Group-Based Outpatient Treatment for Adolescent Substance Abuse

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This manual describes a moderate-intensity group-based approach to adolescent outpatient substance abuse treatment, implemented by the Epoch Counseling Center, Baltimore County, Maryland. The Group-Based Outpatient Treatment for Adolescent Substance Abuse (GBT) program combines a 20-week group counseling intervention with individual and family therapy and is designed to address the issues and problems commonly facing adolescent substance abusers ages 14 to 18 years old. This manual provides an overview of the theoretical basis for the intervention, a brief description of the outpatient drug-free treatment program within which the adolescent intervention was implemented, and a curriculum guide for implementing the treatment protocol.

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Preface

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This group-based adolescent treatment model was developed jointly by Epoch Counseling Center's adolescent treatment staff and clinical researchers at the Social Research Center (SRC), both of which are divisions of Friends Research Institute, Inc. The development and evaluation of this intervention was supported by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration, under its Adolescent Treatment Models (ATM) program. Robert J. Battjes, D.S.W. was the project's principal investigator. Elizabeth C. Katz, Ph.D., and Emily A. Sears, M.S., had lead responsibility for development of the Group Counseling component, while Cynthia A. Adams, M.A., had lead responsibility for the Parent Education and Support Group component. The Epoch Counseling Center Adolescent Treatment Team contributed extensively to the development, testing, and implementation of this Group-Based Treatment curriculum. The Epoch Adolescent Treatment Team included: Richard Bateman, Teal Beatty, Gary Brown, Susan Chirichillo, Chris Collins, Stacy Frank, Diana Givens, Charles Hall, Judith Horst, Jerome Johnson, Wayne Lawson, Barbara Lingenfelter, Donna Lucker, Jan Marshall, Kathleen Nunn, Claudia Reynolds, Anna Soisson, Robert Storey, Gail Swanbeck, Marsha Swilley, and Judy Walsh.

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I. Introduction

A. Adolescent Program Overview

Epoch Counseling Center's Group-Based Outpatient Treatment for Adolescent Substance Abuse (GBT) is a 20-week program that consists primarily of group counseling, with limited individual counseling and family therapy incorporated into the program. In addition, Parent Education and Support Groups are an optional component of treatment. While the treatment program is designed as a 20-week program, length of participation can vary depending on individual client need and attendance. The Epoch GBT is categorized as an Adolescent Level I treatment program according to the American Society of Addiction Medicine Patient Placement Criteria (ASAM-PPC, ASAM, 1996).

The Epoch GBT is designed for youth ages 14 through 17, with 18 year olds included if they are still in high school. It is intended for youth whose treatment needs can largely be met through a moderate intensity, group treatment approach. While the program is primarily a group intervention, individual sessions are included for treatment planning purposes and crisis intervention, and family therapy is provided to address family conflict and communication problems and to teach parents appropriate parenting skills, discipline, and other behaviors needed to help adolescents achieve and maintain abstinence.

B. Theoretical Orientation

The Epoch Counseling Center adolescent treatment program is based on the premise that substance use is primarily learned behavior (Bigelow, Brooner, & Silverman, 1998). Although the role of genetics is acknowledged, it is not emphasized in the Epoch program. The Epoch program has its foundations in social learning theory (Abrams & Niaura, 1987; Bandura, 1977), which primarily explains initiation and progression of use, and conditioning theory (i.e., instrumental and classical conditioning) (Pavlov 1927; Skinner, 1953), which explains progression and maintenance of substance use.

Consistent with social learning theory, adolescents develop beliefs about substance use through modeling, that is, by observing salient role models' (e.g., parents, siblings, or peers) use of substances and experience of consequences. It is these beliefs about the consequences of drinking or drug use (called outcome expectancies), which develop in the absence of personal drinking experience, that influence subsequent use. Research has shown, for example, that children with little or no prior drinking experience hold outcome expectancies for alcohol (Miller, Smith, & Goldman, 1990; Query, Rosenberg, & Tisak, 1998). These early expectancies influence drinking onset such that children with positive expectancies begin drinking earlier than those who hold negative expectancies for alcohol (Killen et al., 1996; Smith, Goldman, Greenbaum, & Christiansen, 1995). Modeling also influences the escalation of substance use. For example, Collins and Marlatt (1981) demonstrated that social drinkers consumed more alcohol in the presence of a heavy-drinking model than when they were exposed to a light-drinking model.

Conditioning theory, both operant and classical, explains substance use escalation and maintenance. Consistent with the theory of operant conditioning, which specifies that behaviors that are followed by reinforcement are repeated (Skinner, 1958), adolescents continue to use

substances because, once they have initiated use, they are reinforced by the positive effects of the substance. Through classical conditioning (Pavlov, 1927) substance use becomes associated with a myriad of cues (e.g., people, places, and things) that are present in the environment whenever the adolescent uses. For example, an adolescent may use the same red lighter whenever he or she smokes marijuana. When the adolescent sees or handles the lighter, she or he is likely to think about smoking marijuana, experience strong urges or cravings, and in the case of some substances (e.g., heroin, Wikler, 1965; 1973) withdrawal-like symptoms. Adolescents use substances in the presence of these cues to offset the aversive sensations and symptoms that exposure to such cues produces. Thus, for example, marijuana may be used to eliminate the craving to use, not simply to obtain the drug's positive effects. As adolescents increase the amount and frequency of substance use, they become tolerant to the effects of the substance and they thus further increase their use of the substance so that they can experience its desired effects.

Lack of parental supervision, poor parent-child relationships, and permissive parenting styles also influence initiation, progression and maintenance of substance use. Research has shown, for example, that greater involvement in substance use was associated with less after-school supervision (Richardson, Radziszewska, Dent, & Flay, 1993) and high levels of parent-child conflict (Duncan, Duncan, Biglan, & Ary, 1998). In addition, parents who were less authoritative and more permissive had adolescents who were more deviant (in terms of drug and alcohol involvement) than those who were less permissive and less authoritarian (Cohen & Rice, 1997). Lack of supervision and high levels of conflict may contribute to the initiation and escalation of substance use to the extent that they provide increased opportunities for adolescents to interact with deviant peers who model more extensive patterns of use. Permissive parenting may contribute to substance use, on the other hand, to the extent that such parents do not provide appropriate discipline. Thus, such parents tend to shield their deviant adolescents from the negative consequences associated with substance use.

Treatment at Epoch Counseling Center is designed to help adolescents unlearn their substance use as well as address some of the family and social factors that contribute to their use. Specifically, in their daily lives, adolescents are exposed to peer pressure and other cues (e.g., places, things) that trigger cravings for or thoughts about using. The GBT teaches adolescents skills needed to resist substance use in these situations and thus break the association between substance use and the myriad of cues associated with that use. Consistent with conditioning theory, if adolescents successfully resist using substances in these situations, conditioned withdrawal, craving and/or thoughts about using will reduce and ultimately extinguish over time.

II. Organizational Overview

A. Administrative Structure

Epoch Counseling Center is an outpatient substance abuse treatment program that has provided substance abuse treatment in Baltimore County, Maryland, for over 30 years, offering a variety of therapeutic and supportive services to adolescents and adults whose lives have been adversely affected by drugs and alcohol. A division of Friends Research Institute, Inc., a private non-profit agency, Epoch Counseling Center currently operates five facilities, serving residents in communities to the east, west, and south of Baltimore City. The clients served by the five facilities are largely low to middle income, with three of the facilities serving economically depressed areas marked by high unemployment rates. The service area populations are predominately Caucasian with one facility serving a sizeable African American population.

The Epoch Counseling Center Director is responsible for securing and managing grants and overseeing the overall operation of the five sites. The Director is a Licensed Clinical Alcohol and Drug Counselor (LCADC) with 15 years of counseling experience in substance abuse treatment and seven years of management experience. LCADC licensure by the Maryland State Board of Professional Counselors and Therapists requires completion of a 60-credit master's degree in a health or human services counseling field, with a minimum of three years clinical experience, two years of which must be post-degree.

Each of the five Epoch Counseling Center sites, which serve both adolescents and adults, is under the direction of a Coordinator. Coordinators are responsible for supervising clinical services and overseeing the day-to-day operations of the clinic, which includes, but is not limited to, scheduling of appointments with prospective clients, providing clients with an overview of the programs and services, determining client eligibility for treatment, and setting fees. As clinical supervisors, Coordinators must also be Licensed Clinical Alcohol and Drug Counselors (LCADC). [The Maryland State Board of Professional Counselors and Therapists may waive the licensure requirement on a case-by-case basis.] Some Epoch Counseling Center Coordinators also possess licenses in social work or as clinical professional counselors.

B. Funding

Funding for Epoch Counseling Center's program comes largely from state and federal substance abuse treatment funds, administered by the Maryland Alcohol and Drug Abuse Administration (ADAA), Department of Health and Mental Hygiene (DHMH), and obtained through the Baltimore County Bureau of Substance Abuse. Additional funding consists of client fees and insurance collections. For three of the five Epoch sites, client fees and insurance collections comprise approximately one-fourth of operating expenses, whereas the two remaining sites are dependent on client fees and insurance collections for one-third to one-half of their operating expenses. ADAA/DHMH funding supports Epoch's overall clinical program, including treatment of both adolescents and adults, and no specific portion of these funds is designated for adolescent treatment.

In addition to ADAA/DHMH support for its clinical program, Epoch Counseling Center receives funding from two sources for specific initiatives. The Baltimore County Office of Safe and Drug Free Schools provides financial support to Epoch, as well as other substance abuse

programs, for the Maryland Student Assistance Program (MSAP), an initiative that is designed to identify students who have, or are at risk for, substance abuse or dependence and to facilitate their transition into treatment, if appropriate. MSAP prevention specialists and addictions counselors conduct drug abuse assessments and provide educational, consultative, and other supportive services within the schools. Under the Community Development Block Grant program, the Baltimore County Office of Community Conservation funds one of the Epoch sites to provide services for the prevention of drug use and other destructive behaviors, an initiative focused largely on younger children and their families. This initiative helps children master educational skills and also focuses on community revitalization, operating from a community outreach center in a low-income neighborhood.

C. Adolescent Program Staffing

Adolescent program staff includes addictions counselors, family therapists, and administrative assistants. Counselors and family therapists typically specialize in adolescent treatment, while administrative assistants are involved with all Epoch clients.

Adolescent Counselors. Adolescent counselors are responsible for conducting intake assessments, providing consultation and assessment services in local schools as part of the MSAP program, delivering the group and individual counseling components of the GBT program, and crisis intervention. Most adolescent counselors have a minimum of a bachelor's degree in psychology, counseling, or social work, and two years of counseling experience in the field of addictions. Counselors are certified by the Maryland State Board of Professional Counselors and Therapists as either Certified Addictions Counselors – Alcohol and Drug (CAC-AD) or Certified Supervised Counselors – Alcohol and Drug (CSC-AD), depending on education and clinical experience. CAC-AD certification requires a bachelor's degree in a health or human services counseling field, with three years of documented clinical experience, at least two years of which must be post-degree. CSC-AD requires an associate's degree in a health or human services counseling field, with two years of documented clinical experience, at least one of which must be post-degree.

Family Therapists. Family therapists are responsible for conducting family therapy sessions and Parent Education and Support groups. They have a minimum of a master's degree in psychology, counseling, pastoral counseling, or social work and at least one year of experience conducting family therapy or counseling. In addition to CAC-AD or CSC-AD certification, family therapists may also possess additional licensure or certification, such as Licensed Clinical Professional Counselor (LCPC) or Licensed Graduate Social Worker (LGSW).

Administrative Assistants. Administrative assistants are responsible for scheduling appointments, collecting fees, monitoring office supplies, and submitting admission and discharge information to the Maryland State Department of Health and Mental Hygiene and to the Baltimore County Bureau of Substance Abuse which monitor the monthly census rates of all substance abuse treatment programs receiving state and county funding. Administrative assistants play pivotal roles in responding to inquiries for information about treatment, initial screening of prospective clients (see Section III.B., Initial Screening, below), referring crisis calls, and managing the day-to-day operations of the treatment facility.

D. Clinical Supervision

Coordinators provide supervision to all clinical staff. Counselors are required to receive weekly clinical supervision for the first two years of employment with Epoch Counseling Center. Coordinators may then adjust the frequency of supervision depending on the counselor's experience and progress. Coordinators are also responsible for providing staff development opportunities on a regular basis. Staff development may consist of scheduled trainings or seminars, which support ongoing continuing education requirements necessary for certification and licensure, and group supervision.

E. Adolescent Clientele and Referral Sources

Approximately 70% of Epoch Counseling Center's adolescent clients are Caucasian with the remainder largely African American, and males comprise approximately 85% of these clients. Epoch accepts self-referrals and referrals from family, criminal justice agencies, community service or health agencies, and/or the educational system. The largest source of referrals is the Maryland Department of Juvenile Justice (DJJ), which accounts for approximately 60% of adolescents who enter treatment. In general, adolescents referred from DJJ have been arrested and/or charged with substance-related (e.g., drug possession or distribution, public drunkenness) or status offenses, with only approximately 10% arrested and/or charged with other offenses. Other sources of referral include parents, legal guardians, or other family members, comprising about15% of adolescent admissions, schools, comprising approximately 15% of admissions, and other health and social service agencies, comprising less than 10% of admissions. Few adolescents are self-referrals, comprising only 1-2% of admissions. While Maryland state law permits youth under 18 years old to seek treatment for substance abuse and dependence without parental consent, only approximately 5% of youth admitted to Epoch Counseling Center enter treatment without parental knowledge.

Referrals from schools comprise only a small proportion of admissions because the Maryland Student Assistance Program (see Section II. B., above) provides some substance abuse counseling within the schools. Most of Epoch's adolescent treatment referrals from the schools come from the MSAP program, although rarely a teacher or guidance counselor refers adolescents directly to treatment.

F. Program Policies and Procedures

Fees. All fees as determined by the sliding fee scale must be paid in full for clients to be allowed to participate in treatment, to reenter treatment, and to complete treatment successfully. Clients who fail to pay fees at one counseling session are required, at the next session, to pay the unpaid balance in addition to the current week's fees so that the balance is paid in full at the next session. If clients fail to meet this requirement, they are not allowed to attend treatment sessions. Thus, treatment is suspended until such time as the balance is paid in full. Such suspensions will result in discharge if the client then fails to attend counseling sessions for 30 consecutive days. Extenuating circumstances may result in fee adjustments for those clients who indicate an inability to pay.

Drug screening. Urine drug screening is performed on a random basis and is done an average of once per month. However, it is the counselor's discretion to test more frequently if it

is clinically indicated (e.g., client refuses to leave a urine specimen or leaves a specimen that is positive or suspect). Urine screens are also conducted if requested by the parent/guardian or parole/probation officers. The standard drug screen tests for amphetamines, barbiturates, benzodiazepines, cocaine, cannabis, opioids, and alcohol. Additional screens may be requested if indicated and typically include quinine, phencylcidine, methadone, and LSD.

A same-sex staff member or parent/guardian supervises collection of all urine samples. If neither a same-sex staff member nor a parent is available, the urine collection is either rescheduled or the counselor will test the temperature of the specimen to ascertain its validity. Occasionally adolescents are unable to leave a specimen. In these instances, the counselor will allow the client to remain in the clinic until s/he is able to leave a specimen or will provide the client with a date and time by which the specimen must be left. If the client refuses to leave a specimen or otherwise fails to leave a specimen as scheduled, the sample is considered a "behavioral positive" test.

At intake adolescent clients under age 18 are required to sign a form authorizing Epoch Counseling Center to release urine drug screening results to the parent or legal guardian (unless the adolescent seeks treatment without parental or guardian knowledge) and referral source. Whereas negative urine test results are reported to the Department of Juvenile Justice, other referral sources, and/or parents/guardians at least once per month, the identified client, parent/guardian, and referral source are informed of positive urine-test results immediately either by telephone or by scheduling an individual or family counseling session. In the case of adolescents under DJJ supervision, counselors discuss drug positive results with the client and parent first, before informing the DJJ agent, because DJJ considers the submission of two drug positive urine samples to be a violation of probation. Positive drug screens, self-reported use, and behavioral positives are all considered indicators of continued substance use and result in an extension of the client's treatment (i.e., additional sessions are required in order to successfully complete treatment; see Treatment Termination, below). A consistent failure to provide samples for drug screening may result in discharge from the program. Also, if a client submits three drug positive urine samples during treatment, especially if consecutive, the counselor may elect to discharge the client unsuccessfully with a referral to a higher level of care. The counselor will most often schedule an individual or family counseling session to discuss whether the client requires a higher level of care than is available at Epoch.

Counseling session attendance. Program policy states that clients who arrive more than 10 minutes after a group session is scheduled to begin are not allowed to attend that session. Counselors can make exceptions to this policy only under unusual circumstances, such as when the client has had transportation problems or the client called to inform the counselor that s/he would be late. To remain active in treatment, clients must have face-to-face contact with their counselors at least once per month. Clients who have no face-to-face contact with their counselor in a 30-day period are discharged from the program for non-compliance. Prior to such discharge, however, counselors make considerable effort to engage clients in treatment during this 30-day period (see Section V, below), and this treatment non-compliance is reported to parents and to referral sources.

Communication with referral sources. Close collaboration between the counselor and referral sources is considered essential for effective treatment. With respect to clients referred through DJJ, counselors communicate with DJJ officers at least once per month and sometimes as often as once per week. Counselors provide DJJ officers with information about clients'

attendance and involvement in treatment as well as results of monthly drug screening and progress towards client treatment goals. Counselors do not discuss specific issues raised by clients during counseling sessions, with the exception of clients who report suicidal or homicidal ideation.

Communication with parents. Communication with parents is ongoing throughout treatment. In general, counselors ask parents to provide detailed information about how the adolescent is doing both at home and at school as well as with respect to his/her drug use and other treatment-relevant behaviors (e.g., association with deviant peers). Counselors, on the other hand, typically provide parents with general information about how the client is doing in treatment unless the client reports suicidal/homicidal ideation or the client and counselor have agreed that it is acceptable to share more specific information about issues raised by the adolescent in treatment. Involvement of parents in the treatment process is discussed further under Section III. G., Family Therapy, below.

G. Treatment Termination

Successful completion. Clients must meet the following requirements in order to successfully complete treatment: (1) they must participate actively in and complete the 20-week program, including all requirements for group, individual, and family sessions; (2) they must have achieved abstinence from all illicit substances and alcohol for a minimum of 90 days prior to the date of discharge, as demonstrated by negative drug screens; (3) all treatment plan goals must be either completed or explanation noted as to why a goal was not achieved by the end of treatment; and (4) all fees must be paid in full.

Administrative discharges/unsuccessful completion. Clients who do not comply with program requirements are either administratively discharged or referred to other treatment programs offering higher levels of care. Clients are administratively discharged if they fail to have face-to-face contact with their counselor for 30 consecutive days, are threatening to staff or other clients, and/or engage in drug use or drug dealing on agency premises. For clients who are non-compliant with urine drug screening requirements and/or fail to make progress on treatment plan goals, behavioral contracts (see Section V.A., Behavioral Contracts, below) are written in an attempt to obtain compliance with these program requirements. If clients are repeatedly non-compliant with the behavioral contracts, they are administratively discharged. Some adolescents who are referred to treatment by DJJ terminate treatment when DJJ supervision ends, even if this occurs before they have successfully completed treatment.

Termination by the Department of Juvenile Justice. DJJ may also terminate treatment prematurely. DJJ may violate the probation of an adolescent for any number of reasons, primarily due to a failure to comply with treatment requirements, positive drug screens (either through the treatment program or through DJJ testing), and a failure to complete community service hours. Adolescents who receive violation of probation mandates typically receive detention in a juvenile justice facility or referral to an inpatient substance abuse treatment facility.

Referral to higher levels of care. Clients who attend treatment but continue to submit drug positive urine samples are referred to other programs for higher levels of care (e.g., residential treatment; intensive outpatient treatment; detoxification). In addition, clients who are determined to have a co-occurring psychiatric disorder may be referred for treatment at clinics

that specialize in treating individuals with co-occurring disorders. When appropriate and feasible, parents and/or guardians are involved in the decision to refer clients for more intensive treatment. Clients are encouraged to return to outpatient treatment upon completion of the more intensive treatment programs, and Epoch Counseling Center maintains ongoing contact with the other agencies to ensure continuity of care when clients are released from the more intensive treatment programs.

III. Overview of the Epoch Counseling Center GBT

Epoch Counseling Center's Group-Based Outpatient Treatment for Adolescent Substance Abuse (GBT) is a 20-week program that consists of 19 group sessions, a minimum of three individual and four family therapy sessions (described in detail below). Parents of adolescent clients are also encouraged to attend biweekly Parent Education and Support Groups (also described below). Although the Parent Education and Support Groups are an optional component of treatment at Epoch, counselors recommend that parents try to attend four of these groups during the 20 weeks of treatment.

A. Inclusion/Exclusion Criteria for GBT

The GBT is appropriate for use with adolescents aged 14-18 who meet Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (1994) criteria for substance abuse or dependence. In addition, adolescents whose substance use does not meet abuse or dependence criteria may also be appropriate for the treatment program if other behaviors or indicators suggest that they are at high-risk for abuse and in need of early intervention (e.g., truancy, petty theft, lying, declining grades, depression). Adolescents 13 years old and younger, 18 year olds who are no longer in school, and individuals over 18 years of age are typically experiencing different developmental issues that may impact the process of recovery than are the 14-18 year olds targeted by this program. Thus, younger children are generally treated in individual counseling sessions, whereas older adolescents receive treatment services either on an individual basis or in an adult group provided at the same facility. To participate in the GBT, adolescents must be deemed suitable for Adolescent Level I treatment according to the American Society of Addiction Medicine Patient Placement Criteria (ASAM, 1996) and for group treatment. According to ASAM-PPC, Level I treatment "encompasses organized outpatient treatment services…provided in regularly scheduled sessions of (usually) fewer than 6 contact hours a week" (ASAM, 1996, p. 209). Those adolescents who are appropriate for Level I treatment are eligible for Group-Based Treatment if they: (1) are free of suicidal ideation; (2) possess adequate intellectual ability to be able to profit from the group curriculum; (3) possess the ability to concentrate; and (4) are free from psychological or behavioral disorders (e.g., hyperactivity) that would make them disruptive to the group process. Adolescents with psychological or behavioral disorders that are being appropriately medicated and supervised by a mental health professional are eligible to participate in GBT. Adolescents experiencing symptoms of withdrawal from alcohol or opioids are referred for detoxification and are re-evaluated upon completion of detoxification to determine their eligibility for GBT using the above criteria. Those adolescents who are not suitable for level I treatment are referred to an appropriate level of care with other agencies, while those who are not suitable for group treatment are seen individually.

B. Initial Screening

The treatment intake process is initiated when the adolescent or his or her parent/guardian contacts the agency by telephone. During this initial phone call, an "Application for Service" form is completed by an administrative assistant who has received special training for this

screening role. Information obtained includes general demographics, referral source, contact information, and specific information regarding the adolescent's drug problem so that a preliminary determination can be made regarding the adolescent's appropriateness for treatment at Epoch Counseling Center. Adolescents who are in need of more intensive services than that provided by Epoch are referred to an appropriate agency. If the adolescent appears appropriate for treatment at Epoch, the caller is provided a brief description of the treatment program, information about what the adolescent will need to bring to the initial intake session (e.g., photo identification, court/referral papers, evidence of insurance and income**,** and the fee for the intake session). The intake appointment is scheduled with the adolescent and parent(s) (unless treatment is being sought without parental knowledge) and typically occurs within two weeks of the initial telephone contact.

While this initial contact is generally handled by administrative assistants, the phone call may be transferred to a counselor or the clinic Coordinator if the adolescent's appropriateness for the program is not clear or if the caller has more specific questions about the treatment program or about how to motivate an individual to seek treatment, etc.

C. Intake Assessment

The adolescent intake assessment lasts approximately three hours. During the first 30 minutes, the Coordinator or an adolescent counselor meets with the adolescent and parents or guardians to determine if the adolescent is likely to be appropriate for either individual or group treatment at Epoch Counseling Center. Those adolescents who are deemed appropriate for outpatient group-based treatment and their parents or guardians are provided information on program policies regarding attendance, urine testing, fee payment, limits on confidentiality, and frequency, content, and potential consequences of communications with referral sources. The adolescent is then asked to sign program forms indicating an understanding of these program policies and procedures. If the adolescent has been referred by outside agencies, such as DJJ or MSAP, s/he is also asked to sign a form allowing the counselor to have ongoing communication with the referral source.

The remainder of the intake session, involving only the adolescent, consists of an in-depth assessment of the client's treatment needs and involves completion of the Global Appraisal of Individual Needs (GAIN; Dennis, 1998). The GAIN is designed to assess both lifetime and recent problem areas that affect and are affected by substance use, including drug use history, involvement in illegal activities and the juvenile justice system, school performance, current mental health status, family history of substance use and psychiatric problems, family environment, etc. Information obtained with the GAIN is used to confirm the adolescent's appropriateness for treatment at Epoch, using ASAM-PPC criteria (see Section III.A., above), and to formulate the initial treatment plan. The Coordinator or counselor assists those adolescents who are not appropriate for outpatient treatment in accessing appropriate services at other agencies (e.g., residential treatment, detoxification).

D. Treatment Planning

The client's first session with his/her primary counselor is an individual session that lasts approximately one hour and involves development of the treatment plan. [As part of the

evaluation project, adolescent clients receive an individual treatment session to prepare them to engage in treatment (see Section VI.B., below). This session, which occurs prior to the treatment planning session, is considered as a supplement to, rather than integral part of, the Group-Based curriculum.] Together the client and counselor discuss and select both short-term (three months or less) and long-term (greater than three months) goals, which provide the foundation for the client's treatment. Once the treatment plan has been formulated and agreed to by the adolescent, the counselor reviews the "group rules" (e.g., being on time, need for regular attendance and active participation, sobriety, confidentiality, and respect for peers and staff). Since groups operate with open admissions whereby clients enter at various points, this advanced review of rules assures that all clients enter group with a similar understanding of the rules and policies governing the group.

E. Group Counseling

Group counseling is the core of the Epoch Counseling Center adolescent treatment program. The group-counseling component consists of 19 weekly group treatment sessions, with each session lasting 75 minutes. The group curriculum is divided into two phases, and clients must complete the first phase, Drug Education, before proceeding to the second phase, Relapse Prevention. Phase I, consisting of four Drug Education sessions, provides clients with the foundation that they need to participate and benefit from Phase II, which consists of 15 Relapse Prevention sessions (See Section IV.A. and IV.B., below, for a list of Phase I and II session topics.)

Phase I sessions provide the knowledge and foundation needed to benefit from treatment and focus on educating adolescents about: (1) Psychological, Physical, and Emotional Aspects of Addiction; (2) Progression of Addiction: Self-Diagnosis; (3) Understanding Relapse; and (4) Family Influences on Addiction. (Specific curricula for Phase I sessions are contained in Section IV.A., below.) Clients must successfully complete the first phase of treatment, that is, attend all four groups and demonstrate an understanding of the material, to move into the second phase of treatment. If a client is absent from any Phase I session, he/she may proceed into the next phase, but must return to the Phase I group to complete the missed session. If more than one Phase I session is missed, the client must remain in the Phase I group until all sessions have been attended.

Phase II focuses on teaching skills needed to resist drug use in the face of triggers and high-risk situations so that the adolescent can become abstinent and avoid relapse once abstinence has been achieved. These group sessions include such topics as coping with stress, managing anger, assertiveness in interpersonal relationships, and managing thoughts about using. (Specific curricula for Phase II sessions are contained in Section IV.B., below.)

Development of the group curriculum. While development of the group treatment curriculum was shaped by the theoretical orientation described in Section I.B., Theoretical Orientation, above, it was most immediately influenced by several pioneers in the field of addictions treatment generally (Carroll, 1998; Monti, Abrams, Kadden, & Cooney, 1989) and, more specifically, adolescent addictions treatment (Bell, 1990; Liddle, unpublished). The structure of the sessions follows Kathleen Carroll's (1998) recommendation, described below. The session on relapse was also influenced by Carroll (1998), specifically her emphasis on identifying triggers and high-risk situations through the completion of a functional analysis. The

work of Tammy Bell (1990) provided the framework for the session that focuses on the progression of substance use. In addition, Bell's work helped shape the developmental level of the lessons so that they were appropriate for adolescents. Howard Liddle's (unpublished) emphasis on the importance of goal setting influenced the development of two sessions focused on this element of treatment.

Many of the remaining lessons were influenced to a greater (e.g., anger management) or lesser (e.g., negative thinking, assertiveness) degree by the work of Peter Monti and colleagues (Monti et al., 1989). In developing the curriculum, we first reviewed Monti et al.'s (1989) lessons and identified topics that seemed most appropriate for adolescent substance abusers. We then worked with the Epoch Counseling Center adolescent clinical staff to modify these lessons so that they would be developmentally appropriate for adolescents. For example, the lessons on coping with stress, managing thoughts about using, and anger management were modified moderately so that the material was appropriate for adolescents. Counselors suggested that cognitive restructuring, which was part of the anger management sessions, was too complex for adolescents and too difficult to accomplish within a group setting. Whereas Monti devoted two sessions to this topic, we condensed the material into a single session and refocused it, placing less emphasis on changing thinking patterns and more emphasis on educating adolescents about sources and consequences of anger and teaching concrete behavioral skills they could use to manage anger.

In working with adolescents, we discovered that some of the lessons adapted from Monti needed substantial revisions. For example, we found that adolescents did not respond well to the concepts of negative thinking or self-esteem, and we have addressed these issues by focusing on the ways in which adolescents demonstrate that they either respect or do not respect themselves. In addition, we found Monti's assertiveness sessions too general for our purposes. Therefore, we developed two assertiveness sessions loosely based on Monti's work. In one session we focus on identifying adolescents' values regarding intimate relationships (both sexual and friendship), sensitivity training, and empowering adolescents to make choices regarding intimate relationships that are consistent with their values. Because we found that youth were unwilling to admit that they had difficulty saying "no" to other people, we focused the second assertiveness session on the challenges they faced in denying themselves risky things, such as drug use and sex, difficulties that they could acknowledge. Therefore, this session focuses on examining reasons why it would be difficult for adolescents to say "no" to themselves and to teach them the skills they need to deny themselves the unhealthful things they want. In addition, we have included material not covered in Monti's manual. Specifically, we have developed a session that focuses on coping with recovery hurdles, that is, chronic or long-standing problems that interfere with efforts to become or remain abstinent from drugs (e.g., no non-drug addicted friends or peers; drug-addicted parents). We have also included two goals groups which involve defining why it is important to set goals in treatment (e.g., serve as motivation to achieve and remain abstinent), helping clients identify long-term goals (e.g., graduating from high school; buying a car), and setting short-term goals that, if accomplished, will eventually lead the client to achieving the long-term goals (e.g., study at least one hour per day). Finally, the curriculum includes three process groups, occurring at various points during Phase II. The process groups, which provide opportunities for adolescents to discuss how information from other sessions is specifically relevant to them and how it can be applied in their lives, are used when material requires more than a single session (e.g., discussion of values; assertiveness in interpersonal

relationships) or when clients need time to consider the material between sessions. In addition, process groups can be used to address optional topics that are relevant to a specific group of clients, but that are not included in the core curriculum (e.g., getting into college; getting a job, the latter material adapted from Azrin & Besalel, 1980). Moreover, these process sessions provide additional opportunities for counselors to check in regarding progress clients have made toward goals developed during the goals groups.

Session structure. Following Carroll's recommendation regarding session format, each group counseling session is divided into three parts. The first part, Part A, is a Warm-up period designed to ease the clients into the group session. This portion of the session is relatively unstructured. At the beginning of the group session, counselors introduce new members to the group. Veteran members are asked to describe the group rules and reinforce group standards that were discussed individually during the treatment planning session (e.g., confidentiality, respect for others). Once new members are introduced, counselors then focus on "checking in" with clients to see how things have been going since the last group session. In particular, counselors ask clients about how they are doing with their drug use and whether any problems arose in the last week (e.g., family, legal, school problems). If a client raises an issue or is in crisis, counselors use their clinical judgment in deciding whether the issue needs to be addressed immediately, whether it will be adequately addressed by the lesson planned for the day, or whether an individual or family session needs to be scheduled. After all clients have been given the opportunity to talk (although not all clients are required to share during this portion of the session each week), counselors then ask those group members who were present to review the topic from the previous week and any homework that was assigned.

The second part of the group counseling session, Part B, focuses on presentation of the didactic material contained in the specific drug education or skills-building lesson. The review of the previous week's topic and/or homework will link this portion of the session to Part A. Counselors begin by discussing the topic for the day and either providing, or eliciting from members, a rationale for why it is important to learn this information. It is up to the counselor to decide whether he/she prefers to present the material to be covered in lecture format or to involve the clients more by eliciting information from them. However counselors choose to present the material, they are responsible for ensuring that all main points of the lesson are covered during the session.

In the third part of the group counseling session, Part C, time is reserved for helping clients generalize the information or skills learned during Part B to their personal lives. This section of the session allows group members to process the lesson learned (i.e., what it means to them). It is particularly important for counselors to recognize that many of the adolescents are already quite knowledgeable and skilled. It is not so much that clients do not know the information or do not have the skills, as it is they do not use the knowledge or skills that they possess. Counselors ask clients to discuss reasons why it may be difficult to use the skills or to incorporate the information that has been covered into their lives. Depending on the reasons given by clients, counselors may opt to: (1) use cognitive techniques, if appropriate, to modify faulty thinking; (2) problem solve with clients about how to adapt the material so it will be useful in their environments; (3) conduct role plays with constructive feedback from counselors and other group members to reinforce skills learned during the didactic portion of the session; (4) assign written exercises and/or homework; or (5) use other exercises that counselors have found useful in the past.

F. Individual Counseling

In addition to the group sessions, adolescent clients attend at least three individual counseling sessions that focus on treatment planning (see Section III.D., above), reviewing and updating the treatment plan, and discharge planning. Additional individual counseling sessions are scheduled on an as needed basis to address issues that cannot (because of time constraints or client wishes) be covered in the group session or for crisis intervention.

Treatment plan review. At least every three months, the counselor schedules an individual, one-hour session with the client to review and up-date the treatment plan. Treatment plans may need to be reviewed more frequently for individuals who progress rapidly through their treatment plan goals in order to establish new objectives and to encourage continued growth and change by the client. Updating goals further strengthens a client's commitment to the treatment process, while failure to do so leaves the client without formal treatment structure and may reduce motivation for treatment. During these sessions, counselors determine whether goals have been completed and, if not, why they were not completed (e.g., were they unrealistic; did the client not work on that goal?). Depending on the outcome of this discussion, goals may be discontinued if they were unrealistic, revised to make it more likely that clients can achieve them, or continued. Clients may also add new goals on which they want to work.

Discharge planning. Prior to completing treatment, adolescents attend a final session with their counselor to review the treatment experience and discuss discharge planning. Although discharge planning generally occurs in an individual session, it may also be completed in a family therapy session if it is clinically indicated. In general, the discharge planning session lasts an hour and focuses on reviewing the client's progress in treatment and discussing plans for maintaining abstinence once the client is no longer in treatment. Discharge planning at Epoch Counseling Center involves completion of the "Aftercare Treatment Plan" form, which asks clients to indicate, among other things, what they will do to remain abstinent (e.g., attend Narcotics Anonymous meetings) and the signs that indicate that they are at risk for relapse. In addition, clients discharged from Epoch are encouraged to return to counseling should they relapse or feel at risk for relapse.

Additional individual counseling sessions. Individual counseling sessions also occur as needed during the course of treatment. Sometimes the group format is not the appropriate venue for an adolescent to disclose personal information. If, for example, the adolescent is experiencing suicidal ideations or a family crisis, s/he may feel more comfortable disclosing and requesting support individually. Thus, additional individual session are scheduled in the event of a crisis, if clients need additional support to achieve or maintain abstinence, if co-occurring mental health issues compound the individual's ability to fully participate in group treatment, etc.

G. Family Therapy

Family therapy is an important component of the GBT program. Family therapy is used to engage parents or other caretakers in the treatment process, to help family members recognize that substance use is a family, not an individual problem, to address issues seen as critical for the development and continuation of substance use (e.g., interpersonal conflict), and to teach family members how they can help adolescents achieve abstinence. In particular, family therapy

focuses on: (1) educating parents about substance use, how they enable their adolescent to continue using, and strategies they can use to help their adolescent recover; (2) reducing family conflict; (3) improving communication; and (4) addressing crises. The initial session(s) focus on educating family members about substance use and on reducing conflict among family members. Importantly, family therapy helps family members recognize how family conflict can contribute to the escalation and maintenance of substance use. Once conflict is reduced, therapists then focus on improving communication patterns within the family.

Family therapists at Epoch Counseling Center are influenced by family systems theory and also incorporate other specific techniques, notably cognitive-behavioral approaches, within the context of family systems theory (Boulding, 1968; Becvar & Becvar, 1993). Thus, Epoch's family therapists focus the therapy sessions on the family as a "system," rather than on the individual adolescent client. Therapists initiate therapy by identifying patterns of behavior and communication that have developed within the family and focusing on how issues or difficulties affect all members of the family system. With regard to the presenting substance abuse problem, therapists emphasize shared responsibility within the system (Becvar & Becvar, 1993). Working with the family system, the family therapist examines the interactions that take place among family members and asks "What is going on?" in an effort to clarify the patterns that take place (Becvar & Becvar, 1993). In this way, family therapists give meaning to the process and context of the interactions instead of focusing on individual family members themselves.

The family therapists also make use of cognitive-behavioral techniques (see Section I.B., Theoretical Orientation, and Section III.E., Group Counseling, above) to complement the systems approach and utilize in-session role-plays and homework assignments so families can practice new methods of communication as part of their efforts to effect change within the system. As part of this treatment process, families of substance-using adolescents are also provided information about addiction, the presenting problem, and are helped to better understand how addiction has affected the family system, how system responses to addiction have further impacted the system, and how abstinence and recovery will also affect the system. It is important for families entering treatment to recognize that changes in an individual affect the family, just as changes within the family will affect the individual (Minuchin & Fishman, 1981). In keeping with Minuchin and Fishman's perspective, the family is helped to recognize that recovery from substance abuse requires change in the family system. New skills for interacting thus need to be developed within the family to support the recovery of the substance-abusing adolescent.

Family therapy sessions may involve the parents or guardians, siblings, grandparents, and/or any other significant individual who lives in the home with the adolescent. If adolescents are living with a legal guardian, counselors consider involving the biological parent in therapy as well as the legal guardian, if at all possible. Family members are required to attend a minimum of four family therapy sessions, although additional sessions may be scheduled depending on the needs and/or at the request of the family (e.g., to address crises). When additional family therapy sessions are requested to address a crisis, the family therapist will schedule follow-up appointments until the crisis is resolved.

H. Parent Education and Support Group

The Parent Education and Support Group is an optional component of the GBT program that is designed to provide parents with information regarding substance use, addiction, the recovery process, etc. In addition, the parent group is an opportunity for parents to gain support from one another in changing existing family patterns and to learn how to strengthen themselves in their relationship with a substance-using adolescent. Parents are encouraged to attend a minimum of four group sessions, which last approximately 60 minutes, during the 20-week period of treatment. Parent group facilitators prepare a calendar of "upcoming topics" that are scheduled on a weekly or bi-weekly basis, depending on each clinic's client load. These calendars are usually prepared two months in advance so that parents initially have four to eight session topics from which to choose. (See Section IV.C, below, for a listing of Parent Education and Support Group session topics and the curricula for each session.)

I. Time Course of Treatment

As described above, clients initiate treatment by contacting the clinic by telephone and are scheduled for an intake appointment within two weeks. The intake process consists of an initial assessment followed by an individual counseling session that is typically held within one week following the initial assessment. This counseling session is intended to prepare the adolescent to initiate treatment. As part of the program evaluation, two different approaches to treatment preparation are compared, such that some youth receive a motivational interview intended to clarify and reinforce their motivation to change their drug use and engage in treatment, while other youth receive a counseling overview that is intended to familiarize them with the treatment process, expectations, and the client role (see Section VI.B., Focus of the Evaluation, below).

Approximately one week following the treatment preparation session, the client meets with his/her counselor for the treatment planning session, as described above. Thereafter, the adolescent begins group counseling, typically during the third week of treatment. The first family therapy session is scheduled as soon as possible, preferably within two weeks of intake and may be scheduled on a bi-weekly to monthly, or as needed, basis thereafter. The second individual counseling session typically occurs during the tenth week of treatment although other individual sessions may be scheduled earlier in treatment depending on the needs of the client. Each month, parents are given a schedule of upcoming topics to be discussed during the Parent Education and Support Group over the next two months. They are encouraged to attend at least one session per month so that they can complete four sessions by the end of 20 weeks.

IV. Curricula

This section provides detailed curricula for the Group Counseling and the Parent Education and Support Group components of the GBT. First, the Group Counseling curriculum will be presented. Detailed session content is included for 21 group sessions. As noted in Section III.E., above, the group curriculum is comprised of two phases, Drug Education (four sessions) and Relapse Prevention (15 sessions plus two optional sessions). Then the Parent Education and Support Group curriculum will be presented, including detailed session content for eight core session topics and four optional session topics. Specific exercises that may be used in conjunction with various sessions are contained in Appendix A, B, and C.

A. Group Counseling Phase I – Drug Education

Group Session 1	Drug Education I: Physical, Psychological, and Behavioral Effects of Drug Use
Group Session 2	Drug Education II: Progression of Substance Use; Self-Diagnosis
Group Session 3	Drug Education III: Relapse
Group Session 4	Drug Education IV: Family Influence

Group Session 1–Drug Education I: Physical, Psychological, and Behavioral Effects of Drug Use

Main Points for this Session

Effects of Alcohol
Effects of Marijuana
Effects of Tobacco
Effects of other drugs, depending on current group composition

Rationale

The purpose of this session is to educate adolescents about the physical, psychological, and behavioral effects of substance use. One particular question that should be asked throughout the course of this session is: Why is it important for adolescents to learn about the effects of alcohol and drugs? Learning about the physical, psychological, and behavioral effects of drugs and alcohol will better equip adolescents to understand some of the effects of drug use they may already be experiencing. This information can help the adolescent identify within themselves the effects of drugs and alcohol, and to understand how different routes of administration of a drug may increase the likelihood of addiction. This lesson is designed to enhance the adolescents overall awareness of how extensive the effects of substances can be.

Session Content

Physical Effects: encompass the effects that alcohol and drugs have on the body. These effects impact different parts of the body, for example, the central nervous system.

Psychological Effects: include the impact substances have on one's emotional state: Does the substance have an effect on depression or anxiety? Does a drug, for example, have an impact on one's self-esteem?

Behavioral Effects: how does a substance influence one's behavior? Are you more aggressive or lethargic? Are you no longer fulfilling your responsibilities?

Note: Counselors may choose at this stage to have the group make a list of effects they think they have experienced; at the conclusion of this portion of the group they can revisit this list identifying the effects as either physical, psychological, or behavioral and discussing them.

Effects of Alcohol

Alcohol is a central nervous system depressant. Physically, it causes an overall dose-related depression on the central nervous system, ultimately slowing down the activity of the brain and spinal cord. Psychologically, alcohol decreases anxiety, increases sedation, and causes a type of "disinhibition" intoxication (or, in other words, how does alcohol "loosen" you up when under the influence?). Because alcohol is legal many do not realize it is actually a sedative-hypnotic drug, acting as an agent in reducing physical and psychological reaction times,

while also impairing concentration, judgment, and awareness. Alcohol effects the central nervous system thereby decreasing anxiety, tension, and inhibitions. Similarly, alcohol also promotes relaxation, thus increasing confidence during social and stressful situations (Landry, 1993). In addition, it is in these social or stressful situations that alcohol may actually have an "expectancy effect," based on setting alone. Expecting to feel a certain way might actually influence the outcome, not simply as a result of the alcohol consumed.

Why is alcohol a depressant when it makes you feel so high and "buzzed?"

Low to moderate doses of alcohol cause people to experience a positive, upbeat, even hyperactive feeling. This initial phase of alcohol use is termed "intoxication" as people feel a behavioral and emotional disinhibition. During this time people are often more talkative, sociable, and self-confident. However, as alcohol use continues and doses continue into a medium to high phase the effect alcohol has on people progresses. Thought processes become impaired, and reaction times and physical dexterity becomes a challenge. As intoxication continues into this phase people may behave in more "exaggerated" ways than normal; assertive people become more assertive, even aggressive, and people who are normally shy may become more outgoing, even sexually and verbally aggressive. High doses of alcohol, however, tend to make people feel depressed, withdrawn, and lethargic. The ability to think and communicate becomes severely impaired. Motor control is impaired to the point of severe lack of coordination. At even higher doses the depression of the central nervous system progresses to the point of sleep, stupor, and possibly coma. As use enters the higher dose phases one can expect to experience a "brief withdrawal syndrome" known as a hangover–including nausea, vomiting, nervousness, and uneasiness.

Tolerance is a common experience as the use of alcohol continues and rates of use begin to increase towards these higher dose phases. This is a process where an individual needs to consume more of the substance to achieve the desired effect. With alcohol, somebody who might typically feel intoxicated after 4 beers now needs to consume 6 or 7 to feel that way. Continuing to drink 4 would no longer have a noticeable effect. Tolerance tends to increase drug use in order for the individual to feel the effects of the drug.

Effects of Marijuana

Marijuana is the "dried leaves and flowering tops of *Cannabis sativa*, a plant containing numerous chemicals, some of which are psychoactive," (Landry, 1993). Tetrahydrocannabinol (THC) is the main psychoactive chemical. Marijuana is generally smoked, although it can be prepared and eaten. Marijuana can be described as a depressant drug with psychedelic properties.

The effects of marijuana are wide and varied depending on dose and frequency of use. For the occasional user marijuana can have a purely psychedelic effect: relaxation, altered sense of time, fantasy thoughts and images, and a preoccupation with the process of thinking. Sensory perceptions can also be heightened by marijuana intoxication. Marijuana has the tendency to intensify auditory and visual perceptions, as well as causing an increase in heart rate. Overall mood elevation, inappropriate laughter, increased appetite, and "red eyes" are also common effects of marijuana use. Depending on dosage and potency these symptoms of use may begin

within a few minutes of use and may last 2-4 hours.

With higher doses of marijuana the experience can become largely negative depending on tolerance levels to the drug. Thinking may become distorted, even suspicious, and mood may shift from elevated to depressed. Apprehension, anxiety, fear, and slight body tremors often accompany this level of marijuana use.

Chronic marijuana use leads to tolerance, as was described with alcohol. The feelings of the occasional marijuana smoker dissipate as use becomes more regular. As use increases the effects become more negative. Such chronic use, typically daily, "may produce a chronic marijuana toxicity state, commonly called an "amotivational syndrome," (Landry, 1993) which describes the common apathy and lack of ambition of chronic marijuana use. Chronic marijuana use also has the following effects:

- poor frustration tolerance
- moodiness
- depression and agitation
- impaired concentration and thought process
- short-term memory loss
- impaired judgement
- impaired coordination
- carcinogenic effects

Effects of Tobacco

Nicotine is the predominant drug in tobacco and is responsible for the addictive nature of tobacco. Inhalation leads to rapid effects of nicotine as the drug quickly passes into the bloodstream. Chewed tobacco is absorbed more slowly through the lining of the mouth. Much like other substances, the effects nicotine has varies by individual depending on dose and frequency of use. Overall though, nicotine in cigarettes causes a wide range of effects that encompass one's entire lifestyle. In general, smokers are less fit than non-smokers and reach exhaustion sooner, and are more likely to miss school, work, or other obligations due to illness. Smoking has been identified as a major cause of heart disease, stroke, several forms of cancer, and a number of other health problems. Some of the most common physical effects/problems resulting from use of tobacco are:

- decrease in sense of taste and smell
- frequent colds
- excessive "smoker's cough"
- gastric ulcers
- chronic bronchitis
- increase in blood pressure and heart rate
- increased risk of asthma
- increased risk of allergies
- emphysema

- heart disease
- stroke
- cancer of the mouth, larynx, pharynx, esophagus, lungs, pancreas, cervix, uterus, bladder

As with alcohol and marijuana described above, the use of tobacco is addictive as smokers experience a developed tolerance for nicotine. As a rather addictive drug, those dependent on nicotine experience a wide range of psychological effects from its use, especially prevalent if not smoking, or trying to quit:

- irritability
- anxiety
- sleep disturbances
- nervousness
- cravings

Effects of other drugs

Cocaine

Cocaine is a stimulant drug that increases the activity of the central nervous system; increased blood pressure, rapid heart rate, and possible panic attacks. Cocaine, crack, amphetamines (such as speed), and methamphetamines cause a range of dose-related effects (Landry, 1993) from alertness, confidence, euphoria, and impulsiveness to agitation/restlessness, psychomotor agitation (uncontrolled physical activity), and stimulant psychosis (delusions/distortions) in thinking in higher and more chronic doses. Stimulants can cause people to become socially disinhibited, exaggerating the impulsiveness they already feel, thus leading to potentially dangerous decisions such as unprotected sex or verbal and physical violence. Chronic use of stimulants often results in people feeling depressed, agitated, and lethargic thus contributing to the craving for more stimulant drugs.

Cocaine is a good example of a drug that can be taken by different routes of administration, thus causing differences in how quickly the effects are felt, contributing to the intensity of the addiction. Cocaine can be snorted, injected, or smoked in the form of crack cocaine. The euphoria resulting from crack, smoking cocaine, is intense and occurs quite rapidly, taking approximately 7 seconds (Landry, 1993). The intensity of this route contributes to the common craving associated with crack use. When cocaine is snorted it takes closer to 4 minutes to reach the brain with the effects occurring within 15-20 minutes. Injecting cocaine may result in a higher euphoria than snorting, but not as quickly and intensely as smoking cocaine. This intense euphoria contributes to the more psychologically addictive component of this drug.

Heroin

Heroin is an opiate, in the same category as alcohol and other depressant drugs. Opiates create a state of initial euphoria. Just like sedative-hypnotics (like alcohol) cause an overall

depression of the central nervous system, the opiates interact with nerve pathways that relate specifically to pain. Like other substances described, the opiates ability to react is determined by dose and potency of the drug. Typically, physicians prescribe opiates for their pain-reducing benefits. Heroin, however, is a morphine-based opiate with no approved medical uses. Additional effects of opiates are a sort of "mental-clouding," drowsiness, respiratory depression (Landry, 1993), as well as nausea, vomiting, apathy, decreased physical activity, and difficulty thinking.

Heroin is another substance, like cocaine, where the route of administration can vary, and the intensity and overall effects of use can be impacted. Snorted heroin is less intensive than injected heroin. Along with the rapid transmission of injected heroin throughout the body, it also seems to have higher risks associated with its use: needle sharing, HIV, hepatitis, and overdose due to unknown purity and potency of the drug, etc.

Ecstasy

Ecstasy is another name for the drug Methylenedioxymethamphetamine (MDMA). Ecstasy is a synthetic, mind-altering drug, with both amphetamine and hallucinogenic properties. The effects, pharmacologically, of Ecstasy resemble those of other amphetamines providing a stimulant effect to the central nervous system. Ecstasy tends to provide a feeling of euphoria, heightened interpersonal feelings or emotional closeness, higher self-esteem, intensified senses of feelings and touch, a gaining of personal insight, eliminates anxiety, provides relaxation, etc.

However, all the effects of ecstasy are not "positive." It can produce detrimental effects in the brain and the body. Ecstasy has been found to contribute to the onset of depression, and harms those parts of the brain responsible for thought and memory. Additional negative physical effects are:

- muscle cramping
- involuntary teeth clenching/grinding
- nausea
- blurred vision
- faintness
- chills/sweating
- dehydration
- exhaustion
- hypertension
- loss of control over body movements
- hampers sexual function
- tremors
- reduced appetite
- heart and kidney failure

Ecstasy is typically sold in tablet or capsule form and ingested orally, however, it may also be injected or snorted. The average dose per use is 1-2 pills. It has been suggested that

Ecstasy pills do not contain pure MDMA, but rather contain other drugs as well including, cocaine, heroin, and LSD to name a few. Consequently, the effects of Ecstasy can be highly addictive, quite dangerous, even deadly, depending on the dose and byproducts of the substance used.

Continued discussion...

Once information is presented, counselors will need to encourage clients to apply what they have learned about the effects of alcohol, marijuana, tobacco, and other substances to their own lives. How many of these physical, psychological, and behavioral effects have they experienced themselves? It is useful to discuss the importance of knowing facts about substances as well as knowing how to identify the effects of substances within you. How does this differ at the end of the session from the lists of effects created at the beginning of the session?

Optional Exercises

Counselors may want to distribute information on these substances, as well as other substances such as hallucinogens and steroids, to adolescents to take home for further perusal. One such resource for information is the US Department of Health and Human Services and SAMHSA's National Clearinghouse for Alcohol and Drug Information. Counselors can acquire information for free through the Clearinghouse. Of particular interest is the Tips For Teens series. In addition, some activities that may be considered for use throughout the session include a quiz on Marijuana facts (see Appendix A) to initially test what adolescents believe to be true regarding cannabis, and *"The First Time/The Worst Time/The Last Time"* worksheet (see Appendix A) to assist client in identifying what they have experienced as a result of drug use and how symptoms seem to progress over time with continued use. To assist clients in learning the different drug categories, counselors may also want to draw columns on a board and provide clients with post-it notes which include one drug name per post-it. Clients would then have to put their post-it note in the appropriate column. This is an interactive way for clients to learn the differences between depressants, stimulants, and psychedelics, as well as to learn the different drugs in each category.

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

- # Identify and list the physical and psychological effects of different substances.
- # Differentiate the drug categories based on their effects: depressants, stimulants, and psychedelics.
- # Identify effects personally experienced based on drug use.

Group Session 2–Drug Education II: Progression of Substance Use; Self-Diagnosis

Main Points for this Session

Progression of substance use
Self-diagnosis
No use contract

Rationale

The purpose of this session is to educate adolescents about progression of substance use from experimentation to dependence and to help them identify their current stage of use. This is important for several reasons. First, clients need to understand that each stage of substance use they achieve (e.g., experimentation) increases their chances of progressing to the next stage of use (e.g., misuse). In addition, the progression of substance use from being fun and controllable to causing significant problems and being out of control often occurs without the adolescents' awareness. Finally, adolescents need to begin to make a connection between their substance use and some of the negative consequences or problems they are experiencing. By developing an understanding of their use, and in particular by making the connection between their use and the problems in their lives, this lesson is designed to increase and strengthen adolescents' commitment to achieving and maintaining abstinence.

Session Content

Progression of substance use.

Counselors should lead a discussion about each stage of use. Clients should be encouraged to offer their own definition of each stage. Below are brief definitions of each stage which have been adapted from the book by Tammy Bell (1990). In considering these definitions, remember that alcohol and tobacco are considered illicit substances for adolescents.

No Use The individual uses no illicit substances.

Experimentation At this stage, the adolescent uses the substance in order to learn more about its effects. The adolescent does not use alone and typically does not buy the substance; rather he or she uses because someone else made it available. The adolescent is quite concerned about being caught and is careful about when, where and how much she or he uses. There are typically no serious consequences associated with use at this stage, although the adolescent may experience some minor negative consequences (e.g, hangover).

Misuse At this stage, the adolescent begins to seek out opportunities to use the substance and uses it "to get high." The adolescent is likely to experience some negative consequences at this point (e.g., parental mistrust; decline in school performance). This is a pivotal point; if the adolescent attributes

	the negative consequences experienced to his or her use, s/he may reduce or discontinue use at this point. If the connection between use and negative consequences is not made, the adolescent is likely to modify his or her life (e.g., avoid non-using friends) to support continued use.
Abuse	Abuse occurs when the adolescent loses control of his or her use; that is, when she or he uses more of the substance or more often than intended or begins to use other, "harder," substances than intended. Efforts to stop or cut down may be temporarily successful but most often, the adolescent returns to "out of control" use quickly. The adolescent is beginning to experience more serious problems from his or her use.
Addiction/ Dependence	At this point, the adolescent meets criteria for psychological or physical dependence according to the Diagnostic and Statistical Manual- Fourth edition (DSM-IV; 1994). Clients must meet at least 3 of the DSM-IV symptoms, with tolerance and/or withdrawal being necessary for a diagnosis of physical dependence. If physical withdrawal is present, the adolescent is likely to require detoxification.

Self-Diagnosis.

Counselors should allot the greatest amount of time to this portion of the session. This section focuses on having adolescents (1) recognize the current severity of their drug problem and/or (2) their risk of progressing from one level of use to another. One strategy for helping adolescents identify their stage of use is to have them complete a *Youth Substance Use Timeline* (see Appendix A). Depending on time constraints, counselors can have clients complete one timeline for each substance used or one timeline for the substance which has caused the adolescent the greatest problems. Clients are asked to start at experimentation and write down the age at which they began to use at each level. For each stage adolescents should write up to three signs/symptoms they were experiencing which indicated that their drug/alcohol use had progressed from one stage to the next. If clients are having difficulty identifying the ages at which they achieved each level of use, counselors can ask questions to facilitate the process (e.g., how old were you when you first drank alcohol without your parent's permission?; how old were you when you first drank alone?).

Encouraging clients to share their timeline with the group and to receive feedback from other group members is likely to make this exercise particularly powerful. For example, clients might be made to see that they progressed to addiction at an earlier age than anyone else in the group or that they began using later than other group members but that their use progressed much more rapidly. Moreover, clients who admit to low levels of use may receive feedback from other group members that helps them to recognize that they are underestimating their level of use as well as ignoring problems that are clearly related to their use.

Sign No Use or Tapering Contract.

Once counselors and clients have finished processing the diagnosis and timeline, they should discuss the reasons for signing a *No Use Contract* (see Appendix A). A *No Use Contract* is a written agreement between the counselor and client that specifies how long and from which substances the adolescent will abstain. Counselors emphasize that *No Use Contracts* are useful because making a commitment to abstinence, in writing, to another person, increases the likelihood that the client will remain abstinent for the specified period of time either because they do not want to disappoint the person with whom they have made the agreement or because they want to avoid feeling bad if they do not "hold up their end of the bargain." The time frame specified in the contract should be determined by the clients. If possible, the counselor should try to encourage clients to remain abstinent until the next group session when a new contract can be signed. If clients are unable or unwilling to agree to stay abstinent for one week, however, the counselor should allow them to sign a contract that specifies a shorter period of time. It is critically important for clients to experience success, especially early in treatment. Therefore it is most important that the time frame selected be reasonable for the clients to achieve. An initial failure may set clients up to feel that they are unable to succeed in treatment and thus they are likely to drop out of treatment prior to achieving any benefit. The number of days that clients agree to remain abstinent can be increased gradually over time. Both the counselor and clients should sign and date the contract and a copy of the signed contract should be given to the clients to take with them.

Some clients may refuse to abstain from substances entirely, particularly early in treatment. In this instance, counselors may discuss with the client the possibility of signing a *Tapering Contract* (see Appendix A). In a *Tapering Contract*, clients agree to reduce their use by a specified amount each week. For example, clients may choose to abstain from substance use on a particular day each week. Or, clients might agree to use fewer times each day. Counselors should be flexible about how clients go about reducing their use to ensure the greatest likelihood of compliance. Again, both the client and counselor should sign the contract and a copy given to clients to take with them.

If a *Tapering Contract* is used, the counselor should discuss with clients the possibility of discussing this decision with their parents. It is extremely likely that parents will become upset if they discover that the drug treatment program is not requiring complete abstinence of their adolescents. To prevent parents from withdrawing adolescents from treatment prematurely, the counselor can help parents understand that abstinence is the ultimate goal for the adolescents and that the reason for the *Tapering Contract* is that it allows the counselor time to work with the clients to increase their motivation to stop their substance use entirely. If compete abstinence were required of certain youth at the beginning of treatment, they might drop out before receiving any therapeutic benefit. If parents understand the reasons for choosing a *Tapering*, as opposed to a *No Use*, contract, they may be more willing to keep their adolescent in treatment and provide the counselor with information about whether or not the adolescents are in fact reducing their use.

<u>Optional Exercises</u>

Counselors may want to use the Adolescent Alcohol Involvement Scale (AAIS; Mayer & Filstead, 1979) when having adolescents "self-diagnose" their level of use. The AAIS asks questions about how often adolescents drink, when they last drank alcohol, the first time they drank, etc. Included with the AAIS is a scoring key that assigns a point value to each of the possible responses. The range of scores is 1 to 79 and adolescents use their total score to determine their level of use from "total abstainer" to "alcoholic-like drinker."

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

- List the signs and symptoms of each stage of substance use
- List symptoms/consequences associated with their own substance use
- Correctly self-identify current level of use (experimentation to dependence)
- Sign no use contract or tapering contract

Group Session 3–Drug Education III: Relapse

Main Points for this Session

Identify consequences of using drugs and alcohol
Define and identify adolescents' personal high-risk situations
Complete *Functional Analysis*
Understand relapse process
Define lapse and relapse

Rationale

The purpose of this session is to help adolescents understand that relapse is not a single event over which they have little control. Rather, they will learn that relapse is a process, which is triggered by events that can occur long before (i.e., days and even weeks) adolescents ever pick up and use. This is important because it teaches adolescents that rather than being an inevitable event that is under the control of a variety of external stimuli (or triggers), relapse is something over which the adolescent can exert some control. Thus, adolescents will learn (1) to identify their personal relapse triggers, (2) to identify signs that the process of relapse has begun and (3) preliminary skills for interrupting the process before it results in a return to substance use.

Session Content

Identify consequences of using drugs and alcohol.

In very concrete terms, counselors will lead a discussion of operant conditioning (Skinner, 1953) and explain its role in the initiation and maintenance of drug use. Specifically, counselors will explain that substance use, at least in the beginning, is heavily controlled by its consequences; that is, if substance use is reinforced by positive consequences, then adolescents will continue or increase their use; if substance use is punished by negative consequences, then adolescents may discontinue or decrease their use. Clients should be asked to discuss the consequences they have experienced from their use and how, if at all, those consequences affected their subsequent use.

Example:

Positive consequences and impact:	Felt high, more friends, fewer inhibitions; started using at every party
Negative consequences and impact:	Embarrassed, friends and family giving me a hard time about use; spent less time with family and non-using friends, hung around with using friends more

Define and identify adolescents' personal high-risk situations.

Once adolescents have demonstrated a clear understanding of the consequences of their use and how these consequences affect use, counselors will then define and discuss high risk

situations. In very concrete terms, counselors will make the distinction between early use, which is controlled by operant conditioning and later use, which is controlled or maintained by classical conditioning (Pavlov, 1927). Specifically, counselors will explain that in the beginning, substance use is a conscious decision; that is, adolescents use because they want to experience the effects of the substance or some other positive consequence (e.g., fit in with peers). Over time, substance use becomes a habit; that is, it is no longer a conscious decision but rather an automatic response that is controlled by the people, places, things, thoughts and feelings that are associated with use. For example, if adolescents use with a certain group of friends, then seeing those friends will trigger the adolescent to think about using. Similarly, if adolescents use drugs to alleviate boredom, over time, they will begin to believe that the only way to relieve their boredom is to use. For adolescents in recovery, these situations that trigger habitual use, that is use in the absence of a decision to use, are known as "High Risk Situations." High Risk Situations are those situations which have become associated with use and in which an adolescent, who is abstaining or trying to abstain, will be reminded of the positive consequences of use (e.g., I won't feel bored; I will get to hang out with my friends), experience strong cravings for the substance and, possibly use the substance.

Complete Functional Analysis.

Counselors will distribute the *Functional Analysis* worksheet (see Appendix A). Under the section labeled "Antecedents," clients are asked to write down the people, places, things, times of day, thoughts, and feelings, that are associated with their use. Counselors should be certain that clients are as specific as possible (e.g., if clients use with friends, they should write down the names of the friends with whom they use). Under the section labeled "Consequences," clients are asked to write down all of the positive and negative consequences they have experienced from their substance use. Once clients have completed the worksheet, counselors will ask clients to recount a situation in which they experienced strong cravings to use. This will help to demonstrate (1) that the antecedents they have listed produce thoughts about using and possibly cravings for the substance, (2) that adolescents frequently use in these situations, (3) their use results in some consequences (either positive or negative), and (4) the experienced consequence may or may not affect subsequent use.

Antecedents	**Associated Questions**	**Examples**
People	With whom do I use?	John, Dionne, Jose, and Phil
Places	Where do I use?	School playground
Things	What paraphernalia do I Use?	Green lighter; roach clip
	Do I wear certain clothes or listen to certain music when I use?	Nirvana t-shirt Nirvana
Times of Day	When do I use?	Before and after school
Thoughts	What am I thinking right before I use?	I am bored, I could use a joint.

Feelings	How do I feel physically and emotionally right are tight, craving before I use?	Bored, anxious, shoulders

Understand Relapse Process.

Counselors will lead a discussion about how the triggers or high risk situations adolescents have just identified will affect their efforts to maintain abstinence. In particular, it should be emphasized that relapse is a process that can begin long before the client ever picks up and uses. In particular, relapse can occur for one person after exposure to one High Risk Situation or it can happen after exposure to many High Risk Situations. The important thing to emphasize here is that High Risk Situations are choice points; that is, points in time in which adolescents must make the decision whether to use or not use and thus experience or avoid certain consequences. To illustrate this point, counselors can use the following examples or develop some of their own.

Ask clients to discuss what choices they would make in the following situations and why:

1. Your friend tells you he scored some really good heroin. He tells you he got it from the same dealer where another friend of yours, who overdosed on heroin just yesterday, bought his heroin. Do you use the heroin?

2. You are scheduled to see your parole officer tomorrow. You have not used cocaine in four days because he told you that you will have to leave a urine sample. He also told you that if you don't show up tomorrow, or if you give a drug positive urine sample, you will be violated and sent to a juvenile detention center since you missed your last few appointments. On the way home from school, you run into a friend who has some cocaine and she asked you to go get high with her. What do you do?

3. Your mother has told you that she will throw you out of the house and change the locks on the door if you don't come straight home from school today and from now on. You believe her because she did the same thing to your older brother a year ago. One your way home, you see some friends getting high and you know, if you stop, you will stay longer than you should and your mom will have locked you out of the house. What will you do in this situation?

4. You have been doing really well in your recovery; your grades have improved, you have gotten a part-time job after school, and you have been getting along better with your family. Your mom is really proud of you and she has promised to help you buy a car if you stay off alcohol. On the way home, you see some friends drinking in the park. They call you over and offer you some. You miss hanging out with them and realize that you would have a lot of fun if you drink with them. You also know that your mom will be able to smell alcohol on you if

you drink. What do you do in this situation?

Counselors can lead a discussion about why it would be difficult to turn down drugs or alcohol in these situations. The reasons it is difficult to say no are what make drug use seem uncontrollable. But as is also illustrated in these situations, when adolescents consciously consider the decision to use drugs, it is evident that both choices have positive and negative consequences. Adolescents should also be asked to discuss how difficult it would be for them to abstain if faced with some of the situations listed on their *Functional Analysis* in the future (e.g., if you were to run into John, Dionne, Jose and Phil and they offered you some pot, how hard would it be for you to turn them down?). They should also explain why it would (e.g., I am bored and miss hanging out with them) or would not (e.g., I know I would be violated and sent to Hickey (juvenile detention) if I gave a positive urine at Epoch) be difficult. Adolescents who state that the negative consequences they have experienced are not sufficient to affect their level of use should be asked to think about and discuss what negative consequences would have to happen in order for them to change their level of use.

Define lapse and relapse.

Counselors should now make the distinction between a lapse and a relapse. A lapse is defined as a single episode of use. Relapse, on the other hand is defined as returning to pre-treatment levels of use. It is important for adolescents to understand that a single episode of use does not mean that they have failed in their efforts at recovery. Rather, just like High Risk Situations, lapses represent choices point when adolescents can choose to discontinue use and learn from the situation or they can continue use and "lose control." However, lapses often lead to relapses. This is because when people break rules they have set for themselves, they often feel guilty, embarrassed, or angry with themselves – they may even feel like failures. People often use these feelings as an excuse to use more because they have used already so it does not matter if they keep using or to make the feelings go away. People may also believe that once they have started, they cannot stop. Whatever the reason, people quickly move from a lapse to a relapse. However, counselors need to re-emphasize that rather than being out of control, drug use is controllable and exposure to High Risk Situations and lapses do not necessarily have to lead to substance use. In fact, if clients can avoid lapsing in the face of High Risk Situations or discontinue before losing control after a lapse, they will have gained a sense of mastery over their use and this will actually produce positive feelings (e.g., feeling proud and successful).

In summary, counselors should emphasize that it is best to stop the relapse process by being aware of high-risk situations and either avoiding them or finding other ways of coping with them (e.g., reminding self about the negative consequences of use). If high-risk situations lead to a lapse, then clients need to remember that they can make the choice to stop using before losing control and that this choice will ultimately make them feel good about themselves.

<u>Optional Exercises</u>

None

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

- # Define relapse as a process not a single event
- # Define high risk situations and list personal high risk situations
- # Distinguish between a lapse and a relapse
- # Discuss drug use as a choice and identify one strategy for avoiding drug use when faced with high risk situations

Group Session 4–Drug Education IV: Family Influence

Main points in this session

Discuss factors that contribute to maladaptive behavior patterns (i.e., drug use, aggression, sexual behavior, psychiatric)
Complete the genogram
Identify family patterns contributing to hurdles to recovery
Emphasize personal responsibility for acquiring change

Rationale

The purpose of this drug education session is to assist the client in understanding the significance of the family influence on behavior, specifically substance use. As a result of this session, clients should be able to understand family patterns and gain some insight regarding the influence of these patterns on their own lives. In order to achieve a sense of commitment to abstinence, it may require the client to "break away" from some of these family patterns. Clients should be encouraged to develop a plan to resist the negative influences present in their environment from family and friends, especially from those who are still using and/or encouraging them to continue using as well.

Session Content

It is important for adolescents to understand their biological inheritance, including strengths and weaknesses passed along to them through the family. In addition, social and psychological influences are also part of the role our parents play along with providing the genetic make-up that contributes to who we are. Clients need to recognize the importance of each aspect and the impact these family factors have. Group members need to understand that their drug and drinking beliefs, attitudes, expectancies, and behaviors have been strongly influenced through the interaction of social influences, culture, family, and peers. It is common for adolescents to be unaware of the variety of factors that influence their behavior and decision making, particularly the influence of genetics and parental/family modeling. The adolescent struggle for an identity amongst their peer group and also separation from family is common and is a primary issue for adolescents as they witness parental behavior. While it is important for adolescent clients to understand that their behavior is directly influenced by the modeling of parents, or other caretakers, that fact should be balanced and placed in context. They are not, as a result of their parents behavior, predestined to a life of addiction. They may be genetically predisposed to addiction, but self-regulation of behavior is possible.

With these concepts in mind it is important to take into consideration the nature versus nurture debate. The beliefs that we have regarding learning and what contributes to our thoughts, ideas, values, behavior, etc. is important. Some people strongly believe that we are predisposed genetically to certain things: behavior, health, etc. Regardless of the environment, it is our biological wiring that largely determines who we are. On the other hand, there are those who strongly believe that we think, feel, behave, etc. in a way that is molded by our

surroundings. The environment and the people in it are more influential in determining who we are than our genetic make-up. The nature versus nurture debate tends to generate discussion as many have specific beliefs. Clients should be encouraged to share their individual beliefs and ideas throughout this group session as they begin to examine their own behaviors and learn to identify where they may have come from.

One possible way to encourage group members to think about family patterns and the environment they live in is to construct a Family Genogram. A genogram is a good way to achieve a clear visual perspective of family patterns and influences. First, however, it is important to help clients understand "how" to properly construct the genogram, especially as clients ask questions specifically related to their individual family histories. For example, "What if my father is dead?" "What if my mom or dad are remarried?" or "I don't know my parents?" Help clients to focus on their primary caregivers while also giving attention to all important and influential family members. Clients may also need some assistance and encouragement in revealing through the genogram any family skeletons they may have. The genogram, however, may prove to be a less threatening method through which clients may share these skeletons. As clients complete the genogram they are encouraged to look for patterns and to share those they have identified with the group. Clients should be encouraged to share how they feel about these patterns, and to share if they feel these types of behaviors or "trademarks" throughout their family history has had any impact on them, positive and/or negative.

Provide clients with crayons or markers to draw the genogram. A genogram is a simple pattern that uses lines to create family lineage and shapes to depict gender of family members. Additional signs can be created to use for family members who are separated, divorced, deceased, etc. The most significant aspect of the genogram though is to color code the patterns to be depicted as present in the family. Colors should be assigned to each behavior or characteristic and clearly indicated by a color code provided. For example, blue = drug/alcohol problem, red = anger/violence problem, orange = mental health issues, yellow = legal problems, brown = teen pregnancy, black = physical illness, purple = high school graduate, green = person you are closest to, etc. Additional colors can be used and additional behaviors or characteristics can be identified.

In addition to the family genogram, discussion can extend beyond the above mentioned characteristics. In general, it seems the genogram identifies "problem areas" within the family structure. Positive family characteristics can and should be identified as well. Counselors should pose questions to the clients regarding how family members have influenced them overall. Using the *"Family Influences"* worksheet (see Appendix A) in addition to the genogram for extended discussion can be quite helpful in assisting clients to think in this way.

Optional Exercises

None

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

- # Understand factors that influence behavior: family genetics and environment
- # Identify and discuss possible origins of personal behavior.
- # Identify family patterns of behavior by using the Genogram model.
- # Identify and discuss what behaviors you have control over and acknowledge your personal responsibility to change.

B. Group Counseling Phase II – Relapse Prevention

Group Session 5	Relapse Prevention I: Goals Group I
Group Session 6	Relapse Prevention II: Coping with Stress
Group Session 7	Relapse Prevention III: Coping with Hurdles in Recovery
Group Session 8	Relapse Prevention IV: Managing Thoughts About Using
Group Session 9	Relapse Prevention V: Process Group I
Group Session 10	Relapse Prevention VI: Respect
Group Session 11	Relapse Prevention VII: HIV/AIDS Awareness
Group Session 12	Relapse Prevention VIII: Assertiveness: Relationships
Group Session 13	Relapse Prevention IX: Process Group II
Group Session 14	Relapse Prevention X: Goals Group II
Group Session 15	Relapse Prevention XI: Refusal Skills
Group Session 16	Relapse Prevention XII: Anger Management
Group Session 17	Relapse Prevention XIII: Process Group III
Group Session 18	Relapse Prevention XIV: Physical Health
Group Session 19	Relapse Prevention XV: Increasing Pleasurable Activities

Optional Group Session; Job Seeking Skills
Optional Group Session; Preparing for Continued Education

Group Session 5–Relapse Prevention I: Goals Group

Main Points for this Session

Define Goals.
Discuss reasons why it is important to set goals.
Goal setting and review.

Rationale

The purpose of this session is to (1) help clients identify important treatment-related and personal goals, (2) develop plans for accomplishing those goals, and (3) review progress and provide reinforcement for successful achievement of goals. Goal setting is an important part of substance abuse treatment because (1) recovery is hard work and it is helpful to have good reasons for working so hard, (2) goals provide structure to the extent that it helps counselors know which areas of a clients' life will need the greatest emphasis, and (3) treatment will be more interesting and will feel more helpful if it is focused on the specific areas that clients feel are most in need of change. Because there are two goals groups during treatment, clients will be at every different stages of treatment/recovery and will therefore be working on different types of goals. For those early in recovery, the main focus of the group will be on learning how to set goals and skills needed to accomplish those goals. For those later in recovery, the main focus of the group will be on reviewing progress, identifying barriers to accomplishing goals or setting longer term goals and developing plans for accomplishing those goals.

Session Content

Define goals.

Counselors will want to elicit from clients their definition of a goal. They should reinforce accurate definitions and provide corrective feedback as necessary. According the *American Heritage Dictionary, 2nd College Edition*, a goal is defined as "1. the purpose toward which an endeavor is directed; objective. 2. The finish line of a race..." (P. 565). Therefore, counselors should be certain that clients definition of a goals includes two main concepts: (1) goals are something that are desirable and/or that clients want and (2) it requires effort to achieve goals. One way to help clients understand the definition of a goal might be to refer to the Functional Analysis completed during the "Understanding Relapse" session and talk about the specific desirable consequences clients' experienced from drug use as goals that they wanted to achieve. These consequences are goals because (1) they are desirable and (2) clients had to expend effort (i.e., to get the drug or alcohol) in order to achieve the effect. Counselors will then want to elicit from clients examples of other goals on which clients can work that can be achieved without the use of illicit substances to achieve. More experienced members of the group may also be asked to share some of the goals on which they have been working since their previous goals group.

Reference: *The American Heritage Dictionary, 2nd College Edition*, Boston: Houghton, Mifflin.

Discuss reasons why it is important to set goals.

Counselors should elicit from clients reasons why it is important to set goals in treatment. There are several reasons why it is important to set goals during treatment. First, recovery is hard work, and setting goals that are contingent upon maintaining abstinence give clients reasons for working hard in their recovery. Second, setting goals provides a framework for treatment. In other words, treatment is more focused because clients and counselors focus their effort during treatment on helping clients achieve their goals. Finally, treatment will be more interesting to clients if they feel that it is focusing on issues that they feel are important or on areas that they feel are in need of change.

Goal setting and review.

If this is the clients first goals group, the focus of the session will be on selecting short-term goals that clients can and need to work on while they are still in treatment. Counselors will have clients complete the *Goals Sheet: Short-term* handout (see Appendix B). Counselors will need to circulate around the room to ensure that clients are completing the form correctly, that they are selecting appropriate goals, and that they understand what is being asked of them on the handout. When checking over the completed handouts, counselors should make sure that the goals selected are ones that (1) clients have a high likelihood of accomplishing, (2) can be easily accomplished before the next scheduled goals group, and (3) involve discrete concrete behaviors in which the client can engage (e.g., attend all classes for a two week period) rather than vague, abstract goals (e.g., increase self-esteem). Goals should also be stated positively, that is as specific, discrete behaviors in which the client can engage (e.g., I will attend all classes during the next two weeks) as opposed to actions the clients should avoid (e.g., I won't skip anymore classes). Counselors should be flexible about the types of goals on which clients choose to work although the goals should be relevant to their drug use. For example, "asking a girl out when sober" may be a reasonable short-term goal for a client who is socially outgoing only when intoxicated.

Examples of appropriate goals for clients at this stage include:

- Attend all classes for a two week period
- Remain drug free for one week
- Make one new non-using friend
- Spend one weekend day with my family
- Exercise three times per week
- Attend AA or NA meetings daily
- Receive a passing grade on upcoming math quiz
- Go to a movie instead of hanging out on the corner with friends
- Ask a girl out when sober

If clients select longer term goals (i.e., goals which will require more than a few weeks to accomplish) counselors should encourage them to think about a smaller step that they can take that will get them closer to accomplishing the longer term goal. For example, a client who states

that she would like to attend college in the fall should be encouraged to work on a smaller step, such as setting up an appointment with her guidance counselor to discuss what she will need to do in order to get into college.

In addition to selecting goals, clients will also be asked to develop specific plans for how they will go about accomplishing the goal, consider possible barriers to accomplishing goals, and solutions for overcoming those barriers. When reviewing clients' plans, barriers, and solutions, counselors should be sure that (1) the plan is specific; that is, that it includes the day and time when the client will work on the goal, where she or he will work on it, who might be available to offer help, etc., (2) the client has listed all possible barriers, and (3) the solutions are reasonable and likely to be effective in overcoming the barriers.

Example: #1 Goal: Attend NA meetings three times per week.
Plan: I will attend the 12:00 pm meetings at the Lutheran Church on Mondays, Wednesdays, and Fridays.
Barriers and solutions: I do not have transportation so I will ask my parents for bus tokens to get to the meeting or I will ask a friend to drop me off and pick me up after the meeting.

#2 Goal: Remain drug free for one week
Plan: I will change my schedule at my part-time job so that I can work during those times when I used to use drugs. My preferred schedule will be Monday through Friday from 3pm to 5pm.
Barriers and solutions: If I am unable to change my schedule at work, I will help my mother with the cooking, shopping, and watching my little brother during my high risk times (i.e., Monday through Friday from 3pm to 5pm).

Clients should be limited to working on two to three goals. This will prevent them from feeling overwhelmed by all the changes they are making in their lives. It will also increase the likelihood that they will accomplish the goals and thus experience success.

If this is the clients second goals group, then counselors will first review clients' progress toward accomplishing the goals they set during the previous goals groups. The focus of the session will vary depending on whether or not clients have successfully accomplished the goals they have set for themselves. *Clients who have accomplished their goals* should be given ample positive reinforcement. The focus of the session for these clients will be to set longer-term goals; that is, goals that will take several weeks or months to accomplish. It is possible that the client will no longer be in treatment by the time such goals are accomplished. These clients should be given the *Goals Sheet: Long-Term* worksheet (see Appendix B) to complete. These long-term goals can build upon the short-term goals on which clients were working previously. For example, the client who wanted to pass an upcoming quiz in math may, at this point in her treatment, want to try and pass her mid-term exam in Math. Clients will also be asked to develop a plan for and strategies for overcoming barriers to accomplishing these goals.

Examples of appropriate goals for clients at this stage include:

- Pass mid-term exams in Math and English
- Attend all classes until the end of the term
- Spend every Saturday with my parents
- Develop a set of non-using friends
- Go to college
- Develop a new hobby to do during times when drugs were used

At this stage, the long-term goals clients select will most likely need to be broken down into a series of specific, consecutive steps that must be taken to accomplish the longer-term goal. Each of the steps will represent a short-term goal, exactly like the short-term goals that clients developed during the previous goals group. When reviewing the forms, counselors should make certain that (1) the steps or short-term goals selected will help the client accomplish his or her long-term goal, (2) the goals are specific, stated positively, and include information about when, where, and how the client will go about completing the step.

A disadvantage to setting long-term goals is that they take a long time to accomplish and therefore the gratification involved in accomplishing them is delayed. In order to keep the clients motivation up, it is necessary for them to feel rewarded for their efforts in accomplishing smaller goals along the way. Therefore, clients are encouraged to think about small, medium-sized, and large rewards they can give themselves for accomplishing a single step, several steps, and the entire goal, respectively. For example, a client might give himself a small reward, such as a day off from studying on Saturday, if he has successfully adhered to his study schedule during the previous week. This same individual may get lunch at McDonald's for successfully adhering to his study schedule for four weeks. Finally, he may go to the State Fair for successfully passing his Math Class. In reviewing the goals sheets, counselors should make sure that the rewards are reasonable (i.e., the individual has the means to get them), and appropriate for the size of the goal; in other words, counselors should make sure that the client does not give himself a large reward for accomplishing a single step, etc. The worksheet includes space for only one mid-range goal. If clients want to work on more than one mid-range goal at a time, counselors can give clients several copies of the goals sheet. Remember that the main purpose of this exercise is to teach the client how to set goals and the strategies to use in order to accomplish them. Thus, it is reasonable if the client is only working on one mid-range goal at a time.

For clients who did not accomplish their goal, the focus of the session will be on determining what barriers prevented them from accomplishing their goals. It is important to remember that failure to accomplish simple goals is a poor prognostic sign and clients who are unable to develop and accomplish goals should be evaluated for more intensive treatment (i.e., more frequent individual and family counseling) or for a different type of treatment. It should be determined whether clients made any progress toward accomplishing their goal. If they did, clients should be reinforced for their effort. However, counselors should not chastise or punish clients who have made no progress toward accomplishing their goal. These clients will be asked to complete the *Barriers Worksheet* (see Appendix B).

The worksheet is designed to get at the more and less obvious barriers that prevented

clients from accomplishing their goals. In reviewing these forms, counselors should pay careful attention to the negative thoughts and feelings that clients write down on their forms. For these clients, counselors will need to decide whether one or more individual counseling sessions are necessary in order to work on modifying the client's self-defeating thoughts and/or to evaluate the client for depression or anxiety. In addition, counselors should make sure that the solutions clients develop are realistic and appropriate for addressing the barriers that interfered with clients' achieving their goals. The *Barriers Worksheet* is designed to identify barriers to accomplishing only one goal. In order to increase the likelihood that these clients will experience success during subsequent weeks, counselors may want to limit these clients to working on a single goal. If they are able to successfully achieve one goal, the counselor may ask the client to work on an additional goal later in treatment. It is important for counselors to evaluate whether (1) the goal selected was truly important to the client and/or (2) the goal selected was too difficult for the client. In the first case, counselors will want to encourage clients to select goals that are more personally relevant, and in the second case, counselors may want to help clients modify goals so that clients have a greater likelihood of success in accomplishing them.

At the end of the session, counselors should have all clients share the work that they did during the session. It is useful for clients to give and receive feedback about their progress as well as learn about setting long term goals as well as working through barriers to accomplishing goals.

Suggested or Optional Exercises

None.

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

- Define goals.
- Provide a rationale for why it is important to set goals.
- Discuss at least one goal they hope to achieve during treatment .
- Demonstrate the ability to develop a goal that is discrete, specific, and stated as an action they can take rather than something they plan to avoid.
- Discuss strategies for accomplishing goals (i.e., making a specific plan; identifying barriers and developing strategies for overcoming those barriers).

Group Session 6–Relapse Prevention II: Coping with Stress

Main Points for this Session

Define stress
Identify personal sources of stress
Identify personal signs and symptoms of the stress response
Learn and rehearse stress management
Learn the interaction between drugs, alcohol, and the body experiencing stress

Rationale

The purpose of this session is to help clients make the connection between stress and coping mechanisms. People often use substances to cope with stress, perhaps not realizing the short-term solution this act may provide, nor understanding that drugs and alcohol may worsen a situation rather than relieve it. Stress can be managed effectively using appropriate strategies, however, these strategies that are more effective in handling stress need to be learned. Through developing an understanding of current stress levels and identifying how their bodies respond to stress adolescents can heighten their personal awareness of stress they experience, how to cope with it, and how to control it for their emotional and physical health.

Session Content

What is stress?

The counselor should initially elicit ideas from the clients about what they believe stress is, while making sure the answers are not what causes stress, but what the actual stress is. What does it mean to them?

Counselors may want to ask what stress means to them and how do they feel when they experience stress? What types of thoughts, feelings, physical symptoms, or behaviors do they experience when they experience stress?

Stress is the way our bodies respond to the environment, both physically and emotionally. Individual reactions to a stressor, that event which causes stress, may differ depending on the perception of the event as positive or negative. How an event is perceived, and the individual's perception of whether or not they can cope with the event and the impact the event will have on his/her life will contribute to the perceived notion of stress.

Some situations may be stressful for one person and not for another. Why might different people perceive stressors differently? Is it a controllable or uncontrollable event? Can I handle this? Do I have the resources available to cope with this? Determining the stressful nature of an event may be determined by the individual's interpretation of the impact this event may have on his/her life. Determining the stressfulness of an event, and whether or not he/she has the ability to cope with the event, will impact the individual's response. Sometimes, if resources are inadequate, or coping strategies are ineffective, the stress may persist.

Elicit from the group examples of types of stress they experience, and what causes stress? Is it controllable or uncontrollable? How do group members' perceptions of what is stressful differ based on their individual perspectives?

If a stressor is controllable, one might want to do something to make the stress go away. On the other hand, if the stressor is uncontrollable one might want to instead manage their feelings about that stressor, which is more controllable if unable to control the stressor itself. It is when stress becomes unmanageable and out of control that it can wreak havoc on the body and mind. Effective coping is characterized by flexibility–a willingness to adapt to the changing demands of the stressor. Adequate perception of the stressor, identifying it as controllable or uncontrollable, is critical to our measure of choice in coping.

To master stress it is important to find the source of stress, how you respond to the stressor to engage the stress response, and look for sources of changing and coping. Strategies discussed here may be good for managing controllable as well as uncontrollable stress.

What happens when we experience a stressful event?

Psychological, physical, and behavioral responses occur when an event is perceived as stressful. Counselors may want to ask clients to identify ways in which stress might be experienced. How do they personally experience stress? Possible responses include the following:

Psychological Responses include feeling upset, inability to concentrate, irritability, loss of self-confidence, worry, difficulty making decisions, racing thoughts, absent-mindedness, anger, depression, fearfulness, etc.

Physical Responses include rapid pulse, pounding heart, increased perspiration, nervous stomach, tensing of muscles, shortness of breath, gritting teeth, increased blood pressure, headaches, etc.

Behavioral Responses include deterioration in performance, use of alcohol, drugs, and/or nicotine, accident prone, nervous mannerisms (pacing, nail-biting, fidgeting), increased or decreased eating and sleeping, crying spells, etc.

How do we cope with stress?

A number of cognitive and behavioral strategies have been developed to help us deal with stress, called coping strategies. With effective coping we begin to view events as less stressful; consequently, we experience fewer physiological and psychological symptoms. However, if our method of coping is ineffective we become more susceptible to the stressor and negative psychological, physical, and behavioral consequences ensue as a result of chronic stress. It is in the event of such chronic stress that it becomes harmful due to the long-term consequences. Consequently, in selecting a coping strategy it is important to determine if the

stressor is controllable or uncontrollable; different types of stressors demand the use of different coping strategies.

The Relaxation Response

The relaxation response undoes what stress has done to you. The relaxation response brings about a decrease in muscle tension, lowered heart rate, lowered blood pressure, a deeper and more controlled breathing pattern, and a peaceful mood unlike the anxiety often produced by the stress response. Unfortunately, the relaxation response is not as easily elicited as the stress response. A stress response may occur automatically, whereas the relaxation response may need to be learned and utilized purposefully. One possible way of "creating" the relaxation response is through progressive muscle relaxation. Just as we are all capable of sustaining a stress reaction, we are also capable of the ability to put our bodies into a state of deep relaxation.

Progressive Muscle Relaxation

Progressive muscle relaxation is a way of isolating one muscle group at a time, creating tension for 8-10 seconds, letting the muscle relax and the tension go. For example, with your right hand, tighten your fist. What happens? You should be able to feel the muscle tension increase and even move up your forearm. The longer you hold the fist, the more tense it will become. The same concept applies with muscles in other areas of the body. If tension exists around the forehead, a headache will persist. As the tension continues to be created so will the discomfort. Once you release your fist and relax you will notice the difference. The muscle tension begins to dissipate and eventually disappear. Whenever tension is created in a muscle and then released, the muscle has to relax. Basic muscle physiology governs this so that it must happen. However, when tensed and released, a muscle will not just revert back to its pre-tensed state, but if allowed to rest will achieve an even higher level of relaxation. This is the theory behind progressive muscle relaxation. If creating tension and then releasing it is applied to every major muscle group then all the muscles should become more relaxed than when you started.

The key to this type of exercise, however, is to take complete control over voluntary muscles by tensing them and forcing them into a state of relaxation. Once muscles relax the other components of the relaxation response will flow naturally. Relaxed muscles require less oxygen so breathing will automatically slow and deepen. Since the heart does not need to work as hard, heart rate and blood pressure decline. Since voluntary muscles are being guided and directed into a state of relaxation bodily functions begin to improve and overall mood changes begin to follow as a state of calmness is achieved.

While the focus is on the body and muscles in this type of activity, it is important to remind clients that the mind can continue to create stress during this process. To be sure that this does not happen, encourage use of the imagination. Imagine a peaceful or favorite place. While thinking of this, continue to relax and encourage a deeper state of relaxation free from the stress that our minds create. Also, encourage clients to practice such relaxation activities; thinking of this as a training for emotions. Focus on what it felt like, what differences were noticed, did any aches or pains go away, does your mood feel calmer? Progressive muscle relaxation is a skill

that requires practice in order to improve and in order to become a more automatic response that one can depend on when a stressor is experienced.

Diaphragmatic Breathing

The diaphragm is a thin, dome-shaped sheet of muscle inserted into the lower ribs. When you breathe, the diaphragm is the muscle that moves air inside the lungs, and is the difference of pressure between breathing in and out which drives blood throughout the body in support of the heart. Focusing on breathing through the diaphragm, or deep breathing, is common as a stress management activity.

Breathing is one of the most natural and healthful functions of the body. Deep breathing exercises have been used for many years as a way of relaxing the body. Have you ever noticed how an infant's abdomen rises and falls with each breath? An infant experiences the art of proper deep breathing. Most adults tend to fill only the upper chest and consequently miss how the increased oxygen intake could relieve tension. Deep breathing can be done anywhere, at any time.

Sitting straight in a chair, place one hand on your abdomen and one hand on your upper chest. Breathe deeply through your nose counting to ten. Hold the breath for a count of five and release slowly through your mouth, also to a count of ten. While you are holding your breath focus on your abdomen to ensure the abdomen is comfortably extended. You should be able to feel the focus of your breath taking place through the abdomen as opposed to the upper chest.

Practicing this form of breathing will bring multiple health benefits. Begin with practicing this at least twice per day. Practice will enable you to draw upon the skill of deep breathing when it is needed to reduce tension. In addition, employing these exercises will strengthen the lungs, relieve bronchitis, improve circulation, oxygenate the blood, and minimize the reoccurrence of respiratory problems.

Effects of stress: What happens if exposed to chronic stress?

If we do not possess the resources and the coping skills to deal effectively with stress, and if left unchecked, it can have serious psychological and physiological effects on us. When stressful patterns persist and you, physically and emotionally, continue to adapt to the stress reaction your body will try to tell you that something is wrong. The body experiencing stress will respond by an increase in frequency, and possibly intensity, of symptoms such as those described earlier. In addition, chronic stress can also lead to poor academic performance, insomnia, sexual difficulties, and drug abuse.

The relationship between stress and substance use

Substance use could be an option for stress management based on the seeming decrease of tension and stress in relation to consumption of alcohol and other substances. Many people use drugs and alcohol as a way of reducing stress. Various factors contribute to the effect that

substances might have on the stress response, such as dose, time elapsed since using, mood prior to substance use, and individual expectancies of the effects of the substances. It seems evident that the effect of substances may actually be most consistent within the confines of the context in which use occurred. Consequently, stressors do not necessarily go away; instead the perception of the stressor is temporarily changed. As a result of the influence of substances and the altered perception, the ability to problem-solve and reach out for appropriate resources is strongly diminished. In addition, substance use:

- does nothing to minimize the stress, but actually creates new stressors (legal problems, increased problems with parents, etc.)
- offers only temporary relief
- increases the stress by an increased focus on the stressful event
- limits the ability to cope by decreasing flexibility-as mentioned before, the willingness to adapt to the changing demands of a stressor

Effective stress management

For many, drugs and alcohol have become the primary method of stress management. Learning alternative strategies will promote one's ability to choose a strategy that will best fit the needs of the stressor, based on perception of the stressor and the coping needs. Some additional "self-care" procedures to manage stress are important. Alternative strategies for coping with stress can be more effective than substance use, and if employed on a regular basis will begin to feel more routine and reliable. The following are some daily emotional and physical strategies to effectively deal with stress:

- maintain healthy eating and regular sleep
- exercise regularly: promotes both physical fitness and emotional well-being
- balance work and play: recreation helps relax your mind
- laugh a lot: laughter makes our muscles relax and releases tension
- learn acceptance: sometimes a difficult problem is out of your control
- talk about it: sometimes another person can share an alternative point of view
- relaxation exercises: visualization, muscles, meditation, deep breathing
- time management: ranking priority tasks to help stay focused and manageable
- modify the environment: limit exposure to stressors
- control/change stressful situations: time and money management, assertiveness, problem-solving, leave a job or relationship
- decrease caffeine and consumption of junk food

Throughout this session clients should be encouraged to connect this information with their own lives and to draw upon personal examples of stress and coping. How many of the effects of stress have they experienced? What kinds of stressors are they currently experiencing? What types of coping strategies have they already tried? What role does their substance use play as a coping strategy for stress? What kinds of alternative strategies can be used? Throughout the course of the session are clients surprised by the amount of stress they experience or by their

chosen methods of stress-management? It is important for clients to clearly understand the impact stress can have on one's life, and to realize the significance of employing healthy coping strategies to target stress when it occurs.

Optional Exercises

Counselors may want to use the following exercises throughout the group to further the discussion and more effectively personalize the topic for the clients: *"Identifying Personal Stressors"* (see Appendix B) *"How to Relax Your Body"* (follow the method described above), and "*Identifying Personal Stressors, Continued*" (see Appendix B). Clients should be encouraged to practice new relaxation skills at least three times during the next week, about 10 minutes each time, to begin feeling comfortable with the activity, which should then increase the chance that such strategies will be utilized in a time of stress.

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

- # Discuss the meaning of stress and understand what stressors are.
- # Identify personal stressors and responses to stress.
- # Demonstrate the ability to practice different stress management techniques: relaxation exercises, diaphragmatic breathing, etc.
- # Discuss how drugs and alcohol can impact stress itself, as well as the bodies stress response.

Group Session 7–Relapse Prevention III: Coping with Hurdles in Recovery

Main points for this session

Define recovery hurdles
Identify personal recovery hurdles
Discuss strategies for handling these hurdles

Rationale

The purpose of this lesson is to help clients identify their personal recovery hurdles, that is, those chronic problems in their lives that make it difficult for them to achieve and maintain abstinence. These problems often reduce the adolescents' ability to cope with other stressors (both daily hassles and major life events) as well as with high-risk situations. Thus, adolescents need to learn to identify the recovery hurdles with which they live everyday and then learn strategies for coping with these hurdles so that they do not overwhelm the clients' coping resources.

Session Content

Define Recovery Hurdles.

Recovery hurdles are chronic, or long-standing problems that adolescents must face every day. They may be problems within the adolescents' environment (e.g., drug addicted parents or no non-drug using friends) or within the adolescent him or herself (e.g., depression; learning disability). Like major life events and daily hassles, some recovery hurdles are controllable whereas others are not. Unlike daily hassles and major life events, adolescents may not be aware of the impact that recovery hurdles are having on them because they live with these problems every day. The problem with recovery hurdles is that they often overwhelm the adolescents' coping resources and thus make it difficult to deal with everyday stressors. Recovery hurdles increase the likelihood that clients will become overwhelmed when faced with unexpected stressors. If adolescents feel overwhelmed, and if they are unable to handle the problems in their life, they are likely to resort to using drugs or alcohol to manage the unpleasant feelings they are experiencing (depression; anxiety). Counselors may want to use an example to illustrate coping resources and how recovery hurdles affect these resources.

Example: Imagine that all the stress you can handle will fit into a normal sized bucket. When the bucket is full, you have no more room to handle any additional stress. When that happens, you are unable to cope and you might feel depressed or anxious; you might also try to find ways to relieve the stress such as using drugs. Now imagine that each of the recovery hurdles you have to deal with takes up space in the bucket. The more space recovery hurdles take up, the less space you have left over to deal with other daily hassles or major life events that are likely to come up. Therefore, your bucket will overflow which means that you won't be able to cope with the stressors you are facing. If you feel as if you can't cope, then you are likely to do something to relieve the unpleasant feelings you are experiencing such as using drugs or alcohol.

Thus, you can see how recovery hurdles can interfere with efforts to achieve and maintain abstinence.

Counselors should make it clear that it is possible to learn how to cope with recovery hurdles and thus lessen the impact that they have on the adolescents' lives. The first things adolescents must do, however, is to identify the specific hurdles with which they must cope.

Identify client's personal recovery hurdles.

Counselors will have clients complete the *Personal Recovery Hurdles* worksheet (see Appendix B). The *Personal Recovery Hurdles* worksheet assesses the following hurdles: (1) family environment and support, (2) neighborhood, (3) academic performance and potential learning difficulties, (4) thoughts and feelings, (5) physical health and (6) other hurdles. Once clients have completed the worksheet, counselors will need to lead a discussion to help clients identify what hurdles are suggested by their responses on the worksheet. In particular, counselors should discuss with clients how each of these things can serve to undermine efforts to achieve abstinence. In addition, by sharing recovery hurdles with the group, clients will be able to recognize that their problems are not unique, that is, that they and other clients share the same impediments to recovery. Spend as much time as is necessary to ensure that each client is able to name at least one recovery hurdle with which they must cope.

Discuss strategies for handling these hurdles.

Counselors may begin by asking clients to suggest any strategies that they might use to cope with their unique recovery hurdles. Alternatively, counselors may teach clients basic problem solving skills using the *Steps in Problem Solving* worksheet (see Appendix B). Essentially, clients are taught to (1) describe the problem in as much detail as possible, (2) come up with as many solutions as possible without worrying about the quality of the solutions, (3) consider the advantages and disadvantages of each solution, (4) choose a solution that is likely to lead to the best outcome, and (5) evaluate whether or not the solution worked. To illustrate how problem solving can help adolescents cope with recovery hurdles, counselors may ask someone to volunteer to work on their recovery hurdle using the strategies outlined above. Alternatively, if adolescents are unwilling to volunteer to work on their recovery hurdles in group, counselors may make up an example that represents the one hurdle that affects the largest number of clients and work through it using the *Steps in Problem Solving* handout. Clients should be reminded that throughout treatment, they will learn other skills for coping with the hurdles they have identified (e.g., anger management and assertiveness).

<u>Optional Exercises</u>

Depending on the hurdles identified, counselors may choose to use other exercises. For example, if clients indicate that they do not have anyone who supports their efforts at achieving abstinence, counselors may want to use the *Asking for Support Skills Guidelines* worksheet (see Appendix B). This worksheet focuses on helping clients first identify where they can find

someone who can provide support. Counselors may want to use the concept of the "surrogate family," that is, a person or group of people (which preferably includes at least one adult) with whom the adolescent is comfortable talking about personal issues and who would be willing to provide the adolescent with whatever support the adolescent needs. In addition, the worksheet addresses the different ways in which people can help; that is by providing emotional support (someone to talk to), information (e.g., about resources in the community), material support (e.g., money, rides to counseling sessions) and physical support (e.g., a safe place to stay). Adolescents may find it difficult to ask for help and reasons for this are assessed and addressed as well. Finally, the worksheet reviews the skills needed to ask for support (e.g., being specific about what the problem is and what type of support is needed; accepting that some people won't be willing to provide support and that this should not discourage the adolescent from going to someone else).

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

- Define recovery hurdles and provide examples
- List their own recovery hurdles
- Engage in effective problem solving
- Use problem solving skills to select a strategy for coping with the recovery hurdles identified.

Group Session 8–Relapse Prevention IV: Managing Thoughts about Using

Main Points for this session

Identify thoughts and feelings that can lead to using drugs or alcohol
Understand the link between thoughts, feelings, and behaviors
Identify thoughts about drug and alcohol use
Identify ways to manage these thoughts

Rationale

Counselors should help clients understand that thoughts about using substances while trying to attain abstinence are normal. It is important, especially while experiencing the early stages of abstinence and recovery, to learn how to protect yourself from using when you experience thoughts about using. It is also important for clients to understand the difference between experiencing thoughts about using and acting on such thoughts in the recovery process. It may help to achieve this if clients have an increased understanding of how thoughts and feelings are directly linked to behaviors.

Session Content

It is important to continue defining the disease of addiction to adolescents. This is a disease prone to relapse. This is not to give the adolescent "permission" to use, but rather to give them "permission" to return to recovery in the event of relapse. The recovery process can take a long time, and the relapse process can take some time as well before the act of using a substance actually takes place. Part of this process, and of this session in particular, involves looking at thoughts and feelings about using. It is important to identify what they are and our ability to manage them.

Thoughts about using are normal. At some point during the initial period of abstinence and occasionally throughout the recovery process someone who has stopped using will think about starting again. Counselors may want to ask clients to share their most recent thoughts about using and draw out examples from those who may have already experienced this. It is important to discuss the thoughts and feelings that contribute to this experience. Sometimes they are obvious and sometimes they are not. However, identifying them will increase the likelihood of awareness regarding a desire to use and strengthen the awareness of one's needs to remain in and commit to abstinence. Increasing awareness of the thought process increases one's ability to exert control over thoughts that might potentially lead to using, and instead replace these thoughts with more effective thought patterns–those that facilitate healthy coping patterns and reinforce abstinence.

Counselors at this juncture may want to use a visual example of the angel versus devil on each shoulder when one is challenged to make a decision. What might the devil represent (cravings, the part of you that still wants to use) for you if you are uncertain about staying clean? Imagine what you might need to tell yourself to challenge these thoughts you are having in order

to stay clean. What might the angel represent, and what might the angel say to combat the devil?

Counselors may also want to initiate a discussion regarding defense mechanisms: What are some of the things we tell ourselves to justify our behavior? For example, "I don't have a problem," "Using this one time won't hurt," "I'll do better in school if I use now," "If he can use then I should be able to use," etc. Different types of defense mechanisms to be explored are: denial, minimizing, rationalizing, intellectualizing, blaming, diversion, projection, etc. Encouraging clients to provide examples of each defense will facilitate the ability to see how these defense mechanisms are utilized to support a return to, or ongoing, substance use.

Learning how to identify thoughts (self-talk), and consequently learning alternative ways of thinking, if defeatist, will promote your ability to "catch" yourself before using the next time you experience such thoughts. Counselors should ask clients to think about their own thoughts: Do you believe you can get through the day without using? If you tell yourself you can't, do you think you'll be able to stay clean? Counselors should also encourage clients to think about the last time they used: What did you tell yourself? What do you usually think about before you make the decision to use?

Common situations which may trigger thoughts about using

As was reinforced in an earlier session (relapse), it is important to identify triggers and to understand the functions served by their substance use. Continuing to address how needs can be met without using substances while reinforcing their "choice point" (the time immediately following contact with a high-risk situation and before use occurs) will be important as clients begin to address the thoughts and feelings they experience during this point and, subsequently, learn how to manage them so use does not occur.

- Memories- Positive memories and remembering all the fun about using: always using holidays and special occasions, can't imagine events without using substances.
- Testing oneself- becoming overconfident or curious; the concept of "having just one."
- Crisis- the overwhelming feeling/desire to use in the event of stress or crisis, "I can't deal with this without a drink."
- Feeling uncomfortable- difficulty with changing ones peer group in the event of sobriety. Because of the memories the belief that you are no longer fun if sober, and feeling out of place and uncomfortable either with new friends, or with the old.
- Self-doubt- the feeling of "why try" if you doubt your ability to be successful, "I've tried to stay clean before, why should this time be any different?"
- One drug is better than another- marijuana is better for you than alcohol, at least I'm not drinking or doing "harder" drugs such as cocaine and heroin.

Once these types of thoughts and feelings are experienced, individuals have a choice to make about whether or not they will follow the path these thoughts have begun to lead them to, the choice point, and use, or will they "manage" the thoughts/feelings which will promote abstinence? It is important for clients to understand this is a skill and may take some time and effort in practicing them in order to feel comfortable and confident.

Skills to Prevent Using

Some possible ways to manage thoughts about using when they occur:

- Challenge them: using other thoughts to challenge the existing thoughts: "I can still do _____ without using and can still have fun." Or "I can do _____ instead."
- Pros and Cons of not using: identifying personal benefits for staying clean can help decrease the desire to use: physical health, improved relationships, improvement at school or work, etc. Focus on what is gained as opposed to what is given up.
- Memories: identify the negative, more painful memories, associated with using: pain, fear, embarrassment, fights, blackouts, health problems, fired or expelled from school, etc.
- Distractions: think about something unrelated to using to help stop the thoughts about using, watch television, read a book, etc.
- Believe in Yourself: be aware of, and remind yourself regularly, of your successes: instead of "I can't do this," say "I've been clean for two weeks, that's the longest I've ever had."
- Delay of Gratification: put off any decisions to use for a brief period of time- most urges to use will build and then decrease in intensity- choose to wait 15 minutes or so to make the decision to use; the urge will most likely pass.
- Leave the Situation: do something different. Try a different activity than the one during which thoughts of using began to occur.
- Call Someone: get in touch with someone who can be helpful (previous session)–who has been helpful to you in the past in talking you through a difficult situation. Perhaps an AA/NA sponsor?
- Imagery: find a personal image to help maintain control of yourself until the urge passes–perhaps an image of a calm, relaxing place. An image might symbolize something such as the drive to climb a mountain and lead to success once you reach the top, etc.
- Relaxation Techniques: remind group members of relaxation techniques learned in a previous session: progressive muscle relaxation and diaphragmatic breathing, that can be utilized in the event of an urge to use to help you focus and gain control.

Counselors should encourage clients to share examples of situations where they have had thoughts about using and what type of skill did they use to challenge those thoughts? Did it work? What could they have done differently? What would they prefer to do next time?

Alternative Ways of Coping/Thinking

It is important to recognize when you face a difficult situation (as normal as it may be), such as experiencing thoughts about using. It may be easy to find a quick and easy solution to resolve the problem, but the problem will not pass and may increase in intensity the next time it is experienced. Finding an effective solution to the problem is in your best interest to more effectively manage such thoughts about using.

Optional Exercises

The following exercises can be used to help guide the discussion and personalize the information by encouraging clients to focus on their own recovery and thought process regarding substance use:

- "Common Thoughts About Using" worksheet (see Appendix B)
- "Methods for Dealing with Thoughts about Using" (see Appendix B)
- "Managing thoughts about Using" worksheet (see Appendix B)

Counselors may also hand out 3 x 5 cards at the end of group: on one side list personal benefits for staying clean, on the other list negative consequences of using. Clients should be encouraged to carry these cards with them to reflect on when fighting the urge and thoughts about using.

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

Identify and discuss thoughts and feelings associated with using.
Achieve an understanding about how thoughts and feelings correspond to "triggers" or other high risk situations which may influence our behavior.
Discuss realistic ways of managing thoughts and feelings to better cope with such triggers for use.

Group Session 9–Relapse Prevention V: Process Group I

Topics that may be Covered During this Session

Processing material raised during previous sessions
Addressing issues not covered in the standard curriculum
Preparing clients for discharge; recovery planning

Rationale

The process groups were developed in response to concerns raised by counselors that they either did not have enough time to adequately process material raised during the more didactic lessons and they felt that they needed time to address issues that were of importance to clients but not covered in the curriculum. Therefore, these sessions may be less structured than the drug education and relapse prevention sessions and they focus on issues that counselors feel are most pressing. Despite the unstructured nature of these groups, they will typically focus on one of three main topics: (1) processing material raised during previous relapse prevention or drug education groups, (2) addressing issues that are not covered in the standard curriculum, or (3) preparing clients for discharge; that is plans for how clients will maintain abstinence once they are no longer in treatment. In general, counselors will only address one of these issues in any given process group. However, since there are three process groups during treatment, counselors may elect to spend one of the sessions processing previous sessions and another session preparing clients for discharge. It should be noted that counselors can conduct a process session whenever they feel it is necessary. However, (1)counselors can only conduct three process groups in a twenty week period and (2) they must be certain that all clients have an equal opportunity for exposure to all of the other planned sessions. Thus, the decision to conduct a process group at an unscheduled time should be made carefully and only under circumstances when counselors believe it to be absolutely necessary (e.g., one or several clients have an intense reaction to a particular topic; a client enters the group and during the "check-in" indicates that she or he is in crisis).

Session Content

Processing Material Raised during Previous Sessions

Each group of adolescents is different and therefore it is not known how they will react to material presented in each of the didactic sessions. For example, an adolescent who has been raped, or who has "consensually" engaged in sex that was not wanted, may have an intense reaction to the lesson on "Assertiveness in Intimate Relationships." The lesson on "Respect" may inspire considerable discussion and there may not be enough time in a single session to allow all clients to discuss their feelings on the issue. Although the counselor may have processed these reactions during the session, there may be residual reactions that need to be addressed in another session. The process sessions are an ideal opportunity for handling such situations. We do not suggest any particular structure for these sessions. Therefore, counselors have a lot of flexibility in how they choose to conduct these sessions from conducting experiential exercises (such as family sculpting or the empty chair technique) to open discussion

of relevant issues. This approach also allows counselors to get a sense of how clients are doing outside of treatment as well as what issues clients may need addressed in subsequent sessions or in individual sessions.

Addressing issues not covered in the standard curriculum

The clients in our centers indicated two additional areas that were not addressed in the curriculum but were of interest to them. The first was job seeking skills. This issue was raised by several clients in the "Increasing Pleasurable Activities" group session (see Group Session 19–Relapse Prevention XV). Specifically, they stated that one of the barriers to participating in pleasurable non-drug activities was that such activities required money and they, the clients, had no legitimate, legal, sources of income. The other issue of interest to clients was the skills needed to apply and get into college. Lessons addressing each of these issues are included as optional group sessions at the conclusion of this section. There are a myriad of other possible topics that counselors may wish to address with clients (e.g., communication skills; giving/receiving criticism; process of recovery). Counselors should feel free to develop curricula addressing any topics of interest to clients not addressed by the structured lessons described in this manual. Counselors are encouraged to consult the book by Monti et al., (1989) as they cover many of the topics counselors may want to address with clients.

Recovery Planning

Recovery planning involves developing a strategy for what clients will do to continue working on their recovery once they are no longer in treatment. The plan can range from attending self-help groups to talking with supportive people, to thinking about the problems that their substance use caused in their life. Counselors will have clients complete the *Recovery Planning* worksheet (see Appendix B), which addresses a number of issues. Clients will begin by writing down all of the reasons why they entered treatment. Next, clients will write down how their life has improved since they have achieved and maintained abstinence. The purpose of these first two exercises is to emphasize the positive change that has occurred in clients' lives since they have stopped using drugs as well as to serve as an indication that things will likely continue to improve if they maintain abstinence. Clients are then asked to write down the things that they will do to maintain abstinence. They are asked to indicate their intention to become involved in self-help groups (including the day, date, and time of meetings they plan to attend) as well as the names and phone numbers of people they can contact if they need to talk to someone. Clients are asked to write down their personal signs and symptoms of relapse as well as what others should do if they become concerned that the adolescent is in the process of relapsing. Finally, clients are asked to refer back to their functional analysis and write down any situations that they are likely to encounter that will be high risk for them and what they will do to avoid relapsing to drug use in those situations. In reviewing the recovery plan, counselors should make certain that clients are specific about the reasons for entering treatment, the benefits of abstinence, and the things that they will do to maintain abstinence. Clients should be encouraged to list at least two people to whom they will talk about their feelings and/or relapse warning signs. Finally, counselors should make sure that clients have made as exhaustive a list as

possible of all of their high risk situations and have come up with reasonable, appropriate coping strategies for handling those situations. Once all clients have completed the *Recovery Planning* worksheet, counselors should have clients share their plan with other members of the group. All group members should be encouraged to provide one another with feedback about the recovery plan including, the quality and specificity of the plan as well as other strategies the client can consider using for coping with high risk situations. It should be noted that even group members who are early in recovery will benefit from discussing recovery planning since many of the topics covered are also relevant to maintaining abstinence while still enrolled in treatment (e.g., planning for high risk situations; acquiring an adequate, non-drug using, support network).

Optional Exercises

None.

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

- Understand and discuss in greater detail information learned in previous lessons, and learn more how the information is relevant to their personal lives.
- Identify and discuss critical aspects of recovery planning in preparation for discharge.
- Discuss issues or concerns affecting their treatment that are not otherwise discussed throughout the group session plans.

Group Session 10–Relapse Prevention VI: Respect

Main Points for this Session

Define Respect
Signs that people do not respect themselves
Reasons why people may behave in ways that are respectful or disrespectful to themselves
Changing behaviors that indicate a lack of self-respect

Rationale

Respect for self and from others is very important to adolescents. In addition, drug use and involvement in other health-impairing or risky behaviors is often a sign that adolescents do not respect themselves. Thus, it is important to discuss how respect for oneself develops and, in particular, the association between self-respect and behavior. By making a commitment to behave in ways that demonstrate respect for oneself, adolescents are both likely to avoid behaviors such as drug use and promiscuous sex which are signs of self-disrespect but will also earn the respect of other important people.

Session Content

Define Respect.

Counselors should ask clients to discuss what the word "Respect" means to them and write this information on the board. In general, adolescents' definitions of the word "respect" should include an emphasis on words, actions, or behaviors that demonstrate that a person or object has value or worth. Considerable time should be spent discussing this and in particular, clients should be asked to indicate (1) how they know when other people respect themselves as well as (2) how they know when someone else is showing them respect. Examples of ways in which people demonstrate respect for others and for themselves are listed below.

Examples:

When people respect themselves, they:

- exercise
- eat healthy foods
- get enough sleep
- are neat in their appearance
- set appropriate limits with people; that is, say no appropriately
- are assertive

When people are showing you respect, they:

- are polite
- make eye contact
- give you their full attention when you are talking to them
- say nice things to and about you

- do nice things for you
- Ask you for help and advice

Counselors should emphasize that respect for self and respect from others influence one another reciprocally. That is, when an adolescent feels respected by others, she or he begins to feel a greater amount of respect for him or herself. On the other hand, the best way to get respect from others is to respect oneself.

Signs that people do not respect themselves.

Ask clients to make a list of signs that people do not respect themselves. Make a list on the board. Examples of ways in which people demonstrate a lack of self-respect are listed below.

Examples

People who do respect themselves:

- have poor nutrition; eat lots of sweets and fats because they give a temporary sense of well-being
- don't exercise or get the proper amount of sleep
- are passive or aggressive with others
- allow themselves to be used by others
- are promiscuous sexually
- use drugs

Given this list, clients should discuss what they do that shows people that they do or do not respect themselves. If clients do not list use drugs or engage in illegal activities, counselors should be certain to emphasize that these are also signs of a lack of self-respect.

Reasons why people may behave in ways that are respectful or disrespectful to themselves.

Counselors should indicate that people engage in ways that are disrespectful for several reasons. First, clients may lack self-respect because of experiences they have made them question their own worth. For example, if they were constantly ignored by parents or were told that they were stupid, they may have come to believe that they were not worthy of respect. Counselors should have clients discuss the experiences they have had in their lives that made them feel as if they were not worthy of respect. Counselors should ask clients to talk about experiences they have had that made them feel valuable and worthy of respect. In discussing methods for increasing self-respect, counselors should have clients focus on the latter rather than the former experiences. In addition to early experiences, clients may engage in behaviors that demonstrate a lack of self-respect because those behaviors serve certain functions. Counselors should refer clients' back to their *Functional Analysis* and talk about how the consequences of their drug use (e.g., fitting in with peers; feeling better about themselves) serve as reasons for using for drugs, a behavior which indicates a lack of self-respect. Have clients talk about the functions served by engaging in other behaviors that demonstrate a lack of self-respect. Some examples are listed below.

Examples*:*

Behavior	**Function**
Promiscuous sex	Feel loved; feel attractive
Allow others to take advantage	Fit in; have other people like you
Eat sweets and high fat foods	temporary sense of well-being; feel good
Use cocaine; smoke cigarettes	Lose or maintain weight

Changing behaviors that indicate a lack of self-respect.

Counselors should begin by discussing reasons for changing behaviors that demonstrate a lack of self-respect. Specifically, if clients want to receive respect from others, they must first show respect for themselves. In addition, by no longer engaging in these behaviors, the clients' self-respect will also improve. Counselors should then ask clients to discuss ways in which they can go about changing these behaviors. Counselors should emphasize that clients have taken the first two steps which are (1) to become aware of things that clients do that are disrespectful and (2) to identify the reasons for engaging in these behaviors. Clients should then be asked to develop ways to meet these needs through healthier means. In other words, clients need to find ways to feel loved and attractive without resorting to promiscuous sex or they need to find healthier ways to lose or maintain their weight without using cocaine or smoking cigarettes. Counselors should make a list of healthy ways to achieve these functions on the board and ask clients to discuss what barriers might prevent them from trying these new behaviors. Counselors should be certain to remind clients of the experiences they have had that made them feel worthy of respect and that they should focus on these experiences whenever they feel as if they are slipping back into old, unhealthy, disrespectful behavior.

Optional Exercises

None.

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

- Define Respect
- Discuss signs that people do or do not respect themselves
- Discuss ways in which they demonstrate respect or a lack of respect for themselves
- Discuss reasons why they engage in behaviors that demonstrate a lack of self-respect
- Discuss strategies for changing behaviors that demonstrate a lack of self-respect

Group Session 11–Relapse Prevention VII: HIV/AIDS Awareness

Main Points during this session

Provide information regarding HIV/AIDS
Encourage self-examination of personal behaviors and health risks
Increase awareness and necessity for behavioral change to decrease risk
Encourage testing if individuals have engaged in behaviors that place them at risk for HIV

These objectives can be achieved by inviting a speaker from the county health department, or through an educational video focused on HIV issues.

Rationale

When using drugs and/or alcohol, inhibitions are lowered and thought processes lose clarity. Oftentimes while under the influence one decides to engage in behaviors that if sober would not be undertaken. These behavioral decisions may be self-destructive–driving while under the influence, unprotected sexual activities, sharing needles if using intravenous drugs, etc. Counselors should be sure to address these risk behaviors with adolescents as part of drug abuse treatment. The risk of HIV should especially be thoroughly addressed to heighten adolescent awareness about their behavior patterns and recognizing if they are putting themselves at risk for infection, and consequently, to address how they can protect themselves. Educating adolescents regarding HIV/AIDS and increasing this personal awareness regarding decision making and using behaviors will increase the likelihood that adolescents will take their using behaviors more seriously, and once knowing the risks will decrease such high-risk behaviors.

Session Content

Whether while using substances or not, adolescents will inevitably be confronted with situations that may put them at risk for HIV, or any type of sexually transmitted diseases. It is important for adolescents to be equipped with the information that may reinforce the ability to say "no" or to remember the necessity of protection when confronted with sexual situations.

It is also important to discuss with adolescents the dangers of sharing needles if using drugs intravenously. Ensuring clients understanding of the increased risks of infection if sharing needles is important, and consequently, to educate clients on the cleaning of needles; to be sure the needle is clean before using. There are also a number of needle exchange programs within cities that are designed to address the concern of clean needles and preventing the spread of infectious disease.

Either the speaker or video selected to distribute and provide this information should be sure to address the following topics:

1. Distribute facts regarding HIV/AIDS, the disease and transmission of the disease

2. Self-examination of behaviors:
    a. clients should identify their behaviors (substance use, sexual activities, etc.) that put them at risk
    b. as discussed above, clients should be able to describe the relationship/dynamic between using substances and increased risk for engaging in high risk behaviors, and for contracting diseases.
3. Assist clients in identifying what behavioral/lifestyle changes should be made to begin decreasing risk:
    a. the issue of reinforcing goals of abstinence from all substances
    b. honest evaluation of sexual practices; protected versus unprotected versus abstinence
    c. honest evaluation of using behaviors: injection versus other forms of administration, sharing needles if injecting, and additional paraphernalia used in the process.
    d. clients should be reminded of previous sessions where it has been encouraged to talk to someone they trust to get support in changing and in accomplishing their goals.
4. Should clients get tested for AIDS?
    a. presenter or video should be sure to promote honest evaluation and examination of behaviors, which will result in the ability to identify whether behaviors are risky and would warrant testing
    b. counselors should encourage testing of any client who has engaged in high risk behaviors
    c. counselors should address fears of getting tested and what it might mean to the individual
    d. reinforce coping skills for dealing with these fears (while maintaining the goal of abstinence)
    e. address the importance of being proactive about health and the importance of early treatment of HIV infection/AIDS
    f. clients should be supplied with information regarding testing sites, times, and the legal responsibility for testing to remain anonymous

<u>Optional Exercises</u>

None.

<u>Session Objectives</u>

Clients who attend this session and have assimilated the information covered, should be able to:

Understand factual information regarding HIV/AIDS.
Discuss behaviors that put one at risk for contracting HIV and other sexually transmitted diseases.
Identify personal behaviors that put you at risk.

Identify and discuss lifestyle changes to prevent further risk, and individuals who can be supportive of these changes.
Discuss information about testing and preparing oneself for testing and results.

Group Session 12–Relapse Prevention VIII: Assertiveness: Relationships

Main points to be covered during the didactic portion of this session

Explore values
Discuss choices in intimate relationships
Discuss reasons it can be hard to be assertive in intimate relationships
Describe elements of an assertive response and potential benefits

Rationale

Subtle pressure by a boy- or girlfriend or from friends can lead an adolescent to engage in sexual behaviors for which she or he may or may not be ready. It can also lead to experimentation with alcohol and drugs and involvement in other self-destructive or dangerous behaviors (e.g., shoplifting; driving in a car with an intoxicated driver). Involvement in dangerous or self-destructive behaviors that are inconsistent with an adolescent's value system often stems from a reluctance to stand up for him- or herself within the context of an intimate relationship. By discussing adolescents' values and reasons why it may be difficult to adhere to those values in intimate relationships, it is possible to help adolescents' make responsible choices with regard to sex, substances, and other important behaviors.

Session Content

Explore Values.

The main focus of this part of the session is to elicit information about the adolescents' value systems with regard to sex and other behaviors (e.g., illegal activities; drug use) within the context of intimate relationships. Although the main focus of this session is on dating relationships, the issues raised in this lesson are also relevant to other intimate relationships (such as those with close friends and family). Adolescents' values can be elicited by using the *Values Assessment Scenarios* (see Appendix B). The scenarios have been written (1) so that the main character's reactions are not clear until the end and (2) so that counselors can stop at critical points and get clients reactions. The scenarios should not be presented as a handout. Rather, they should be presented either as an overhead or orally so that clients cannot read ahead. As clients respond, counselors should summarize clients' values on the board and then lead a discussion about how values affect decisions and behavior. Counselors should ask clients to think about how they may feel when their behavior is inconsistent with their values (e.g., lack of self-respect; feeling bad; etc).

Discuss Choices in Intimate Relationships.

Intimate relationships offer many opportunities to make choices. These choices include how quickly to progress sexually (e.g., how early in the relationship is it appropriate to kiss, engage in heavy petting, oral sex, intercourse), what types of sexual behavior are appropriate (e.g., oral sex; sexual intercourse) as well as when to use condoms or to switch to other forms of birth control. These are difficult choices and there is often disagreement between partners about

them. These disagreements may result in one individual acting in a way that is inconsistent with his or her values because he or she fears that if he or she does not go along, the other person may not like him or her anymore. Counselors should have clients discuss their values and how they affect each of these potential choices within the context of their intimate relationships. Counselors may need to provide examples of how the values they stated affect the decisions they make.

Examples:

- If you feel that sexual intercourse is inappropriate on a first date, then you should make clear to your date what behaviors you feel are appropriate (e.g., kissing; petting; etc.)
- If you feel that sex without a condom is unsafe until you have dated someone for six months and both of you have been tested for HIV, then you will need to make this clear to your partner

Discuss Reasons it can be Hard to be Assertive in Intimate Relationships.

By clarifying their values, adolescents increase the chances of making decisions that are consistent with those values. Nonetheless, it can still be quite difficult to say no in intimate relationships. Counselors should spend a considerable amount of time discussing why this might be. In particular, counselors should see this as an opportunity to conduct some sensitivity training. For example, counselors may ask the boys to discuss why they think it might be harder for girls than for boys to feel comfortable about having sex without a condom. They may ask girls to talk about why boys feel pressure to have sex. Counselors should also elicit other reasons why it might be difficult to adhere to one's values within the context of intimate relationships; clients' responses should be written on the board. In addition, counselors should have adolescents consider and discuss the consequences of not adhering to their values.

Examples:

Reasons why it is difficult to adhere to one's values in intimate relationships

- don't want to hurt the other person's feelings or upset him or her
- afraid that the person will not like you anymore; don't want to be rejected
- afraid that they will think you are a prude
- afraid that they will make fun of you

Consequences of not sticking to their values

- feel bad about yourself
- feel like a slut/tramp
- other people think you are a slut/tramp
- mad at yourself for giving in; for not sticking up for yourself
- feel bad about yourself
- get pregnant; STD

Describe Elements of an Assertive Response.

Counselors will review the handout, *Elements of an Assertive Response in Intimate Relationships* (see Appendix B). Counselors should acknowledge that it can be difficult to be assertive but that (1) the client does not know how his or her partner will react until she or he tries being assertive. She or he might discover that the partner respects him or her for sticking up for him or herself. In addition, the client might discover that the partner has the same values but was acting against them because of pressure from other friends or because of misunderstanding of what the client wanted. Counselors should also talk about the things clients can say to themselves to combat the fears associated with being assertive.

Examples of self-statements that support assertive behavior:

- if they care about me, they would not want to make me do something I am not comfortable with because that would hurt my feelings.
- even if this person does not like me, there are others who will even if I don't want to...
- I am not a prude, I just believe that sex should be shared with someone you love.
- They are making fun of me because they are insecure about their decisions to have sex.
- They are just trying to make themselves feel better.

Optional Exercises

Counselors may want to include a role play to have clients practice the assertiveness skills within the context of an intimate relationship. Counselors should reinforce positive elements of the role plays and provide corrective feedback as needed. It is best to select a situation that one of the clients has personally experienced or counselors can use one of the role plays listed below or develop one of their own. Before each role play, have the client discuss the clients values with respect to the situation, what choices are suggested by those values and then practice assertive responses consistent with those choices.

Role Play #1. You are out on a date with someone you really like for the first time. She or he invites you to go back to his or her house because his or her parents are out for the evening. There will be no else in the house except for you and your date.

Role Play #2. You have been dating your boy-/girlfriend for four months. S/he has been pressuring you to have sex for the last couple of weeks. S/he says that s/he really loves you and wants to show you in the only way s/he knows how. Besides, everyone else is doing it and you don't want to be a prude. His/her parents are out of town for the weekend and your boy/girlfriend invites you to his/her house. You know that s/he is expecting that this will be "it;" you will have sex for the first time.

Session Objectives

Clients who attend this session and have assimilated the information covered, should be

able to:

- # Discuss their values in intimate relationships
- # Talk about how those values affect behavior
- # Discuss the consequences of not adhering to one's values and reasons why it is difficult to adhere to one's values
- # Discuss elements of an assertive response and strategies for overcoming the fear of acting assertively

Group Session 13–Relapse Prevention IX: Process Group II

Topics that may be Covered During this Session

Processing material raised during previous sessions
Addressing issues not covered in the standard curriculum
Preparing clients for discharge; recovery planning

Rationale

The process groups were developed in response to concerns raised by counselors that they either did not have enough time to adequately process material raised during the more didactic lessons and that they felt that they needed time to address issues that were of importance to clients but not covered in the curriculum. Therefore, these sessions may be less structured than the drug education and relapse prevention sessions and they focus on issues that counselors feel are most pressing. Despite the unstructured nature of these groups, they will typically focus on one of three main topics: (1) processing material raised during previous relapse prevention or drug education groups, (2) addressing issues that are not covered in the standard curriculum, or (3) preparing clients for discharge; that is plans for how clients will maintain abstinence once they are no longer in treatment. In general, counselors will only address one of these issues in any given process group. However, since there are three process groups during treatment, counselors may elect to spend one of the sessions processing previous sessions and another session preparing clients for discharge. It should be noted that counselors can conduct a process session whenever they feel it is necessary. However, (1) counselors can only conduct three process groups in a twenty week period and (2) they must be certain that all clients have an equal opportunity for exposure to all of the other planned sessions. Thus, the decision to conduct a process group at an unscheduled time should be made carefully and only under circumstances when counselors believe it to be absolutely necessary (e.g., one or several clients have an intense reaction to a particular topic; a client enters the group and during the "check-in" indicates that she or he is in crisis).

Processing Material Raised during Previous Sessions

Each group of adolescents is different and therefore it is not known how they will react to material presented in each of the didactic sessions. For example, an adolescent who has been raped, or who has "consensually" engaged in sex that was not wanted, may have an intense reaction to the lesson on "Assertiveness in Intimate Relationships." The lesson on "Respect" may inspire considerable discussion and there may not be enough time in a single session to allow all clients to discuss their feelings on the issue. Although the counselor may have processed these reactions during the session, there may be residual reactions that need to be addressed in another session. The process sessions are an ideal opportunity for handling such situations. We do not suggest any particular structure for these sessions. Therefore, counselors have a lot of flexibility in how they choose to conduct these sessions from conducting experiential exercises (such as family sculpting or the empty chair technique) to open discussion of relevant issues. This approach also allows counselors to get a sense of how clients are doing outside of treatment as well as what issues clients may need addressed in subsequent sessions or

in individual sessions.

Addressing issues not covered in the standard curriculum

The clients in our centers indicated two additional areas that were not addressed in the curriculum but were of interest to them. The first was job seeking skills. This issue was raised by several clients in the "Increasing Pleasurable Activities." Specifically, they stated that one of the barriers to participating in pleasurable non-drug activities was that such activities required money and they, the clients, had no legitimate, legal, sources of income. The other issue of interest to clients was the skills needed to apply and get into college. Lessons addressing each of these issues are included as optional group sessions at the conclusion of this section. There are a myriad of other possible topics that counselors may wish to address with clients (e.g., communication skills; giving/receiving criticism; process of recovery). Counselors should feel free to develop curricula addressing any topics of interest to clients not addressed by the structured lessons described in this manual. Counselors are encouraged to consult the book by Monti et al., (1989) as they cover many of the topics counselors may want to address with clients.

Recovery Planning

Recovery planning involves developing a strategy for what clients will do to continue working on their recovery once they are no longer in treatment. The plan can range from attending self-help groups to talking with supportive people, to thinking about the problems that their substance use caused in their life. Counselors will have clients complete the *Recovery Planning* worksheet (see Appendix B), which addresses a number of issues. Clients will begin by writing down all of the reasons why they entered treatment. Next, clients will write down how their life has improved since they have achieved and maintained abstinence. The purpose of these first two exercises is to emphasize the positive change that has occurred in clients' lives since they have stopped using drugs as well as to serve as an indication that things will likely continue to improve if they maintain abstinence. Clients are then asked to write down the things that they will do to maintain abstinence. They are asked to indicate their intention to become involved in self-help groups (including the day, date, and time of meetings they plan to attend) as well as the names and phone numbers of people they can contact if they need to talk to someone. Clients are asked to write down their personal signs and symptoms of relapse as well as what others should do if they become concerned that the adolescent is in the process of relapsing. Finally, clients are asked to refer back to their functional analysis and write down any situations that they are likely to encounter that will be high risk for them and what they will do to avoid relapsing to drug use in those situations. In reviewing the recovery plan, counselors should make certain that clients are specific about the reasons for entering treatment, the benefits of abstinence, and the things that they will do to maintain abstinence. Clients should be encouraged to list at least two people to whom they will talk about their feelings and/or relapse warning signs. Finally, counselors should make sure that clients have made as exhaustive a list as possible of all of their high risk situations and have come up with reasonable, appropriate coping strategies for handling those situations. Once all clients have completed the *Recovery Planning*

worksheet, counselors should have clients share their plan with other members of the group. All group members should be encouraged to provide one another with feedback about the recovery plan including, the quality and specificity of the plan as well as other strategies the client can consider using for coping with high risk situations. It should be noted that even group members who are early in recovery will benefit from discussing recovery planning since many of the topics covered are also relevant to maintaining abstinence while still enrolled in treatment (e.g., planning for high risk situations; acquiring an adequate, non-drug using, support network).

Optional Exercises

None.

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

- Understand and discuss in greater detail information learned in previous lessons, and learn more how the information is relevant to their personal lives.
- Identify and discuss critical aspects of recovery planning in preparation for discharge.
- Discuss issues or concerns affecting their treatment that are not otherwise discussed throughout the group session plans.

Group Session 14–Relapse Prevention X: Goals Group II

Main Points for this Session

Define Goals
Discuss reasons why it is important to set goals
Goal setting and review

Rationale

The purpose of this session is to (1) help clients identify important treatment-related and personal goals, (2) develop plans for accomplishing those goals, and (3) review progress and provide reinforcement for successful achievement of goals. Goal setting is an important part of substance abuse treatment because (1) recovery is hard work and it is helpful to have good reasons for working so hard, (2) goals provide structure to the extent that it helps counselors know which areas of a clients' life will need the greatest emphasis, and (3) treatment will be more interesting and will feel more helpful if it is focused on the specific areas that clients feel are most in need of change. Because there are two goals groups during treatment, clients will be at every different stages of treatment/recovery and will therefore be working on different types of goals. For those early in recovery, the main focus of the group will be on learning how to set goals and skills needed to accomplish those goals. For those later in recovery, the main focus of the group will be on reviewing progress, identifying barriers to accomplishing goals or setting longer term goals and developing plans for accomplishing those goals.

Session Content

Define goals.

Counselors will want to elicit from clients their definition of a goal. They should reinforce accurate definitions and provide corrective feedback as necessary. According the *American Heritage Dictionary, 2nd College Edition*, a goal is defined as "1. the purpose toward which an endeavor is directed; objective. 2. The finish line of a race..." (P. 565). Therefore, counselors should be certain that clients' definition of a goals includes two main concepts: (1) goals are something that are desirable and/or that clients want and (2) it requires effort to achieve goals. One way to help clients understand the definition of a goal might be to refer to the *Functional Analysis* completed during the "Relapse" session (see Group Session 3–Drug Education III: Relapse) and talk about the specific desirable consequences clients' experienced from drug use as goals that they wanted to achieve. These consequences are goals because (1) they are desirable and (2) clients had to expend effort (i.e., to get the drug or alcohol) in order to achieve the effect. Counselors will then want to elicit from clients examples of other goals on which clients can work that can be achieved without the use of illicit substances to achieve. More experienced members of the group may also be asked to share some of the goals on which they have been working since their previous goals group.

Reference: *The American Heritage Dictionary, 2nd College Edition*, Boston: Houghton, Mifflin.

Discuss reasons why it is important to set goals.

Counselors should elicit from clients reasons why it is important to set goals in treatment. There are several reasons why it is important to set goals during treatment. First, recovery is hard work, and setting goals that are contingent upon maintaining abstinence give clients reasons for working hard in their recovery. Second, setting goals provides a framework for treatment. In other words, treatment is more focused because clients and counselors focus their effort during treatment on helping clients achieve their goals. Finally, treatment will be more interesting to clients if they feel that it is focusing on issues that they feel are important or on areas that they feel are in need of change.

Goal setting and review.

If this is the clients first goals group, the focus of the session will be on selecting short-term goals that clients can and need to work on while they are still in treatment. Counselors will have clients complete the *Goals Sheet: Short-term* handout (see Appendix B). Counselors will need to circulate around the room to ensure that clients are completing the form correctly, that they are selecting appropriate goals, and that they understand what is being asked of them on the handout. When checking over the completed handouts, counselors should make sure that the goals selected are ones that (1) clients have a high likelihood of accomplishing, (2) can be easily accomplished before the next scheduled goals group, and (3) involve discrete concrete behaviors in which the client can engage (e.g., attend all classes for a two week period) rather than vague, abstract goals (e.g., increase self-esteem). Goals should also be stated positively, that is as specific, discrete behaviors in which the client can engage (e.g., I will attend all classes during the next two weeks) as opposed to actions the clients should avoid (e.g., I won't skip anymore classes). Counselors should be flexible about the types of goals on which clients choose to work although the goals should be relevant to their drug use. For example, "asking a girl out when sober" may be a reasonable short-term goal for a client who is socially outgoing only when intoxicated.

Examples of appropriate goals for clients at this stage include:

- Attend all classes for a two week period
- Remain drug free for one week
- Make one new non-using friend
- Spend one weekend day with my family
- Exercise three times per week
- Attend AA or NA meetings daily
- Receive a passing grade on upcoming math quiz
- Go to a movie instead of hanging out on the corner with friends
- Ask a girl out when sober

If clients select longer term goals (i.e., goals which will require more than a few weeks to accomplish) counselors should encourage them to think about a smaller step that they can take that will get them closer to accomplishing the longer term goal. For example, a client who states that she would like to attend college in the fall should be encouraged to work on a smaller step, such as setting up an appointment with her guidance counselor to discuss what she will need to

do in order to get into college.

In addition to selecting goals, clients will also be asked to develop specific plans for how they will go about accomplishing the goal, consider possible barriers to accomplishing goals, and solutions for overcoming those barriers. When reviewing clients' plans, barriers, and solutions, counselors should be sure that (1) the plan is specific; that is, that it includes the day and time when the client will work on the goal, where she or he will work on it, who might be available to offer help, etc., (2) the client has listed all possible barriers, and (3) the solutions are reasonable and likely to be effective in overcoming the barriers.

Example: #1 Goal: Attend NA meetings three times per week.
Plan: I will attend the 12:00 pm meetings at the Lutheran Church on Mondays, Wednesdays, and Fridays.
Barriers and solutions: I do not have transportation so I will ask my parents for bus tokens to get to the meeting or I will ask a friend to drop me off and pick me up after the meeting.

#2 Goal: Remain drug free for one week
Plan: I will change my schedule at my part-time job so that I can work during those times when I used to use drugs. My preferred schedule will be Monday through Friday from 3pm to 5pm.
Barriers and solutions: If I am unable to change my schedule at work, I will help my mother with the cooking, shopping, and watching my little brother during my high risk times (i.e., Monday through Friday from 3pm to 5pm).

Clients should be limited to working on two to three goals. This will prevent them from feeling overwhelmed by all the changes they are making in their lives. It will also increase the likelihood that they will accomplish the goals and thus experience success.

If this is the clients second goals group, then counselors will first review clients' progress toward accomplishing the goals they set during the previous goals groups. The focus of the session will vary depending on whether or not clients have successfully accomplished the goals they have set for themselves. *Clients who have accomplished their goals* should be given ample positive reinforcement and other group members. The focus of the session for these clients will be to set longer-term goals; that is, goals that will take several weeks or months to accomplish. It is possible that the client will no longer be in treatment by the time such goals are accomplished. These clients should be given the *Goals Sheet: Long-Term* worksheet (see Appendix B) to complete. These long-term goals can build upon the short-term goals on which clients were working previously. For example, the client who wanted to pass an upcoming quiz in math may, at this point in her treatment, want to try and pass her mid-term exam in Math. Clients will also be asked to develop a plan for and strategies for overcoming barriers to accomplishing these goals.

Examples of appropriate goals for clients at this stage include:

- Pass mid-term exams in Math and English
- Attend all classes until the end of the term
- Spend every Saturday with my parents
- Develop a set of non-using friends
- Go to college
- Develop a new hobby to do during times when drugs were used

At this stage, the long-term goals clients select will most likely need to be broken down into a series of specific, consecutive steps that must be taken to accomplish the longer-term goal. Each of the steps will represent a short-term goal, exactly like the short-term goals that clients developed during the previous goals group. When reviewing the forms, counselors should make certain that (1) the steps or short-term goals selected will help the client accomplish his or her long-term goal, (2) the goals are specific, stated positively, and include information about when, where, and how the client will go about completing the step.

A disadvantage to setting long-term goals is that they take a long time to accomplish and therefore the gratification involved in accomplishing them is delayed. In order to keep the clients motivation up, it is necessary for them to feel rewarded for their efforts in accomplishing smaller goals along the way. Therefore, clients are encouraged to think about small, medium-sized, and large rewards they can give themselves for accomplishing a single step, several steps, and the entire goal, respectively. For example, a client might give himself a small reward, such as a day off from studying on Saturday, if he has successfully adhered to his study schedule during the previous week. This same individual may get lunch at McDonald's for successfully adhering to his study schedule for four weeks. Finally, he may go to the State Fair for successfully passing his Math Class. In reviewing the goals sheets, counselors should make sure that the rewards are reasonable (i.e., the individual has the means to get them), and appropriate for the size of the goal; in other words, counselors should make sure that the client does not give himself a large reward for accomplishing a single step, etc. The worksheet includes space for only one mid-range goal. If clients want to work on more than one mid-range goal at a time, counselors can give clients several copies of the goals sheet. Remember that the main purpose of this exercise is to teach the client how to set goals and the strategies to use in order to accomplish them. Thus, it is reasonable if the client is only working on one mid-range goal at a time.

For clients who did not accomplish their goal, the focus of the session will be on determining what barriers prevented them from accomplishing their goals. It is important to remember that failure to accomplish simple goals is a poor prognostic sign and clients who are unable to develop and accomplish goals should be evaluated for more intensive treatment (i.e., more frequent individual and family counseling) or for a different type of treatment. It should be determined whether clients made any progress toward accomplishing their goal. If they did, clients should be reinforced for their effort. However, counselors should not chastise or punish clients who have made no progress toward accomplishing their goal. These clients will be asked to complete the *Barriers* worksheet (see Appendix B).

The worksheet is designed to get at the more and less obvious barriers that prevented clients from accomplishing their goals. In reviewing these forms, counselors should pay careful

attention to the negative thoughts and feelings that clients write down on their forms. For these clients, counselors will need to decide whether one or more individual counseling sessions are necessary in order to work on modifying the client's self-defeating thoughts and/or to evaluate the client for depression or anxiety. In addition, counselors should make sure that the solutions clients develop are realistic and appropriate for addressing the barriers that interfered with clients' achieving their goals. The Barriers Worksheet is designed to identify barriers to accomplishing only one goal. In order to increase the likelihood that these clients will experience success during subsequent weeks, counselors may want to limit these clients to working on a single goal. If they are able to successfully achieve one goal, the counselor may ask the client to work on an additional goal later in treatment. It is important for counselors to evaluate whether (1) the goal selected was truly important to the client and/or (2) the goal selected was too difficult for the client. In the first case, counselors will want to encourage clients to select goals that are more personally relevant and the second case, counselors may want to help clients modify goals so that clients have a greater likelihood of success in accomplishing them.

At the end of the session, counselors should have all clients share the work that they did during the session. It is useful for clients to give and receive feedback about their progress as well as learn about setting long-term goals as well as working through barriers to accomplishing goals.

Optional Exercises

None.

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

- Define goals
- Provide a rationale for why it is important to set goals
- Discuss at least one goal they hope to achieve during treatment
- Demonstrate the ability to develop a goal that is discrete, specific, and stated as an action they can take rather than something they plan to avoid.
- Discuss strategies for accomplishing goals (i.e., making a specific plan; identifying barriers and developing strategies for overcoming those barriers).

Group Session 15–Relapse Prevention XI: Refusal Skills

Main Points for this Session

Elicit situations in which adolescents will have difficulty saying no to themselves and others
Discuss reasons why it is difficult to say no
Discuss strategies for saying no

Rationale

When turning down opportunities to use drugs and alcohol, engage in sexual activities or other risky behaviors, adolescents are saying no to a great many benefits (e.g., opportunities to relax and "mellow out;" hang out or fit in with peers; etc) that they received from those behaviors. Although treatment most often focuses on helping adolescents "say no" to others, adolescents in our treatment programs indicated that they found it much more difficult " to just say no" to themselves than to other people. Therefore, this lesson focuses on exploring the things that prevent adolescents from "saying no" to themselves (e.g., fear of social isolation; boredom and loneliness; lost opportunities for sexual activity or for a relationship; etc.). This is important because adolescents won't say no to others if they are unable or unwilling to say no to themselves. This lesson will also cover, to a lesser extent, the skills needed to say no to other people. By addressing adolescents' ambivalence about giving up drugs and other risky behaviors as well as providing them with the skills they need to say "no" to others will increase the likelihood that they will maintain abstinence from drugs, avoid unwanted pregnancies or STDs, etc.

Session Content

Elicit situations in which adolescents will have difficulty saying no to themselves and others.

Counselors should begin by discussing the fact that clients will invariably encounter situations in which they will be offered drugs or alcohol, opportunities to have sex (with or without a condom), etc. These situations may be problematic for adolescents not so much because they are unable to say no to others but because by saying no, they are denying themselves something they want. Thus, the difficulty is in saying no to themselves. Given this rationale, counselors should elicit from clients situations in which they feel they will have difficulty saying no to themselves. If clients have difficulty coming up with situations, counselors may want to refer clients back to their functional analysis. The situations that clients identified as being high risk are likely to be examples of situations in which it will be difficult to say no. In addition, counselors can use the *Refusal Skills Scenarios* (see Appendix B) to stimulate discussion. Counselors may also want to come up with examples of other situations in which adolescents will have difficulty saying no, such as:

- when they are offered drugs by someone as part of foreplay
- when they are short on cash and someone asks them to help by selling some pot, "Just this once"
- when they want something – sneakers, a jacket – that they cannot afford to buy

and it would be easy to shoplift the item without being caught

- when they are at a party and everyone else is drinking and having a good time.

Discuss reasons why it is difficult to say no.

The main focus of this section is to help adolescents gain an understanding of why they would engage in these behaviors given that they risk relapsing to drug use, being violated by a probation officer, getting into trouble, feeling guilty, becoming pregnant, etc. Counselors will thus lead a discussion about what clients stand to gain from engaging in the activity as well as what they would lose, or miss out on, if they were to say no. It is important to remember that the sheer number of consequences is unimportant; rather it is the emphasis that the client places on the anticipated consequences. Thus, an adolescent may state that "feeling good" is the only positive consequence of unprotected sex, and the possibility of STDs and feeling guilty as being the negative consequences. In addition, the adolescent may say that the negative consequence of saying no is that she or he will not get to have sex and that she or he does not know when she or he will have another opportunity to do so. Thus, the adolescent may choose to have sex because the opportunity to feel good and to have sex is seen as more important, and more likely, than the possibility of getting an STD, pregnant, or experiencing a few minutes of guilt. Again, counselors may want to use the scenarios provided (or others they have developed) to stimulate discussion of the things clients will get by saying yes and will miss out on by saying no.

Discuss strategies for saying no.

The focus of this section is on helping clients develop the skills they need to say no to themselves as well as to other people. Counselors may want to begin by asking clients to offer suggestions for what they will need to do to make it easier to deny themselves something they want. If clients do not mention considering the consequences associated with their decision, then counselors should present this idea for discussion by the group. In addition, counselors should make certain that the following points are discussed:

1. Adolescents must be convinced of the value of saying no if they are to do so.
2. The reason it is difficult to say no in these situations is because the balance of costs and benefits appears to favor saying yes. For example, an adolescent may choose to use drugs when they are offered as part of foreplay because the benefits of saying yes are that she or he will get to have sex, have fun, feel good, whereas the costs of saying no are that she or will not get to have sex, may get rejected by this individual, and then spend a boring evening alone.
3. In such situations, adolescents often don't think about the negative consequences of saying yes (e.g., pregnancy or STDs) or the positive consequences of saying no (e.g., feeling good about him or herself; feeling proud that she or he stuck to their commitment to not use drugs). This is because these consequences are often delayed, taking several weeks or months to occur, and they are relatively infrequent events. The positive consequences of saying yes and negative consequences of saying no are immediate and much more frequent; thus they tend to have a greater impact on the adolescents behavior.

Counselors can use any number of creative strategies for accomplishing this session aim. For example, counselors may ask one client to pick a situation in which she or he would have difficulty saying no and then demonstrate out loud how they would talk themselves out of saying yes and into saying no. Alternatively, counselors may want to select a situation from among those listed by clients or from one of the scenarios provided and lead a five to ten minute debate. Group members will be split into two groups, one arguing in favor of saying yes and one group arguing in favor of saying no. Counselors will then lead a discussion about the arguments raised by each side.

Optional Exercises

Discuss elements of an assertive response.

Counselors will distribute the *Elements of an Assertive Response* handout (see Appendix B) to clients and lead a discussion about the specific skills involved in assertively saying no to others. They should review the three main elements of an assertive response: (1) be specific or clear about what you will or won't do, (2) leave no room for negotiation, and (3) make eye contact. Counselors should use the handout to guide their discussion, and in particular be certain to discuss why each of the samples is or is not an assertive response.

Use exercises to practice refusal skills.

Counselors can assess clients' skill in using the skills discussed previously through the use of role plays. Counselors can use situations provided by clients earlier, the included scenarios, the roles plays described below, or other situations counselors develop themselves. Counselors should be certain to reinforce the positive elements of the role play and provide corrective, but non-punitive, feedback about elements which need improvement.

Role Play #1. You are walking home from school. Along the way, you pass the park where some of your friends are hanging out and drinking. They call you over, tell you it's been a while since they've seen you and offer you a bottle of beer.

Role Play #2. You are home alone and bored on a Saturday afternoon when the phone rings. It is one of your friends who is inviting you to go out. You know that your friend will probably be drinking and will want to go shoplifting at the mall.

Role Play #3. You are out on a date. You really like this person and are having a really good time on your date. At some point in the evening, your date pulls out a joint, lights it up, tokes, and then offers it to you.

Role Play #4. You are out on a date. You suspect that your date has been smoking pot and this has made him/her really horny. S/he keeps coming on to you. Although you really like this person, you don't want to have sex with him/her while s/he is under the influence of pot.

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

- # List situations in which they will have difficulty saying no
- # Discuss reasons why it may be difficult to say no; specifically state the positive and negative consequences of the decision
- # Discuss skills needed to increase the chances that adolescents will say no to themselves
- # Demonstrate knowledge of elements of an assertive response and ability to use those skills effectively.

Group Session 16–Relapse Prevention XII: Anger Management

Main points for this session

Identify adolescents' typical responses to anger and the consequences of these responses
Identify signs that one is becoming angry
Discuss strategies for managing anger

Rationale

It is inevitable that adolescents in recovery will encounter situations that make them angry. Anger is a particularly problematic emotion for adolescents in recovery because, in addition to serving as an excuse for returning to drug use (e.g., I will get back at them for hurting me; I know marijuana will calm me down), it can also result in other serious negative consequences (e.g., damaged relationships; injuries; arrests). Therefore, it is important to learn how to manage anger in order to avoid drug use and other potential negative consequences.

Session Content

Identify adolescents' typical responses to anger and the consequences of these responses.

Counselors will lead a discussion about situations that make adolescents angry, the different ways adolescents express anger, and the consequences they are likely to experience as a result of how they express their anger. Counselors can begin by either asking clients to describe recent situations in which they became angry or by offering some examples of situations that frequently make adolescents angry (e.g., parents criticizing them; friends snubbing them; failing a class; etc). Counselors will then discuss the different ways in which adolescents express their anger (e.g., becoming physically aggressive; swallowing or suppressing angry feelings). Each of these anger responses can have a number of negative consequences. For example, adolescents who become physically aggressive might get hurt and/or arrested. Those who make offensive comments may irreparably damage important relationships. Those who swallow their anger may begin to have physical symptoms such as headaches or tension. It is important to emphasize throughout the lesson that anger is controllable and manageable. The first step in managing anger is knowing when one is becoming angry.

Counselors may use the scenarios below, or ones they have developed that are appropriate for their group of clients, to elicit typical anger responses and the consequences of those responses. Present each scenario and ask adolescents to talk about how they would respond if the situation described happened to them.

- Your parents are giving you a hard time because you failed another class. You can't understand why they are making such a big deal out of it. *If this were you, how would you respond?*
- Your parents are poor and can't afford to buy you new clothes. Some kids at school are making fun of the fact that you are wearing your older siblings' old clothes. *If this were you, how would you respond?*

- You are at party when you see your best friend hitting on your boy/girlfriend. *If this were you, how would you respond?*
- Your boss criticizes you in front of your co-workers. *If this were you, how would you respond?*
- You find out that your girl/boyfriend has been cheating on you. *If this were you, how would you respond?*
- You find out that your best friend got tickets to a concert you really wanted to see and did not invite you to go with him/her. *If this were you, how would you respond?*
- Even though you have been clean for a while, you discover that your parents have been searching your room for drugs. *If this were you, how would you respond?*
- You find out that your brother has been going into your room and using your stuff without your permission. *If this were you, how would you respond?*

As an alternative, or in addition, counselors can have clients complete sections I, II, and III of the *Anger Management* worksheet (see Appendix B). These sections of the *Anger Management* worksheet focus on (I) eliciting a recent situation in which the adolescent became angry, (II) their response to that situation, and (III) the consequences they experienced from that response. Counselors should ask clients to share their responses with the group.

Identify signs that one is becoming angry.

Counselors may want to begin this section by re-emphasizing the fact that adolescents can control their anger. In particular, it is important to remind adolescents that anger often feels out of control. However, their response to a situation can vary depending upon how they look at it. Counselors should provide an example to illustrate how adolescents' perceptions of a situation can change the way they react to it.

Examples: If your friend rushes you off the telephone, you may think it is because she does not like you anymore. In this case, you are likely to feel hurt and angry. But, if you know it is because she has been grounded and that she will be in even bigger trouble if her parents find her on the phone, you will likely feel sorry for your friend but you won't be angry.

Counselors should make it clear that in order for adolescents to control their anger, they must first realize when they are becoming angry. Sometimes anger happens so fast that adolescents feel as if they do not have time to stop themselves from responding. Other times, anger builds over time. In either case, each person has a different set of anger signals that indicates that they are becoming angry. Anger signals tend to fall into one of three categories: either physical emotional, or behavioral. Examples of each category of anger signals is provided below:

Example:

Physical	**Emotional**	**Behavioral**
Tight muscles	Depression	Isolation

Headaches	Frustration	Restlessness (inability to sit still)
clenched teeth	Racing thoughts	Physical aggression
agitation	Inability to Concentrate	

If the *Anger Management* worksheet is being used, adolescents should be asked to complete section IV. They should be instructed to write down the anger signals they experienced the last time they became angry. These symptoms are likely to represent the typical anger signals for that adolescent.

Discuss strategies for managing anger.

If the *Anger Management* worksheet is used, counselors may want to refer clients to the skills guidelines described in section V. Adolescents are instructed to first calm down. They may be reminded to use some of the stress management strategies, specifically diaphragmatic breathing, they learned in the "Coping with Stress" session (see Group Session 6–Relapse Prevention II). Counselors may also want to review the problem solving skills presented in the "Coping with Hurdles" session (see Group Session 7–Relapse Prevention III). In addition to diaphragmatic breathing, adolescents should also be asked to come up with other ways in which they can calm themselves down (e.g., leave the room; go for a walk; talk to someone). Counselors should write the list on the board and ask clients to discuss which strategy would work best for them. Counselors should then lead a discussion of adaptive ways of communicating their feelings to others. For example, using "I statements" rather than "blaming statements," making eye contact, and being specific about what, if anything, they want the other person to do. In addition to teaching appropriate ways to communicate feelings, counselors may also want to remind clients about the problem-solving skills and assertiveness skills they learned in previous lessons as these are also effective strategies for coping with situations that make adolescents angry. Finally, it should be made clear to adolescents that there are some situations that they cannot change and therefore they need to change how they feel about that situation.

Optional Exercises

None.

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

- # Discuss typical responses to anger and the different consequences the adolescent experiences because of those responses
- # List physical, emotional, and behavioral signs that they are becoming angry
- # Discuss strategies for managing anger

Group Session 17–Relapse Prevention XIII: Process Group III

Topics that may be Covered During this Session

Processing material raised during previous sessions
Addressing issues not covered in the standard curriculum
Preparing clients for discharge; recovery planning

Rationale

The process groups were developed in response to concerns raised by counselors that they either did not have enough time to adequately process material raised during the more didactic lessons and that they felt that they needed time to address issues that were of importance to clients but not covered in the curriculum. Therefore, these sessions may be less structured than the drug education and relapse prevention sessions and they focus on issues that counselors feel are most pressing. Despite the unstructured nature of these groups, they will typically focus on one of three main topics: (1) processing material raised during previous relapse prevention or drug education groups, (2) addressing issues that are not covered in the standard curriculum, or (3) preparing clients for discharge; that is plans for how clients will maintain abstinence once they are no longer in treatment. In general, counselors will only address one of these issues in any given process group. However, since there are three process groups during treatment, counselors may elect to spend one of the sessions processing previous sessions and another session preparing clients for discharge. It should be noted that counselors can conduct a process session whenever they feel it is necessary. However, (1) counselors can only conduct three process groups in a twenty-week period and (2) they must be certain that all clients have an equal opportunity for exposure to all of the other planned sessions. Thus, the decision to conduct a process group at an unscheduled time should be made carefully and only under circumstances when counselors believe it to be absolutely necessary (e.g., one or several clients have an intense reaction to a particular topic; a client enters the group and during the "check-in" indicates that she or he is in crisis).

Processing Material Raised during Previous Sessions

Each group of adolescents is different and therefore it is not known how they will react to material presented in each of the didactic sessions. For example, an adolescent who has been raped, or who has "consensually" engaged in sex that was not wanted, may have an intense reaction to the lesson on "Assertiveness in Intimate Relationships." The lesson on "Respect" may inspire considerable discussion and there may not be enough time in a single session to allow all clients to discuss their feelings on the issue. Although the counselor may have processed these reactions during the session, there may be residual reactions that need to be addressed in another session. The process sessions are an ideal opportunity for handling such situations. We do not suggest any particular structure for these sessions. Therefore, counselors have a lot of flexibility in how they choose to conduct these sessions from conducting experiential exercises (such as family sculpting or the empty chair technique) to open discussion of relevant issues. This approach also allows counselors to get a sense of how clients are doing outside of treatment as well as what issues clients may need addressed in subsequent sessions or

in individual sessions.

Addressing issues not covered in the standard curriculum

The clients in our centers indicated two additional areas that were not addressed in the curriculum but were of interest to them. The first was job seeking skills. This issue was raised by several clients in the "Increasing Pleasurable Activities." Specifically, they stated that one of the barriers to participating in pleasurable non-drug activities was that such activities required money and they, the clients, had no legitimate, legal, sources of income. The other issue of interest to clients was the skills needed to apply and get into college. Lessons addressing each of these issues are included as optional group sessions at the conclusion of this section. There are a myriad of other possible topics that counselors may wish to address with clients (e.g., communication skills; giving/receiving criticism; process of recovery). Counselors should feel free to develop curricula addressing any topics of interest to clients not addressed by the structured lessons described in this manual. Counselors are encouraged to consult the book by Monti et al., (1989) as they cover many of the topics counselors may want to address with clients.

Recovery Planning

Recovery planning involves developing a strategy for what clients will do to continue working on their recovery once they are no longer in treatment. The plan can range from attending self-help groups to talking with supportive people, to thinking about the problems that their substance use caused in their life. Counselors will have clients complete the *Recovery Planning* worksheet (see Appendix B), which addresses a number of issues. Clients will begin by writing down all of the reasons why they entered treatment. Next, clients will write down how their life has improved since they have achieved and maintained abstinence. The purpose of these first two exercises is to emphasize the positive change that has occurred in clients' lives since they have stopped using drugs as well as to serve as an indication that things will likely continue to improve if they maintain abstinence. Clients are then asked to write down the things that they will do to maintain abstinence. They are asked to indicate their intention to become involved in self-help groups (including the day, date, and time of meetings they plan to attend) as well as the names and phone numbers of people they can contact if they need to talk to someone. Clients are asked to write down their personal signs and symptoms of relapse as well as what others should do if they become concerned that the adolescent is in the process of relapsing. Finally, clients are asked to refer back to their functional analysis and write down any situations that they are likely to encounter that will be high risk for them and what they will do to avoid relapsing to drug use in those situations. In reviewing the recovery plan, counselors should make certain that clients are specific about the reasons for entering treatment, the benefits of abstinence, and the things that they will do to maintain abstinence. Clients should be encouraged to list at least two people to whom they will talk about their feelings and/or relapse warning signs. Finally, counselors should make sure that clients have made as exhaustive a list as possible of all of their high risk situations and have come up with reasonable, appropriate coping strategies for handling those situations. Once all clients have completed the *Recovery Planning*

worksheet, counselors should have clients share their plan with other members of the group. All group members should be encouraged to provide one another with feedback about the recovery plan including, the quality and specificity of the plan as well as other strategies the client can consider using for coping with high risk situations. It should be noted that even group members who are early in recovery will benefit from discussing recovery planning since many of the topics covered are also relevant to maintaining abstinence while still enrolled in treatment (e.g., planning for high risk situations; acquiring an adequate, non-drug using, support network).

Optional Exercises

None.

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

- # Understand and discuss in greater detail information learned in previous lessons, and learn more how the information is relevant to their personal lives.
- # Identify and discuss critical aspects of recovery planning in preparation for discharge.
- # Discuss issues or concerns affecting their treatment that are not otherwise discussed throughout the group session plans.

Group Session 18–Relapse Prevention XIV: Physical Health

Main Points for this session

Describe elements of a healthy lifestyle: exercise, nutrition, sleep habits
Discuss the effect of these elements on stress tolerance and mood
Evaluate individual healthfulness of their lifestyle
Enhance overall health in recovery by developing a plan to improve health

Rationale

Substance use can have a serious impact on all aspects of our lives including, but not limited to, nutrition, exercise, and sleep habits. This session is designed to heighten the substance-abusing adolescents' understanding of their own lifestyle patterns, and offers the opportunity to create a plan to improve their physical health. An essential part of the treatment process involves helping clients to change their lifestyle patterns. Understanding the link between addiction, behavior, and attitudes regarding personal health will prove helpful in initiating and maintaining the recovery process.

Session Content

What is meant by "lifestyle?"

Lifestyle is a general term used to reference how you live your life on a day-to-day basis. Each of you live your life according to what you set as your priorities, and your daily life is influenced by these decisions. One aspect of a lifestyle is to question whether or not it is healthy or unhealthy. This can be determined, in part, by looking at whether or not your lifestyle is characterized by keeping various aspects of life in balance, such as exercise, nutrition, and sleep. Our bodies speak to us when we do not keep these things in balance, and it is important to listen to what our bodies tell us, to pay attention to how you are feeling physically and emotionally. It is important to recognize signs and symptoms when you don't feel well physically, as well as to recognize different emotions– when are you feeling agitated, irritable, unable to think clearly, having a lack of energy, etc.?

Counselors should pose various questions to clients to facilitate a discussion of lifestyles: Do different people have different lifestyles and different priorities? How might they differ? It would be helpful to compare and contrast different groups of people: how do athletes live compared to priests compared to rock stars/rappers? In order to be successful and maintain a certain desired image how is your lifestyle reflected? What qualities do you need to have? To be "successful" at using substances/dealing, how might your own lifestyle be dictated? What would you need to do in order to change? What would you say characterizes your current lifestyle? Is it what you want to have in 5-10 years? How might it change? Are you satisfied with how your lifestyle is currently? What would be difficult to change if not satisfied?

As mentioned above, nutrition, exercise, and sleep are some aspects of a general lifestyle that reflect who we are:

Healthy nutrition focuses on the following things:

- the importance of recognizing the value of healthy eating habits
- recognizing the significance of the food pyramid and how you can incorporate it into your daily life
- many people eat for reasons other than hunger- a variety of emotions often play a role in when people choose to eat- boredom, stress, anger, depression, happy, etc.
- a well-balanced diet provides your body with nutrients needed to keep your body healthy, and affects how you look, how you feel, and how your body operates
- it is important to recognize these feelings and what we do as a result of them, how do we cope as a result?
- the importance of gaining knowledge and insight into personal eating habits

The value of exercise:

- a key to a healthy and active lifestyle
- strengthens the heart, lungs, lowers blood pressure, etc.
- gives more energy, improves sleep, lessens stress/tension (refer back to stress chapter)
- benefits extend into physical, emotional, and spiritual well-being

The value of healthy sleeping patterns:

- the importance of recognizing how much sleep you need to be productive and to feel refreshed during the day

How does sleep, nutrition, and exercise affect stress tolerance and mood?

Counselors should be sure to spend some time discussing the connection between emotions, coping, and general day-to-day habits. Unhealthy habits in your life they may lend a hand in feelings of depression, anxiety, stress, etc. Similarly, the reverse may occur and these types of emotions may in turn contribute to unhealthy lifestyle patterns. It is important to recognize how these patterns and cycles of emotions and behaviors are interwoven and influence one another. To take this another step further, it is important to realize that just as emotions and lifestyle are connected with each other, lifestyle also influences use of substances, and the impact such behavior has. Counselors should encourage clients to think about how their substance use has influenced their lifestyle. What changes have they noticed in themselves since first using? Clients should be honest in evaluating how substance use tends to affect, or influence, other life choices. For example, it may be difficult for clients to see how involvement with drugs/alcohol plays a part in problems at school, with a disruption of extracurricular activities such as sports, changes in sleeping habits, changes in eating habits, change in friends, and an overall change in general interests and hobbies, etc. On the other hand, healthy nutrition, exercise, and sleep habits can contribute to a more positive mood and positive self-image, and can be achieved more naturally than through the use of substances. Lack of, or deficiencies in, these areas can contribute to increased negativity, decreased tolerance of stress, a change in affect, etc. Encourage clients to make this connection between lifestyle choices and mood by evaluating through personal examples how use of substances has impacted what they chose to do in a

certain situation, how they handled a conflict, or affected the way they think and feel about themselves as a result.

However, in order to initiate the change process, clients must recognize the following:

- the importance of gaining knowledge and insight into your own habits/lifestyle patterns, and identifying any connections with emotions and the use of substances
- the importance of recognizing patterns/daily and to improve them if necessary
- identify how patterns and lifestyle might be shaped/influenced by what they see around them amongst family and friends
- increase awareness of some basic emotions that dictate our lives: when are you feeling hungry, angry, lonely, and tired? These emotions directly tie into the basic aspects of our lifestyle–eating, sleeping, and exercising habits.
- does this impact the decisions and behaviors in which you engage?
- are you interested in making the investment to change?

Recognition of these factors is the first step in the change process.

Developing and executing a plan to improve overall health is the next. It takes a certain amount of willpower to set goals and work towards accomplishing them. Establishing what goals you have to improve your health is a good place to start. Also, by establishing goals you increase the potential for making an honest commitment to change. Looking at lifestyle priorities is linked directly as well with what goals are established for recovery efforts. In particular, if you have identified the connection between your daily activities and substance use, then you may be more confident and motivated to invest time and energy in activities supporting recovery and a drug-free lifestyle.

Healthy eating, sleeping, and exercise habits are important and strongly encouraged.

Making these changes can, however, be difficult. Journaling or logging activities in these areas may be encouraging and promote a commitment to ongoing efforts. To further support these efforts clients should be encouraged to make lists of things they would enjoy doing, for example, running, biking, etc. Also, are there things you have enjoyed doing in the past prior to using drugs that you would like to do again, or things you have always wanted to do and have not yet done? It may be difficult to initiate these activities, and clients should be encouraged to discuss why it might be difficult and some of the feelings they anticipate as a result. As a result, it is also helpful to discuss what type of support is available as these changes are being made, and as the efforts continue.

It can be extremely difficult to break habits and form new commitments.

It is important for clients to be patient and to give credit for the attempts made and energy put into the process. Since changes will take time, clients need patience and ongoing determination in order to be successful. Overall improvement will be evident through improved mood, increased ability to cope effectively, to think clearly, etc.

Optional Exercises

- "My Physical Health Worksheet" (see Appendix B)
- "The Lifestyle Log" (see Appendix B)

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

Identify the various characteristics of their current lifestyle.
Discuss if they are satisfied with their current lifestyle.
Understand the value of healthy eating habits, exercise, and sleep.
Discuss the connection between these lifestyle elements and overall mood and behavior.
Discuss the process of change and incorporate personal needs for change to occur for these lifestyle characteristics.

Group Session 19–Relapse Prevention XV: Increasing Pleasurable Activities

Main Points for this session

Describe the importance/significance and benefits of increasing pleasurable activities
Discuss a method to increase pleasurable activities in your life
Discuss obstacles to increasing pleasurable activities in your life

Rationale

This session is designed to continue the emphasis of identifying lifestyle patterns and recognizes the importance of replacing substance using behaviors and time with alternative, healthy activities. This session provides adolescents with the opportunity to both further examine their day-to-day life and to create a plan to increase the pleasurable activities in their lives. Whereas the previous chapter emphasizes physical health in relation to substance use, this chapter extends that concept to include support of changes that include social and interpersonal activities.

Session Content

Those who use substances often feel a void in their lives after they stop using. The social environment and time spent using substances is realized as much greater and more significant in one's life once the substance use has ceased than while it was occurring. Since using substances is considered a pleasurable activity by those who use, the absence of this activity in one's life can be a major problem. This is especially true for those individuals who have not chosen to abstain from substances voluntarily. Once this void is present in a person's life it tends to create, or contribute to, more negative feelings such as boredom, loneliness, depression, etc. Since the presence of pleasurable activities tends to do the opposite, and contributes to more positive feelings and a more positive mood, it is important in the early stages of abstinence and recovery to make a conscientious effort to make time for pleasurable activities. Each individual in recovery struggles with different things. For those who think this is not possible need to especially consider the importance of pleasurable activities in the midst of other daily responsibilities and obligations, such as homework, household chores, a job, etc.

It is important to distinguish between what "should" be done and what "needs" to be done each day versus things you "want" to do. Too many "shoulds" contributes to the belief that you need to reward yourself because you have not been doing things that you personally chose to do. Consequently, the danger exists that such rewards may be in the form of drugs and/or alcohol. Maintaining a focus of evaluating the "shoulds," "needs," and "wants" in your life may encourage you to think more specifically about how you spend your time and what activities you already engage in. By evaluating current activities you can begin to prioritize each day. You may be uncomfortable changing all current activities immediately, and may prefer to make these changes more gradually. Regardless of how the changes are made, substance-using behaviors are being replaced by other pleasurable, drug-free activities. As others see you engaging in new,

drug-free activities the element of trust in others regarding your commitment to recovery will probably strengthen. Hopefully, an increase in more pleasurable activities, and having "fun" without using substances, will fill the void initially created by abstinence. This should in turn result in "missing" drugs and alcohol less, and consequently, the less likely you may be to rely on such substances to create such "fun" in your life.

How do you increase pleasurable activities in your life?

Three main steps can be identified to help increase pleasurable activities:

1. Identify some pleasant activities that you would either want to get involved in or that you already do and you want to increase the time spent doing them. Brainstorm a list of such activities that are pleasurable to you: increase things you used to do/haven't done in a long time but used to enjoy. Increase things you have always thought about doing but haven't made the time for. It would also be important to think about activities that you can do for free, or for only certain amounts of money.
2. Some activities might become "positive addictions"–an addiction that may not feel so good at first but gradually becomes more desirable and is beneficial (i.e., exercise). These types of activities should be non-competitive, should not depend on others to carry out, has some personal value (physical, spiritual, mental), you can improve with practice; accept your level of performance without criticizing yourself.
3. Develop a pleasurable activities plan: schedule a small block of time each day (30-60 minutes) for pleasurable activities and to schedule time each day, but do not plan out the activity. If the pleasurable activity is too planned and structured then the personal time you have set a side may begin to feel more like another obligation.

Obstacles to increasing one's pleasurable activities.

There are a number of obstacles that can impede one's ability to make a successful change in achieving and maintaining abstinence. With the recognition that filling the void abstinence leaves with other pleasurable activities, it is important to keep in mind the following ideas to avoid potential obstacles:

- Commitment: It is important to establish the priority and also to possibly rearrange other activities in your life to make the new activity happen.
- Balance: The goal is to achieve balance between what you "should" and "need" to do, and those things you "want" and "choose" to do. Shoulds and wants may not always be equal parts in your life, but the balance you achieve will come by achieving satisfaction with your day-to-day life and increasing the activities in your life that you enjoy and are not required to do.
- Planning: What might happen in a day to interfere with your planned personal time? How might you compete with different demands on your time? (This would be a good opportunity to reflect back to the goals sessions and identifying possible barriers.)

- Pleasantness: You need to be sure to identify pleasant activities to take part in that you truly do enjoy.
- Anxiety: Anxiety can interfere with your ability to engage in, and consequently enjoy, the pleasurable activity. This anxiety may decrease in time with practice. If not, then you may need to choose another activity that you are more comfortable with from the beginning. It will be important to consider finances and transportation in your brainstorming of ideas as these two aspects may pose a problem if needed for certain activities and may contribute to the anxiety you might feel. Be sure to engage in activities that are both feasible and realistic.
- Control: It is important to stick by a plan that will allow you a certain measure of control over your daily schedule.

Optional Exercises

- "Pleasurable Activities Schedule" (see Appendix B)

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

Understand the importance of incorporating pleasurable activities into your life.
Discuss a realistic plan for how pleasurable activities can be introduced and maintained.
Discuss obstacles, and create a plan, for coping with barriers to following through with this plan.

Optional Group Session 1: Job Seeking Skills

Main Points for this Session

Finding Job Opportunities and selecting the appropriate job
Making initial contact/calling for interviews
Completing Job Applications
Interviewing Skills
Follow-up contact
Obtaining personal and professional references

Rationale

The job seeking session was developed as an optional lesson to be implemented during one or more of the process groups, depending on the adolescents' needs, because adolescents frequently complained that one of the greatest barriers to developing a non-drug using lifestyle was insufficient money. Therefore, the purpose of this lesson is to provide adolescents with some of the basic, preliminary skills needed to obtain employment. The material for this lesson is based on the work of Azrin and Besalel (1980). For a more detailed manual on teaching job seeking skills, counselors are strongly encouraged to consult: Azrin NH & Besalel VA (1980). Job Club Counselor's Manual: A Behavioral Approach to Vocational Counseling, Austin, TX: Pro-Ed. In addition to describing lesson plans, the manual also includes sample letters and worksheets.

Session Content

Finding job opportunities and selecting the appropriate jobs.

Counselors should distribute sheets of paper so that clients can notes. Counselors should begin by eliciting from clients ideas about how to obtain information about job opportunities. Counselors should encourage clients to be creative and to talk about any of the ways that they, or people they know, obtained jobs in the past. Examples of ways to find job opportunities are listed below.

Examples:

- classified ads
- internet
- help wanted Advertisements
- word of mouth
- friends/family
- taking initiative
- previous employers

Counselors and clients should discuss any issues involved in finding job opportunities each of these ways. For example, the advantage of getting a job referral from a family member is that the employer may be willing to hire the adolescent on the family member' s

recommendation alone however, the disadvantage is that the employer may have higher expectations for that adolescent because of what they know about the family member who made the referral.

Clients and counselors should then spend some time discussing how to selecting appropriate jobs. It should be emphasized that although the primary reason adolescents want to get a job is for money, that there are other good reasons for getting a job. First, jobs are opportunities to help the adolescents identify what they want to do later in life. Once high school is over, adolescents will need to decide whether they will go to college or look for full time work to support themselves. The jobs they hold during high school may shape decisions about what their major will be in college or about what types of jobs they will be seeking when they graduate. Second, jobs are opportunities to gain valuable experience that will help adolescents obtain jobs in their field of interest in the future. Finally, jobs may provide opportunities for networking. That is, clients can make valuable contacts with people who can help them get jobs in the future. Thus, the decision about what job to take should not be based exclusively on salary but also on the clients skills and interests. Clients should thus be encouraged to make a list of all their interests (e.g., working with people; computers) and skills (e.g., typing). Counselors should then have clients make a list of jobs that match those skills and interests. For example, an adolescent who enjoys working with people and is skilled at typing might consider clerical work.

Making initial contact/calling for interviews:

Counselors should review the following information: (1) resumes and cover letters, (2) making telephone contact with potential employers, and (3) working papers.

(1) Because most jobs that adolescents are seeking will not require resumes, it is still useful to spend some time discussing the differences between good and bad resumes and the importance of good grammar and careful editing and accurate spelling on both resumes and cover letters. Counselors should also discuss what to do if clients do not have any or extensive work experience. Counselors may want to either bring in sample resumes and cover letters that clients can copy or download such information from the internet. If counselors have access to the internet, they may want to show clients how to search for information on the internet regarding resumes and cover letters (as well as how to search for jobs).

(2) Counselors will want to review the skills needed for making telephone contact with potential employers and to conduct role plays to allow clients to practice these skills. Counselors should review telephone etiquette; specifically using proper language (e.g., no curses; minimize use of the filler words “like” and “you know”), being polite, and clearly stating their reasons for calling. The specific elements that should be included when clients make an initial telephone are listed below:

<u>Example</u>:
Elements to be included when making initial contact by telephone:

1. Ask for the manager, human resources department or the person named in the advertisement. Let the person know the specific advertisement to which you are responding.

2. *If the individual is available*, (a) ask if it is a good time to speak. If it is, (b) describe the position for which you are applying and why you are interested in the position, (c) describe the skills and experiences you have that make you a good fit for the job, and (d) ask if you can schedule a personal interview to discuss the job further.

3. *If the individual is not available*, (a) ask if you can leave a message, (b) describe the position for which you are applying, (c) leave your name, telephone number, reason for your call, and times you are available to take the return call (provide several options).

(3) Counselors should review with clients the process needed to obtain working papers and encourage clients to obtain working papers prior to applying for jobs.

Completing job applications.

Counselors should obtain job applications from local business where clients are most likely to be looking for employment (e.g., Fast Food Restaurants; malls and retail shops). Clients should be given copies of applications and counselors should describe the process of completing the applications. In particular, clients should be encouraged to type the application, if possible or to print neatly. Clients should fill in all sections of the application honestly and to the best of their ability. If possible, clients should be encouraged to request two copies or make a photocopy of the application so that they can use one application as a draft copy and then transfer the information to the original once they are satisfied with how the information is presented. In general, adolescents do not need to report any legal problems unless they have been tried and convicted as adults. However, it may make sense to discuss with adolescents how to handle a situation in which they are asked about their legal history. Specifically, clients should be encouraged to be honest about the history but also about the fact that they are in treatment and actively making changes in their lives. They can even talk about how obtaining employment will help them in their efforts at achieving a drug and criminal-free lifestyle.

Interviewing skills.

Counselors should review with clients (1) interview etiquette, (2) proper attire/appearance, and (3) proper language. Counselors should prepare role plays so that clients have the opportunity to practice the interviewing skills discussed. In addition, counselors may ask clients at the previous session to dress for the session as if it were a job interview. Counselors can then give clients feedback about their clothing choices.

(1) Clients should be encouraged to be early or on time to interviews and reasons for this should be discussed. Clients should be prepared to answer questions about (a) personal strengths and weakness (clients should be able to list one or two of both), (b) past work experience, (c) future goals, (d) why you think you are a good candidate for the job, (e) legal history, (f) drug history. Counselors should warn clients that a urine drug screening may be required as part of the hiring process and to be prepared to answer questions about their legal history. Counselors should also discuss proper eye contact and in particular the fact that appropriate eye contact sends a message of self-confidence to employers. Counselors should provide feedback about eye contact to clients during mock interviews.

(2) Clients should be encouraged to wear clean, neat clothes that are reasonably conservative (something they would wear to church or court is probably appropriate). They should make certain to be neatly groomed with their hair combed and/or neatly styled and their hands and nails clean. If girls are planning to wear skirts, they should be careful about the length (no micro-minis). Clients should avoid excessive perfume or jewelry. They should minimize peircings; if possible, other than earrings, clients should consider removing any other body peircings. Clients should not wear hats or skullcaps and should avoid wearing shirts with logos.

(3) These skills are similar to those for making telephone contacts. Specifically, clients are encouraged to use polite, respectful language. They should be reminded not to use the employers first name unless they are invited to do so; always refer to him or her as Mr. or Ms. Clients should become aware of their use of filler words, such as "like" and "you know" and be careful to minimize their use during the interview. Clients should also become aware of their use of curse words and work on eliminating from everyday use prior to the interview.

Follow-up contact.

Follow-up contact is important for two reasons. First it lets the employer know that the adolescent is interested in the job but it also demonstrates that she or he is professional. Clients should be encouraged to write a follow-up letter within one to two days after the interview, thanking the employer for his or her time and reiterating the clients' interest in the position. Clients should include information about where employers can contact the client if they require additional information. Counselors should also make it clear that it is good practice to write a thank you letter even if the client is told at the time of the interview that they are not a good candidate for the position. This is because another position, for which they are better suited, may become available with the same company in the future and their chances of being considered for that position is better if the client behaves professionally. Finally, clients should be encouraged to contact the employer one week after the interview to inquire about the statue of their application and when they can expect to hear about the final decision. Again, this lets the employer know that the client is interested in the position.

Obtaining references.

Counselors should have clients make a list of the people they believe will provide positive personal and professional references for them. If clients are uncertain about the quality of the reference, they should be encouraged to: (1) find someone else to provide a reference, (2) talk to the person and ask if they can provide a positive reference for employment, or (3) have someone else contact the person as a potential employer to find out what type of reference the individual will provide. Counselors should review the skills needed to successfully request a reference from someone. Those skills are listed below.

Examples:

Skills needed to request a reference:

- Be polite
- Describe the position
- Be specific about what you need (a letter; a telephone call)
- Ask the person if they feel they can provide a positive reference
- Be certain the thank the person for providing the reference

Optional Exercises

Counselors should consult the Azrin and Besalel manual (referenced above) for any additional exercises or worksheets.

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

List ways to find job opportunities; different reasons for seeking employment; and appropriate jobs given their skills and interests
Skills needed to make telephone contact with potential employers
Describe appropriate attire/appearance and language for an interview
Skills needed for a successful interview
Reasons for follow-up contact and skills needed to obtain positive references

Optional Group Session II: Preparing for Continued Education

Main Points for this session

How to prepare for continued education
How to find the college that is right for you
How to apply and obtain references
Paying for education

Rationale

The preparing for continued education session was developed as an optional lesson to be implemented during one of the process groups as determined by the needs of the group. One significant aspect of the skills building sessions, or relapse prevention, is establishing goals. Adolescents are encouraged to think of both short-term and long-term goals and to identify barriers that may keep them from accomplishing these goals. Adolescents who are "older," perhaps juniors or seniors in high school, may be uncertain about the future, uncertain about whether or not to find a job or to go to college. Determining some future plans may furthermore promote a commitment to abstinence if there is a desire to succeed with new hopes for the future and goals in place.

Session Content

Counselors should begin the session by eliciting ideas from clients about how to obtain information regarding colleges, technical schools, computer schools, etc. and in how to make the decision about whether or not continued education is for them. Encourage clients to talk to other people who may have gone on for advanced degrees, and perhaps those who did not but wish they had. It is important to begin entertaining these ideas as a possibility while still in high school so you have the support and knowledge of your high school's guidance center and counselors.

There are a number of things that should be considered while in high school if considering college. Your performance while in high school is extremely important. It is important to study and do well as your high school records are a significant portion of the application process and in the school's consideration for new admissions. In addition to the standard high school coursework, however, there are also a number of standardized tests which need to be completed for admission to college: the PSAT, SAT, and the ACT. Standardized tests can come quite naturally to some individuals, while others need to prepare by studying and taking practice tests. You need to identify your own style of test-taking and prepare for these tests accordingly. You can prepare by reviewing study guides that are available for purchase at your local bookstore (e.g., the series of Barron's study guides publish for each standardized test available.). It is also important that if preparing for these tests that you familiarize yourself with the testing dates and begin preparing well ahead of time. Also, it is possible to retake the tests if you feel you did not do well and believe you could improve your scores. Consequently, consider taking these tests as early as possible in high school, thus giving yourself plenty of time to retake

them if desired.

It is also important while in high school to begin researching colleges and other institutions, as well as careers of interest. Some schools specialize in certain areas of study aimed toward particular careers. Other colleges are liberal arts and are more diverse in their available courses, thus exposing you to a wider variety of subjects and majors in which to specialize. One of the best ways to research options for continued education are to talk to those around you who may be able to assist you. Talk to teachers, guidance counselors, parents, friends, etc., anybody you trust who can provide you with some information. In addition, much like the Barron's study guides, there are also books available in your local bookstore or library that serve as guides to national and local colleges. They will provide you with information such as: student body population, ratio of students to professors, stats regarding men to women and ethnicity, any special programs the school offers, and a description of the surrounding community. These guides provide at least enough information that if you are interested in learning more about the school you can contact them and request brochures, additional information, and application packets. It is extremely important to remember when making contact with these schools that you do so politely. Be sure to request the information you need by saying "please" and "thank you," and to be specific so you are certain to receive the information you have requested and are anticipating.

Along with researching schools, it is also important to begin identifying what type of career you might like to have, consequently, what type of school should you look at attending? There are community colleges, four-year colleges and universities, technical schools, computer programming schools, clerical programs, automotive, mechanical, and electrician programs, etc.

The Application Process

Once the application packets are received you should plan to devote some time to completing them. You do not want to complete them at the last minute, immediately before the deadline for the institution to accept new applications. Once received you should make one or two copies of each application so you have a practice copy available. You will need to either write legibly or type the application. A practice copy will ensure that you have presented the information in a way that you are pleased with and represents you well. You should be sure to provide valid contact information (address, phone numbers, e-mail addresses, etc.) in order to schools to reply to the application. You should also be sure to answer all questions honestly. Starting this process early, therefore, also allows you time to ask for help in completing the application if you are either unsure of what is being asked, or if you are unsure of how to answer. In addition, the application packet will also inform you of what other information is required to request admission to an institution, such as letters of reference, essays, high school records, etc. Beginning early with the application process provides you the additional time you will need to complete these additional steps as well.

References

Most applications will request that you either list personal and/or professional references,

and/or included letters of recommendation along with the application. If you are simply listing reference names, it is important to be sure to provide accurate contact information for each. If letters of recommendation are required be sure to be courteous when making these requests, again, be polite and say "please" and "thank you." Also, be sure to make these requests well in advance of the application deadline. You want to be sure to provide individuals writing these letters on your behalf plenty of time to complete and mail the letter. These individuals may also want to spend some time talking to you about your goals for attending that particular institution, your careers goals, etc. Discussing these things with you will assist them in promoting you as an asset to the school and one deserving of admission.

Essays

Some schools will require an essay, or two, as part of the application process as well. They may provide you with a topic to write on, or it may be a standard personal statement essay. Allow yourself plenty of time to discuss the content of what you want to say with parents, teachers, guidance counselors, etc. You should also start this process early so you allow yourself plenty of time to prepare drafts of your essay, receive feedback, make revisions, etc., prior to sending the final draft along with your application. Be sure to type the essay, unless it specifically instructs to handwrite, and carefully proof read for grammar and typographical errors.

Financial Aid

Can I afford to continue my education? This is one of the primary concerns students have when examining the possibility of attending school beyond high school. To address these concerns, you should contact the financial aid department of each school/program and request a packet of financial aid information applicable to that particular school. Be sure to be clear in making this request so they send both the information and the forms that you need to apply for financial aid. Teachers and guidance counselors can also be helpful in providing you with some information and support regarding financial aid, as well as guides available on this as they are for general college information and study guides for standardized tests. The internet can also provide valuable information regarding available financial aid. In addition to financial aid packages, you should also research as much information as possible regarding the various scholarships, grants, and loans that are available to students. As is the case with applying to school, there are applications and essays also required for financial aid and a host of other funding possibilities.

Discussing financial aid for school with your parents is also important. You may need to discuss some aspects of family finances with your parents in order to accurately complete financial aid forms. You also need to discuss with them their ability to help pay educational expenses. As with application packets, pay close attention to details regarding deadlines. If you need your parents to assist in the process you want to make sure to allow plenty of time for them to participate in the process with you, or get the information to you, so you are able to return the necessary documents to the school on time. Recognition of deadlines is extremely important for each aspect of applying to school, as well as applying for financial aid, in order to remain

eligible for admission.

Other issues to be considered

You will also need to look into housing and transportation issues depending on schools you are applying to. If commuting to school, you need to make sure you have reliable transportation. If moving to campus, make sure you have also researched school housing options and associated costs with housing, meal plans, etc.

There are a number of issues that may come up with clients as a result of discussing post-high school options. There may be uncertainty about applying to college, uncertainty about a career, uncertainty about their ability to do well in college, etc. Clients will need encouragement to ask people they trust and respect for advice in making some of these decisions. The anxiety associated with these decisions should be normalized. In addition, clients may also have anxiety about asking for help, either with completing applications and essays, with whom to ask to be a reference, talking to parents about finances and supporting this expense, etc. Time should be allotted within this lesson to process such potential issues.

Optional Exercises

None.

Session Objectives

Clients who attend this session and have assimilated the information covered, should be able to:

Formulate an appropriate plan to begin the process of learning about different educational programs and the requirements to apply, and therefore to attend, the program of choice.

C. Parent Education and Support Groups

Parent Education and Support Group 1: Enabling Addicts
Parent Education and Support Group 2: Communication
Parent Education and Support Group 3: Stages of Addiction
Parent Education and Support Group 4: Understanding Adolescence
Parent Education and Support Group 5: Parenting Styles
Parent Education and Support Group 6: Setting Limits
Parent Education and Support Group 7: Anger Management
Parent Education and Support Group 8: Maintaining Recovery After Treatment

Optional Group Session 1: Single Parenting/Blended Families
Optional Group Session 2: Co-Dependency and Boundary Issues
Optional Group Session 3: Discussion of Video "Seven Worst Things Parents Do"
Optional Group Session 4: Stress Management

Parent Education and Support Group 1: Enabling Addicts

Main points to be covered during the didactic portion of this session

Define "enabling" behavior in relating to substance abusers.
Describe the types of behaviors that "enable" an addict to continue using.
Describe the consequences of enabling, for the addict and for the person trying to help.
Discuss behaviors that are supportive of recovery rather than enabling addiction.

Rationale

This session focuses on providing information and encouraging discussion about how family members can best interact with their substance-abusing adolescents to support them in their recovery rather than enabling alcohol and/or drug use. Parents, in their well-meaning attempts to show love and support, sometimes make it easier for their adolescents to continue using. Common “mistakes” parents make are: not confronting suspicions of use, denying to themselves and others that use exists, and agreeing to lie to school and work authorities and friends so their kids won’t get in trouble. The problem is that if kids don’t ever have to experience the consequences of their drug use (suspension from school, loss of job, arrest for possession), they will have no reason to stop using. This is why remaining quiet enables use. Sometimes parents are trying to protect their kids and sometimes they’re trying to protect themselves (“I don’t want anyone to know there are drug addicts in our family.”) Denial is one of the main reasons addiction continues. Addicts in denial can’t help themselves. Families in denial can’t help their addicted teen.

Session Content

Define "enabling" behavior in relating to substance abusers

Enabling in the substance abuse field refers to situations where family members do something that prevents chemically dependent people from experiencing the full impact of the painful and/or negative consequences of their drug/alcohol use. One of the most common types of enabling occurs when parents "cover up" for their kids with the school, bosses, etc.

For example, your 17-year old can't make it to work Saturday morning because he's hung over from abusing alcohol severely the night before. You call in for him and say he's "sick." Maybe you do it because you know another absence will result in your teen being fired and you know he needs that job to save for college. (You certainly can't afford to pay his tuition). Though your motives are caring, the result is that your teen gets the message he can "get away with" that kind of behavior. He doesn't experience any consequences to his abusing alcohol (such as losing his job) so there's no reason for him to stop doing what he's doing. Without realizing you've done it, you've "enabled" him. In other words, you've made it more likely he'll continue to abuse alcohol and continue to be irresponsible.

Exercise #1: "*How Enabling Prolongs Addiction*" (see Appendix C) (The counselor may want to read the handout to the group or ask volunteers to read it.)

Describe the types of behaviors that "enable" an addict to continue using:

1. Covering for them by lying to someone so the adolescent won't get in trouble. (*Example*: Mary doesn't tell her husband, Jim, that she found marijuana in daughter Shelly's room because he would "throw a fit." (In fact, Mary's inability to effectively handle situations like this enables both Shelly's use and Jim's inappropriate expression of anger. The family gets stuck in a dynamic that doesn't change.)

2. Taking care of their responsibilities either because you're covering for them or because you just don't have the energy to fight about it anymore. (*Example*: Ken mows the lawn though his son Chuck has agreed to do it. Ken is tired and doesn't have the energy for an argument.)
3. Saving face with others. Parents may not want relatives, friends, and authorities to know about their teen's alcohol/drug abuse because they feel it reflects badly on them.

(*Example*: *Kim and Ron don't tell their good neighbors, the Holleys, that their son is in trouble with drugs because they think the Holleys will think they're lousy parents. (Of course, what they don't know is that the Holley's daughter is in rehab and they are afraid to share that information with others too.*)

Exercise #2: "*Parental Enabling Checklist*" (see Appendix C)
(The counselor will ask the parents to complete the exercise on their personal behavior and feelings. The counselor then will either ask volunteers to share their strongest responses or ask them to save them for the processing at the end.)

Describe the consequences of enabling, for the addict and for the person trying to help.

For the chemically-dependent person, the main consequence of being enabled is that he will continue to use. The addict's denial of his problem is reinforced by what seems to be the family's denial of the problem. The addict misses an opportunity to gain insight into the seriousness of the problem. And because he isn't having to face the consequences of his addiction (because family members are covering up for him), he minimizes the problem and doesn't understand his family's "over-reaction."

For the parent, the main consequence of enabling is frustration that all of the support and love he's giving isn't making things any better. And, things don't get any better! Parents eventually feel helpless and hopeless. *"What more could I do?"; "After everything I've done for*

you, you repay me this way!"; and *"I give up!"* are common laments. When addicts hear comments like these, they think their parents are the one's with the problem, not them.

Discuss behaviors that are supportive of recovery rather than enabling addiction.

The first thing you should do is get support from people who understand how addiction affects the family and/or have gone through it themselves (Al-Anon, Nar-Anon groups, Church, friends, etc.). Find people who can help you decide what is helpful vs. enabling for your child, and find people you can vent your feelings of frustration, inadequacy, sadness, and fear, with. There is great relief in finding out you are not the only one with these problems. This is a disease, not a family disgrace. And don't take on the responsibility for your teen's drug/alcohol use; a user has made his own decision.

Exercise #3: "*Alternatives to Enabling*" (see Appendix C) (The counselor may want to read the handout to the group or ask volunteer(s) to read it.)

To emphasize the important points from the handout "Alternatives to Enabling":

1. Don't nag, preach or make "if you loved me" appeals. Only make threats and set consequences that you're willing to follow through with. Making a consequence and not following through is probably worse than not making a consequence at all. Offer support but you have to let your teen make his own decisions. Shielding him by keeping him from situations where there will be alcohol or throwing away drugs you find, only prolongs the inevitable: he'll have to say "no" on his own for recovery to work.

2. Have patience with the recovery process. The problem developed over time and will have to be healed over time.

The remaining time might be used for questions and any processing what wasn't done in conjunction with the didactic piece. At the end of session, the counselor may want to pass out Al-Anon and Alateen directories of meetings in their area. He or she will explain that these hour-long meetings are free and open to anyone whose life is being adversely affected by a substance abuser. At meetings, they will get information and support from people who are going through the same kinds of problems as they are (relationship, legal, financial, etc.).

Session Objectives

Parents who attend this session and have assimilated the information covered, should be about to:

- # Define enabling behavior.
- # Recognize at least one of their own past behaviors that may have enabled their adolescent's drug or alcohol use.
- # Verbalize the consequences of enabling.
- # Suggest one alternative behavior he/she might use rather than the enabling behavior they referred to in #2.

Parent Education and Support Group 2: Communication

Main points to be covered during the didactic portion of this session

Define communication.
Discuss why we engage in communicating.
Discuss the attributes that make communication effective.
Discuss how we can improve our listening skills and self-expression.
Identify ineffective communication and suggest alternatives.

Rationale

This session focuses on providing information and encouraging discussion about effective communication. Initially communication will be defined, and sending and receiving skills will be identified. Parents will be asked to compare and contrast their communication styles. The group leader will help parents evaluate in which ways their communicating styles have been effective vs. ways in which they haven't been. Common pitfalls will be discussed. The goal of this session is to aid parents in communicating with their children in a way that will enhance their relationships with them.

Session Content

Define communication.

According to Webster's Ninth New Collegiate Dictionary, *communication* comes from a Latin word meaning "to participate or to share." When we communicate, we're attempting to make a connection between ourselves and another person. Communication can be verbal or non-verbal and is most often a combination of the two. Sometimes, often without realizing it, we send "mixed messages" to other people. This happens when our body language contradicts what we say verbally. For example: Ron tells his son, Todd, that he's really interested in hearing about the ball game he pitched. But all the while Todd is talking, Ron is flipping through the newspaper.

There are two parts to any communication no matter how small: a message is sent and that message is received. To put it another way, one person expresses something and another person listens. When the listener responds back, she becomes the sender and the original expresser becomes the receiver or listener. There can, of course, be many listeners to the same message, such as when someone gives a speech or acts on the stage. There can also be multiple senders, such as when thirty members of a choir sing the same song in unison. But if a person expresses himself and there's no one there to listen (or observe if it's non-verbal), it is not "communication," because no connection has been made and nothing has been shared.

This is not to say that because communication is a connection that it is always pleasant or that it always makes a relationship better. We all have had experiences where communication has been destructive. Sometimes people mean to be hurtful. But more often, what comes out is different from what they really meant to say because of strong emotion and/or weak communication skills. For example: Stella, upset because her daughter, Jessie, came in hours after her curfew, yelled, "You're just no good!" Stella really meant that she's angry that Jessie

disrespected her rules. She also had been terrified something had happened to Jessie. Many people are more comfortable expressing anger than fear. If Stella really thought Jessie was "no good," she wouldn't be so worried about her.

Stella's communication resulted in Jessie getting hurt and angry and made her even more likely to disobey in the future. The real messages Stella wanted to communicate but was too angry and/or unskilled to express effectively were, 1) "I need you to follow the house rules or there will be consequences" and 2) "It's dangerous out there at night. I love you and I'm terrified I might lose you."

It is often difficult to “decode” the message someone is sending when they speak. They may seem to be saying one thing but actually mean something different, as in Stella’s example. It is not unusual for a speaker to expect her listener to be a mind reader. People frequently get angry that they are misunderstood, no matter how poorly they’ve communicated their message.

Discuss why we engage in communicating.

As mentioned above, people engage in communication to make connections with others. Sometimes we communicate in order to become less isolated and lonely, like the new neighbor who introduces herself around the neighborhood. Sometimes we communicate to ask advice ("How do I get to Main Street?") or to give our advice or help ("You look lost, where are you trying to go?") We might say something just to "get it off our chests," just to get attention, to teach something, to show we care or that we don't care.

Sometimes people engage in conversations because they want to and sometimes because they have to (ex: being called on in class). There are a hundred reasons why someone might initiate a conversation. But all examples of communication, no matter how short, have one thing in common: The person initiating the communication has a goal. He is trying to accomplish something and usually, he hopes for a specific response from the listener. It's often hard for people to accept a response from the listener that's different from what they expected or wanted. (Ex: "Will you marry me?". . . "No!")

Discuss the attributes that make communication effective.

As stated above, someone who initiates communication with another is trying to achieve something. When it's a situation where you asked for something and then got it, it's easy to see that the communication was effective. (Ex: being offered a job after the interview; getting people to vote for your candidate; getting a date with the girl you like; having your kids follow the rules of the house.)

It's a little harder to see that communication can be effective even when you don't get what you want. We can't control another person's behavior or responses. But when we can express our ideas, our wishes, our feelings clearly so that they're understood and the listener can reflect the message back, showing she understands it correctly, the communication has been effective, even if the parties have different opinions.

If you feel something in your household needs to change and you're able to deliver that message honestly, in a focused way, without giving mixed messages and without character assassination, you are communicating effectively. When your listeners can reflect back to you what they've heard and it's accurate (even if they don't agree with it), they're demonstrating good listening skills – the other component of effective communication.

For example, the following illustrates effective communication:

> "Josh, if you plan to continue living with us here at the house, you must be in by our stated curfew of 11pm. If you're late even once in the next 30 days, we will insist you move out the next weekend. Do you understand?"
>
> "No more chances, that's cold."
>
> "That's the deal."
>
> "Yeah."

Though Josh doesn't like the situation, he clearly understands what the rules are and he wasn't disrespected in the exchange.

Discuss how we can improve our listening skills and self-expression.

Half of the credit for effective communication goes to effective listening. Like anything else, good listening skills can be learned and practiced. The most important thing is to make sure you're really hearing what the person is saying and not what you expect them to say or hope they'll say. Don't anticipate their message, even if you've heard the same thing a hundred times before. It might be different this time and you'll miss it. Force yourself to keep an open mind.

There are three basic types of listening modes: 1) **Competitive or combative listening**, 2) **Passive or Attentive Listening** and 3) **Active or Reflective Listening**. Competitive listening occurs when the receiver is just waiting for an opening in the sender's message so he can jump in and take over the conversation. This is ineffective listening, and therefore, ineffective communication. In Passive Listening, the receiver is genuinely interested in the sender's point of view and listens intently, perhaps indicating he's paying attention by nodding his head. In Active listening, the receiver is also genuinely interested in the sender's message but she's more assertive in making sure she understands the message the way the sender meant it. She accomplishes this by paraphrasing and reflecting back in her own words, what she heard, in order to verify that she did understand it. Passive and Active listening are components of effective communication. Competitive listening is not.

Listen not only for the meaning of the words the speaker uses but also the feeling behind the words. Tone of voice and body language can give you a lot of information about the message's meaning. "School's alright" can mean anything from "I really like school" to "I really hate it" to "I don't want to talk about it."

People often don't express what they mean very well. Part of the job of a good listener is to help the talker figure out what he wants to say by asking open-ended instead of yes-no questions. (Ex: Saying "Tell me about your day" is more helpful than asking, "Did you have a good day today?")

Whenever possible, be an "active listener." Reflect back to the person what you think they're saying and check with them to make sure your perceptions are correct. Generally people want their feelings to be understood and want empathy rather than advice. When someone really wants advice, they'll usually ask for it.

Exercise #1: *"Typical Responses"* (see Appendix C)
(Distribute handout. The counselor may want to ask parents to put themselves in this situation. What response would they like to hear?)

Once parents have discussed which response they would most want to hear, ask them to talk about what their responses as parents have been to similar situations in the past. Ask them if they've been effective or whether they want to try something new.

Identify ineffective communication and suggest alternatives.

It's important for people to develop their own style of expression that reflects them rather than trying to imitate someone else. Trying to sound like someone other than yourself makes you sound fake and people will have trouble trusting what you say. But that isn't to say that we can't all learn some good techniques by watching people who express themselves well.

Good communicators make "I" statements rather than "you" statements. They take responsibility for their feelings rather than blaming others for "making them" feel a certain way. In fact, people can't make us feel anything unless we choose to let what they say affect us. For example, Sam turned to Kate angrily and made the "you" statement: "You embarrassed me when you told everyone about our son's drug problem." To communicate more effectively, he could change this into an "I" statement by saying, "I felt embarrassed when you told everyone about our son's drug problem."

Good communicators **talk with** someone, **not "at"** them. Too often people are so hyped up about what they want to say that they don't wait for their listener's response or ignore it if they do wait. If your listener feels you could just as easily be talking at the wall than with him, he's not going to be very engaged in your topic. The best communicators show respect and enthusiasm toward their audience. Conversation should be like a tennis match, with long volleys back and forth, not like a volleyball game with someone "spiking the ball" and the other side trying to defend against it.

Listeners can follow conversation better if its focused on one topic rather than jumping around. When there's a problem that needs to be solved, the speaker must be specific about what her concerns are and attack the problem not the person. It's much more effective to say, "John I need you to take the trash out, it's been piling up for 2 weeks," rather than, "John, you're a lazy

bum!" Communication in the first example reflects the actual situation more accurately than the second and it's more effective because John is more likely to take care of the trash when the request is clear and he isn't being disrespected by being called a name. (The speaker is much more likely to get what she wants in the first example.)

The following are some common pitfalls that hamper effective communication:

1. Parents often make the mistake of pulling rank on their kids when they are unable or unwilling to explain their decisions. Hearing "Because I said so," is frustrating and disrespectful for adolescents. It also doesn't give them any useful information about why a certain behavior is being requested of them. For example: "Why can't I hang out at Joe's house?" "Because I said so, " doesn't give your daughter any clue about your concerns. A better response might be: "Why can't I hang out at Joe's house?" "Because Joe's parents both work. I don't want you alone with Joe because he's much older than you and ready for a more advanced relationship," (a specific concern is addressed). Your daughter still won't like it and will probably still argue but the discussion will be about the potential problems of the relationship and not a power struggle between you and your teen. If she continues to argue after you've made your position and reasons clear, then you can pull rank: "I'm the parent and my rules stand while you live here."

2. Using the past as ammunition in an argument is a common mistake parents make. Effective communication centers on what's happening in the present, not what used to happen. For example, saying to your daughter, "I'm concerned about you going to this party because there might be a lot of pressure on you to drink to fit in," is a lot more effective than saying, "I can't trust you to stay sober because you got drunk at the party you went to last month."

Exercise #2: *"Pitfalls in Communicating"* (see Appendix C)
(Counselor should give parents handout and ask them to put a check mark next to the two "don'ts" they find themselves doing most often. Ask them also to be thinking about how they might rephrase their requests in order to be more effective and to have a better chance of getting what they want. After parents have finished filling in the questionnaire, ask them to share the results; encourage them to come up with their own answers about what they might do differently and then open it up to the group for feedback.)

Once this exercise is finished, and parents have had a chance to go over the exercise, ask them if there are any questions and then ask them to recap what they learned about communication.

Session Objectives

Parents who attend this session and have assimilated the information covered, should be able to:

Define what communication is.

Discuss what parents are trying to achieve when they communicate with their teens.
Define the components of effective communication.
Evaluate their listening skills and verbalize how they are going to improve them.

Parent Education and Support Group 3: Stages of Addiction

Main points to be covered during the didactic portion of this session

Discuss the stages of addiction.
Describe the signs and symptoms of each stage.
Discuss how the child's addiction affects the family in each stage.
Discuss the changes for client and family that occur in the recovery phase.

Rationale

This session focuses on providing information and encouraging discussion about the Stages of Addiction that an adolescent commonly goes through as drinking or drugging becomes a problem. Signs and symptoms of each stage will be discussed in order to help parents better recognize where in the addiction cycle their child is and what to expect at each stage. Parents will also be urged to talk about how their child's addiction is affecting their family and compare and contrast that with how families are generally affected. Finally, changes that typically occur in the recovery phase will be discussed.

Session Content

Discuss the Stages of Addiction and describe their signs and symptoms.

There are four stages of addiction. Prior to that, a kid can be categorized as a "**non-user**," which applies when an adolescent doesn't use alcohol or drugs at all except on rare occasions when a parent or guardian approves and supervises the use. This might happen during a religious ceremony or celebration. In this case, the adolescent has not been "seeking" alcohol or drugs and it doesn't trigger continued use.

The first stage is **"Experimentation."** During this stage, it's the adolescent's idea to try alcohol or a drug, usually because he's curious. It is not a planned event but rather it's offered to the kid, most often by a friend. The first drugs tried are almost always tobacco, alcohol, or marijuana (though not necessarily in that order.) Tolerance to alcohol or drugs is very low at this point so it may be obvious to anyone who sees him that the kid has been using. If confronted, he's likely to tell the truth about the use.

At this point the alcohol or drug use has not caused obvious consequences. Relationships have not been damaged; responsibilities such as school, work, and household chores haven't been neglected; there usually aren't any legal or health consequences. Unfortunately, on rare occasions, an adolescent becomes seriously ill or even dies during his first use. This has been documented with inhalant use particularly. Also, if the adolescent drives while drinking or using, the possibility exists that he'll have an accident or be charged with a D.W.I.

The Experimental Stage is very short-lived. A person using a time or two is probably "experimenting." After that, he's moved into the **"Social or Misuse"** category (Stage 2). In adults, this level of indulgence is called "social use," but because alcohol and all drugs are illegal for minors, adolescent use is considered "misuse."

In stage 2, tolerance begins to increase (she needs more of a substance to have the same kind of high). The adolescent starts making plans about use—where to get it, how to pay for it, when to use. A kid is still able to control her use. For example, if a teen decides when she goes to a party that she's going to drink four beers and then sober up before going home, she can usually stick to the plan. Kids are still primarily using with friends at this point though they often develop two different groups of friends: the "users" and the "non-users." Toward the end of this stage, a kid may begin using alone.

In the misuse stage, a person becomes less fearful and willing to try other substances. She often develops a "drug of choice." There isn't a physical dependence but there might be the beginnings of a psychological dependence. Kids associate their use with relaxation, having fun, and fitting in and begin to believe they won't have those things if they stop using. For the most part, kids are still meeting their obligations and aren't suffering much in the way of consequences. They are getting better at hiding their use and though they might be willing to talk about it when confronted, they tend to be more defensive than previously. It becomes important to kids to prove to themselves that their use isn't out of control so they develop and follow "rules of use." (For example: Jeffrey finds it's not a problem following his plan of drinking only on Friday and Saturday nights and never on school nights, therefore, he "knows" he's not an alcoholic.)

Once kids enter the "**Abuse"** stage (stage three), things change a lot. Tolerance to the alcohol or drug increases. Recurring consequences of use are likely, including school, family, work, or legal problems. There is a higher possibility of health consequences as well, in terms of accidents under the influence, and overdose. This is the stage where kids can no longer totally control their use. They use more than they intended and spend more money than intended which may cause them to lie, cheat, steal or deal in order to get drugs, causing personal values to erode. More and more time is spent planning for the use, getting the drug, using it, and recovering from it. Therefore, other commitments fall by the wayside. Typically grades slip, kids skip school and work and don't follow family rules. Mood swings frequently appear or become more evident. The only friendships they keep up are with those who will use drugs with them or supply them.

The rules the adolescent made to "prove" to himself he didn't have a problem, have been either violated or changed. For example: Now Jeffrey tells himself that he can use on weekdays because he can "handle it" but that he won't use everyday because that's what addicts do. Consequently, he doesn't use one or two out of seven days in order to stay in "denial" about his problem. Denial is very prominent in this stage. Denial sounds like lying but it's really a psychological defense that keeps an addict from realizing the true severity of his problem. The more dependent he becomes on having his drug, the more scared he becomes of having to give it up.

The final stage of addiction is **"Dependence."** In this stage, the adolescent spends most of her time planning for use, acquiring the substance, using, and coming down, then starts over again. There are few if any friends left. There may be using buddies, but some dependent users prefer to use alone so as not to have to share their supply. Although someone dependent on alcohol or drugs may be able to function well enough to hide his addiction for a while, eventually it becomes apparent. School, work, family, legal, and sometimes health consequences occur

repeatedly. In the case of adolescent users, school, family, or legal problems, or a combination of them, typically brings the kid into treatment.

One of the main things that distinguishes dependence from abuse is that people use just to "feel normal," rather than to get high. The body is so adapted to the drug at this point, that many users no longer get high but use so as not to feel sick, depressed, or anxious. Some drugs create a physical dependence (alcohol, tobacco, heroin, pills such as oxycontin or xanax) and the body experiences withdrawal when the drug is withheld. Withdrawal can be painful and in some cases, dangerous, if not monitored. The existence of physical withdrawal symptoms is a clear indication that a person has become dependent. Other drugs can create a strong psychological dependence (marijuana, cocaine). Marijuana may have been used to de-stress and mellow out; cocaine might have been used to rev up and gain confidence. Typically, major mood swings accompany the cessation of both drugs—increased anxiety when stopping marijuana after having become dependent, and depression when coming down from cocaine.

Discuss how the child's addiction affects the family in each stage

a) **No Use:** The family is not affected yet.

b) **Experimentation Stage:** Some parents don't take this stage seriously and say: "All kids experiment; I did." Others worry immediately, especially if there's been addiction in the family previously. Many parents don't confront the behavior even if they realize it's going on because they don't want to "make too big thing about it," don't know what to say, or are in denial that anything could really be happening. This is the best stage to talk to your kids about use though, because they are the most open to hearing other points of view--they don't yet have an investment in using. Express your concerns calmly but seriously.

c) **Misuse Stage**: Often in this stage, parents suspect use but minimize it or deny it to themselves if there haven't been any obvious consequences. Many parents don't want to believe there could be an addiction problem brewing because they don't know what to do about it, or feel guilty because they think it reflects badly on them as parents. When parents do confront their kids, some do it by trying to negotiate, using bribery such as: "If you stop using, I'll buy you that DVD you want." Others react by blaming other kids. (Ex: "My son wouldn't have tried this if it hadn't been for the neighbor.") These parents attempt to eliminate the problem by limiting where their kid can go and who he can hang out with, possibly even changing schools or neighborhoods. Though moving to an area less inundated with drugs or restricting who your kid is allowed to see, is sometimes helpful in terms of reducing their exposure, drugs are available everywhere and you can't keep an eye on your kids twenty-four/seven. Honest, two-way, discussion, offering firm guidance and setting limits based on concern, generally work best. Ultimately, a kid has to choose how he'll deal with the issue of drugs in his life.

d) **Abuse Stage**: But the time an adolescent has settled into the abuse stage, her addiction has significantly affected family functioning and typically several things have happened:

1. Parents experience some combination of the following feelings: guilt ("Is this my fault?"), shame ("What will others think and how will this reflect on my family?"), anger ("Why should I have to go through this?"), depression and helplessness ("It doesn't matter what I do, it won't make a difference.")
2. Fighting among family members may be occurring. Any already existing problems between parents will likely be accentuated as teens often play one parent against the other. If a parent is angry at the kid, the other may try to protect him, which causes further divisions in the marriage relationship. Other siblings will likely receive less attention than the using teen and may get lost in the shuffle.
3. It's likely that one or both of the parents will inadvertently "enable" their adolescent's use. No parent wants to see his kid suffer or experience negative consequences. Consequently he may intervene when the child is about to be expelled, fired, locked up, etc., following a natural parental instinct to protect. But this generally back-fires because it's human nature that if you haven't had to experience the negative consequences of your actions, you're going to continue to act in the same manner. And although it's important to understand what happens to people when their drug use is out of control, it doesn't mean you should tolerate such things as angry outbursts, laziness, extreme irritability and disrespect. Putting up with these things is enabling the addictive life-style as well.

e) **Dependence Stage**: Once dependence has set in, families tend to feel very helpless and hopeless. Many parents begin to believe there's nothing they can do to help and that the addiction isn't going to change. It's common for parents at this stage to distance themselves emotionally from addicts, as a coping skill. Some parents will say: "I wash my hands of him." Anger, blaming others, guilt and shame exists on all sides. At times, physical distancing is truly necessary as a "tough love" approach may be the most beneficial to the addict and the family.

After a family has lived with the chaos of active addiction for a while, it can start to feel "normal" because people have adapted themselves to accommodate it. They might have forgotten what is used to be like before. All family problems are likely to be blamed on the addiction and on the "identified patient" (the addicted teen), thus obscuring the reasons some of the problems originally existed. It's important to look at these issues as well as heal the hurts caused directly by the addiction; that's why family therapy is such an integral part of adolescent treatment.

Discuss the changes for client and family that occur in the recovery phase.

Once your adolescent begins treatment, it's best that you as well as the child, be hopeful yet realistic and patient. Recovery is a process, not an event. Many people make the mistake of

thinking that the battle is won once treatment has started and they can relax, but it is only then that the real work starts.

In early recovery, people are typically ambivalent about giving up their drug or alcohol. They're aware it's caused them some pain but they also remember the pleasure it provided (relaxation, feelings of belonging, lessening of anxiety, a way to numb out when things seemed too tough.) For teens, especially, there is a lot of peer pressure to use and they fear not fitting in if they're clean and sober. For these reasons, and others, it's normal for addicts to have ambivalence about abstinence (though also normal for families to only see the pain and negative consequences of drugs). Relapse is a common occurrence. It doesn't mean the addict isn't trying or isn't motivated. It means he doesn't understand his triggers, still has some ambivalence, hasn't developed sufficient coping skills yet, is scared, etc. It can be very difficult for parents when their kid relapses. It's especially difficult to hold on to faith and trust after several relapses. Remember that he is trying and support the effort, not the immediate result. But if relapses are continuous, a higher level of care, like inpatient, is probably needed.

Recovery is not just abstinence, though abstinence is a central part of it. Recovery is about forming new habits, developing new coping skills, making peace with past behaviors and finding new and more honest and intimate ways of relating to others. These are huge changes and change is frightening for everyone. As your addicted teen gradually makes these changes, you will need to consider what changes you as parents want to make as well. A family is a system and when one part changes in a major way, the equilibrium is changed. Other members may find they need to change their perceptions and behavior as well, in order to achieve balance again.

Finally, though your addicted adolescent does need your support and attention at this time–don't forget that your other children need you as well. And most important, don't forget to get yourself the support YOU need. Alanon and Naranon provide free meetings for the families and friends of addicts. It's a place to vent and talk to other families who have been there. It's a place to find hope that things really can change for the better.

<u>Session Objectives</u>

Parents who attend this session and have assimilated the information covered, should be able to:

- # Name and explain the differences among the stages of addiction.
- # Talk about signs to look for in evaluating the severity of their adolescents' problem.
- # Discuss ways addiction generally affects families and compare and contrast it with how their families have been affected personally.
- # Identify changes they can anticipate in their adolescents and in their families in recovery, recognizing that some changes will be gradual rather than immediate.

Parent Education and Support Group 4: Understanding Adolescence

Main points to be covered during the didactic portion of this session

Describe the changes kids go through in their teenage years (biologically, emotionally, interpersonally, cognitively, educationally and morally).
Discuss some of the fears and concerns that kids have today. Compare and contrast them with your fears and concerns growing up.
Discuss what kids want and need from parents. Compare and contrast that with what you wanted and needed at that age.
Explain how parents can help their kids have a less troubled and stormy adolescence.

Rationale

This session focuses on providing information and encouraging discussion about what it's like to be a teenager today. We'll address adolescents' fears, concerns, what they need, what they want, and why they're particularly vulnerable to the lure of alcohol and drugs. Parents will be asked to think back to what the teenage years were like for them and ask them to use that knowledge in attempting to understand where their kids are coming from—recognizing that some things have changed whereas others are universal. We'll also touch on what you as parents can do to help your teens navigate through these difficult years.

Session Content

Describe the changes kids go through in their teenage years (biologically, emotionally, interpersonally, cognitively, educationally and morally).

Psychologist Erik Erikson devised a theory in which he divided the human life span into eight stages of development. He believed that each stage is associated with a task that has to be accomplished in order for people to be healthy and happy. None of us accomplish these tasks perfectly but most of us do a fair job.

In adolescence Erikson said, the task is for a person to find his identity -- to discover who he is as a unique person, separate from his parents and everyone else in the world. When he's successful, the adolescent has some degree of self-acceptance and confidence that being "me" is a good thing. When the teen is not very successful in this quest, he is filled with confusion about who he is; he doesn't have confidence that his thoughts and feelings make sense; and he doesn't think that being "me" is a good thing.

Many more dramatic changes happen to a person in adolescence than in any other stage of life. These changes occur in every area of life and greatly influence a teen's emerging identity. "Adolescence" is really defined more by the start and finish of these changes than by exact years. Think back to your teenage years; what change affected you the most significantly?

Exercise #1: "*Parenting Styles: Chart of Stages*" (see Appendix C)

(Distribute handout. The counselor may want to read the handout to the group or ask volunteer(s) to read it.)

Biological changes: Huge physical changes happen during adolescence. Kids experience big growth spurts and hormones start raging. Teenagers' bodies reach maturity far more quickly than their emotions. Each decade, teenagers mature physically at a slightly younger age than the decade before. Still, there has always been a lot of variation among kids. Some begin puberty as young as age 9 and others not until ages 15 or 16. Kids at either end of the continuum experience a great deal of anxiety because they feel "different."

Emotional/Interpersonal changes: Teens still have a great need to feel loved by their parents but they get very particular about how they want that love shown (e.g., not in public, and not too mushy!!) Teens shift their focus of attention from their families to their peers. It is natural at this time for the close, intimate (not necessarily sexual) relationships of their lives to be with friends and boyfriends/girlfriends. Adolescents tend to go to their peers for advice and this is hard on parents, who often miss the closeness they used to share when their children were younger.

Cognitive/Educational changes: Teenagers are able to think in abstract ways and can put their own personal spin on ideas. Adolescence is a time when kids think they know more than their parents. (And sometimes they do.) This doesn't stop parents from telling them, "I've already forgotten more than you'll ever know!" The truth is however, that knowledge in technological fields especially, continues to expand. Teenagers today are exposed to advancements their parents' generation couldn't have dreamed of. Many thirteen-year old kids today know more about computers than their parents do. Technology has made the world a smaller place and the competition for jobs will be much keener for these kids than it was for their parents. Very few teens will spend their whole career in one company or even in one field as their parents may have.

Moral changes: Adolescence is the time when we develop our conscience. Younger children make decisions based on rewards and punishments. Teenagers have the capability to weigh what is best for them against what is best for others. Sometimes they choose to put another person or the community's needs before their own. Adolescents are developing their identity and they feel most comfortable when the decisions they make are consistent with their identity (how they see themselves). For example, if a teen has determined that she is a "fair" person, she'll feel better about herself when she makes "fair" decisions.

(The counselor may now want to ask parents what change they remembered being hardest for them in their own adolescence.)

Discuss some of the fears and concerns that kids have today.

Compare and contrast these with your fears and concerns growing up. Adolescents have great concerns about not fitting in and being "different." There is excruciating pressure for kids to perceive themselves as "normal." Puberty can be an especially embarrassing time if a kid's body begins changing way before or way after her friends.

Although divorce and blended families now are commonplace, a kid might be afraid friends in intact families will look down on him. Peer pressure, as it's always been, is huge in the teenage years. Today there is tremendous pressure for both boys and girls to be sexually active in order not to be considered "losers." Studies show that in the majority of first-time sexual encounters among teens, protection isn't used. So predictably, sexually-transmitted diseases and unwanted pregnancies emerge as problems. Drugs, in some circles, are also considered cool. Drugs are far more available and cheaper than they were twenty years ago.

The media is an even stronger force today than it was for the parent's generation. Ads emphasizing thinness have fueled a whole generation of dieting children. Some estimates suggest that 75% of all girls and 25% of all boys diet at least once before the age of fourteen. Violence is an every-day occurrence for many teenagers. Domestic violence is up. Drive-by shootings are common-place in many cities. Today's generation of adolescents is the first to witness an epidemic of teens killed in their classrooms throughout the country. Unlike any previous generation, kids today are growing up believing there is no "safe" place. Perhaps this is part of the reason that teen suicide has tripled over the last three decades while suicide among the general population has stayed about the same. Another reason may be the current availability of firearms. Recent statistics suggest that 2/3 of all teen suicides are from self-inflicted gunshot wounds.

Adolescents today are more vulnerable to the lure of drugs for several reasons. Many kids can't imagine a future with a lot of promise and figure feeling good in the present might be the best they can hope for.

Heroin is as available today as marijuana was in their parents' generation and it's just as cheap. Both drugs are much purer now as well. Marijuana itself, although not legal, has become culturally legitimized because so many parents experimented with it in their youth and because people believe it's "nothing compared to heroin." Kids have grown up watching the older generation (both first hand and through the media), handle their problems with booze and pills.

Exercise #2: "*What Kids Want*" (see Appendix C) *(*The counselor should distribute Handout #2 at this time and ask parents to do the exercise. The correct answers that parents should have checked as not being important to kids are: 5, 8, 11, and 14. After parents have finished, ask them to guess which answers are correct. Counselor might ask parents to discuss which items on the list they already do well, hope to get better at, or are willing to try. The counselor might also ask if there's anything they feel they can't do or don't want to do.)

Discuss what kids want and need from parents.

Compare and contrast that with what you wanted and needed at that age.

According to the quiz, there are a couple of themes that are evident in behaviors teens like to see from their parents: they want to be shown respect, and they want consistency. Although many teens will say they don't want discipline and limits set on them, most know that's what they need. In an unsafe and confusing world, boundaries and structure can create safety.

Adolescence is supposed to be, by definition, a time of experimentation. What is difficult today is that experimenting is a lot more dangerous than it was for previous generations (drugs are more potent, sexually-transmitted diseases are more lethal, arguments are as likely to end in gun-fights as fist-fights). Yet, experimentation is necessary for adolescents to discover who they are. They need boundaries and limits that don't budge so that they can figure out where they stop and other people begin.

It's natural for teenagers to struggle with authority, just as it has always been throughout time. But if rules make sense and are negotiated in a respectful way, where kids have input as is appropriate, they will see a loving parent behind the rules and not a "selfish bully."

Explain how parents can help their kids have a less troubled and stormy adolescence.

The best thing that parents can do for their kids is be a better parent than they had. One of the great demands life places on us is asking that each generation surpass the one before. So what is a good parent? (The counselor might want to elicit responses to this question from the audience at this time.)

A good parent doesn't shirk the responsibilities of parenthood. One of the responsibilities is offering support in the form of empathy and understanding when your son's girlfriend breaks up with him or when your daughter gets cut from the basketball team. It is an appropriate time to share with your kids that the same kinds of things happened to you in your adolescence and though it was painful, the future held even better opportunities that you couldn't see at the time.

The other responsibility of parenthood is to set good and reasonable rules and limits. Many parents err on the side of being too permissive because they don't want to "crush their kids' spirits" and because they want to be buddies rather than parents. (Being buddies is more fun.)

Kids, even teenagers, need to believe there's someone in-charge who will be there for them when they need them. (Even though as time goes on and they get older, they'll need guidance and protection less and less.) Adolescents need a good role model of responsibility and authority, something they can use as an example as they learn to become responsible and learn to trust their own judgment.

Some parents err on the other side and rather than being too permissive, are too authoritarian. These parents don't give their teens enough opportunity to make their own decisions and mistakes in situations where failure wouldn't be devastating. Authoritarian parenting can result in either rebellion, where limits are continually tested, or submission, where adolescents are fearful and fail to develop their own behavioral code. Adolescents in this situation have to leave home before they can learn to be their own authorities.

Well-meaning parents often try to shelter their kids from the harshness of life. And although that impulse is a loving one, kids need to understand the world as it really is, not some fairy-tale version of how it should be. Probably the best thing parents can do is learn good coping skills themselves so they can role model them for their kids. The best gift parents can give is to teach their kids how to manage in a difficult world.

Session Objectives

Parents who attend this session and have assimilated the information covered, should be able to:

- # Discuss the kinds of changes their teens go through during the adolescent years. And compare and contrast their kid's experience with their own.
- # Discuss the real and imagined fears and concerns their kids have and compare them with their own experience of adolescence.
- # Discuss what their kids want vs. what they need and compare that to their own wants and needs at that age.
- # Describe what they can and cannot give their kids as parents. And recognize they may not be able to give their kids all they'd like to give.

Parent Education and Support Group 5: Parenting Styles

Main points to be covered during the didactic portion of this session

Describe the characteristics of the Authoritarian (or traditional) style of parenting.
Describe the characteristics of the Permissive style of parenting.
Describe the characteristics of the Neglecting style of parenting.
Describe the characteristics of the Authoritative style of parenting.
Explore each group member's style of parenting. Discuss how is it like or not like their partner's or their parents' parenting styles.
Discuss what members would like to change about their parenting styles.

Rationale

Some parents raise their kids in the same way they themselves were raised because they don't realize there are other options. Other parents try to parent their kids as differently from their own experience as possible because they don't agree with their parents' style but find that their style doesn't work that well either. This session will discuss the predominant styles of parenting and help parents to evaluate the efficacy of their personal styles.

Session Content

Describe the Authoritarian (or Traditional) Parenting Style.

Parents who predominantly use the Authoritarian parenting style tend to be highly organized in their use of authority and rely on punishment rather than praise to manage their children's behavior. They take their role as family leader very seriously and value responsibility a great deal, both in themselves and in their children. Authoritarian parents show their love by setting high expectations for their children and rewarding successes and also by making the best possible decisions they feel they can make to ensure their children's welfare.

Authoritarian parents value obedience as a virtue and don't encourage negotiation when setting rules. They expect their children to accept their decisions because they "said so," and want them to be "seen and not heard." Acceptance of their rules equals respect and respect is very important to them. They feel that their children's behavior defines them as parents, and how they're viewed in the community (through the behavior and successes of their children), is very important to them.

Authoritarian parents don't intend to be overly harsh or rigid. Their goal is to teach their kids "right" so they grow up to respect their elders. Unfortunately, this often back-fires and it's only a matter of time before their children seriously challenge their authority.

Even parents whose predominant style of parenting isn't authoritarian, might use this traditional style under certain conditions. One example might be when their child is involved in an intense situation and the parents are afraid the kid might make the same mistake they themselves made years earlier. They might try to "force" a better outcome for the child by over-controlling the situation.

Describe the Permissive Parenting Style.

Parents who predominantly use the Permissive parenting style tend to be warm and accepting in their demeanor with their children. They believe children need a lot of freedom to make their own decisions and therefore, they set few limits. Family rules are often not clearly defined or enforced. Permissive parents tend to yield to coercion by the child and give him the message that he can do what he wants as long as it makes him happy.

Permissive parents believe there's no such thing as "too much" freedom. They show their love by giving children a lot of freedom, in the hopes it will make them independent thinkers and "their own person." They are afraid of breaking a child's spirit. Often, however, this demand that a child take responsibility for himself and his decisions from an early age, confuses a kid. It also skews his conception of his place in the world. Many adults he meets will not want to be addressed by this kid as an equal, the way he addresses his parents.

Parents whose predominant style of parenting isn't permissive, might find this style appropriate to use at times. This may especially be true as the child reaches later adolescence and has increased in maturity. He's then better equipped to make independent decisions. But even with young children, at times it's important to allow them to make decisions for themselves on small issues in order to help them begin building strong self-images.

Describe the Neglecting Parenting Style.

Parents who predominantly use the Neglecting parenting style tend not to be very involved in their child's life. They don't make a lot of demands or set/enforce rules. They seem to be unresponsive to many of their child's needs. The message they seem to be sending is: "you don't matter and I don't have time for you."

In this culture, we consider "good parents" to be more involved in their kids' lives than someone with a neglecting parental style would normally be. There are situations, however, when well-meaning and caring parents neglect their kids because they are so overwhelmed and without support that they don't have the time or the energy for anyone else. They may be spending all the internal resources they have just trying to keep financially afloat in order to provide a home for their children.

Describe the Authoritative Parenting Style.

Parents who predominantly use the Authoritative parenting style tend to be what many in this culture today consider "good parents." They communicate well with their children and respect others' opinions but hold firm in their own positions. They get input from their kids before setting family rules. Rules are clear, explicit, and consistently enforced. Authoritative parents use logical and appropriate consequences, incentives, and negotiation in their discipline. The message they give their kids is that kids are important, loved, intelligent, good, and worthy of respect. They require that their children treat them with respect as well and firmly confront inappropriate behavior.

Many good parents act authoritatively in some situations but not all. Familiar situations lend themselves most easily to this type of parenting. Parents feel comfortable, and clearly know what to do so they're more relaxed and don't feel the need to over-control.

Exercise #1: *"Personal Parenting Styles"* (See Appendix C)
Leader should pass out the first exercise and request parents complete it. She can then ask them to talk about situations where they've demonstrated each of the four parenting styles and why they made those choices.

Explore Personal Styles of Parenting—How Does Your Style Differ from Your Parents?

You might give some thought to how and why you developed the parenting style you now have. Some people, consciously or unconsciously, imitate their parents' style. Perhaps it never occurs to them that there are other options. Other people resented the style their parents used with them and try something totally different when it's their turn.

It's not uncommon, for instance, to see a person raised under the authoritarian system rebel against that and over-react, thereby flip-flopping over to permissive. One thing you hear over and over is that it's hard to be consistent in your parenting. The other thing you hear a lot is that once you become a parent yourself, you realize how difficult parenting really is and you begin to forgive your parents for all their "mistakes."

It is a particularly difficult situation to deal with when you and your partner have very different parenting styles. It's difficult because it's very important for the sake of the children that both parents give the same messages to the kids, enforce the same rules, and back each other up, otherwise, splitting will occur, which is very confusing for the child. When two parents have very different styles, most often what you see is one parent being over-involved (more authoritarian) and the other being under-involved (more neglecting). Kids find ingenious ways to play one parent against the other, so you need to look out for that.

Discuss How Parents Might Like to Change Their Styles.

Although your kids might be used to having a certain parenting style used with them, it's possible to change the style in gradual ways as the situation suggests it. Think about ways you're interested in changing and, small steps you might take in that direction.

Exercise #2: "*Parenting Traits Assessment"* (see Appendix C)
Leader should pass out the second handout and two different color magic markers. Ask parents to mark on the Parental Choices continuum, with one color, where they believe they fall at present on each trait and then mark with the other color, where they'd like to be on the continuum for that trait. The leader can then lead a discussion about behaviors parents might engage in to produce those desired changes.

Session Objectives

Parents who attend this session and have assimilated the information covered, should be able to:

- # Define the Authoritarian Parenting Style and be able to identify if and when they use it.
- # Define the Permissive Parenting Style and be able to identify if and when they use it.
- # Define the Neglecting Parenting Style and be able to identify if and when they use it.
- # Define the Authoritative Parenting Style and be able to identify if and when they use it.
- # Discuss problems that arise when different caretakers in a family have differing styles and how problems might be handled.
- # Discuss changes they'd like to make in the ways they parent.

Parent Education and Support Group 6: Setting Limits

Main points to be covered during the didactic portion of this session

Explain what limit setting is and why it's important to set limits with adolescents.
Discuss how limits should be set and how to get kids to respect them.
Explain why consequences (both good and bad) are more effective than punishments.
Describe appropriate positive and negative consequences for specific behaviors.
Explore stumbling blocks to effective limit setting and suggest solutions.
Discuss important things to keep in mind when limit setting is difficult.

Rationale

Although adolescents balk when limits are set for them by authority figures, they need the safety of boundaries and structure that don't crumble as kids push against in trying to define themselves. The differences between consequences and punishment when rules are broken will also be discussed. In this session, appropriate limits will be discussed and how mutually beneficial rules can be negotiated between parents and kids.

Session Content

Explain what limit setting is and why it's important to set limits with adolescents.

The idea of having to "live within limits" is a concept that turns off most adolescents and many adults as well. We've grown up in a culture that celebrates freedom. Consequently, some parents are hesitant to set too many restrictions on their kids for fear of breaking their spirits. Other parents go over-board, setting rules that are unnecessarily rigid because that's what their parents did or maybe because they think a "good parent" makes it clear who's "in charge" by being tough.

Setting realistic limits (rules and consequences) is one of the major responsibilities parents face in raising their kids, but they may never have had good role models to show them how to do it well. As much as kids complain and argue about limits being placed on them, they need structure. And although they probably aren't very aware of it, they want the structure of limits too, because boundaries make them feel safe. You've probably seen that kids who don't have limits set for them will "act out," in effect asking parents, schools, and other authority figures to make it clear how far they can go. Adolescence is a time of experimentation, and adolescents are supposed to push the boundaries. Skillful parents have learned when to yield and when to stay firm.

By setting clear limits (rules and consequences), parents can establish or re-establish their authority in the family. If specific consequences are not set, kids will probably not take the rules seriously and will push the limits. Parents then become frustrated and anxious when their children break the rules. This leads to arguments and typically increases the likelihood of children acting out. By clearly establishing rules and consequences with children up front, parents can greatly reduce the need to nag, lecture, or constantly remind their kids about

appropriate behavior later on. By pre-determining limits, parents are not forced to make these decisions in the heat of an argument, but rather have time to think them through. They are therefore more effective and apply rules more consistently. Backed up by mutually agreed upon rules, parents are more adept at handling confrontations and provocations with their children.

Discuss how limits should be set and how to get kids to respect them.

The following are things to keep in mind when setting limits:

1. *Pick your battles*. Don't constantly monitor and correct everything your teen does. Forget the little things so that you can focus on the big ones. When you correct everything, your teen will tune you out. It might help to start with just a couple of rules if you haven't set or enforced rules previously. It's important to decide what is and is not negotiable. For instance, the rule of not allowing drug use is likely to be non-negotiable. But with something like phone privileges, you have more opportunity to solicit your teen's opinion and have him be more involved in the decision-making process. It's important that you explain your reasons for the rules you suggest. When you disagree about a rule, the ultimate decision is yours. But it's important that your teen understand the rationale behind the decision so that though he doesn't agree with it, he realizes it's not a random decision.

2. *Listen to your child*. It is important to understand your teen's needs and to recognize that her needs are different from yours. To continue with the issue of phone use, remember that staying connected with friends is vitally important to adolescents. Let her know that you understand her point of view. Just because you listen doesn't mean you have to agree with her, but it is important to listen without interrupting or arguing. Another example is the frequent battle over cleaning. Having a clean house is probably more important to you than to your children. Teens will often try to get away with exerting the least amount of energy possible around the house. This doesn't mean you shouldn't try to instill certain behaviors in them but recognize that their needs are different from yours. Decide what you can and cannot live with. It's also important to recognize when your teen is attempting to change the way she behaves. Even when it's not perfect, small changes are significant and should be acknowledged. Bigger changes take more time to develop. Reward all attempts.

3. *Be clear and specific when you and your teen establish the rules*. For example, say "midnight" rather than "not too late" or "clean the bathroom on Sundays" rather than "clean the bathroom regularly." When there are two parents involved, it's important that the parents present a "unified front" when it comes to rules and consequences for breaking them. Kids will often try to "split" parents and get one to side with them against the other (especially if parents don't live together anymore). It's important for the child that parents each reinforce the rules in the same way.

4. *Decide on positive and negative consequences together with your teen*. Find out how your teen defines "positive" and "negative," which may be different from the way you do. For example, you may think withholding his allowance one week is a strong negative consequence for your son, whereas he might think having to stay in on a Saturday night is much worse. One the other hand, you may believe your daughter would consider getting a new jacket to be a great reward, whereas a great reward to her might be spending the weekend with her girlfriend's family at the beach. Your child needs to understand the consequences, clearly, ahead of time, so that he can make a behavior choice based on that knowledge. If he has been involved in the negotiation process of setting curfew and knows that breaking that rule will result in having to stay in the next Saturday night, he can weigh the cost of that decision before he acts. And though he might not like having to take the consequence, he'll know that he, and not his parents, has been responsible for the outcome. It's important that parents pick consequences that they are willing to consistently follow through on. If they aren't consistent, consequences have no meaning.]

5. *Don't repeat yourself*. Remind your teen once about the agreed-upon consequence and then follow through with applying it if the situation demands it. If you give several warnings before following through on consequences, you are unintentionally reinforcing kids to ignore the rules and they'll accuse you of nagging. Teens learn that if not listening to you in the past has caused you to abandon the rules, they'll continue to not listen. Don't engage in a power struggle. Calmly state that your daughter has made her choice and must take the resulting consequence. Demonstrate desirable behavior by example. If she yells and tries to fight with you about having to take the consequence, don't get pulled into the fight. Tell her that she needs to follow through on the agreement but she doesn't have to like it.

Explain why consequences (both good and bad) are more effective than punishments. Describe appropriate positive and negative consequences for specific behaviors.

We all experience what are called "natural" consequences in life. These consequences follow the natural rules of nature and physics. For example, when we don't eat, the consequence is that we get hungry. When we don't wear a coat, we get cold. When we touch something hot, we get burned.

Logical consequences result from the social order we live in. They represent our culture's idea of what is fair and just. For example: tell lies and people won't trust you; get caught cheating and you'll get an "F;" Cry wolf often enough and no one will come to your aid; don't study and you'll flunk; don't work and you won't get paid. It's important that when adolescents break agreed-upon rules, the consequences they face make sense and are appropriate to the behavior.

Parents sometimes confuse providing consequences with being "in control" of their children. Your kid's behavioral decisions are influenced by the consequences you set, but kids

control their own behavior, not you. Children are quick to lose respect for their parents when consequences are not logical and are used with intimidation to produce fear—that is what punishment does. Punishment is generally either physically or verbally abusive, or both. When children are punished, they feel humiliated, and they learn to be fearful of more punishment rather than respectful of the rules. Children and teens may consider any unpleasant consequence of their behavior as punishment. But the difference is that consequences flow naturally from the behavior and are not abusive, demeaning, or unnecessarily harsh. They are not punishing but instructive and are appropriate responses to undesirable behavior.

There are many differences between punishment and logical consequences. Punishment is meant to express the power of personal authority. It is not always tied directly to specific misbehavior and can be random and unpredictable. Punishment sends the message that the child is "bad." It's associated with a threat, either open or concealed. Punishment demands submission. Logical consequences, on the other hand, are directly related to the misbehavior. (For instance, when John is late for his curfew one night, he's instructed to be in even an hour earlier the next night.) Logical consequences don't imply any judgment about whether the child is "good" or "bad," only whether the behavior was. Logical consequences permit a child to learn from his mistakes and to make a different choice the next time. Whereas, when a child is punished, he doesn't learn anything except how to avoid punishment and to be afraid. It's important that your teen understand your expectations, whether he agrees with them or not. It isn't fair to deliver consequences when it hasn't been clear up front which behaviors successfully follow the rules vs. which don't.

It's also important to have a system of "graduated sanctions," meaning that the consequence set should be at the same severity level as the infraction. The consequence for your child not emptying the garbage as agreed might be withholding her allowance for a week. If she is caught shoplifting cosmetics from the drugstore, the consequence needs to be tougher to reflect the relative importance and danger of the misbehavior. *(Leader might ask the group at this point to discuss some suitable consequences for shoplifting.)*

Rewards can be just as meaningful as restrictions when setting consequences andcan be accomplished by giving more of something rather than taking something away. In general, consequences should be related as closely as possible to the nature of the rule. The following exercise gives examples of rules and negative and positive consequences they might be used. Generally speaking, the kinds of things that might reasonably be used to set up consequences for following or breaking the rules have to do with time (curfews, time on the phone, etc.), allowances (increases or decreases), social activities (dances, time away with friends, etc.), use of the car, and related things.

Exercise #1*: "Setting Consequences"* (See Appendix C) (The counselor may want to read the handout to the group or ask volunteers to read parts. Ask clients to discuss the consequences.)

Explore stumbling blocks to effective limit setting and suggest solutions.

Here are six stumbling blocks parents frequently face when establishing rules and consequences. They are listed below:

1. **Rules and consequences are not in force:**
   Teens are very literal and will continually argue about interpretation of limits. It is important to make these rules very clear, workable, and enforceable. You must get your child on-board before the system can work. She must acknowledge that she understands what will happen if she doesn't follow the rule. If she doesn't acknowledge it, the rule is not "in force." When she doesn't follow the rule, consequences must be consistently enforced.

2. **Limits are perceived as optional, not mandatory:**
   Limits and rules that are mandatory MUST be obeyed by your child. You must make it clear to the child that this is the case. When a rule/limit isn't completely clear and there seems to be some flexibility in defining it, it will not be considered mandatory by your child.

3. **Too many rules are made at one time:**
   Parents often focus on trying to change every one of their child's negative behaviors at once. Parents should pick no more than two or three rules to set at one time or it becomes too confusing. Pick your battles! Start first with the behaviors that are most important to you to change.

4. **Consequences are not effective:**
   Often consequences are not appropriate to the behavior. They may be too severe or not severe enough. They should be logical and relevant to the violation. It's important to discuss consequences with your child and let him help you set something that is appropriate. He'll appreciate being treated with respect and is more likely to follow something he had a part in deciding.

5. **No consistency:**
   One of the worst things parents can do is not investigate to make sure their child has done what he was supposed to do. It's also very detrimental if parents don't follow through on giving their child the consequences they agreed upon, or only follow through in a sporadic way. Your child will not respect your limits if they're applied inconsistently.

6. **Rules are not stated as a contract:**
   Limits should be written out in clear language in a contract that both parents and children sign to indicate they understand what's involved and agree about what will happen if the agreement isn't followed. If

rules aren't written down, either party might get confused and remember the arrangement as being different from what it was.

Exercise #2: *"Setting up a Contract for Rules and Consequences"* (See Appendix C). (The counselor will hand out the contract form and ask each parent to list up to three rules and positive and negative consequences that might be associated with each. Remind them to "pick their battles" and work first on the most important behaviors they want to change.)

Discuss important things to keep in mind when limit setting is difficult.

Setting limits is tough and you need to believe that it's important to stay tough and follow through. Remember that using structure and limits is meant to protect your kids and help them develop their own structure. You have to keep your kids safe even if they won't like you for it. This is particularly hard when you are worried that you'll lose the good rapport you have with your children, which is why understanding their needs and soliciting their opinions is so important.

Think about using limits as a way to teach. The goal of parental discipline is to teach your teen how to operate effectively in the world and to teach her to eventually set her own personal limits. Setting limits and using discipline is about teaching, guiding, and leading, not punishing. An example of how Epoch does this is by enforcing our rule that a client is not allowed into group if he is more than 15 minutes late. We do this to avoid disruption of the group, but also to encourage clients to be better time managers.

If you feel bad or guilty setting limits, ask yourself why this is so. Perhaps you had an overly strict parent and are worried about being too strict yourself so you've moved to the other extreme. Being aware of why you parent as you do is important in understanding why it may be difficult to stick to your guns. Use this awareness to fortify yourself when you're about to "give in" and not enforce a rule.

Setting limits sends a message to your teens that you care about their well-being. When done in a non-authoritarian way, it's clear that you're setting limits to guide them, not to control their lives. Pay attention to the messages you send your kids. Listen to the messages they send you, and let them know that you hear them.

You are also setting limits for them in order to care for yourself and your own sanity. It's important to model self care for your kids. Having them out until 3 a.m. means you may not get sleep because you're worrying about them. They need to understand how their behaviors affect you and their siblings. It's important to encourage respect within the household.

Get support. Who can help you stick to enforcing the rules? Do you have a friend or family member whom your teen can check in with while you're at work? Whom can you turn to for emotional support when you need it? One place to get support is at a parenting group such as this one.

Session Objectives

Parents who attend this session and have assimilated the information covered, should be able to:

- # Discuss why limit setting is important.
- # Identify problems associated with being too lenient, too strict, or inconsistent.
- # Discuss why setting and carrying out consequences are important when setting limits.
- # Discuss what appropriate consequences are and talk about why consequences are better than punishments.
- # Recognize actions they usually take that might be counter-productive and be able to offer more appropriate alternatives.
- # Acknowledge that setting limits and sticking to them can be difficult. They will recognize the need to get support when necessary from other parents and/or from professionals.

Parent Education and Support Group 7: Anger Management

Main points to be covered during the didactic portion of this session

Discuss attributes of anger as an emotion.
Explore other feelings that may be underneath the anger.
Describe common styles of expressing anger.
Explore the participants' styles of anger expression.
Discuss the effectiveness of these styles of expression and offer options.

Rationale

This session focuses on providing information and encouraging discussion about the nature of anger and its styles of expression. Anger is a natural and healthy emotion but it often gets expressed between family members is an inappropriate and unhealthy way. Difficulty in dealing with and expressing one's anger can contribute to relapse in a person in recovery, especially early recovery. And, inappropriately expressed anger can erode connections between the using adolescent and her support system. The purpose of this session is to help parents recognize and find more effective ways to express their own anger and to encourage its healthy expression in their children.

Session Content

Anger is a human emotion, no better or worse than any other feeling we have (sadness, happiness, fear, excitement, etc.) It isn't inherently good or bad but it gets a lot of bad press. You often hear people say they need to learn to "control" their anger, and "Anger Management" workshops are very commonplace. (You don't hear people talking about "controlling their sadness" or "managing their excitement.") Most likely, anger frightens people because an inappropriate outward expression of it (hitting, screaming, throwing things, being physically and verbally abusive, using the silent treatment) hurts other people.

There probably isn't enough attention paid to the inappropriate inward expression of it. Turning anger inward toward one's self can cause depression and contribute to such physical maladies as ulcers, high blood pressure, migraines, and heart attacks, among others.

The positive side is that an emotion having this much destructive power when released inappropriately, must also have considerable constructive power when released in an appropriate way (by speaking up in a direct, assertive way). Physiologically, anger releases chemicals into our bloodstreams which make us stronger, faster, and more energized. The key is in finding a way to use this increased energy positively, to get our needs met. Anger can give us the impetus to "act" rather than sitting around hoping things will change. The simple fact that we feel angry is a signal that something is wrong and needs to be addressed.

Explore feelings underneath anger.

Anger often masks other feelings that are more difficult or painful to show others, such as sadness, hurt, fear, embarrassment, helplessness, etc. Sometimes people don't realize there's another feeling beneath their anger. For example, when Chuck got passed over for the promotion he felt he deserved, he blew up and called his supervisor names behind his back. Chuck understood he was angry, and for good reason because the decision was unfair. But he didn't realize that he was actually hurt. Losing the promotion made him question whether or not he was "good enough" and that made him feel vulnerable, which he hated. It was much more comfortable to feel angry, because it was energizing, rather than hurt, which would be draining.

Traditionally in our society, it's been more acceptable for men than women to show their anger. And women are more positively reinforced for showing their sadness and vulnerability than men are. In dealing with their children, parents of both genders mask their hurt and fear with anger. When teenagers come home hours later than curfew, both Fathers and Mothers more easily express their displeasure and annoyance rather than their fear that something might have happened to their kids. Being in touch with our fears makes us feel vulnerable, whereas being in touch with our anger makes us feel in control.

Exercise #1: "Styles of Expressing Anger" (see Appendix C)
Leader might want to ask parents to talk about a time they "went off" in an angry way rather than expressing the feeling underneath it, and why they made that choice.

Describe common styles of expressing anger.

The healthiest and most productive way of expressing anger is by doing it calmly and directly. By being calm it doesn't mean you are backing down. It means that you are clearly stating how you feel and what you want from the other person. People are more likely to give you what you want if they understand what you're asking for and if they don't feel abused by the way you asked.

For example: Molly, angry that Deana interrupts her all the time, said to her one day: "It upsets me that you interrupt me so much and talk over me when I try to say something. Why does that happen?" Deana, a good friend, responded by saying: "I'm sorry . . . I didn't realize I was doing that. I don't mean anything by it. I guess I do it to everybody." By saying how she felt in an appropriate and clear way, Molly got the apology she wanted and the reassurance that her friend wasn't disrespecting her on purpose. Deana found out that she'd been doing something irritating that she didn't even know she was doing.

When people are direct in expressing their anger (as well as other feelings), better, more intimate communication is possible, which leads to stronger, closer relationships. Many people, however, never learn to express anger in this productive way. The two most common styles of inappropriately expressing anger are aggressively, thereby escalating the situation into an argument, and passive-aggressively, thereby stuffing feelings and/or expressing them indirectly through sarcasm or avoidance of the other person. In the example above, an escalating/aggressive style of expression on Molly's part might have created the following scene:

Molly: "Some friend you are . . . you treat me like crap! It's a wonder anybody will be your friend, the way you shoot off your big mouth, trampling on everybody."

Deana: "I do not! Look who's talking about being a lousy friend . . . you're never there when I need you . . . always thinking about yourself," etc., etc., etc."

Being aggressive can make a person feel more powerful temporarily but the end result is that he alienates the other person and both people lose because the friendship can start to unravel. As an argument escalates, it's easy to bring in past grudges that have nothing to do with the topic at hand and you sometimes end up with a "stand off" where neither person is willing or even knows how to get back to neutral ground. For some people, there's consolation in the fact that they didn't "give in" and lose the argument. But that's meager consolation when in the end good friends have all left and the only people who interact with you are people afraid to speak up.

The other extreme occurs when someone stuffs their feelings in order to avoid confrontation. In the previous example, Molly probably wouldn't let Deana know at all that her behavior was upsetting. Instead, Molly might not invite Deana to her party Saturday night in order to get back at her. Deana might never know why she wasn't invited and may never find out that she upsets Molly with her conversational style. The end result is that the problem doesn't get addressed and solved AND avoidance weakens the friendship.

People who stuff their feelings do it for a number of reasons: They may be afraid of hurting the other person or afraid of being rejected by them. They may be afraid that if they start telling the truth, they'll lose control (as in, "Don't get me started. . ."). This may be especially true of people who've stuffed feelings for a long time. Other people, women especially, have been brought up to believe that being angry isn't appropriate (or "lady-like," or "Christian," etc.) Still others grew up in homes where expressing anger wasn't allowed because it wasn't safe to do so because of retaliation.

Explore the participants' styles of expressing anger.

The style we've developed to express (or not express) our anger was most likely influenced by the style used by people important to us in our childhood. Our style has also, in turn, influenced the styles our children have developed. Many kids grow up not realizing there's any other way possible to express themselves except the way their parents did. Other kids purposely try to do the opposite so as not to become like their parents. Take a minute to think about your style of expression and how it developed.

Exercise #2: *"Making Things Better Rather than Worse"* (see Appendix C)
Leader should give parents the handout and ask them to complete it. She can then ask parents to talk about a time they inappropriately expressed anger and how they hope to do it next time. Ask parents to talk about how to de-escalate rather then escalate an angry situation.

Discuss the effectiveness of the styles of anger expression parents are using and offer options.

Ask parents if they're content with he way they express anger—does it bring them the desired results (good communication, respect, positive changes when needed, strengthened relationships)? Most people have trouble expressing anger appropriately in some situations, or with certain people. For instance, you may do pretty well with it until you're really stressed out and /or sick and you fly off the handle at the drop of a hat. Or, you might do fine with your wife but yell at your kids because you're mad at the boss and are afraid to let him know that.

In many families, kids aren't allowed to express anger at their parents because it's considered disrespectful. It might help these parents to realize that a lot of adolescent anger has nothing to do with the parents at all but with teenage sensitivity and growing pains. And even when your child is upset by something you said or did, it doesn't mean what you did was wrong.

People often think they have no control over how their anger comes out but that is generally not true. The following tips might help:

Take action early, before you start to boil over, in order to avoid a confrontation.

a. If you feel yourself about to boil over, take a "time out" as you'd have your kids do.

b. When someone else tries to escalate an argument with you, just don't play along. A person can't argue by himself.

c. It's important to prepare for your "high risk" times, times you know you're most vulnerable to losing control (when you're tired, hungry, sick, stressed, etc.) During those times, find ways to be by yourself.

d. Try to remember that lashing out might feel good for a minute but regrets feel bad for a very long time.

<u>Session Objectives</u>

Parents who attend this session and have assimilated the information covered, should be able to:

Discuss the benefits of using anger appropriately in order to get positive results.
Identify more complex feelings beneath their anger.
Compare and contrast the different styles of anger expression and evaluate the pros and cons of each.
Identify their preferred way of dealing with their anger and be able to suggest how their style developed. They'll also discuss how their style has affected their children's style of anger expression.
Evaluate ways expressing their anger has helped them get their needs met vs. ways it has hampered it.

Parent Education and Support Group 8: Maintaining Recovery after Treatment

Main points to be covered during the didactic portion of this session

Explore reasonable expectations for families to have of their adolescent in early recovery.
Describe the predictable stages in the recovery process.
Discuss adolescent and family attitudes and behaviors that can enhance recovery vs. those that can hamper recovery.
Discuss signs that relapse has happened or is about to happen.
Explore how mutual trust can be re-developed in the family.

Rationale

Parents often expend a great deal of energy and emotion in confronting their using adolescents and getting them into treatment. Many parents don't realize that after that accomplishment considerable attention must be given to relapse prevention and development of an awareness of new family dynamics, which may have changed with sobriety. The purpose of this session is to prepare parents for behaviors and emotions they can expect from themselves and their adolescents during early recovery.

Session Content

Explore expectations about recovery.

It's natural for families to breathe a sigh of relief after their kid's successful discharge from treatment and to imagine that life will be much easier thereafter. What often happens, however, is that although life gets easier in some ways, it temporarily gets harder in other, unexpected ways. Disappointment over dealing with new obstacles sometimes makes addicts relapse and families give up hope. Parents need to understand that their newly clean and sober kids typically find the following things happening to them in early recovery:

1. They get flooded with all kinds of strong emotions, feelings that were numbed while using. They may never have learned to express these feelings appropriately and sitting with them is uncomfortable. Some people in early recovery feel sad and guilty about past behaviors. Many are lonely because they no longer associate with drug buddies and haven't developed other friendships. Sometimes they're angry because it's hard to find a good job, a date, or do better in school and their expectation had been that sobriety would bring those things into their lives. In fact, sobriety probably will but it takes time and many people in early recovery don't anticipate that.

2. They have repair work to do in their relationships. Although family members and friends have supported a recovering person's efforts, there are usually past hurts and disappointments that will take time to heal. Loved ones will need time to redevelop trust that has likely been compromised by the addict's lying and irresponsibility.

3. If they've been using for a long time and/or since a young age, newly-clean people will have to get to know themselves. This is especially true of adolescents because

they began using before they matured physically and emotionally. Recovery is, in part, about discovering who you are as a sober person, deciding what your values are, and developing coping skills (other than using) to deal with the stress of growing and changing.

4. They suddenly have more money in their pockets and more time on their hands. Though these are "good" things to have, they can be triggers for relapse. Recovering people need structures and routines in place to help them manage their money because they've been used to "blowing it" on their using lifestyle. They also need recovery-friendly leisure activities because boredom is a major trigger for relapse, especially among adolescents.

Though it's a good and reasonable thing to be hopeful about the future, it's also important that a recovering person and his family have realistic expectations about the present. There is hard work that still needs to be done once the client leaves the treatment facility. Anticipating that can prevent unnecessary disappointment.

Describe Stages of Recovery.

According to Terrence Gorski, a major figure in the relapse prevention field, there are six stages in the recovery process: (Gorski, 1989).

1. **Pre-treatment** The beginning of the treatment experience where the client recognizes he has a drug or alcohol problem and begins to accept he's powerless to control use. He seeks help.

2. **Stabilization** While still in treatment, he recovers from the initial acute withdrawal symptoms. He begins to feel his feelings rather than being numb. He starts to think more coherently; judgment and concentration get better.

3. **Early Recovery** He comes out of formal treatment and begins to learn how to function without substances in his body. He starts developing and practicing coping skills and learns how to tolerate anxiety. He may still get cravings. He needs help structuring his time. Developing healthy routines is useful because drinking and/or drugging was a routine and it's helpful to exchange those "bad" habits for good ones.

4. **Middle Recovery** His primary goal is changing his lifestyle to be consistent with his values. He learns to manage self-doubt. His family begins to trust him again. Boredom and complacency can be a problem because he may feel he is "cured" and doesn't have to work hard at recovery anymore. Cross addictions sometimes happen at this time. The recovering person may begin using something besides drugs in a compulsive way (ex: exercise, sex, food, etc.)

5. **Late Recovery** He develops self-esteem and puts into practice a personal belief system rather than only relying on what others tell him he should think/feel/do.

6. **Maintenance** He recognizes that he has to be vigilant about recovery and monitors himself for warning signs of relapse. He's learned to enjoy life drug-free.

Discuss family and adolescent attitudes that enhance or hamper recovery.

Although it isn't unusual for recovering addicts to relapse, it is not inevitable. Like other diseases, there can be periods of exacerbation of symptoms as well as periods of remission. And as with other diseases, if a person takes care of herself and does the things she's been advised to do, the chances of relapse greatly diminish. While in the active addiction phase, an addict experiences cravings, and uses drugs to relieve them. In recovery, she learns that just because she gets cravings, it doesn't mean she has to use. She finds that cravings pass relatively quickly if she waits them out. When she gets through a craving episode without use, it makes her stronger. She realizes it's possible to resist and therefore, it's more likely she'll resist the next time as well. Over time, cravings occur less frequently and eventually become almost non-existent.

According to Gorski, attitudes that enhance the recovery effort are: 1) Accepting that addiction is a disease; 2) Recognizing that the disease is treatable; 3) Accepting that though some people can drink/use socially without getting out of control, you can't. You need to make peace with that. (You can't play major league baseball either, but that doesn't bother you much. Why should this?; and 4) Recognizing that you need support and can't indefinitely manage alone.

Attitudes that hamper recovery and make relapse more likely are: 1) Believing that you're "bad" for having been an active addict. That contributes to low self-esteem, which contributes to relapse; 2) Believing that you'll never get better and get your life back; 3) Telling yourself that if you wait long enough, someday you'll be able to use successfully. (If you're truly an addict, you won't be able to.) And, resentment about not being able to use is a big trigger for relapse; 4) Believing you can maintain sobriety without support.

If your adolescent does relapse, it's important to view the experience as part of the process and learn from it. It's a signal that something has to change (get more support, hang out with different people, get more sleep and better nourishment, take the disease more seriously, find better ways to cope with stress, etc.) If the person learns from the relapse experience and changes his recovery plan accordingly, then the relapse has been "useful."

If your child relapses continually however, more treatment is needed. That treatment may be high level substance abuse treatment and/or mental health counseling. Sometimes there is an underlying cause that thwarts a kid's best efforts, such as depression or difficulty dealing with traumatic events in the past. It is important to rule out these possibilities.

Discuss signs of possible relapse.

After a kid has been in recovery a little while and has been doing well, changes in his behavior may signal relapse or potential relapse. Some things to watch for are the following: dishonesty, impatience, self-pity ("This recovery stuff is too hard."), cockiness ("This recovery stuff is so easy."), becoming more secretive, becoming more isolated, doing something else addictively (cross-addiction), excessive guilt.

Some situations are especially hard for people in early recovery and it's important to remember that they may trigger relapse. Holidays can be especially hard emotionally. Any kind of loss is difficult, especially the death of a loved one, but also a relationship breakup, failing school, not getting into college, getting fired, etc. Illness and injury are also significant triggers for two reasons: 1) The person's stamina is reduced and he's likely to feel irritable, angry, and /or sorry for himself and 2) He may be prescribed medication that produces effects similar to his drug of choice (pain killers, muscle relaxers, etc.)

If you suspect that your adolescent has relapsed or is about to relapse, don't keep quiet and hope it will go away (because it won't). Confront her, in a supportive, non-judgmental, but firm way.

Discuss re-developing mutual trust in the family.

In the midst of struggling with addiction in the family, both adolescent users and their parents wonder if they will ever put the experience behind them and go back to "normal." The answer is "yes," health and happiness is possible and "no," things will never be what they once were. But that means life could be better than ever.

Recovery from addiction is a journey. It's a personal journey for your adolescent but it is also a family journey. It's a difficult and sometimes heart-breaking journey. But, like other life-defining events, it can build character. Many families who've been successful in healing from addiction feel that they've achieved a greater level of intimacy and closeness than they ever would have if they hadn't struggled with this experience. Before they get to that point though, many adolescents feel betrayed by parents for having been sent away to inpatient. But most, over time, recognize that it was needed and understand their parents' caring intentions behind it.

Many parents find it very difficult to trust their kids again, though they want to, given the child's history of lying and covering up his behavior. Let your child know what they can do to get that trust back. Set small goals for them, and when they're successful, trust them with bigger things. Be clear but reasonable with your expectations.

Lastly, practice forgiveness as a family. You will need to forgive your child and she will need to forgive you. You all will need to forgive yourselves for being less than perfect. It is the only way to completely move on.

<u>Session Objectives</u>

Parents who attend this session and have assimilated the information covered, should be able to:

Define their expectations and hopes. They'll recognize that expectations should be different from hopes and consistent with the stage of recovery the family is in.
Discuss the predictable stages of recovery.

- # Evaluate their attitudes and behaviors to determine how they might change them to enhance the recovery process. They'll also understand ways their adolescent's behavior is helping or hurting his recovery.
- # Recognize systems of relapse and potential relapse.
- # Put these events in perspective and talk about ways struggling with substance abuse has strengthened the family.

Parent Education and Support Group–Optional Topic 1: Single Parenting and Blended Families

Main points to be covered during the didactic portion of this session

Describe the general characteristics of single-parent and Blended Families.
Explore the challenges children in these families face.
Explore the challenges parents in these families face.

Rationale

This session provides a forum to discuss issues specifically affecting single parent and blended families. How this type of family situation affects parents and step-parents as well as how it affects children, will be addressed. Goal: Parents will be able to recognize and discuss the special challenges that affect non-traditional families.

Session Content

General characteristics of Single-Parent and Blended Families

1. Remember that step-families and single-parent families are families born of "loss" (either death, divorce, or abandonment). Both parents and kids need a chance to talk about their feelings and grieve their losses.

2. When change happens, serious thought needs to be given to whether or not to move. When two families are blended together, it's often best to get a new living space, if possible—something that's new to everyone, in order to avoid "territory wars." Otherwise, the kids who stay put are like the "home team" and the other kids feel like the "away team." In the case of divorce or death, where there is only one parent left and there aren't other kids joining the family, it's often best to stay put rather than move because it offers kids a sense of continuity.

3. New (blended) families will have new structures, rules, dynamics and values. Expect that adjustment will be difficult for some kids and even for some parents. But creating a solid, fair structure though open discussion will help everyone.

4. Kids don't want to be disciplined by somebody new. When the spouse who leaves was the usual rule enforcer, kids are likely to test the remaining parent and anyone he or she brings into the family. Be respectful but firm in establishing your new role as disciplinarian. In a step-parenting situation, it's important that there's unity between the two adults and that each backs the other up.

5. In families where there never were two parents, the sole parent (usually the mother) has to take on both roles. Find support for yourself whenever possible, among other adults, for our own peace of mind. And to help the kids, invite in healthy male role models (uncles, good friends, grandfathers, etc.)

6. Expect, also, that kids have fears, shame, and sadness about never having had two parents. Give them an opportunity to talk about the situation.
7. When step-parents enter the home, some parents are hesitant to evidence a strong bond with the new partner in front of the children because kids can feel jealous of the attention or feel that the departed parent is being betrayed. But it's important to make it clear that the new primary bond is strong and dependable. It's good role modeling. If your strong connection isn't evident, you might inadvertently suggest to kids that another divorce or separation is likely. The new parental bond needs to be nurtured. Take some time alone as a couple but balance it with time around the whole family. When some degree of comfort has been reached, it's also good for kids to have time alone with the new step-parent to get to know him or her better, and in a different way.

8. Perhaps most importantly, be positive and hopeful. There will be stress and difficulties, but there are in all families. Focus on the great possibilities the new situation offers. In some ways, at least, it will be better than what you had before. Today non-traditional families have almost become the tradition. It won't be difficult to find another blended or single-parent family in your neighborhood. Perhaps you can give each other support over the adjustment period.

Challenges for the Children

1. Kids often feel that when a parent leaves the family, it's the kid's fault. Parents need to help them understand that isn't so and that the problems had nothing to do with them.

2. Children are likely to react to having a "new" (step) parent in different ways, depending upon age. Older adolescents have a much stronger sense of family history and may find accepting a new parent to be very difficult. They also are almost to the point of leaving home to be on their own. Don't tolerate disrespect but allow them to choose how connected to become.

3. Change is hard for most kids. There are a lot of compromises being asked of them, so whenever possible, keep routines familiar and unchanged.

4. If the family moves into a new living space, make sure kids have some place that is only theirs. If they can't have a room to themselves, give them at least a drawer or shelf so they don't always feel like visitors.

5. It is usually good to let the kids' friends visit regularly so kids will realize that some things will remain the same.

Challenges for the Parents

1. When a family loses a parent, it's not unusual for a teenager to try to "take the place" of the parent who's gone. Although the extra help might be welcomed by the overwhelmed remaining parent, it's important to let kids have their childhoods. Stressed-out parents need to get support from other adults.

2. In cases of divorce, preserving old relationships is important. Don't speak ill of the person who has left—he or she is still your kids' parent and is loved by them. Don't put the kids in the middle. When you need to discuss something with your ex, do it in person; don't make the kids relay a message.

3. In cases of blended families, it's not unusual for "newly created" siblings to have strong feelings about each other, either good or bad. Don't rush kids into having to form "one big happy family." Allow it to naturally occur. Conversely, it might also happen that new teen siblings become sexually attracted to each other. Anticipate this possibility and help them deal with this potentially explosive and shaming possibility, early and calmly.

Parent Education and Support Group–Optional Topic 2: Codependency and Boundary Issues

Main points to be covered during the didactic portion of this session

Describe characteristics of being co-dependent.
Describe characteristics of good parenting.
Compare and contrast the two styles.

Rationale

This session provides an opportunity to talk about co-dependency and boundary problems between parents and kids. To some degree, our society unwittingly teaches and advocates co-dependent traits in parents because taking care of one's own needs is generally considered "selfish" and consistently putting someone else first is considered altruistic and saintly. In reality however, a person who is depleted from giving and has inadequate means of being replenished, can't be of much help to herself or her children.

We'll discuss five co-dependent behaviors that have been inappropriately equated with good parenting skills in our culture. We'll also address how co-dependent behaviors might be adjusted to produce healthier and more satisfying relationships between parents and kids.
Goal: Parents will be able to recognize their co-dependent behaviors and suggest alternative ways of relating.

The word "co-dependency" was originally coined to define family situations were active addiction was going on and the non-drinking spouse expended a huge amount of energy trying to "help" the addict by trying to control his/her drinking. These days, co-dependency can refer to any relationship where a person is more focused on the behavior of another than on his own. Low self-esteem and a feeling of powerlessness always underlie this situation. The co-dependent person "needs to be needed" in order to feel good about himself and he's afraid that if he isn't able to control or manipulate the other person's actions, he will suffer. Co-dependent people don't believe they can get what they want if they directly ask for it so they try to coerce others into giving it to them under the guise of having the other person's best interests at heart. Most of the time, of course, this all operates on an unconscious rather than conscious level.

Someone who is co-dependent can be said to have poor boundaries. She tends to be intrusive in other people's lives. Today we'll talk specifically about co-dependent parents and how they treat their kids, as well as how they might adjust their behavior in order to create a healthier family situation. As stated earlier, many co-dependent behaviors are considered "good parenting skills" today. Parents have typically learned their parenting skills from their parents, who learned them from their parents, on down the line.

Session Content

Compare and Contrast Co-dependent Parenting and "Good" Parenting

1. Co-dependent parents feel they have to control their kids. They're afraid to let their kids make any of their own mistakes. Underlying this often is the parent's fear that if his kid doesn't need him anymore, he'll be obsolete.
   Good parents let their kids make the decisions they can responsibly make based on their age and level of maturity. Don't worry . . . they'll always need you. And they'll appreciate your trusting them—it will likely make you closer.

2. Co-dependent parents feel superior to their kids. Some treat their children like their property, expecting them to think the same way they do. When they give presents, it can be with a feeling of arrogance: "What would she do without me? Nobody else cares for their kids this much." They don't believe their kids can make good decisions without their advice.
   Good parents show that they believe in their child's competency and admire and respect the person they're becoming. They make it clear that they can appreciate the ways their kids don't agree with them because it makes for interesting discussion. They give presents only when they want to, out of love.

3. Co-dependent parents feel that their kids "owe them" for what they do for them. Who hasn't heard the expression: "How could you do this to me after all I've done for you?" It's a type of emotional blackmail, aimed at making the child feel guilty so he doesn't act out or leave.
   Good parents develop a feeling of mutual respect in the family, where people do things for each other because they want to and enjoy it.

4. Co-dependent parents often feel they need to be perfect. This filters down to their kids, who understand early on that they are a reflection of their parents and had better not mess up either. Parents who work very hard to be "perfect" and legitimately do excel, are tremendously disappointed when their successes don't mean much to their kids. (Kids who aren't co-dependent themselves, don't see that their parent's success reflects on them. They understand they have their own lives and that they're responsible for their own successes and failures.)
   Good parents know that the better you are at accepting your humanity and imperfections, the easier it will be for your kids to accept theirs. Paradoxically, the more relaxed a person is (because he's not so worried about failing), the more creative, and consequently, more successful he's likely to be. Accepting trial and error as a necessary and natural part of life is good role modeling for kids.

5. Co-dependent parents often feel that their kids are more important than they are. This can really put a burden on a child who understands early on that his parent is living through him vicariously. These are the situations where parents want their kids to have what they never had and will work themselves to death in order to produce it (without any thought for their own wants or needs). These are also the situations where parents pressure their kids to be the great athlete, doctor, lawyer, businessman, etc., that they never could be.
   Good parents teach their kids that all people are equally important and that all dreams are worthy. Parents who feel their kids are more important than they are let themselves be pushed around. This is the "doormat" syndrome. Kids need to be taught when it's

appropriate to say “no.” It’s part of a parent’s responsibility to role model that for them. It’s important and wonderful to love your kids deeply but that doesn’t mean they are “worth” more than you are. They also aren’t worth less than you. One of the most important things you can teach your kids is self-respect. And, you can teach it best by example.

Parent Education and Support Group–Optional Topic 3: "The Seven Worst Things Parents Do"

Main points to be covered during the didactic portion of this session

Show the video, "The Seven Worst Things Parents Do."
Discuss the major points in the video.
Present the eleven "best things" parents might do instead.
Help parents evaluate what they currently do and suggest alternatives.

Rationale

This session provides education regarding common behaviors well-meaning parents do that are counter-productive to getting the results they want with their kids. It also provides alternative, more effective strategies. Goal: Parents will recognize themselves in the situations the video presents, and realize it's not unusual for parents to face these situations. They will be able to brainstorm with peers and the group leaders to develop more effective strategies of parenting.

Session Content

The Seven Worst Things a Parent Can Do

1. Baby your child and not expect enough from her.
2. Put your marriage last and focus too much on your children.
3. Push your child into being involved in too many activities.
4. Ignore your own emotional and spiritual life because you're so focused on your kids.
5. Try to be your child's "best friend" rather than his parent.
6. Fail to give your child enough structure.
7. Expect your child to fulfill YOUR dreams.

The Eleven Best Things a Parent Can Do

1. If the past is getting in your way, clear it up. Make peace with past mistakes (both yours and your kids') and remember that today can be a new start.
2. Talk to others about your personal issues even if you're ashamed.
3. Remember there are no "perfect" parents, families, or children.
4. Remember that YOU are the parent. It isn't your kid's job to raise you or be your support.

5. Remember that one small change, done consistently as promised, is worth a thousand that lack good follow-through.

6. Learn to relax and have fun. Make sure you're not too rigid.

7. On the other hand, if you're too lax, tighten up the rules and boundaries.

8. Give yourself permission to make mistakes as you're trying to change. In moving from extremes in your behavior to a healthy center, it might feel funny or "not you" at first. Be patient.

9. Examine your own values and lifestyle and make changes as necessary.

10. Show leadership. Lead by good example.

11. Don't be afraid to experiment to see what works best for your family's needs.

Parent Education and Support Group–Optional Topic 4: Stress Management

Main points to be covered during the didactic portion of this session

Discuss the things that are most stressful in parents' lives.
Discuss coping mechanisms parents are currently using.
Acknowledge those coping skills that are effective.
Develop more effective strategies in cases where skills haven't been effective.

Rationale

The general pace of life these days is fast and many parents report they are very stressed. This session provides an opportunity to talk about the kinds of stress parents deal with, how they typically handle stress, and how they might handle it more effectively.

Goal: Parents will be able to recognize and discuss their stressors, their usual coping skills, and how they might better handle stress.

The following are suggestions that might help parents reduce their level of stress:

1. Give up the idea that you have to be "perfect." No matter how well you do, you won't be able to do it all. So, prioritize what you need to do and do the most important things first. Let the rest go for another day. (Many people base their self-esteem on how much they can accomplish. If you want to be less stressed . . . find another way to feel good about yourself!)

2. Get enough sleep. Put yourself on a regular sleep schedule. Relax an hour before you go to bed if possible. Don't drink caffeine in the evening. Alcohol may seem like it makes you sleepy but it can cause you to wake up in the middle of the night. Don't eat a big meal. Sleep in a comfortable bed in a safe location.

3. Learn to manage your time better.
    a) Notice how you spend your time. Take an inventory.
    b) Write down what you intend to accomplish (a, b, c, etc.). Rank order it according to importance and make a commitment to yourself that you won't tackle (b) until you've finished (a). If all you get done that day is (a), it will be better than spending the day disorganized and side-tracked to the extent that you don't finish anything.
    c) Learn to say "no" to people. Don't volunteer for every opportunity. And especially, don't say you'll do something you don't want to do just to please people or to look good.
    d) Take regularly scheduled breaks (whether at home or at work), where you stretch, walk, take a bubble bath, talk to a friend, etc. The time you spend nurturing yourself will be well-spent because you'll be much more productive over-all.

4. Some “coping techniques” seem to work well but eventually backfire because they cause their own problems. Trying to de-stress by drinking, smoking, eating, or shopping too much, can lead to compulsive habits. This is not recommended for two reasons: you may unwittingly develop an addiction and, you never get the chance to develop healthier, more effective coping skills.

5. Regular, moderate exercise is proven to be a good stress-buster. You can work out at a gym, but it doesn’t have to be that fancy. Brisk walking is great exercise, as is dancing, gardening, bowling, tennis, etc. Do something that you like so it doesn’t feel like drudgery.

6. Many people these days like to formally meditate. There are good books and classes to teach you how. Listening to relaxing music, reading, gardening, practicing martial arts, making models, doing jigsaw puzzles, among other things, can also be meditative. Anything meditative can lower blood pressure.

7. There are several breathing exercises that can also relax you. (The leader may want to demonstrate breathing techniques at this point.)

8. Don’t compare yourself to other people. Everyone has their own strengths and weaknesses. Continually trying to compete with a co-worker, spouse, friend, or the “Joneses,” is a prescription for unnecessary stress.

9. Don’t try to solve everyone’s problems for them, even your children’s. You may be enabling unhealthy behavior or preventing your kids from maturing if you do everything for them.

10. Finally, ask for help whenever you need it. Remember-- it makes people feel good to help someone else out, especially a friend.

V. Special Issues Regarding Program Implementation

A. Behavioral Contracts

Counselors use several different types of behavioral contracts to assist clients in achieving or maintaining abstinence and to encourage them to adhere to program rules or to engage in the treatment process.

No Use Contracts (see *No Use/Tapering Contracts,* Appendix A) represent an agreement between the client and counselor that the client will abstain from using alcohol or illicit substances for a specified period of time. The length of time specified in the contract varies from as little as one day to as long as one month depending, for example, on the clients' motivation to discontinue drug use, their beliefs in their ability to maintain abstinence, and their criminal justice status. When contracts are written for periods of less than one week, such as when clients are resistant to changing addictive behavior, the counselor will check in with the client at the next appointment to determine success in adhering to the contract during the week. Contracts are adapted according to one's ability to abstain, with urine drug screening used to determine if drug use is continuing. In general, it is important for clients to experience success as early in treatment as possible; therefore no use contracts are written so that clients have the greatest likelihood of success in adhering to them. It is believed that experiencing success early in treatment enhances self-efficacy and motivates the client to attempt longer periods of abstinence as treatment progresses.

Tapering contracts, like no use contracts, are designed to help clients gain control over their substance use. Tapering contracts, which specify reductions in use, are used when clients are unable or unwilling to achieve even a brief period of abstinence. For example, clients may agree to use one fewer time per day. When tapering contracts are used, it is useful to get quantitative urine screening results so that counselors have objective evidence that clients are in fact reducing their use. Because many parents expect immediate results once adolescents enter treatment and may feel that treatment will not be effective if adolescents are allowed to commit to only a day of abstinence or to reductions in use, parents are informed of the rationale for tapering or brief no-use contracts to prevent them from withdrawing their adolescent from treatment prematurely.

Other behavioral contracts are used to address behavioral problems (e.g., tardiness, poor attendance, failure to achieve treatment plan goals) and to improve a client's compliance with program policies and treatment objectives. Behavioral contracts specify the problem behavior (e.g., arriving late to treatment sessions), the specific concrete behaviors that the client must display (e.g., arrive at least five minutes prior to the scheduled time of the treatment session), and the consequences for not adhering to the contract (e.g., DJJ officer will be informed; discharged from treatment). For those clients who are struggling to adhere to the program policies discussed with them at the beginning of treatment, behavioral contracts can serve to enhance clients' motivation for treatment by clearly specifying the behaviors the client must display and the consequences for not following the contract. It is important that a behavioral contract of this type be specific and concrete, as well as discussed thoroughly with the client, with client and counselor signatures verifying such discussion. Because failure to comply with the terms of the contract may result in discharge from treatment, it is important that there be no room for interpretation of the intent of the contract or how to adhere to the terms of the contract.

B. Non-Compliance

One way in which clients fail to comply with the treatment program is by failing to attend scheduled sessions. At Epoch Counseling Center, the counselors contact clients by telephone immediately following missed sessions to determine the reason for not attending. Counselors also send follow-up letters to serve as a reminder of the next scheduled appointment. For DJJ-referred clients, counselors also inform the client's DJJ supervisor about the missed appointment. In general, individual make-up sessions are scheduled only in the case of clients whose attendance and performance in treatment has been good and who had extenuating circumstances that led to the missed appointment (e.g., lack of transportation, family emergency).

In addition to missing appointments, clients may arrive at therapy sessions late and/or fail to provide urine specimens as scheduled. Counselors first attempt to determine the reason for the non-compliance. If non-compliance is due to a time conflict, transportation difficulties, etc., counselors problem-solve with clients to resolve these issues. If non-compliance is due more to motivational issues, counselors make use of behavioral contracts. Because behavioral contracts are frequently seen as punitive, counselors make every effort to reinforce clients when they comply with contracts and with program rules. Continued non-compliance that is not resolved even after contracts have been developed may lead to premature termination of treatment or referral to a higher level of care.

C. Continued Substance Use During Treatment

Some clients fail to achieve abstinence even after several weeks of treatment. In these instances, counselors explore the reasons for clients' failure to achieve abstinence (e.g., ambivalence about modifying addictive behavior, situational reasons such as parental substance use, physical dependence). Depending on the reason, counselors may develop a tapering contract to help clients experience success as a means of motivating efforts to further reduce and ultimately discontinue use. Counselors may also schedule extra individual counseling sessions to provide clients with additional support as they make the effort to stop using. In certain cases, such as when clients are physically dependent or submit three consecutive drug positive urine samples, counselors may determine that the client is unable to achieve abstinence in an outpatient treatment setting and will therefore refer the client to a higher level of care (e.g., detoxification, residential treatment).

D. Attending Treatment Sessions Intoxicated

Clients who arrive at the clinic intoxicated are not allowed to participate in treatment sessions. If clients are found to be intoxicated after having entered a group, they will be asked to leave. An individual counseling session is scheduled at another time to discuss the behavior and to discuss the importance of being sober when attending counseling sessions. If clients attend more than one session intoxicated, counselors may use behavioral contracts to gain control over use or consider referral to a higher level of care. Whenever clients are intoxicated, counselors ensure a safe ride home for the individual either through a family member, friend, or public

transportation. In addition, parents or guardians and DJJ, if appropriate, are informed of the behavior.

E. Lack of Parental Involvement in Treatment

In some instances, parents or guardians are reluctant or unwilling to be involved in the treatment process despite having been involved in initiating treatment. Because parents can be important sources of support for adolescents in recovery, adolescent counselors make a concerted effort to involve them in treatment. During the intake process, the Coordinator or counselor emphasizes the important roles that parents play in the adolescents' recovery including practical assistance (e.g., transportation, paying fees) and also in terms of emotional and social support for both continued use (i.e., enabling behaviors) and abstinence. In addition, efforts are made to identify barriers to parental involvement in treatment and problem-solve with parents to overcome those barriers. For example, counselors will schedule evening appointments for working parents. Counselors make sure to inform parents that family therapy includes anyone in the home, which can help to ensure that childcare is not an issue. Finally, counselors attempt to engage parents by offering support to parents who may be feeling overwhelmed and frustrated with their adolescent and who feel as if there is nothing they can do to make a difference.

F. Co-Occurring Mental Disorder/Learning Disabilities

A client's ability to successfully engage and participate in treatment may be hindered by co-occurring mental disorders and/or learning disabilities. For clients currently in mental health treatment, permission is obtained at intake for the Epoch counselor to maintain ongoing contact with an adolescents' mental health professional. If an untreated co-occurring mental disorder is identified during substance abuse treatment, the client is referred to an outside agency for assessment and treatment. Clients are allowed to continue in treatment at Epoch only if the co-occurring disorder is also being appropriately treated. In instances where clients are diagnosed with serious mental disorders (e.g., psychosis), these individuals are referred to an appropriate clinic that specializes in treating adolescents with co-occurring disorders.

The presence of a learning disability also complicates treatment and needs to be considered in substance abuse treatment. Depending on the nature of the disability, clients may have difficulty learning the information or skills presented throughout group lessons. Sometimes the counselor can adapt the presentation of material to meet the needs of a learning-disabled client so that s/he is able to participate and benefit from the group treatment experience. However, it is not always possible to provide additional attention to those who have difficulty reading, comprehending, or completing written work in group sessions. These individuals are assigned to individual counseling so that they may receive appropriate attention.

VI. The Evaluation Project

Given the magnitude of the adolescent substance abuse problem in the United States, it is surprising that so few studies have been conducted to evaluate treatment approaches for adolescent substance abusers (Ralph & McMenamy, 1996). While a number of studies show that adolescent substance abusers who receive treatment fare better than those who do not (Catalano, Hawkins, Wells, & Miller, 1990-1991), research suggests that no single treatment approach is superior (Henggeler, 1997). Moreover, aspects of treatment contributing to effectiveness have not been identified. As part of its efforts to identify effective treatments for adolescents, the federal Center for Substance Abuse Treatment undertook the Adolescent Treatment Models (ATM) program, providing financial support to evaluate the effectiveness of 10 community-based adolescent treatment programs. (See Stevens & Morral, 2003, for a description of the ATM program and the individual treatment models.) The program described in this manual was one of the programs evaluated through the ATM.

A. Overview of the Program Evaluation

The Social Research Center (SRC) received an Adolescent Treatment Models grant from the Center for Substance Abuse Treatment to evaluate the effectiveness of Epoch Counseling Center's Group-Based Outpatient Treatment for Adolescent Substance Abuse (GBT). The SRC and Epoch are both divisions of Friends Research Institute, Inc., a private non-profit agency that has conducted substance abuse treatment and research for over 45 years.

Between July 2000 and December 2001, adolescents who applied for treatment at Epoch Counseling Center were recruited to participate in the evaluation project if they were between the ages of 14 and 18 (18 year olds were included only if still in high school), were suitable for a moderate intensity group-based outpatient substance abuse treatment program, and had a parent or legal guardian available to consent to participation (if the youth was under 18 years old). Upon receiving written informed parental consent and adolescent assent to participate, study participants received comprehensive psychosocial and behavioral assessments at the initiation of treatment and 6- and 12-months thereafter, with the assessments conducted by trained research interviewers (see Section C, below).

In addition to this quantitative program evaluation, a small number of these youth participated in a qualitative evaluation, consisting of a series of in-depth ethnographic interviews, designed to examine the youths' self-perceptions in relation to their substance abuse, their perceptions of their treatment experiences specifically and their social worlds in general, and how their perceptions changed during the course of treatment**.**

B. Focus of the Evaluation

The primary focus of this program evaluation is to determine the effects of Epoch Counseling Center's GBT on adolescent clients' substance use and criminal behavior 6- and 12-months following the initiation of treatment. In addition to this focus on the GBT, the evaluation also examines whether a brief motivational intervention at the beginning of treatment improves treatment engagement, retention, and outcome of these adolescent substance-abusing clients. In this latter component of the evaluation project, Motivational Interviewing (MI) was compared

with Counseling Overview (CO), a more traditional approach to preparing clients for treatment participation. The CO intervention oriented the youth to treatment but did not address motivation for treatment. Adolescents entering treatment at two Epoch facilities received a single-session MI intervention, while adolescents entering the remaining three Epoch facilities received a single-session CO intervention. Halfway through the study enrollment period, the facilities initially employing MI switched to CO, and conversely the facilities that initially employed CO switched to MI. Each of these two interventions was delivered in a single, 75-minute individual session by a counselor who was trained and supervised in the specific intervention approach.

Motivational Interviewing (MI). According to the MI perspective, motivation is viewed as a state of readiness or eagerness to change addictive behavior (Miller & Rollnick, 2002). MI is heavily influenced by the Stages of Change theoretical model (Prochaska & DiClemente, 1992). The Stages of Change model specifies six stages through which individuals progress in the process of change: *Precontemplation*, in which individuals fail to recognize they have a problem; *Contemplation*, in which individuals acknowledge they have a problem and are beginning to think about making a change; *Determination*, in which individuals have made the decision to make a change but have not yet undertaken any steps to change; *Action*, in which individuals take active steps to change; and *Maintenance*, in which individuals make efforts to maintain changes. *Relapse* occurs when maintenance efforts fail. Miller (1999) suggests that individuals cycle through these stages several times, which may facilitate learning about how to achieve and sustain change successfully.

The MI approach is non-confrontational and is based on the belief that clients are responsible for changing (Miller, 1999). Five basic principles are identified that guide the MI therapist: express empathy, develop discrepancy between the client's current substance using behaviors and his/her broader goals, avoid argumentation, roll with resistance rather than challenge it, and support self-efficacy (Miller & Rollnick, 2002). The MI therapist uses these strategies to accomplish specific goals, including: (1) helping the client recognize that substance use is causing problems in his/her life; (2) eliciting statements from the client that indicate motivation to change behavior; (3) enhancing the client's self-efficacy regarding his/her ability to change addictive behavior; and (4) eliciting plans for how change will be accomplished. The MI therapist selects the appropriate goals for treatment during the session depending on the client's stage of change. For example, the therapist may focus on the first two goals, or all of them if time permits, for a client in the contemplation stage, whereas the therapist may focus exclusively on the latter two goals for a client in the determination stage.

One important difference between motivational interviewing and other approaches is how client resistance is handled. Resistance is viewed as a normal part of the change process. Thus, rather than challenging resistance, which will likely promote further defensiveness on the part of the client (Miller & Rollnick, 2002), the MI therapist "rolls with it." Rolling with resistance involves reflecting resistant statements back to the client; the client is thus able to consider and explore his or her feelings about change more deeply. The process of rolling with resistance and reflecting resistant statements frequently results in the client making self-motivational statements, that is, statements indicating a commitment to change. The therapist then supports these self-motivational statements and encourages the client to make a more formal commitment to change by developing a plan for achieving abstinence.

Motivational interviewing within the current evaluation project consisted of two carefully planned and individualized treatment phases delivered within one 75-minutes counseling session. The MI therapist structured the session using the stages of change model and the motivational interviewing principles, as described above. The first phase of this session focused on obtaining information about personal problems with substance use, decisional considerations using a decisional balance worksheet (i.e., listing costs and benefits of continuing use versus discontinuing use), future plans, and building either a commitment to initiate change or continue in the change process. The second phase continued this motivational process by working with the client to develop a personalized action plan. This plan is geared to orient the client to thinking specifically about how the desired change will be achieved. A "Change Plan Worksheet" was used to guide the development of this action plan. The "Change Plan Worksheet" was then used as a basis for recapitulation – a strategy whereby the counselor offered a broad summary of what has transpired throughout the session. Recapitulation typically emphasized the client's self-motivational statements, specific plans for change, and the perceived consequences of changing versus not changing. The ultimate goal of this MI session was to have the client make a formal commitment to discontinue substance use based on the personal costs already experienced from use and the anticipated benefits of abstinence.

Counseling Overview. The counseling overview session was designed as a minimal, non-motivational intervention, against which the motivational intervention could be assessed. This intervention sought to prepare newly admitted clients to initiate treatment, attempting to increase their understanding of the treatment process by exploring and discussing their expectations about treatment. A number of aspects of counseling were examined in this session, including: defining counseling and the counseling relationship; discussing how different treatment modalities work together to effect change; and discussing the adolescent's thoughts or concerns about starting treatment. For adolescent clients with prior treatment experiences that may shape their view of treatment at Epoch Counseling Center, counselors explored these prior treatment experiences with the client, and discussed any concerns they may have about treatment that stem from these prior experiences.

C. Assessment Instruments

Global Appraisal of Individual Needs (GAIN). The primary assessment instrument, used at intake for both clinical and evaluation purposes, was the Global Appraisal of Individual Needs-Initial (GAIN-I), while the monitoring version of the GAIN (GAIN-M90) was used at 6- and 12-month follow-ups for evaluation purposes only (Dennis, 1998; Dennis, Dawud-Noursi, Muck, & McDermeit, 2002a; Dennis, Titus, White, Unsicker, & Hodgkins, 2002b). The GAIN-I is a bio-psycho-social assessment instrument that integrates research and clinical assessments, consisting of eight core sections, including background, substance use, physical health, risk behaviors, mental health, environment, legal, and vocational, and examines recent prevalence of problems, breadth of symptoms, and service utilization. The counselor uses this information to formulate an individualized treatment plan with the client that serves as the framework, albeit a "work-in-progress," for the client's treatment. The GAIN-M90 focuses on the most recent 90-day period preceding each follow-up assessment.

Motivational Assessment. Because the assessment of Motivational Interviewing was an important supplemental aim of this project, two instruments were used for evaluation purposes

only to assess motivation at both intake and approximately one-week following the Motivational Interview/Counseling Overview session:

(1) Circumstances, Motivation, and Readiness scales (CMR) is an 18-item questionnaire designed to assess motivation across treatment modalities with both adults and adolescents (Melnick, 1999; De Leon, Melnick, & Hawke, 2000). The CMR is comprised of four scales: (1) Circumstances 1 – external influences to enter or remain in treatment; (2) Circumstances 2 – external influences to leave treatment; (3) Motivation – internal recognition of the need to change; and (4) Readiness – perceived need for treatment (Melnick, 1999).

(2) Desire for Help Scale (DH) is one of several scales comprising a motivational assessment instrument developed by Simpson and his colleagues at Texas Christian University (Simpson, 1992; Simpson & Joe, 1993; Knight, Holcum, & Simpson, 1994). DH measures readiness to engage in treatment.

Treatment Participation and Engagement Measures. Approximately six weeks after beginning treatment, study participants were administered for evaluation purposes the Working Alliance Inventory (Youth) (Horvath & Greenberg, 1989) and the Client Evaluation Scales (Simpson & Chatham, 1995), brief assessments to determine aspects of treatment engagement, including the quality of their relationship with their counselor and attitude towards treatment. At this time, counselors also completed the Counselor Rating of Client (Simpson & Chatham, 1995), which assesses treatment engagement/participation.

Additional Measures. Additional measures completed for evaluation purposes at intake and at 6- and 12-month follow-up interviews included the Rosenberg Self-Esteem Scale (Rosenberg, 1965, 1979); the Social Skills Rating System (Gresham & Elliot, 1990); the Drinking-Related Locus of Control Scale (Donovan & O'Leary, 1978; Hirsch, McCrady, & Epstein, 1997); and the Adolescent Relapse Coping Questionnaire (Myers & Brown, 1996).

D. Integration of the Evaluation into the Epoch Adolescent Program

Adolescents applying for treatment at Epoch Counseling Center who met study eligibility criteria as described above were recruited to participate in the study during their initial intake session. Clients who assented, and whose parents provided informed consent, were introduced to a research interviewer, who administered the GAIN, which was used for both clinical and evaluation purposes, and other evaluation instruments, as indicated above. Upon completing the initial assessment of the participant, the research interviewer scheduled the next two counseling sessions: (a) the motivational interview or counseling overview session, conducted by a specially trained counselor who was not the counselor assigned for ongoing treatment, held during week 2; and (b) the individual treatment planning session with the client's assigned counselor, held during week 3. Because the clients did not meet with their assigned counselors (i.e., the counselor with whom they would continue in treatment) until the third week of treatment, the research interviewers informed counselors of any issues that emerged during the initial assessment requiring immediate clinical attention (e.g., suicidal ideation; client was in acute withdrawal). Such emergency intervention was rarely required. In these instances, the client was seen by a counselor immediately to determine the appropriate next course of action (e.g.,

referral to the emergency room; referral for detoxification or inpatient treatment). Following the motivational interview or counseling overview session, treatment proceeded according to the group-based treatment model as described in Section III, above.

E. Status of the Program Evaluation

Recruitment. Out of 224 adolescents who were eligible and available to enter group-based treatment, 209 (93.3%) agreed to participate and were enrolled in the evaluation study. Of those enrolled, 15 (7.2%) failed to return for treatment following their initial intake appointment. Thus, the program evaluation focused on 194 youth who agreed to participate and initiated treatment.

Follow-up Assessments. Of the 194 youth who agreed to participate and initiated treatment, 176 (90.7%) were located and re-interviewed for the 6-month follow-up, and 173 (89.2%) were located and re-interviewed for the 12-month follow-up.

Treatment Retention. Data regarding retention of youth in treatment indicate that the GBT was highly successful in retaining adolescents in treatment, regardless of the type of treatment preparation that they received (i.e., motivational interviewing or counseling overview). Of 194 study participants, 157 (80.9%) were retained in treatment at least 30 days, and 103 (53.1%) were retained for 90 days or more. While only 37 study participants (19.1%) successfully completed the program, an additional 19 (9.8%) were referred to another substance abuse treatment program at discharge, typically reflecting the need for a higher level of care.

Relevant to a consideration of treatment retention, the qualitative evaluation component has indicated that retention data must be considered with caution. Some of the youth who were pressured to enter treatment by the juvenile justice system were able to "navigate" through treatment, doing what was required of them until their probation requirements were met, without actually engaging in the treatment process. By contrast, other youth were engaged in the treatment process and genuinely attempted to change, yet some of these youth prematurely dropped out of treatment, believing that they had received all the help that they needed.

Implementation Challenges. Implementation of the preparation for counseling component (i.e., the Motivational Interview and the Counseling Overview) at the beginning of treatment interfered with treatment initiation. In order to assure that these interventions were distinct for evaluation purposes, a separate staff was required for each preparation approach. Thus, specially trained counselors who were not the clients' regular counselors delivered these interventions. This delayed the clients' initial contact with their adolescent counselors generally for two weeks or more following intake. The adolescent counselors universally agreed that preparation for counseling should be integrated into the GBT and not provided as an adjunct to treatment.

While the GBT emphasized the involvement of families, and especially parents/caregivers, in the adolescents' treatment, Epoch clinical staff found that they were unable to engage a number of families in treatment. In some cases the parents' own substance abuse interfered with their becoming involved, while in other cases the parents wanted to relinquish responsibility to Epoch. Lack of family involvement was especially true for the optional Parent Education and Support Groups. Only one of the five Epoch facilities was able to implement this treatment component to an appreciable extent. Out of 72 study participants enrolled at this facility, a parent/caregiver of 38 clients (52.8%) attended one or more parent group meeting. [Of

the 64 youth at this facility who were retained in treatment at least 30 days, 37 (57.8%) had a parent/caregiver attend at least one parent group session.] Epoch clinical staff was somewhat more successful in involving families in family therapy, yet even this was considerably less than specified in the treatment protocol, and variation among facilities with regard to family therapy participation was substantial. Out of 194 study participants, at least one family therapy session was held with the families of 72 youth (37.1%), with the percentage of families participating in at least one session ranging from 2.7% to 69.4% across the five Epoch facilities. (Of the 157 youth who were retained in treatment at least 30 days, 44.6% had at least one family session, with the percentage ranging from 2.8% to 70.0% across the five facilities.) It should be noted that, while adolescent clients and parents were informed that participation in at least four family therapy sessions was required for successful program completion, youth were not penalized if parents refused to participate, and these youth were able to successfully complete the program regardless of parental involvement.

Outcome. Evaluation of program outcomes is currently in process.

References

Abrams, D.B., & Niura, R.S. (1987). Social learning theory. In H.T. Blane & K.E. Leonard (Eds.), *Psychological Theories of Drinking and Alcoholism* (pp. 131-178). New York: Guilford

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*. Washington, DC: APA.

American Society of Addiction Medicine (ASAM; 1996). *American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition.* Bethesda, MD: ASAM.

Azrin, N.H., & Besalel, V.A. (1980). *Job Club Counselor's Manual. A Behavioral Approach to Vocational Counseling.* Austin, TX: Pro-Ed, Inc.

Bandura, A. (1977). *Social Learning Theory.* Englewood Cliffs, NJ: Prentice Hall.

Becvar, D.S, & Becvar, R.J. (1993). *Family Therapy: A Systemic Integration.* Needham Heights, Massachusetts: Allyn and Bacon.

Bell, T. (1990). *Preventing Adolescent Relapse: A Guide for Parents, Teachers, and Counselors*. Independence, MO: Herald/House Independence Press.

Bigelow, G.E., Brooner, R.K., & Silverman, K. (1998). Competing motivations: Drug reinforcement vs non-drug reinforcement. *Journal of Psychopharmacology, 12,* 8-14.

Boulding, K.E. (1968). General systems theory—The skeleton of science. In W. Buckley (Ed.), *Modern systems research for the behavioral scientist* (pp. 3-10). Chicago: Aldine Publishing Company.

Catalano, R.F., Hawkins, J.D., Wells, E.A., & Miller, J. (1990-1991). Evaluation of the effectiveness of adolescent drug abuse treatment assessment of risks for relapse, and promising approaches for relapse prevention. *International Journal of Addictions, 25,* 1085-1140.

Cohen, D.A., & Rice, J. (1997). Parenting styles, adolescent substance use, and academic achievement. *Journal of Drug Education, 27,* 199-211.

Collins, R.L., & Marlatt, G.A. (1981). Social modeling as a determinant of drinking behavior: Implications for prevention and treatment. *Addictive Behaviors,* 6 (3), 233-239.

De Leon, G., Melnick, G., & Hawke, J. (2000). The motivation-readiness factor in drug treatment: Implications for research and policy. *Advances in Medical Sociology, 7,* pp. 103-129.

Dennis, M.L. (1998). *Global Appraisal of Individual Needs (GAIN) manual: Administration, scoring, and interpretation*. Bloomington, IL: Lighthouse Publications.

Dennis, M.L., Dawud-Noursi, S., Muck, R.D., & McDermeit, M. (2002a). *The need for developing and evaluating adolescent treatment models.* Binghamton, NY: Haworth Press.

Dennis, M.L, Titus, J.C., White, M.N., Unsicker, J.L., & Hodgkins, D. (2002b). *Global Appraisal of Individual Needs (GAIN): Administration guide for the GAIN and related measures.* Bloomington, IL: Chestnut Health Systems [online]. Available at www.chestnut.org/li/gain.

Donovan, D.M., & O'Leary, M.R. (1978). The drinking-related locus of control scale: Reliability, factor structure, validity. *Journal of Studies on Alcohol, 39(5),* pp. 759-84.

Duncan, S.C., Duncan, T.E., Biglan, A., & Ary, D. (1998). Contributions of the social context to the development of adolescent substance use: A multivariate latent growth modeling approach. *Journal of Drug and Alcohol Dependence, 50,* 57-71.

Gresham, F. M., & Elliot, S. N. (1990). *Social Skills Rating System.* Circle Pines, MN: American Guidance Service.

Henggeler, S.W. (1997). Treating drug abusers effectively. In: J.A. Edgerton, D.M. Fox, & A.I. Leshner (Eds.), *The development of effective drug-abuse services for youth* (pp. 253-279). New York: Blackwell Publishers.

Hirsch, L.S., McCrady, B.S., Epstein, E.E. (1997). The Drinking-Related Locus of Control Scale: The factor structure with treatment seeking outpatients. *Journal of Studies on Alcohol, 58(2),* pp. 162-6.

Horvath, A.O., & Greenberg, L.S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36,* pp. 223-233.

Killen, J.D., Hayward, C., Wilson, D.M., Haydel, K.F., Robinson, T.N., Taylor, C.B., Hammer, L.D., & Varady, A. (1996). Predicting onset of drinking in a community sample of adolescents: The role of expectancy and temperament. *Addictive Behaviors, 21,* 473-480.

Knight, K., Holcum, M., & Simpson, D. D. (1994). *TCU Psychosocial Functioning and Motivation Scales: Manual on Psychometric Properties.* Fort Worth, TX: Institute of Behavorial Research, Texas Christian University.

Landry, M. (1993). *Understanding drugs of abuse: The processes of addiction, treatment and recovery.* Washington, D.C.: American Psychiatric Publishing, Incorporated.

Liddle, H. (Unpublished). Group treatment for adolescent substance abuse: An efficacy approach.

Mayer, J., & Filstead, W.J. (1979). Adolescent Alcohol Involvement Scale. *Journal of Studies on Alcohol, 40,* 291-300.

Melnick, G. (1999). *Assessing Treatment in Special Populations.* Unpublished final report submitted to the National Institute on Drug Abuse.

Miller, P.M., Smith, G.T., & Goldman, M.S. (1990). Emergence of alcohol expectancies in childhood: A possible critical period. *Journal of Studies on Alcohol, 51,* 343-349.

Miller, W.R. (1999). Motivational Enhancement Therapy Manual: A Clinical Research Guide for Therapists Treating Individuals With Alcohol Abuse and Dependence (NIH Publication No. 94-3723). Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, US Department of Health and Human Services.

Miller, W., & Rollnick, S. (2002). *Motivational Interviewing: Preparing People for Change.* New York: Guilford Press.

Minuchin, S., & Fishman, H.C. (1981). *Family therapy techniques.* Cambridge, Massachusetts: Harvard University Press.

Monti, P.M., Abrams, D.B., Kadden, R.M., & Cooney, N.L. (1989). *Treating alcohol dependence*. New York: The Guilford Press.

Myers, M.G., & Brown, S.A. (1996). The Adolescent Relapse Coping Questionnaire: Psychometric validation. *Journal of Studies on Alcohol, 57(1),* pp. 40-46.

Pavlov, I.P. (1927). *Lectures on Conditioned Reflexes.* New York: International Publishers.

Prochaska, J.O., & DiClemente, C.C. (1992). Stages of change in the modification of problem behaviors. In M. Hersen, R.M. Eisler, & P.M. Miller (Eds.), *Progress in Behavior Modification*. Sycamore, IL: Sycamore Press.

Query, L.R., Rosenberg, H., & Tisak, M.S. (1998). The assessment of young children's expectancies of alcohol versus a control substance. *Journal of the Addictions, 93,* 1521-1529.

Ralph, N., & McMenamy, C. (1996). Treatment outcomes in an adolescent chemical dependency program. *Adolescence, 31,* 91-107.

Richardson, J.L., Radziszewska, B., Dent, C.W., & Flay, B.R. (1993). Relationship between after-school care of adolescents and substance use, risk taking, depressed mood, and academic achievement. *Pediatrics, 92,* 32-38.

Rosenberg, M. (1979). *Conceiving the Self.* New York: Basic Books.

Rosenberg, M. (1965). *Society and the Adolescent Self-image.* Princeton, NJ: Princeton University Press.

Simpson, D.D. (1992). *TCU Forms Manual: Drug Abuse Treatment for AIDS-Risk Reduction DATAR.* Fort Worth, TX: Institute of Behavioral Research, Texas Christian University.

Simpson, D.D., & Chatham, L.R. (1995). *TCU/DATAR Forms Manual.* Fort Worth, TX: Institute of Behavioral Research, Texas Christian University.

Simpson, D.D., & Joe, G.W. (1993). Motivation as a predictor of early dropout from drug abuse treatment. *Psychotherapy, 30,* pp. 357-367.

Skinner, B.F. (1953). *Science and Human Behavior.* New York: McMillan.

Smith, G.T., Goldman, M.S., Greenbaum, P.E., & Christiansen, B.A. (1995). Expectancy for social facilitation from drinking: The divergent paths of high-expectancy and low-expectancy adolescents. *Journal of Abnormal Psychology, 104,* 32-40.

Stevens, S.K., & Morral, A.R. (2003). *Adolescent Substance Abuse in the United States: Exemplary Models from a National Evaluation Study.* Binghamton, NY: Haworth Press.

Wikler, A. (1973). Dynamics of drug dependence: Implications of a conditioning theory for research and treatment. *Archives of General Psychiatry, 28,* 611-616.

Wikler, A. (1965). Conditioning factors in opiate addiction and relapse. D.I. Wilner & G.G. Kassenbaum (Eds.). New York: McGraw-Hill.

Appendix A

Phase I: Drug Education
Exercises

Group Session 1–Drug Education I: Physical Psychological and Behavioral Effects of Substance Use

- *"The First Time/The Worst Time/The Last Time*
- *"Marijuana (How Much Do You Know)"* (answer key included)

Group Session 2–Drug Education II: Progression of Substance Use; Self-Diagnosis

- *"Youth Substance Use Timeline"*
- *"No Use/Tapering Contract"*

Group Session 3–Drug Education III: Relapse

- *"Functional Analysis"*

Group Session 4–Drug Education IV: Family Influence

- *"Family Influences"*

Group Session 1: Physical Psychological and Behavioral Effects of Substance Use

The First Time/ The Worst Time/ The Last Time

Try to remember the first time, the worst time, and the last time you used. Write what you are comfortable sharing with the rest of the group.

The First Time

The first time I used alcohol or other drugs I was (age) _____

I was with _____

What we were doing _____

_____

Why I decided to try it _____

_____

What happened? _____

_____

_____

How I felt before _____

_____

How I felt during _____

_____

How I felt afterward: Physically _____

_____

Emotionally/mentally _____

_____

The Worst Time

The worst time I had with alcohol or other drugs I was (age) _____

I was with _____

What we were doing _____

_____

Why I decided to do it _____

What happened? _____

_____

_____

How I felt before _____

_____

How I felt during _____

_____

How I felt afterward: Physically _____

_____

Emotionally/mentally _____

_____

Did you use again after this experience? _____

Why or why not? _____

_____

The Last Time

The last time I used alcohol or other drugs I was (age) _____

I was with _____

What we were doing _____

_____

Why I decided to try it _____

What happened? _____

_____

_____

How I felt before _____

_____

How I felt during _____

_____

How I felt afterward: Physically _____

_____

Emotionally/mentally_____

_____

What made you decide to quit? _____

_____

Marijuana

(How much do you know?)

Multiple choice questions!

1. The marijuana plant comes from:

    a. the tomato plant
    b. the hemp plant
    c. the poppy plant

2. Marijuana has _____ chemicals in it:

    a. zero; it's totally natural
    b. three
    c. one hundred
    d. over four hundred

3. What is Hashish?

    a. a concentrated form of marijuana, compressed
    b. tar from the bottom of your shoe from the street
    c. a candy bar

4. Once marijuana is smoked it goes:

    a. only to the brain
    b. into your kidneys

c. into every cell in your body

5. Amotivational Syndrome means:

a. smoking marijuana makes you more energetic
b. smoking marijuana tends to make you lose interest in long-term pursuits
c. smoking marijuana before any activity helps to motivate you

6. Marijuana effects your central nervous system by:

a. memory loss
b. irregular sleeping habits
c. producing unexpected mood changes
d. all of the above

7. Marijuana can affect male sexuality by:

a. decreasing levels of testosterone (male hormone)
b. growing breasts
c. decreasing sperm count, leading to infertility
d. creating birth defects
e. turning you into a female
f. none of the above
g. a, b, c, and d

8. Which statement is true?

a. marijuana has no withdrawal
b. marijuana expands the mind
c. marijuana increases sexual performance

d. marijuana smoke has more cancer-causing chemicals than tobacco

e. marijuana wears off in a few hours

Marijuana Worksheet Answer Key

1. b

2. d

3. a

4. c

5. b

6. d

7. g

8. d

Group Session 2: Progression of Substance Use; Self-Diagnosis

Youth Substance Use Timeline

Age

No Use

First time tried substance _____
What was it:
_____

Experimented _____
Signs:
_____
_____
_____

Misused

_____
Signs:
_____
_____
_____

Abused

Signs:
_____ _____
_____
_____

Addicted/ _____
Dependent
Signs:
_____
_____
_____

No-Use/Tapering Contract

I, _____, promise to not use any nonprescribed, mood-altering chemicals (alcohol and other drugs) for the following period of time:

_____ 1 day

_____ 2 days

_____ 3 days

_____ 4 days

_____ 5 days

_____ 6 days

_____ 1 week

_____ 2 weeks

_____ 3 weeks

_____ 1 month

_____ _____
Signature of client Date

I/We, _____, as parent(s) or guardian(s), promise to monitor the participant's behavior and report suspected use to the counselor(s) during the drug education program.

_____ _____
Signature of parent/guardian Date

_____ _____
Signature of parent/guardian Dat

Group Session 3: Functional Analysis

Functional Analysis

Antecedents (What triggers me to use drugs)	**Consequences** (What happens when I use drugs)
People (Who do I use with?) Places (Where do I use?) Things (What paraphernalia do I use?; Do I wear certain clothes or listen to certain music when I use?) Times of day/events (When do I use?) Thoughts (What thoughts do I have just prior to using?) Feelings (How do I feel physically and emotionally just before I use?)	Positive (What good things happen to me when I use?) Negative (What bad things happen to me when I use?)

Group Session 4: Family Influences

Family Influences

Take a moment to think about your family and how different members may have influenced you...

1) What is your mother best at?

2) What is your father best at?

3) How were your parents a positive influence on you?

4) What is an important lesson that your parents or another family member taught you?

5) What types of things does your family value? (Ex: school, hard work, religion, honesty)

6) What are your mother's best qualities?

7) What are your father's best qualities?

8) In what ways would you like to be similar to your parents or another family member?

9) In what ways would you like to be different?

Appendix B

Phase II: Relapse Prevention

Exercices

Group Session 5–Relapse Prevention I: Goals Group I
Group Session 14–Relapse Prevention X: Goals Group II

- *"Goals Sheet- Short-term"*
- "*Goals Sheet- Long-term"*
- *"Barriers"*

Group Session 6–Relapse Prevention II: Coping with Stress

- *"Identifying Personal Stressors"*
- *"Identifying Personal Stressors, Continued"*

Group Session 7–Relapse Prevention III: Coping with Hurdles in Recovery

- *"Personal Recovery Hurdles"*
- *"Steps in Problem Solving"*
- *"Asking for Support Skills Guidelines"*

Group Session 8–Relapse Prevention IV: Managing Thoughts About Using

- *"Common Thoughts About Using"*
- *"Methods for Dealing with Thoughts About Using"*
- *"Managing Thoughts About Using"*

Group Session 9–Relapse Prevention V: Process Group I
Group Session 13–Relapse Prevention IX: Process Group II
Group Session 17–Relapse Prevention XIII: Process Group III

- *"Recovery Planning"*

Group Session 12–Relapse Prevention VIII: Assertiveness: Relationships

- *"Values Assessment Scenarios"*
- *"Elements of an Assertive Response in Intimate Relationships"*

Group Session 15–Relapse Prevention XI: Refusal Skills

- *"Refusal Skills Scenarios"*
- *"Elements of an Assertive Response"*

Group Session 16–Relapse Prevention XII: Anger

- *"Anger Management"*

Group Session 18–Relapse Prevention XIV: Physical Health

- *"My Physical Health"*

- *"Lifestyle Log"*

Group Session 19–Relapse Prevention XV: Increasing Pleasurable Activities

- *"Pleasurable Activities Schedule"*

Group Session 5: Goals Group I
Group Session 14: Goals Group II

Goals Sheet: Short-Term

Often, when people come into treatment, there are many things that they want to change in their lives. For example, some may not be doing as well in school as they would like or may be having difficulty getting along with important people in their lives. Others may want to improve their health. Whatever it is that they want to improve, setting goals can help them begin to make the changes that they want to make. Goals are the good things people want that they must work for in order to get.

Since you are new to treatment, the best way to get started on making positive changes is to think about the areas in your life (school, relationships, substance use, legal, work, etc.) that you want to change. Pick the one which is most important to you now and write it down in the spaces provided.

One area of my life that I want to change or make different:_____
_____

Now, the next thing you need to do is think about how you want this area of your life to improve. Be as specific as you can and be positive. For example, don't write, "I want to stop failing classes." Instead write, "I want to receive passing grades in math and science this semester."
What changes do I want to make:_____
_____
_____
_____

Now, think about what the first thing is that you need to do to make the changes you want to make. Again, be specific and try to think in terms of things that you can do to begin making the changes you want to make. For example, don't write, "I need to study harder." Instead, write, "I will devote three hours per week to studying math and two hours per week to studying science."
Short-term Goal #1:_____
_____

Now, work on a plan for how you will go about accomplishing that goal. You should include when (that is, the days and times you will study math and science) and where (that is, where you will do the studying) you will do the things you listed in the previous section.
Plan:_____
_____
_____
_____

Now, think carefully, is there anything that will get in the way of your following your plan and accomplishing your goal? Write down any of the distractions or barriers that will get in your way. Be as specific as possible.
Barriers:_____
_____

What will you to do to avoid having these distractions get in your way. Again, be as specific as possible.

Solutions:_____
_____
_____

When you accomplish this goal, how will you feel? Please be specific._____
_____
_____
Okay, now you are ready to start thinking about other areas of your life that you want to change.
A second area of my life that I want to change or make different:_____
_____

What changes do I want to make:_____
_____
_____
_____

Short-term Goal #2:_____
_____

Plan:_____
_____
_____
_____
_____

Barriers:_____
_____
_____

Solutions:_____
_____
_____

How will I feel when I accomplish this goal?_____
_____

_____

A third area of my life that I want to change or make different:_____
_____
What changes do I want to make:_____
_____
_____
_____

Short-term Goal #3 :_____
_____

Plan:_____
_____
_____
_____
_____

Barriers:_____
_____
_____

Solutions:_____
_____
_____
_____

How will I feel when I accomplish this goal?_____
_____
_____

Group Session 5: Goals Group I
Group Session 14: Goals Group II

Goals Sheet: Long-term

Now that you have successfully accomplished some short-term goals, it is important to start thinking about some long-term goals that you want to work on. Look on your Goals Sheet: Short-term, because some of things that you listed as areas of your life that you wanted to change may be appropriate long-term goals. Unlike short-term goals, long-term goals may take from several weeks to several months to complete.

First, think about one area of your life that you want to improve that represents a long-term goal. Be specific and state the goal positively. For example, don't say, "I don't want to fail any courses this semester." Instead say, "I want to receive a passing grade in math."

Mid-range Goal #1:_____
_____

So that you don't get discouraged, it is often helpful to break long-term goals down into the smaller steps that you will need to take to accomplish the goal. These small steps or short-term goals, should be designed so that they can be accomplished in one to two weeks. The idea is that each time you accomplish a step, you are that much closer to accomplishing the long-term goal. When developing steps, be specific about what you will do as well as how and when you will do it. Be sure to state each step positively. For example, if the long-term goal is to receive passing grades in math, the steps you would take might include:

1) On Monday October 8th, at the end of class, talk to my teacher to find out:
    a) current grade
    b) grades needed on quizzes and assignments to pass class

If teacher is unable to give this information immediately, schedule a time with teacher when the information will be available.

2) On Monday October 15th, at the end of class, ask teacher or parent to assist in locating a tutor
3) On Tuesday, October16th, after school, call tutor to schedule first meeting
4) etc.

Remember, as you write each step, be sure to include information about when, where, and how you will go about accomplishing that step. Consider barriers to accomplishing each step (See Step 1 of the example), and come up with ways to overcome the barriers.

In addition, it may not be possible to come up with all the steps you will need to take to accomplish the goal right away. With the above example, you may need to wait until you meet with the tutor before you can come up with the rest of the steps you will need to accomplish your goal of passing math this semester.

What steps will I need to take in order to accomplish my long-term goal (Be sure to include when and how you will go about accomplishing the step):

1)_____

2)_____

3)_____

4)_____

5)_____

6)_____

7)_____

8)_____

Because long-term goals take a while to accomplish, it is important to keep your motivation up. One way to do this is give yourself rewards for accomplishing the small steps or a portion of the goal. You should give yourself small rewards frequently. For example, if you stick to your study schedule during the week, you might want to reward yourself on Saturday with (a) a day off from studying or (b) an ice cream sundae. Give yourself medium-sized rewards occasionally, such as when you have stuck to your study schedule for 4 weeks or passed quizzes in math. For example, you might take yourself to a movie or out to lunch at McDonald's. Finally, be sure to give yourself a large reward (e.g., a day at an amusement park) when you have accomplished your long-term goal.

Some small rewards I will give myself:
1)_____
2)_____
3)_____

Some medium-sized rewards I want to give myself:
1)_____
2)_____
3)_____

Some large rewards I want to give myself:

1)_____
2)_____
3)_____
When I accomplish this goal, how will I feel:_____
_____

Group Session 5: Goals Group I
Group Session 14: Goals Group II

Barriers Worksheet

Barriers are things that happened or that you did that prevented you from accomplishing the goals you set for yourself.

The barriers that got in the way of your accomplishing your goals may be obvious; maybe you made a conscious decision to not work on your goals because they weren't all that important to you. Or, perhaps, you had planned to go home and study after school but as you were walking home with your friends, you decided you would put off studying until later and hang out with your friends instead – then you never got around to studying.

Sometimes the barriers are less obvious; particularly when they are thoughts or feelings that you had whenever you thought about working on your goals. For example, every time you thought about sticking to your study schedule, you might have thought "studying isn't going to make a difference, I am just not that smart," or you might have felt anxious and tense. To avoid these thoughts and feelings, you might have avoided working on your goal.

In order to make progress in treatment, and to make improvements in your life, it is important to figure out what barriers got in your way this time so that you can overcome them while you are working on your goals over the next few weeks.

Pick one of the goals you had planned to work on during the past several weeks and write it down here.

_____

_____

#A1 How many times during the past several weeks did you even think about working on your goal?

_____

If one or more times skip to A2

If none, then the barrier was that you did not remember to work on the goal. Was this because:

a) The goal was not all that important to you (circle one) Yes No

If yes, then you need to select a different goal (ask the counselor for another Goals Sheet: Short term and try to select a goal that is more important to you).

If no, then was it because

b) You simply forgot about it once you left treatment.

If yes, write down what you can to do remind yourself to work on the goal over the next few weeks._____

_____

_____

_____
_____

#A2 Look over the plan you developed for accomplishing your goal. Was it specific enough; that is, did you include when, where, and how you were going to go about accomplishing that goal? Did you include someone who could help you accomplish the goal?

If not, then, try to make a more specific plan (write it in the space provided below)

_____
_____
_____
_____

#A3 Each time you thought about working on your goal, what thoughts would go through your head?

_____
_____
_____
_____
_____

What can you do to keep these thoughts from getting in the way of accomplishing your goal?_____
_____
_____
_____
_____

#A4 Each time you thought about working on your goal, how did you feel both physically and emotionally?

_____
_____
_____
_____
_____
_____

How can you manage these feelings so that they do not interfere with your accomplishing your goal during the next few weeks?_____
_____
_____
_____

#A5 If you did do some work on your goal, what did you do?

_____
_____
_____
_____

#A6 If you did start working on your goal, what happened that made you stop working on it?

_____
_____
_____
_____
_____

What can you do to avoid letting those things interfere with your accomplishing your goal in the future?_____
_____
_____
_____

#A7 Is there anything else that you think of, that got in the way of your accomplishing your goal? Write them down in the spaces provided.

_____
_____
_____
_____
_____

What can you do to keep those things from interfering with your accomplishing your goal in the next few weeks? Write them down in the spaces provided.

_____
_____
_____
_____
_____

IDENTIFYING PERSONAL STRESSORS

We experience stress on a daily basis. It is helpful if we can identify stressors that we experience, so that we can begin to identify what we need to do to cope with them.

Please check off all the stressors listed below if you have experienced them in the last 1-2 months.

- ☐ **recent illness**
- ☐ **financial difficulty**
- ☐ **fight with friends**
- ☐ **unwanted pregnancy**
- ☐ **family violence**
- ☐ **worried about weight**
- ☐ **not having friends**
- ☐ **sexual problems**
- ☐ **problems in school (behavior)**
- ☐ **birth of a child**
- ☐ **death of someone close to you**
- ☐ **break-up with girlfriend/boyfriend**
- ☐ **attending new school**
- ☐ **good friends having problems**
- ☐ **feeling anxious**
- ☐ **anniversary of a loved one's death**
- ☐ **separation/divorce of parents**
- ☐ **problem with alcohol**
- ☐ **family stress (parents')**
- ☐ **hearing prejudice remarks**
- ☐ **moving to a new place**
- ☐ **trouble with police**
- ☐ **problems in school (academic)**
- ☐ **problems with drugs**
- ☐ **parent substance abuse problem**
- ☐ **losing a game**
- ☐ **parent late coming home (worry)**
- ☐ **baby-sit siblings regularly**
- ☐ **feeling depressed**
- ☐ **parent's don't trust you**

IDENTIFYING PERSONAL STRESSORS, CONTINUED

Of the stressors already identified within these last 1-2 months...

- **What stressors do you experience on a regular basis?**

- **Of these stressors, which of them are controllable?**

- **If controllable, how are they controllable?**

- **What are possible solutions for coping with these stressors?**

Personal Recovery Hurdles

Answer the following questions. Be as honest as possible.

1. Family Substance Use

a. How many people in your family (besides yourself) use drugs? _____

b. How many people in your family (besides yourself) use alcohol? _____

c. How many of those people in your family who use drugs or alcohol live in the same house as you? _____

d. Have you used drugs or alcohol with any of those family members (circle one)? Yes No

e. Do any of those family members offer you drugs or alcohol, even though they know you are trying to quit (circle one)? Yes No

2. Family Support

a. Would you consider your family to be "close-knit?" Yes No

If yes, please describe

_____

_____

_____

b. Do people in your family help one another out with problems? Yes No

c. Is there anyone in your family you can talk to about problems and concerns? Yes No

If yes,
who?_____

_____

d. Does anyone in your family reinforce you (that is, tell you that you are doing a good job) in your efforts to achieve abstinence from drugs or alcohol? Yes No

If yes,
who?_____

_____

e. Have any of your family members stopped using drugs or alcohol altogether or stopped using in front of you because they don't want to put you at risk for relapse (circle one)? Yes No

f. Does anyone in your family criticize you about your past drug or alcohol use (circle one)? Yes No

g. Does anyone in your family tell you that you <u>won't</u> be able to stay off drugs (circle one)? Yes No

3. Family Environment

a. Using the scale below, <u>how well do you get along with</u> your family (circle one)?

0	1	2	3
Not at all	Somewhat	Moderately	Extremely

b. How often do you argue or fight with members of your family (circle one)?

< Infrequently, less than once per month
< At least once per month
< Once every two weeks
< Once per week
< Several times per week
< Every day

c. Is there anyone at home when you arrive there after school? Yes No
If yes, write, in the spaces provided, who is at home and their age (if under 18):

Name	**Age**
My Mother _____	_____ (example)
My Brother _____	*10* ____ (example)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

d. How many days per week do you arrive home from school and there is no one there?
_____ days per week

e. Would anyone notice if you did not come home immediately after school (circle one) ?
Yes No

4. Neighborhood

a. Do you feel safe in your neighborhood (circle one)? Yes No
if yes, do you feel safe enough to go outside at night by yourself (circle one)?
Yes No

b. Is there a lot of violence and crime in your neighborhood?
Do you hear gunshots regularly Yes No
< Have you seen people shot or stabbed Yes No
< Have you or someone in your neighborhood been mugged Yes No
< Have you or someone in your neighborhood had your (or their) house robbed Yes No

c. Are there abandoned buildings in your neighborhood? Yes No
d. Are there crack houses in your neighborhood? Yes No
e. Do you have any neighbors that do <u>not</u> use drugs or alcohol? Yes No
If yes, are any of those neighbors that do <u>not</u> use drugs or alcohol your age?

f. How far from your house did you have to go in order to buy your drugs?
_____blocks

5. Friends

a. How many friends do you have?_____

b. How often do you see these friends (circle one)

1X/week 2-3X/week 4-5X/week 6X/week every day

6. Academic performance

a. Do you go to school? Yes No

b. How many days per week do you go to school? _____ days per week

c. How many classes do you miss per week? _____ classes

d. Which classes are easiest for you? What are your grades in those classes?

Easiest classes	Grade
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

e. Which classes are hardest for you? What are your grades in those classes?

Hardest classes	Grade
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

f. Which statement best describes how you feel about your school performance (circle one).

I couldn't do any better even if I tried harder and it does not bother me because I don't really like or care about school

< I couldn't do any better even if I tried harder and it bothers me because I am embarrassed about my school performance

< I could do better if I tried harder but I don't really like or care about school

< I could do better if I tried harder and it bothers me because I am embarrassed about my school performance

g. Does anyone at home ask you about, check, or help you with your homework (circle one)? Yes No

h. Does anyone at home care whether or not you go to school? Yes No

7. Other Hurdles

a. Do you feel sad and/or depressed on more days than not? Yes No

b. Have you gained or lost weight recently without trying to? Yes No

c. Do you feel anxious or keyed up on more days than not? Yes No

d. Do you have trouble getting out of bed in the morning? Yes No

e. Are you short-tempered; that is, do you get angry easily? Yes No

f. Do you get sick (i.e., with colds or the flu) more often than our friends or family? Yes No

g. Do you have trouble staying awake in class? Yes No

h. Do you smoke cigarettes? Yes No

i. Do you shower/bathe regularly (once per day)? Yes No

j. Do you exercise regularly (run, play basketball)? Yes No

k. Do you eat regularly (at least 3 meals per day)? Yes No

l. Have you ever asked someone for help with a problem or support in the past? Yes No

If yes, write down what happened

_____

_____

_____

_____

_____

_____

_____

Write down the hurdles you will need to overcome in order to successfully achieve and maintain abstinence. Include any other hurdles that are not included on this form.

_____

_____

_____

_____

_____

_____

_____

_____

_____

STEPS IN PROBLEM SOLVING

Step One – identify the problem:

_____

_____

_____

Step Two – list all the possible solutions

1. _____
2. _____
3. _____
4 _____
5. _____

Step Three – Determine the consequences of each solution

PROS	CONS
1. A._____	1. A. _____
B._____	B. _____
2. A._____	2. A. _____
B._____	B. _____
3. A._____	3. A. _____
B._____	B. _____
4. A._____	4. A. _____
B._____	B. _____
5. A._____	5. A. _____
B._____	B. _____

Step Four – Pick the solution that results in the most good outcomes and the fewest bad outcomes

_____

Step Five – How well did the solution you picked work?

Asking for Support Skills Guidelines

" What is the problem or hurdle you need to overcome (write it down in the space provided)?

_____

_____

_____

" What type of support or help do you need?

< Help with problem solving
someone who can help you consider your options or someone who has dealt with similar problems
< Moral support
someone who will give you positive feedback for your efforts or who "understands where you are coming from"
< Sharing the load
someone who can help you out with your responsibilities
< Information or resources
someone who is knowledgeable about community resources (for example, math tutors in your area) or knows people who can be helpful
< Emergency help
someone who can provide you with money, clothing, transportation or a safe place to stay

In the space provided, write down what type of help you need to overcome the hurdles you have identified:

_____

_____

_____

Who might be helpful to you? You can consider the following people:

< Someone who is already in your life who has been helpful in the past
< An acquaintance (like a teacher, guidance counselor, neighbor) who has been neither helpful or hurtful to you in the past but is someone you are willing to ask for help

In the space provided, write down the names of people who you feel might be helpful to you. Be sure to include only those people who are not actively abusing drugs or alcohol. Include as

many people as you; don't worry too much about how well you know the person, you won't know until you ask, whether or not they can (and are willing to) be helpful to you:

_____

_____

_____

_____

_____

_____

< Don't expect people to read your mind! People won't know you need their help unless you tell them.

< Begin by letting them know you want to discuss a problem that you have with them. For example, you might say one of the following things:

"I was wondering if it would be all right for me to talk to you about a problem I have been having?" OR

"I have a problem that I thought you might be able to help me with. Is it all right if I talk to you about it now?"

In the space provided, write down what you will say to let someone know that you want help from them:

_____

_____

_____

< If they say they are willing to discuss this with you, then describe the problem and the type of help you would like from them. Be as specific as possible about what you want from them. For example, you might say:

"Sometimes things get really crazy in my house when my mom and dad fight. I was wondering if it might be all right for me to come and spend some time at your house when my mom and dad get into it?" OR *"Do you think your parents would mind if I came over to your house when things get hot over at my house? Would you mind if I asked them myself?"*

In the space provided, write down what you will say to let that person what the problem is and HOW they can help:

_____

_____

_____

_____

_____

_____

_____

< If they are willing to help, make certain to thank them. For example, you might say:
"Thanks a lot. You are really helping me out by letting me stay at your place when things get crazy at my house."

In the space provided, write down how you will let them know that you appreciate their help:

_____

_____

_____

_____

Common Thoughts About Using

_____Good memories- remembering all the fun times while using drugs or alcohol, always using on holidays or special occasions. Not paying attention to the negative memories.

_____Testing oneself- becoming overconfident or curious. *"I can have just one."*

_____Crisis- overwhelming feeling/desire to use in stressful situations or crisis. *"I can't handle this without being high/drunk."*

_____Feeling out of control- not believing that you can get through a strong craving without using. *"I had to use, I was so angry with _____."*

_____Feeling uncomfortable- because of memories you may believe that you are not fun when sober, you may feel out of place or uncomfortable with old or new friends. *"People won't like me as much or think I'm fun if I'm straight. I'll be boring."*

_____Self-Doubt- the feeling of "why try" if you doubt your ability to be successful getting clean. *"I've tried to stay clean before– why should this time be any different?"*

_____One drug is better or safer than another– *"I'm only using marijuana." "At least I'm not using heroin, cocaine, LSD, etc."*

_____Being able to follow your own rules that prove to you that you don't have a problem. *"I never use in school." "I never drink before it's dark outside."*

_____Comparing your use to that of others– *"I don't use as much as _____."*

_____Seeing drug use as the only option to deal with a particular situation. *"The only way I'll have any fun is to be high." "There's nothing else to do but use drugs when I'm bored." "I can't deal with my mother unless I'm high."*

Methods for Dealing with Thoughts about Using

Think about negative memories, not just the good ones
Remember the negative, more painful memories associated with using drugs and alcohol: legal charges, expulsion from school, fights with family, friends, etc., alcohol poisoning, blackouts, fear of negative consequences, coming to treatment, etc.

Think it out
If I use now, what will happen? Try to think about the future instead of only being focused on the present.

Challenge these thoughts about using and come up with more honest and realistic thoughts to replace thoughts about using.
Ask yourself: "Is this always true?" "Am I ignoring certain information?" Example: "I can't get through school without being high." Is this true? Have you ever made it through the day without using? How? What is a more accurate statement?

Distractions
Think about something unrelated to using to stop thoughts and get through cravings. Watch T.V., call a friend, do homework, play basketball, take a walk, etc.

Change surroundings if they lead to more thoughts about using
Certain places, people, & things will trigger thoughts and cravings. Avoid these if possible or make changes. For example, if you always use in front of a friend's house, don't walk past it. Leave a situation if you have to. Break the connection between triggers and using.

Get through the craving/ delay use
If you use during a craving, you reinforce your belief that you can't get through a craving without using. When you are able to get through the craving, you can become more confident that you don't *have* to use when you get a craving. Put off any decision to use for a brief period of time. Cravings usually go down if you can wait them out.

Believe in yourself
If you find yourself doubting your ability to stay clean, think about your successes. If you used every day, being clean even one day is a success. Instead of saying, "I can't do this," say to yourself, "I've been clean 3 days which is longer than I ever thought I'd be able to."

Call someone
Call a person who can be helpful in supporting you to stay clean. Who has been helpful to you in the past in talking you through a difficult situation? Maybe this is a relative or friend, someone who has been through what you are going through.

Relaxation technique

Stress often leads to thoughts about using. Use a variety of stress-reducing exercises or activities including exercise, deep breathing, progressive muscle relaxation, distractions, etc.

MANAGING THOUGHTS ABOUT USING

Choose a situation that you have recently experienced which has triggered a thought about using:

What thought did you have about using following this event?

What did you do?

What skill do you believe you could use to more effectively manage these thought and prevent use from occurring?

What could you then do differently?

Group Session 9: Process Group I
Group Session 13: Process Group II
Group Session 17: Process Group III

Recovery Planning

Now that you are near the end of treatment, you need to think about what you will do to maintain abstinence once you are out of treatment; that is, you need to develop a recovery plan.

The first thing you will want to do is think about all of the reasons why you came to get treatment for your drug problems in the first place. It is important to periodically remind yourself about how bad things had gotten because of your substance use and what is likely to happen if you go back to using. Write those things down here:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10)_____

You will also want to think about how things are in your life compared to how things were when you were using. In particular, how has your life gotten better since you stopped using drugs and alcohol. Right now, focus on only those things that have already happened since you stopped using drugs; don't include things that will happen in the future. Write those down here:

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10)_____

Now you have a number of good reasons for maintaining abstinence; that is, things that you want to avoid (reasons for entering treatment) and things you want to keep (good things that have happened since becoming abstinent).

Maintaining abstinence is hard work – and just because you are nearly finished with treatment does not mean that your work is done. You have to work on maintaining abstinence every day of your life. Given that you have good reasons to do this work (both the good things that are happening now as well as the goals you have for yourself), what are some of the things you will do to help maintain abstinence from drugs and alcohol. Be specific! For example, don't say, "I will talk to someone." Instead say, "I will talk to my parents whenever I feel the urge to use drugs;" or "I will get an after school part-time job during the times when I used to hang out with my friends and use drugs. Because money is a trigger for me, I will open a bank account and will deposit my pay check into that account rather than cashing it."

What are the things I will do to maintain abstinence from drugs and alcohol:

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

9) _____

10)_____

Attendance at Alcoholics Anonymous and Narcotics Anonymous can be helpful for teens in recovery. You need to think about the extent to which attendance at AA and NA meetings will be an important part of your recovery plan.

Are you planning on attending AA or NA meetings? Yes No
If yes, how frequently: _____
Do you have a sponsor? Yes No
What is his/her first name: _____

Phone number: _____
Write down the day, time, and addresses of the meetings you plan on attending:

Day	Time	Address
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____
7) _____	_____	_____

People with drug and alcohol problems tend to isolate themselves; in particular they don't talk to people about what they are thinking and how they are feeling. For this reason, talking to people is an important part of recovery. You should think about the people you trust and in particular, who you will talk to about your feelings, urges to use drugs/alcohol, cravings, etc.
List family/friends you can talk to if you feel that your recovery is in danger

Name	Phone #
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

These people can also be helpful in pointing out to you that you seem to be slipping back to your old ways. Remember, relapse is a process and you will begin to show signs that you are getting closer to using drugs before you actually pick up and use. It is possible to prevent a relapse if you, and the other people you have asked to help you, know what to look for.

Here are some examples of signs and symptoms of relapse that you, and the people you have asked to help you in your recovery, can be looking out for.

1. I tell people that I am "okay" although it is obvious to them and to me that I'm not.

2. I don't recognize the connection between my behavior and the consequences I experience; I blame others for my problems.
3. I stop putting effort into my recovery (e.g., I stop going to meetings; I stop seeing my aftercare counselor, I show up late to meetings; I cancel appointments)
4. I have difficulty concentrating; I am forgetful; I spend a lot of time daydreaming
5. I think it is unfair that others can drink or do drugs recreationally/socially; I become angry and resentful toward people who drink socially
6. I am anxious, tense; down, depressed, irritable; I experience mood swings; I am easily angered and I overreact to minor slights
7. I have low energy; I am unmotivated; nothing interests me
8. I begin to have health problems
9. I begin to isolate; I stop spending time with positive people
10. I begin to act impulsively; I cause problems for myself by acting without thinking
11. My grades in school are slipping; I am not taking care of my responsibilities at home or at work; I miss days of work
12. I stop taking care of myself; my appearance starts to decline; I get sick more often

What other signs and symptoms of relapse should you, and the people who you have asked to help you, be looking for:

_____
_____
_____
_____
_____
_____

If you monitor yourself carefully, you will know when you have stopped working your recovery and have started to relapse when you start to notice these signs and symptoms. The key is, you need to make a plan for what you will do if you begin to relapse. Be specific; include who you will talk to, and where you will go for help. For example, your plan might include talking to your mom and asking her to help you contact Epoch Counseling Centers to get you back into treatment. Be sure to let others know about your plan so they can help you with it.

Also, you may not be aware of changes in your behavior and attitude but the people you have asked for help with your recovery may be. However, you may not be receptive to feedback from these people. Therefore, you need to make a plan in advance for what they should do if you won't listen to them when they tell you that they are worried about you.

In the spaces provided, write down your plan for what you will do if you begin to relapse. What should other people do if they become concerned about you and/or your behavior? What should they do if you are not receptive to their feedback?

_____
_____

_____
_____
_____
_____
_____
_____
_____

Finally, the best way to approach recovery is to "Be Prepared." If you are aware of the situations that will make it difficult for you to maintain abstinence, you can make a plan for how to avoid those situations or cope with them if you can't avoid them. Spend some time writing down the situations or events that you may encounter that may make it difficult for you to maintain your abstinence.

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

Write down a strategy for overcoming each of the high risk situations you listed. Be as specific as possible.

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

Values Assessment 1

Amanda is out on her first date with Kellon. She is thrilled to be out on a date with him because she likes him a lot and wants him to like her. At one point in the evening, they are alone and Kellon begins to kiss Amanda.

***Question**: What would you do if you were in this situation?*

Kellon then starts to move his hands over parts of Amanda's body.

***Question**: What would you do if you were in this situation?*

When Kellon begins to move his hands under her clothing, Amanda moves away quickly. Kellon asks, "What's wrong?" Amanda says, "Nothing. It's getting late. I'd better be getting home." Kellon says, "Not now, Amanda, I really care about you. This is the best way I know how to show you. Besides, everyone else is doing it. Don't you care about me?" Amanda says, "Of course I care..." Kellon cuts her off and says, "then show me you care."

***Question**: What would you do if you were in this situation?*

Amanda closes her eyes and lets Kellon do what he wants. She does not enjoy it but hopes Kellon will really care about her after this.

***Question**: What would you do if you were in this situation?*
***Question**: If you were Amanda, how would you feel?*

Values Assessment 2

Maurice is hanging out with his friends Terrence, Jerry, and Jim. At some point, Jim starts bragging about the fact that he and his girlfriend, Tracey, have been having sex for the last few months and she wants sex from him all the time.

***Question**: What would you do if you were in this situation?*

Terrence and Jerry enthusiastically participate in the conversation. Terrence, who has been dating Robin for only a couple of weeks, tells the others that they have already been having oral sex and that he expects to do it with Robin this weekend.

***Question**: What would you do if you were in this situation?*

At some point, Jerry notices that Maurice has not gotten involved in the conversation. Jerry asks, "Maurice, you're not saying anything. You're not a virgin, are you?" Maurice, and his girlfriend Terry, have not had sex. In fact, Maurice is a virgin.

***Question**: What would you do if you were in this situation?*

Because he is embarrassed, Maurice makes up an excuse for his lack of participation in the conversation. He tells Jerry, "Of course I am not a virgin. Terry and I have been having sex for a while." While he is saying this, Maurice begins to feel bad because he really likes Terry and is certain that she will be mad at him for telling his friends they have had sex.

***Question**: What would you do if you were in this situation?*
***Question**: If you were Maurice, how would you feel?*

Values Assessment 3

Sherryce and Damian have been dating for three months and have been using condoms whenever they have sex. Sherryce recently started taking birth control pills. Damian feels that, because Sherryce is protected against pregnancy, they no longer need to use condoms. One night, they are parked in a secluded spot and they begin to make out. When Damian is about to enter her, Sherryce stops him so she can put a condom on him. Damian says, "Come on Sherryce, you're on the pill. We don't need to use rubbers anymore."

***Question**: What would you do if you were in this situation?*

Sherryce knows that Damian has slept with a lot of different girls; sometimes, because he was high at the time, he did not even know their names when he slept with them. She also knows that Damian did not use condoms when he had sex with these girls.

***Question**: What would you do if you were in this situation?*

Now that she and Damian are having sex, Sherryce believes she is the only one that Damian is having sex with. But, she is not ready to stop using condoms. Sherryce says, "I know we agreed that I would take the pill so we could stop using condoms. But, I am just not ready, yet." Again, she tries to put the condom on him. Damian stops her and says, "Sherryce, sex feels so much better without a condom. I want it to be really good for both of us." Sherryce looks as if she is about to refuse to have sex and so Damian pulls away from her and says, "If you cared about me, you wouldn't make me wear a condom anymore."

***Question**: What would you do if you were in this situation?*

Afraid she will lose Damian if she insists, Sherryce gives in and agrees to have sex without a condom.

***Question**: What would you do if you were in this situation?*
***Question**: If you were Sherryce, how would you feel?*

Group Session 12: Assertiveness: Relationships

Elements of an Assertive Response In Intimate Relationships

Tell the person what you want
Be specific about what you do want and what you don't want.

Let the person know that nothing they say will change your mind
Use words that indicate that there is no room for negotiation. E.g. "I want..." "I don't want..." "I won't..."
Don't phrase it in the form of a question; e.g., "Why don't we...?" or "Don't you think that..." because it leaves room for the person to disagree with you or to try and convince you to do what they want.

Make eye contact
The more eye contact you make, the more convincing you will be. If you look down at your feet, or over their shoulder, they will think that you have doubts about your decision and will continue to pressure you.

EXAMPLES

Assertive Statement: "Kellon, I really do like you but I don't want to do this right now. I am just not ready. Let's go see the movie we had planned on seeing, instead."
Non-Assertive Statement: "Kellon, I'm not sure I am ready to do this right now. Couldn't we go do something else, please?"

Assertive Statement: "Sonia, I will not have sex with you unless we use a condom. I don't want to take the risk of getting you pregnant."
Non-Assertive Statement: "Sonia, don't you think we should use condoms? I mean, you could get pregnant"

Assertive Statement: "Jim, I really like you and I enjoy making out with you. But I am not ready to go any further."
Non-Assertive Statement: "Jim, I like the kissing, I'm just not certain this is the right thing to be doing."

Assertive Statement: "Yes, I am a virgin. I really like and respect Terry and I want to wait until she is ready to have sex."
OR
Assertive Statement: "I am not getting involved in the discussion because it really is none of your business what Terry and I do."

Refusal Skills Scenarios

Scenario # 1

Jim and Martin entered a new school together this year. Although Jim has been in treatment and has recently given up drinking, Martin has been hanging out with a new set of friends, taking midnight joy rides and drinking. Because Jim and Martin have been best friends for years, Jim has been going along with Martin and his new friends, even though he does not want to start drinking again. One night, after drinking for a while, the group decides to break into the school to smash some windows and graffiti the hallways. Jim has not been drinking and he tells Martin he isn't interested in going along. Martin says, "Jim, don't be a wimp. We're just going to have some fun. The school can afford it. We're not going to hurt anybody."

***Question**: If you were Jim, what would you do?*

***Question**: If you were in this situation, and did not want to go along, how would you tell Martin?*

Scenario # 2

The "guys" have gone out to a party on a Saturday night. Brian is really excited to have been asked to tag along. He feels that he is starting to get "tight" with his friends. Right now, he feels like these guys are closer than his family. He spends all his time with them. Everyone at the party is smoking pot. Brian is on probation for possession of a controlled substance and has been in treatment for his pot smoking. Brian's good friend Tom offers him a hit off a joint. Brian knows he shouldn't because he has a scheduled urine test at the treatment center tomorrow and he doesn't want to violate his probation but he also doesn't want to be "uncool" by telling Tom this.

***Question**: If you were Brian, what would you do?*

***Question**: If you were in this situation, and did not to smoke pot, how would you tell Tom?*

Scenario # 3

Tina and Terry have been friends for a long time. Tina really likes Terry and wants her to be her best friend. She's really cool and always seems to know what to say. Tina finally get invited to go over to Terry's house. She is very excited and walks over after school. Both girls are talkative and silly. Terry gets up, goes over to her parents liquor cabinet. Tina starts to get a tight stomach. She has recently entered treatment because her parents caught her drinking at home and she has been trying to stay clean. Terry comes over with a bottle, takes a sip and starts bragging about how cool it is to drink. Terry begins to get nervous because she does not want to start drinking again but she also wants Terry to think she is cool.

***Question**: If you were Tina, what would you do?*

***Question**: If you were in this situation, and did not want to drink, how would you tell Terry?*

Elements of an Assertive Response

Tell the person what you want
Be specific about what you do want and what you don't want.
Be specific about what you will do and won't do

Let the person know that nothing they say will change your mind
Use words that indicate that there is no room for negotiation. E.g. "I want..." "I don't want..." "I won't..."
Don't phrase it in the form of a question; e.g., "Why don't we...?" or "Don't you think that..." because it leaves room for the person to disagree with you or to try and convince you to do what they want.

Make eye contact
The more eye contact you make, the more convincing you will be. If you look down at your feet, or over their shoulder, they will continue to pressure you.

EXAMPLES

Assertive Statement: "I am in recovery. I don't use drugs anymore. Please don't offer me cocaine anymore."
Non-Assertive Statement: "I'm just not in the mood right now. Why don't we go hang out at the mall instead?"

Assertive Statement: "You can do what you want, Jim, but I am not going to shoplift at the mall with you."
Non-Assertive Statement: "I don't know, Jim. I am not sure this is a good idea. We could get caught."

Assertive Statement: "I do love you and enjoy making love to you. But, I am not ready to stop using condoms. I will not have sex with you unless you agree to use condoms."
Non-Assertive Statement: "I do love you and I want to show. I am just not sure whether I am ready to stop using condoms."

Group Session 16: Anger

Anger Management

Typical Anger Responses and Consequences

1) Think about the last time you became angry. Using the spaces provided, briefly describe what happened and how you felt both physically and emotionally (ex. Mom and dad searched my room. I felt frustrated that they don't trust me. My shoulders and jaw hurt).

_____
_____
_____
_____
_____

2) In the space provided, write down how you reacted, or what you did (ex. I yelled at them to keep their hands off my stuff or I am leaving and then went to my friends house).

_____
_____
_____
_____

3) In the space provided, write down what happened as a result of your reacting this way (ex. My parents were convinced I was using and had me arrested).

_____
_____
_____
_____

4) In the spaces provided, what anger signals did you experience the last time you got angry

	Physical	*Emotional*	*Behavioral*
ex.	Headaches	Racing thoughts	Inability to sit still
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

V. Skills Guideline

1. **Calm down** – in order to come up with a rational, alternative response, you need to calm down.
   If you can, you will probably want to leave the situation before you act on your anger. In this case, you can use any of a number of strategies to calm down including:
   - go for a walk
   - talk to a friend
   - distract yourself

   If you can't leave the situation, you can calm yourself down by using the following breathing exercise.
   - Take a deep breath in; your stomach should move out as your lungs fill
   - Breath out, counting slowly to 3 or 4.
   - Repeat 3 or 4 times

2. Once you have calmed down, you can express to the other person what they did that made you upset or what you do or don't want them to do.
   For example, "It upsets me when you do things that let me know you don't trust me."
   OR "The stuff in my room is private. I don't want you going through my stuff again."
3. Remember, sometimes you will have to accept that the other person will not change their behavior or apologize for hurting you. In this case, you need to focus on the fact that you acted appropriately and avoided experiencing significant negative consequences by taking control of your anger.

Group Session 18: Physical Health

MY PHYSICAL HEALTH

It is important to recognize that while we are using drugs our priorities change and we may not take good care of ourselves.

What changes have you noticed about your health as a result of using drugs?

Complete the following–how did substance use affect:

While actively using	***Current***	***Future?***

Your Diet:

Your Sleep Patterns:

Exercise:

Group Session 18: Physical Health

LifeStyle Log

Nutrition	***Exercise***	***Sleep***

Document daily habits/patterns	***List possible activities and document daily/weekly Exercise***	***Document projected and actual sleep patterns***

Group Session 19: Increasing Pleasurable Activities

PLEASURABLE ACTIVITIES SCHEDULE

<u>A Menu of Pleasurable Activities</u> (drug-free, should be limited to no-cost)

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

<u>Appointments for Personal Time</u>	***Activity?***
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Appendix C

Parent Education and Support Group Exercises

Parent Education and Support Group I: Enabling Addicts

- *"How Enabling Prolongs Addiction"*
- *"Parent Enabling Checklist"*
- *"Alternatives to Enabling"*

Parent Education and Support Group 2: Communication

- *"Typical Responses"*
- *"Pitfalls in Communicating"*

Parent Education and Support Group 4: Understanding Adolescence

- *"Parenting Styles: Chart of Stages"*
- *"What Kids Want"*

Parent Education and Support Group 5: Parenting Styles

- *"Personal Parenting Styles"*
- *"Parenting Traits Assessment"*

Parent Education and Support Group 6: Setting Limits

- *"Setting Consequences"*
- *"Setting Up a Contract for Rules and Consequences"*

Parent Education and Support Group 7: Anger Management

- *"Styles of Expressing Anger"*
- *"Making Things Better Rather than Worse"*

Parent Education Support Group I: Enabling Addicts

Exercise #1

HOW ENABLING PROLONGS ADDICTION

The Process of Addiction

A teen becomes an occasional user. For a while, drugs and alcohol produce the desired effect without creating a lot of problems for him. He thinks it will always be this way.

- He begins to depend (physically or psychologically) on having the drug. He needs more of the drug to get the same high. He starts lying, hiding use, slacking off on responsibilities.
- He needs the drug just to feel "normal." He does things against his values in order to use. He's burning bridges with friends, family, maybe school or work.
- Negative consequences of his use start to mount. He likely has legal as well as social consequences. His health may be affected. He may have lost a friend to using or have overdosed himself.
- He finally realizes on his own (or though intervention by loved ones) that drugs and alcohol are poison for him. He decides the many negative consequences of using outweigh the rewards drugs originally brought into his life. He gets treatment and stops using.

This is a fairly normal progression of use. But, when the user has enablers around him, he is prevented from getting to step 5. Enablers shield a user from experiencing the pain of negative consequences. Therefore, without meaning to, enablers diminish the changes their loved one will get useful treatment.

Parent Education Support Group I: Enabling Addicts

Exercise #2

PARENT ENABLING CHECKLIST

The following are things parents often think, do, or say that inadvertently enable their adolescent's use. Place an "x" next to the three things you find yourself doing most often.

_____1. I attribute my child's behavior to "just being a teenager," thinking he'll grow out of it.

_____2. I don't think my child could have a problem—it must be his friends' influence.

_____3. Sometimes I let my kid out of family responsibilities if she complains enough.

_____4. I let my teen drink at home where I can keep an eye on him so he's not out driving.

_____5. I don't want friends and relatives to know my kid's doing drugs —it's a family secret.

_____6. I don't ask her because I don't want to have to deal with it and don't know how to handle it.

_____7. I think I may be making something out of nothing—what if I accuse her and I'm wrong?

_____8. I cover for my hung-over kid and tell the boss he's sick so he won't get fired.

Parent Education Support Group I: Enabling Addicts

Exercise #3

ALTERNATIVES TO ENABLING

"Enabling" is doing anything that prevents chemically dependent people from experiencing the full impact of painful or negative consequences resulting from their chemical use. **Enablers** do not realize they are helping the addict/alcoholic to continue using.

How family members can help:

- Don't regard this as a family disgrace. Recovery from alcoholism/chemical dependency can come about as in recovery from any other illness.
- Don't nag, preach, or lecture to the alcoholic/addict. Chances are he has already told himself everything you can tell him. He will take just so much and shut out the rest. You may only increase his need to lie or force him to make promises he cannot possibly keep.
- Don't use the "if you loved me" appeal. Since the behavior is compulsive and cannot be controlled by willpower, this approach only increases his guilt. It is like saying, "If you loved me you would not have cancer."
- Avoid any threat unless you think it through carefully and definitely intend to carry it out. There may be times, of course, when a specific action is necessary to protect children. Idle threats only make the alcoholic/addict feel you don't mean what you say.
- Don't let the alcoholic/addict persuade you to drink or use with him on the grounds that it will make him use less or make you closer. It rarely does make him use less and drinking is not conducive to intimacy. Besides, when you condone his use, he puts off getting help.
- Don't expect an immediate 100% recovery. In illness, there is a period of convalescence. There may be relapses and times of tension and resentment.
- You can offer support and understanding but don't try to protect the recovering alcoholic/addict from uncomfortable situations in life. He must learn on his own what are slippery areas and triggers for him and how to cope with stress. The alcoholic/addict must be in charge of his own recovery program.
- Do offer love, support and understanding in his quest for sobriety and save some for yourself. Plan your own recovery because your life is changing too. To do nothing for yourself, is the poorest choice you can make.

Parent Education Support Group 2: Enabling Addicts

Exercise #1

TYPICAL RESPONSES

Imagine you're a teenager unhappy with his job in the second week of work. Tell us which response you'd prefer to get from your parents, and why.

You are 17 and are really disappointed that the job you worked hard to get has turned out to be a dud. You tell your parents, "Man, this job is nowhere." Responses they might have:

1) "That's a shame when you worked so hard to get it."

2) "Why are you complaining, at least you've got a job?"

3) "You sound bummed out; do you want to talk?"

4) "So, get another job."

5) "Jobs are hard to come by. I'd hate to see you go through all that again. What about hanging in there for another couple of weeks and see what happens?"

What has your response been as a parent in similar situations in the past. Do you think its been effective or do you want to change it?

Parent Education Support Group 2: Enabling Addicts

Exercise #2

PITFALLS IN COMMUNICATING

Place an "x" next to the three communication pitfalls that you find yourself falling into most often. Think about alternative ways to respond and be ready to discuss them.

_____ **1.** Lecturing **("I did it this way and that's how it should be done.")**

_____ **2.** Diagnosing **("You're doing that because you're holding a grudge.")**

_____ **3.** Name Calling **("You're no good, just like your Dad.")**

_____ **4.** Changing the Subject **("Let's talk about happier things.")**

_____ **5.** False Praise **("Don't listen to them, you're the prettiest girl in the school.")**

_____ **6.** Preaching **("You have to stay away from boys with cars.")**

_____ **7.** Ordering **("I forbid you to ever see her again.")**

_____ **8.** Criticizing **("You're always messing up. You're no good.")**

_____ **9.** Interrogating **("Who talked you into skipping school?")**

_____ **10.** Threatening **("If you mess up one more time, I'm kicking you out.")**

Exercise #1

PARENTING STYLES: CHART OF STAGES

AREA OF DEVELOPMENT	WHEN ADOLESCENCE BEGINS	WHEN ADOLESCENCE ENDS
Biological	**Beginning of growth spurt and puberty.**	**Physical maturity reached.**
Emotional	**Beginning of detachment from parents.**	**Reaching separate sense of identity.**
Interpersonal	**Shifting interest from parents to peers.**	**Development if intimacy with peers.**
Cognitive	**Start of more advanced reasoning abilities.**	**Full development of those abilities.**
Educational	**Entry into Junior High School.**	**Completion of schooling.**
Moral	**Becoming turned into other's expectations.**	**Beginning to behave by the dictates of personal conscience.**

Exercise #2

WHAT KIDS WANT

A study on middle schoolers was done which asked a hundred thousand kids aged 12-14 what they most wanted from their parents. Listed here are the "top ten" they gave along with four items that didn't make the list. Put a check next to the four things you believe kids **did not** choose as being important to them (Mueller, W., 1994).

____ 1. Parents who don't argue in front of them.
____ 2. Parents who treat each family member the same.
____ 3. Parents who tell the truth.
____ 4. Parents who are tolerant of others.
____ 5. Parents who give them enough money for an allowance.
____ 6. Parents who welcome their friends into their homes.
____ 7. Parents who make their family feel like a "team" with "team spirit."
____ 8. Parents who treat them like "buddies" rather than kids.
____ 9. Parents who answer their questions.
____ 10. Parents who discipline them when needed but not in front of their friends.
____ 11. Parents who are smarter than other kids' parents.
____ 12. Parents who concentrate on their good points instead of their weaknesses.
____ 13. Parents who are consistent.
____ 14. Parents who protect them from the harsh realities of the world.

Exercise #1

PERSONAL PARENTING STYLES

Can you think of situations where you've used each of the four parenting styles?

Authoritarian._____

_____.

Permissive _____

_____.

Neglecting _____

_____.

Authoritative _____

_____.

Exercise # 2

Parenting Traits Assessment

Involvement in Child's Activities

Involved **Uninvolved**

Level of Freedom for Teen

High **Low**

How are Decisions/Limits Made?

Parent Only **Parent and Child Negotiate** **Child Only**

Who Is Responsible for Child's Behavior?

Parent **Parent and Child** **Child**

Limit Setting and Enforcement

Rigid **Flexible** **Loose**

How Are Rules Communicated?
Does Child Know What's Expected of Her?

Clearly **Not Clearly**

Use of Praise and Positive Reinforcement

Frequent **Infrequent**

Affectionate?

High **Low**

Exercise #1

SETTING CONSEQUENCES

Here are some examples; ask parents to think of other possibilities.

SITUATION: Sam is continually late for school.

(**Note:** First make sure that Sam's being late is due to his irresponsibility and testing limits rather than something you need to investigate, such as: his transportation continually letting him down; problems sleeping (indicating possible depression); difficulties at school that make him not want to go.)

Rule: Sam will be in his classroom and ready to start school at 7:45 am each school day. (This should be handled one week at a time. It would be unreasonable to expect the child to be on time every day for the entire semester. The rule must not seem too overwhelming to comply with.)

Negative Consequences for non-compliance:
First offense: Sam will be grounded the following Saturday, including no going out, phone calls, TV or friends over.
Second offense: Sam will have to forfeit an agreed upon portion of his allowance for the week. (If he doesn't get an allowance, he must pay his parents an agreed upon amount of money.) **Positive Consequences for compliance:**
Each week that he is on time every day, Sam can borrow the car that Saturday night (with the tank filled for him).

SITUATION: Kim refuses to do her assigned chores.

(**Note:** First make sure that the chores are appropriate to her age and ability and that siblings are assigned comparable chores.)

Rule: Kim will complete her assigned chores each day for a week after being reminded only once. She'll complete them in a timely manner and without griping or doing them poorly.

Negative Consequences for non-compliance:
First offense: Kim will pay a sibling or parent an agreed upon amount of money in exchange for him doing "her" chores.
Second offense: Kim will be responsible for both her chores and a sibling's chores for the following week. (If this isn't feasible, the parents can assign a chore that isn't usually her responsibility.)
Positive Consequences for compliance: Each day that she completes her chores successfully, Kim can have 15 minutes added to her Saturday night curfew.

Exercise #2

SETTING UP A CONTRACT FOR RULES AND CONSEQUENCES

Rules

1. _____
   _____
   _____
   _____

2. _____
   _____
   _____
   _____

3. _____
   _____
   _____
   _____

Consequences

Positive *(for compliance)* _____
_____
Negative *(for non-compliance)* _____
_____

*Positive (for compliance)*_____
_____
Negative (for non-compliance) _____
_____

Positive (for compliance) _____
_____
Negative (for non-compliance) _____
_____

Signed _____ _____ *Date* _____
parent(s) *adolescent*

Exercise #1

STYLES OF EXPRESSING ANGER

To me, anger is a _____ emotion.

Significant people in my childhood expressed their anger in these ways:

My Father (or male role model) _____.

My Mother (or female role model) _____.

Brothers and sisters _____.

Friends _____.

As a child and teenager, I expressed my anger by:

_____.

In the present:

Today I express my anger by:

_____.

When I do express anger, it makes me feel:

_____.

Exercise #2

MAKING THINGS BETTER RATHER THAN WORSE

INSTEAD OF raised voice	**use a calm voice**
INSTEAD OF rapid speech	**use moderate speech rate**
INSTEAD OF frowning	**use composed expression**
INSTEAD OF staring	**use normal eye contact**
INSTEAD OF sneering	**have relaxed mouth and jaw**
INSTEAD OF pointing	**use relaxed hand movements**
INSTEAD OF invading other's space	**maintain a comfortable distance**
INSTEAD OF sarcasm, threatening	**use assertive communication**
INSTEAD OF swearing, put downs	**use assertive communication**
INSTEAD OF following or intimidating	**withdraw**
INSTEAD OF standing up	**remain seated**
INSTEAD OF physical contact	**make no physical contact**
INSTEAD OF drinking alcohol	**don't excessively drink**
INSTEAD OF taking drugs	**don't take drugs**
INSTEAD OF carrying weapons	**don't carry weapons**
INSTEAD OF going to places that put you at risk (ex: bars)	**avoid environments you know put you at risk**
INSTEAD OF threatening body language (clenched fists, folded arms)	**use relaxed body language**
INSTEAD OF rapid breathing	**breathe slowly and steadily**
INSTEAD OF being in a crowd	**keep sufficient space around you**