



**NATIONAL DEVELOPMENT AND RESEARCH INSTITUTES, INC.**

71 West 23<sup>rd</sup> Street, New York, New York 10010

212-845-4400 [www.ndri.org](http://www.ndri.org)

Version 11/2006

**GROUP MOTIVATIONAL INTERVENTION  
(GMI-20) MANUAL:  
A Cognitive-Behavioral-Motivational  
Treatment Approach**

**Jeffrey Foote, Ph.D.**

**The study was funded by grant no. DA12209 (Stephen Magura,  
Principal Investigator) from the National Institute on Drug Abuse**

The following are key background articles on the theory of the treatment and its evaluation that should be read as part of preparation for implementing the treatment:

Foote J, DeLuca A, Magura S, Warner A, Grand A, Rosenblum A, Stahl S. A group motivational treatment for chemical dependency. Journal of Substance Abuse Treatment, (17) 3: 181-192, 1999.

Rosenblum A., Foote J, Cleland C, Magura S., Mahmood D, Kosanke N. Moderators of effects of motivational enhancements to cognitive-behavioral therapy. Am. J. Drug Alcohol Abuse 1:35-58, 2005.

References in the text:

Deci, E.L., & Ryan, R.M. Intrinsic motivation and self-determination in human behavior. New York: Plenum, 1985.

Ryan, R.M., & Deci, E.L. Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. American Psychologist, 55, 68-78, 2000.

For further information on the implementation of GMI, contact [jefffoote@aol.com](mailto:jefffoote@aol.com)

For further information on the GMI research and evaluation, contact [magura@ndri.org](mailto:magura@ndri.org) or [rosenblum@ndri.org](mailto:rosenblum@ndri.org)

# Table of Contents

- **Theoretical Background and Clinical Procedures**
- **Session Guide to Four Introductory Sessions**
- **20 Session Texts**

Session #1 – A Hard Choice: Finding your own Place

Session #2 – Making a Decision about Using: Looking at Consequences

Session #3 – A Road to Change: Asking for Help

Session #4 – Roadblocks to Getting Help: Isolation and Honesty

Session #5 - Identifying Triggers

Session #6 - External Triggers

Session #7 – Family and Significant Others

Session #8 –Personal Consequences of Use

Session #9 – Internal Triggers: Sadness, Boredom and Shame

Session #10 – Sex and Intimacy

Session #11 – Internal Triggers: Anger

Session #12 – Building a Recovery Environment

Session #13 – Relapse Justifications

Session #14 – Self Help Programs

Session #15 – Cravings and Urges

Session #16 – So...Why Don't I Feel Any Better?

Session #17 – Making Conscious Decisions

Session #18 – Problem Solving

Session #19 – Refusing Substances

Session #20 – Returning to Old Behaviors: Dealing With a Lapse

- **Extras**

Getting Rid of Paraphernalia

Probability of Use Scale

Relapse Analysis Chart

## Introduction

The GMI-20 treatment is a 20 session relapse prevention and cognitive-behavioral approach specifically geared toward the client in early recovery or just re-entering treatment and recovery. In addition, the GMI approach incorporates motivational principles derived from Self-determination Theory (SDT). SDT postulates a spectrum of motivation for action, ranging from fully externally motivated to fully internally (or “autonomously”) motivated (Deci and Ryan, 1985; Ryan and Deci, 2000). GMI is designed to increase autonomous motivation for the actions relevant in early treatment of addiction. The sessions are semi-structured and use written session handouts as the topical jumping off point for each particular group. In addition to the handout topic, each group session also includes a brief check-in period, a brief wrap-up period to discuss individual high-risk situations, and at times “home handouts”, handout topics to be reviewed and thought about by clients between sessions. These would typically be reviewed the next session after the brief check-in period. Clients will all have their own folders for session and home handout material, which will be left in their counselor’s office in between sessions.

Throughout the addiction treatment world, treatment approaches have traditionally been group oriented, for financial as well as philosophical reasons. A specific focus of group treatments has also been centered around “the group” as the source of therapeutic change. Attachment to and reliance on the group is encouraged, therapeutic changes are expected to occur in the group, and group members are often expected to be the main source of feedback to other clients in the group.

While this model has strengths, several factors call for a shift in this way of conducting groups. One significant factor is the increasing severity of psychiatric and social difficulties found in substance abusing clients. Additionally, treatment lengths have been significantly shortened in recent years, such that there is less opportunity for the long-term development of group cohesion. Both of these factors lead us to an approach in the GMI-20 in which the group leader is the main driving force in the group, keeping the group focused and moving with the material, offering feedback and encouragement, clarifying concepts, and reigning in clients who are drifting off the therapeutic focus. To do this, group leaders must be familiar with the session material, including the core concepts of each session, the expected flow of that session, highlights not to be missed by the group, as well as typical sticking points or confusing issues often encountered in a particular session. Additionally, in this approach, the leader is active in making connections for clients between their own lives and the material being discussed, as well as pointing out connections between client issues in the group.

This manual will describe the format of the GMI-20 sessions. We will begin, however, with a brief description of cognitive- behavioral (CBT) approaches, as well as of the elements of Self-determination Theory (SDT) that inform GMI.

## Focus of a Cognitive-Behavioral Approach

The central focus of CBT is on teaching clients skills to help them 1) **Identify** high-risk

situations for relapse and using; 2) develop strategies to **Avoid** those situations if possible; 3) if avoiding high-risk situations is not feasible, learning skills that will enable them to **Cope** with those high-risk situations without using substances.

The treatment comprises skills training in a number of areas including identification of “triggers” and high-risk situations, managing frequently encountered problems early in recovery, and developing the skill of functional analysis; that is, analyzing problem behaviors (typically use episodes) for their precursors, effects, and future ways to cope with this sequence of events.

CBT places a heavy emphasis on **doing** rather than **talking about**. Behavioral practice is an essential component of CBT, both in the sessions in the form of role plays, and outside the sessions in the form of systematic rehearsal and application of the skills learned in treatment.

The following are considered the essential “active ingredients” of CBT:

- Functional analysis of substance abuse
- Training in recognizing and coping with craving, managing thoughts about substance use, problem solving, planning for emergencies, recognizing risky decisions and situations, and refusal skills
- Examination of thinking with regard to substance use
- Identification and review of past and future high-risk situations
- Encouragement and review of practice of new skills outside of the sessions
- Practice of skills within the session

## **Focus of the Self-determination Model**

The GMI approach incorporates motivational principles derived from Self-determination Theory (SDT). SDT postulates a spectrum of motivation for action, ranging from fully externally motivated to fully internally (or “autonomously”) motivated. The behavioral difference between these types of motivations is that those who are externally motivated enjoy the action less and persist in it for a shorter period, while those who are internally-autonomously motivated enjoy the action more and persist in it longer. As mentioned, GMI is designed to increase autonomous motivation for the actions relevant in early treatment of addiction. An important aspect of SDT is the finding that a treatment environment can be created which is “autonomy-supportive”, which will powerfully affect the level of autonomous motivation for change in individuals. Thus, in an approach utilizing SDT elements of motivation, clinicians aim to create such a treatment environment.

SDT postulates that there are three critical elements in creating an autonomy-supportive environment, which are to support the innate needs for autonomy, relatedness, and competence (described with the acronym ARC). Environments that effectively support and foster development in these areas have been shown to facilitate shifts toward autonomous or internalized motivation for action. These elements are key in shifting

clients toward autonomous or internal reasons for action (whether the action is changing use, entering treatment, or merely considering issues). That is, the extent a person’s surroundings are “autonomy supportive” will facilitate a perception that their reasons for acting are their own, consistent with their beliefs, and not forced. By utilizing these elements, clinicians can create an autonomy-supportive environment for their clients, helping clients internalize their motivation for taking action (i.e. “make it their own”). Conversely, autonomous reasons for acting can be undermined by a non-autonomy supportive setting, which would include the use of external contingencies and pressure. Within each of these elements, there are several ways to provide such support, as outlined in the table below. (These elements are discussed extensively in the “Group Motivational Intervention Training Manual”, separate document).

<b>Elements of Autonomy-Supportive Environments (ARC)</b>		
<b>Element 1</b> <i>Support for Autonomy</i>	<b>A</b>	<ul style="list-style-type: none"> <li>➤ providing non-controlling information                             <ul style="list-style-type: none"> <li>- promoting personal “ownership”</li> <li>- developing a discrepancy</li> </ul> </li> <li>➤ absence of pressure to act in a certain way – “un-sticking” the resistance</li> <li>➤ supporting a sense of choice                             <ul style="list-style-type: none"> <li>- identifying, acknowledging and integrating ambivalence</li> <li>- develop/provide actual options for taking action</li> </ul> </li> <li>➤ providing/helping develop a meaningful rationale for the action</li> </ul>
<b>Element 2</b> <i>Support for Relatedness</i>	<b>R</b>	<ul style="list-style-type: none"> <li>➤ use of empathic interaction                             <ul style="list-style-type: none"> <li>- acknowledgement of the other’s perspective</li> <li>- acceptance of the other’s perspective</li> </ul> </li> <li>➤ promotion of sense of group membership/commonality</li> <li>➤ promotion of identification with a positive model</li> <li>➤ use of positive reinforcement (interpersonal feedback)</li> </ul>
<b>Element 3</b> <i>Support for Competence</i>	<b>C</b>	<ul style="list-style-type: none"> <li>➤ use of encouragement /direct support for competence</li> <li>➤ use of optimal challenge/”bite-sized chunks”</li> <li>➤ use of positive reinforcement (task-related feedback)</li> <li>➤ task-specific training for the action in question</li> </ul>

In creating an autonomy-supportive environment, it is important to understand the role of these underlying elements and strategies throughout the sessions. Again, creating such an environment is critical in helping individuals shift their motivation for action toward more autonomous or internalized reasons.

### **Combined CBT and SDT: GMI-20**

These two approaches offer tremendous advantages when combined into one treatment. GMI is conceived as a treatment approach that is responsive to the need for the “tools” of change (understanding “triggers”, high-risk situations, coping strategies, etc) early in the behavior change process, as well as addressing the ongoing ambivalence concerning such change.

On the motivational “front”, GMI incorporates an understanding of motivation for change including: 1) motivation for taking a specific action is specific to that action, and does not necessarily generalize to other actions, and 2) perception of autonomy of motivation for

action fluctuates over time. Number 1 above implies that we must help clients examine a number of areas of life functioning, and decide upon what is a reasonable expectation of change in each area, with the clients “approval” of that change plan. Number 2 implies that during a course of treatment, a client’s perception of “why” they are making the changes they are attempting to make may shift. For example, over time, a client who is initially fully externally motivated for action can start to shift toward a more internal perspective of why they are seeking change. Likewise, a person internally motivated can and will experience temporary shifts into a more externalized perception of their own reasons for acting. Attention to this allows the clinician to more carefully follow the client, and to help them resolve these moments (hours, days, months) of heightened resistance to the change process that would be expected to accompany such a shift. Use of the autonomy supportive elements defined in SDT is designed to address both of these motivational phenomena.

Use of CBT techniques as the core of the treatment approach interacts especially well with these motivational elements. In particular, it allows for clients to simultaneously begin some of the steps of concrete change, while being allowed/encouraged to consider their own internal reactions to such changes. Additionally, working with clients to begin this change process concretely allows them to experience increased confidence in their competency, as well as a sense of autonomy in the concrete actions they begin to take. Since CBT has a behavioral focus, client motivation for specific actions can be examined in relation to taking those specific actions.

## **Structure of the Groups**

The GMI-20 module is a twenty session, manual-driven series of 1 - 1½ hour groups to be delivered to patients in the early stages of treatment. The groups are led by a trained therapist, and should be structured roughly as follows:

1) initial check-in (approx. time: 10-15 min.) - includes introduction of new patients, inquiry concerning medications/12-step/drug and alcohol use, and any crisis-type events that would be important to process briefly.

2) home handout review (approx. time: 15 min.) – discussion of clients thoughts about the home handout topic including reading of responses they may have written down, collection of any written material by clients for their folders. “Homework” (home handouts) is considered a vital part of achieving lasting change. The use of these handouts in the GMI-20 is designed to have clients continue to think actively about the change process in the context of their real lives, not just in our treatment center. Clients should be encouraged to take this process very seriously, as in fact one of the most important lessons they can learn from us is how to monitor and take seriously their recovery and change process 24 hours a day. While we want to promote the urgency of attending to their home handouts, we do not want to create a “bad high school”-like atmosphere in which clients are guilty for not attending to their handouts. In this sense, “homework” is certainly voluntary, but should be described to clients as an important opportunity to keep building their recovery and change.

3) topic handout (approx. time: 45-60 min.) - session handout(s) is then given to each member, and they are encouraged to read aloud, with different members taking turns voluntarily. The group leader should stop the reading regularly (every few sentences), to



help clarify and paraphrase what is being read and ensure that all members understand and are involved. Throughout the session, it is imperative that the leader attempt to involve all patients in relating personally to the material and thinking about how it pertains to their life. Specifically, it is important for clients to think through how this all relates to their struggle to not use and to build a lifestyle that is supportive of their recovery. Each written session ends with several questions. It is often the case, however, that by the time this section is reached, these questions have been fully covered. If that is the case, the questions can be used to reiterate what has been discussed. The groups are intended to be welcoming, warm, supportive and clarifying of issues. Generally, the use of written material seems to promote a lively discussion and be quite involving of patients, which is the goal. Be aware that this is an early treatment group. Because of this, patients may be somewhat anxious about the format and expectations, and display this anxiety by talking too much, not talking at all, or going off the topic. Use of the written materials to gently return the group to a productive and central focus is important at these times.

4) wrap-up (approx. time: 5-15 min.) – includes clarifying the “home handouts” for that session with brief explanation, and brief discussion of any high-risk people/places/ situations for each client that will occur between sessions. This last should include brief discussion of actions to be taken to provide protection from high risk.

## Goals

The goals of the GMI-20 sessions include the following:

- 1) establish rapport/alliance/connection with each patient that will allow them to:
  - a) return for the next session
  - b) increase their understanding of the treatment process
  - c) increase their understanding of the recovery process
  - d) increase their motivation to learn about and work on change
  - e) return to treatment should they relapse or drop out
  
- 2) use the elements of Cognitive-behavioral treatment to work with clients in the following areas:
  - a) **Identify** high-risk situations for relapse and using
  - b) develop strategies to **Avoid** those situations if possible
  - c) learning **Coping** skills that will enable them to effectively navigate those high-risk situations without using substances.
  
- 3) use the elements of Self-determination theory to create an autonomy-supportive treatment environment: support for autonomy, relatedness and competence (ARC). This is aimed at helping each client shift toward increasingly internalized or autonomous reasons for changing problematic behavior. Ultimately, the most powerful work we can do with clients is that which teaches them to hold their recovery as their own.
  
- 4) create a safe and welcoming group environment so as to promote retention and completion of treatment. This includes creating a group environment in which addiction can be discussed non-judgmentally and without the use of labels (e.g.: “addict”, “crackhead” etc.)

5) conduct an active and involving semi-structured group therapy intervention that is not didactic or psycho-educational in nature. This includes eliciting involvement of clients on a personal level (relating to their own lives).

A detailed session guide is provided for the first four GMI sessions, which are designed as a motivational introduction to the treatment (or a “preamble”). This is provided because the content of these four sessions may be unfamiliar even to therapists who have received prior training in cognitive-behavioral methods. The remaining 16 sessions address topics that should be more familiar to such therapists, although the structure of each session is enhanced with motivational content.

# Therapist's Session Guide

## Module: Treatment Introduction

### (First 4 Sessions)

## Session # 1: A Hard Choice – Finding Your Own Pace

**Session Overview** - This session discusses the special period of just beginning treatment, in particular with the idea that this is an emotionally scary and difficult time. It cautions that people are feeling particularly bad about themselves and the state of their lives, have recently used substances, and are at high risk for not returning to treatment. The central message is that this is all part of the normal process of change, and that if they are patient, and allow themselves to establish their own pace, they will get through this time.

### **Paragraph #1**

For most people, entering treatment for an alcohol or other drug problem can be scary and confusing. This is to be expected, and it is important to be patient and give yourself time to adjust to the important step you have taken. This will be one of the biggest challenges you have ever faced. Walking through this door is step one.

### **Issues -**

- 1) Starting treatment is difficult: coping with formal treatment and the process of change is emotionally challenging and daunting
- 2) This is normal/expectable: normalize the emotional reaction, as well as predict/inoculate for the future

### **ARC elements –**

1) Relatedness support (use of empathic interaction - acknowledgement) - session starts with empathic acknowledgement of the emotional discomfort many are experiencing in the group, both about being in treatment, as well as about making change. Also “taking care” of them by pointing out the importance of giving themselves time to adjust, and not to be hard on selves because of discomfort.

2) Competence support (use of encouragement) – session also starts with immediate support for the effort they are making in walking through their discomfort. If clients minimize or externalize this effort by stating they “had no choice” in one way or another, important to point out that it is still taking an effort on their part, and that they are succeeding. (Also important in general to

respond to such externalization efforts by pointing out that there is always a choice being made).

3) Autonomy support (supporting choice – acknowledging ambivalence) – simple acknowledgement of the fact that this process is uncomfortable, that we understand that, and that of course this would be something that anyone would struggle with deciding to do.

### **Paragraph #2**

Changing your use of alcohol or other drugs is a long-term process. There is a critical time in this process that you should be aware of, however, and that time is **now**, when you have just decided to come for treatment. This is a time when most people are feeling a variety of emotions, including pride about trying to help themselves, shame about their addiction, fear about what will come next, and uncertainty about whether they can handle all of this. In addition, this is also a time when your brain has been most recently exposed to the drug or alcohol you are attempting to give up.

### **Issues -**

- 1) Identification of this moment/time period as critical: pointing out that because of emotional lability of this time, this is a unique and important moment in their decision to make a change.
- 2) Identification of specific emotions: mentions several common possibilities for them to identify with, and as a spur for discussing their own unique emotional responses during this time.
- 3) Recency of use: touches on this fact, which can be expanded upon in discussing the chemical/physiological pull exerted by these powerful chemicals of choice. Also that recency of use effects their clarity (negatively), and also plays a (at times big) role in their lability.

### **ARC elements –**

- 1) Relatedness support (use of empathic interaction – acknowledgement and acceptance) – continues with theme from first paragraph of explicitly identifying emotional states they may be experiencing, to help reduce desire to shut down/defend in response to those states. Use of empathic acknowledgement here also aimed at identifying painful or pleasurable states as way to have client feel understood.
- 2) Relatedness support (sense of commonality) – identification of painful emotions in the group setting is, as always, also aimed at establishing a sense of commonality with the other group members. Identifying and normalizing these emotions works toward breaking down the normal and expected interpersonal barriers that exist between members, who often enter treatment in an emotionally guarded way.
- 3) Autonomy support (providing non-controlling information) – the entire paragraph is a statement

of information about emotions that are typical as part of this change process. Stating this in this manner “gives” this information to the client by removing it from the arena of semi-recognized and/or hidden emotional states, and places these responses into the arena of normal, understood and expected behavior, an important concept for the client to have.

### **Paragraph #3**

The net effect? Evidence shows that this is the time when you are most *likely not to return to treatment*, despite your very good intentions. While we wish this weren't the case, it is a simple fact of addiction. At this very vulnerable and uncertain time, it can seem much easier to stay away from treatment and the process of changing "just a little bit longer". And in fact, *it is easier*. Why? Because getting intoxicated or high takes away the uncertainty and fear, at least for the moment. In a way, the choice to get high makes sense. None of us likes to feel afraid and uncertain, and facing painful feelings and situations is a real challenge.

### ***Issues -***

- 1) Identification of dropout as a possibility: specifically pointing out that dropping out of treatment is a big risk at this moment, because of:
  - a) the uncertainty and fear of stopping use **and** entering treatment
  - b) the relief provided from these feelings by using substances
  
- 2) Reasonableness of this possibility: points out that dropout would be a reasonable reaction

### ***ARC elements –***

1) Autonomy support (absence of pressure – un-sticking the resistance) – there is a clear aim in the framing of this information being provided to make it clear to the client that there are several choices at this stage, and that they include leaving treatment. Additionally portraying this as a reasonable (if not helpful) choice works toward creating an environment where we are explicitly not pressuring them into staying by scaring them with the negative consequences of this choice. All of this is geared toward lowering their resistance created by the a priori expectation that we will push them to stay in treatment *for us*. By pointing out that of course it's normal to want to leave, the interpersonal “fight” about this is abandoned, and they are left with a much more autonomous decision to make.

2) Autonomy support (supporting sense of choice – integrating ambivalence) – the other central thrust here in autonomy support is explicitly pointing out the unspoken other side of their ambivalence about treatment. The paragraph highlights to “benefit” side in the cost/benefit equation of using/dropping out of treatment, by pointing out the anxiety reduction inherent in drug/alcohol use. This explicit discussion of ambivalence allows open acknowledgement of the ambivalence, and the beginning of integration of this ambivalence as a normal and expected part of the process.

**Paragraph #4**

The decision at this moment is of course yours and yours alone. What may be helpful to keep in mind, however, is that the desire to stay away, the desire to isolate, and such thoughts as “I am an especially shameful person”, or “This isn’t exactly the right treatment center for me”, are all part of ***the normal process of change***. Our experience shows that every person has their own ***pace*** for deciding to stop using and deciding to get help. Even more importantly, that pace for each person often changes from day to day and week to week, so that one day you are very eager to “change my life around”, and the next day the whole idea seems a little too much.

***Issues -***

1) Identification of normal response to change: describes a variety of emotional responses that would typically be held private by a client, states these are normal and expected parts of change process.

2) Introduction of “pace”: describes the idea that each person has their own pace of change, and that this must be established by the individual, not someone else.

3) Variability of “pace”: furthers the pace idea by stating that they may fluctuate on the pace, with variable rates depending on them.

***ARC elements -***

1) Autonomy support (*providing non-controlling information – personal “ownership”*) – a central aim of this paragraph is to provide information concerning this stage of the change process, so that the client is aware that their responses are normal and expectable within the realm of changing addictive behavior. The goal then would be to allow the client to integrate these responses as an acceptable part of the range of their behaviors, and not keep these feelings separate, as something that is outside of themselves, thus increasing the likelihood of them being acted on impulsively. The concept of autonomy support here is that the fuller the acceptable range of response available to the client, the more likely they are to stay engaged in the process of change.

2) Competence support (*“bite-sized chunks”*) – the subtler message here concerns competence. What most clients have experienced on their own or in treatment is failure...failure to stay in treatment, failure to control or stop their use (multiple times), failure to fend off negative consequences in their life. Making the point that they are the ones to establish an appropriate ***pace*** for change is not only a relief for many (“they won’t push me beyond my limits”), but more importantly conveys advice toward and acceptance of the idea that there are different paces for different people. This is a huge shift for many, away from the stance that ***we*** are going to ask them to do things that are hard, to the idea that ***they*** are going to need to decide at what speed to

change. Concretely, this relates to building competence by stressing that going too fast, or asking too much of themselves can lead to being overwhelmed and not staying with it. Tumbles along the way are not failures, but struggles to establish how best and in what time to do this changing.

3) Competence support (direct support for competence) – not to be understated is the direct support for client competence. The first statement of the paragraph is just that, telling clients that “of course” the decision to change is **theirs**.

#### **Paragraph #5**

This group and this treatment center will be here to help with these life changes today, tomorrow and next year. Hopefully, this group can be a place to begin the changes you decide are right for you. **We only encourage you to listen to your whole self, not just your fears, worries and uncertainties.**

#### ***Issues -***

- 1) Long term view: describes the change process as a long term one
  
- 2) Encouragement for hanging in there: provides encouragement and support for sticking with a process that is difficult and confusing

#### ***ARC elements -***

- 1) Relatedness support (positive interpersonal reinforcement) **AND...**  
Competence support (direct support for competence) – explicit support here for the client’s inherent ability to make the right choice for themselves. This reinforces the relationship between therapist and client as one grounded in respect for them as people and for their autonomy (positive reinforcement), as well as predicting their ability to be constructive (competent).
  
- 2) Autonomy support (supporting a sense of choice) – describes the process of change as a long term one, and points out that in fact the client can decide to do this at any time, including **not** deciding on change at present.

#### **Questions**

- 1) What is difficult for you about coming to treatment?

**Concretize** - The question is aimed concretely at having clients think through and be specific about the emotional and practical hurdles of being involved in treatment.

**Frame** – The asking of this question at all may be unusual for clients, and is conveying the message (continuing from the body of the session) that we are not asking them to ignore the difficulties of treatment (and change). Implies an acceptance of ambivalence.

2) What do you think treatment here has to offer you?

**Concretize** – Is pushing the client to develop for themselves the positive reasons they would stay and utilize treatment.

**Frame** – Asking the question at all implies a sense that they are the one to decide whether this will be a helpful experience for them or not, promoting autonomy and competence.

3) Can you tell when you've decided something at your own pace, instead of someone else's pace? How?

**Concretize** – This question is slightly more complicated to understand, but the struggle in the group to understand it is helpful. Is meant to elicit from each person an exploration of what we mean by "pace", in particular the concept that they can be the one to decide how they want to proceed. Also to have clients start to identify the ways that they feel pushed by others and thus not making autonomous decisions.

<p><b><u>Treatment awareness exercise:</u></b> As I sit here right now, am I having a hard time being here? Why? Am I bored, sleepy, scared, shy? Do I feel understood here?</p>
--

Am I having a hard time speaking up? Am I having a hard time listening to others? Do I feel the need to talk a lot?

We conclude the session with an "exercise" that is meant to more experientially connect the clients with their discomfort in the treatment process. This should be relatively brief and "light", but still allow for some acknowledgement in the present moment of this type of struggle to be in a treatment setting, as was discussed during the session. This is also a further implicit statement by the therapist that such discomfort and ambivalence is acceptable and part of the process of change.



## Session # 2: Making A Decision About Using – Looking At Consequences

**Session Overview** - This session discusses the idea that while everyone in the group has in general had some struggle with addiction, it is important for each individual to examine for themselves the consequences of this use in their own life. The central idea is that each person must conclude for themselves, based on this examination, whether they feel they have a problem that is worth making an effort to change, or not. The group focuses on identifying specific areas in individual's lives, to have them judge whether their substance use has produced a negative **or** a positive effect in that area (cost/benefit analysis). The idea that consequences can be negative or positive is central to allowing for an open, non-defensive examination of the role of substances in the group member's lives.

### **Paragraph #1**

The struggle with addiction often brings with it a sense of failure, feelings of shame, and a sense of being stigmatized or outcast. Because of this, it can be very difficult and painful to look at the state of our lives with open eyes. It is important, however, to begin to understand **why** we are here. While there are a variety of reasons that people come to treatment, there is a common link between everyone in this group, which is that the use of alcohol or other drugs has had a negative impact on our lives in some way. This fact, no matter how simple, can be difficult to accept.

### **Issues -**

- 1) Painful emotions associated with addiction process: states that there is often a history of emotional turbulence and pain for people in the group associated with their use, and that as a result, clients can find it difficult to objectively examine the effects of their use on their life.
- 2) One objective consequence of use: states that all in the group share in common the negative effect of alcohol or other drug use in their life, to whatever degree
- 3) Difficult to accept: points out this fact can be blurred by defensiveness, difficult to see clearly

### **ARC elements –**

- 1) Autonomy support (development of discrepancy) – this paragraph helps clients begin to develop a discrepancy between their use and what they would like for themselves by directly discussing the issue of this discrepancy between painful consequences and continuing use. Consequences are discussed non-judgmentally and sympathetically, followed by the invitation to consider what these consequences might be.

2) Relatedness support (commonality) – there is the clear proposition here that this feature of addiction – having suffered negative consequences due to use – is a common link between all group members. By describing/discussing this, we hope to lower the barriers between group members and establish a sense of group cohesion.

### **Paragraph #2**

In coming to grips with this fact, it is important to clearly examine the **specific** ways in which alcohol or other drugs have affected our lives. Usually, people are suffering the consequences of this use in their lives. Some of the effects of use have been external (e.g. job performance, family relations), while others have been internal (e.g. feelings of self-hatred and despair). Some of these effects have become apparent to ourselves and others, some we have managed to conceal.

### ***Issues -***

- 1) Being specific about consequences: pushes the issue of consequences by noting that in order to see the effects of use clearly, given the fact that this is a painful process, it is important to be specific about the effects in each individual's life. Goes on to categorize by internal and external consequences
  
- 2) Concealment of consequences: clients have had the experience that some consequences are public and out in the open in their lives, while others up to that moment are still concealed.

### ***ARC elements –***

1) Autonomy support (developing a meaningful rationale for action) – the focus here is on having clients begin to consider the specific evidence in their own lives of negative consequences of use. In general, the important issue in developing a rationale for change is that the evidence of a need for change either be supplied by the client, or make sense to the client's perception of reality. In this interaction, the therapist can certainly suggest areas or specific consequences, but it is important to reconcile these with the client's experience. Also be careful with rationales for change supplied by clients that have a generic or timeworn feel to them (statement: "I'm sick and tired of being sick and tired", question: "what specifically are you tired of"?). Rationales built on generic reasoning are not building a sense of autonomous reason for acting; in fact, quite the opposite.

### **Paragraph #3**

No one knows you better than yourself. Whether a counselor, spouse, EAP, parent, parole officer or friend thinks you "have a problem with \_\_\_\_\_" (alcohol, cocaine, heroin etc), the only person that **really** matters in deciding that is you. A good way to decide for yourself is by honestly examining various parts of your life to see if they are going the way you want, and deciding whether alcohol/drugs is playing a part in that. Keep the question simple: Does my use of alcohol/other drugs **help, hurt, or make no difference to:**

a) my relationships with family/spouse	HELP	HURT	NO DIFF
b) my relationships with friends	HELP	HURT	NO DIFF
c) my job (performance, relations etc)	HELP	HURT	NO DIFF
d) my health		HELP	HURT NO DIFF
e) my legal status/risk	HELP	HURT	NO DIFF
f) my finances	HELP	HURT	NO DIFF
g) how I feel each day/my mood	HELP	HURT	NO DIFF
h) how much I like myself		HELP	HURT NO DIFF
i) other areas of my life	HELP	HURT	NO DIFF

For those areas where you felt alcohol/drugs are **helpful** to your life, discuss **how** they are helpful specifically (“benefits” of use): \_\_\_\_\_

For those areas where you felt alcohol/drugs are **hurting** your life, discuss **how** they are hurting specifically (“costs” of use): \_\_\_\_\_

**Issues -**

- 1) You be the judge: you (client) are the one who has to judge whether you have a problem with use. Specifically, if this is not of much consequence to you, then it doesn’t really matter if others think it is of consequence.
- 2) Two-sided examination of consequences: forcing the issue of being specific about areas of possible effect in their lives. Also, explicitly introducing the concept that there are cost **and** benefits to use (“hurt” and “help” as possibilities), and that the way to figure out the total consequence is by weighing **both** sides of the equation.

**ARC elements –**

1) Autonomy support (providing non-controlling information – “ownership”) – a specific focus here is giving clients the clear message that **they** are the critical ones to evaluate their use and its consequences, not us or someone outside them. Being very specific about the areas of consequences allows it to be personalized and meaningful to their life. Also embedded in this exercise is the choice of whether something is negatively **or** positively effected. Clearly then the agenda is not the expected one of treatment providers pushing the costs of use in their lives, but is allowing the agenda and outcome to be driven by them.

2) Autonomy support (providing non-controlling information – “discrepancy”) – this paragraph sets up the “weighing” process in such a way as to promote an honest cost-benefit analysis. The autonomy supportive goal of such an analysis is the development of a discrepancy for the client. Suggesting that there are in fact positive consequences/aspects of use and that these are acceptable and part of the real world equation usually allows the client to more honestly consider the negative aspects of use as well. When a more open and clear-sighted analysis is able to be

performed, the weight of the negatives can more clearly be seen. Additionally, the negatives can be seen somewhat shorn of their stigmatized and emotionally painful baggage, which allows for them to be more fully considered, instead of deflected continuously.

3) Autonomy support (sense of choice – “ambivalence”) – acknowledging and integrating ambivalence is central to this whole session. Cost-benefit analyses are particularly good vehicles for realizing ambivalence and recognizing it as acceptable. This paragraph specifically announces there are two sides to the equation (ambivalence in behavioral terms), and that these sides must both be examined and reckoned with.

#### **Paragraph #4**

In figuring out how much your use bothers you, it can be helpful to place the costs and benefits you described above on an “Action Scale”(see next page). An Action Scale can help in “adding up” costs and benefits of any action or behavior in your life. In this case, the **action** is your use of alcohol or drugs. Place your costs and benefits on each side of this scale, and then give a “weight” to each item. Finally, add up each side of the scale.

#### ***Issues -***

1) Adding up costs and benefits: just a continuation of the examination of costs and benefits, making it more graphic for clients by having it be expressed in numbers and relative weights, as well as having there be a “visual” aspect to conceptualizing this. This can be very useful as an image that can be carried around mentally for many clients, allowing them to “weigh” the costs and benefits of a given situation for themselves.

#### ***ARC elements –***

1) Autonomy support (sense of choice – “ambivalence”) – same as above. Again, critical here is the fact that the client is assigning the weights, not the therapist. Support for autonomy of decision-making and weighing of their own values.

#### **Paragraph #5**

Finally, the question is: “**Do the costs of my use outweigh the benefits**”? If not, then attempting to change this behavior of using may not be such a good idea for you at this time. If the costs of using **do** outweigh the benefits, then you are probably ready to seriously consider how to go about making changes that will benefit you. People on both sides of this equation can make use of this group; it is just important to know where you stand at the outset, so that you can set goals that make sense for **you**. Setting goals based on what someone else thinks should happen are often a setup for failure and disappointment, which most people in this group have had enough of.

#### ***Issues -***

1) Final analysis of costs and benefits: points out that if they have added up the costs and

benefits, and costs are less than what they get from using, then “why stop”? Goes on to recommend **not** attempting to make a behavioral change if that is in fact what the equation adds up to, because it doesn’t make sense in that context. Also, if costs are more, then equates that with being ready to actually act on the behavior.

2) Group for all: makes the claim that whichever side of the equation client falls on, they can still use the group, just may be for different purposes.

3) Appropriate goals: last point is that the importance of knowing how the equation comes out is to establish reasonable goals based on that, and not based on someone else’s idea that they should be changing. Also that goals not based on the cost/benefit equation may be a setup for failure and disillusionment down the road.

### ***ARC elements –***

1) Autonomy support (*absence of pressure to act in a certain way*) – Clearly, the message here is “it is paramount that you decide what is best for you”. We are explicitly stating that the choice of paths is contingent on what they decide about costs/benefits, not on anything else. In this way, the therapist is going way out of the way to stay out of it, to allow the client to mull this over and consider not only the cost/benefit, but also the personal responsibility they have in figuring out how and if to change. Central mechanism in lowering resistance, but also quite “secretly” confrontational in leaving this important decision squarely in the client’s lap.

2) Competence support (*use of optimal challenge*) – In describing the importance of setting goals based on where they are motivationally, are bringing up idea that they are capable of making a change, but that this change plan needs to be matched to what it is they really want for themselves. This is then supporting competence through realistic goal setting, making it clear we want them to succeed through having a plan suited for them.

3) Relatedness support (*empathy – acceptance of other’s perspective*) – The “emotional glue” to this paragraph and session is having this discussion in an empathic and accepting environment. In particular, what is being “accepted” here is that clients are ambivalent, and can have views and desires that include **not** changing their current behaviors. This last paragraph in particular allows for divergent paths, with these paths based on where each client is at. This creates an accepting and positive group environment as well.

### Questions

1) Are there differences between how you view your use and how others view it?

**Concretize** – Asking the client to think about the issue of discrepancy between people in their life putting pressure on them to change or to view their behavior a certain way, versus how they may actually see their behavior. Concretizing by thinking about actual people and their views.

**Frame** – Question pushes the issue of autonomy in self-evaluation and decision making.

2) How do you handle those differences?

**Concretize** – Is bringing up a new topic, which is to start thinking about how they may want to handle this issue of autonomy now that it has been so highlighted for them in the group. Typically, the way differences in opinion about the need to change have been handled by argumentation, shutdown, or minimization of the problem to others and even themselves. The group has opened up the possibility of not having to defend their behavior, but instead being able to validate what they feel about their situation, and to operate accordingly. This begins the process of relating to their own decision-making in a different way.

## Session # 3: A Road To Change – Asking For Help

**Session Overview** -This session discusses the idea that once clients have decided they want to change their behavior of using alcohol and/or other drugs, the next step is negotiating asking for help. The session focuses in particular on the issues they will encounter in getting treatment in a formal treatment setting. A checklist is utilized to help identify those areas of the treatment environment that could be problematic. The central point made is that these problems will exist, and that thought needs to be given as to how to not let these issues derail them from their own goal of shifting out of destructive behaviors.

### **Paragraph #1**

Everyone in this group has in common the use of alcohol and/or other drugs. What is unique about everyone here, however, is their own decision about how much of a problem that substance use is, and whether it is worth changing. In trying to decide that, people usually think about several things: what **other** people think about their using, what **they** think about their own using, and what effect it is having on their life, if any. In earlier groups, some of you used “Action Scales” to help decide whether your use was something you saw as a significant problem. If you come to the conclusion that your use of alcohol or other drugs is a problem worth changing, then the next question becomes: “**How** can I change”? Specifically, today we will talk about **getting help from others** in dealing with your substance use, and the problems encountered in this early stage of the process.

### **Issues -**

- 1) **Commonality and uniqueness**: commonality in group of all members having some problems related to use; uniqueness in varying degrees of problem as assessed by each client.
  
- 2) **Assessment of problem of use**: reiterates from previous session (which some members were not there for) idea of weighing the costs and benefits of use in deciding whether, *from their own perspective*, there is a substance problem *worth changing*.
  
- 3) **Getting help**: states group will deal with problems of asking for help

### **ARC elements –**

- 1) **Autonomy support (developing a meaningful rationale)** – this paragraph is a restatement of the central themes of the 4 session module, which is that after consideration of the consequences (costs and benefits), the client has a decision/choice to make about changing behavior and getting help for that. Central idea is that this is their choice, and that what we are doing is helping them assess different aspects of the change process; i.e. assessment of problem followed by decision concerning getting help.

### **Paragraph #2**

Getting help from others can take many forms, including talking with family, friends, and religious leaders (priests, rabbis etc), or attending 12-step or self-help programs. Another “formal” way to ask others for help is to work with a professional treatment center such as the one you are sitting in now. All of these avenues are valid...all have their problems and pitfalls. We will focus in this group on the issues of being involved in formal treatment, especially those issues that may arise in the early stages of coming for help.

#### ***Issues -***

- 1) Different ways to get help: describes the idea of getting help from others once client has decided to seek help, both informal and formal routes, and states focus here will be on the issues in seeking formal treatment, as in the treatment they are currently receiving.

#### ***ARC elements –***

- 1) Autonomy support (providing non-controlling information) – paragraph is relatively informational in nature, just laying out the concepts of the session

### **Paragraph #3**

Reluctance to deal with formal treatment programs is common, and can be based on a number of things, including: 1) previous negative treatment experiences, 2) fears about what “treatment” is and possible bad experiences, and 3) mixed feelings about stopping or cutting down on drug or alcohol use. We will focus on what could happen ***while you are in treatment*** that would make you want to leave treatment.

#### ***Issues -***

- 1) Apprehensions about treatment: describes problems/fears people face in considering treatment, including previous experience, fears, and reluctance to change behavior
- 2) Predicting problems: states we will discuss treatment events that could cause dropout

#### ***ARC elements –***

- 1) Relatedness support (use of empathy) – describes fears about being in treatment and the desire to leave treatment as common, understandable and acceptable. The very nature of having this open discussion about wanting to drop out of treatment is somewhat of a shift for clients, and can have the effect of providing support for a larger array of responses than they might have thought would be acceptable in treatment.

### **Paragraph #4**

At present, you have chosen to make the effort to show up here and ask for help...for that you deserve a lot of credit. To protect your effort, it is helpful to predict what obstacles may lie ahead for you. Most people will have some moments in treatment where they think: “I just don’t want to deal with this - - - anymore”! Predicting those moments ahead of time can help you stay on the course you want. With the lists below,



check off those things that *could* make you want to drop out of treatment:

***I keep using alcohol and/or drugs, and....***

- I worry about my counselor's reaction
- I worry about my group's reaction
- I feel too \_\_\_\_\_ (ashamed / guilty / disappointed / hopeless / something else....)

***I don't feel the counselor.....***

- understands me
- respects me
- encourages me
- other.....

***I feel.....***

- afraid to speak in the group
- afraid to open up to others
- my business is my business
- other.....

***I don't like.....***

- the inconvenience of coming to treatment
- the cost of treatment
- being uncomfortable in a group
- other

***Issues -***

- 1) Acknowledgement of effort: starts with crediting them for their effort to come in for treatment, acknowledging how difficult that is
- 2) Predicting problems: states that because this effort deserves protecting, we will discuss treatment events that could cause dropout
- 3) Lists potential problem areas: provides categories and specific issues that can arise in treatment with the treatment itself, which could lead to reluctance to return. All areas contain issues that may be uncomfortable for a client to acknowledge, and that may well not have been brought up without the checklists. Friendly, supportive encouragement is helpful during this process, as clients can feel "on the spot" in discussing them. Assurance by the therapist that they will not "take it personally" can also help relieve some tension.

***ARC elements –***

- 1) Competence support (direct support for competence) – Congratulates clients on succeeding in the act of coming in for treatment. This is in fact a difficult thing they have accomplished, and noticing this successful effort is very much perceived as support for their competence.
- 2) Competence support (task-specific training for the action in question) – The central theme of the paragraph is to help the client identify potential problems in moving forward in a constructive way, and then help them to resolve these potential problems, or at least to understand they may arise. This is designed to relieve some tension/apprehension the client may have in moving forward in the treatment setting, and allow them to feel more able to cope with the setting.

3) Relatedness support (promotion of sense of group membership) – Identifies the struggle to come to/stay in treatment as a struggle for many in the group. The use of humor (“don’t want to deal with this ---- anymore”) can also promote a feeling of a common bond in the group.

#### **Paragraph #5**

For all the reasons people in this group listed above, coming to a treatment program can be a difficult choice to make and then stick with. As you can probably tell from hearing other group members concerns about treatment, most everyone has worries about what could happen. One of the main reasons it is so important to understand your concerns ahead of time, however, is to help you keep track of your initial reason for coming; that is, **to help you change behaviors you feel are hurting you**. If you get overwhelmed or derailed by the treatment process itself, then you are in danger of losing sight of this goal. *That* would be a real shame, because the last thing most people need in this very tough struggle is to once again feel defeated or demoralized. Protect yourself.

#### ***Issues -***

- 1) Acknowledgement of difficulty of treatment: starts by reiterating what has just been covered: many issues arise in treatment that are difficult or anxiety provoking, and this is a common experience for those in the group and in general.
- 2) Keeping track of why treatment at all: states that while these difficulties will arise, we are discussing them now as an inoculation against their de-focusing effect. Issue is not to resolve all these potential problems, but to understand they will occur, and not to let them take center stage instead of the goal of changing destructive behaviors.

#### ***ARC elements –***

- 1) Autonomy support (supporting a sense of choice – acknowledging ambivalence) – Primary here is the acknowledgement of fears and concerns about how much the client wants to continue with the treatment process. This, as always with the acknowledging of ambivalence, is aimed at lessening the tension caused by such ambivalence, including the result of wanting to flee as a way of reducing the tension. Making the ambivalence acceptable and normal significantly shifts its potentially negative impact.
- 2) Competence support (use of encouragement) – This paragraph directly encourages the client to protect that which they have decided is important for them, to change destructive behaviors that hurt them. This is described as an achievable task, but one that requires effort and care.
- 3) Relatedness support (empathic interaction) - Language here is protective of the client, acknowledging the potential for them to be disappointed and exhorting them to take care of themselves in the ways identified in the session.

**Paragraph #6**

From our experience, having some ideas of what you want out of treatment can help avoid frustration, disappointment and dropout. Our last topic today is a discussion of what you can do to make treatment work for you. Based on how you see your problems right now, think about the following questions:

- 1) What is it you want from treatment?
- 2) What will help you accomplish those goals in treatment?
- 3) What could get in your way?
- 4) Can you tell when you're moving at your own pace, instead of someone else's pace? How?

***Issues -***

- 1) Considering what you want: discusses the practical strategy for avoiding losing focus in treatment, which is to think through what the client's goals are, and signs for them that they are not sticking with what they want. The questions are meant to re-emphasize the issues from the session of identifying their own goals, and in particular of realizing ahead of time what treatment events could be problematic for them (shyness, continued use etc).

***ARC elements –***

- 1) Autonomy support (providing non-controlling information) – Tone adopted here is one of giving them our friendly, concerned advice ("from our experience") to think through this process for themselves. The other aspect of autonomy support here is the encouragement to develop their own plan for self-protection and constructive behavior, to "own" this process for themselves.

## **Session # 4: Roadblocks to Getting Help – Isolation and Honesty**

**Session Overview** -This session deals with the specific experiences of isolation and self-hatred as part of the emotional fabric many people have been living with during their addiction. The cycle of attempting to change and ending up in repeated demoralizing relapses is discussed, with the slow drift toward less and less contact with other people. The specific issue of dishonesty as a very common consequence of use is also discussed, with its effect of further isolating the individual. Finally, it is pointed out that the struggle to change the destructive behavior is very difficult alone, and encouragement is offered to allow others into the process of helping change begin.

### **Paragraph #1**

For many people, dealing with their addiction becomes an isolated, lonely and vicious struggle. A common experience in this struggle is the repeated attempt to stop, to "make this the last time", and then finding yourself right back at it again the next day, week or year. This is discouraging and demoralizing, and often leads to a sense of failure, shame and self-loathing. In addition, there is a lot of misunderstanding about the addiction process, and a tremendous stigma attached to it. All of this can easily add up to a powerful sense of isolation and a cutting off from people in your life.

### **Issues -**

- 1) **"This struggle is difficult"**: coping with addiction and the process of change is very difficult and discouraging. It is difficult to cope with because of:
  - a) repeated failures at "stopping" or attempting to change things
  - b) social condemnation and stigma
  
- 2) **Negative feelings toward self**: you may have negative feelings because of this, including *self-attacking* emotion (shame, guilt, self-disgust, humiliation)
  
- 3) **Isolation**: this all leads to isolating of yourself, which increases the negative emotion and the difficulty of getting help

### **ARC elements –**

- 1) **Relatedness support (use of empathic interaction - acknowledgement)** - simple identification of negative emotions, especially self-directed, as very painful and difficult. We are empathizing with fact that not being able to stop something when you want, and incurring the consequences of

stigmatization and self-hatred, is a very painful and very discouraging process to go through, sometimes lasting years. Acknowledging that it may have also led them to withdraw and be alone and lonely. (It is imperative that, whatever the content being discussed, clients feel they are “heard” by the therapist in the particulars of their story).

2) Relatedness support (*commonality*) – the “failed struggle” and experience of isolation are described as common and part of the addiction process. This makes the point that these very private, painful and humiliating aspects of addiction are something they have in common with the other group members, and need not continue to be a source of “outsiderness”. Additionally, there is the implicit proposal here that being alone and isolated is a negative consequence for the individual.

3) Autonomy support (absence of pressure / “un-sticking” the resistance) - clients often enter treatment feeling ashamed, “weak” and like failures. They have also gotten this message repeatedly from people in their life and from the social stigmatization of addiction. A common consequence is that they are also defending against getting the same message from treatment providers (“its about time you started to do something”, “you are really bad off” etc). By *simply* identifying how hard this struggle is, and how normal it is to struggle with the addiction and with the subsequent feelings, we are working to disengage from the resistance they bring (expectations). Through this process, clients can more openly begin to assess their perception of the consequences of addiction in their life, and start the process of considering change.

### Paragraph #2

Another common feature of addiction is not being truthful. While this is not something people are proud of, it is an almost inevitable part of the addiction process. It is very hard to meet the demands of daily living (e.g. job responsibilities, family and social relationships) while at the same time meeting the demands of an addiction. Usually, something has to give. Often, one of the first things to go is the ability to be honest with others and with ourselves. For example, given the choice, most people would rather tell their boss that they were “out sick” rather than “recovering from yesterdays binge”. Likewise, most people find it easier and less painful to tell themselves: “I’ll be able to cut back on my drinking”, rather than: “I thought I could stop two years ago and I still haven’t”.

### **Issues –**

1) Honesty is difficult: hard to fully reveal self in early recovery

a) this is very normal in early recovery stage

2) Good reasons for lack of honesty:

a) addiction often crowds out other responsibilities, and not performing these is embarrassing, shaming, and conflict-producing, all of which are difficult to deal with

3) Examples of external and internal reasons to not be honest:

- a) external - fear of real world consequences or conflicts
- b) internal - emotionally painful to acknowledge own "failure", sense of being unable to control oneself, self-attack about this

***ARC elements –***

1) Relatedness support (use of empathic interaction - acceptance) **AND...**

Autonomy support (non-controlling information – developing a discrepancy) – this is the combination use of these two techniques. We are pointing out that, although people do not like to be dishonest, they in fact often are, for a variety of compelling reasons. Discussed in an empathic, accepting way, this allows for true consideration by the client of what they may view as unacceptable or egregious behavior. Less defended consideration of this behavior is critical in developing an internal discrepancy about acting this way, and a subsequent desire to change.

There are several important points in an empathic/informational presentation: a) present this symptom (lack of honesty) as information/data common to addiction, not as a moral or ethical problem; b) highlight the understandability of this symptom as a casualty of this disorder; c) use humor (being honest with "the boss" about drinking seems quite comical) as an in-road to this painful topic which actually makes clients feel quite badly and ashamed. Humor can also help establish a sense of emotional genuineness between therapist and group, important in reducing a sense of hierarchical distance between group and leader.

2) Autonomy support (supporting a sense of choice) - statement being made that they may well not want to do something (be honest), and that this is normal, acceptable and at times quite reasonable. Explicitly normalizing this often hidden/shameful experience makes clear that we (treatment) are not going to condemn them and force them to change, but that in fact this is up to them if they so choose.

**Paragraph #3**

The problem in not sticking with the truth is that it once again leaves you isolated and alone. Not only don't you get to talk about your **real** life and get some help with the actual problems, you are also left feeling separate and apart. This gives you two messages: 1) you are different and don't belong; and 2) no one **really** understands you.

***Issues –***

1) Consequences of lack of honesty: even though lack of honesty is understandable, there is a significant downside of this for you, which includes:

- a) can't tell others what is actually going on in your life, which makes it very difficult to get others help
- b) gives you bad emotional experience of feeling even more separate, different than

others, misunderstood and alone

***ARC elements –***

1) Relatedness support (use of empathic interaction - acceptance) - empathy here in relating to the emotional price they probably pay for lack of honesty, and framing the problem as a price **they** pay, not as an abusive or immoral act toward others. Helps relieve some degree of shame and humiliation.

2) Autonomy support (non-controlling information – developing a discrepancy) - Continues the work of encouraging the development of discrepancy, pointing out that in fact the goal of not being honest is reduction of conflict, but that there is a heavy price to be paid for this that is often not factored into the equation: they **feel** alone, different and unhelpable, and they are significantly unhelpable to the extent that no one knows the nature of their problem. Done empathically (above), allows the client to consider the relative truth of this for themselves.

**Paragraph #4**

And finally, all of this separateness, lack of being understood and isolation can add up to deciding to use. For in fact, one of the central truths of changing addictive behaviors is that it is very tough to do on your own. The degree to which you put up barriers to change (by isolating or not being truthful) is the degree to which it's just you and your addiction talking. While this "exclusive relationship" can be comforting, the conversation is nothing new. Treatment and change are your choice and for your benefit...let yourself have this if you feel ready.

***Issues –***

1) Danger of relapse/use: idea that a consequence of isolation and lack of honesty is relapse

2) Change is very difficult by yourself: key element throughout treatment is the idea that change/recovery takes support and that recovery is not an issue of how strong or tough you are, but of learning to use others for help.

3) Recovery is for you: brings up the idea that recovery can give them something, instead of being either just a prohibition against certain behaviors, or being for someone else.

***ARC elements –***

1) Relatedness support (use of empathic interaction - acceptance) - idea is presented that they consider being honest and allow others to help them *as a way to be good to themselves*. Suggests they are in a lot of needless pain and isolation, which could be significantly reduced by allowing others to know what is going on.

2) Relatedness support (commonality) – central here is highlighting commonality of being a group

of people who struggle to allow each other in, and who'd prefer to go it alone.

3) Autonomy support (*supporting a sense of choice*) – the statement “Treatment and change are your choice and for your benefit...let yourself have this if you feel ready”... is an attempt to reframe the very powerful resistant stance many clients are in, which is basically that others (S.O.'s, jobs, treatment providers) are the ones who want a change, not them. This can be subtle, but is very often part of the client's psychological stance. Since this is also being framed positively, it works to encourage the idea that this is most importantly a loss for **them** first and foremost, and something that they can have for themselves.

#### Questions

1) Have you not been honest about your drug or alcohol use for any of the following reasons?

- a) you are afraid others (or yourself) would be disgusted by you
- b) you are afraid others (or yourself) would think you are “weak”
- c) you are afraid of real world consequences (job, relationship loss etc)
- d) you feel overwhelmed at the idea of trying to change
- e) you are afraid you can't change

**Concretize** - The question is listing a number of possible experiences the client may have had concerning reasons to not be honest. This “menu” is intended to spark a connection to their own behavior, which should then be discussed in the group. This is a mechanism for personalizing the material and making explicit in the group material that clients might otherwise not access.

**Frame** - The tone of the question and the fact that many options are presented as to why people will not be honest, are intended to convey the message that this is behavior common to addiction, that many of these reasons are a product of emotionally painful processes, and that we don't think they are weak, disgusting, or unable to change. Explicit discussion of this painful material also sets a tone of normalizing these affects.

2) Have you noticed feeling alone because of these fears?

**Frame** - The message being conveyed is that we understand you may be experiencing painful loneliness, and that this can be a burdensome **consequence** of the fears many people experience about reaching out for help.

3) Have you found yourself avoiding others who could be supportive of your recovery?

**Concretize** - The main goal of this question is to have the client spell out **how** they avoid others, **who** they are avoiding, and **why**.



4) What behaviors and thoughts can you identify that tell you when you are beginning to isolate?

**Concretize** - This question is intended to elicit **specific** thinking on the client's part about behaviors and cognitions that they can start to recognize as associated with or leading to isolating behavior. Essentially CBT in nature, this is intended to give clients a beginning sense that there are concrete ways to start to approach these problems.

5) What strategies can you use to help make the decision not to isolate?

**Concretize** - Again, we are seeking specific action plans (at least one) about how they will deal with the above-identified progression to isolation. This question is also important if only to stimulate the client to **start** considering strategies.

6) Do you relate to the idea that "if I was stronger, I wouldn't need anyone's help with this anyway"?

**Frame** – The implicit basis for this question is underlining the idea that this addiction struggle is not about character, and that specific behaviors need to be put in place. We are putting forward the idea that “strength” has very little to do with preventing relapse, and that maintaining that idea is probably not helpful to recovery. Putting forward this concept also delivers the empathic message that they don't have to work so hard at being perfect, and that we will accept them even if they let their guard down.

**Reminder:** Partial truths *also* keep you alone in your own world. Have you noticed that you:

- 1) decide to let someone believe a partial truth?
- 2) tell people what **they** want to hear?
- 3) tell people what you **wish** were true?

**Concretize** - This “reminder” section is another attempt to list a menu of potential behaviors they may identify with. The three listed possibilities are quite common in people's experience, and will often bring chuckles of recognition. If possible, get examples of these in client's lives.

**Frame** - The main empathic thrust of this session is to help clients feel the loss inherent in the acts of isolation and lack of honesty. While they often perceive isolating as a relief, the degree to which they can start to resonate to this emotional loss, the easier it will be for them to identify the behavior when it occurs.

**Tip #1:** It is important to **ask for** and **take** help from others to successfully change our behaviors.

**Tip #2:** You belong in this group

**Tip #3:** You deserve help

We conclude the session with these straightforward statements that mirror the ARC elements. These particular statements are designed to simply and directly address the needs for relatedness (tips #'s 1-3) and competence (tips #'s 2-3). The statements also close the group in a supportive manner.

# GMI-20 SESSIONS

## #1 - A Hard Choice Finding Your Own Pace

For most people, entering treatment for an alcohol or other drug problem can be scary and confusing. This is to be expected, and it is important to be patient and give yourself time to adjust to the important step you have taken. This will be one of the biggest challenges you have ever faced. Walking through this door is step one.

Changing your use of alcohol or other drugs is a long-term process. There is a critical time in this process that you should be aware of, however, and that time is **now**, when you have just decided to come for treatment. This is a time when most people are feeling a variety of emotions, including pride about trying to help themselves, shame about their addiction, fear about what will come next, and uncertainty about whether they can handle all of this. In addition, this is also a time when your brain has been most recently exposed to the drug or alcohol you are attempting to give up.

The net effect? Evidence shows that this is the time when you are most likely **not to return to treatment**, despite your very good intentions. While we wish this weren't the case, it is a simple fact of addiction. At this very vulnerable and uncertain time, it can seem much easier to stay away from treatment and the process of changing "just a little bit longer". And in fact, **it is easier**. Why? Because getting intoxicated or high takes away the uncertainty and fear, at least for the moment. In a way, the choice to get high makes sense. None of us likes to feel afraid and uncertain, and facing painful feelings and situations is a real challenge.

The decision at this moment is of course yours and yours alone. What may be helpful to keep in mind, however, is that the desire to stay away, the desire to isolate, and such thoughts as "I am an especially shameful person", or "This isn't exactly the right treatment center for me", are all part of **the normal process of change**. Our experience shows that **every person has their own pace** for deciding to stop using and deciding to get help. Even more importantly, that pace for each person often changes from day to day and week to week, so that one day you are very eager to "change my life around", and the next day the whole idea seems a little too much.

This group and this treatment center will be here to help with these life changes today, tomorrow and next year. Hopefully, this group can be a place to begin the changes you decide are right for you. **We only encourage you to listen to your whole self, not just your fears, worries and uncertainties.**

Questions

- 1) What is difficult for you about coming to treatment?
- 2) What do you think treatment here has to offer you?
- 3) Can you tell when you've decided something at your own pace, instead of someone else's pace? How?

**Treatment awareness exercise:** As I sit here right now, am I having a hard time being here? Why? Am I bored, sleepy, scared, shy? Do I feel understood here?

Am I having a hard time speaking up? Am I having a hard time listening to others? Do I feel the need to talk a lot?

## #2 - Making A Decision About Using Looking at Consequences

The struggle with addiction often brings with it a sense of failure, feelings of shame, and a sense of being stigmatized or outcast. Because of this, it can be very difficult and painful to look at the state of our lives with open eyes. It is important, however, to begin to understand **why** we are here. While there are a variety of reasons that people come to treatment, there is a common link between everyone in this group, which is that the use of alcohol or other drugs has had a negative impact on our lives in some way. This fact, no matter how simple, can be difficult to accept.

In coming to grips with this fact, it is important to clearly examine the **specific** ways in which alcohol or other drugs have affected our lives. Usually, people are suffering the consequences of this use in their lives. Some of the effects of use have been external (e.g. job performance, family relations), while others have been internal (e.g. feelings of self-hatred and despair). Some of these effects have become apparent to ourselves and others, some we have managed to conceal.

No one knows you better than yourself. Whether a counselor, spouse, EAP, parent, parole officer or friend thinks you "have a problem with \_\_\_\_\_" (alcohol, cocaine, heroin etc), the only person that **really** matters in deciding that is you. A good way to decide for yourself is by honestly examining various parts of your life to see if they are going the way you want, and deciding whether alcohol/drugs is playing a part in that. Keep the question simple:

Does my use of alcohol/other drugs **help, hurt, or make no difference to:**

- |  |      |      |         |
|--|------|------|---------|
| a) my relationships with family/spouse | HELP | HURT | NO DIFF |
| b) my relationships with friends       | HELP | HURT | NO DIFF |
| c) my job (performance, relations etc) | HELP | HURT | NO DIFF |
| d) my health                           | HELP | HURT | NO DIFF |
| e) my legal status/risk                | HELP | HURT | NO DIFF |
| f) my finances                         | HELP | HURT | NO DIFF |
| g) how I feel each day/my mood         | HELP | HURT | NO DIFF |
| h) how much I like myself              | HELP | HURT | NO DIFF |
| i) other areas of my life              | HELP | HURT | NO DIFF |

## GMI Session #2

For those areas where you felt alcohol/drugs are **helpful** to your life, discuss **how** they are helpful specifically (“benefits” of use): \_\_\_\_\_  
\_\_\_\_\_

For those areas where you felt alcohol/drugs are **hurting** your life, discuss **how** they are hurting specifically (“costs” of use): \_\_\_\_\_  
\_\_\_\_\_

In figuring out how much your use bothers you, it can be helpful to place the costs and benefits you described above on an “Action Scale”(see next page). An Action Scale can help in “adding up” costs and benefits of any action or behavior in your life. In this case, the **action** is your use of alcohol or drugs. Place your costs and benefits on each side of this scale, and then give a “weight” to each item. Finally, add up each side of the scale.

Finally, the question is: “**Do the costs of my use outweigh the benefits**”? If not, then attempting to change this behavior of using may not be such a good idea for you at this time. If the costs of using **do** outweigh the benefits, then you are probably ready to seriously consider how to go about making changes that will benefit you. People on both sides of this equation can make use of this group; it is just important to know where you stand at the outset, so that you can set goals that make sense for **you**. Setting goals based on what someone else thinks should happen are often a setup for failure and disappointment, which most people in this group have had enough of.

### Questions

- 1) Are there differences between how you view your use and how others view it?
- 2) How do you handle those differences?

## GMI Session #2

*Life change/Recovery benefits:*

*Value of Benefit*

a) _____	_____
b) _____	_____
c) _____	_____
d) _____	_____
	Total benefit (add) _____

*Life change/Recovery costs:*

*Amount of cost*

a) _____	_____
b) _____	_____
c) _____	_____
d) _____	_____
	Total cost (add) _____



## #3 - A Road To Change Asking For Help

Everyone in this group has in common the use of alcohol and/or other drugs. What is unique about everyone here, however, is their own decision about whether that substance use is a problem, and whether it is worth changing. In trying to decide that, people usually think about several things: what **other** people think about their using, what **they** think about their own using, and what effect it is having on their life, if any. In earlier groups, some of you used "Action Scales" to help decide whether your use was something you saw as a significant problem. If you come to the conclusion that your use of alcohol or other drugs is a problem worth changing, then the next question becomes: "**How** can I change"? Specifically, today we will talk about **getting help from others** in dealing with your substance use, and the problems encountered in this early stage of the process.

### ***Predicting bumps in the road...***

Getting help from others can take many forms, including talking with family, friends, and religious leaders (priests, rabbis etc), or attending 12-step or self-help programs. Another "formal" way to ask others for help is to work with a professional treatment center such as the one you are sitting in now. All of these avenues are valid...all have their problems and pitfalls. We will focus in this group on the issues of being involved in formal treatment, especially those issues that may arise in the early stages of coming for help.

Reluctance to deal with formal treatment programs is common, and can be based on a number of things, including: 1) previous negative treatment experiences, 2) fears about what "treatment" is and possible bad experiences, and 3) mixed feelings about stopping or cutting down on drug or alcohol use. We will focus on what could happen **while you are in treatment** that would make you want to leave treatment.

At present, you have chosen to make the effort to show up here and ask for help...for that you deserve a lot of credit. To protect your effort, it is helpful to predict what obstacles may lie ahead for you. Most people will have some moments in treatment where they think: "I just don't want to deal with this - - - anymore"! Predicting those moments ahead of time can help you stay on the course you want. With the lists below, check off those things that **could** make you want to drop out of treatment:

***I keep using alcohol and/or drugs, and....***

- I worry about my counselor's reaction
- I worry about my group's reaction
- I feel too \_\_\_\_\_ (ashamed / guilty / disappointed /  
hopeless / something else....)
- other

***I don't feel the counselor.....***

- understands me
- respects me
- encourages me
- other

***I feel.....***

- afraid to speak in the group
- afraid to open up to others
- my business is my business
- other

***I don't like.....***

- the inconvenience of coming to treatment
- the cost of treatment
- being uncomfortable in a group
- other

For all the reasons people in this group listed above, coming to a treatment program can be a difficult choice to make and then stick with. As you can probably tell from hearing other group members concerns about treatment, most everyone has worries about what could happen. One of the main reasons it is so important to understand your concerns ahead of time, however, is to help you keep track of your initial reason for coming; that is, ***to help you change behaviors you feel are hurting you.*** If you get overwhelmed or derailed by the treatment process itself, then you are in danger of losing sight of this goal. *That* would be a real shame, because the last thing most people need in this very tough struggle is to once again feel defeated or demoralized. Protect yourself.

***What do I want to get out of it?...***

From our experience, having some ideas of what you want out of treatment can help avoid frustration, disappointment and dropout. Our last topic today is a discussion of what you can do to make treatment work for you. Based on how

you see your problems right now, think about the following questions:

- 1) What is it you want from treatment?
- 2) What will help you accomplish those goals in treatment?
- 3) What could get in your way?
- 4) Can you tell when you're moving at your own pace, instead of someone else's pace? How?

## #4 - Roadblocks to Getting Help Isolation and Honesty

For many people, dealing with their addiction becomes an isolated, lonely and vicious struggle. A common experience in this struggle is the repeated attempt to stop, to "make this the last time", and then finding yourself right back at it again the next day, week or year. This is discouraging and demoralizing, and often leads to a sense of failure, shame and self-loathing. In addition, there is a lot of misunderstanding about the addiction process, and a tremendous stigma attached to it. All of this can easily add up to a powerful sense of isolation and a cutting off from people in your life.

Another common feature of addiction is not being truthful. While this is not something people are proud of, it is an almost inevitable part of the addiction process. It is very hard to meet the demands of daily living (e.g. job responsibilities, family and social relationships) while at the same time meeting the demands of an addiction. Usually, something has to give. Often, one of the first things to go is the ability to be honest with others and with ourselves. For example, given the choice, most people would rather tell their boss that they were "out sick" rather than "crashing from yesterdays cocaine binge". Likewise, most people find it easier and less painful to tell themselves: "I'll be able to cut back on my use", rather than: "I thought I could stop two years ago and I still haven't".

The problem in not sticking with the truth is that it once again leaves you isolated and alone. Not only don't you get to talk about your *real* life and get some help with the actual problems, you are also left feeling separate and apart. This leaves you with two messages: 1) you are different and don't belong, and 2) no one *really* understands you.

And finally, all of this separateness, lack of being understood and isolation can add up to deciding to use. For in fact, one of the central truths of changing addictive behaviors is that it is very tough to do on your own. The degree to which you put up barriers to change (by isolating or not being truthful) is the degree to which it's just you and your addiction talking. While this "exclusive relationship" can be comforting, the conversation is nothing new. Treatment and change are your choice and for your benefit...let yourself have this if you feel ready.

### Questions

- 1) Have you not been honest about your alcohol/drug use for any of these reasons:
  - a) you are afraid others (or yourself) would be disappointed in you

- b) you are afraid others (or yourself) would think you are “weak”
- c) you are afraid of real world consequences (job, relationship loss, etc)
- d) you feel overwhelmed at the idea of trying to change
- e) you are afraid you **can't** change

2) Have you noticed feeling alone because of these fears?

3) Have you found yourself avoiding others who could be supportive of making these life changes?

4) What behaviors and thoughts can you identify that tell you when you are beginning to isolate?

5) What strategies can you use to help make the decision not to isolate?

6) Do you relate to the idea that "if I was stronger, I wouldn't need anyone's help with this anyway"?

Reminder: Partial truths *also* keep you alone in your own world. Have you noticed that you:

- 1) decide to let someone believe a partial truth?
- 2) tell people what you think **they** want to hear?
- 3) tell people what you **wish** were true?

**Tip #1:** It is important to **ask for** and **take** help from others to successfully change our behaviors.

**Tip #2:** You belong in this group

**Tip#3:** You deserve help

# Identifying Triggers

An important step in the process of changing your use of alcohol and/or other drugs is acknowledging that there is a problem and deciding that working on that problem is important. This in itself, however, is often not enough. In particular, the first days, weeks and months of change can be a stormy time. Your thoughts and feelings about yourself and your substance use can often seem jumbled and confusing. This can be a vulnerable time, one in which both your hopes of making changes in your substance use, as well as the danger of slipping back into old behavior are great. It is also a time when many people need all the help they can get to begin this process of change.

One important way to protect these new changes is to work at identifying what puts you in danger of returning to less healthy behaviors that you have decided to change. Those things that put your changes at risk are called “**triggers**”. Triggers can be thoughts, feelings, situations, people, objects, and your own behavior. What triggers all have in common is that they are associated for you with using alcohol/other drugs, or with old behaviors that you are trying to change.

There are two important types of triggers: 1) those that are produced by you (**internal**), and 2) those that are in the world around you (**external**). Depending on how well you have been able to identify triggers, and develop successful, alternative behaviors (other than using drugs/alcohol) when you encounter them, triggers can be relatively harmless or they can be quite dangerous. Research shows that in order to stick with the changes you have decided to make, most people find it easiest to avoid triggers as much as possible early in the change process

Listed below are specific examples of internal and external triggers. Some of these examples will apply to you, others will not. Use these lists as a starting point, by checking off those triggers that seem to apply to you personally. The easiest way to identify triggers that are most likely to be risky for you is to think about and describe situations, thoughts and feelings, people, etc. that are often present right before, during or after you use alcohol/drugs. Again, some of these examples will apply to you, others will not.

## **Internal Triggers**

Feelings:	angry	_____	ashamed	_____
	discouraged	_____	guilty	_____
	sad	_____	anxious	_____
	excited	_____	insecure	_____
	lonely	_____	jealous	_____
	happy	_____	bored	_____
	abandoned	_____	other	_____

Thoughts: "Now that I'm going to stop using, let me use one last time..." \_\_\_\_

"People around me were overreacting about my problem..." \_\_\_\_

"I think I can use a little and then stop..." \_\_\_\_

"Cocaine was my problem, alcohol is probably O.K..." \_\_\_\_

other \_\_\_\_\_

Behaviors:

social isolation	_____
acting impulsively	_____
not being truthful	_____
being unreliable	_____
getting overextended	_____
other	_____

**External Triggers ("People, Places and Things")**

People: my old drug supplier \_\_\_\_\_  
 people with whom I feel angry/  
 ashamed/excited etc. \_\_\_\_\_  
 my drinking/using buddies \_\_\_\_\_  
 other \_\_\_\_\_

Places: bars and clubs \_\_\_\_\_  
 my car \_\_\_\_\_  
 sports events \_\_\_\_\_  
 work/lunch time \_\_\_\_\_  
 newsstands/pornography \_\_\_\_\_  
 other \_\_\_\_\_

Situations/Things:  
 before/during/after sex \_\_\_\_\_  
 payday/checkday \_\_\_\_\_  
 when socializing \_\_\_\_\_  
 other \_\_\_\_\_

For each individual, the examples above may ring true, or need some modification to fit your circumstances and life. Whatever your internal and external triggers are, however, not planning ahead so you can alter or avoid them can result in slipping back into old behaviors. Unfortunately, that can be a very heavy price to pay for not identifying and keeping track of your own high-risk areas. It is not a price you have to pay if you put in the time and energy to protect yourself.

Thinking it through:...yes...this is a big job to take on. It will also be helpful over the coming days, weeks and months to keep track of those times when you feel like “throwing in the towel” because of this. Everyone has “down” and discouraged moments and days. At those times, it can help to try and think through your reasons for choosing to make a change in your life, see if those reasons still make sense to you, and remember that you’re not alone in this.

## What You Can Do

Here are several general ideas about dealing with triggers:

a) **Structure your time.** Structure in the new changes that you are making in your life. For example, get a daily planner and plan the day ahead hour by hour. For some this may mean coming up with new activities that will keep their minds and bodies busy all day. For others, this may mean cutting things out of a too-packed schedule that leaves no time for the changes you are trying to make in your life. Whatever it is for you, idle time, boredom and loneliness are powerful triggers for most people, and it is important to plan ways of dealing with these feelings in order to support the changes you are trying to make in your life.

b) **Develop a support network.** Sober family, friends and associates not only help prevent boredom and loneliness, they are also extremely important in achieving a healthier lifestyle. Without developing a life that includes new behaviors that are attractive, the pull of old behaviors is much stronger.

c) **Make a specific, detailed plan** of what you will do when you encounter various kinds of triggers.

Remember, these are only tools (“tricks of the trade”); it’s really your choice to use them or not. We can only offer our experience that using these tools will result in your feeling more confident in your ability to make and maintain the changes you’ve decided upon, whatever those changes may be.



# Home Handout for Session 5 Identifying Triggers

**#1** During the day, keep track of times when your thoughts drift to the idea of using alcohol/other drugs. Then, write down what the situation is and how you have been feeling just prior to this. This is the best way to start connecting your external and internal triggers to the start of a lapse to use.

DAY: \_\_\_\_\_ TIME: \_\_\_\_\_ PLACE: \_\_\_\_\_

OTHER PEOPLE PRESENT: \_\_\_\_\_

MOOD: (e.g.: Bored, Angry, Lonely, Happy, Sexy etc) \_\_\_\_\_

-----

DAY: \_\_\_\_\_ TIME: \_\_\_\_\_ PLACE: \_\_\_\_\_

OTHER PEOPLE PRESENT: \_\_\_\_\_ MOOD: \_\_\_\_\_

-----

DAY: \_\_\_\_\_ TIME: \_\_\_\_\_ PLACE: \_\_\_\_\_

OTHER PEOPLE PRESENT: \_\_\_\_\_ MOOD: \_\_\_\_\_

---

**#2** Think about the last several times you have tried to stop using, or have actually stopped. Jot down whatever you can remember about the external and internal triggers that may have contributed to you starting to use again in the hours, days and weeks before that lapse.

Most recent lapse -

When? \_\_\_\_\_ Approx. time sober before lapse: \_\_\_\_\_

Triggers to lapse 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Next most recent lapse -

When? \_\_\_\_\_ Approx. time sober before lapse: \_\_\_\_\_

Triggers to lapse 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

# External Triggers

## Triggers re-visited

Triggers are those people, situations, thoughts and feelings that you associate with your alcohol or other drug use. Just the sight/thought/smell/ sound of that trigger is often enough to start a physical and psychological reaction *as if you had the alcohol/drug in your hand*. Once this has occurred, actual use may not be far away. There are two types of triggers: **internal** (thoughts and emotions) and **external**. Today we'll discuss external triggers.

## External triggers

External triggers are those people, places or situations that remind you of using alcohol/drugs. Below are some common examples of external triggers. Again, put a check mark next to those that are associated with use for you.

## ***External Triggers (“People, Places and Things”)***

People: my old drug supplier	_____	
people with whom I feel angry/ ashamed/excited etc.	_____	_____
my drinking/using buddies	_____	_____
<i>other</i> _____	_____	_____
 Places: bars and clubs	_____	
my car	_____	_____
sports events	_____	_____
work/lunch time	_____	_____
newsstands/pornography	_____	_____
<i>other</i> _____	_____	_____
 Situations/Things:		
before/during/after sex	_____	_____
payday/checkday	_____	_____
when socializing	_____	_____
<i>other</i> _____	_____	_____

## Questions

- 1) Which of the triggers listed above are the hardest for you to avoid?
- 2) What strategies can you think of to avoid or alter these if they occur?
- 3) What external triggers are the most painful to think about avoiding?
- 4) What people, places or situations are not associated with using for you?

## What you can do

Currently you are beginning to make changes in your life that will promote a healthier lifestyle. At this point, a great solution for dealing with high-risk external triggers is to avoid them. This requires becoming familiar with what they are, and planning alternative actions.

Sometimes, however, this is not possible. For instance, you may live in a neighborhood where drugs/alcohol are highly visible or you may work in a situation where you must attend business functions where alcohol is served. Likewise, you may be in a situation where you are trying to make changes to develop a healthier lifestyle, and your significant other is not.

When in situations such as these, the first action to consider is to remove yourself from the environment. If you are unable to avoid these situations, it can be very helpful to start to learn “refusal skills”, that is, how to say “no” to offers of drugs/alcohol and mean it. The more quickly you can refuse an offer, the less likely you will be to slip into old behaviors. The more time you give yourself, the more room you leave for rationalization (“one beer might not be so bad”).

In summary: 1) remove yourself; 2) provide alternatives to yourself; and 3) learn “refusal skills” and other coping strategies

**Exercise #1 – Avoiding the Problem:** Think of a situation where you might be pressured to use/drink. Have other group members role-play people who might pressure you into this situation, and practice how you could handle the situation by working out a plan to **avoid** it. Be specific.

--- Can you imagine an avoidance strategy that would not work well? ---

**Exercise #2 – Coping with the Problem:** Think of a situation where you are likely to encounter a trigger involving other people. Be specific. Have other group members role-play people who might pressure you while you are in this situation, and practice how you could handle the situation by **coping** with it then.

--- Can you imagine a coping strategy that would not work well? ---

### Tools for Helping Myself Checklist

- |  |          |
|--|----------|
| 1) I have let others in my life know that I have a problem with alcohol and/or other drugs.  | YES / NO |
| 2) I am letting others in my life help me in ways that I choose. (How?)  | YES / NO |
| 3) I review my list of “triggers” daily, and add new items to the list as I realize them.  | YES / NO |
| 4) I have clear-cut plans (not just hopes) for how to deal with each and every one of the triggers I have listed. (What are they?) | YES / NO |
| 5) I have structured my time each day in such a way that:  |          |
| a) I avoid my identified triggers, or have support for when I have to deal with them   | YES / NO |
| b) I include activities that support the changes I wish to make each day   | YES / NO |

# Home Handout for Session 6

## Identifying External Triggers

**#1)** Below is the same list of people, places and situations we used in the group session. Please check off those that have been related to your use in the past. Feel free to add to the list. During the course of the next several days, keep this checklist with you. Use it to keep track of times when you encounter any of these people, places or situations, and **make a check mark** on the page next to that encounter. This is a great way to start noticing these external triggers.

External Triggers (**“People, Places and Things”**)

People: my old drug supplier                      /  /  /  /  /  /  /  /  /  /  /  

    people who make me angry/  
          ashamed/excited etc.                                   /  /  /  /  /  /  /  /  /  /  /  

    my drinking/using buddies                                   /  /  /  /  /  /  /  /  /  /  /  

    other people \_\_\_\_\_   /  /  /  /  /  /  /  /  /  /  /  

Places: bars and clubs   /  /  /  /  /  /  /  /  /  /  /  

    my car   /  /  /  /  /  /  /  /  /  /  /  

    sports events   /  /  /  /  /  /  /  /  /  /  /  

    work/lunch time   /  /  /  /  /  /  /  /  /  /  /  

    newsstands/pornography   /  /  /  /  /  /  /  /  /  /  /  

    other places \_\_\_\_\_   /  /  /  /  /  /  /  /  /  /  /  

Situations/Things:

    before/during/after sex   /  /  /  /  /  /  /  /  /  /  /  

    payday/checkday   /  /  /  /  /  /  /  /  /  /  /  

    when socializing   /  /  /  /  /  /  /  /  /  /  /  

    other situations \_\_\_\_\_   /  /  /  /  /  /  /  /  /  /  /  

**#2)** For any of the people/places/situations that occurred, notice whether it produced a desire to drink/get high. What did you do in response to that urge? What could you have done differently?

## Family and Significant Others

The use of alcohol and other drugs can affect many areas of our lives, including our relationships with our families. "Family" may mean something different to each person in this room. It can include a spouse, partner, friends, children, parents, etc. By the time many people arrive at the point of seeking treatment, they are often having a series of difficulties with these most important people in their lives. These problems are not only painful to deal with, but they also take time to work out while you are making changes in your own life.

Today we are going to begin to explore the relationship between drug and alcohol use and family relationships. It is helpful to examine how your family feels about your drug and/or alcohol use and your being in treatment. For example, family members may be drinking and using, which can have an impact on your own attempts to make changes in your life. Review the following list and check those items that apply to your family:

### My family:

- wants to think I don't use/ don't use much
- knows of my use, but does not speak about it
- tries to stop me from using
- gets angry and stops speaking with me
- uses/drinks as well
- does not know of my use
- does not see my use as a problem
- does not trust me
- is very involved in my life/treatment
- is not involved in my life because of my use

Family members may also have misconceptions concerning treatment and the changes you are making. For example, they may not understand why you want to go to meetings and treatment so regularly or so often. Family members may be anxious to discuss certain issues with you but hold off out of fear that you might slip into old behaviors. Often, there is a high degree of mistrust based on a history of dishonesty.

In addition, as you progress in making changes in your life, your family may not understand what you are experiencing or how difficult it may be for you. When treatment works well, people go through many powerful and personal changes that family members may be surprised by and may not understand. Sometimes family members may continue to react to you as though you were behaving in old ways because that is what they have learned to expect from you. It is important to understand that your relationships will change while you are trying to create a healthier lifestyle. This change process can be slow, and it requires attention, acknowledgement and *very often*, patience.

## Questions

- 1) How is your "family" reacting to your involvement in treatment?
- 2) Is it difficult for your family to trust you? How do you react to this?
- 3) How is your family helpful in your efforts to make more positive life changes?  
How are they not helpful?
- 4) What can you do to help the process of re-establishing trust?

Once you have answered the questions above, it is helpful to take some time to consider the benefits and costs of getting your family involved with changes you are trying to make in your life. You should know that the clinical and research evidence is very clear on this topic: in changing addictive behaviors and lifestyles, involving significant others in the process significantly increases the odds of doing well. Remember, however, that as always, these are "tools" to help you, and it is your choice whether or not to use them. These are also tools that need to be used at your own pace. We think that if you choose to use them, you'll begin to feel much more confident in your ability to change, and that your success at changing will be enhanced.

Sometimes families need help in understanding and adjusting to changes you are making. When this happens, you can help them by suggesting that your family/significant other speak to one of the family workers here at the program. You can then sign a release that will allow the family worker to contact your family member.

## Home Handout for Session 7 Family and Significant Others

Take some time to think about the role that you want your family or significant people in your life to have in your treatment and recovery.

**#1:** In what ways is your family supportive of your changes and recovery?

**#2:** In what ways is your family not supportive of or helpful in your changes and recovery?

**#3:** What role, if any, do you want your family to have in your treatment?

## Personal Consequences of Use

In coming to grips with the need for help with substances, it is important to clearly examine the specific ways in which alcohol and/or other drugs have affected your life. Some of these effects have been external (e.g. job performance, family relations), while others have been internal (e.g. feelings of self-hatred and despair). Some of these effects have become apparent to you and others, some have gone unrecognized or concealed.

### ***The Bad News...Negative Consequences of Use***

A helpful way to start this examination is to honestly assess various parts of your life to see if they are going the way you want. Next, consider whether alcohol and/or other drugs is playing a part in your life going that way. For many people, there have been dramatic *negative consequences* that are clearly connected to using. For others, the consequences are less clear. When you use, there can be effects in many areas of your life; in your relationships with your family, friends, co-workers, etc.; in your job/school performance; your legal status; your health and your finances. You also may experience internal consequences associated with your use; these might include feelings of shame or guilt, feelings of hopelessness, a lack of confidence etc.

What negative **external** consequences of use have you had?

- relationship problems
- employment problems
- legal problems
- health problems
- financial problems
- other \_\_\_\_\_

What negative **internal** consequences of use have you had?

- feelings of shame/guilt
- depression
- poor self-esteem
- hopelessness
- loneliness
- other \_\_\_\_\_

### ***The Bad News Part II...Positive Consequences of Use***

There is an aspect of substance use that is often overlooked: the *positive consequences* of using. This may sound strange, but you used substances for reasons, many of them very powerful reasons. For instance, using may have helped you feel socially popular. Many people find that when they're high, they are more outgoing, comfortable and social with others. They might be more able to take risks and try new things. When straight, they're more likely to feel awkward and shy. Some people use substances to alleviate feelings of depression, loneliness or boredom. In addition, substances are often used to



increase feelings of “sexiness” or to get past fears related to sex. Last, drinking or using is just plain pleasurable. All these reasons can make the decision to stop particularly difficult to stick with.

What positive **external** consequences of use did you/do you have?

- provided a group of “using buddies”
- provided an income (dealing)
- gave me a lifestyle/filled my time
- improved sexual performance
- made me more productive
- other \_\_\_\_\_

What positive **internal** consequences of use did you/do you have?

- increased feelings of arousal
- lifted my mood
- improved my self-esteem
- relaxed me socially
- made me feel less lonely
- other \_\_\_\_\_

*Breaking up is hard to do...*It is natural to feel concerned or upset about giving up some of these “positives”. At this early stage, it is also natural to wonder how these will be replaced, or *if* they will be replaced. We will discuss the issue of building new activities and lifestyles. However, it is important to acknowledge that with all the “negatives” using has created in your life, you are also giving up something important in your life when you choose to stop using. We suggest you give this some time to sink in, and then begin to put this back into the larger picture of what it is you want in your life.

**Questions**

- 1) During abstinence, have you noticed yourself remembering the positive aspects of your use more than the negative? Vice-versa?
- 2) Is it difficult to be honest with the group or others about these positive things you miss?
- 3) If you have had periods of abstinence in the past, have you tended to “blur” or forget the full picture of what your use was actually like for you?
- 4) Do you believe there are other ways to feel positively without using?
- 5) Are you worried about the loss of some of the “positives” discussed above?

There is a time-honored expression in the recovery community: “**KEEP IT GREEN**”. Regularly reviewing the whole picture of what your life is like when you are using is a great way to accomplish this.

# Home Handout for Session 8

## Avoiding Relapse Drift: Mooring Lines\*

### How it Happens

Relapse does not suddenly and unexpectedly occur. It does not happen without warning and it does not happen quickly. The gradual movement, however, can be subtle and so easily explained away (denied) that often a relapse feels like it happened suddenly. This gradual movement away from sobriety can be compared to a ship slowly drifting away from where it was moored. The drifting movement can be so slow that it is almost imperceptible.

### Interrupting the Process

In the course of regaining control over an addiction each person identifies certain behaviors that he/she knows work to maintain a drug-free lifestyle. These “mooring lines” need to be clearly spelled out in a very specific way so that they are visible and measurable. These are the ropes that hold the recovery in place and prevent the relapse drift from beginning without being noticed.

### Maintaining a Recovery

Use the Mooring Lines Recovery Chart to identify and monitor the behaviors that are holding your recovery in place. Follow these guidelines when filling out the form:

1. Identify 4 or 5 specific behaviors that are now sustaining your recovery (e.g. working out for 20 min., 3 times per week).
2. Include items such as exercise, therapist and group appointments, scheduling, self-help meetings, eating patterns, etc.
3. Do not list attitudes. They are not as easy to measure as behaviors.
4. Note specific people or places that are known triggers and need to be avoided during the recovery.

The checklist should be completed regularly (probably weekly). When two or more items cannot be checked, it is an indication that relapse drift is occurring. Sometimes circumstances interrupt your ability to maintain the mooring lines. Vacation, illnesses and holidays can contribute to the cessation of behaviors necessary to maintain sobriety. It is important to note that vulnerability to relapse is high during these times. Use the chart as an indicator of when you are more vulnerable to relapse and decide what specific responses you need to make when the chart indicates they are necessary.

## Mooring Lines Recovery Chart

During the process of achieving abstinence you have had to develop specific behaviors to support this change - behaviors that work for you in maintaining abstinence. It is all too easy under certain circumstances to drop more than one of these "mooring lines" (the lines that tie you to your recovery), thereby setting up the opportunity for your recovery to drift towards relapse. Charting the behaviors and checking occasionally to make sure the lines are secure can be very useful.

Use the chart below to list those activities and changes that are vital to your continuing recovery. If there are specific people or things you need to avoid, list those. Refer back to your list periodically to assure yourself you are not becoming vulnerable to relapse, or to giving up on these hard won changes.

<b>Mooring Lines To Maintain</b>	Date	Date	Date	Date	Date
1					
2					
3					
4					
5					
<b>Specifically to be avoided:</b>	Date	Date	Date	Date	Date
1					
2					
3					

\*Adapted from: Richard Rawson, Matrix Model Manual, Matrix Institute on Addictions, Los Angeles, CA.

## Internal Triggers: Sadness, Boredom and Shame

### Triggers re-visited

Triggers are those people, situations, thoughts and feelings that you associate with your alcohol or other drug use. Just the sight/thought/smell/sound of that trigger is often enough to start a physical and psychological reaction *as if you had the alcohol/drug in your hand*. Once this has occurred, actual use may not be far away. There are two major types of triggers: **external** (people, places and situations) and **internal**. Today we will be discussing internal triggers.

### Internal triggers: Sadness, Boredom and Shame

Internal triggers are those thoughts and feelings that occur within us that might lead to using. Thoughts and feelings often thrown together as if they were one category include 1) sadness/regrets, 2) loneliness/boredom/anxiety and 3) shame/humiliation. These are in fact three very different states that need to be understood and dealt with in different ways if you want to prevent these feelings from acting as internal triggers to relapse.

### Sadness/Feeling “blue”

It is normal to feel sad or down at times, particularly early in this change process (1-3 months). What is most helpful is to be **aware** of these feelings, because they can be powerful triggers for using. Many people are used to the frantic chaos created by their use, and have never slowed down enough to notice sadness or regret, believing the feelings were just caused by use. Taking the time to reflect on how you feel, especially if how you feel is not so good, can be painful and difficult. It can also be crucial to sustaining change. For many people, the ordeal of addiction has caused great pain and havoc to themselves and those close to them, and “digging out” of this chaos will naturally involve not only the hopefulness of change, but also the sadness and regrets of damage done and opportunities missed. Taking the time to recognize this and experience the pain and sadness of it can ultimately help move forward and unload some of this baggage. This is a difficult process, however, and should be done with the help and support of those around you, not on your own.

### Loneliness, Boredom and Anxiety

Another set of uncomfortable emotions often experienced are loneliness, boredom and anxiety. While sadness and regrets are a natural response to what we have been through, boredom/loneliness/anxiety can be a *natural response to change*. Starting a new lifestyle without the use of substances means changes in old ways of being, including leaving old, destructive relationships (e.g. “using buddies”), changes in activities (no more bar time after work or joints before bed), and developing new and unknown activities and relationships. While these are all necessary parts of recovery, they are also a recipe for feeling bored, lonely and anxious. Most important is to recognize these feelings and to understand that

they are a normal part of change and recovery. With this recognition, you can start to reduce these feelings and move forward.

### Shame and Humiliation: A Special Category

Because of what you have been through, it is often true that the damage done during the addiction process causes great shame or humiliation in recovery. This should not be confused with regrets and sadness, which are painful but reasonable responses to what has happened. Unlike those feelings, shame and humiliation are self-destructive responses that leave you no room to grow or move. Instead, they often lead to isolation, anger, and confusion over how to move forward. Feelings of shame are often accompanied by ideas like: "I really haven't suffered enough yet", or "The problem isn't addiction, I'm just a bad person", or "What did I ever do to deserve to be trusted by this group". Unlike sadness and regrets, dwelling on these thoughts and feelings leads nowhere fast (except to relapse). Experiencing the uncomfortability of sadness can lead *back to other people* and to positive connections; dwelling on your "badness" leads *away* from other people and into hiding. Learning to recognize the difference between these two types of emotions is critical.

### Exercises:

1) Identify a time recently when you have felt: a) sad, b) ashamed, and c) bored or lonely. What were your thoughts associated with those feelings. Where did those feelings lead you? Did you communicate those feelings to anyone?

2) There are certain common thought patterns often associated with handling emotions in a self-destructive way. Which ones do you identify with?

- Personalizing** - thinking situations revolve around you.
- Magnifying** - blowing negative events out of proportion
- Minimizing** - glossing over positive features and focusing on the negative
- Either/or thinking** - "either I'm a loser or a winner"
- Jumping to conclusions** - "I have a swollen gland. This must be cancer."
- Over-generalizing** - "I always fail"
- Self-blame** - blaming your self rather than behaviors that can be changed.
- Catastrophizing** - expecting the worst out of situations

3) What are some strategies you can use to manage the three types of emotions we have discussed (sadness/regrets, boredom/loneliness/anxiety, and shame)?

## Home Handout for Session 9

### Reflective Writing - A Means To Self-Awareness

One of the goals during this change process is learning to separate thoughts, behaviors, and emotions. Once awareness of each of these processes is gained, it is more possible to control what one thinks and how one behaves. In an effort to be less reactive to powerful new feelings, it is important to recognize and begin to try to understand “un-medicated” emotions. Many people find writing an effective tool for identifying and clarifying how they are feeling and why they are feeling that way. It is not necessary to be a good writer to use this tool. It is often used effectively by people who do not like to write and who have never written much in the past. Follow the simple instructions to accomplish the exercise:

1. Find a private, comfortable, quiet place and time specifically for writing and feeling.
2. Begin by taking several deep breaths and relaxing.
3. Write in response to a question you have asked yourself about your feelings. For example: “What am I feeling right now?”; “Why am I angry?”; “Why am I sad?”; “Is this shame or regret I’m feeling?” etc.
4. Allow the words to flow; forget spelling, punctuation or syntax.
5. If emotions surface, allow yourself to feel them before you continue writing.

Performing this exercise can help in starting to separate different types of emotions, which otherwise can all run together. In particular, it may help in separating differences between sadness/regrets vs. loneliness/boredom/anxiety vs. shame/humiliation. See if you can use this quiet time to reflect on your experience of these different states.

You may also find that starting to acknowledge emotions in this quiet time can reduce the amount of blaming of other people and circumstances that you might otherwise do. Last, identifying emotions of early recovery can also help in avoiding the “emotional building” process that often leads to relapse. New ideas for ways to make positive lifestyle change often follow increased self-awareness.

## Sex and Intimacy

For many people struggling with alcohol and other drug use, problems with sexuality are often part of the picture at some point. Although in the beginning alcohol or other drugs may have increased sexual confidence, sexual feelings and performance, this effect usually wears off in the later stages of use. Sexual problems at these later stages are different for different people. Some people were unable to have sexual relations due to their use, while others were unable to have sex without using.

After *stopping* using, many people continue to experience difficulties with sex as well as intimacy. While these problems may have felt like sexual problems during use, what often emerges after a period of sobriety from substances is a tremendous sense of vulnerability in being either sexually or emotionally intimate. For some, this results in anxiety, fearfulness and withdrawal, while others begin a pattern of more compulsive sex or relationship-making.

What may be helpful to understand is that these patterns and responses are normal reactions to a huge change in your life. For many people, using or getting high served a very specific function in the area of sex and intimacy: it reduced anxiety and allowed them to feel relaxed, brave, confident and sexual. For some, getting high was what it took to just plain be able to tolerate sex. When you make a decision to not use substances, you are also making a big change in the way you are sexual and intimate. *You are making a decision to be intimate with another person without a chemical chaperone.* At the very least, this is a big change...on the other hand, this can be terrifying to the point that you feel unable to tolerate this intimacy.

What to do? Making changes in your substance use is a long-term process, and is one that involves changes in many areas of your life, including your sex life. The 12 Step programs often suggest staying out of new relationships for the first year of this major life change. Why? Partly out of a healthy respect for how difficult and disruptive it can be to manage a new relationship in this new "skin".

Recovery can certainly involve establishing or re-establishing intimacy with the important people in your life. Recovery also can involve having a meaningful and satisfying sex life. What seems important at this moment in time, however, is to go at a pace you can deal with. In the area of relationships, however, getting a feel for this pace can be very difficult to do without some major upheavals. Relationships and sex can seem very alluring at this time. We strongly encourage you to walk rather than run in this area for now, and to trust that it will get better in time.

**Thinking it through:** Making lasting positive change is best accomplished when you can get emotional support in your life for these changes. This is not only a "nice" idea, but also one that is supported by research findings in this area. The trick can be to begin to understand for **yourself** and for **your life** what emotional support and closeness mean to you.

**Questions**

- 1) Since starting to make changes in your substance use, has your sex life been affected in any of the following ways?
  - (a) less interest in sex
  - (b) less satisfaction from sex
  - (c) less satisfaction for your partner (partner complaining)
  - (d) compulsive sexuality (have to have sex with either self or others)
  - (e) difficulties in physical performance (no orgasm, partial erection, lack of feeling?)
- 2) Are you frightened (worried) that sex will be difficult or not much fun without alcohol and other drugs?
- 3) Is there someone in your life with whom you can talk honestly about these issues?
- 4) What are your plans for sex during the next three months?
- 5) What are your plans for a relationship in the next three months?
- 6) Does getting emotionally intimate with another person seem frightening to you at this point? In what ways?
- 7) Are you able to "go at your own speed", both in emotional intimacy and sex?



## Home Handout for Session 10: Avoiding Relapse Drift: Mooring Lines\*

### How it Happens

Relapse does not suddenly and unexpectedly occur. It does not happen without warning and it does not happen quickly. The gradual movement, however, can be subtle and so easily explained away (denied) that often a relapse feels like it happened suddenly. This gradual movement away from sobriety can be compared to a ship slowly drifting away from where it was moored. The drifting movement can be so slow that it is almost imperceptible.

### Interrupting the Process

In the course of regaining control over an addiction each person identifies certain behaviors that he/she knows work to maintain a drug-free lifestyle. These “mooring lines” need to be clearly spelled out in a very specific way so that they are visible and measurable. These are the ropes that hold the recovery in place and prevent the relapse drift from beginning without being noticed.

### Maintaining a Recovery

Use the Mooring Lines Recovery Chart to identify and monitor the behaviors that are holding your recovery in place. Follow these guidelines when filling out the form:

1. Identify 4 or 5 specific behaviors that are now sustaining your recovery (e.g. working out for 20 min., 3 times per week).
2. Include items such as exercise, therapist and group appointments, scheduling, self-help meetings, eating patterns, etc.
3. Do not list attitudes. They are not as easy to measure as behaviors.
4. Note specific people or places that are known triggers and need to be avoided.

The checklist should be completed regularly (probably weekly). When two or more items cannot be checked, it is an indication that relapse drift is occurring. Sometimes circumstances interrupt your ability to maintain the mooring lines. Vacation, illnesses and holidays can contribute to the cessation of behaviors necessary to maintain sobriety. It is important to note that vulnerability to relapse is high during these times. Use the chart as an indicator of when you are more vulnerable to relapse and decide what specific responses you need to make when the chart indicates they are necessary.

## Mooring Lines Recovery Chart

During the process of achieving abstinence you have had to develop specific behaviors to support this change - behaviors that work for you in maintaining abstinence. It is all too easy under certain circumstances to drop more than one of these “mooring lines” (the lines that tie you to your recovery), thereby setting up the opportunity for your recovery to drift towards relapse. Charting the behaviors and checking occasionally to make sure the lines are secure can be very useful.

Use the chart below to list those activities and changes that are vital to your continuing recovery. If there are specific people or things you need to avoid, list those. Refer back to your list periodically to assure yourself you are not becoming vulnerable to relapse, or to giving up on these hard won changes.

<b>Mooring Lines To Maintain</b>	Date	Date	Date	Date	Date
1					
2					
3					
4					
5					
<b>Specifically to be avoided:</b>	Date	Date	Date	Date	Date
1					
2					
3					

\*Adapted from: Richard Rawson, Matrix Model Manual, Matrix Institute on Addictions, Los Angeles, CA.

# Internal Triggers: Anger

Triggers re-visited

Triggers are those people, situations, thoughts and feelings that you associate with your alcohol or other drug use. Just the sight/thought/smell/sound of that trigger is often enough to start a physical and psychological reaction *as if you had the alcohol/drug in our hand*. Once this has occurred, actual use may not be far away. There are two major types of triggers: **internal** (thoughts and emotions) and **external**. Today we'll discuss internal triggers.

Internal triggers

Internal triggers are those thoughts and feelings that occur within you that might lead to using. One internal trigger is feelings of anger. Below are some experiences that are associated with anger. Circle "Y" (YES) next to those that have commonly resulted in anger for you and "N" (NO) next to those that have not. Next, indicate whether this anger has led to use.

<u>Experience</u>	<u>Anger?</u>	<u>Use?</u>
My spouse/partner wants too much from me	Y / N	Y / N
My boss is a jerk/doesn't appreciate me	Y / N	Y / N
I missed my train	Y / N	Y / N
I feel ashamed of my use/relapse	Y / N	Y / N
No one really understands how difficult recovery is for me.	Y / N	Y / N
Other _____	Y / N	Y / N

It is normal to experience feelings of anger. However, it is important to consider changing what has become your automatic response to anger: using alcohol/ drugs. The first step toward that goal is to become aware of your anger and how it is associated with using. Once you are aware, then you can build strategies to deal with anger in an effective manner. Remember, the goal is not for you to never get angry; everyone gets angry at times. Instead, the goal is to learn how to manage your anger in a way that is not destructive to you.

Often, anger is a response that is familiar and comfortable. It sometimes is covering other feelings that are uncomfortable; feelings of sadness, shame, guilt

or hopelessness. Again, it is important to understand the relationship that anger has with your using. In particular, it is critical to begin to see how anger has been and is connected to drifting towards or causing a relapse. By making these connections, you will have taken an important step toward managing your anger and preventing it from endangering the changes you are making.

**Exercise:** Discuss how people or situations make you angry and how anger has led to using. Try to think of other ways you might have expressed your anger to avoid using.

**Role-play exercise:** One group member will enact a situation that has made them angry, which has ultimately led to using. Another member will play the recipient of the anger. Following this, two other members re-enact the scene attempting to use more effective means of dealing with the situation.

**Thinking it through:** When you notice a flare-up of anger, ask yourself the question: "Is it more important to me to prove I'm right/feel I'm right, or to protect my sobriety"?

# Home Handout for Session 11

## Internal Triggers: Anger

On this page, keep track of times between sessions when you feel anger at a person or situation. Note the circumstances, who or what is involved, and your behavior.

1a) Situation

1b) Who/what involved

1c) Response/behavior

---

2a) Situation

2b) Who/what involved

2c) Response/behavior

## Building a Recovery Environment

Using drugs and alcohol is often quite isolating. As part of the progression of using, you may become increasingly isolated from important people in your life, both in your social/work life and in your personal life. Another common result of use is that your social circle, if it exists at all, is made up largely of others who also use alcohol and other drugs. Early in the process of making changes, this can present a practical and emotionally difficult problem: associating with people who are using substances puts the changes that you are trying to make in danger; not associating with them can leave a large social and personal emptiness. In other words, if you stop associating with people who are using, and that leaves no one to spend time with, what do you do?

Another way to think about this is that when you are using, a lot of time and energy is spent in and around the whole *process* of using. This includes planning ahead and anticipating use, buying, using, crashing/being hung over, and finally, cleaning up the mess (including your relationships and responsibilities). Take this whole routine out of your life, and there is a large hole there. Often, by letting go of this lifestyle, you find yourself feeling alone and without a structure and support system. For some, this isolation can lead to anxiety, depression and boredom; for others, it might feel comfortable to be alone.

**Change usually works best with support.** Early on, many people find it difficult to know how to ask for help. In the moment, it can feel more comfortable to be alone than to reach out. The problem, however, is that being alone makes you more vulnerable to relapse. When you experience a trigger, it helps to be able to reach out to someone and get support in making it through that particularly tough minute, hour, or day.

### What you can do

There are many ways to develop a network that is supportive of the changes you are making in your life. Often, people begin to build their own support network through AA, NA or other support programs. For many, it is comforting to be around other people who are struggling with addiction at various stages, and who can share their experience and hope. Others become involved in spiritual or reflective activities, such as church or meditation. Many people try to re-establish family relationships or friendships that were damaged or lost due to their use. Some people involve themselves in activities that are positive; for instance, going to sober social functions, community activities, church activities, exercise, volunteer work, hobbies, etc.

**The hardest part is taking the first step.** Once you take a chance and make the initial effort, it becomes easier to try new things and new ways of being. You need to be ready to try several new things until you find activities and people with whom you feel comfortable. You should also expect to feel like a fish out of water in these new ventures for a while. This is normal with any new activity, but you can feel particularly vulnerable and uncomfortable when emerging from the protected world of alcohol and drug use. However, once you begin to establish a supportive network, coping with life

without substances does start to become easier.

## **Questions**

- 1) Do you have people who are supportive of the changes you are making? Who are they?
- 2) How do you ask for help? Do you find it difficult to ask?
- 3) What work have you done to establish sober supports?
- 4) What is most difficult for you so far in trying to establish new relationships and activities in your life?
- 5) Who are you afraid to approach for support? Why? What would help you approach them?
- 6) What positive activities have you thought about or begun to develop? What gets in the way of developing these?

# Home Handout for Session 12

## Behavioral Change Index\*

Name \_\_\_\_\_

Date \_\_\_\_\_

Choose the answer that would most closely and accurately describe your life during the past month.

1. During an average week I typically exercise:
  - a. Not at all.
  - b. 1-2 times per week.
  - c. 3-6 times per week.
  - d. Every day.
  
2. Most of the friends I see:
  - a. Are heavy alcohol and/or drug users.
  - b. Drink alcohol frequently and/or use drugs frequently.
  - c. Drink alcohol and/or use drugs occasionally.
  - d. don't drink or use.
  
3. Interactions with my family:
  - a. Usually involve serious arguing, or are so bad we don't communicate at all.
  - b. Are usually tense and uncomfortable.
  - c. Are generally positive, with occasional flare-ups.
  - d. Are positive and productive with open communication.
  
4. I am able to talk about problems in my life:
  - a. Never.
  - b. Only very infrequently.
  - c. With very select friends and a therapist.
  - d. With friends and family.
  
5. I use alcohol:
  - a. Daily.
  - b. 3-6 times per week.
  - c. 1-2 times per week.
  - d. Not at all.
  
6. My sex life is:
  - a. Terrible.
  - b. Not enjoyable and satisfactory most of the time.
  - c. Fairly enjoyable and satisfactory most of the time.
  - d. Very enjoyable and always satisfactory.



7. I eat a well-balanced meal:
  - a. Almost never.
  - b. 1-2 times per week.
  - c. 3-6 times per week.
  - d. Every day.
  
8. I engage in some healthy social-recreational activities, (e.g., movies, bowling, skiing, swimming, reading, etc.):
  - a. Never.
  - b. 1-2 times per week.
  - c. 3-6 times per week.
  - d. Every day.
  
9. I've taken a healthy, relaxing vacation:
  - a. Over 3 years ago.
  - b. 1-3 years ago.
  - c. In the past year.
  - d. In the past 3 months.
  
10. I pay my bills:
  - a. I've stopped paying them/I pay when they go to a collection agency.
  - b. Within ten days after the due date.
  - c. After the second notice.
  - d. Before the due date.
  
11. On weekend mornings:
  - a. I am usually still up using drugs/alcohol.
  - b. I'm occasionally still up using drugs/alcohol or experiencing the after effects of drug/alcohol use.
  - c. I'm occasionally hung over from alcohol.
  - d. I usually feel clearheaded and healthy.
  
12. I use pain medications, sleeping medications, and/or tranquilizers:
  - a. Daily.
  - b. 3-6 times per week.
  - c. 1-2 times per week.
  - d. Never.
  
13. I've missed or been late for work or other serious obligations (in the past month):
  - a. 4 or more times.
  - b. 2-3 times.
  - c. 1 time.
  - d. Never.

- 14. I've been involved in spiritual activities of some sort in the past month:
  - a. Never.
  - b. Once.
  - c. 2-3 times.
  - d. Weekly or more often.
  
- 15. I've read the newspaper, read a news magazine, or watched TV news during the past week:
  - a. Not at all.
  - b. About 1 time per week.
  - c. 2-3 times per week.
  - d. Almost every day.
  
- 16. My normal sleep pattern is:
  - a. Totally chaotic, no regular pattern, sleep when exhausted.
  - b. Irregular, long periods awake and binges of sleep.
  - c. Somewhat regular, 5-6 hours per night.
  - d. Regular, 7-8 hours per night.
  
- 17. I attend to the care and maintenance of my home/apartment:
  - a. Almost never.
  - b. Once per week.
  - c. Several times per week.
  - d. Every day.
  
- 18. In the last three months I have changed my residence/living situation:
  - a. 3 or more times.
  - b. 2 times.
  - c. Once.
  - d. Not at all.
  
- 19. I smoke marijuana:
  - a. Daily.
  - b. 3-6 times per week.
  - c. 1-2 times per week.
  - d. Not at all.

Scoring Key

a = 4   b = 3   c = 2   d = 1

Subject Score \_\_\_\_\_

Score 50-80 - Extreme involvement in dependence lifestyle behavior  
Score 40-49 - Significant involvement in dependence lifestyle behavior  
Score 30-39 - Moderate involvement in dependence lifestyle behavior  
Score 20-29 - Minimal involvement in dependence lifestyle behavior

\*Copyright, Richard Rawson, Matrix Model Manual, Matrix Institute on Addictions, Los Angeles, CA.

## Relapse Justifications

For most people, once they have decided to make an effort to stop using alcohol and other drugs, it becomes difficult to use these substances *simply because they feel like it*. The impulse to use runs into conflict with the decision you have made not to use in the rational part of your brain. With structure and assistance, the rational brain can win this struggle and you can avoid lapsing.

In our experience, however, the impulse to use does not go away that easily, and often generates a process called **relapse justification**. Relapse justification is a result of the rational part of your brain attempting to make sense of the very powerful messages it gets urging you to use. As you are pushed by these impulses toward use (through cravings and triggers), the rational brain attempts to provide a logical explanation to justify behaviors which will *allow you to use*. These justifications provide a momentary "logical" reason to use which would never hold up under closer inspection.

It is important to consider relapse justifications *before they occur*. A person moving closer and closer to alcohol/drug use *shuts out information* which could prevent a slip. So, at the earliest moment a justification is considered, it is important to recognize the justification and reject it. If you wait too long you may close off your mind to thoughts and information which could help you redirect thinking and behavior.

It is helpful to recall justifications which were most convincing to you in the past. Recognizing justifications and examining their true nature ahead of time gives you a big advantage when they enter your mind. The following list of relapse justifications is designed to help you identify those which were the most convincing in the past. Identify justifications which sound most familiar, and try to recall the circumstances in which they occurred. Remember, in the future, you may have to react quickly when a justification enters your mind.

### "Accidents" and Other People

These types of justifications suggest to you that you have very little choice in the matter, usually because another person is involved or a situation arises seemingly without warning. Examine each of the following justifications and consider alternative reactions to each, or what could have prevented the situation.

- 1) It was offered to me. What could I do?
- 2) An old (using) friend called and we decided to get together.
- 3) I was cleaning my house and found \_\_\_\_\_ I'd forgotten about.
- 4) I had friends for dinner and they unexpectedly brought \_\_\_\_\_.
- 5) I was in a bar and someone offered me some \_\_\_\_\_.

**Catastrophic Events**

Sometimes, one catastrophic event is reserved as the justification for relapse. In other words, nothing could possibly lead to a resumption of use except for this one unlikely catastrophic event or situation. Unfortunately, catastrophic events occasionally occur. Think about what type of event would be difficult for you to deal with. Think through the consequences of compounding this event with use.

- 1) **My spouse left me. There's no reason to stay clean.**
- 2) **I just got injured. It's ruined all of my plans. I might as well use.**
- 3) **I just lost my job. Why not ?**

**For a Specific Purpose**

These justifications center around the apparent usefulness of alcohol/drug use to accomplish some specific goal. Think about each one and consider other ways of accomplishing this goal. Consider the frequently counter-productive effect of relying upon alcohol/drugs to serve the purpose stated.

- 1) **I'm gaining weight and need \_\_\_\_\_ to control my weight.**
- 2) **I'm out of energy. I'll function better with a little \_\_\_\_\_.**
- 3) **\_\_\_\_\_ helps me to meet people.**
- 4) **I can't enjoy sex without \_\_\_\_\_.**

**Depression, Anger and Boredom**

These justifications suggest that use would be a sensible response to negative emotional states. Reflect on the ultimate consequences of using as a response to negative emotions. Consider each justification and try to identify situations where you are particularly susceptible to this type of justification. Last, think about a way of preventing or dealing differently with the situation which gave rise to the justification.

- 1) **I'm depressed. What difference does it make if I use or not?**
- 2) **Things can't get any worse. I might as well use.**
- 3) **I'm hopeless. I just can't deal with life. Why not use?**
- 4) **If he/she thinks I've used, I might as well use.**

**Not a Problem Anymore**

This category of justification may not have been significant prior to your decision to enter treatment. They are extremely dangerous, however, after a period of abstinence. If you have stopped use in the past, recall what happened after starting again. If this is your first period of abstinence, it is important to understand the likelihood of re-addiction. If you resume use, and be ready to reject justifications suggesting otherwise.

- 1) I'm back in control. I'll be able to stop when I want to.**
- 2) I've learned....I'll only use small amounts and only once in awhile.**

**Testing Yourself**

This set of justifications suggests that using again will not lead to re-addiction or that you merely want to see if you can handle certain situations. Remember, the justification appears to make sense for a moment. The real reason for using is to get the drug into your brain, and the result of this could well be loss of control and re-addiction.

- 1) I'm strong enough to be around \_\_\_\_\_ now.**
- 2) I just want to use "one more time."**
- 3) I want to see if I can say "no" to \_\_\_\_\_.**
- 4) I want to see if I can be around my old friends.**
- 5) I want to see how \_\_\_\_\_ feels now that I've stopped.**

**Celebration**

These justifications suggest that use is acceptable for special occasions or when things are going very well. Reflect on circumstances where you justified use in this way. What was the result of the "celebrating"? Did things keep going well after celebrating? Did it actually feel like celebrating?

- 1) I'm feeling really good. One time won't hurt.**
- 2) I'm doing so well. Things are going great. I owe myself a reward.**
- 3) This is special and extraordinary... it deserves a special reward.**

**Other Drugs and Alcohol**

These justifications suggest that other drug use is not a problem and can even be useful in controlling your "main drug". One of the shortest routes back to re-addiction to this "main drug" is by way of other drugs and alcohol. Reflect on the role of other drugs and alcohol in prior relapse episodes.

- 1) I'm having a craving for \_\_\_\_\_. A drink or a joint will calm me.**
- 2) My drinking and cocaine weren't related. It's O.K. for me to \_\_\_\_\_.**
- 3) My problem is with \_\_\_\_\_, not \_\_\_\_\_. Anyway, you can't give up everything.**

## Self Help Programs

For many people who have decided to come to treatment, the use of alcohol and other drugs has become a large and overwhelming part of their lives. Successfully making changes in this area involves not only "stopping", but also typically needs to include making other lifestyle changes. One of the most important of these can be getting support for a new lifestyle. This treatment center is a support when you are here, but is not realistically a support "24/7". Finding this type of ongoing support can be crucial, especially in this early phase of change. This session will explore some of the options that are available including the 12-Step programs, Women In Sobriety, Rational Recovery and SMART Recovery. These programs are not for everyone; however, it is helpful to understand what support systems may be helpful to ***you in particular*** to help you achieve your goals. As they say in the 12-Step programs, "take what you need...leave the rest".

12-Step Programs - An important part of many people's recovery outside of the formal treatment setting includes active involvement with the 12-Step programs.

Alcoholics Anonymous (AA) is the oldest and largest of these, which also include Narcotics Anonymous (NA), Cocaine Anonymous (CA), Sexual Compulsives Anonymous (SA), Gamblers Anonymous (GA) and others. The 12-Step programs are made up of people who have decided to try to stay sober. Meetings are free and held throughout the day and evening, seven days a week. The only stated "requirement" for attendance is the desire to stop drinking and/or using drugs. AA and other 12-Step programs can be found in the telephone directory, and most urban areas such as New York have a central Alcoholics Anonymous or "Intergroup" office which can provide meeting schedules and literature.

As the name states, anonymity is an important value in the 12-Step programs; membership is in no way discussed outside of the meetings, which are conducted on a first name basis only. Although the social stigma for alcohol/drug dependence, compulsive gambling etc has lessened somewhat in recent years, anonymity is essential in fostering an atmosphere of trust and openness. Trust and openness are also fostered through "home groups", or the group you decide to attend regularly. In this group you will see many of the same people over time, which can be important in feeling comfortable, at home and safe in sharing.

The foundation of the programs is the Twelve Steps and Twelve Traditions, which provide a framework for self-examination and for maintaining sobriety. Another important component of the fellowship experience is sponsorship. Sponsorship involves affiliating with another member who has been in recovery for a substantial period of time (usually > 1 year of sobriety). A sponsor provides guidance, education and support. Through their personal experience a sponsor can help a newcomer learn how to stay sober.

Women For Sobriety - is an organization that helps women who have problems with substances. Groups are for women only, are usually small (6-10 people) and last an hour and a half. They are often run by a moderator who is not a trained professional.

They are organized so that women will feel more comfortable addressing their concerns, concerns that they might not bring up in a mixed gender group.

SMART Recovery - is an abstinence-based program that emphasizes that people drink and use drugs as a means of coping. It is based on rational emotive therapy, which examines the way you think about your life and how these ideas or understandings about the world can lead to problems. Meetings also include "homeworks" where people set goals regarding what they want to do in the future to support the changes in their lives.

Rational Recovery - is a program that looks at a person's "addictive voice" and the thoughts and feelings that go along with using. They encourage the growth of more rational thoughts so that they will be more powerful over irrational cravings.

What you can do

While starting a new activity can be intimidating and frightening, especially in a social setting, the only way to decide which support group might be helpful is to go to some meetings. We strongly recommend that you give them a realistic chance. The best way to give this chance is to go to several different meetings, because they are all different, and people often have the experience of feeling much more comfortable in one meeting than in another. Again, it is important that you feel comfortable and safe, and it is also important to give it a chance to work for you. If you are reluctant to attend a group, you can go to a 12-Step meeting held on-site here at Smithers (see the list at the registration desk), or go to another meeting with someone from this group. Last, your groups here can be a place to discuss your experiences and "compare notes" with others.

Exercise

People can feel uncomfortable with the idea of support group meetings for a variety of reasons. Check those concerns you might have about meetings:

- "I can do it alone." "I am not one of those people who need meetings."
- "Meetings are for religious fanatics. AA is a cult"
- "I don't believe in that "higher power" stuff.
- "I have no time for meetings. My Smithers treatment is enough."
- "I went to one meeting and I really did not think it was for me."
- Other concerns: \_\_\_\_\_

Once you have read through this handout, it might be helpful to take some time to consider the benefits and costs of attending support groups, and developing clear plans for how to do this. Remember, these are all tools available to help you ***if you find them helpful***...it is your decision to use them or not. Our experience has been that many who do choose to use such support begin to feel more confident in their ability to change, and enhance their chances of success.

***One type of support group – The 12-Steps***

Thoughts and suggestions:

- ⇒ While each person's change process is personal and unique, many people need support outside of treatment to stay sober. Sobriety does not simply involve willpower. The 12-Step programs are often a place to get this support.
- ⇒ Involvement in 12-Step programs does not require you to deny other aspects of your life such as your family, work, etc.
- ⇒ 12-Step program attendance does not require religious belief. There may be some things about 12-Step programs that you do not like and other aspects of the meetings that you do like. Give it a chance.
- ⇒ It is important to think about how to make time for your recovery and for the support you need. In the past, a great deal of time was spent in drinking/using. Meetings can help you stay motivated and offer twenty-four hour support, which professional treatment programs like Smithers cannot do.
- ⇒ You cannot judge 12-Step programs by one meeting. No two groups are exactly alike. Shop around for ones that fit your temperament and meet your needs (including some that are all male or female). Only by attending several meetings will you discover if there is a right one for you.
- ⇒ **“Take what you need...leave the rest...”**



## Home Handout for Session 14: Avoiding Relapse Drift: Mooring Lines\*

### How it Happens

Relapse does not suddenly and unexpectedly occur. It does not happen without warning and it does not happen quickly. The gradual movement, however, can be subtle and so easily explained away (denied) that often a relapse feels like it happened suddenly. This gradual movement away from sobriety can be compared to a ship slowly drifting away from where it was moored. The drifting movement can be so slow that it is almost imperceptible.

### Interrupting the Process

In the course of regaining control over an addiction each person identifies certain behaviors that he/she knows work to maintain a drug-free lifestyle. These “mooring lines” need to be clearly spelled out in a very specific way so that they are visible and measurable. These are the ropes that hold the recovery in place and prevent the relapse drift from beginning without being noticed.

### Maintaining a Recovery

Use the Mooring Lines Recovery Chart to identify and monitor the behaviors that are holding your recovery in place. Follow these guidelines when filling out the form:

1. Identify 4 or 5 specific behaviors that are now sustaining your recovery (e.g. working out for 20 min., 3 times per week).
2. Include items such as exercise, therapist and group appointments, scheduling, self-help meetings, eating patterns, etc.
3. Do not list attitudes. They are not as easy to measure as behaviors.
4. Note specific people or places that are known triggers and need to be avoided.

The checklist should be completed regularly (probably weekly). When two or more items cannot be checked, it is an indication that relapse drift is occurring. Sometimes circumstances interrupt your ability to maintain the mooring lines. Vacation, illnesses and holidays can contribute to the cessation of behaviors necessary to maintain sobriety. It is important to note that vulnerability to relapse is high during these times. Use the chart as an indicator of when you are more vulnerable to relapse and decide what specific responses you need to make when the chart indicates they are necessary.

## Mooring Lines Recovery Chart

During the process of achieving abstinence you have had to develop specific behaviors to support this change - behaviors that work for you in maintaining abstinence. It is all too easy under certain circumstances to drop more than one of these "mooring lines" (the lines that tie you to your recovery), thereby setting up the opportunity for your recovery to drift towards relapse. Charting the behaviors and checking occasionally to make sure the lines are secure can be very useful.

Use the chart below to list those activities and changes that are vital to your continuing recovery. If there are specific people or things you need to avoid, list those. Refer back to your list periodically to assure yourself you are not becoming vulnerable to relapse, or to giving up on these hard won changes.

<b>Mooring Lines To Maintain</b>	Date	Date	Date	Date	Date
1					
2					
3					
4					
5					
<b>Specifically to be avoided:</b>	Date	Date	Date	Date	Date
1					
2					
3					

\*Adapted from: Richard Rawson, Matrix Model Manual, Matrix Institute on Addictions, Los Angeles, CA.

## Cravings and Urges

In the early stages of stopping substance use, many people experience a strong desire to use their substance(s) of choice. This desire can be fleeting, lasting moments or minutes, or can last for hours. It may be a response to many things, including remembering your last use of substances with pleasure, or feeling “down” or bad and wanting to shift your mood.

A common term for this strong desire to use is “craving”, and can include not just wanting to use, but also experiencing physical sensations associated with using, such as a tight stomach, sweating and giddiness. While this is common in the early stages of change, episodes of craving may also persist for weeks, months, and sometimes even years after last use. Craving does not mean something is wrong...in fact it may mean something is right! You're not using! You can expect craving to occur from time to time...the issue really is: are you prepared to cope with it when it occurs.

As we have said, most people's experience of craving and urges is that they are time-limited. That is, they usually last only a few minutes and at most a few hours. Rather than increasing steadily until they become unbearable, *they usually peak after a few minutes* and then die down, like a wave. *At the time they are occurring, this can be an incredibly helpful fact to remember.* Urges will become less frequent and less intense as you learn how to cope with them.

### What you can do

***An ounce of prevention...*** The most effective way to deal with cravings and urges is to try to prevent them in the first place. This can be done by *reducing your exposure to triggers*. What does “reducing your exposure” mean? Well, it means ***not coming into contact*** with those thoughts, feelings, situations, people etc. that you have already identified as “triggers “ for you. This could include taking actions like getting rid of alcohol/drugs in the house, not going to parties or bars, reducing contact with friends who drink or drug, not allowing yourself to sink into isolation and depression, and so forth. Ultimately, planning ahead is the key in this strategy.

***A pound of coping...*** At times, situations that trigger craving cannot be avoided or planned for, and it is necessary to find a way to cope with the craving/urge itself. Many people try to cope with urges to use by gritting their teeth and toughing it out, also known as “white-knuckling it”. While this is generally a bad idea (because it doesn't work well), it is a particularly bad idea when the cravings are too strong to ignore for long. Here, many people fall prey to the incorrect idea that not using is a matter of strength: the stronger they are, the better they'll do. NOT TRUE! What HAS been shown over and over is that if the only thing between you and using is whether you can will yourself to stay in the house, you will probably end up using.

So...how to cope with cravings once begun? There are many different strategies. What is important to realize is that the changes you are making involve a learning process, in which you need to learn about and develop behaviors other than the ones you know well; that is, drinking or using other drugs. How simple it is to respond to an urge to use BY USING! It is a known path, tried and true, that you don't even have to think about to do. Drinking and using other drugs is a well-learned behavior, but one that must now be unlearned if anything is to truly change. To do so, you must have new possibilities in place.

Listed below are examples of activities that people engage in to deal with cravings once they have occurred. Promptly engaging in an activity as a way to deal with a craving is known as a “distraction” technique, and can be extremely effective *if you use it* (ahhh, those pesky personal choices again...)

Going to a movie	Exercising	Jogging/walking
Lifting weights	Aerobics	Biking
Reading	Eating	Smoking
Talking about it with someone		
Other _____		

Some of the examples listed may apply to you, or you may use other things to distract you when you are having a craving. What is most important is to plan ahead of time how you will respond to an episode of craving and develop strategies to deal with it. This will go a long way toward not automatically reaching for a drug or drink (the old learned behavior) when you have a craving.

**Suggestion: Don't be strong...be smart!**

**Questions**

- 1) Which of the above activities do you think would be helpful in dealing with a craving episode?
- 2) What other activities would be helpful for you when you have a craving?
- 3) What would get in your way from using one of these activities at the time you are having a craving? For example, people often think they will “call someone” at that time, but then “don't happen to have the number with them”, or “couldn't reach anyone” at that time.

**You will have urges to use or drink: *planning ahead* is what you can do about it now...**

## So...Why Don't I Feel Any Better?

For many people, the decision to stop using was a mixture of getting sick of the negatives of using, and wanting something better out of day-to-day life. And in fact, when you initially stop using, there is often an immediate improvement in how you feel, look and act. But buyer beware! For many, there is also an expectation by both themselves and those around them that all of life will improve, and that things will keep getting better and better. Many people are surprised when difficulties remain in parts of their lives. It is important to understand that changing old, entrenched behavior is a complicated process, with both positive and negative aspects. In this session, we will review the positive and negative results of the changes you are making.

Some of you might be making these changes for the first time while others have had previous experience. These types of changes in life, behavior, attitude, and self-image take work and may feel difficult at times; the process, however, does not have to be frightening or intimidating.

**(For those with prior periods of abstinence):**

- 1) What are some of the difficulties you encountered in your day-to-day life while abstinent?
- 2) What positive things did you experience in your prior abstinence?

**(For those new to abstinence):**

- 3) What positive and what negative experiences do you anticipate in being abstinent? (e.g. in your behavior, emotions, lifestyle etc.)

It is important to discuss the questions above openly. The group can help in "comparing notes" about the expectations and the reality of the changes you are making. Try to benefit from the experience of the group about expecting too much or too little of the new life you are fighting to put in place. Having too dismal **or** too rosy a picture of "your new life" life can lead to disappointment, anger and relapse. It can be very helpful to catch this process before it gets the best of you. Below is a list of some areas in which people's expectations of their new life don't jive with the reality of that life. See if any apply, and create a list for yourself.

- \_\_\_\_\_ I feel depressed when I expected to feel good.
- \_\_\_\_\_ I feel more confused about my future rather than less confused.
- \_\_\_\_\_ I have more tension in my relationship(s) rather than less.
- \_\_\_\_\_ People are expecting too much of me too fast.
- \_\_\_\_\_ Sex is worse/non-existent rather than better
- \_\_\_\_\_ other \_\_\_\_\_

These discrepancies between expectations and reality can be overwhelming, and can trigger use. As usual, the first step in preventing that trigger is to be aware of it. Starting to come to grips with the reality of your new life and comparing notes with others will help you live with this initial stage of change.

## Home Handout for Session 16: Weighing the Decision

In Session #\_\_, we discussed the idea that both deciding to come for treatment and deciding to make life changes are choices you make, with costs and benefits to each. These costs and benefits may change over time and need to be re-evaluated to keep this decision fresh and real for you. Take the time to do that re-evaluation now.

- 1) For both your decision to come to treatment and your decision to try recovery, briefly list the benefits and costs of these to you at present:

*Treatment benefits:*

a) \_\_\_\_\_

b) \_\_\_\_\_

c) \_\_\_\_\_

d) \_\_\_\_\_

*Treatment costs:*

a) \_\_\_\_\_

b) \_\_\_\_\_

c) \_\_\_\_\_

d) \_\_\_\_\_

*Life change/Recovery benefits:*

a) \_\_\_\_\_

b) \_\_\_\_\_

c) \_\_\_\_\_

d) \_\_\_\_\_

*Life change/Recovery costs:*

a) \_\_\_\_\_

b) \_\_\_\_\_

c) \_\_\_\_\_

d) \_\_\_\_\_

## Making Conscious Decisions

*Steve had been sober for about three months after using cocaine and alcohol for four years. One evening he came to group and stated that he had used. When asked about his use, he said "it caught me by surprise...I went out with friends and ended up picking up". Steve recounted the following: A good friend invited him to go gambling in Atlantic City. Steve felt that gambling had not been a problem for him and that he could go on this trip. Other friends were joining them as well, including a former love relationship which had ended with a great deal of conflict and fighting. On the way to Atlantic City, things felt tense between Steve and this woman. As the group went down to gamble, Steve stayed away from the bar, although others were drinking around him. Eventually, however, Steve felt so tense with his social group that he "found himself over at the bar". At first Steve ordered a club soda, but a friend (former drinking buddy) joined him and invited him to "drink one for old times sake". After what turned into several beers, the friend suggested that they go up to his room because he had some cocaine with him. Steve agreed.*

Many of the ordinary, mundane choices that are made every day seem to have nothing at all to do with using alcohol and other drugs. Although they may not involve making a direct choice about whether to use/drink, they may move you one small step closer to returning to these old behaviors. Through a series of minor decisions, you may gradually work your way closer to the point where drinking/using becomes very likely.

People often see themselves as passive when it comes to relapse: "Things just seemed to happen in such a way that I ended up in a high-risk situation and then used – it took me by surprise". What often goes unrecognized is that perhaps dozens of little decisions brought them closer and closer to their eventual use. Because so many choices don't seem to involve drinking/using at the time, it can be difficult to recognize the connection between current behaviors and thoughts, and the role they play in leading toward use.

### **What to do**

Your drug or alcohol use does not start at the point you pick up the drink or drug. Instead there are events that lead up to using. It is helpful when you are beginning to make changes to think through every choice you have to make, no matter how irrelevant it may seem to drinking/using. By thinking ahead about each possible option you have and where each of them may lead, you can anticipate dangers that may lie along certain paths. These are dangers that you may wish to avoid. It may feel awkward at first to have to think about every decision, but after a while it becomes second nature and happens automatically without much effort.

By paying attention to your decision making process, you will have a greater chance to interrupt the chain of decisions that could lead to a return to old behaviors. This is important, because it is much easier to stop the process early, before you wind up in a high-risk situation that you had wanted to avoid, rather than later when you are in a situation that is harder to handle.

**Eyes open**... Awareness of your internal and external world is a powerful tool in maintaining change...keeping your eyes on the road you have chosen will help protect you from many accidents...YOU are worth protecting !!!

### **Exercise**

Discuss how you are dealing with/planning to deal with the following situations which could typically serve as triggers:

- 1) whether to keep liquor in the house for guests
- 2) whether to go to bars to see old drinking friends or to certain areas where you used to buy or use drugs
- 3) whether to go to a party where people might be are using/drinking
- 4) what route to use when driving or when going home (i.e., do you pass an area where you would buy drugs or a liquor store)
- 5) making (or not making) plans for the weekend
- 6) whether to tell people about your recovery or keep it a secret
- 7) whether to start conversations at AA/NA meetings
- 8) planning how to spend your free time after work
- 9) whether to throw away your drug-using paraphernalia

### **Questions**

- 1) Have you ever lapsed or relapsed and felt it happened "out of the blue"?
- 2) What are some early warning signs for you of lapse?
- 3) What have you done in the past or currently that has worked to protect you from slipping toward old behaviors?



## Home Handout for Session 17: Avoiding Relapse Drift: Mooring Lines\*

### How it Happens

Relapse does not suddenly and unexpectedly occur. It does not happen without warning and it does not happen quickly. The gradual movement, however, can be subtle and so easily explained away (denied) that often a relapse feels like it happened suddenly. This gradual movement away from sobriety can be compared to a ship slowly drifting away from where it was moored. The drifting movement can be so slow that it is almost imperceptible.

### Interrupting the Process

In the course of regaining control over an addiction each person identifies certain behaviors that he/she knows work to maintain a drug-free lifestyle. These “mooring lines” need to be clearly spelled out in a very specific way so that they are visible and measurable. These are the ropes that hold the recovery in place and prevent the relapse drift from beginning without being noticed.

### Maintaining a Recovery

Use the Mooring Lines Recovery Chart to identify and monitor the behaviors that are holding your recovery in place. Follow these guidelines when filling out the form:

1. Identify 4 or 5 specific behaviors that are now sustaining your recovery (e.g. working out for 20 min., 3 times per week).
2. Include items such as exercise, therapist and group appointments, scheduling, self-help meetings, eating patterns, etc.
3. Do not list attitudes. They are not as easy to measure as behaviors.
4. Note specific people or places that are known triggers and need to be avoided.

The checklist should be completed regularly (probably weekly). When two or more items cannot be checked, it is an indication that relapse drift is occurring. Sometimes circumstances interrupt your ability to maintain the mooring lines. Vacation, illnesses and holidays can contribute to the cessation of behaviors necessary to maintain sobriety. It is important to note that vulnerability to relapse is high during these times. Use the chart as an indicator of when you are more vulnerable to relapse and decide what specific responses you need to make when the chart indicates they are necessary.

## Mooring Lines Recovery Chart

During the process of achieving abstinence you have had to develop specific behaviors to support this change - behaviors that work for you in maintaining abstinence. It is all too easy under certain circumstances to drop more than one of these “mooring lines” (the lines that tie you to your recovery), thereby setting up the opportunity for your recovery to drift towards relapse. Charting the behaviors and checking occasionally to make sure the lines are secure can be very useful.

Use the chart below to list those activities and changes that are vital to your continuing recovery. If there are specific people or things you need to avoid, list those. Refer back to your list periodically to assure yourself you are not becoming vulnerable to relapse, or to giving up on these hard won changes.

<b>Mooring Lines To Maintain</b>	Date	Date	Date	Date	Date
1					
2					
3					
4					
5					
<b>Specifically to be avoided:</b>	Date	Date	Date	Date	Date
1					
2					
3					

\*Adapted from: Richard Rawson, Matrix Model Manual, Matrix Institute on Addictions, Los Angeles, CA.

## Problem Solving

People often find themselves confronted by new or difficult situations. A situation becomes a problem if the person has no effective coping response available to handle it. As you begin to make changes in your life, you may encounter the following types of problems:

- a) being in situations where drinking and drug use has occurred in the past
- b) being in situations that feel particularly difficult after you have stopped drinking or using drugs (i.e. social pressure, cravings).
- c) difficulty in developing activities that may be useful to maintain the changes you are making (e.g. new recreational habits).

Effective coping requires recognizing that you face a problem, and coming up with an alternative to dealing with it that does not include either responding “on impulse” or “doing nothing.” Coming up with an effective solution requires that you pause to assess the situation, so that you can decide which actions will be in your best interest.

Sometimes the problem situation may involve wanting to drink or use; at other times, it may be unrelated to substance use. In either case, your tendency may be to act impulsively to find a quick and easy solution. If you don't find a good solution, then the problem can build up over time, and the pressure may eventually get to you and trigger drinking/using. Effective problem solving strategies must therefore be a part of the overall change process, since the occurrence of problems can easily set the stage for a return to use.

### Problem recognition

The first step is to recognize that a problem exists. You can get clues that a problem exists in several ways.

- a) Clues you get from your body (indigestion, craving, sweaty palms, etc.).
- b) Clues you get from your thoughts and feelings (anxiety, depression, loneliness, fear, etc.).
- c) Clues you get from your behavior (overworking, being erratic, etc).
- d) Clues you get from noticing the way you react to other people (anger, lack of interest, withdrawal, etc.).
- e) Clues others give you (avoidance, criticism, or anger with you).

### Identify the problem

What is the problem? Now that you have recognized that something's wrong, try to identify the problem as precisely as possible. Gather as much information and as many facts as you can to help clarify the problem. Be concrete, and define the problem in terms of behavior whenever possible. Try to break it down into parts; you may find it easier to manage several small parts rather than confront the entire problem all at once.

For instance, your cousin is getting married this weekend. When you really think it through, this is a dangerous situation for you if you plan to remain abstinent. How to solve this?

## **Consider various approaches**

It is important to develop a number of solutions to a given problem, because the first one may not be the best. The following methods will help you to identify several approaches that might be useful in solving a problem, so that you will be more likely to settle on a good solution and implement it effectively.

### ➤ *Brainstorming*

Get all your ideas out into the open so you can decide how well they solve your problem without rejecting any of them too hastily. It is helpful to write them down, so that they can be reviewed when deciding which one to try. Remember, the more ideas the better.

### ➤ **Consider your behaviors and thoughts**

When a problem involves conflict with other people, it is often helpful to act, such as by speaking up in an assertive manner. Negative emotional reactions to events may be best handled by examining the way you think about the situation. This may reduce your negative emotional reaction without having to change a situation that may be beyond your control. In some situations, looking at both your *behaviors* and *thoughts* may be necessary to deal effectively with the problem.

### ➤ *Select the most promising approach*

Think ahead. Identify the most probable outcomes for each approach; be sure to include both positive and negative outcomes, both long and short-term consequences. Arrange all the potential solutions according to their consequences and their desirability. The solution that maximizes positive consequences and minimizes negative ones is the one to try first.

### *Implement your Solution*

Assess how your solution is working. Remember that the solution may not be immediate; you may have to keep working at it. Evaluate the strengths and weaknesses of your plan as you proceed by asking yourself: “What difficulties am I encountering? Am I getting the results I expected? Can I do something to make this more effective?” If the plan doesn’t seem to be helping after you give it a fair chance, move to another solution and follow the same procedure.

**Reminder:** A build-up of frustration can lead to your using. Understanding that problems take time to solve can help reduce the frustration. Stay with it!

### Exercise:

#### ***1. What sort of problems have you encountered since you’ve been in treatment?***

2. Choose a problem and go through this process step-by-step in order to see how you might handle the problem.

- a. How did you recognize the problem?
- b. Did you consider various solutions? What were they? If you did not, are there other solutions you might have considered?

- c. Did the solutions include behavioral and cognitive strategies?
- d. How effective was the solution?

3. Are there problems that seem unmanageable in this way?

4. Can the group help solve them?

## Refusing Substances

In the early stages of trying to make changes in your use of alcohol and other drugs, a very common situation is to be offered a drink or drug by others. Being able to turn this “opportunity” down can require more than a sincere decision to stop using. It requires specific *refusal skills* to act on that decision.

The social use of alcohol/drugs is very common in day-to-day life, and it is likely that you will encounter such a situation at some point. Even the person who avoids old “using buddies”, bars, neighborhoods, etc. will still find himself/herself in situations where others are using or making plans to use. For example, family gatherings, neighborhood functions, and work functions are a few situations where substances might be present. Some people may innocently offer substances because they are unaware of your history and your efforts. An offer to use may be a one-time casual offer or it may involve repetitious urgings and pressure. Different situations will be more difficult for different people.

### What to do

Practicing assertiveness or *refusal skills* will help you to respond more quickly and more effectively when these types of situations arise. There are many types of assertive responses to an invitation to use, depending on who is offering and how the offer is made. Sometimes a simple, “No, thanks anyway” will suffice. At other times, additional strategies will be necessary. In some cases, telling the other person about the changes you are trying to make will be useful in eliciting support; at other times, it will be unnecessary to share that information. Below are some suggestions based on other’s experiences.

- 1) When refusing an offer to use, “**No**” should be the first word you say. It cuts off the person offering substances; when you hesitate to say no, people may wonder whether you really mean it. In addition, it is important to be assertive through your body language: keep your head up, your face forward and *make eye contact* while you are making these statements.
- 2) If the person is repeatedly pressuring you, ask him/her to **stop offering**. For example, if the person suggests that you should use with him/her in the name of friendship, an effective response would be, “if you want to be my friend, then don’t offer me a drink/drug.”
- 3) Avoid using excuses (“I’m on medication for a cold right now”), and open-ended answers (“no thanks, not right now”). Both of these imply that you might use at a later date, thus setting yourself up to be in the same situation with that person in the future.
- 4) When refusing a drink/drug offer, **don’t feel guilty**; remember, you aren’t hurting anyone by not using; you have the right to say no.
- 5) Be aware that these experiences of being offered alcohol or other drugs and turning them down can be upsetting. This is because part of the natural response is to also want to say “**yes**”. This is normal, and doesn’t mean you’re slipping closer to use or that you should actually use. It’s hard to say “no” to a substance you’re used to saying “yes” to. Practice helps, and giving yourself a pat on the back each time you do is also important. You truly deserve the credit.
- 6) Because these experiences can be upsetting, stay aware of your reactions after the experience. You may need some support after these events.

## **Exercise**

- 1) Have you received any offers or pressure to use recently? If so, in what kinds of situations/from who?
- 2) Have you successfully turned down offers of alcohol or other drugs recently? How were you able to accomplish this?
- 3) What "offer" situation can you imagine that could be particularly difficult for you?
- 4) What strategies (including the ones noted above) might you use in dealing with offers to use or to drink?

# Home Handout for Session 19: Behavioral Change Index\*

Name \_\_\_\_\_ Date \_\_\_\_\_

Choose the answer that would most closely and accurately describe your life during the past month.

1. During an average week I typically exercise:
  - a. Not at all.
  - b. 1-2 times per week.
  - c. 3-6 times per week.
  - d. Every day.
  
2. Most of the friends I see:
  - a. Are heavy alcohol and/or drug users.
  - b. Drink alcohol frequently and/or use drugs frequently.
  - c. Drink alcohol and/or use drugs occasionally.
  - d. Don't drink or use.
  
3. Interactions with my family:
  - a. Usually involve serious arguing, or are so bad we don't communicate at all.
  - b. Are usually tense and uncomfortable.
  - c. Are generally positive, with occasional flare-ups.
  - d. Are positive and productive with open communication.
  
4. I am able to talk about problems in my life:
  - a. Never.
  - b. Only very infrequently.
  - c. With very select friends and a therapist/group.
  - d. With friends and family.
  
5. I use alcohol:
  - a. Daily.
  - b. 3-6 times per week.
  - c. 1-2 times per week.
  - d. Not at all.
  
6. My sex life is:
  - a. Terrible.
  - b. Not enjoyable or satisfactory most of the time.
  - c. Fairly enjoyable and satisfactory most of the time.
  - d. Very enjoyable and satisfactory.
  
7. I eat a well-balanced meal:
  - a. Almost never.
  - b. 1-2 times per week.
  - c. 3-6 times per week.
  - d. Every day.

8. I engage in some healthy social-recreational activities, (e.g., movies, bowling, skiing, swimming, reading, etc.):
  - a. Never.
  - b. 1-2 times per week.
  - c. 3-6 times per week.
  - d. Every day.
  
9. I've taken a healthy, relaxing vacation, or time away for myself:
  - a. Over 3 years ago.
  - b. 1-3 years ago.
  - c. In the past year.
  - d. In the past 3 months.
  
10. I pay my bills:
  - a. I've stopped paying them/I pay when they go to a collection agency.
  - b. After the second notice.
  - c. Within ten days after the due date.
  - d. Before the due date.
  
11. On weekend mornings:
  - a. I am usually still up using drugs/alcohol.
  - b. I'm occasionally still up using drugs/alcohol or experiencing the after effects of drug/alcohol use.
  - c. I'm occasionally hung over from alcohol.
  - d. I usually feel clearheaded and healthy.
  
12. I use pain medications, sleeping medications, and/or tranquilizers:
  - a. Daily.
  - b. 3-6 times per week.
  - c. 1-2 times per week.
  - d. Never.
  
13. I've missed or been late for work or other serious obligations (in the past month):
  - a. 4 or more times.
  - b. 2-3 times.
  - c. 1 time.
  - d. Never.
  
14. I've been involved in spiritual activities of some sort in the past month:
  - a. Never.
  - b. Once.
  - c. 2-3 times.
  - d. Weekly or more often.
  
15. I've read the newspaper, read a news magazine, or watched TV news during the past week:
  - a. Not at all.
  - b. About 1 time per week.
  - c. 2-3 times per week.
  - d. Almost every day.
  
16. My normal sleep pattern is:
  - a. Totally chaotic, no regular pattern, sleep when exhausted.
  - b. Irregular, long periods awake and binges of sleep.
  - c. Somewhat regular, 5-6 hours per night.
  - d. Regular, 7-8 hours per night.



- 17. I attend to the care and maintenance of my home/apartment:
  - a. Almost never.
  - b. Once per week.
  - c. Several times per week.
  - d. Every day.
  
- 18. In the last three months I have changed my residence/living situation:
  - a. 3 or more times.
  - b. 2 times.
  - c. Once.
  - d. Not at all.
  
- 19. I smoke marijuana:
  - a. Daily.
  - b. 3-6 times per week.
  - c. 1-2 times per week.
  - d. Not at all.

Scoring Key                      Subject Score \_\_\_\_\_  
a = 4    b = 3    c = 2    d = 1

Score 50-80 - Extreme involvement in dependence lifestyle behavior  
Score 40-49 - Significant involvement in dependence lifestyle behavior  
Score 30-39 - Moderate involvement in dependence lifestyle behavior  
Score 20-29 - Minimal involvement in dependence lifestyle behavior

\*Copyright, Richard Rawson, Matrix Model Manual, Matrix Institute on Addictions, Los Angeles, CA.

## Returning to Old Behaviors: Dealing With a Lapse

While it is helpful to have strategies to cope with cravings and high-risk times, lapses into old behaviors can occur, including slips into use. While a lapse can feel like a major crisis, it is important to have a way to react constructively to these episodes. An analogy is a small kitchen fire: what is important about that fire is that the whole house has not burned down; panicking will only make it harder to put out the fire.

If a lapse or slip back into use occurs, it is likely to be accompanied by feelings of guilt, shame, failure, hopelessness and anguish. Allowing these feelings to dictate our actions at this time is the same as panicking in a fire. Instead, it is important to understand that these feelings are a normal response to a slip, but that they are not going to change what has happened or offer a way to terminate the use episode. It is important not to be overwhelmed by the negative emotions at these times, and to have a rational plan of action for returning to the positive changes you have begun to make in your life. Last, it is critical to learn from the events that occurred in order to reduce the likelihood of another lapse. This takes a careful analysis of the events, people and emotions that preceded the lapse.

### ***What to do after a lapse***

#### Personal Emergency Plan: Lapse

During the period right after a lapse to substance use (1-10 days), you are extremely susceptible to deciding to continue to use. This is partly because you are feeling bad about it, and partly due to the "abstinence violation effect" (AVE). AVE is the idea many people fall into that "*now that I've crossed that line, I might as well stay over here a little while*". This is not only dangerous in the short term, but usually inaccurate, because "a little while" is a very tough amount of time to control. It is important to develop an emergency plan in case one slips, so that your previously thought out plan can be used, at a time when you may not be thinking very clearly. Here are some suggestions for that emergency plan:

#### If I experience a lapse:

- ⇒ I will remind myself that I am in a period of high danger in terms of continued use.
- ⇒ I will get rid of any remaining drugs or alcohol immediately and get away from the setting where I slipped.
- ⇒ I will realize that one day of drinking or using does not have to turn into a full blown relapse.
- ⇒ I will try not to let feelings of guilt/shame determine my actions because I know they will pass in time.

- ⇒ I will reach out and call for help from someone else.
- ⇒ At my next group, I will examine this lapse with my group, discuss the events prior to my lapse, and identify triggers and my reaction to them. I will work with my group to set up a plan so that I will be able to cope with a similar situation in the future.
- ⇒ I will use my “Relapse Analysis Chart” to help me review what led up to this lapse, so that I can learn from this and better protect myself in the future.

**YOU DO NOT HAVE TO LAPSE WHILE MAKING CHANGES IN YOUR LIFE, BUT IF YOU DO, REMEMBER: LAPSES ARE ONLY A TEMPORARY DETOUR ON THE ROAD. LEARN FROM THEM AND MOVE ON.**

**Questions**

- 1) In past slips or lapses, did you feel like it “just happened out of nowhere”?
- 2) If you had a slip, would you find it difficult to focus on your emergency plan instead of on your feelings?
- 3) What has been your emotional reaction to past slips? What has been your behavioral reaction (i.e. how did you act)?

## Home Handout for Session 20: Avoiding Relapse Drift: Mooring Lines\*

### How it Happens

**Relapse does not suddenly and unexpectedly occur. It does not happen without warning and it does not happen quickly. The gradual movement, however, can be subtle and so easily explained away (denied) that often a relapse feels like it happened suddenly. This gradual movement away from sobriety can be compared to a ship slowly drifting away from where it was moored. The drifting movement can be so slow that it is almost imperceptible.**

### Interrupting the Process

In the course of regaining control over an addiction each person identifies certain behaviors that he/she knows work to maintain a drug-free lifestyle. These “mooring lines” need to be clearly spelled out in a very specific way so that they are visible and measurable. These are the ropes that hold the recovery in place and prevent the relapse drift from beginning without being noticed.

### Maintaining Recovery

Use the Mooring Lines Recovery Chart to identify and monitor the behaviors that are holding your recovery in place. Follow these guidelines when filling out the form:

1. Identify 4 or 5 specific behaviors that are now sustaining your recovery (e.g. working out for 20 min., 3 times per week).
2. Include items such as exercise, therapist and group appointments, scheduling, self-help meetings, eating patterns, etc.
3. Do not list attitudes. They are not as easy to measure as behaviors.
4. Note specific people or places that are known triggers and need to be avoided.

The checklist should be completed regularly (probably weekly). When two or more items cannot be checked, it is an indication that relapse drift is occurring. Sometimes circumstances interrupt your ability to maintain the mooring lines. Vacation, illnesses and holidays can contribute to the cessation of behaviors necessary to maintain sobriety. It is important to note that vulnerability to relapse is high during these times. Use the chart as an indicator of when you are more vulnerable to relapse and decide what specific responses you need to make when the chart indicates they are necessary.

## Mooring Lines Recovery Chart

During the process of achieving abstinence you have had to develop specific behaviors to support this change - behaviors that work for you in maintaining abstinence. It is all too easy under certain circumstances to drop more than one of these "mooring lines" (the lines that tie you to your recovery), thereby setting up the opportunity for your recovery to drift towards relapse. Charting the behaviors and checking occasionally to make sure the lines are secure can be very useful.

Use the chart below to list those activities and changes that are vital to your continuing recovery. If there are specific people or things you need to avoid, list those. Refer back to your list periodically to assure yourself you are not becoming vulnerable to relapse, or to giving up on these hard won changes.

<b>Mooring Lines To Maintain</b>	Date	Date	Date	Date	Date
1					
2					
3					
4					
5					
<b>Specifically to be avoided:</b>	Date	Date	Date	Date	Date
1					
2					
3					

\*Adapted from: Richard Rawson, Matrix Model Manual, Matrix Institute on Addictions, Los Angeles, CA.

## GETTING RID OF PARAPHERNALIA

### Alcohol and other Drugs

Early in treatment it is advisable to dispose of any remaining alcohol or other drugs still in your possession. Your home, your car, and the places you frequent need to be as safe as you can make them. Keeping a little cocaine or pot around, or a few beers in the refrigerator, to prove to yourself they are not a problem, is not wise. These drugs serve as powerful triggers that will continually provoke your addicted brain, which can in turn begin the craving process. Interrupting the craving process at the earliest possible stage is a basic principle in relapse prevention.

### Paraphernalia

Paraphernalia, items used for, or related to, your alcohol/drug use, can trigger intense cravings. The memories related to these things are often still powerful enough to stimulate strong physiological responses. It is important to remove all paraphernalia from your environment as early in your recovery as possible. Use the following checklist to remind you of items that you might eliminate:

- |  |   |
|--|---|
| <input type="checkbox"/> Wrapped liquor        | <input type="checkbox"/> Bic Pens         |
| <input type="checkbox"/> Opened liquor         | <input type="checkbox"/> Lighters/Torches |
| <input type="checkbox"/> "Airplane" liquor     | <input type="checkbox"/> Spoons           |
| <input type="checkbox"/> Drink mix             | <input type="checkbox"/> Storage boxes    |
| <input type="checkbox"/> "Last bit" drug stash | <input type="checkbox"/> Phone numbers    |
| <input type="checkbox"/> Pipes                 | <input type="checkbox"/> Mirrors          |
| <input type="checkbox"/> Straws                | <input type="checkbox"/> Needles/Syringes |
| <input type="checkbox"/> Screens               | <input type="checkbox"/> Using clothes    |

### People

People can be triggers also. Once you have eliminated all the paraphernalia from your environment, you will be ready to think about people you need to avoid- at least temporarily. Create an environment for yourself that is as safe as possible and you will greatly increase your chances of achieving a successful recovery.



## RELAPSE ANALYSIS

### Theme

Relapse analysis is a very helpful process for people to undertake following a lapse back to some use of substances. A central theme in relapse analysis is the idea that relapse or use does not occur suddenly and unpredictably. It often feels like it happens that way to a client. A relapse analysis is designed to help the client understand the context of the relapse in order to better “see it coming” the next time. The following points are important to keep in mind when working with a client who has relapsed:

1) Relapses occur after periods of extended sobriety (usually a month or more). If the episodes of drug use are closer together, than the client needs to focus on stopping drug as opposed to avoiding relapses. The techniques are different

2) A relapse is not a failure. At least 50% of the people who successfully complete outpatient treatment experience a relapse at some point. It is often part of the process. It is certainly not recommended and many people are able to recover without relapsing. If it occurs, however, it needs to be viewed as an opportunity for learning more about the client’s unique vulnerabilities.

3) Relapses need to be viewed as more than isolated events that occur in a limited context. Often events and behaviors begin to form a gestalt that signals a vulnerability to relapse before the actual relapse occurs. It is vital that the therapist be able to recognize when this is happening. The client needs to learn to recognize this process and how to interrupt it in order to sustain life-long sobriety.

4) If a relapse occurs, the client should be considered to be extremely susceptible to continuing use until a balance has been regained in treatment and in his/her lifestyle. Extra precautions need to be in effect for several weeks to avoid continuing use.

### Format

The relapse analysis needs to be done by the individual immediately after the relapse occurs. When a client discloses a lapse during treatment, he/she should be given the opportunity to tell the story of the event in his/her own words. This is a necessary therapeutic exercise for the client and he/she will probably need prompting to talk about the details. The client often feels disinclined to discuss the particulars because of a desire to leave the issue behind or because of feelings of having failed the therapist or group. Discussing the lapse is a cleansing process, in particular, the process leading up to use. It is important for the therapist, however, to limit the amount of group time spent on an individual’s relapse, and to try to have this discussion be of benefit to others in the group. What is not helpful is a blow-by-blow account of buying/using/crashing etc, as these types of details can easily trigger others in the group (i.e. no “war stories”). After the client tells the story briefly, they should be strongly encouraged to think through the events leading up to the relapse at home with the help of the “Relapse Analysis Chart”. It is helpful for the therapist to briefly review this sheet with the client in the group to make sure they understand the format. This may also be done after group is over. In either case, in the following group, the client should review this chart for several minutes. The worksheet is shared by the individual with the group, and necessary changes in the treatment plan or the person’s lifestyle are agreed upon. Each category on the chart should have some entries listed in the lower boxes. In addition to highlighting the “building up to relapse” idea, this is an excellent exercise in separating feelings from thoughts and events.



## Goals

- 1) To prevent similar relapses from happening without the client being aware of how/why they occur.
- 2) To encourage the client to focus on the larger picture of the context in which the relapse occurred as opposed to the isolated event.
- 3) To reframe the self-deprecation that often follows a relapse into an acceptance of the addicted process.
- 4) To remove the fear and mystique from a relapse episode and give the client a workable plan for staying drug-free.
- 5) To acknowledge the feelings the client is experiencing and to help him/her understand that the behaviors can be controlled even through the feelings cannot.

## Handout: Relapse Analysis Chart

The categories itemized across the top of the chart should be explored by the client as to events that occurred within the 1-4 week period preceding the relapse. Every change or stressor should be noted whether or not they seem pertinent. The categories include:

- ⇒ Career Events- Events or a change in status relative to a career or a job.
- ⇒ Personal Events- Events or a change in the status of relationships with family/ friends as well as other events or situations unrelated to any other category.
- ⇒ Treatment Events- Events or a change in the status of the regular treatment plans as well transition from one phase of treatment to another.
- ⇒ Drug/Alcohol Related Behaviors- Behaviors directly related to drug and alcohol consumption (e.g., drinking, going to bars, visiting a dealer, etc).
- ⇒ Behavioral Patterns- New or resumed behaviors that are part of addiction (e.g.: lying, stealing, behaving, compulsively, isolating, etc).
- ⇒ Relapse Cognitions- Thoughts that seem to justify relapse, even if they were brief and seemed minor. Being aware, at any point, that a relapse might be in progress.
- ⇒ Health Habits Status- Events or a change in status or routine of normal eating, sleeping, exercise, or grooming behaviors. Illness or injuries are particularly pertinent.

There may not be significant events in every single category. It is important to get a picture of the client's overall vulnerability before the actual relapse occurred.

**RELAPSE ANALYSIS CHART**

Name: \_\_\_\_\_ Date of Relapse: \_\_\_\_\_

A relapse episode does not begin when drug ingestion occurs. Frequently there are pre-use events that occur which are indicative of the beginning of a relapse episode. Identifying your individual pre-use patterns will allow you to interrupt the relapse episode before the actual drug use and to make adjustments to avoid the full relapse. Using the chart below, note events occurring during the week immediately preceding the relapse being analyzed.

<b>CAREER EVENTS</b>	<b>PERSONAL EVENTS</b>	<b>TREATMENT EVENTS</b>	<b>DRUG/ALCOHOL RELATED BEHAVIOR</b>	<b>BEHAVIORAL PATTERNS</b>	<b>RELAPSE COGNITIONS</b>	<b>HEALTH HABITS STATUS</b>
--------------------------	----------------------------	-----------------------------	--	--------------------------------	-------------------------------	-------------------------------------

**FEELINGS RELATIVE TO ABOVE EVENTS**