For example, in a study of youth with substance use difficulties, Vettese, Dyer, Li, and Wekerle found that child abuse was positively associated with ER difficulties and negatively associated with self-compassion [23]. This inability to manage emotions may result in unregulated distress, encouraging patterns of avoidance, rumination, self-harm, suppression of emotions, and harmful behaviors in an attempt to manage emotions [24]. Emotional consequences of childhood maltreatment include maladaptive views toward self and others, such as shame, self-criticism, loneliness, dissociation, and sense of isolation from both people and emotions [25, 26].

Self-criticism and shame play a central role in causing distressing emotions such as anxiety, guilt, anger, and self-hatred, which result from self-appraisal as unwanted, unworthy, and inadequate. Shame relates to global, negative feelings about the self, and has been described as an intense negative emotion that can result in feelings of inferiority and powerlessness [27]. It has been strongly implicated in behaviors that enable individuals to escape feelings of worthlessness and failure, such as disordered eating and SUDs [28]. Heightened shame and self-criticism significantly increase vulnerability to addictive behaviors, particularly substance use, in an attempt to avoid or eliminate these unwanted thoughts and feelings [27, 29].

Maladaptive behaviors are a form of self-medication to regulate negative affect [30]. The self-medication hypothesis is a well-known substance use model developed to explain the impact of trauma exposure on the development of SUDs [31]. According to this hypothesis, individuals with a history of trauma and post-traumatic stress disorders (PTSD) may experience a lack of resources to cope with trauma and manage negative emotions that persist over time, and turn to substance use to soothe themselves, modulate the effects of distressful psychological states, and relieve painful emotions (anger and sadness) or physical sensations (hyperarousal in individuals with PTSD).

Emotional deficiencies, which cause suffering, may motivate individuals to seek solace through substance use as a form of self-treatment [32]. Suh et al. [33] found a significant association between using substances and difficulty managing emotional states, which indicates a co-occurrence of SUDs

and ER deficits. Experiencing rage, shame, loneliness, self-alienation, emptiness, depression, and anxiety as intolerable emotions can drive individuals to use substances in order to regulate and maintain their emotional states [31].

Self-regulation plays a central role in managing, controlling, and coordinating emotion, cognition, and behavior. According to the ER models, fundamental difficulties coping with experiences and emotions are core factors of depression and anxiety disorders [34]. Difficulties in self-regulation cut across multiple diagnostic domains and reflect broad classes of maladaptive psychosocial functioning and behaviors, including SUDs. Several scholars have suggested that a primary focus in mental health and substance use treatment intervention should be the improvement of ER skills, in order to treat SUDs effectively [15, 25, 35]. There is evidence that positive emotions help replenish a depleted sense of self-regulation, making it possible once again to control behaviors [6]. Thus, Odou and Brinker [36] found that the self-compassion strategy is valuable for recovery from SUDs and may enhance one's regulation of emotions or behaviors, especially when experiencing distress.

1.2 Self-Compassion

"If you don't love yourself, you cannot love others. You will not be able to love others. If you have no compassion for yourself then you are not able of developing compassion for others" -Dalai Lama.

Compassion is the state of being aware of and affected by the suffering of others, feeling kindness toward their suffering, and attempting to alleviate it [7]. However, having compassion for others but not oneself is futile, since the self and others are integrated in a common humanity. Thus, self-compassion involves a sense of common humanity, being caring and compassionate toward one's own suffering and distress, which drives a desire to alleviate and heal one's own suffering with kindness, understanding, and recognition that all humans are imperfect and make mistakes. In a similar vein, Kurtz and Ketcham wrote, "Spirituality begins with the acceptance that our fractured being, our imperfection, simply is: there is no one to "blame" for our errors – neither ourselves nor anyone nor anything else. Spirituality helps us first to see, then to understand, and eventually to accept the imperfection that lies at the very core of our human be-ing" [37].

Neff's conceptualization of self-compassion is grounded in the Buddhist tradition of well-being, which focuses on understanding the self. Neff [7, 38] described self-compassion as a healthy form of self-acceptance that includes acceptance of one's painful experiences, along with a desire to lessen the pain and treat oneself with kindness. Neff [7, 38] described self-compassion as composed of three positive-response (compassionate) and three negative-response (uncompassionate) dimensions: self-kindness versus self-judgement, common humanity versus isolation, and mindfulness versus over-identification. Self-kindness is being emotional, warm, kind, and supportive to oneself rather than judging oneself harshly or being self-critical during times of difficulty. A sense of common humanity is the recognition that life's difficulties are part of shared human experience, rather than viewing them as isolating, separating, or the plight of just some people. Acknowledging that suffering and distress are part of the human condition enables individuals to see the similarity between their own experiences and those of others. Moreover, common humanity promotes a sense of connectedness with others, thereby lessening feelings of isolation. Mindfulness is being aware of painful thoughts

and feelings instead of being completely absorbed in them. It refers to a balanced approach to negative emotions, which neither suppresses nor exaggerates them. Gilbert proposed an alternative theoretical approach of self-compassion that is rooted in the evolutionary model of social mentality theory [25]. He conceptualized self-compassion as a social motivation that involves skills and attributes of compassion [39, 40], such as non-judgmental concern for one's well-being rather than taking a condemning, self-critical stance; empathy for the suffering of others or oneself; sensitivity; distress tolerance and understanding of one's painful feelings and memories rather than self-criticism or avoidance; and development of self-warmth [41].

Self-compassionate individuals do not repress or avoid painful feelings; they acknowledge and feel compassion without over-identifying with them [7]. In times of suffering, self-compassion helps transform negative emotions into a more positive state and facilitates more effective coping with one's own problems and/or the environment [12, 42, 43]. It is based on components of ER (e.g., awareness and accepting emotions) and requires individuals to experience and explore their negative emotions [7]. Therefore, self-compassion can be an effective emotion-regulation strategy, enabling the processing and acceptance of emotional pain by means of paying full attention to thoughts and feelings and treating them with understanding [11]. During times of distress, self-compassion acts as an adaptive emotion-regulation strategy that promotes psychological health by decreasing self-criticism, a sense of isolation, alienation, and avoidance of painful experiences, thoughts, and emotions [7, 44, 45]. Furthermore, the self-compassion approach encourages a sense of connection with others, which protects individuals against isolation, loneliness, and shame, characteristics of maladaptive emotional response [34]. Similarly, Gilbert [25, 39] proposed that self-compassion may play a significant role in facilitating the use of more adaptive ER strategies; strengthening a self-compassionate stance improves the regulation of emotional responses to perceived threats. Better self-soothing leads to enhanced ER, because it reduces sensitivity to threats, and increases the ability to effectively access, tolerate, and express emotions. Thus, self-compassion builds emotional resilience by neutralizing the threat system that generates insecure attachment, defensiveness, and autonomic arousal [25].

According to Gilbert, compassion flows in three directions: towards another person, which represents its most basic focus; from others towards oneself; and towards oneself (self-compassion) [39]. Any of these dimensions can be a focus in Gilbert's compassion focused therapy (CFT). Based on neuroscientific evidence, it was developed for people with high levels of shame, self-criticism, and unkindness and unsupportive attitudes toward themselves. CFT focuses on developing "competencies and brain systems that play important roles in threat regulation, well-being, and prosocial behavior" (p. 33). It addresses three types of affect-regulation systems: the threat-and-protective system, the resource-seeking and drive system, and the contentment, safety, and soothing system [40]. According to the underlying theory of CFT, psychopathology is an expression of unbalanced systems of affect regulation, which are rooted in attachment relationships [40]. In this case, the threat-based system is activated disproportionately, and the contentment, safety, and soothing system is often relatively inactive [46]. Conversely, individuals with a high level of self-compassion have a greater capacity to activate and maintain positive affective experiences associated with the soothing system, such as feelings of safety, affiliation, and warmth [47].

1.3 Self-Compassion and SUDs

There is a growing body of empirical evidence that demonstrates an association between emotion dysregulation and SUDs [48, 49]. It has been posited that one of the main motives for substance use is the avoidance of negative emotions, such as anxiety and depression [50]. According to Kober's model [51], substances are capable of regulating negative emotions through their unique pharmacological characteristics and their ability to bring about positive affective states, which in turn reinforce increased substance use. The high prevalence of emotion dysregulation among substance users suggests the potential of incorporating ER training into substance-use treatment. Against this background, teaching individuals with SUDs how to respond to their emotions more adaptively and providing self-compassion-based therapy could be beneficial.

Despite the robust empirical evidence that self-compassion can help in developing effective ER skills to cope with the characteristic negative emotions of people with SUDs [8, 11, 52], the research on the relationship between self-compassion and SUDs is limited. In a review of the literature pertaining to self-compassion, Finlay-Jones found that self-compassion is linked to key mechanisms of the ER models of depression and anxiety [34].

The few studies published to date show a negative association between self-compassion and alcohol use disorders [53, 54]. For example, in an investigation of the correlation between self-compassion and alcohol use among 77 participants in Australia, Brooks et al. found that initially, participants scored significantly lower than the general population on the positive subscales of self-compassion, self-kindness, common humanity, and mindfulness, and significantly higher on the negative subscales of over-identification, isolation, and self-judgment [53]. After 15 weeks in a treatment program that included a range of clinical interventions (community counselling, detoxification, needle and syringe programs, and more), there was a significant increase in self-compassion, mindfulness, common humanity, and self-kindness compared with the findings at the beginning. Furthermore, there was a significant decrease in self-judgment, isolation, over-identification, and alcohol use, which was associated with an increase in self-compassion. In another study, Rendon examined the relationship between alcohol use, self-compassion, mindfulness, and self-esteem among 300 psychology students in United States [54]. The results indicated that alcohol use was negatively correlated with self-esteem, self-compassion, and psychological symptoms. In addition, self-compassion was found to be a predictor of psychological health.

Summarizing the literature reviewed above, it seems that individuals with SUDs are characterized by ER deficits, and uncompassionate ways of responding, including (a) shame; (b) self-criticism; (c) negative emotions (depression, anxiety, hostility); and (d) loneliness, isolation, and alienation. A limited body of research has examined the relationship between self-compassion and SUDs. Nevertheless, it is reasonable to argue that self-compassion techniques and therapies might initiate and promote long-term recovery from SUDs through effective ER strategies that enable the acceptance of emotional pain and compassionate treatment of thoughts and feelings.

1.4 Self-Compassion Builds Recovery Capital

Research has shown a negative correlation between self-compassion and negative emotions, such as anger [8, 10], and a positive correlation between self-compassion and positive emotions, such as happiness, optimism, love, and conscientiousness [9]. Positive emotions are associated with multiple interrelated benefits, beyond the pleasant subjective feeling; these include broadened cognition, enhanced creativity, increased productivity, and improved physical and mental health [55]. In her broaden-and-build theory, Fredrickson argued that positive emotions such as joy, interest, contentment, and love are capable of alleviating the effects of negative emotions [13, 14, 56]. They broaden one's thought–action repertoires, and, over time, build personal resources, ranging from the physical and intellectual to the social and psychological, all of which can contribute to an overall sense of well-being. These personal resources function as reserves that can be drawn on in subsequent moments and in different emotional states. Thus, positive emotions may be adaptive in the long term, by building personal resources that function as psychological reserves for continued growth. A review of the literature on interventions based on self-compassion suggest considerable alleviation of negative affect [8], promotion of emotional resilience [57], enhancement of sense of well-being by helping individuals feel cared for, connected, and emotionally calm [47], and improvement and strengthening of interpersonal relationships, social connectedness, and sense of belonging [58, 59].

This new theoretical perspective on positive emotions is part of the positive psychology field, which shifts attention from pathology and dysfunction to positive emotions and optimal functioning. In positive psychology, positive emotions are seen as a means to achieving a long-term sense of well-being and psychological growth [56]. Neff's conceptualization of self-compassion represents a positive emotional stance towards oneself, characterized by kindness and caring. High levels of self-compassion often generate positive emotions, which contribute to higher rates of psychological well-being and life satisfaction [9]. Both of these areas of focus are based on the fundamental view that health is more than the absence of illness and that fostering individual and social resources can help people, organizations, and communities thrive [56, 60]. Similarly, a comprehensive vision of global health (wellness) views long-term recovery from SUDs as far more than simply the alleviation of the symptoms of substance use. The focus is on moving beyond the reduction of substance use-related pathology to the creation of personal, family, and community resources.

Based on the broaden-and-build theory, in the present article I posit that self-compassion is an emotionally positive self-attitude that enables individuals to build personal and social resources, that is, RC, to overcome SUDs. RC is a comprehensive concept for understanding the wide range of personal and social resources that are required in the effort to initiate and sustain long-term recovery from SUDs. The term was first used by Cloud and Granfield to denote the key personal and social resources necessary to initiate and sustain recovery [61]. Cloud and Granfield identified four components of RC [61]. The first is cultural capital, which refers to the values and beliefs associated with cultural group membership, such as AA or NA. The second is physical capital, which includes financial assets and status, especially housing (shelter), clothing, and food. Third is human capital, which comprises the acquired and inherited traits – such as knowledge, skills, and mental health – that enable individuals to function effectively in society and face the challenges of the recovery effort.

The fourth component is social capital, which includes various close (especially family) relationships that are supportive of recovery efforts. It has been suggested that individuals with social capital are in a much better position to initiate and maintain successful recovery [62]. This comprehensive view of recovery represents the interconnectedness of all aspects of the individual's life that enable successful reintegration into society. It is the thesis of the current article that AA and NA members practice self-compassion as a means to build RC, which in turn enables them to initiate and sustain long-term recovery.

1.5 The Practice of Self-Compassion in AA and NA Programs

There is no research on the practice of self-compassion in AA and NA programs, but self-compassion is a central component in their processes for initiation and promotion of long-term recovery. The novel contribution of the current article to the literature is in describing the practice of self-compassion in AA and NA programs, and in presenting meaningful examples of AA and NA statements which support the concept of self-compassion. In NA's Basic Text [63], a member is quoted as saying, "In the Eighth Step, I made a list of people whom I had harmed, and I put myself first on the list. I hurt a lot of people, but none as much as I hurt myself. I had nothing but contempt for myself, so there was no limit to the pain I inflicted on myself... Instead of inflicting more hurt, I practice love, compassion, and forgiveness" (p. 226). Neff argued that engaging in negative thinking towards the self is common; people are often much harsher and unkinder toward themselves than toward others [57]. Self-compassion requires recognition of one's own suffering and being caring, kind, and compassionate toward one's own suffering and distress, rather than reacting critically and judgmentally. This eventually helps foster "positive mind states such as happiness and optimism" [57]. In other words, self-kindness includes working actively towards understanding our shortcomings, defects, and failures. In this spirit, Kurtz and Ketcham wrote, "It is only by ceasing to play God, by coming to terms with errors and shortcomings, and by accepting the inability to control every aspect of their lives alcoholics can find peace" [37].

Self-compassion is the foundation for feelings of self-acceptance. In fact, it provides individuals with what Ellis referred to as "unconditional self-acceptance," where the "individual fully and unconditionally accept[s] himself whether or not he behaves intelligently, correctly, or competently and whether or not other people approve, respect or love him" [64]. This is key to psychological wellness. Developing increased acceptance and positive emotions along with lower negative emotions by relating to oneself in a compassionate way enables more adaptive regulation of painful emotions [34]. Members of AA and NA view their recovery as a long-term process of self-acceptance: "I had no idea the solution would begin with acceptance of myself. From this position, I naturally developed the capacity to accept and care about others" [63]. Self-acceptance is important in providing emotional safety, which in turn enables one to see the self clearly without feeling ashamed or guilty, and to foster a sense of social connectedness. Another member explained, "At last, acceptance proved to be the key to my drinking problem. After I had been around AA for seven months . . . I was finally able to say...I really, really am an alcoholic of sorts. And it's all right with me.

From that moment on, I have not had a single compulsion to drink. And acceptance is the answer to all my problems today" [65].

Other members referred to the shame and guilt that characterize individuals with SUDs [66]: "For years, we avoided seeing ourselves as we really were. We were ashamed of ourselves and felt isolated from the rest of the world. Now that we have the shameful part of our past trapped, we can sweep it out of our lives if we face and admit it" [63]. Self-acceptance enables recovering individuals with SUDs to cope with the feelings of shame and guilt that cause them to feel alone, isolated, and like they don't belong. Experiencing shame harshly attacks individuals' selves, causing them to feel unlovable, and leading to desires to withdraw or escape from others, which leaves them alienated and alone with their distress: "Everything was controlled by the drugs. I felt shame and guilt and would regularly judge and punish myself" [63]. Conversely, self-compassion provides individuals with a sense of being gentle and self-forgiving, being kind rather than judging harshly or being self-critical: "One thing that really helped was when I started to realize that all the criticism was coming from inside me, and that what I was getting from the people around me in meetings was encouragement and approval" [63], or as another member put it: "I have never experienced anything like that night. I expected judgment and criticism, but what I actually received was nothing but love. I was embraced by the addicts in that room" [63].

Moreover, self-compassion does not separate the self from others, but integrates the individual with others in a common humanity [7]. Thus, an effective way to increase self-compassion is by giving compassion to others [67]: "Learning his secret gave me more compassion for my father—and more compassion for myself. I have a disease that has occurred in my family several times. I did not choose to be addicted. I am unable to take the disease away" [63]. Self-compassion provides individuals with a sense of common humanity, and understanding of life's difficulties as a part of a shared human experience; this promotes a sense of connectedness with others, thereby lessening feelings of isolation.

AA and NA activities also include prayers and meditation. In Step 11, the members are asked to connect with their "higher power," as an act of self-love through prayer and/or meditation. According to members, prayers and meditation increase compassionate responses toward oneself and others, which in turn transform negative emotions into positive emotions that have the ability to "correct" the effects of negative emotions [13, 14]: "Even when you don't really want it for them and your prayers are only words and you don't mean it, go ahead and do it anyway. Do it every day for two weeks, and you will find you have come to mean it and to want it for them, and you will realize that where you used to feel bitterness and resentment and hatred, you now feel compassionate understanding and love" [63].

Mindfulness is the final component of self-compassion. Mindfulness emphasizes the need to take a balanced approach to negative emotions, to acknowledge, and to feel compassion for them, without over-identifying with their feelings [7, 38]. Learning to be mindful promotes greater emotional balance, in that it "allows us to distinguish between those aspects of our experience we can change and those we can't" [57]. This concept can also be associated with the "serenity prayer," which was written by Niebuhr in 1926 [68] and is widely used in the AA and NA programs, "God grant me the serenity to accept the things I cannot change; courage to change the things I can; and wisdom to

know the difference." This prayer teaches members the wisdom to distinguish one from the other (acceptance versus change), "which comes with growth in our spiritual program" [63]. Thus the members of AA and NA practice mindfulness, as embodied in the prayer. By means of maintaining such a balanced approach and by allowing expression of both negative and positive emotions, "we learn how to level out the emotional swings that got us into trouble both when we were up and when we were down" [65]. Another member stated, "I listened as people shared their experience. What fascinated me was the ability of NA members to express their feelings, good and bad" [63].

Newcombe examined the relationship between different aspects of the AA program and levels of shame and self-compassion among 148 active AA members [69]. The findings indicated positive correlations between level of engagement in AA, length of time attending meetings, time clean, and self-compassion. The AA activities that best predicted lower shame and higher self-compassion included engagement in social activities outside of AA meetings, meeting with sponsors, and speaking at meetings. In addition, participants who completed Step 5 (sharing with another human being) and Step 9 (make amends) had significantly lower levels of shame and higher levels of self-compassion than those who had not completed those steps. Moreover, sharing the message with another suffering addict or with the group (Step 12) has been shown to give the messengers meaning in life, which is an expression of spiritual growth and the individual's sense of wholeness [70].

2. The Conceptual Model

According to the conceptual model of the present article (see Figure 1), self-compassion is a positive emotional stance towards oneself that enables individuals to build recovery capital to initiate long-term recovery. My underlying assumption in developing this model was based on the broaden-and-build theory [13, 14], which views positive emotions as having the ability, over time, to repair the effects of negative emotions and build personal resources, ranging from physical and intellectual to social and psychological resources. These personal resources serve as reserves that can be drawn from in different emotional states

The practice of self-compassion in AA and NA programs activates two stages of recovery, early recovery initiation and long-term recovery process. Self-compassion can initiate an early recovery process by transforming negative emotions into positive emotions, thereby promoting a sense of wellness. In addition, self-compassion promotes a long-term recovery process, by building RC, including social capital (by strengthening a sense of common humanity, social connectedness, and interpersonal relationships versus a sense of isolation and alienation, which characterize individuals with SUDs), human capital (by serving an effective emotional regulation strategy because it enables emotional pain to be accepted and held with kindness, in turn promoting mental health and well-being), and spiritual growth (by sharing the message with other suffering addicts (Step 12), which provides one with a sense of meaning in life).

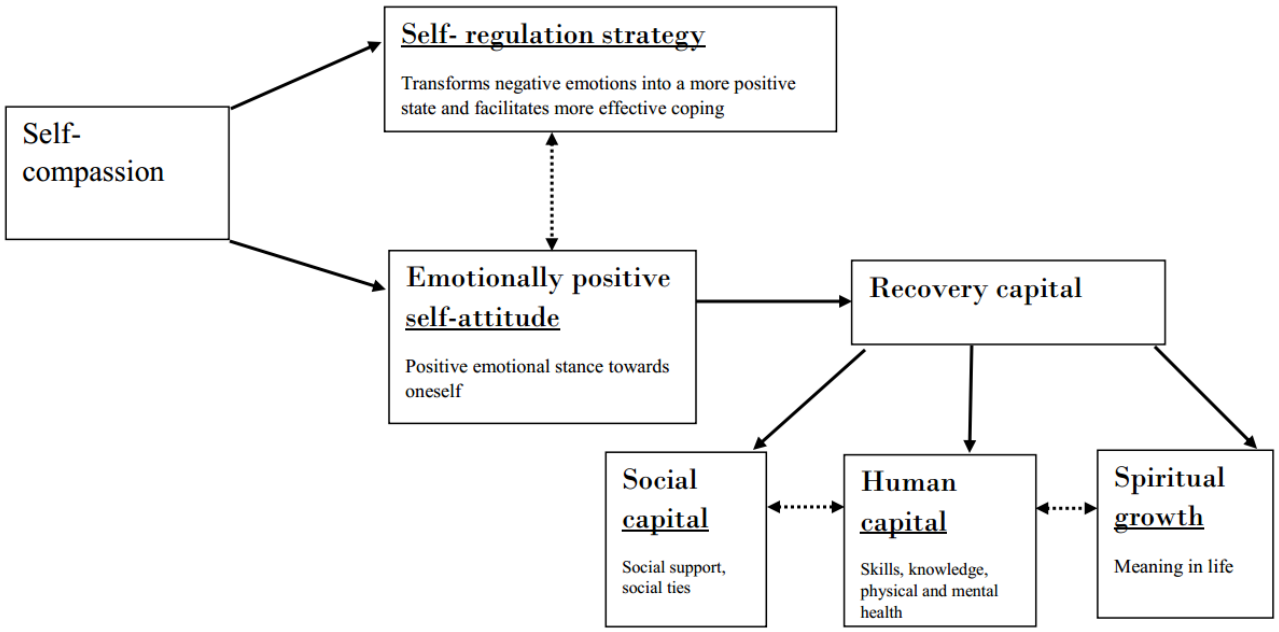

Figure 1 Self-compassion enables individuals to build recovery capital and to initiate and maintain long-term recovery from SUDs.

3. Conclusions

Self-compassion is an essential component of physical and mental wellness and fits in well with the comprehensive vision of long-term recovery from SUDs, which refers to the attainment of physical, psychological, relational, and spiritual health recovery that represents the interconnectedness of all aspects of the individual's life [71]. Self-compassion as a holistic wellness also fits well with the World Health Organization's definition of health as "a state of complete physical, mental, and social well-being" [72].

Self-compassion can be perceived as an ER strategy that promotes emotional balance in stressful situations that otherwise might create the ER difficulties that characterize individuals with SUDs. It enables improvement and strengthening of interpersonal relationships, social connectedness, and a sense of belonging, rather than the sense of loneliness and alienation common among individuals with SUDs. Moreover, as an emotionally positive self-attitude, self-compassion enables individuals to build RC — the wide range of personal and social resources that are required in the effort to achieve long-term recovery from SUDs.

3.1 Implications and Future Research

Self-compassion interventions have shown effective results in general and clinical research [25, 73, 74]. Moreover, self-compassion intervention is a helpful tool, with a variety of potential beneficial psychological outcomes in diverse fields, including trauma, post-traumatic stress disorder, depression, anxiety, neurotic perfectionism, and sense of personal failure. Accordingly, Neff noted,

"Remembering that suffering and personal failure happen to all people helps put one's experience into perspective, also enhancing the ability to be mindful of one's thoughts and emotions and to not over-identify with them" [38].

Given the many positive outcomes that self-compassion intervention has been associated with in research in the field, it seems that effective therapeutic intervention in long-term recovery from SUDs should integrate self-compassion interventions. To this end, it should include: (a) assessment of one's self-compassion, using tools such as Neff's six-part self-compassion scale (SCS), in which three parts test the positive aspects and the other three, the negative aspects of her construct [38]; (b) targeting of those who score on the low-to-lowest level of self-compassion, in order to provide appropriate intervention; and (c) strengthening the individual's self-compassion by encouraging participation in AA or NA programs, and other self-compassion interventions, such as CFT [40].

To conclude, several scholars in the field of substance use have noted that the concept of RC reflects a shift in focus from the pathology of SUDs to a strengths-based paradigm that focuses on the internal and external resources required to initiate and sustain long-term recovery [75]. This article contributes to the field by presenting the role of self-compassion in building RC to initiate and promote long-term recovery from SUDs. Further research is necessary to investigate how RC can advance the capacity of individuals to overcome problems related to substance use and the significance of other key components, such as hope and forgiveness, as RC.

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