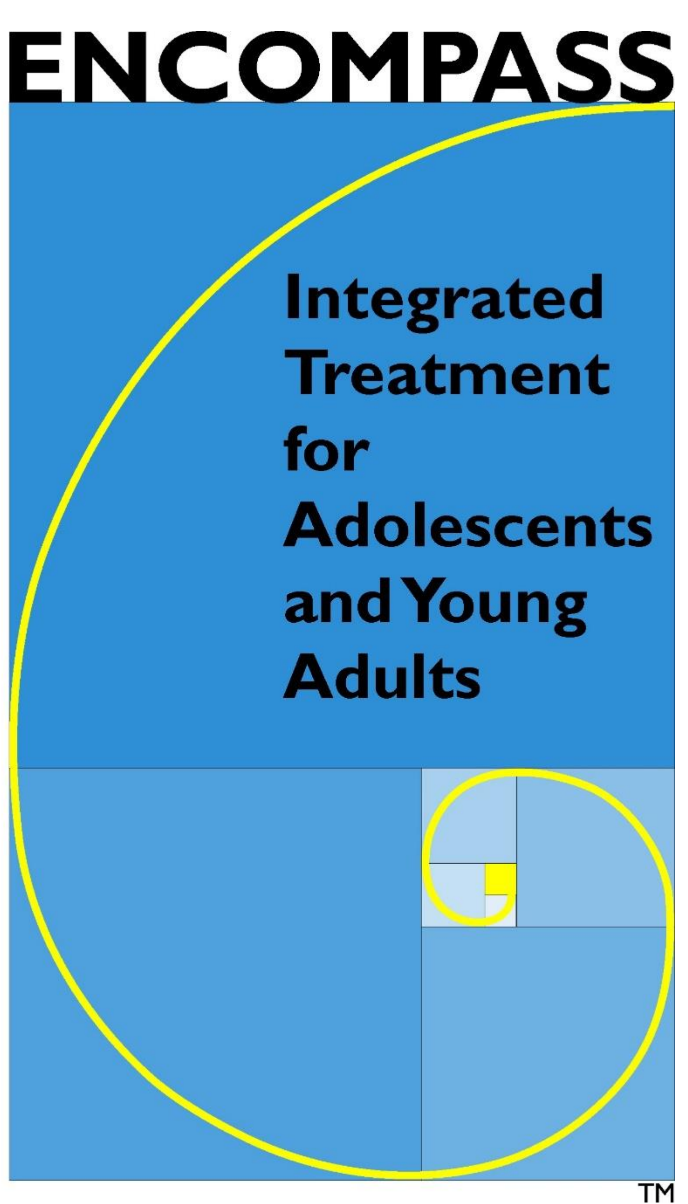
TREATMENT INTERVENTION MANUAL



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ACKNOWLEDGEMENTS AND OVERVIEW OF *ENCOMPASS*

This manual includes all materials and procedures for implementing the *Encompass* intervention including: *Encompass* MET/CBT Manual, Participant's Workbook; contingency management procedures, clinical assessments and outcome measures, fidelity/adherence measures, and data entry templates.

Individual MET/CBT is the foundational core of the *Encompass* intervention. The *Encompass* MET/CBT manual is an adapted version of the ***Treatment Research Manual: Cognitive-Behavioral Therapy for Adolescent Substance Use Disorders,*** originally developed and developmentally adapted for adolescents by Dr. Holly Waldron and colleagues at the University of New Mexico, Center for Family and Adolescent Research and which has been used in a number of their published studies. The blending of principles of motivational interviewing have been shown to facilitate patient engagement and strengthen therapeutic alliance when combined with the more structured, skills-based and directive elements found in cognitive-behavioral strategies (Miller, 1999; Miller and Rollnick, 2002). Thank you to Jennifer Wyatt for taking the lead in revising the current version of the manual to further strengthen and more seamlessly integrate and update motivational interviewing approaches throughout the manual including recommendations from the Motivational Interviewing Network of Trainers (MINT).

We are grateful to Dr. Waldron for providing MET/CBT training for members of our clinical research team as well as ongoing clinical supervision and fidelity/adherence monitoring throughout one of our first clinical trials: **A Randomized Controlled Trial of Fluoxetine and Cognitive Behavioral Therapy in Adolescents with Major Depression, Behavior Problems, and Substance Use Disorders (Riggs et a. 2007)**. We subsequently adapted the manual for implementation in a multisite trial conducted in the National Institute on Drug Abuse (NIDA) Clinical Trials Network (CTN): **A Randomized Controlled Trial of Osmotic-Release Methylphenidate (OROS-MPH) for Attention Deficit Hyperactivity Disorder (ADHD) in Adolescents with Substance Use Disorders (SUD) (Riggs et al., 2011)** and a similarly designed single site trial: **A Randomized Controlled Trial of Atomoxetine for Attention-Deficit/Hyperactivity Disorder in Adolescents with Substance Use Disorder (Thurstone et al. 2010).** Each of these similarly designed studies, all participants received 12 or 16 weeks of manual-standardized, weekly outpatient individual MET/CBT (targeting substance abuse) throughout the placebo controlled medication trials (targeting co-occurring depression or ADHD).

Results of these studies provided empirical support for medications that can be safely used to treat co-occurring depression or ADHD in adolescents concurrently receiving substance treatment even if they have not yet achieved abstinence. Taken together, these studies also provided a standardized, research-based approach for integrating the treatment of SUD and co-occurring psychiatric disorders that informed the development of *Encompass.* Contingency management (CM)/motivational incentives was added to MET/CBT to replace the weekly research payments provided to study participants. Ample research has shown that the addition of CM/motivational incentives to individual MET/CBT has greater acute and post-treatment

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effect size compared to MET/CBT alone (i.e. higher rates of abstinence achieved during treatment; > sustained reductions in substance use) (Tripodi et al. 2010; Stanger et al. 2016; Riggs, 2016). *Encompass* utilizes the "fishbowl" method developed by Petry and colleagues to reinforce or reward the following behaviors: 1) Treatment compliance (one prize draw for each CBT session attended); 2) Abstinence (one prize draw for each consecutive week with a negative urine drug screen, escalating scale with resets); and 3. Increased engagement in nondrug, prosocial activities (one prize draw for each of two pre-negotiated activities completed weekly).

Encompass intervention appears to be unique in its utilization of a well-established evidence-based substance treatment intervention MET/CBT + CM and research-based approach to integrated or concurrent treatment of co-occurring psychiatric disorders. *Encompass,* therefore*,* addresses an important gap with regard to the lack of integrated mental health and substance treatment models and clinical services. This is important because a large body of research indicates that the majority of adolescents referred for substance treatment have co-occurring psychiatric disorders which predict poorer substance treatment outcomes if left untreated.

SAMHSA's National Registry of Evidence-Based Practices (NREPP) currently lists only one intervention for co-occurring disorders --- Adolescent Community Reinforcement Approach (ACRA) --- meeting SAMHSA's evidence-based practice criteria. It is clear, based on the description and outcomes provided, that ACRA is an efficacious adolescent substance treatment intervention that utilizes manual-standardized individual MET/CBT very similar to *Encompass* MET/CBT. ACRA has also been shown to increase utilization of mental health services by referring adolescents with co-occurring mental health problems and/or psychiatric disorders to community-based mental health treatment programs or providers and actively facilitating linkage to such services. Recent review of the literature revealed several relatively small studies piloting substance treatment interventions for adolescents combined with other treatment components or modalities targeting a single co-occurring condition such as depression or PTSD. Thus, to our knowledge, *Encompass* appears to be the only truly integrated intervention that combines a well-established substance treatment intervention with proven efficacy (MET/CBT + CM) with a research based approach for providing concurrent assessment and treatment for other co-occurring psychiatric disorders. *Encompass* can also be flexibly adapted for implementation in a broad range of behavioral health and primary care settings including community-based mental health and substance treatment programs and school-based health clinics. *Encompass* is currently in the early stages of national dissemination. Pooled outcomes from three community-based and three school-based Encompass sites/programs indicate that Encompass produces at least comparable reductions in substance use and somewhat higher rates of abstinence than other evidence-based substance treatment interventions and significant reductions in co-occurring psychiatric symptom severity with more than 50% remission of co-occurring ADHD, depression, or anxiety disorders by the end of treatment (see *Encompass* Outcomes section).

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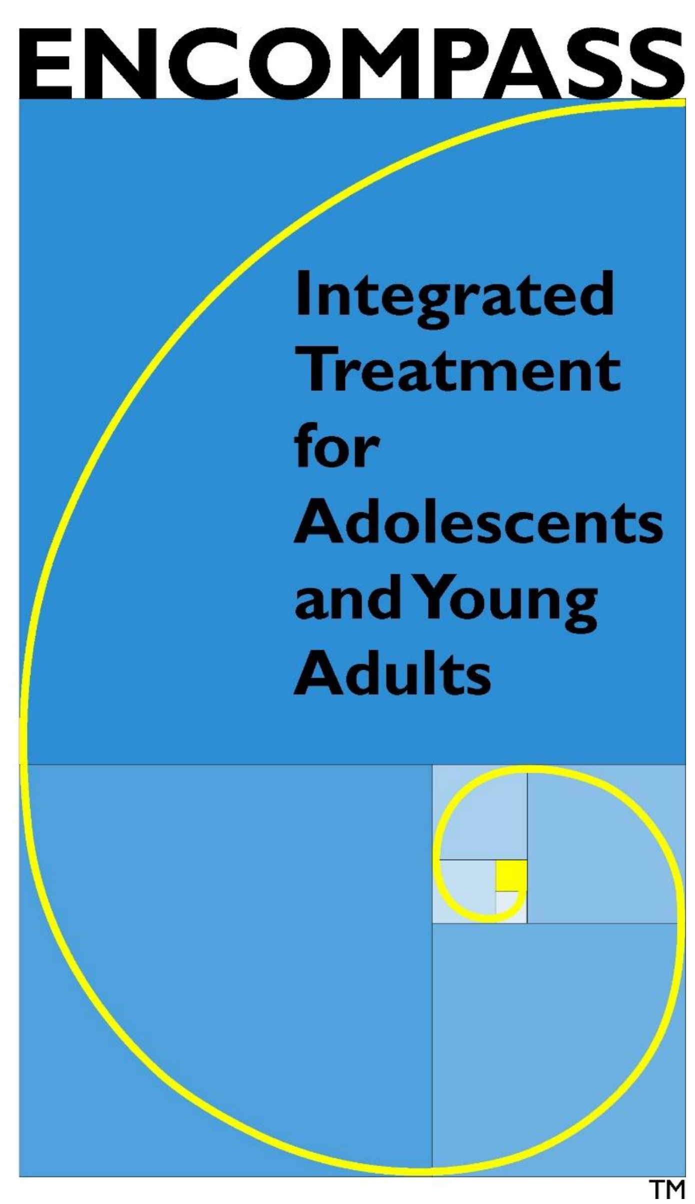
MET/CBT MANUAL



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OVERVIEW OF *ENCOMPASS* MET/CBT

The manual is comprised of 16 modules. The first three are to be done in sequence whenever possible with all patients as they are essential for building motivation for change (Module 1: Motivation and Engagement) and establishing treatment goals (Module 2: Personal Feedback and Goal Setting). The functional analysis in Module 3 provides essential and specific information regarding a patient's specific 'triggers for use" and high risk situations which help guide the selection of subsequent skills training modules to individually tailor treatment for each patient. Modules 1-3 can generally be completed in the first three sessions. For most patients, Module 4: Coping with Cravings should be the first skills module after completing modules 1-3. However subsequent modules can be flexibly selected and sequenced as clinically indicated. It is it is important to note that a module does not have to be completed in a single session. Some skills training modules may require two sessions to complete. Although most sessions are individual, as many as three family sessions may be included when a specific family problem or issue directly influences or triggers the adolescent's substance use (e.g. parent /child communication problem; parent/sibling substance use etc). It is also important to include the final module "Wrapping Up/Saying Goodbye" for all patients who will not be continuing to see the same *Encompass* therapist for continuing care after completing the primary *Encompass* intervention.

Guide for Structuring MET/CBT Sessions

This following format should be generally adhered at each session with the exception of session #1 when there won't be at-home practice to review and no TLFB until session #2. It is perfectly acceptable to change the order in which you discuss things (e.g., you may want to include discussion of pro social activities tried during the week as part of the check in). The following is intended to be a general guide for structuring sessions in order to ensure that there is sufficient time to teach/introduce and practice new skills and discuss practical ways of practicing those skills in the upcoming week (i.e., "at-home" practice).

A. Check In

The beginning of each session is for "checking in" with the patient by asking, *"How did your week go?"* and/or *"What challenges did you face this week with your sobriety/substance use?"* The general check-in is meant to be brief, so it is important to avoid being sidetracked by the patient. Remember what was said so you can refer to it within the context of the session and skills chosen for that week. You will use all the information you gather from the "check-in" to help you select the topic for this session. Kadden (1992) writes:

> There is frequently conflict between the desire of patients to get help with their immediate problems and the desire of the therapist to get on with the day's agenda. As a result, the first phase of the session often lasts longer than the therapist would like but shorter than the patient desires. (p. 11)

When you do a status check at the beginning of the session, use an open-ended question (e.g. *How have you been doing since I saw you last?*) followed by reflective listening. Except in the event of crisis, keep this check-in relatively short (<5 minutes). It is easy to get sidetracked. At times the therapist may need to gently remind the patient that therapy is time-limited and help redirect the session back to the primary treatment focus.

B. Review of Substance Use in the Past Week/Since the Last Session

The check-in at the beginning of each session should segue in a natural flow to review of substance use (for each substance used) since the last session using calendar-based Time Line Follow Back (TLFB) procedures, starting in session #2 and accounting for all days through the day of the last session. It is important that during this process the therapist be mindful that the patient may be feeling concerned about answering these direct questions about substance use, perhaps wondering how the information will be used. Assure him/her that this information is important for guiding treatment and will NOT be shared with other people (e.g., parents, schools, probation, etc.) Patients often start out answering questions vaguely, but, with encouragement and using principles of motivational internview, patient's typically become comfortable with identifying and describing their use. The therapist should help them to anchor their memory in specific events of the past week, birthdays, school and sporting events, parties and other social events. It is important to establish a rhythm early in treatment, allowing enough time to establish a tight procedure without becoming overly bogged down in the process. Ideally, it should take about 5 minutes after a few sessions of practice.

C. High Risk Situations

Reviewing and documenting the patient's report of substance in the past week/since last session provides an opportunity for the therapist to identify and recognize times the patient did and did not use since the last session and to explore with the patient the context, circumstances, and environmental cues or internal triggers for use as well as the context/setting/circumstances and times the patient did not use in the past week. The therapist should be especially alert to times the patient did not use in circumstances, situations, or times of day that the patient would normally or habitually use. These are opportunities to explore if the patient used new a new coping strategy, problem solving or decision-making skills to thwart urges or "triggers" or high risk situations for substance use. it is also important to ask non-judgemental, open ended questions about the specific circumstances and context of times the patient used substances in an effort to increase patient's awareness of the relationship between environmental cues, mood states, external factors and circumstances and their patterns of use. A patient's growing recognition of triggers and high risk situations is a critical first step towards changing substance use behaviors and learning how to anticipate and manage high risk situations and build self-efficacy regarding behavior change. This exploration also helps the therapist identify skills needed (module selection) that may be most helpful or useful in helping patients change their substance-using behaviors. Review of substance use since the last session also provides an opportunity for the therapist to identify and acknowledge circumstances, situations, and patterns of non-use. It is especially important to identify when the patient did not use substances that appear to break old patterns and explore relationship between times of non-use and application of skills acquired during treatment. The patient should be asked to describe one or more high-risk situations in which he/she did and did not use since the last session. The discussion should include any specific actions that were taken to avoid or cope with the situation(s) or, in cases when the patient did use, what could have been done differently. Try to elicit as much detail as possible. Patients who are **not** trying to reach abstinence can still be asked to describe a situation that they recognized as high risk and to talk about their thoughts and feelings (triggers) in this situation. You might suggest skills they could use under these circumstances; however, take care not to push these patients too far if they are unwilling to consider abstinence. Motivational interviewing skills can be used to evoke "change talk" with some of these patients.

D. Review Assigned Home Practice

It is critical that you remember to review the at-home practice assigned the last time you saw the patient "making an effort to praise all approximations to compliance with the assignment"

(Kadden et al., 1992, p.14). When doing this, explore any difficulties encountered in carrying out the assignment. When necessary, it can be helpful to reinforce the importance of extra-session practice of skills when learning new behavior/skills, e.g. *"practice outside of sessions makes all the difference."* If a patient arrives at the session without completing his/her homework, simply remind him/her of the details of the assignment and take the time at the beginning of that session to complete it together. This may require some adaptation of the assignment, such as performing an additional role-play. Encourage the patient to try this or a similar assignment again during the next week and offer more suggestions on how to approach it. Be careful not to assign only written at-home practice as some patients become easily frustrated with these types of assignments. The worksheets in the patient workbook can be started during the session and then assigned for at-home practice. The best assignments are ones that require the patient to observe old and to monitor new behaviors. Take enough time at the end of the session when assigning at-home practice to make sure the patient understands the assignment and its purpose. Compliance and completion of at-home practice assignments can be significantly enhanced by asking the patient to identify or anticipate high risk situations, circumstances, scenarios or opportunities to practice relevant skills that are likely to arise in the upcoming week.

E. Agenda Setting/Providing Rationale

The initial check-in, review of substance use /TLFB and discussion of high-risk situations and home practice provides important information to collaboratively guide the focus /next steps in treatment and selection and ordering of modules that will be most useful for each individual patient. The therapist should establish clear expectations and provide a rationale for the tasks and focus of each session. While you expect your patient to participate in the session's activities, it is important that you inform him/her about the topics you plan to cover during the session and the rationale. Typically, this will occur after you have collaborated on choosing a module for the current session. Checkin at the next session will guide whether it makes sense to continue focusing on skills acquisition and consolidation in the current module or collaboratively decide which module and skills would be most useful to focus on next. Giving the patient choices promotes stronger involvement and participation and may decrease resistance to treatment (Myers et al., 1998). With some patients, it works well to choose a module at the end of the preceding session, but remain flexible as patients' needs may change over the course of the week. For other patients, it works better to choose the session at the beginning of the new session. Either approach is fine.

Whenever possible, connect the topics that the patient would like to discuss with a particular skill or skills, e.g. arguments with family might provide a strong rationale for the Communications module or described isolation for doing the Social Support module. Connecting topics with current life events is not always possible. However, such segues will be more effective if the issues become part of the context for the skills portion which takes place next and reinforces the spirit of collaboration so important in sessions.

It is essential that you invite and encourage input. With patient input, there is a greater likelihood of buy-in for that session. However, with some patients this buy-in will be difficult to accomplish. You may want to say something like:

> *I realize we still have lots of material to cover. Considering what you have just told me about what happened [what you are worried about…what you want to get done, etc.], perhaps it would be a good time to work on these skills . . .*

After a few sessions, the rhythm and flow of the session, such as starting with check in and review of at-home practice and ending with assignment of at-home practice, will become established. If you are working with a patient who may benefit from additional structure, you can write these steps down on a flip chart or white board as a reminder. When introducing the module, provide a clear rationale for the topic. The rationale for the new skills should be related to patients' substance use goals whenever possible (if they have set one) and to dealing with other problems that they have identified. If a patient has not set a substance use goal, continue to forge ahead and try to make connections between substance use and other current life problems. Look for an opportunity to discuss the patient's substance use. You will find examples for presenting the rationale at the beginning of each module.

F. Coping Skills Training

The heart and soul of a cognitive-behavioral therapy is the extent to which the therapist is able to effectively teach, model, review (as necessary), and rehearse specific skills with the patient. The most effective way to do this is usually to explain the new skill step-by-step using relevant examples from the patient's life, to model different approaches, and then to have the patient practice with what you've modeled or another life example. Over time, you will develop your own style for teaching the skills. However, be careful not to lecture and to use language that the patient can understand. Skills guidelines can be presented verbally, written on a white board or flip chart, and printed in handouts (handouts are available for patients for their therapy folder.) When you are modeling for a patient, it is reasonable to use some personal examples, e.g. times when you have tried to change a habit and things that have worked or not worked in this process. This form of self-disclosure can be very helpful. At the same time, it should not include intimate and personal details of your life and should not be overused during treatment. In order to keep the patient involved, it is important to include him/her as much as possible as you teach new skills. Maintain involvement by using examples from his/her life as you teach, and especially when you start to practice skills.

The in-session practice is central to the skills-training program, as these are the main strategies by which patients acquire new skills. While practice typically takes place during the latter part of the session after the new skills have been taught, practice can be introduced at any time during the session when it is relevant to do so, e.g., a role play during the check in may reinforce a particular skill that was used (or not) to manage a high risk situation. The in-session practice will often involve the therapist and patient practicing the new skill together, typically using role plays.

G. Role Plays

Behavior rehearsal role plays are very important for learning new skills. As you do role plays, you will feel like a teacher, an actor, and a therapist! Reassure the patient by sharing that role playing can be an awkward process but that, with practice, it becomes much more comfortable. Role plays are an opportunity to provide empathy for patients and to understand better the difficult situations they often face in their lives. Be willing to dramatize. The patient may look at you as if you have two heads at first, but over time they will appreciate your knowledge about their particular life scenarios. It shows that you really care when you tolerate some smirking and a bit of disdain early on.

H. Pro-Social Activities: One of the critical components of *ENCOMPASS* is to have the patient select and engage in activities that are incompatible with drug use and that help him/her to form

new relationships with non drug-using peers and mentors or pro-social adult role models. The therapist should be helping the patient to identify these activities as early as the first or second session. Therapist and patient collaboratively select two such activities each week and patients may earn one prize draw for each of two activities completed (with documentation of completion) the following week. A clinical strategy to guide selection of appropriate activities should be based on consideration of: a. activities that are enjoyable but non-drug-related or incompatible with substance use; b. activities that occur during high risk times of the day or week (i.e. after school; weekends); c. activities that put the adolescent in association with non-substance involved peers and/or of pro-social adult role models or mentors that facilitate building a more drug-free lifestyle. It is important to discuss realistic steps toward engaging in these activities and to help in this process when it seems that might be necessary with a particular patient who is having difficulty. Examples of appropriate activities are listed in the Participant's Workbook.

I. Assigning At-Home Practice

The final thing you will do in the session is to assign at-home practice. As a rule, the focus of at home practice assignments will be an extension of those skills introduced or practiced during the current session. A key strategy for successful completion of at home practice assignments is to select specific situations or circumstances or high risk situation that is likely to arise or present an opportunity to practices the specified skill in the upcoming week in the context of of the patient's real life experience. For example, if anger has been identified as an internal 'trigger for use" and anger management skills is the focus of the current session, ask the patient to identify two specific situations or circumstances in the previous week or upcoming week that are likely to elicit anger. Role play at least one of the scenarios and teach new skills and elicit demonstration of new skills in the session. A relevant at home practice assignment for the next week could then be to apply these new skills in the relevant anticipated scenarios or circumstances that offer a naturalistic opportunity to practice the skill. Another way to increase completion of assigned at home practice is to avoid labeling it as "homework". Selecting an alternative skills practice exercise may also be useful if the anticipated opportunity/scenario doesn't arise.

PARTICIPANT'S WORKBOOK

Each patient will be given a Participant's Workbook at the beginning of treatment. The patient workbook contains didactic material, handouts, and at-home practice assignment worksheets that will be completed and collected as therapy progresses. (The same materials have been integrated into this manual in the appropriate modules.) Let patients know that the workbook belongs to them and will be an important source of information during the therapy and afterwards. Ask them to bring it in each week, as you will be using the materials together during sessions. It is best to encourage them to take responsibility for bringing it in from week to week. If they forget it one week, ask them how they might be able to remember to bring it the following week. Have them practice those solutions. If a patient has great difficulty remembering to bring it in weekly, you could keep the workbook in a locked cabinet at the clinic. It is useful to have extra materials for sessions readily available in case you need them during a session. Some patients and therapists may prefer to select/receive specific worksheets and/or at home practice exercises each week instead of using and keeping track of a Participant's Workbook. In which case it is useful for therapists to keep module-specific materials on hand. For patients who have trouble keeping track of their Participant's Workbook, the therapist may choose to have module-specific worksheets printed as separate handouts for at home practice.

THEORETICAL FOUNDATIONS

Background

The effectiveness of skills-based cognitive-behavioral (CBT) interventions for adult substance abuse has been well established in several clinical research trials conducted in the United States. Such research has shown empirical evidence for the efficacy of CBT for a variety of psychiatric disorders in adults and adolescents, including depression, anxiety disorders, and substance abuse and dependence. The following manual incorporates the basic content of the several different adult skills training approaches (Carroll, 1998; Kadden et al., 1992; Monti et al., 1989). Because of its emphasis on developing coping skills and the continuous practice of these skills in vivo, CBT has proven to be an effective treatment model for reducing substance use and preventing relapses (Marlatt and Gordon, 1985). It has been shown that learning processes play an important role in the development of substance use disorders (SUD). It follows that learning processes can also help individuals reduce their substance use and maintain abstinence. CBT is compatible with other treatments including 12-Step programs, psychotherapy, family interventions, pharmacotherapy, and substitution maintenance programs (Beck et al., 1993).

In two randomized trials comparing the effectiveness and cost-effectiveness of five short-term outpatient interventions for adolescents with cannabis use disorders, Motivational Enhancement Therapy plus Cognitive Behavioral Therapy (MET/CBT) was shown to be as effective as and significantly more cost effective than the longer and resource intensive family treatment approaches (Multidimensional Family Therapy and Family Support Network) also tested (Dennis et al., 2004). In a review of evidence-based psychosocial treatments for adolescent substance abuse, individual CBT was evaluated in seven studies (Waldron and Turner, 2008). Six out of the seven studies found significant pre- to post-treatment reductions in substance use with the CBT modality. Therefore, individual CBT as a treatment for adolescent substance use has received the classification of “well-established” treatment.

Some authors have cautioned that skill-based strategies found effective in adult populations may not be directly transferable to adolescents and young adults because of differences in drug use patterns, consequences, post-treatment stress, and coping strategies (Brown et al., 1989). However, evidence for the effectiveness of cognitive-behavioral treatments in the adolescent population is accumulating (Deas and Thomas, 2001; Myers and Brown, 1990a; Myers and Brown, 1990b; Myers et al., 1993).

The substance abuse treatment field has accepted that adult models of addiction and treatment, unless modified, are inappropriate for adolescents. Consequently, new theoretical frameworks, basic research, and corresponding interventions have been devised specifically for adolescents (Godley et al., 2001; Sampl and Kadden, 2001; Webb et al., 2002). Hence, the following manual incorporates the basic content of the adult skills training approaches with the addition of a developmentally appropriate focus, e.g. shortened and simplified verbalizations for adolescents.

Developmental Issues for the Adolescent Patient

Key developmental issues during adolescence include separation/individuation with a consolidation of identity and values (Erikson, 1959; Mahler, 1975). Thinking during this stage becomes more future-oriented with trying out of adult roles and behaviors. Building and maintaining peer groups are extremely important. In the area of cognitive development, adolescents are moving from concrete thought operations to abstract thought operations (Piaget, 1969). They are beginning to think through and beyond the literal meanings of things, with a

more developed sense of cause and effect. The primary developmental task of adolescence is to assert separateness from parents and other family members and to experiment more forcefully with belonging to various peer groups. To achieve this more differentiated sense of self, adolescents have to negotiate numerous external limits set by family and other authorities and demands for conformity by traditional and more deviant peer groups. Skills development is critical during this time in the service of increasing self-efficacy and a sense of mastery. During this stage, adolescents are learning how to: identify affective states and to cope with negative emotions; use self-observation and self control; and manage disappointment and loss in non-self destructive ways that also preserve self esteem. Following normal developmental pathways, there should be an increase in executive functioning, which overrides impulsive "acting out" on momentary desires with greater consideration of the consequences of actions (not just short-term but long- term as well). Adolescents' need for power and experimentation are also important developmental tasks. With a fragile sense of self, adolescents often display great sensitivity to getting their feelings hurt. In order for treatment programs with adolescents to be successful, each of the above developmental issues needs to be addressed. Without doing so, you can expect premature dropout.

Adolescents with substance abuse have even greater vulnerabilities in terms of developmental and skills deficits. They can have deficits in psychosocial and academic functioning, with low self-esteem often accompanied by feelings of shame. Because of their substance use, they often have had less success in critical life domains as compared to non-using peers, most particularly in academics and in developing healthy, mutually satisfying relationships. Substance-dependent adolescents have difficulty managing themselves from an internal locus of control. Instead, they often operate from an external locus of control. They can be easily influenced by what others might tell them to do or not to do instead of following an integrated sense of right and wrong. They have inadequate coping skills to use in day-to-day events and when facing personal crises.

By joining with the adolescent where he/she is, the therapist has opportunities to increase skills in problem solving and communication, to enhance self-observation skills, and to build awareness of decision-making and ambivalence. To be most effective, the therapist should steer him- or herself toward the role of coach, rather than of an authority figure by encouraging each step in the adolescent's progress. It is important to focus on technical skills training as a means of patients improving their lives versus interpreting their skill deficits as the result of intrinsic failure or lack of talent. Use of techniques, such as modeling and practicing with role plays, will foster self-efficacy and mastery in the adolescent. The supportive therapist should establish a therapeutic environment which is empathic and non-judgmental and which helps the adolescent honestly assess his/her strengths and weaknesses.

Why Individual CBT and Motivational Interviewing?

CBT is a short-term, comparatively brief approach with structured activities and expectations. Combined CBT with Motivational Enhancement Therapy (MET) has been demonstrated to be among the more cost-effective behavioral therapies for this population (Dennis et al., 2004). These features also make it well-suited for the cognitive attention span and developmental needs of adolescents. In clinical trials comparing the outcomes of different behavioral treatments, the most cost-effective interventions were combined CBT and Motivational Enhancement treatment arms. In individual CBT, the patient can safely express and challenge ideas, build self-efficacy, and establish appropriate boundaries within the confines of a therapeutic relationship. The expectation then is that each of these tasks will be practiced with family, peers, and other members of the patient's community.

While there may be advantages to a group process for adolescent substance use treatment, such as modeling by peers and development of new support systems, there are also disadvantages (Dishion et al., 1999). In an individual treatment, there is ample opportunity to provide attention to the particular problems and issues of the patient without becoming sidetracked by the group process. During Phase 1 of this treatment, sessions allow for particular attention to an individual's readiness for change, exploring internal incentives and barriers to change in a therapeutic process. Individual treatment also allows the therapist to tailor interventions to the patient's specific goals, strengths and weaknesses, and skills. CBT requires a detailed examination of the substance using behavior (during the functional analysis described below), a process that is done carefully during the individual sessions.

In a manual on CBT for treating adults with cocaine addiction, Carroll describes the primary aims of CBT as "to help [patients] recognize, avoid and cope (1998, p. 1). That is, RECOGNIZE the situations in which they are most likely to use . . . AVOID those situations when appropriate, and COPE more effectively with a range of problems and problematic behaviors associated with substance abuse." There are several features of an individual CBT that make it particularly promising as a treatment for adolescent substance use disorders (SUD).

Strengths of CBT for Treating Substance Use

- Collaborative vs. authoritarian patient/therapist relationship
- Active versus passive (requires participation)
- Highly structured and focused
- Views the substance problem as a *technical* one with a technical solution versus a *moral failure*
- Teaches patients to apply skills, and not just willpower, to maintain abstinence
- Helps patients change the way they view themselves, their life, and their future

Theory behind the Therapy

During this therapy, patients will learn to set behavioral goals and to effectively use new coping skills. Patients are taught to generalize these skills to specific situations to reduce or eliminate their substance use. Skills training interventions such as thought management or assertive refusal to participate in drug use will help adolescents manage situations in which they experience pressure to use. The skills training approach outlined in this manual is based upon the Stress and Coping Theory (Lazarus and Folkman, 1984) and Social Learning Theory (Bandura, 1977). These models construe addiction as a maladaptive way of coping with stress. Stressors, such as family and school problems, are situational demands upon an individual; the resulting interaction between the individual and the demands results in stress. Lazarus and Folkman describe a cognitive approach to understanding how one's appraisal of a situation and perception of control in that situation determines the level of stress experienced. Stress then is considered an imbalance between environmental demands and an individual's resources. Coping is the attempt by the individual to meet demands and to restore equilibrium between the individual and the environment. Without adequate coping skills to meet the demand, substances may be used as an attempt to restore equilibrium. A key principle of *all* sessions in this skills-based treatment is to *decrease* the internal and external pressures on the patient to use (e.g. negative self-concept, peer pressure) and concurrently to *increase* feelings of control for the

patient (e.g. skills to manage cravings, refusal skills). The premise of the Social Learning Model is that patients can take responsibility for learning new behaviors and can learn to better manage their genetic and social learning vulnerabilities. In this model coping skills are taught to help remediate deficits that have been missed during adolescence and perhaps earlier.

There are several ways that people *learn* to use drugs, including modeling and classical and operant conditioning (Carroll, 1998). In this treatment, modeling, recognition of triggers, verbal feedback, and praise are powerful tools used to relearn behaviors to obtain abstinence. In the manual, there are several different exercises used to produce behavior change, including role playing, behavioral rehearsal, activity scheduling, systematic desensitization (imaginary and *in vivo*), assertiveness training, social skills training (communication), and exposure and response prevention. The patient's diagnosis, level of intellectual functioning, personality style, and particular skill deficits are taken into account when choosing particular strategies. Behavioral therapy is different from other therapies in its aims and strategies. The synopsis below can be useful as the therapist considers his or her approach to treatment.

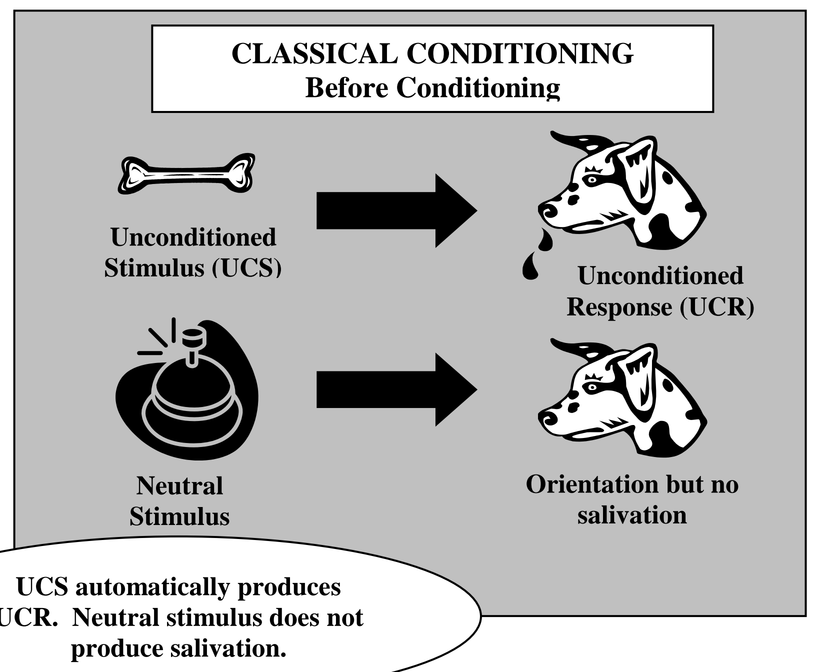
Features of Behavioral Therapy

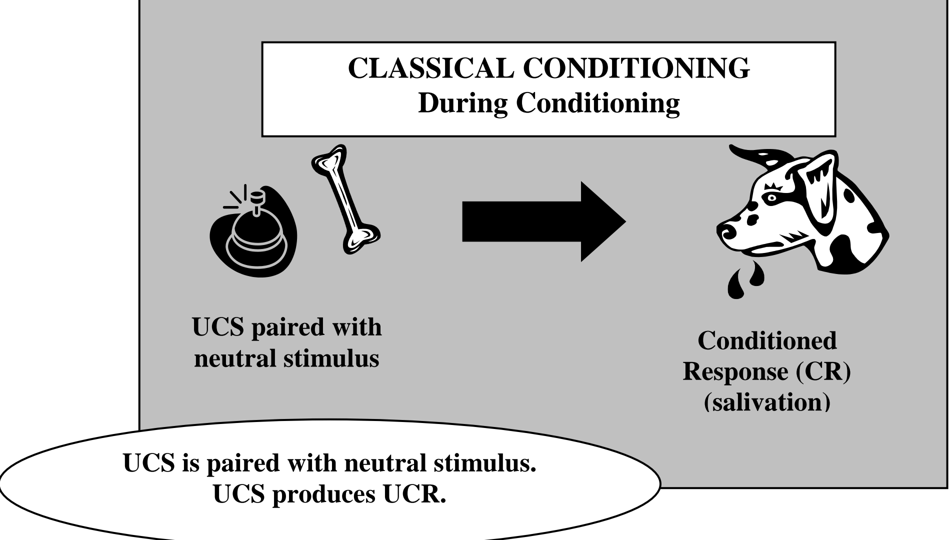
- Concentrates on maladaptive behavior rather than on some presumed underlying cause
- Concentrates on the here-and-now (present)
- Utilizes specific, clearly-defined treatment goals
- Selects treatment methods specific to the identified problem
- Subjects its techniques to empirical testing (i.e. strategies should produce a desired change such as completing an objective or reaching a goal)
- Uses learning principles to modify maladaptive behavior

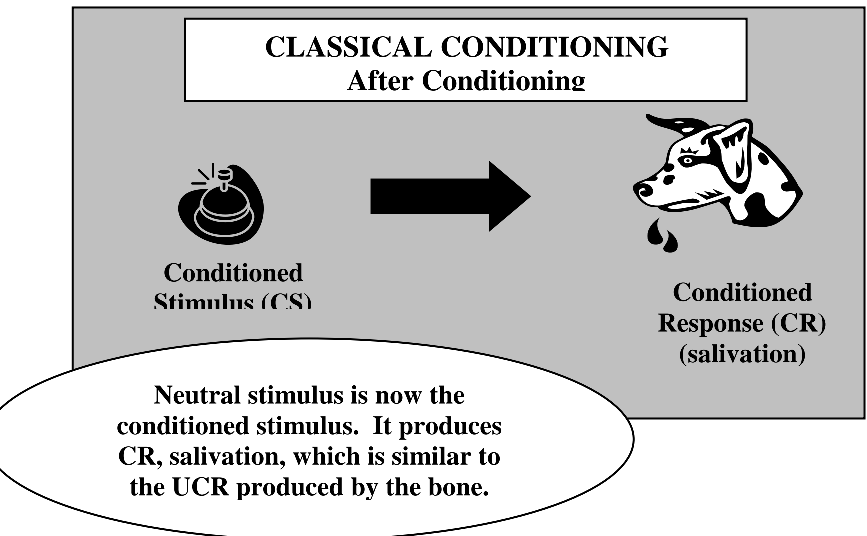
Classical Conditioning

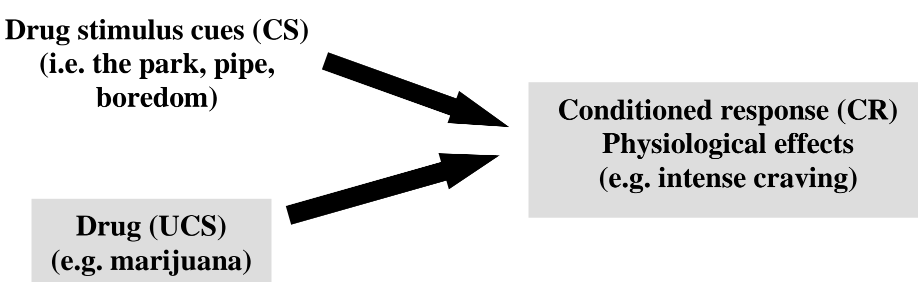
An understanding of classical conditioning is integral to the effective delivery of this treatment, in particular toward the management of high-risk exposures and for the reduction of cravings. While you won't likely use the technical terms in the treatment setting, it's important to understand them. First, let's define some terms. **Classical conditioning**, also called Pavlovian conditioning or respondent conditioning, is a two-step learning process in which repeated pairings of a **conditioned stimulus (CS)** with an **unconditioned stimulus (UCS)** elicits a **conditioned response (CR).** Over time, repeated exposures to the conditioned stimulus *without* the unconditioned stimulus would produce the same conditioned response. In Pavlov's conditioning experiments with dogs, the presentation of food was the unconditional stimulus because it evoked the natural response of salivation in preparation for eating. In Pavlov's conditioning experiments, the neutral stimulus is the tone. When the tone gets paired with the food, the previously neutral tone elicits salivation. The newly conditioned tone is the CS. The salivation is referred to as the conditioned response.

The sequence of steps in classical conditioning (before, during and after) is illustrated in the three diagrams below.


CLASSICAL CONDITIONING
Before Conditioning
Unconditioned Stimulus (UCS)
Unconditioned Response (UCR)
Neutral Stimulus
Orientation but no salivation
UCS automatically produces UCR. Neutral stimulus does not produce salivation.


CLASSICAL CONDITIONING
During Conditioning
UCS paired with neutral stimulus
Conditioned Response (CR) (salivation)
UCS is paired with neutral stimulus. UCS produces UCR.


CLASSICAL CONDITIONING
After Conditioning
Conditioned Stimulus (CS)
Conditioned Response (CR) (salivation)
Neutral stimulus is now the conditioned stimulus. It produces CR, salivation, which is similar to the UCR produced by the bone.



In a drug use application, the unconditioned stimulus (UCS) would be the drug itself, as it evokes the natural response of craving on its own. The conditioned stimulus (CS) could be any number of things such as drug paraphernalia, places, and certain people. Over time, the user pairs these neutral stimuli with the unconditioned stimulus to produce a conditioned response. Eventually, exposure to the stimulus cue alone will produce the same response as without the stimulus. For patients trying to manage cravings, the effect of exposure to a conditioned stimulus is a loss of internal control as, once the association with a drug is made, the response is automatic. A primary aim of treatment is to help patients recognize their stimulus cues (from hence forward in this manual called "triggers") and to avoid them whenever possible. In addition, the treatment emphasizes finding alternative activities to produce a desired physiological effect, such as a relaxed state.

Operant Conditioning

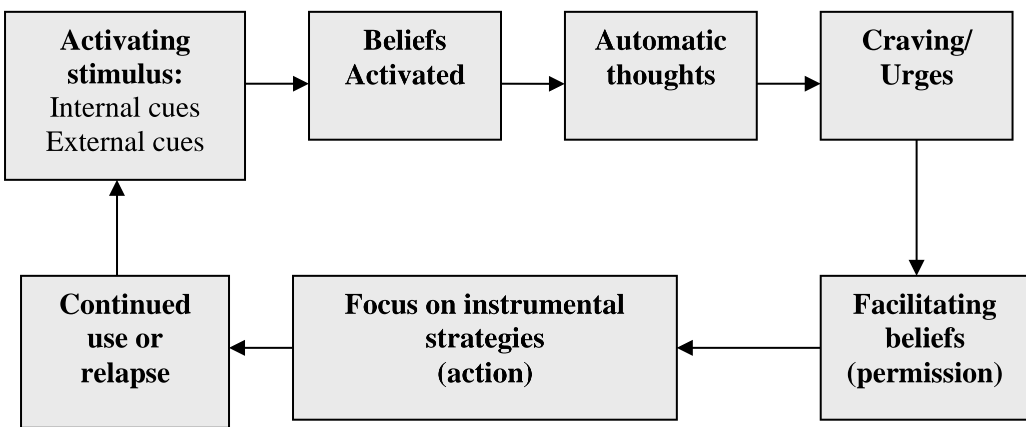
Operant conditioning is another learning process, which features prominently in the unlearning of behaviors in this treatment. Operant conditioning is an analytical response having to do with cause and effect. An understanding that behaviors are either strengthened (increased) or weakened (decreased) by their consequences is essential to affecting change with substance abusing patients. Simply stated, substance use is developed and maintained through the consequences (positive and negative) of use behavior. It is important to remember that these consequences are unique for every patient. Patients learn to expect positive experiences, thereby reinforcing their use. Pleasant thoughts, feelings, and physical sensations associated with use typically become stronger as time goes on. On the other hand, negative consequences in a variety of domains -including interpersonal, academic, and employment, among others- tend also to increase as use progresses to dependence. With information about a patient's reinforcers, therapists can establish healthy behavior changes. Carroll (1998, p. 18) writes: "Therapists attempt to help patients develop meaningful alternative reinforcers to drug abuse, that is, other activities and involvements (relationships, work, hobbies) that serve as viable alternatives to . . . abuse and help them remain abstinent." The therapist's task is to help the patient evaluate both the positive and negative consequences of substance use and, ideally, to tip the balance toward change.

Contributions of Cognitive Therapy

Cognitive therapy was designed to reduce unpleasant or uncomfortable feeling states by challenging and altering thoughts and beliefs and how one processes and interprets events. Cognitive therapy changes affective states (moods) by teaching how to cope with and redirect negative reactions. Instead of behaving maladaptively in response to feelings and errors in thinking, adolescents are taught how to apply cognitive restructuring.

The publication of *Cognitive Therapy of Substance Abuse* significantly boosted applications to the treatment of substance use disorders (Beck et al., 1993). In this seminal text, Beck and his colleagues apply the fundamentals of cognitive therapy to the treatment of addictions. Recognizing the potency of cognitions in determining maladaptive behaviors, cognitive therapy specifically addresses the patient's expectations and beliefs. Specifically, it addresses drug-related beliefs and the automatic thoughts that contribute to urges and cravings. This model is depicted in the diagram below:

Complete Model of Substance Abuse

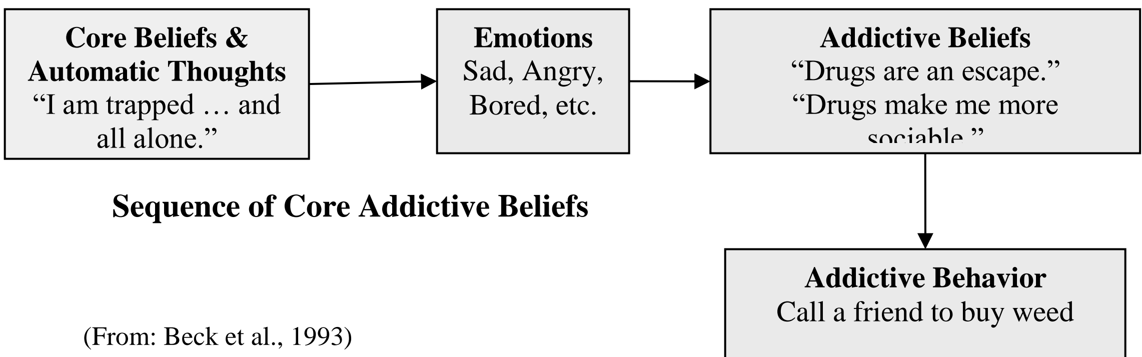


(From: Beck et al., 1993)

The Role of Core Addictive Beliefs

Understanding how core addictive beliefs influence behavior can be immensely beneficial in supporting behavior change with patients. Understanding how beliefs affect behavior is challenging for adults, and even more so for adolescents who are not well-practiced in making rational decisions when they are emotionally upset. Training in cognitive restructuring with adolescents can help them recognize differences and similarities between things (categorize) and to separate thoughts from feelings and behavior (decrease impulsivity).

The diagram below describes the sequence of steps from *core beliefs & automatic thoughts*, through negative *emotions* and *addictive beliefs*, finally, to choosing an *addictive behavior*.



Sequence of Core Addictive Beliefs

(From: Beck et al., 1993)

The premise is that if addictive beliefs can be altered, the patient can make decisions toward abstinence. In CBT, therapists help their patients articulate their core beliefs and automatic thoughts whenever possible, focusing on altering the compelling and self-destructive addictive beliefs they might hold. By no means exhaustive, below is a list of common addictive beliefs that drive using behaviors. A list of these beliefs can be invaluable as the therapist explores the patient's motivation to use.

Common Addictive Beliefs

- That one needs the substance to maintain psychological and emotional balance
- That it will improve social and intellectual functioning
- That one will find pleasure and excitement from using
- That the drug will energize the individual and provide increased power
- That the drug will have a soothing effect
- That the drug will relieve boredom, anxiety, tension, and depression
- That the craving will continue indefinitely and possibly get worse

Readiness to Change and Using Motivational Interviewing

Defining Readiness to Change

The Stages of Change model has been the basis of developing effective interventions to promote different health behavior changes, including substance abuse treatment models.[1] It is a model of intentional change, which focuses on the decision making of the individual and involves emotions, cognitions, and behavior (DiClemente and Prochaska, 1998). The model emerged from an examination of several psychological and behavioral theories about how change occurs and incorporates a biopsychosocial framework for understanding addiction. In the four-stage model, the stages are defined in this way:

- **Pre-contemplation:** The patient is not yet considering change or is unwilling or unable to change. He or she may be unaware that there is a problem.

- **Contemplation:** The patient acknowledges concerns and is considering the possibility of change, but is ambivalent and uncertain.

- **Action:** The patient is actively taking steps to change but has not yet reached a stable state.

- **Maintenance:** The patient has achieved initial goals such as abstinence and is now working to maintain gains.

[1] Motivational Interviewing (MI) and the Stages of Change model are often confused and fused. In fact, they developed separately but synchronously. The Stages of Change model provided some theoretical backbone for MI as it developed. MI is considered to be useful for people who are in the early stages of change (Treasure, 2004). For the purposes of this intervention, we are choosing to incorporate the concept of readiness to change as a means to non-judgmentally define a starting point with the patient (e.g., during delivery of the Personal Feedback Report in Module 2).

Adolescents with substance use disorders often enter treatment with a weak interest in changing these problem behaviors. Research indicates that assessing a patient's stage of change at the beginning of treatment may enhance engagement in a variety of ways. Identifying stage of change at the outset can lower resistance by addressing the patient's stated goals and can increase compliance by teaching skills that are immediately applicable (Klein et al., 2005). The advantages of matching interventions to the patient's readiness to change have been enumerated in current addictions literature (Connors et al., 2001; Miller, 1999; Velasquez et al., 2001). While these citations are not specific to adolescents, it seems reasonable that the same benefits exist with this population.

Substance-dependent patients are commonly reluctant to give up a known coping mechanism, in particular the substance use itself. It is understandable that they might feel ambivalent about giving up a coping strategy without other skills in their toolbox. Peer influences and a lack of significant negative consequences at early stages of dependence may make ambivalence particularly strong for adolescents. Therapists can sidestep such "resistance" by choosing interventions which address areas of concern to the patient. For example, a patient may be reluctant to address refusal skills for his/her substance use, but will be at "readiness" to learn and practice skills for assertive communication with peers and/or family members. An additional example would be the patient who enters treatment reporting negative consequences attached to poor affect regulation, such as legal problems, and expresses an interest in learning anger management skills.

A Stages of Change model sees therapy as a "process" of change and discards assumptions that any one approach must be used toward one end (Joseph et al., 1999). Patients are more able to move to a higher stage of change with new skills. These new skills may result in a patient making different choices about his/her substance use. The acquisition of new skills may assist someone who is in the contemplation stage to move toward the preparation stage or beyond. It is important to re-evaluate a patient's readiness to change throughout treatment by listening for change talk, such as, *"I can try that," "I guess I could do that," "That wouldn't be so hard,"* or *"It might be worth it."* These kinds of statements often herald the need to establish new substance use goals. In this intervention, therapists will use the University of Rhode Island Change Assessment (URICA) to obtain a baseline measure of readiness to change (DiClemente and Hughes, 1990).[2] (See Appendix H for URICA assessment and scoring template.) While we acknowledge that this measure does not necessarily capture all facets of motivation or successfully predict substance use outcomes, it does provide a baseline score that has clinical utility. This score will be used to open a discussion on readiness to change and motivation (see **Module 2**, **Personal Feedback Report & Goal Setting**).

Effectiveness of Front-Loaded Motivational Interviewing in a CBT Intervention

Studies with adults have demonstrated that combining Motivational Interviewing (MI) strategies with other evidence-based treatments for substance abuse, in particular CBT, has a positive impact on treatment compliance and retention (Carroll et al., 2001; Litt et al., 2005). When MI was used during interviews at emergency rooms and primary care clinics with teens assessed to be at risk for developing a drug and/or alcohol disorder, higher rates of follow-up were demonstrated (D'Amico et al., 2008; Monti et al., 1999). The Adolescent Cannabis Check-Up (ACCU) used MI to provide strategies for quitting or reducing cannabis use (Martin et al., 2005).

[2] The URICA is a 32-item self-report measure that includes 4 subscales measuring the stages of change: Pre-contemplation, Contemplation, Action, and Maintenance.

High satisfaction ratings indicated that this intervention was well received by the adolescents, a group whose members had not indicated they were seeking treatment and who didn't endorse seeing their cannabis use as a problem at the time they were interviewed. In fact, 75% indicated that they would be interested in more meetings to further discuss their use, if these were available. With this in mind, the authors of this manual front-loaded the intervention with modules focusing on Motivational Interviewing strategies and a Personal Feedback Report (PFR) with the goal of enhancing the acceptability of a pre-planned, longer CBT intervention.

Motivational Interviewing

Motivational Interviewing is a **collaborative**, **goal-oriented style of communication** with **particular attention to the language of change**. It is designed to **strengthen personal motivation for** and **commitment to a specific goal** by **eliciting and exploring the person's own reasons for change** within an **atmosphere of acceptance and compassion**" (Miller & Rollnick, 2013, p 29). The primary elements are **relational** and **strategic**.

The main strategies of Motivational Interviewing, when delivered effectively, can deflect opposition and significantly increase engagement and compliance with treatment (Miller and Rollnick, 2002).

Main Principles of Motivational Interviewing

The four central principles of Motivational Interviewing are summarized below (Treasure, 2004):

1) Express empathy by using reflective listening to convey understanding of the patient's point of view and underlying drives.

2) Develop the discrepancy between the patient's most deeply held values and his/her current behavior (i.e. tease out ways in which current unhealthy behaviors conflict with the wish to 'be good' or to be viewed to be good).

3) Sidestep resistance by responding with empathy and understanding rather than confrontation.

4) Support self-efficacy by building the patient's confidence that change is possible.

Components of the MI spirit (Miller & Rollnick, 2013)

Partnership	Acceptance	Compassion	Evocation
Collaboration between two "experts"	Accurate empathy demonstrates understanding	"...To give priority to the other's needs" (p 20)	Hallmark of MI; drawing out internal motivation

Motivational Interviewing Core Skills

OARS form the core skills used in Motivational Interviewing. Reflections are a hallmark of MI and will be the most frequently used skill followed by affirmations, open-ended questions, and summaries. Aim for a ratio of 4 reflections: 1 open-ended question. *If in doubt, reflect.*

Open ended question	• Elicits more than a yes/no answer • Often starts with What, How, Tell me about, Describe • Can be broad, or narrowed to elicit specific information
Affirmation	• Reflection of a person's strengths, skills, abilities, values, efforts • Specific, meaningful, accurate • Sounds more like a statement of fact than an opinion and often begins with "You..."
Reflection	• Expresses empathy, emphasizes *change talk*, tests hypotheses, invites clarification, prompts elaboration • Simple, forward-moving, feeling, double-sided, amplified, metaphor
Summary	• Provides structure, captures momentum, highlights *change talk* • Often followed up with a k*ey question*, such as "What do you make of this?" or "What do you think you might do next?"

Change Talk

Change talk is defined as client statements related to their desire, ability, reason, or need to change. Increased *change talk* is associated with actual behavior change. In MI, counselors use skills strategically to respond to, evoke, and strengthen *change talk.*

Listen for *DARN CAT*:

Desire:	"I wish I could quit smoking."	"I want to find a job."
Ability	"I quit before; I can do it again."	"I could go back to school."
Reason	"My PO would get off my back."	"I might do better in school."
Need	"I've got to keep my driver's license."	"I have to take my meds."
Commitment	"I will stop smoking weed."	"I will go to the doctor."
Activation	"I am ready to stop smoking weed."	"I've been noticing my self-talk."
Taking steps	"I took a different way home."	"I called 3 places about jobs."

Notice the difference between "My PO would get off my back" and "I might do better in school." The first displays external motivation, meaning that the reason to change is primarily imposed from an outside source, while the second statement demonstrates internal motivation, where the benefit of change is personally important to the individual.

In MI, the ultimate goal is to spark internal motivation. Meeting the client where they are often means starting in the external realm. Be patient and listen for opportunities to evoke reasons for change that are personally important to the client, such as goals or values that are incompatible with substance use. As you facilitate the modules, remember to reflect and elicit *change talk* along the way.

Strategies to Elicit Change Talk

The strategies below strategically elicit *change talk*. Remember to reflect before moving on to get the most out of each question. The goal is to keep the client thinking and talking, as they are the source of *change talk,* and increased *change talk* is correlated with behavior change.

- **Ask evocative questions**: Ask open-ended questions for which Change Talk is the answer. (Miller & Rollnick, 2013, pp. 171-178)
  - DESIRE:
    - What do you hope to get out of treatment?
    - How would *you* like for things to change?
  - ABILITY
    - Of the options you've considered, what seems most possible for you?
    - What do you think you might be able to change?
  - REASON
    - What might make it worth your while to...?
    - What's the downside of how things are now?
  - NEED
    - How urgent does this feel to you?
    - What do you think *has* to change?
  - ⃠ QUESTIONS TO **AVOID**:
    - ⃠ Why haven't you changed?
    - ⃠ What are the three best reasons for you to drop out of treatment?
    - ⃠ Note that these questions, while open-ended, elicit Sustain Talk and could increase discord in the counseling relationship.

- **Ask for elaboration or examples**. (Rosengren, 2009, p. 95)
  - Tell me more about what it looks like when you get depressed.
  - Tell me about a time using substances got you in trouble with your parents.

- **Query extremes.** (Miller & Rollnick, 2013, pp. 171-178)
  - Suppose you continue on as usual, without changing. What do you imagine are the worst things that could happen?
  - If you were completely successful in changing, what are the best things that could happen?

- **Explore pros and cons.**
  - What are the cons of staying the same?
  - What are the pros of making the change?

- **Look back or Look forward**. (Miller & Rollnick, 2013, pp. 171-178)
  - If you were to have a week off from your symptoms/problems, what would you do first?
  - What were things like before you started smoking weed?

- If you look ahead, how might things be different if you stopped using pills?

- **Use Change Rulers**. (Miller & Rollnick, 2013, pp. 171-178)
    - Ask about ***importance*** and ***confidence*** to change using a scale of 0-10, where 0 means "not at all important" and 10 means "extremely important."
        - How ***important*** is it for you to make this change on a scale from 0-10?
        - How ***confident*** are you that you can make this change on a scale from 0-10?
            - Follow-up: If the number is greater than 0:
                - Tell me why you're a 4 and not a 1.
                - What makes you a 6?
                - What might it take to move you from a 4 to a 5?
    - ⃠ Avoid follow-up questions like, "Why are you a 6 and not a 10"?
        - ⃠ The answer to this question is Sustain Talk.

- **Explore goals and values:** Develop discrepancy between the person's current behavior and goals and values of importance to them (Miller & Rollnick, 2013, pp. 171-178).

Responding To Change Talk

Use your *EARS* when you hear *change talk* and remember to respond to it before moving on. In MI, counselors strategically respond to strengthen motivation for, and commitment to, change. Use your *EARS* as a guide.

ELABORATE	• Ask for elaboration. ○ "Tell me more about…" ○ "What might it be like if you…" ○ "What else?"
AFFIRM	• Affirm a person's efforts, goals, values, strengths, and successes. ○ "You are committed to…" ○ "Your hard work has…" ○ "It is important to you to…"
REFLECT	• Reflect Change Talk you hear to evoke more of it. ○ Listen for DARN CAT.
SUMMARIZE	• Capture momentum by highlighting Change Talk and reflecting the main points of the conversation. ○ Follow up with a Key Question, such as

Ambivalence: A Mixture of Change Talk and Sustain Talk

As young people begin to consider making a change, they often come up reasons to change and reasons to stay the same. In MI, counselors focus on eliciting *change talk*. At times, it becomes important to acknowledge *sustain talk;* that is, reasons to stay the same.

If you decide to reflect *sustain talk*, do so simply and briefly. Listen for opportunities to reflect *change talk* that might be intertwined with *sustain talk.* Add a "time stamp," such as "right now" or "yet" to leave the possibility of change open. Several methods described below may help, and some may look familiar.

- Simple Reflection (Rosenberg, 2009, p. 153)
    - Stay close to the client's statement, but keep the conversation moving.
    - This is especially helpful when a client is agitated or upset. Reflecting simply can defuse the person's anger and help them feel heard.

- Amplified Reflection
    - Adds intensity using extremes. People will often qualify their statements, which creates movement. *No sarcasm.*
        - "There are absolutely no reasons to change your alcohol use."
        - "You are 100% happy with your life as it is right now."

- Double-sided Reflection (Miller & Rollnick, 2013, pp. 198-204)
    - Acknowledge both sides: To change or not to change.
    - Instead of using "but" which tends to negate part of the statement, use "and" to reflect the ambivalence.
    - State Sustain Talk first, then Change Talk.
        - "It's going to be a challenge to take your medication every day, and you may also have fewer side effects if you do."
        - "Smoking weed is something you have been doing with your friends, and now it's getting in the way of your driver's license."

- Shifting Focus (Rosenberg, 2009, p. 153)
    - Acknowledge that the current area is not productive right now, and shift to another topic.
        - "It sounds like applying for school is too difficult for you right now. What area do you think you can make some progress in?"
        - "Before thinking about changing your use of marijuana and cigarettes, you'd rather focus on reducing alcohol first."

- Emphasizing Autonomy (Miller & Rollnick, 2013, pp. 198-204)
    - Simply stating that the decision to change rests with the client.
        - "It's really up to you."
        - "I wonder what you'll decide to do."
        - "The decision is yours to make."

Note that the above strategies may not be effective for all clients. Use your best clinical judgment when selecting a strategy for a given situation with a particular young person. They are meant to be evocative; that is, to prompt a response. In addition to thinking strategically, consider your relationship with the client. Use only strategies that you feel will preserve rapport. Think of the above list as a menu of options.

Motivational Interviewing Four Processes

The *four processes* comprise the method of Motivational Interviewing: "They may flow into each other, overlap, and recur. It is the confluence of these four processes that best describes MI" (Miller & Rollnick, 2013, p 26). Rather than being sequential and separate phases, they serve as a road map for the clinician as they guide the client toward change. The questions below will assist you in self-assessing and progressing through the *four processes*.

Engaging
- How comfortable is the person in talking with me?
- Do I understand the person's perspective and concerns?
- Does this feel like a collaborative partnership?

Focusing
- What goals for change does this person really have?
- Are we working together for a common purpose?
- Do I have a clear sense of where we are going?

Evoking
- What Change Talk am I hearing?
- Am I steering too far or too fast in a particular direction?
- Is the Righting Reflex pulling me to be the one arguing for change?

Planning
- What would help this person move forward?
- Am I remembering to evoke, rather than prescribe a plan?
- Am I retaining a sense of curiosity about what will work best for this person?

(Miller & Rollnick, 2013, p 32)

ELICIT – PROVIDE – ELICIT: A Tool for Providing Information

EPE is an MI-consistent tool for sharing information. It guides clinicians to provide material in small pieces, taking time to prioritize the individual's interest and elicit their thoughts and reactions.

ELICIT:

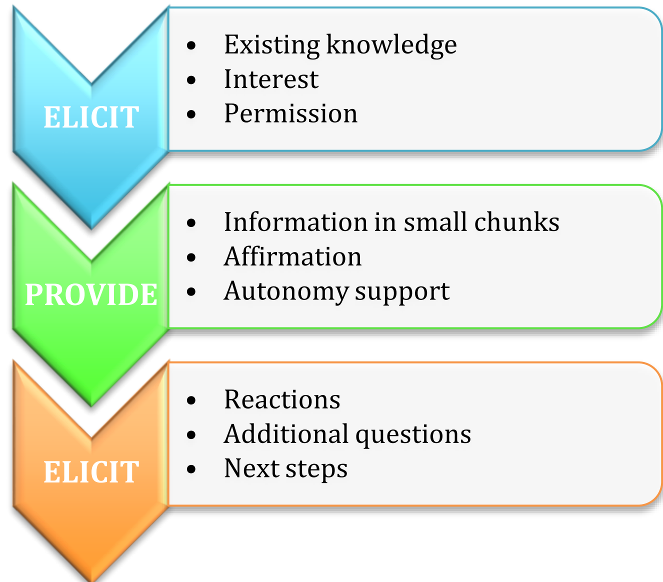
- *Existing knowledge*: "What do you already know about ways to treat depression?"
- *Interest*: "What methods to manage anxiety are you interested in discussing?"
- *Permission*: "Would it be OK to share some information about marijuana's effect on memory?"

PROVIDE:

- *Information in small chunks*: Share one piece of information at a time, choosing facts that are relevant to the client's interests using understandable language.
- *Affirmation*: "You've done some research on how alcohol affects people and are wondering how it might be affecting you."
- *Autonomy support*: "I am here to help you sort through your options; the decision about which to try is yours."

ELICIT:

- *Reactions*: "What do you make of that?" or "This surprises you"
- *Additional questions*: "What else might you be interested in learning more about?"
- *Next steps*: "What might be the next step?"



PHASE 1: BUILDING MOTIVATON FOR CHANGE

MODULE 1: Motivation & Engagement

Summary of Tasks

- Explain confidentiality with its restrictions (presenting legal document when applicable by state rules and regulations)
- Briefly describe therapy process
- Gather information on presenting problem(s) and current situation
- Initiate discussion on substance using behaviors and consequences (using OARS)
- Introduce Ruler Questions to explore "ready, willing, and able"
- Begin discussion on involvement of family or significant other(s)
- Summarize "change talk" and prepare for next session (delivery of Personal Feedback Report and Goal Setting)

Reviewing Confidentiality

The first thing you will cover when meeting with a new patient is confidentiality. The therapist should carefully explain to the patient that, unless they share information which falls under one of the exceptions to confidential information (e.g., danger to self, duty to warn, and known or suspected child or elder abuse or neglect), you will not break their confidence with anyone, including legal guardians, family members, or other collateral contacts, such as probation officers or teachers. Issues of safety, in particular instances of poor judgment, often arise when working with this population. Reassure your patient that specific information relating to such circumstances or events will remain private unless there is a need for disclosure specifically mandated in state rules and regulations. [3] You may, in certain instances, encourage the patient to disclose information to an important adult or suggest that he/she disclose within the context of a family session or telephone contact. The therapist will also review and sign the **Permission to Record** form with the patient. Before starting to record the session, specifically say that recordings are used to supervise the therapist and are *not* available to others for review without the patient's expressed, written permission to do so.

Presenting Session Rationale

High dropout rates in therapy are often related to a poor initial connection, caused by common therapeutic pitfalls. These pitfalls include getting into arguments or "debates" about the presenting problems, talking too much and not listening to the patient, not asking about the patient's concerns regarding treatment, and overwhelming the patient with too much information, among others. It is helpful for the therapist to use the first contact with the patient as an opportunity to validate the presenting problems with extreme care. This cannot be overstated, as there is no more important task in laying the foundation for a successful treatment.

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[3] In some states, therapists are required to have the patient and legal guardian(s), when applicable, review and sign a legal form that explains the rights of the patient and the responsibilities of the therapist, including protection of confidentiality and any exceptions. Therapists should be prepared to explain and answer questions about state regulations on protected information in language that can be understood by a teen.

For both experienced and inexperienced therapists alike, the first interview with an adolescent can provoke anxiety, leading therapists to talk too much and listen too little—even more so when you are learning a new intervention. While there are specific content areas to cover in this session (see *Summary of Tasks* above), the focus of the first session is to establish rapport and to engage the patient ***using motivational interviewing skills.*** This translates into "doing less"—asking fewer question, talking less, and avoiding telling the patient what to do. "Doing less" gives you plenty of room to connect with empathy and will prevent you from falling into the "authority/expert trap."

In presenting a rationale for this session to the patient, you can say:

> *We will be meeting on a weekly basis for the next 16 weeks, so I'd like to begin by getting to know each other. I will be asking you some questions about your life and what is happening with your substance use. I will also explain what we will be doing in the therapy so you know what to expect. Feel free to ask any questions or speak up if something is not clear. How does that sound?*

Listen carefully to your patient's response(s), reflecting what you hear before launching into the key interventions outlined below. In many cases, patients' answers will be brief, and their body language (e.g., sitting back, arms folded, eyes downcast) might indicate that there might be more on the patient's mind than what is being said. If this is so, consider asking a follow up question such as, "*What are your thoughts about being here today?*". Take this opportunity to use a reflection to respond to any concerns or questions he/she might express about being in therapy or his/her understanding of the process. Ask your patient's permission to share more about what will happen in your work together.

> *You mentioned feeling upset about being here today. A lot of people come in here expecting to be labeled and told what to do. I am really glad that you brought up your feelings about being here and starting therapy. That is not at all unusual. Would you be OK with me telling you more about what we will be doing together?*

Take the time to listen to your patient at this point in the session, exploring any concerns that he or she might express. At other times, a short answer is nothing more than the patient letting you know he/she is ready to move forward with the session. At this time, keep moving forward with the interventions outlined below.

Describe the Therapy Process

It can be helpful to learn something about previous therapy experiences, if there have been any. You can ask any of these open-ended questions to elicit information:

- *What have your therapy experiences been like?*
- *What did you like? What didn't you like?*
- *What was helpful? What wasn't helpful?*
- *What do you hope to get out of this therapy?*

Briefly reflect and summarize what patients tell you about previous therapy experiences and their expectations about your work together:

It sounds as if you really liked . . . but didn't like . . . It helps when the person you are working with gives you ideas of what you can do. You are interested in learning some new ways to manage your anger and to get along better with your family. Those are excellent things for us to work on together.

If they haven't been in treatment before, you can ask them about their expectations for this therapy:

It would be very helpful for me to hear a little bit about how you are feeling about coming to therapy, as this is a new experience for you. Some people come with expectations or ideas of what it will be like—sometimes these are positive, sometimes negative. What were you thinking about therapy before coming?

Be careful not to jump into agreeing with or confronting what patients say about their previous therapy experiences or negative expectations (if they are negative). Remember, your job is simply to listen and reflect (not to persuade or convince by force of argument). By using these questions and reflective statements, you will greatly reassure your patient that you will be an active listener.

When you begin, it is tempting to launch into how "effective" this therapy can be, which is not likely what your patient is concerned about at this time. Most adolescents are going to be more interested in the "facts," such as how often you are going to meet, for how long, and what is expected of them. The entire intervention does not need to be described in detail at this point. However, you should be prepared to explain how this therapy might be different from previous experiences the patient may have had. You can choose to cover this topic at the beginning of the session or towards the end, whatever seems to flow better within this particular interaction. The therapist should clearly explain that there is a topic for each session as well as a structure. You can give some examples of different topics, but be careful not to get bogged down with a lengthy description. This session would be a good time to explain that the patient will have his/her own workbook to keep information and for at-home practice assignments. The therapist can visually introduce session topics by showing the patient the Table of Contents sheet, which lists the different modules.

The following items should be included in this discussion:

- Duration of the treatment (17 weeks, meeting once a week for therapy)
- Length of the sessions (45 minutes to one hour)
- At least 14 of the sessions will be individual with up to three "family sessions" (involvement of family member(s) or a significant other)
- After the first few weeks of meeting, the structure of sessions will follow a "formula" that they can expect from week to week:
    - Check-in (hearing about their successes and challenges from week to week)
    - Review of past skills learned (how they were applied) including review of the at-home practice completed
    - Deciding on a new skill to learn (or skill to review)
    - Learning (reviewing) skill
    - In-session practice (usually role plays)
    - Collaborating on at-home practice assignment

For some patients, it can be helpful to have these items written on a board or flip chart so that they can visualize what will be happening as you meet from week to week. It is important to lay the groundwork for session structure during the first session so that the patient knows what to expect each time s/he comes in for a visit. This formula will also provide a good reference should a patient tend to have trouble sticking to the session structure or to veer off topic. While going over this information, you should impart a hopeful and realistic message about the opportunities to address the issues that brought the patient to therapy (although you may know only a small slice of what the issues are at this point). Assure patients that the work done *together* will be rigorous, but they can expect a tangible return on their hard work with positive outcomes if they maintain active participation.

Breaking the Ice: Explore Presenting Problem and Current Situation

When gathering information about what brought the patient into treatment and his/her current situation, be aware that he/she may not trust *why* you want to know this information. The patient may have had an experience in which sharing personal information seemed to backfire; his or her perception might be that personal information was used against them by a previous therapist, teacher, or by some agency, such as the legal system.

It works well to start with an open-ended question to elicit information. Follow the patient's response by a reflection. See the example dialogue below between the patient (C) and the therapist (T):

T: ***Tell me why you decided to participate in this treatment.***
(Or)
What are some concerns that you have in your life right now?

C: *My probation officer told me I had to start therapy to stay out of detention and work on my anger issues. Also I need some money to pay off the court. I don't think I need to be here for substance use, but I need clean UA's for the court.*

T: ***That helps me understand your current situation a lot. Thanks. While you don't see a problem with your use right now, you've been ordered by your probation officer to work on your anger issues and marijuana use or go to lock up. Plus you need the money and clean UA's to take care of your court obligations.***

The use of an open-ended question followed by a reflection or brief summary will help you to stay out of the "question/answer trap" which happens so easily in opening sessions. The beginning of treatment is a good time to ask the patient if he/she knows of any specific barriers to being able to come to weekly sessions with you and to do some problem solving. Typically, the fewer questions you ask, the more information you are likely to receive. Be careful to use simple language without "talking down" to your patient.

You might want to ask about key life domains at this time (e.g., home and family, school, employment, hobbies or interests, special skills). With simple questions, you can learn a lot about patterns of thinking, ways of seeing the world, and about your patient's current environment and circumstances:

- *Who do you live with? How long have you been living there? Tell me what it's like living with ___________.*

- *What school do you attend? Grade? How is school going for you?*
- *Tell me about your strengths, the kinds of things you are good at.*
- *What sort of interests do you have (or have you had in the past)?*
- *What would your best friend say about you if he/she were describing you to me?*

You can, of course, develop your own favorite list of questions. The key is to make sure the questions are mostly open-ended and to follow them up with a reflection (or possibly an affirmation).

Substance Use Behaviors: Assessing Motivation

Now that you have explained the basic structure of the intervention, explored some aspects about current life circumstances, and allowed your patient to share his/her feelings about being in therapy, you will continue to use motivational interviewing to investigate concerns about substance using behavior directly. Your abilities to use empathy (also known as active listening, reflection, or understanding) lay the groundwork for eliciting "change talk." Start out with a simple open-ended question. For example, see the dialogue below between a therapist and his/her patient:

T: ***Tell me about any concerns you have had about your marijuana use.***

C: *I don't worry about how much weed I smoke. My dad has been all over my case about it and about getting a job. It's really getting old!*

T: ***You don't see reasons to worry about how much you are using. However, your dad won't leave you alone about your weed use and also about getting a job.***

The therapist's use of a simple reflection here can be effective in eliciting change talk and is likely to encourage the patient to elaborate on the reflected statement.

C: *Yup, he thinks that I should be working all the time. We fought about it again this morning before coming here, and I'm just tired of it.*

T: ***So you guys aren't getting very far with this subject. It's exhausting fighting about the same thing over and over.***

<u>The therapist is responding primarily with reflective listening</u>. This is not the only strategy you will use in motivational interviewing, but it is very important. It should make up a substantial proportion of therapist responses in this first session.

In this example, the therapist may elicit change talk by asking another open-ended question, followed by a summary:

T: ***What do you think about your dad's arguments about you smoking weed and getting a job?***

C: *I can see that he has a point. I suppose he's right that it is hard for me to get going in the mornings. But the more he screams at me, the more I want to use* [sounding frustrated]. *Then I don't get up in the morning when I want to. I will never get a job at this rate.*

T: ***It doesn't help when your dad yells at you. In fact, it's making it harder for you to cut down on your use. You are concerned that your weed use is interfering with getting up in the morning and you won't get work if you don't do something about it. You aren't sure what to do about your smoking just yet.***

By using reflective statements, the therapist stays out of the "expert trap" and reinforces change talk.

C: *Yeah—I don't know if it's the weed itself, but I'm going out late every night since school ended just to get away from my dad. If my dad would get off my back, I might be around more. We used to hang out in the summer. It was OK.*

T: ***You would spend more time at home if he stopped yelling at you—like you did in the past and you might be smoking less.***

C: *Yeah.*

By using open-ended questions, reflections and summaries, the therapist is able to begin a neutral and non-judgmental discussion about the substance using behavior with the patient. Typically, patients will feel reasonably comfortable talking about their use under these circumstances and may spontaneously begin to voice reasons for either continuing to use or for changing their use. In either case, the therapist should resist the temptation to voice arguments for change prematurely (unless you are reflecting or summarizing the patient's own statements).

Using Personal Rulers

Scaling questions, in *Encompass*© referred to as the Personal Rulers, are helpful at this stage of engagement to understand where the client falls in different dimensions of motivation. Motivation for change has various components that often operate independently. It can be very helpful at this stage of engagement for you to have an understanding of where your patient falls in different *dimensions* of motivation. Motivation for change has various components, as suggested by the phrase "ready, willing, and able." The three different dimensions of motivation to change, described below, usually operate independently.

Importance	Confidence	Readiness
• The degree to which making the change is beneficial at this time • Reasons to change might be *external* or *internal*, such as "to get my parents off my back" or "I might do better in school if I cut down on the weed," respectively. • Change becomes more likely with numbers 5 or higher, and the sequence of interventions in *Encompass©* seeks to build motivation for change.	• The degree to which the person perceives they are able to make the change • There may be a discrepancy between importance for making the change and the person's view of their ability to be successful: "I *could* quit if I wanted to" or "I *couldn't* quit if I wanted to." • Drawing out past successes and building new skills increases self-efficacy, especially if the importance is high.	• The degree to which the person feels the time is "right" to make the change • A sense of urgency might be expressed or conversely, a person might express that they are not yet ready to make the change.

1) **Importance of change:** This dimension involves the individual perceiving that the change is important or beneficial in a personal way, e.g., the reasons to change outweigh the reasons to stay the same.

2) **Confidence to change**: This dimension involves the individual's level of personal confidence or self-efficacy to change, e.g., a person can be willing to change but might doubt his/her ability to do so.

3) **Readiness to change:** This dimension involves the individual's seeing and feeling that this is the "right" time to make the change, e.g., "It's important for me to do this now."

The **Personal Rulers Worksheet** is an excellent way to initiate a discussion on each of these dimensions of change. Using these questions (all open ended) allows you to join with the patient in a non-judgmental way. Using them also provides a baseline on "ready, willing, and able" that comes directly from the patient's belief system (versus being based on ideas that the therapist develops from outside data or from making false assumptions).

Script for Presenting the **Personal Rulers Worksheet:**

> *Now, I'd like to ask you three questions, and for each one, I'd like you to give me a rating on a scale that goes from 0 to 10.*

PERSONAL RULERS WORKSHEET

Importance Ruler: How important to you is it that you change your substance use?

0	1	2	3	4	5	6	7	8	9	10

Not Important	Somewhat Important	Fairly Important	Important	Very Important	Extremely Important

Confidence Ruler: How confident are you that you can change your substance use?

0	1	2	3	4	5	6	7	8	9	10

Not Confident	Somewhat Confident	Fairly Confident	Confident	Very Confident	Certain

Readiness Ruler: How ready are you to change your substance use?

0	1	2	3	4	5	6	7	8	9	10

Not Ready	Somewhat Ready	Fairly Ready	Ready	Very Ready	Completely Ready

Facilitating Personal Rulers. Use the language below to facilitate the Personal Rulers. Note that the number given is not as important as the reasons. The Personal Rulers are a specific Motivational Interviewing strategy to evoke *change talk.*

> "Let's look at these rulers together. A 0 (zero) means not at all and 10 means extremely. Mark where you fall right now in how important, confident, and ready you are to change your substance use."

Allow the client time to mark all three rulers. Then, discuss each ruler inserting their numbers into the follow up questions listed below:

- ➲ "What makes you a 4 and not a 1?"
- ➲ "Tell me why you're an 8."
- ➲ "What makes you a 1 and not a 0?"

Choose 3-4 scale degrees below the client's number when possible. Avoid follow-up questions such as, "Why are you a 6 and not a 10?" The answer to this question is *sustain talk*.

Clients may feel differently about the substances they are using. Give the client colored pens and ask them to mark where they fall for each substance at this time. For example, a client may be motivated to change their use of alcohol and non-medical prescription pain pills, but they may not be ready to change their marijuana use. Reflect what you hear. If the numbers are on the low end, insert time stamps such as "right now," "yet," and "at this time" to leave open the possibility for change. Remember that this is a starting point, and motivation to change is highly amenable to intervention.

When discussing each ruler, ask "What else?" and reflect to continue evoking change talk. **When given the opportunity to talk, people begin to discover more reasons for change that may not have occurred to them initially.**

Sample Dialogue

> *T: Tell me what makes you a 3 and not a 0 for importance to change your weed use.*
>
> *C: It would be more important to me if I were in school and had a job. I'm not doing much of anything right now, so I don't see why it really matters.*
>
> *T: Being successful in school and a job are two reasons for quitting that you have already thought of. Right now, you aren't working or in school so it hasn't been necessary to stop yet.*
>
> *T: What makes you a 4 and not a 1 for confidence to change your weed use?*
>
> *C: I've tried a bunch of times to quit, even a few months ago. It works for a few days, but then I just start again. I've never been able to go more than a few days.*
>
> *T: You have tried before, and what you were doing stopped working after a few days. You've been frustrated when you haven't been able to keep it going.*

T: Tell me what makes you a 6 and not a 2 on your readiness to quit?

C: I guess it's important for me to be able to stop using at some point. I wasn't planning to smoke this much weed when I go to college.

T: You are thinking about a time in the future when you would quit smoking weed. It doesn't fit in with your goals.

When you have completed discussing all three rulers for the substances identified, offer a *summary + key question* that highlights *change talk, affirmations,* and assesses the client's current motivation for change:

> T: Pulling this all together, you're more ready to change your use of alcohol and prescription pills than marijuana right now. You know you don't want to smoke as much weed in college and will probably change that in the future. Your freedom is important to you and with your parents being concerned about your substance use, they've put you on lock down which is not fun. You've used your friend's Xanax sometimes and might consider finding another way to deal with your anxiety if it worked for you. You've had some bad experiences with alcohol, one of which scared you and your friends, and you could see yourself not drinking as much. Thinking about all of this, what do you think might be the next step for you?

The Personal Rulers can and should be revisited throughout treatment if you sense that the patient's importance, readiness, and confidence levels may have changed. Scaling questions are useful for quick assessments especially when combined with MI skills and strategies to reflect and evoke *change talk.*

Wrapping Up: Brief Explanation of How CBT Works

The final portion of the session should be spent briefly explaining how cognitive-behavioral therapy works in a substance use treatment. Remember, you will have plenty of other opportunities for explanations later, so keep it brief and simple. At this point, it's important to be direct, stating that this therapy will focus primarily on substance use. In doing so, you will also be speaking with your patient about several important areas of his/her life, such as family, friends, school, work, and self-care. Share that one of the important ideas behind the cognitive-behavioral approach is that substance use "doesn't just happen" but is a "habit." It serves "some purpose." Emphasize that you will work together to find technical solutions to the patient's problems.

It is important to state clearly your belief that a patient's use is connected with "thoughts" and "feelings," and that it is normal to experience particular people, places, events, or other circumstances as "triggers." By introducing these terms early in the treatment, you will help them look at their substance use in a new way. This can be an excellent time to use an example, even if it isn't specific to the patient, e.g. "*Lots of people who get nervous in groups like to get high before they go to a party or as soon as they get there,*" or "*When you get steamed up, really angry, it can feel like a big relief to have a cigarette.*" Importantly, these kinds of statements convey that you do not see the patient's use as a "failure." This may be refreshing for them to hear, as many patients will be used to hearing criticism for not being able to "control" their behavior.

It is important to remember that your patient may want to change a behavior, but doesn't necessarily know *how* to do so. This is often a very good time to share that one advantage of cognitive-behavioral therapy, where new skills are learned and practiced, is that it offers *technical solutions* to problems. Try to give an example which will be relevant to the patient.

> *You have mentioned that it is really hard living at home right now and that sometimes you meet your friends to smoke just to get out of the house. We will start working on some skills to help you at home when it starts to feel like an argument is going to start between you and your dad.*

Many of our patients are used to feeling failure. What may commonly be labeled "resistance" may not be that at all. Our patients often believe at the outset that the problems they have are too large to overcome. Let them know that starting therapy is a first step toward building new skills.

It is important to end each session providing a simple summary of the change talk that you have heard. Draw together what your patient has told you using a summary reflection.

> *Let me see if I have a good picture—at least where you are right now. I've heard two things so far that concern you about your weed use. One is that you think it might be having some effect on you getting a job because you are staying out late a lot and not getting a good night's sleep. It is also interfering with your relationship with your dad, which used to be close. And let me know if I've missed something.*

Finally, explain what will happen in the next session (Personal Feedback Report and goal setting).

> *Next time we meet, I will be giving you some feedback from the questionnaires you completed before we started treatment. We'll be taking a closer look at the drugs you have used, including alcohol and cigarettes, and how they have fit into your life so far. That will help us put together a plan and set goals about things that are important to you. You are the expert with this and no one else can decide what you are going to do. How does that sound to you?*

At-Home Practice

For at-home practice, start out slowly with something simple and easily achievable for your patient. This will help your patient build confidence in the process of taking ideas home to work on and reinforce that they can "only be successful." You might choose to use the **Taking it Home** sheet to write down what you have assigned. If so, ask the patient to bring the sheet back the following week with notes about how the practice went for them. Suggested options include:

- Complete the **Supportive People Checklist**.
- Ask the patient to think about pros and cons of inviting a certain family member or significant other to sessions. Have them write down these pros and cons on a list.
- Use the **Personal Rulers** follow-up questions to further explore their motivation for change. You could have them look at one of the "dimensions" of change (importance, confidence, or readiness). Ask them to describe "why" they are at a certain number (see above). What "would it take" for them to move to a higher number on one of the scales?

- The **Happiness Scale** (see **Module #2: Personal Feedback Report/Goal Setting**) could be completed to help them with the goal setting to take place in the next session.
- Give the **Goal Setting** work sheet (see **Module #2: Personal Feedback Report/Goal Setting**) to patients who seem eager to start writing down their ideas for change.

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MODULE 2: Presenting Personal Feedback Report & Goal Setting

Summary of Tasks

- Summary of motivational statements ("change talk") elicited in the first session
- Check in regarding participation of family member/significant other
- Review **PERSONAL FEEDBACK REPORT (PFR)**
- Introduce goal setting and complete exercise

Check In and Review of At-Home Practice
As this session will be the first time that you will be checking in and reviewing at-home practice with the patient, it can feel a bit awkward, particularly as you are just getting to know each other.

> *Before we start with a review of our last session and your at-home practice, I want to check to see if you have any questions or things you want to tell me about our last session, or anything else that seems important for me to know.* (Pause) *Let's take a few minutes to talk about what we did last time and your at-home practice. How did that go?*

If you used the **Taking It Home** worksheet, take a look at it together. Remember, there is no way that your patient can "fail" in this exercise, e.g., if it was not completed or even attempted, that's ok. The emphasis is, of course, on completing the practice. You will do so together during the session—adjusting as necessary if the assignment cannot be replicated in the session, e.g., do a relevant role play. A very important part of this discussion is to explore *reactions* to the assignment and *barriers* to completion. Assure your patient that doing at-home practice is something new and you will work together to make assignments meaningful and helpful. This process gets easier as you get to know each other. In addition, after today's session, you will have a lot more information about the patient's own "agenda," as he/she sets personal goals. Continue to use reflective statements to engage your patient. Reviewing at-home practice (when it has not been completed) is one of the most challenging tasks of this intervention. Maintaining the spirit of MI (which is non-directive) and asking the patient to "do" something can feel like a bind. If you listen carefully to and acknowledge the patient's experience, feelings, and beliefs, you are doing something! Change comes in small steps, and this discussion is part of the change process. Most patients will participate willingly when they recognize that you are behind them and that the reason for the assignment is to make sure that they get what they need out of your time together. Once this discussion is completed, you are ready to move on to the session topics.

Presenting Session Rationale
In this session, your primary objective is to engage the patient in a "behavior change" discussion through two interventions: presenting the Personal Feedback Report (PFR) and patient-directed goal setting.

In presenting a rationale for this session, you can say:

> *Today, we will be doing a few things together. We will be going over the answers you gave in your initial assessment for substance use.* (See below for a more complete script on how to introduce the PFR, including what to do if a patient does not want to

participate.) *After that, we will spend some time setting goals that are important to you and talking about ways I can support you in meeting those. How does that sound?*

The information presented and discussed in the patient's Personal Feedback Report (PFR) sets the stage for further exploring personal choice and behavior change, specifically as it relates to the patient's current use of substances. During this process, the therapist will continue to listen for the patient's own arguments for change.

The PFR is an opportunity to share in a straightforward manner the clinical information ascertained in the intake diagnostic and clinical assessment. The symptoms reported by the patient during the initial diagnostic interview to generate diagnoses of substance use disorders are in fact negative consequences associated with substance use. The number of symptoms endorsed for each SUD diagnosis is a measure of substance severity (mild, moderate, severe). The amount, pattern and frequency of use for each substance is ascertained using the calendar-based TLFB (#days used in past/28 days for each substance). This information is pulled together in the form of a Personalized Feedback Report that is given to the patient and serves as the basis for discussion of patients' use compared to normative population data for individuals of same age, gender, demographic as the patient.

The therapist should give the patient a copy of his or her PFR and lead the patient through a review of the information. It is best for each person to have his/her own copy to increase the collaborative nature of the process.

***Example:* Therapist script for presenting normative data compared to patient's reported use patterns in the PFR**

For this section, you will need the current table from NIDA's website titled similar to: **"Monitoring the Future Study: Trends in Prevalence of Various Drugs."** You will use this during the session with the client to look up normative data and fill in the worksheet comparing patient's self-reported patterns, frequency, and amount of substance use (for each substance) ascertained from the calendar based **TIMELINE FOLLOW BACK** (# days/past 28 days) at intake.

> *T: Let's see how your substance use compares with other people your age. You are in the 10th grade and have been using marijuana on the weekends. 14% of young people your age have used marijuana at least one time in the past month. That's 14 out of 100 people.*
>
> *C: No way that's right. Way more people than that smoke weed in my school.*
>
> *T: The number seems low to you.*
>
> *C: Definitely. All of my friends smoke weed.*
>
> *T: The people you spend most of your time with all smoke weed.*
>
> *C: Yup.*

T: I can see how you would think that. We tend to think that everyone does what our friends do. These numbers are from a bigger sample.

C: What do you mean?

T: Think about your high school: Lots of different students. These numbers are saying that out of 100 people in your high school, 14 have smoked at least once in the past month.

C: I know people who don't smoke weed in my school, but I still think the real number is higher. People lie on surveys, anyway.

T: It seems like the number of people who do smoke weed is more than 14, and you can also think of some people in your school who don't smoke.

In the above dialogue, notice how the OARS, strategies to elicit *change talk,* and methods to respond to *sustain talk*, worked together to move the conversation forward and connect the PFR to Goal-setting. In *Encompass,* each exercise informs the next.

T: *The number seems low to you.*

C: Definitely. All of my friends smoke weed.

T: The people you spend most of your time with all smoke weed.

C: Yup.

T: I can see how you would think that. We tend to think that everyone does what our friends do. These numbers are from a bigger sample.

C: What do you mean?

T: Think about your high school: Lots of different students. These numbers are saying that out of 100 people in your high school, 14 have smoked at least once in the past month.

C: I know people who don't smoke weed in my school, but I still think the real number is higher. People lie on surveys, anyway.

T: It seems like the number of people who do smoke weed is more than 14, and you can also think of some people in your school who don't smoke.

Repeat the same process for other substances, including tobacco and e-cigarettes. Remember to "roll with resistance." People need time to consider information that is contrary to their current perception before deciding whether or not to change their minds. Some particularly useful skills when presenting this information are as follows:

- ➲ Reflect and affirm. Look for opportunities to affirm the client's existing knowledge and reflect understanding of their perspective.
- ➲ Emphasize autonomy. Decisions whether to believe information or make changes are up to the client.
- ➲ Respond to *sustain talk* briefly.
- ➲ Look for opportunities to reflect and evoke *change talk.*

INCORPORATING PATIENT –REPORTED NEGATIVE CONSEQUENCES OF SUBSTANCE USE INTO PFR – the symptoms endorsed by the patient during the intake diagnostic interview to generate specific SUD diagnoses are in fact negative consequences of substance use that should be included and discussed during the PFR using MI approach and pulling for self-reflection and change talk in preparation for treatment goal setting.

Example Dialogue/Script:

T: This next section lists out specific symptoms you endorsed for marijuana. You noted that you are buying more marijuana than you used to, as you need to smoke more to get the same effect (1). You've stopped playing soccer after school (2) and your parents have you on lock down (3) because you're having difficulty in school (4). This puts you in the moderate category.

C: It's really not that bad. I only smoke on the weekends and grades are bad because my math teacher has it in for me.

T: There might be other reasons besides weed that things are challenging for you. (Complex reflection)

C: Exactly. My parents just pick on the weed because they want to control me. If they would just let me smoke, everything would be fine.

T: You and your parents fight about weed a lot. (Simple reflection)

C: Yes. They hate that I smoke and want me to do better in school. If I could get my school sorted out, they might leave me alone and I could do whatever I wanted again.

T: If you could get your grades up, your parents might get off your back. (Simple reflection)

C: Yes. I'm pretty behind, though. I'm not sure it's possible to catch up.

T: You're wondering how you might go about improving your grades. (Forward-moving reflection)

C: Yes, especially because math is really hard and my teacher hates me. But I like English and chemistry, so those classes are OK.

T: You've done pretty well in English and chemistry. What has helped you succeed in those classes? (Affirmation; OEQ: Asking for elaboration about past successes)

C: The stuff we learn is way more interesting and the assignments are easier.

T: English and chemistry seem to come easier to you than math. (Simple reflection)

C: Yes. Maybe I can ask my chemistry teacher to help me figure out what to do. He's cool.

T: You are resourceful, thinking of people who might be able to help. (Affirmation)

C: He's been there for a long time and he likes me.

T: He knows the system. (Complex reflection)

C: Yes. And I think he'd want to help me get my grades up.

T: Let's see if I understand: Your parents are on your back about a lot of things. They don't like that you smoke weed and they think it's the reason that you're having trouble with your grades. You're thinking there might be some other explanations, too. You've got English and chemistry covered; it's math that's tricky for you right now. If you could get your grades up, your parents might lighten up a bit and let you have more freedom. You'd really like that. You've thought about asking your chemistry teacher for help because he knows the school and might have some good ideas for where you can start working on your math grade. What do you think might be the next step? (Summary + key question)

C: (Pauses) The more I think about it, the more I like the idea of talking to my chemistry teacher. That could work for real.

T: This is a great segue into our next topic: Goal-setting. People tend to make more progress when they have a clear plan. You can think of this as an experiment: You keep trying until you discover what works for you. In Encompass©, we like to have at least two goals to start: One substance use goal and one non-substance use goal. Since we've been talking about your math grades, what do you think about starting there?

C: Sure.

T: I'd like you to do the writing as these are your goals. (opens CBT Workbook to p 12) Under Goal #2, write in what you'd like to change. (top box)

*C: * Writes "bring up math grade" **

T: Next, list your top three reasons for wanting to bring up your math grade.

C: Writes: "less fighting, can do what I want" (stops writing and starts thinking)

T: How else might it be helpful if you brought up your math grade? (OEQ: Asking for elaboration)

C: Ummm…it would be less stressful for me. One less thing to worry about.

T: You've got enough going on without having to deal with this, too. (Complex reflection)

C: Exactly.

(continue facilitating through the rest of the boxes for this goal)

T: You've got a good plan to work on your math grade. Now let's talk about substances.

C: I'm not quitting weed.

T: You feel pressured to stop smoking. (Complex reflection)

C: Yes. That's why my parents dragged me here. They think weed is the cause of all of my problems. Honestly, it helps me focus.

T: Weed helps you sometimes. (Simple reflection in response to sustain talk; added time stamp.)

C: Yes. It also calms me down when I'm stressed.

T: You've mentioned that before; things have been stressful for you lately. (Complex reflection; linking previous information)

*C: Yes. Everybody thinks kids have it so easy. My dad says that all the time * rolls eyes **

T: Things have gotten even harder for you recently: Arguing with your parents, grade in math, other stuff. (Collecting summary)

C: Yes. And I'm tired of being stressed all the time. I just want some time to relax. I come home from school and my mom has a bunch of chores for me to do. And then we fight over that.

T: All of you are sick of fighting. (Complex reflection)

C: Yeah, I guess. It didn't used to be this bad.

T: You're in a tough spot. On the one hand, smoking weed has helped you to deal with stress and on the other, it's causing some, too. (Double-sided reflection)

C: It helps me way more than it hurts me.

T: One of the goals of Encompass© is just that: To understand how a substance fits into a person's life. Often people start using because they are trying to change how they feel. (Responding to sustain talk using shifting focus; giving information)

C: It definitely chills me out.

T: You've got to have ways to relax. (Affirmation: Identifying goal or value)

C: Oh yeah. I need time to hang with my friends and do what I want after being in school all day.

T: You've been smoking more recently partly because you've been so stressed. (Reflection of feeling)

C: Sort of. It's what me and my friends like to do.

T: Let's finish up today by setting a substance-related goal. It's the same process you did for improving your math grade.

Right now, other things are more important than changing your marijuana use. Sometimes it's helpful for people to learn more about the effects of substances, good and not-so-good, on their lives. That's one place we could start.

C: You mean like pros and cons?

T: Uh huh.

C: As long as you're not going to try to convince me that I need to quit. I'm tired of people telling me that.

T: Any decisions to do things differently belong to you. We'll talk about how weed fits into your life, what it might do to help and how it might be not-so-helpful at times. It's your choice what to do with that information. (Responding to sustain talk with emphasizing autonomy)

C: OK. So what should I write for the goal?

T: You mentioned pros and cons. How about using those words? (Complex reflection + OEQ)

*C: * Writes "pros and cons of weed" **

T: What might be the top 3 reasons for you to talk about pros and cons of weed use? (second box on Goal-setting worksheet)

C: I don't have a choice. My parents are making me be here. We need to talk about something.

T: It's something you're willing to talk about. (Simple reflection)

*C: Yes. * Writes "need to talk about something" **

T: What are two more reasons it might be helpful to talk about pros and cons? (OEQ, asking for elaboration)

C: (pauses and thinks) I've never really thought about it before.

T: You might notice new things about the effects of smoking weed. (Complex reflection)

*C: I guess. * Writes "maybe learn new things" **

T: Almost done. One more benefit to talking about pros and cons of weed use.

C: Ummm. (pauses and thinks) I don't know.

T: So far, we've got "need to talk about something" and "maybe learn new things." (Collecting summary)

C: Ummm. (still thinking) Maybe my parents will be happy that I'm coming here. Maybe they'll get off my back.

T: One possible benefit could be that your parents see you making progress. (Complex reflection)

*C: Maybe. * Writes "parents leave me alone." **

T: Today we talked about how your weed use compares with other people your age and what specific symptoms of cannabis use disorder apply to you. You don't think that weed is the cause of all your problems and wonder if there are other explanations for what you're experiencing right now. You set some initial goals. At the next session, we'll start the Functional Analysis, where we talk about the pros and cons of weed, and more specifically for you, what you like or don't like about it. For home practice, what do you think about getting started on the goal to improve your math grade? (Summary + OEQ)

C: OK. I'll talk to my chemistry teacher tomorrow.

T: Sounds good. Let me know how it goes and if there's anything I can do to support your goals. School systems can be confusing; maybe between you, your chemistry teacher, and me, we figure out how you can bring up your math grade. (Giving information)

In the above dialogue, notice how the OARS, strategies to elicit *change talk,* and methods to respond to *sustain talk*, worked together to move the conversation forward and connect the PFR to Goal-setting. In *Encompass©,* each exercise informs the next.

Wrapping up PFR and Transitioning to Goal Setting
Now that we have gone over information about your drug, alcohol and cigarette use and some of their specific consequences for you, the last item we will talk about has to do with how ready you are to change your use. We will do this by looking at the score you had on the change assessment questionnaire you took before this session.

Now it's time to introduce a new skill, really the first one that we are working on together. This exercise may be familiar. Perhaps you have done goal setting before, at school or somewhere

else. Or, perhaps you have never done this. I am going to show you a particular way to set goals ***that are important to you*** *and then how to break them down so that you can get them accomplished. How does that sound?*

Patients may be reticent or reluctant to set goals. Some may start out with a belief that this exercise is really not going to benefit them. They may not understand what the purpose is or assume that it is for you to "measure them" (like grades in school or other "reports" that they may be used to seeing about themselves). If this is the case, listen to their concerns or questions before you begin. Acknowledge that it is difficult to set goals, but also very important, and you will help them. Continue to emphasize how valuable goal setting will be for patients in getting what they want from therapy; emphasize that there is no "right" or "wrong" to any of the goals they might set. With some patients, it might be helpful to share a specific example of when you set a goal in your life, wrote down a change plan, and saw how it benefited you over time.

When you do goal setting, it is important to remember your MI skills, asking open-ended questions and using reflections. During this process, you may find opportunities to develop discrepancy, looking for examples of differences between *where they are* (the status quo) and *where they would like to be* (goal-directed change). At first, they may only state one goal *("I want my license").* Applaud them on their excellent start and help them make connections between different areas in which they might set short-term goals. Indeed, achieving a short-term goal may be closely related to their substance use, e.g. unless they pay their court fines, do community service, and have clean UA's, they won't be able to apply for a license.

To keep the exercise structured, it is helpful to use the practice sheets in the therapy notebook and to have patients write down ideas during the session. You could write this outline on a white board to get them started:

- *The changes I want to make are . . .*
- *The most important reasons why I want to make these changes are . . .*
- *The steps I plan to take in changing are . . .*
- *The ways other people can help me are . . .*
- *I will know if my plan is working if . . .*
- *Some things that could interfere with my plan are . . .*

During the process, it is important to have the patient identify which people in their lives can support the completion of these goals. You will learn something about his/her support system or lack of one. At that time, you may want to let patients know that *you* plan to support them in any way possible toward the successful achievement of their goals. You can model for the patient by sharing an example of when you set a goal for yourself, describing how: you broke down the goal into small, achievable steps; you managed the barriers that arose; and how you might have asked for support from others.

WARNINGS FOR GOAL SETTING

- Don't develop a list of vague, negative and nonspecific (non-measurable) goals, e.g. "*I want to do something about my drug use." (*Instead*, "I want to stop using marijuana and drink only on the weekends, no more than 2 beers a day.")*
- Don't design goals that are too complex and difficult to attain with the patient's current skills and abilities, e.g. a goal to get all A's in school when the patient has a recently diagnosed learning disorder.
- Don't leave out important steps that are necessary to complete a goal, e.g. patient wants to get a car but has not made plans to get a permit.
- Don't include goals that are not under the control of the patient, e.g. wanting to go out with a specific person when the patient cannot control whether or not that person likes him/her.

When a Patient Has Difficulty Setting a Substance Goal

The goal setting process is an opportunity to talk about substance use in a neutral, non-judgmental way and you do not want to avoid the topic. At the beginning of treatment, nearly everyone is ambivalent about giving up substances. The patient may be thinking about whether he/she wants to quit and/or whether he/she will be able to. The patient may be court-ordered to treatment and stuck in a mode of reacting against control/authority that mandates decreased drug use. With court-mandated adolescents, it is important to emphasize personal choice and responsibility in the context of being court-ordered. Rather than presenting the possible or likely negative outcomes of their non-compliance, you can ask them what they think will happen if they choose not to comply with court-ordered treatment (looking at consequences).

To ask your patient what his/her goal is regarding his/her substance use, remember to use an open-ended question: *What are you thinking you would like to change about your use?* (This open-ended sentence structure could be used to ask about any areas of change, e.g. school, family, peer relationships, work, etc.)

For patients who are unable to identify any goals, you can have them complete **The Happiness Scale** during the session. (If the patient completed this for at-home practice for this session, you can use this now to help with framing goals.) **The Happiness Scale** will help patients identify their level of satisfaction with particular areas of their life. During this process, it will become clear to patients that you are interested in helping them with multiple areas, not just their substance use. When you discuss their responses on **The Happiness Scale**, you can start with areas that have been rated high (higher satisfaction). This encourages the patient to talk and allows you to find out what is going well in his/her life. Then, you can move on to the areas in which there is lower satisfaction and which might be more emotional, such as school failure, relationship problems, job loss, family issues, and substance use (Godley et al., 2001).

How to Write Goals and Plans

You will need to teach patients how to frame and write goals, as well as the steps to achieving their goals (specific plans). It is important that they write down their own goals and plans in order to keep them motivated. If it is necessary, you can offer to do the writing during the

session to engage patients, as long as the words themselves are theirs. You will need to show most patients how to set goals. Written goal statements and interventions should be **simple** and **brief**, as well as **measurable** by *how often*, *when*, or for *how long*. Goals should be stated **positively,** rather than negatively, e.g. what he or she *wants* and *will do*, rather than what he or she *does not want* and *will not do*.

Below are strong goal and plan statements:

- *"I will pull my grades up from all F's to four C's and a B by the end of this semester."*
- *"I will finish my GED by the end of this month."*
- *"I will ask my parents if they will talk with me about borrowing the car on Thursday night."*

Watch out for goals and plans which set the patient up for feeling failure. The list of "don'ts" below will help you identify weak goals and change plans.

In conclusion, it is important to let your patient know that you will return to these goals (and their objectives) regularly throughout the treatment to make sure that he/she is getting enough support and guidance to make the changes identified.

At-Home Practice

You can ask the patient to continue working on the goal setting sheet for at-home practice. (Keep in mind that for some patients, this assignment will be too large and overwhelming.) Emphasize that people reach goals one step at a time, and that it works best to break things down into small tasks.

Options:

- You might suggest choosing one goal (e.g., identifying the one which is "most important"), writing specific steps a patient could take immediately toward reaching that goal. Make sure participant understands how to identify: concrete steps to achieve at least one goal; possible barriers; and support persons/systems. If patients have not already done so, have them focus on the "reasons why" they would be setting each goal.
- Rank goals in order of importance and difficulty. Write down reasons for answers.
- Decide together to follow through on one or more change plan "steps." (If appropriate, complete a role play in session to prepare.)
- Complete the Happiness Scale if the patient indicates resistance to setting goals or is uncertain what goals s/he might set.

I would like to change these things in my life…	Goal #1	Goal #2	Goal #3	Goal #4
The reasons I want to make these changes are…				
Specific things I can do <u>right now</u> to help me meet my goals…				
What might interfere…				
Who can help me and how…	Person : How: Person: How:	Person : How: Person: How:	Person : How: Person: How:	Person : How: Person: How:

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HAPPINESS SCALE

This scale is intended to estimate your current happiness with your life in each of the areas listed. You are to circle one of the numbers (1-10) beside each area. Numbers toward the left end represent various degrees of unhappiness, while numbers on the right reflect increasing levels of happiness. Ask yourself this question as you rate each life area: *"How happy am I with this area of my life?"* In other words, select the number on the scale (1-10) that best fits exactly how you feel **TODAY**. Try to exclude yesterday's feelings and concentrate only on the feelings of today in each of the life areas. If an area doesn't apply to you, please skip that one.

		Completely Unhappy									**Completely Happy**
1.	Drug use or non-use (choose one)	1	2	3	4	5	6	7	8	9	10
2.	Alcohol use or non-use	1	2	3	4	5	6	7	8	9	10
3.	Cigarette use or non-use	1	2	3	4	5	6	7	8	9	10
4.	Relationship with boyfriend or girlfriend	1	2	3	4	5	6	7	8	9	10
5.	Relationships with friends	1	2	3	4	5	6	7	8	9	10
6.	Relationships with parents or caregivers	1	2	3	4	5	6	7	8	9	10
7.	School performance	1	2	3	4	5	6	7	8	9	10
8.	Social activities	1	2	3	4	5	6	7	8	9	10
9.	Recreational activities	1	2	3	4	5	6	7	8	9	10
10.	Personal habits (e.g. getting up in the morning, being on time, finishing tasks)	1	2	3	4	5	6	7	8	9	10
11.	Legal issues	1	2	3	4	5	6	7	8	9	10
12.	Money management	1	2	3	4	5	6	7	8	9	10
13.	Emotional life (feelings)	1	2	3	4	5	6	7	8	9	10
14.	Communication	1	2	3	4	5	6	7	8	9	10
15.	General happiness	1	2	3	4	5	6	7	8	9	10

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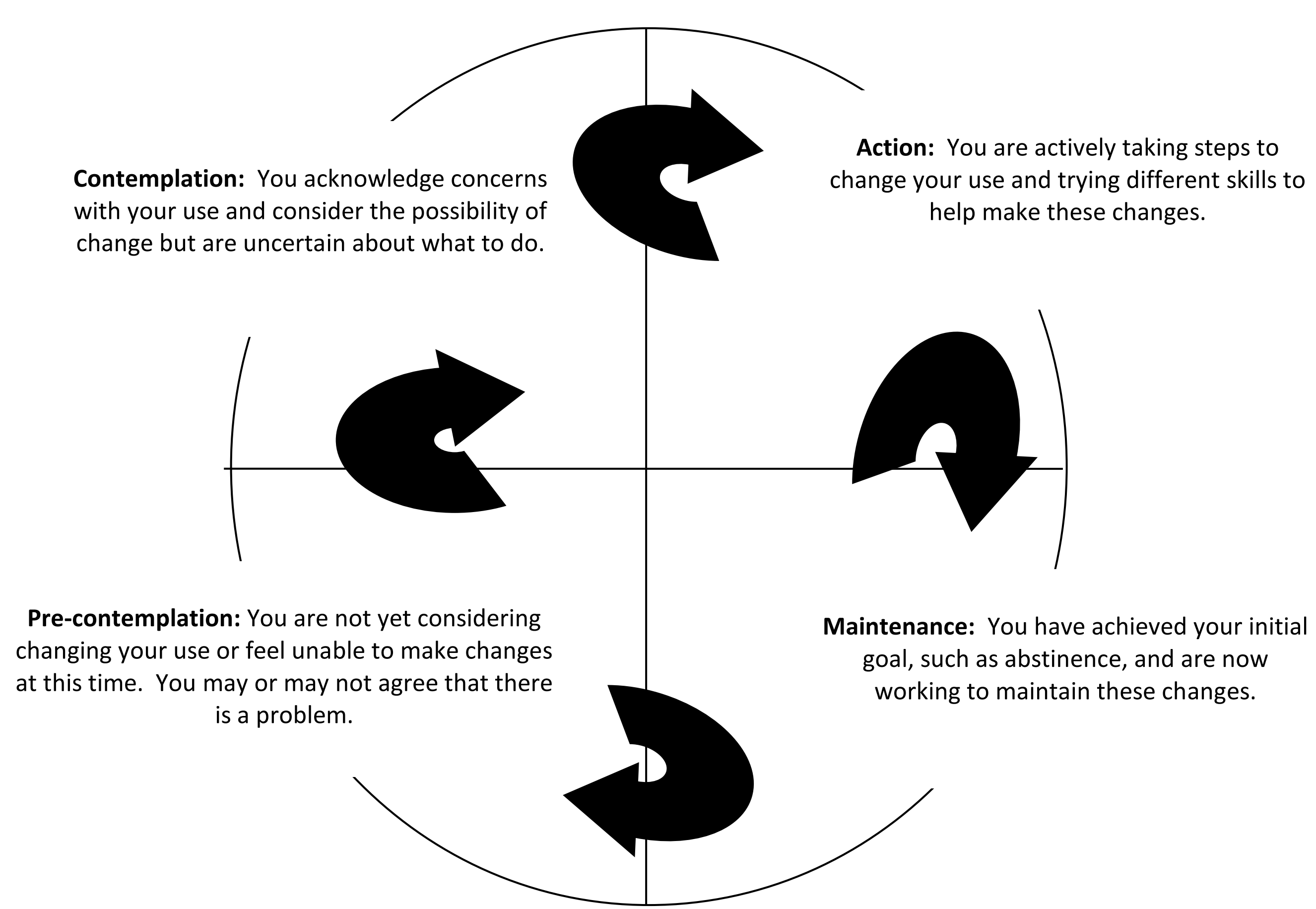
<u>**READINESS TO CHANGE WHEEL**</u>



MODULE 3: Functional Analysis/Exploring High Risk Situations

Summary of Tasks

- Review goals and summarize all change talk statements from last session
- Define a high risk situation
- Explain the purpose of the functional analysis (FA) is to identify high risk situations and the pros and cons of using
- Engage patient in performing functional analysis
- If time allows, complete the *Functional Analysis of Prosocial Behavior* (see Appendix H). (You could do this exercise instead, if it seems to be an appropriate focus with patient.)

Presenting Session Rationale

A functional analysis is a structured interview that examines the antecedents and consequences of specific behaviors, such as drinking or using drugs (Meyers and Smith, 1995). This information is integral in identifying stimulus cues associated with higher risk for substance use. During the Functional Analysis, the patient also identifies the positive and negative consequences of using or not using substances. In addition, the patient may identify adaptive (positive or prosocial) reinforcing behaviors that compete with problem behaviors. In general, developing alternative methods of coping with high-risk situations without using substances involves learning specific skills and strategies. The functional analysis is an exercise which involves active participation. Its purpose is to examine patterns of use in detail and to increase the patient's understanding of connections between thoughts, feelings, triggers, and consequences of use. Triggers can best be explored by looking at the events that precede a substance-using event. Exploring positive and negative consequences helps identify past, current, and future reinforcers. Once an individual knows the situations and problems that contribute to his/her use, he/she can begin to learn coping strategies and other skills to manage those situations.

In presenting a rationale for this session, you might say:

> *There's a lot for me to get to know about you. Today, we are going to spend some time looking closely at your use patterns. This will really help us come up with a plan for ways to help you quit (stay sober).*

With a resistant adolescent who has not identified a desire to change his/her use, you might say:

> *Last week you set some really important goals for yourself. I realize that quitting using is not one of them. Let's look at your patterns of use anyway. Sometimes when we do this, we uncover some pretty interesting things about why you are using besides that you have fun. We will look at what you enjoy about using* [substance] *so I can understand why you don't want to stop now.*

Key Interventions

Explain the Purpose of the Functional Analysis (FA)
The therapist will give a brief explanation of the purpose of the Functional Analysis. As it is early in treatment, patients may be minimally engaged and some patients will be disinterested in discussing their substance use. You will begin the session by reviewing their goals. If they have identified a goal for substance use behavior, you will explain that this process is to help identify their thoughts and feelings (triggers) related to substance use, as well as their reasons for using.

If patients have not identified a substance goal, you will look at their goals; even one will do. Choose this one goal as an example of how to make a behavior change. Ask them for more specifics about their goal. For example, if the patient states, *"I want to get off probation and stay out of trouble with the law,"* you could ask, *"What do you think is going to happen in the next few months* [with your legal situation]? *What are you going to do about it?"* In this way you can lead up to the connection between substance use and legal problems. For instance, probe what would happen if they have a positive urinalysis (UA). How might their substance use jeopardize getting off probation? Listen to what they are saying to you and then gently explore possible connections between their goal (getting off probation) and their substance use. After doing this, they may still be skeptical about how this exercise relates to their life and goals. However, don't let their skepticism stop you from completing the functional analysis. Let them know that you aren't certain what will be uncovered in doing the FA, but that you know that you will find interesting and important patterns in their use. Convey that they will be able to use that information. You can explain that the functional analysis can be used for any "habit" or behavior which they are trying to change, not just substance use, e.g. quitting smoking, getting into arguments, biting nails, etc.

In-Session Exercise: Performing the Functional Analysis
The functional analysis for substance use is conducted as an interview, but also involves completing a written chart about the identified behavior (Godley et al., 2001).

The purpose is to help the patient identify and understand connections between their thoughts, feelings, and antecedent and consequent behaviors associated with substance use. Clearly defining what a trigger is will be very important for this therapy. Triggers are defined in their workbook this way:

> *Triggers are thoughts, feelings or behaviors that come before you use and which can lead to wanting to use. They can be external (persons, times of day, places) or internal (thoughts, emotions, physical feelings).*

This would also be a good time to define a craving. You can tell patients that during the next session, you will describe cravings in detail with strategies on how to cope with them. You can say:

> *A craving is a strong feeling or urge for something (for example, a drug, food, sex, thrill, etc.) that feels uncomfortable and sometimes uncontrollable.*

You can choose how you are most comfortable conducting the interview. However, it is important that you write down the information you gather. You may do the writing, as long as

you describe the conclusions you are drawing from the information and that you give a copy of your notes to the patient. If you have the patient write the information, you can also take notes. Or, you can both take notes during the session. As the patient will be asked to review the information and to add to it for at-home practice, it is important that he/she know how to record his/her own observations. You will continue to use the Motivational Enhancement Therapy strategies that you used in Module #1 Engagement in order to elicit more information from the patient. Conducting the FA should never be a confrontational process. Ultimately, the goals of the FA are to help the patient feel more in control of his/her using behavior and to understand the consequences of his/her use (short-term and long-term).

The interview is divided into five sections. You may do these in any order. However, it is often helpful for the patient to begin with external triggers, as these are often more obvious and easier for the patient to articulate.

1. **External Triggers:** Patients are usually quite proficient at describing the events of their lives—who, where, and when. When beginning to gather information about substance use patterns, you may ask the patient to tell you about a "typical" day. Have him/her include all the different times he/she used on that day. (Weekday patterns may be different from weekend ones, so you may want to ask about each separately or ask for the differences.)

    > *Sometimes it's easiest to do this by having you describe a typical day including all the times you used in that day. We will also want to know who you used with* [let them know that you aren't interested in names, as you are just looking for patterns], *where you used* [home, work, school, cars, parks, etc.], *and when* [after waking up, before school, during lunch, after work, waiting for the bus, before sleep, etc].

    Ask them to be as specific as possible, reminding them that this information is important. The information will help patients come up with a plan for changing their behavior. By exploring these patterns, the adolescent may realize that there are definite patterns to his/her substance use behavior. Make sure that he/she understands the reasons you are asking these questions, e.g. you are looking for clues about the sorts of triggers (stimulus cues) that he/she may have. Knowing their triggers will help them to keep cravings under better control.

2. **Internal Triggers:** Internal triggers include the thoughts, feelings, and somatic (body) sensations that occur right before using. Patients often have difficulty recognizing and labeling their thoughts and feelings. They may need training to recognize what occurs right before a decision to use drugs. You may want to prompt them by asking them to think about the last time they used: *"What were you thinking about right before you used, and what were you feeling?"* As you begin to generalize to other experiences, encourage the patient to report as many thoughts and feelings as possible. By outlining the cognitive and emotional process, the patient is able to recognize that a specific decision to use was made under particular emotional circumstances. You will also address with patients how they feel physically right before using. The purpose of this question is to identify bodily sensations that may relate to emotional states, such as anger or anxiety. When patients use drugs as a response to emotional triggers, it may mean that drug use occurs because the patient has not yet learned more adaptive

responses to unpleasant emotional states. Patients may not want to become abstinent, but they might want to change a particular pattern of using, i.e. a response to an emotional trigger, such as anger or boredom. A patient might say, for instance, *"I'm not going to stop smoking, but I don't want to do it just because I'm angry."* If you hear a statement like this, strongly praise his/her insight and have him/her consider this as a new goal for treatment.

For patients who are having a difficult time identifying and/or expressing thoughts or feelings, it can work well to have them illustrate a scene or set of visual images. For instance, you could have the patient describe a scene in which he/she recently used, and help him/her articulate the images during the episode (Godley et al., 2001, p. 35).

> *Why don't you close your eyes and imagine where you usually use* [substance]. *Where were you* [sitting, standing, playing video game, etc.]*? Who else was there? What do you remember about what you were thinking at that time? What do you remember about what you were feeling at that particular time? Do you remember how your body felt? Can you describe it?* [Encourage them to use sensation words such as tight, tense, restless, sweaty, etc.]

3. **Substance Use Behavior:** The patient will have completed a standardized substance use questionnaire before beginning CBT (K-SADS). While it is useful to review this assessment before you meet with the patient, it is still important to gather the information directly. You may choose to begin the FA by gathering substance use information with these questions. Introducing the topic can be accomplished by stating:

> *I realize that you have already completed an assessment about your* [substance] *use. It's important for me to learn as much as possible about what you use, how often, and other patterns. This will really help us in the therapy.*

This helps you establish the expectation of <u>direct discussion</u> about their substance use in these sessions, in addition to all of the other things you will be doing together. This is an opportunity to begin to hear their description of what, how much, how often, etc. they use and to become familiar with the language they use to describe these patterns. You will want to get as much specific information as possible about the substances they use, how much they are using (e.g. joints, spliffs, drinks, grams, etc.), how often, and over how long a period of time (e.g. hours, days, weeks). If a patient is using several different substances heavily, you will want to do a separate functional analysis for each substance, as there may be different triggers and consequences associated with each one.

4. **Short-Term Positive Consequences:** Before discussing the different positive and negative consequences of use (below), make sure that the patient understands what a <u>consequence</u> is. It is defined in their workbook. You might ask them:

> *When I say consequence, what do you think I mean?* [If they are unsure, refer them to the definition in their workbook.] *Yes, it is what happens after something—the result of a certain behavior. In this case, we are talking about what happens after you use, either right away or later, sometimes even years*

> *later. It can be either positive, like feeling calm after using, or negative, like a headache after drinking a lot.*

Adolescents will report positive consequences of use, the things they like about using. It is important to understand the positive consequences they experience, as you will address how each consequence can be achieved in non-drug using ways. You may begin by asking the patient, *"What about using substances do you like?"* It is important to get as much information as possible including pleasant thoughts, feelings (mood states), and physical sensations associated with use.

5. **Long-term Negative Consequences:** The final step in the functional analysis is to identify the common negative consequences associated with substance use. It is important that the patient make direct connections between their substance use and negative outcomes. Some patients will not identify any negative consequences. Rather than pushing them to find these, remember to use the different principles of motivational interviewing, in particular developing discrepancies. Ask questions that will help them identify problems in their lives, i.e. at home, at school, and with peers. You might say:

> *There are probably some negative things you have noticed about your use although it's often not as easy to see these when you are having fun and feeling less bored* [after using]. *Also, the negative things sometimes take a while to become clear. Because they aren't always obvious, we will take some time to explore what these negative consequences might be for you.*

Some common negative consequences include poor school performance or difficulty obtaining a job, family conflicts, and loss of non-using friends. Identifying negative consequences and writing these down can have the immediate effect of enhancing motivation to change.

With some adolescents, it will be useful to consider a "biphasic response" to certain substances (Patterson and O'Connell, 2003, p. 81). Adolescents typically live in the moment and don't consider both the long- and short-term effects of a drug when deciding whether to use again. When they are about to use, they are usually thinking about the positive ways it will make them feel in the short-run. These expectations for a positive experience after using are called "positive outcome expectancies" (Marlatt and Gordon, 1985). What they often don't consider is how they will feel after the substance wears off. He/she might experience physical discomfort, followed by emotional upset from feelings such as guilt and anxiety. It is helpful to teach the patient how to anticipate this two-fold response, both the short-term positive and negative consequences of using. For some patients, this recall of the negative consequences that result from use can be a deterrent.

How It Works When It Goes Well

Do not expect to complete the functional analysis during one session. You may need to use two or even three sessions to complete the functional analysis (particularly if the patient is dependent on more than one substance). You should let the patient know that the FA will be an ongoing exercise throughout the treatment. You and the patient will continue, like avid investigators, to gather information about his/her external and internal triggers, as well as

negative and positive consequences associated with use. The critical task is to help the patient understand that by using this tool, he/she can become an "expert" on his/her own substance using behavior.

If a patient has difficulty answering the questions in the functional analysis, encourage him/her by giving examples. You do not want to skip over any of the particular steps if patients are struggling to identify information. If they are having difficulty, have them focus on one recent substance using experience, move slowly, pausing when they are stuck. If you proceed with care and patience, all patients will be able to make some statements about their use. Remember, this experience may be the first time someone has asked them these questions and listened to their answers without criticizing them.

Completing the functional analysis is a tremendous accomplishment for the patient and can help establish a strong working relationship. By exploring difficult material in a non-confrontational manner, you may begin to hear the patient say things such as, *"I never really thought about that…I guess I have been using a lot more in the last few months."* Or *"I didn't realize that I always use before I start my homework. Maybe that's why I don't finish it."* Or, *"I didn't use last night before I went to sleep for the first time in a few months."* As patients begin to explore exceptions to their use patterns, you will be able to support sobriety sampling. Sobriety sampling is a process in which the patient chooses to abstain under certain circumstances for a particular period of time. When the patient mentions a time when he/she did not use or could not because of certain circumstances, ask him/her what strategies and coping mechanisms he/she used to make being sober at that time easier. Exploring these non-using events will emphasize that they already have some skills/strengths to make sobriety sampling easier. The information that you obtain doing the functional analysis provides the bridge to the next session—**Core Module #3 Managing Urges and Cravings.**

At-Home Practice

Now that you have gathered this information with the patient, there are many opportunities for at-home practice. Some patients will complete the **FUNCTIONAL ANALYSIS** on their own, specifically, sections in which limited information has been gathered. You can encourage them to add to their FA. Keep in mind that it may be difficult for many patients to do on their own until they have a better understanding of their triggers and how to identify positive and negative consequences. If a patient is having a difficult time identifying internal triggers, let him/her know that understanding his/her internal processes can be hard. Reassure him/her that self-awareness will become easier in time. Ask patients to observe their use behavior before the next session and to take notes about situations leading up to the use. Their observations will help them identify triggers in more detail. They can write notes on the FA and bring them to the next session.

Below are other options for at-home practice:

Options:

- Complete the **EXPECTATION OF EFFECTS QUESTIONNAIRE**. It will help them identify positive consequences of substance use. If they are using different substances, have patients use a different color pen or pencil to indicate their patterns for each substance.

- Examine possible negative outcomes and negative expectancies of using by having the patient complete the sheet, **SOME CONSEQUENCES OF DRUG USE.** Negative outcomes are things that have already occurred, and negative expectancies are events that might happen in the future. While discussing this sheet later, you might have them identify the negative consequences which concern them most and describe why. Let them know that not all of the negative consequences listed will apply to them *now.* The implication is that these negative consequences could occur to patients in the future if their use patterns do not change.

- Another option for patients who have been able to identify strong negative consequences is to show them how to rewrite a negative consequence into a "benefit" of not using, i.e. *"I might get arrested"* could be written, "*live without worrying about the law*." This exercise is fairly sophisticated, and it will not work with all patients. You could then type these statements for the patient and make a wallet-sized card titled, **BENEFITS OF SOBRIETY** that can be carried by the patient. (For patients who are less far along, this exercise could be done later during the course of treatment.)

EXPLORING YOUR USE PATTERN

When we are trying to change a habit, it is important to look carefully at what is happening right **before** and **after** that behavior. During this session, we will complete something called a functional analysis of your substance use. (Don't worry about the fancy term ☺.) Doing this activity together will help us come up with a plan to help you stop using. If you know what your personal triggers are and what all the different consequences are (good and bad), you can take more control over the behavior.

For example,noticing that you smoke marijuana **after** you have had an argument with your parents and thinking *"I need it"* (to calm down), will help you realize that feeling angry and upset may be triggers for using. Knowing about your triggers, you can take other steps to help you with anger. For instance, you can choose a different activity to calm yourself down.

We will look at what you use, how much and how often, and any patterns connected with "who," "when," and "where." While it is sometimes difficult to know what you are **thinking** and **feeling** before you use, doing this exercise will help. Together we will explore the thoughts and feelings which may be connected with your use.

Some Words to Know

Craving = A strong feeling or urge for something (for example, a drug, food, sex, thrill, etc.) which feels uncomfortable and sometimes uncontrollable.

Trigger = Triggers are thoughts, feelings or behaviors that come before you use and which can lead to wanting to use. They can be *external* (persons, times of day, places) or *internal* (thoughts, emotions, physical feelings).

Substance of Choice = There may be several substances that are used. There is usually **one** which is strongly preferred, as it has the greatest positive effects (calming, pleasurable, etc.).

Consequences = Something that happens as a result of substance use. They can be either positive (feeling calm after using) or negative (drug or alcohol hangover).

It's also important to understand **WHY** we are doing something in order to change that behavior. We will look at the things you **LIKE (PROS)** about using as well as all of the things you **DON'T LIKE (CONS)** about using. It is expecting a lot of yourself to give up something you enjoy or which helps you feel better. We can look for other ways to make you feel this way (positive). Understanding pros and cons often helps us make good decisions about what we want to do in the future.

The information we gather is meant to help you, and it will not be shared with anyone else. It is our tool to keep us on track with the therapy.

FUNCTIONAL ANALYSIS FOR DRUG-USING BEHAVIOR

EXTERNAL TRIGGERS	INTERNAL TRIGGERS	DRUG USING BEHAVIOR	POSITIVE CONSEQUENCES	NEGATIVE CONSEQUENCES
1. Who are you usually with when you use drugs?	**1.** What are you usually **thinking** about right before you use drugs?	**1. What** drugs do you usually use?	**1.** What do you like about using drugs with__________________? (who) **2.** What do you like about using drugs ____________________? (where)	What are the negative results of your drug use in each of these areas: **a.** Family members **b.** Friends **c.** Physical feelings
2. Where do you usually use drugs?	**2.** What are you usually **feeling physically** right before you use drugs?	**2. How much** do you usually use?	**3.** What do you like about using drugs ____________________? (when) **4.** What are some of the pleasant thoughts you have while you are using drugs?	**d.** Emotional feelings **e.** Legal situations **f.** School situations **g.** Job situations
3. When do you usually use drugs?	**3.** What are you usually feeling **emotionally** right before you use drugs?	**3.** Over **how long** a period do you usually use drugs (hours, days, weeks, etc)?	**5.** What are some of the pleasant physical feelings you have while you are using drugs? **6.** What are some of the pleasant emotional feelings you have while you are using drugs?	**h.** Financial situations **i.** Unprotected sex (e.g. unwanted pregnancy, HIV/STDs) **j.** Victim or perpetrator of violence (e.g. date rape, sexual assault, unwanted sex) **k.** Other situations

EXPECTATION OF EFFECTS QUESTIONNAIRE

Directions:
Below is listed a number of ways in which drugs may affect you. Indicate how you think the drugs you have preferred will generally affect you by putting a check mark in the appropriate place on the scale between each descriptor. For example, on the "happy-sad" scale, you would place a check mark by "happy" if drugs would make you happier, by "sad" if they would make you sadder, and between "happy and sad" if the drugs you take would have neither effect. Do not worry about right or wrong responses.

How would moderate use of your drug of choice generally affect you? *(You can do this for more than one drug--just use a different color.)*

1. happy ---------------------------------- sad

2. tense ----------------------------------- relaxed

3. loud ------------------------------------ quiet

4. depressed ------------------------------ elated (happy)

5. daring ---------------------------------- cautious

6. sleepy ---------------------------------- wide awake

7. patient ---------------------------------- impatient

8. clumsy ---------------------------------- coordinated

9. excited ---------------------------------- calm

10. bored ------------------------------------ interested

11. polite ------------------------------------ rude

12. quick responses ------------------------ slow responses

13. obedient --------------------------------- defiant/argumentative

14. outgoing --------------------------------- shy

15. aggressive ------------------------------- non-aggressive

16. responsible ------------------------------ irresponsible

17. more sexual ----------------------------- less sexual

18. more humorous ------------------------- less humorous

19. self-conscious --------------------------- unself-conscious

UNDERSTANDING HIGH RISK SITUATIONS

(as they relate to your sobriety)

At the time I was tempted to use:

1. I was (where?): ____

2. I was with (whom?): ____

3. What was happening in the situation just before I felt tempted to use?: ____________

____

4. Right before I felt tempted, I felt (emotions): ____________________________

____

5. Right before I felt tempted, I was thinking (self talk): ______________________

____

6. What tempted me the most to use in this situation? ________________________

____

7. I believed that the pros of using would be: ____________________________

____

8. I believed that the cons of using would be: ____________________________

____

9. ☐ My **pros** proved to be true ☐ My **cons** proved to be true

10. ☐ I decided to use ☐ I decided not to use

11. If I decided to use: What else might I have done to avoid using?

____

12. If I decided not to use: What exactly did I do to help me avoid using?

____

13. Describe any bigger problems or concerns in my life that may have influenced my decision in this situation: ____

____

Adapted with permission from Miller, W.R., ed. COMBINE Monograph Series, Volume 1. Combined Behavioral Intervention Manual: A Clinical Research Guide for Therapists Treating People with Alcohol Abuse and Dependence. DHHS Publication No. (NIH) 04-5288. Bethesda, MD: NIAAA, 2004.

SOME CONSEQUENCES OF DRUG USE

A. Legal

1. Engaging in illegal activities to obtain drugs (e.g. stealing, buying/selling)
2. Losing license
3. Being put on probation
4. Going to jail

B. Family

1. Changes in relationships with family members (e.g. increasing time alone, avoiding family)
2. Loss of trust
3. Arguments about drug use
4. Spending money needed by family on drugs
5. Lack of motivation or drive to do things
6. Mood changes that create suspicion or uncertainty in family members

C. Social

1. Loss of friendships
2. Neglected hobbies, interests, or school activities because of drug use (e.g., sports, clubs, etc.)

D. School or job problems

1. Absences
2. Suspension
3. School drop out
4. Threat of job loss or loss of job

E. Physical

1. Health concerns (e.g., worries about damaging body organs, increased illnesses)
2. Withdrawal symptoms
3. Avoiding medical attention
4. Accidents due to drug use

Questions to ask yourself:

1. Which consequences have you experienced? *(Indicate by circling item)*
2. Which consequences are you most concerned about? *(Indicate by putting a square around item)*
3. Which consequences would most likely make you reduce drug/alcohol use? *(Indicate by putting a star by item)*

Assign At-Home Practice
Work with the adolescent on an assignment, such as finding information about an activity or sampling one or two new pro-social/non-drug activities that are enjoyable but incompatible or inconsistent with substance use. Ideal activities are those that the patient finds fun /enjoyable and which put them in association with non-substance using peers and pro-social adult role models (e.g. principle based martial arts; yoga; basketball team; rec center, etc). The idea is to increase the adolescent's frequency of engagement alternative activities to using drugs in ways that assist the patient in building a more sustainable drug free lifestyle that can help patients maintain treatment gains after completing *Encompass.* In Encompass, the therapist and patient negotiate two such activities each week. The patient receives an opportunity to draw for a prize for each of the two activities completed (with documentation). Selection of 2 non-drug prosocial activities/week should normally begin by the end of the second session (usually Module 2) and may be the focus of 'at home 'practice because these activities are often related to specified treatment goals. Selection of pro-social activities at the end of Module 3 /Functional Analysis can be even more strategically selected to occur at high risk times of the day or the week to reduce exposure to "external triggers" or used to avoid high risk situations be activities that occur at high risk times of day or week (ie after school, weekends, etc).

PHASE 2: SKILLS MODULES

MODULE 4: Coping with Cravings and Urges to Use

Summary of Tasks

- Illustrate a craving and have patients describe their own cravings
- Teach how to recognize triggers and reduce exposure to them
- Instruct on skills used to manage cravings
- Write down a craving plan enumerating skills taught to cope with cravings

Introducing Skills Modules Phase of Treatment

At this point in treatment, you will be emphasizing the importance of acquiring and practicing new skills to manage high-risk use situations and meeting the goals established in the former phase. In each session, you will be asking the patient to identify a high-risk situation(s) from the previous week and an anticipated high-risk situation(s). You will emphasize the skills that can be used to meet these challenges.

This is a good time to emphasize that the **in-session** and **at-home practice** are central to the skills-training program, as these are the main strategies by which patients acquire new skills. Explain that skills and behaviors learned in therapy will have a greater chance of success if practiced outside the therapy session. Role plays are meant to be close to "real life" events so they will have meaning. Let patients know that the therapy workbook with skills handouts and practice exercises is for them to keep, giving them some immediate ownership in the therapy process. At this time, you may want to show them the different skills modules in their therapy workbook to let patients know that you will be covering them together. Aside from the first three modules, which you will want to complete in order, you will be able to choose modules based on a collaborative process of decision-making as you continue the therapy. Give patients the message that you believe they will have important ideas for the skills and practice necessary to address the problems in their lives.

Presenting Session Rationale

Cravings, or urges to use, are most often experienced early in treatment, but episodes may persist for weeks, months, and sometimes even years after some people stop using substances. It is important to inform the patient that experiencing cravings may be uncomfortable, but is very common; having them does not mean something is wrong. Tell patients that they should expect cravings to occur from time to time and they will learn to be prepared to cope with them. If a patient has recently become abstinent, he/she may experience cravings as a direct result of not having enough of the drug in his/her body (withdrawal). You may need to explain the difference between withdrawal symptoms and cravings. The purpose of this session is to help patients understand what a craving is, to validate their experiences with cravings, and to teach them skills to manage them.

In presenting a rationale for this session, you might say:

Cravings can feel pretty out of control, especially when you have just quit. I want to make sure that you have some tools to help you move through them right away. Do you have some things you already use to help you get through them?

With a resistant adolescent who has not identified a desire to change his/her substance use (and who might be denying having cravings), you might say:

Even though you're pretty sure you don't want to try quitting, you may at some point. It's good to have some tools to help you get through the tough times when you might want to use. Let's go through those tools now so you can be prepared.

Key Interventions

Defining Cravings

Most patients will be able to describe what a craving feels like. They will be less familiar with their personal triggers. They also may never have verbally expressed the sensations associated with a craving to anyone else. The therapist can begin the session by giving patients a working definition with some examples of cravings to help them put their experience into words. You can share an example of one of your own cravings, such as with particular foods. By sharing a personal example, you will be validating your patient's experience. Sights, sounds, smells, or other cues from their environment, such as driving past a dealer's house or seeing drug paraphernalia, can trigger cravings. Cravings may include physical feelings, such as tightness in the stomach, feelings of nervousness throughout the body, and headaches. Their "mind" may be telling them how good it would feel to use or that they "need" to use because if they don't, they will keep feeling empty inside, bored, angry, or some other mood state. Keep reminding them that these are normal reactions for their body and mind. There are different types of cravings, and you want to explain these different types to the patient:

Common Types of Cravings

- Response to withdrawal symptoms
- Response to lack of pleasure and desire for excitement
- Response to anxiety
- "Conditioned" response to drug cues

Continue to remind them throughout the session that cravings are uncomfortable but they are normal and not dangerous; they are not "going crazy." Cravings are time-limited; they usually last only a few minutes. Rather than increasing steadily until they become unbearable, they usually peak after a few minutes and then die down, like a wave. The image of the wave can be very effective as you describe a craving and the process of controlling it. Many patients can relate to the imagery of a wave, or you can help them find and use their own images to describe what their cravingsfeel like. You offer relief when you let patients know that cravings will become less frequent and less intense as they learn to cope with them.

Reducing Exposure to Control Cravings

During this session, you will emphasize ways in which the patient can restructure his or her environment to reduce exposure to triggers. With the information gathered during the functional analysis, you have specific data about the types of situations, feelings and thoughts that trigger cravings. You want to help the patient learn to recognize urge "triggers" so he/she can reduce exposure (i.e. get rid of substances, avoid going to locations where there will be substances, reduce contact with using friends or acquaintances). Patients are taught how to recognize urge triggers and ways to reduce exposure. Remind them that the easiest way to deal with cravings is to avoid triggers in the first place. As stimuli cannot always be avoided, patients are taught specific coping strategies and will identify a craving plan for different high-risk situations. Some triggers are hard to recognize, and self-monitoring can help you recognize them. Patients are taught how to use the **DAILY RECORD OF URGES** and/or **SELF-MONITORING RECORD** during the session.

Techniques for Helping Patients Reduce & Manage their Cravings
Sometimes a person cannot avoid a craving, and it is necessary to find a way to cope with it. There are many different strategies for coping with cravings. The four skills described below provide a simple, easy-to-remember menu of choices. As you teach these skills, emphasize that certain ones will work better in certain situations and for certain people. Each skill can be useful as a tool to enhance control over body and mind in a high-risk situation. When covering these skills, make sure that you ask the patient what strategies they have used in the past to manage a craving successfully. This conversation will reinforce their belief that they can cope with the strong urges they may be having currently.

1. **Distracting activity:** With this skill, you are trying to change the focus from internal to external. Explain that because cravings are uncomfortable, it can be very useful to think of other activities to do when patients might normally be using and throughout the day and night. While doing the functional analysis, many patients will describe a daily routine which includes few, if any, non-substance using activities. It is probably not realistic to expect the patient to take up new hobbies, join new social groups, or make other large-scale changes immediately. However, you will encourage them to make small steps in healthy, prosocial directions by sampling new activities. Ask patients to think of other things they like to do, such as reading, going to a movie, attending a cultural event, shopping, or exercising. When they experience a break from using and the sensation of doing something pleasurable while clean, they often express feeling happier and more in control of their behavior. When they try a new activity, make sure to reinforce this attempt by praising their ingenuity and adventurousness. During the session, you may ask the patient to start writing a list of all the activities they can think of. You can also have the patient complete the **RECREATION QUESTIONNAIRE** either during the session or at home to help them think about alternate activities besides using drugs. This exercise may remind them of activities they used to enjoy, but have stopped because of their drug use. There is additional information about increasing pro-social activities in Module #6 Negative Mood Regulation.

2. **Talk it through:** With this skill you are encouraging the patient to use his or her support system, as well as other community resources. There is a long tradition, with 12-Step facilitation programs leading the way, of utilizing support persons to call on during risky times to maintain sobriety. Talking to family and/or friends about a craving when it occurs can help pinpoint the source of the craving and relieve the uncomfortable feelings. Remind patients that cravings are nothing to be ashamed of or

to feel bad about. Many adolescents are not used to talking with family about their substance use, and you will want to make sure that, if they do, they will not be further shamed or punished for sharing their feelings. Friends can often be good resources for self-disclosure about cravings. Some friends may also be trying to quit or have already done so. Even if they are not trying to quit, they may be very willing to help their friend manage a craving. Help the patient make good decisions about whom he/she asks for help.

3. **Self Talk:** You will teach the patient to remind him- or herself of the benefits of not using and the negative consequences of using. You will help the patient generate self talk based on these new thoughts. When experiencing a craving, many people have a tendency to remember only the positive effects of drug use and often forget the negative consequences of use. The patient should be encouraged to use self-talk, such as, "*I really won't feel better if I have one hit*," and that, "*I stand to lose a lot by using.*" Sometimes it is helpful to have these benefits and consequences listed on a small card that they can keep with them. Tell patients that what they say to themselves about their use will affect how they experience and handle their urges. Self talk can be put to use to strengthen or weaken urges. The process of making self-statements becomes so automatic that they may not even notice when it is happening. Hidden or automatic self-statements about urges can make them harder to handle. For example, *"Now I want to have a hit. I won't be able to stand this. It's going to get stronger and stronger until I blow up or use."* Other self-statements can make the urge easier to handle:

> *This urge is uncomfortable, but in 15 minutes or so, my body will be calmer and I will be feeling like myself again. I'll call my cousin to help pass the time. I've been through worse ones* [urges] *before and it eventually passed.*

The use of self talk introduces the patient to cognitive restructuring. Cognitive restructuring is when you *identify* and *change* negative thought patterns that are contributing to use. This topic is covered in much greater detail in Module #6 Negative Mood Regulation (titled *How to Feel Better: Managing Negative Moods* in the patient workbook). Recognizing which pattern of negative self talk is contributing to cravings will be helpful to the patient. However, it requires diligent practice to examine thoughts carefully and to challenge them as well. Some patients might gain from introducing cognitive restructuring early in treatment. However, it does require a level of maturity and patience to follow the steps described below. You will need to gauge a patient's readiness to practice this particular skill in depth at this time or later in the treatment. Cognitive restructuring may not be effective with all patients if it is done too early. One option is to introduce it here as "self talk" and to let the patient know that he/she will be learning more about how to do it later in treatment.

Start by helping the patient identify self talk statements which strengthen his/her urges to use. In each of the statements below, you can see how the patient's thoughts could sabotage sobriety:

> *I can't stand it. If I don't get high, I'm going to blow up.*
>
> *Everybody is mad at me; I might as well get high.*

I haven't been drinking all month. Having a couple of beers tonight won't matter.

Next, have the patient identify which self-talk statements can be used to weaken his/her urges to use. These new positive self statements are constructive and provide motivation to staying sober:

I'll make it through this. It won't be so bad if I can get out of the house.

I'm o.k. and I've been doing really well [with not using]. *I don't want to blow it now.*

If I drink tonight, I'll be starting all over again.

This self talk is often so automatic and quick that it's hard to catch it and then stop the behavior. Let the patient know that it takes some practice and not to get discouraged. An effective challenge to an urge will make you feel better (less tense, anxious, angry) and more in control. You and your patient may want to read the handout **USING *SELF TALK* TO MANAGE A CRAVING** during the session and/or have him/her work on it at home; then, you can discuss it during the next session.

4. **Urge surfing:** Many people try to cope with their urges by trying to be strong, gritting their teeth, and toughing it out. Some urges, especially when you are in a beginning stage of sobriety, are just too strong to ignore. When this happens, it can be useful to stay with your urge to use until it passes. This technique is called *urge surfing*. The idea behind urge surfing is similar to the idea behind many martial arts—one overpowers an opponent first by going with the force of the attack. By joining with the opponent's force, one can take control of it and redirect it to one's advantage. This technique of gaining control by first going with the opponent also allows one to take control while expending minimal energy. Urge surfing is similar. You can initially join with an urge instead of meeting it with a strong opposing force. Suggest to the patient that using urge surfing will greatly increase his/her confidence for managing cravings. To teach this skill, you may review the **STEPS FOR URGE SURFING** in the handout section.

In-Session Practice

Once you have completed teaching the four skills described above, the patient will practice by designing a **CRAVING PLAN.** He/she will be using the skills that he/she has learned. Let patients know how important it is to be prepared for situations that might arise. Remind them that cravings can come when they least expect them. Have them describe *which* activities they would pick and *whom* they might call if they were having a craving. Which activities are immediately available? Which ones would need some preparation? Would they be willing to speak with a family member, friend, other support person, or group member if they are in trouble with a craving? You can do a role play of how they would ask for that help. A **CRAVING PLAN** should be as specific as possible and should be written down. Another important part of designing this plan is to acknowledge which skill(s) they are least likely to use and have patients explain why. The plan should be realistic and should match the skill(s) they are most likely to choose with the high-risk situations they will encounter.

At-Home Practice
Let the patient know that he/she will be developing his/her **CRAVING PLAN** throughout the treatment. Therefore, it will be important to keep working on the plan at home. In fact, it is helpful to tell them that this plan will be refined over the weeks and months during which they are learning to be sober. In addition to working on the **CRAVING PLAN**, there are several exercises which they can do at home:

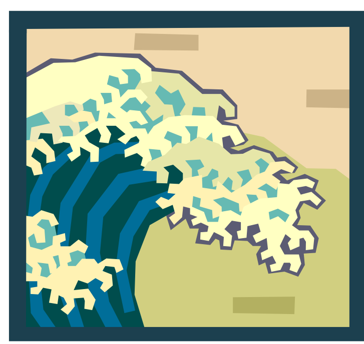
Options:

- Have the patient complete the **DAILY RECORD OF URGES TO USE** for all days between this session and the next. The record is usually fairly easy for most patients to follow and complete. However, make sure you review it before assigning it. It helps patients become very aware of when they are using their **CRAVING PLAN** and when they are not, as well as about the intensity of their cravings under certain circumstances.

- It is important to practice continually how to identify high-risk situations. Have the patient identify high-risk situations by using the **PERSONAL TRIGGERS LIST**. Explain that once we know about situations and problems that contribute to using, he/she can look for ways to deal with these precedents.

- Using the **SELF MONITORING RECORD** on his/her own can help a patient build confidence in knowing and understanding his/her substance use behavior patterns as well as what happens when they decide NOT to use. As this is a more complex assignment, it is useful to practice one example with patients before assigning it as homework. To practice during the session, have patients share a recent example of when they either did use or didn't use when having a craving. In the **SELF MONITORING RECORD**, the patient answers several questions in a systematic way to uncover patterns of use (or non-use). Ask his/her to recall his/her thoughts and feelings at the time of use, as well as the positive consequences of using (or non-using), and the negative consequences of using (or non-using). When patients were successful and did not use, ask them to record what specific methods and skills they employed.

- To increase pro-social (non-substance using) activities ask the patient to start writing a list of all the activities he/she would like to try. You can have the patient complete the **ACTIVITIES QUESTIONNAIRE** to help him/her think about alternative activities to using drugs. This activity may remind patients of activities they used to enjoy, but have stopped because of their substance use. They could also look at **FINDING ACTIVITIES YOU ENJOY** in Module #7 Negative Mood Regulation. This will help them identify and use distracting activities to manage cravings.



COPING WITH YOUR CRAVINGS

Cravings can feel pretty out of control, especially when you have just quit using a substance. The purpose of this session is to help you understand what cravings are and to teach you skills to manage them. Cravings, or urges to use, usually weaken and occur less frequently the longer you have been sober. However, triggers are wired in our brains like computer circuitry; our brains will remember triggers and respond to them for weeks, months, and sometimes even years after you stop using.

For example, if one of the places you always smoked marijuana was behind the baseball diamond at a neighborhood park, you may experience a craving to use for many weeks or months (or even years later) if you walk by or think about being at that spot. Remember, this craving may not be very strong as time passes. However, you will still want to be prepared to cope with these feelings.

Skills Used to Help Manage Cravings

Distracting Activities: Think of other things you like to do, such as reading, a hobby, going to a movie, talking on the phone, shopping, or exercising. Once you get interested in something else, you will find that the cravings usually go away. Think about activities you used to enjoy, but have stopped because of using or for other reasons.

Talk it Through: It's important to use your **support system** (remember the people you put on your goal sheet). Talking to a friend or sometimes a family member about a craving can sometimes help relieve the feelings. Cravings are nothing to be ashamed of or to feel bad about. You want to make good decisions about whom you ask for help. Identify someone who won't make you feel worse about having a craving and who might understand what it feels like.

Self Talk: Your self talk (thoughts you say to yourself) can help you. The process of making self-statements becomes so automatic, that you may not even notice that you do it. For example, *"Now I want to have a hit. I won't be able to stand this. It's going to get stronger and stronger until I blow up or use."* Other reassuring self talk can make the urge easier to handle: *"This urge is uncomfortable, but in 15 minutes or so, my body will be calmer and I will be feeling like myself again."* Remind yourself of the "cons" (negatives) of using. Tell yourself that you really won't "*feel better if you just have one hit*," and that "*you stand to lose a lot by using*."

Urge Surfing: Some urges, especially when you are in a beginning stage of sobriety, are just too strong to ignore. When this happens, it can be useful to stay with your urge to use until it passes. This technique is called *urge surfing*. The idea behind urge surfing is similar to the idea behind many martial arts—one overpowers an opponent first by going with the force of the attack. This is not easy to do at first, but with practice, it can become very satisfying and empowering to know that you can quiet an urge.

Remember, cravings may be uncomfortable, but are a very common experience. Having them does not mean something is wrong. You should expect cravings to occur from time to time and should be prepared to cope with them when they do.

CRAVINGS PLAN WORKSHEET

It is important to have a strong plan that you can use when a craving or urge to use happens. Each of these skills will be useful at one time or another. You may start with learning and relying on one more than another to keep you safe from slipping. That's fine. However, consider each one carefully so that you have the strongest plan possible and try them out in different situations. Often you will be using more than one skill at a time. That's great!

Distracting Activities	Self Talk	Talking it Through	Urge Surfing
What kinds of activities might keep you from focusing on your cravings? Try to think of ones that might make you feel the same way **WITHOUT USING,** e.g., need to feel excitement (manage boredom) going snowboarding instead.	What **POSITIVE** statements can you say to yourself when you are having a craving to keep you from giving in to it? These positive statements are often connected with your **PERSONAL GOALS**, e.g., *"I am going to get this job, but not if I get high tonight."*	Who could you talk to if you were having a craving to use? It's important to let these **SUPPORT PEOPLE** know you might be relying on them to help so give them a "heads up." Think about what specific things you would like from these people, e.g., to talk about the craving, *not* to talk about it, go for a walk, etc.	When might you use Urge Surfing to help you manage a craving? At first practicing this skill may feel a little uncomfortable, but after a little practice you will start to appreciate how empowering it feels to be able to **FLOW THROUGH A CRAVING**. Let the thoughts, physical and emotional sensations pass through and around you until they die down.
List distracting activities below: 1. 2. 3. 4.	Write positive self-statements below: 1. 2. 3. 4.	List people who would be helpful to talk to below: 1. 2. 3. 4.	Choose times to practice Urge Surfing below: 1. 2. 3. 4.

<u>USING *SELF TALK* TO MANAGE A CRAVING</u>

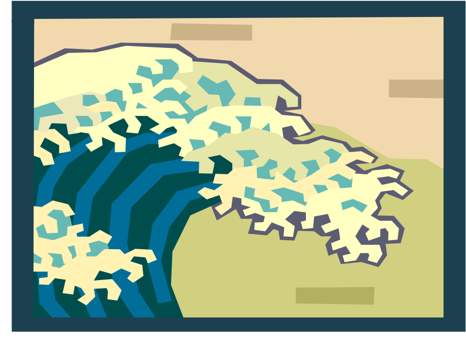
1. Pinpoint what you tell yourself about a craving that makes it harder to cope. One way to tell if you are on the right track is when you hit upon a <u>self-statement</u> (those are the automatic thoughts going through your head) that makes you feel uncomfortable.

Example: *"I am so bored. I will die if I don't get high immediately!"*

2. Use <u>self talk</u> (thoughts you say to yourself) to help challenge the belief that you are *"going to die"* if you don't get high. If you can look at things differently (*"I'll be o.k. if I don't get high," "this boredom will pass in time ... there is something I can do to take care of the boredom")*, it will make you feel better (less tense, anxious, panicky), although it may not make the feelings disappear entirely. Below is a list of different questions and statements to help you generate new self-statements (think different thoughts). If you try these, your craving should get weaker.

a. What will it feel like to let myself just sit here and be quiet?
b. What is the evidence that I will "die" if I don't get high immediately?
c. Will this uncomfortable feeling last forever?
d. What happens to feelings and thoughts when we let them "just be?"
e. What is the worst thing that will happen to me if I don't use?
f. Will using make me feel better or worse in the short run? In the long run?
g. Will I be ok if I let myself experience sitting through this urge?
h. What are some of the bad things that might happen if I *do use* right now?
i. What are some good things that might happen if I *don't use* right now?

Use these substitute thoughts or self-statements as long as you need to until you start feeling more comfortable about yourself and the situation. This strategy will also help you change your beliefs about life and substances. For instance, you might be saying to yourself now, *"I am just as good a friend when I don't use as when I am high." "I'll be o.k. if I don't smoke weed at the party."* Using substitute statements is more than the power of positive thinking. You must actually believe in what you are saying to yourself. Take your time with this exercise and be patient with yourself. It's not easy to change thoughts, but it really works.



PRACTICE EXERCISE
Learning New Self Talk for Managing Cravings

One way to cope with thoughts about using substances is to remind yourself of the benefits of not using, the unpleasant consequences of using, and the high-risk situations that may make it hard to keep your commitment to being sober. Use this sheet to make a list of a few important reminders in each category.

Positive benefits of not using: ____

____

____

____

____

Unpleasant effects or negative consequences of using: ____________________________

____

____

____

____

High-risk situations which make it difficult to keep your commitment not to use (such as hanging out with using friends):____

____

____

____

____

Overall level of personal commitment to remaining sober:

1 2 3 4 5 6 7 8 9 10

None **Extremely high**

Sometimes it helps to write a list of all the positive things about NOT USING onto a pocket-sized index card. Read this card whenever you start to have thoughts about using. This can really help.

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STEPS FOR *URGE SURFING*

1. Describe all the ways you experience the craving (your thoughts, your feelings, and, especially, how your body feels). Do this by sitting in a comfortable chair with your feet flat on the floor and your hands in a comfortable position. Take a few deep breaths and focus your attention inward. Allow your attention to wander through your body. Notice where in your body you experience the craving and what the sensations are like. Notice each area where you experience the urge, and tell yourself what you are experiencing. For example: *"Let me see . . . My craving is in my mouth, nose, and in my stomach."*

2. Focus on one area in which you are experiencing the urge. Notice the exact sensations in that area. For example, do you feel hot, cold, tingly, or numb? Are your muscles tense or relaxed? How large an area is involved? Notice the sensations and describe them to yourself. Notice the changes that occur in the sensation. *"Well, my mouth feels dry and parched. There is tension in my lips and tongue. I keep swallowing. As I exhale, I can imagine the tingles and sensations of being high."*

3. Repeat focusing on each part of your body that experiences the craving. Pay attention to and describe to yourself the changes that occur in the sensations. Notice how the urge comes and goes. Many people notice that, when they urge surf, the craving vanishes after a few minutes. The purpose of this exercise, however, is not to make the craving go away, but to experience the craving in a new way. If you practice urge surfing, you will become familiar with your cravings and learn how to ride them out until they go away naturally.

REMINDER SHEET

<u>Coping with Cravings and Urges</u>

Urges are common in the recovery process--not a sign of failure. Therefore, try to learn from them about what triggers your cravings.

Urges are like ocean waves. They get stronger only to a point and then they start to go away.

You win every time you defeat an urge by not using. Urges only get stronger if you give in and feed them. An urge will eventually weaken and die if you do not feed it.

REMEMBER: Stopping a substance can cause cravings TEMPORARILY! It is common to experience a variety of different uncomfortable sensations and feelings when your body and mind are getting used to not having the drug in your system. These can include: irritability, sleeplessness, decreased appetite, anxiety, restlessness, headaches, stomach aches and drug craving, all of which can make it difficult to remain abstinent. **Try to hang on! They will eventually go away (usually within a few days).**

Skills you can use:

1. **Distracting Activities**
2. **Talk it Through**
3. **Urge Surfing**
4. **Self Talk (remind yourself of the benefits of not using)**

For the next week, make a daily record of urges to use drugs or alcohol, the intensity of those urges, and the coping behaviors used.

Fill out the **DAILY RECORD OF URGES**

- **a.** *Date*
- **b.** *Situation:* Include anything about the situation or your thoughts or feelings that seemed to trigger the urge to use.
- **c.** *Intensity:* Rate your craving, where 1 = none at all, 100 = worst ever.
- **d.** *Coping behavior:* Use this column to note how you attempted to cope with the urge to use. Note how well your coping behavior worked to withstand the craving and perhaps what might work better next time.

Examples:

Date	**Situation (include your thoughts and feelings)**	**Intensity of cravings (1-100)**	**Coping behaviors used**
5/16/09	Was feeling stressed. Had a disagreement with my dad.	**75**	Shut myself in room and listened to music. Felt better after 20 minutes.
5/17/09	Antsy at bedtime. Trouble getting to sleep.	**60**	Played hoops. Took a hot shower.

DAILY RECORD OF URGES TO USE

Date	Situation (include your thoughts and feelings)	Intensity of cravings (1-100)	Coping behaviors used

SELF- MONITORING RECORD

TRIGGERS (What sets me up to use?)	THOUGHTS AND FEELINGS (What was I thinking?) (What was I feeling?)	BEHAVIOR (What did I do then?)	POSITIVE CONSEQUENCES (What positive thing happened?)	NEGATIVE CONSEQUENCES (What negative thing happened?)

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PERSONAL TRIGGERS LIST

Instructions: Many people develop regular habits about when and where they use drugs, and also when they don't use drugs. Common drug use situations include when you first wake up, before, during or after school/work, with a particular friend, and at parties. We are going to look at the times you are least likely and most likely to use.

A. Times you are LEAST likely to use:

	SITUATION/ACTIVITY	DAY	TIME
1.	Therapy sessions	Tuesday	5:00 p.m.
2.	______________________________	__________	__________
3.	______________________________	__________	__________
4.	______________________________	__________	__________
5.	______________________________	__________	__________

B. Times you are MOST likely to use:

	SITUATION/ACTIVITY	DAY	TIME
1.	Friends after school	Weekdays	3:00 p.m.
2.	______________________________	__________	__________
3.	______________________________	__________	__________
4.	______________________________	__________	__________
5.	______________________________	__________	__________

ACTIVITIES QUESTIONNAIRE

1. How do you spend your free time now?

____

____

2. Are you participating in any activities on a regular basis?

Yes ___ No ___ If **YES**, name them:

____

____

3. What activities do you participate in occasionally?

____

____

4. What do you like about those activities?

____

____

5. What activities have you never participated in, but would consider trying?

____

____

6. When in the next few days can you try a few new activities?

Day **Activity**

______________ ____

______________ ____

7. Did you participate in those activities (#6)?

Yes_____ No ____

If Yes, what did you like about them?____

If No, why not?____

MODULE 5: Communication Skills

Summary of Tasks

- Explain "How Communication Happens" using teaching sheet
- Teach, model and practice verbal and non-verbal communication skills
- Introduce styles of communication (passive, aggressive, assertive)
- Address point that communication styles can be culturally constructed
- Describe how to give and receive criticism *constructively*

Presenting Session Rationale

Presenting a rationale for this session can be challenging, as adolescents often feel blameless and believe that the fault in their blowups or miscommunications lies with others, e.g. parents, teachers, members of law enforcement. Or, patients may be feeling hopeless about changing the ways in which they communicate. It is very important that you provide relevant examples to show them how their communication skills can be improved. Let them know that effective communicators tend to feel more appreciated and understood; they can deal with problems more smoothly, calmly, and easily.

In presenting a rationale for this session to the patient, you might say:

> *Learning how to get your point across and to listen well will really help—hopefully, it will make it easier for you to get along with people* [at home, school, with friends]. *Sometimes we don't even know when we're in trouble with how we are communicating. I'm going to teach you how your body and language can be used to get people to listen.*

With a resistant adolescent, you might say:

> *It's really hard to get people to listen sometimes. This may not seem important now, but let's come up with some examples of times when you couldn't get your point across* [school, friends, law, etc.] *and see if we think these might come up again. I'll teach you some ways you might have more success. I'm going to teach you how your body and language can be used to get people to listen. Learning how to get your point across can really help.*

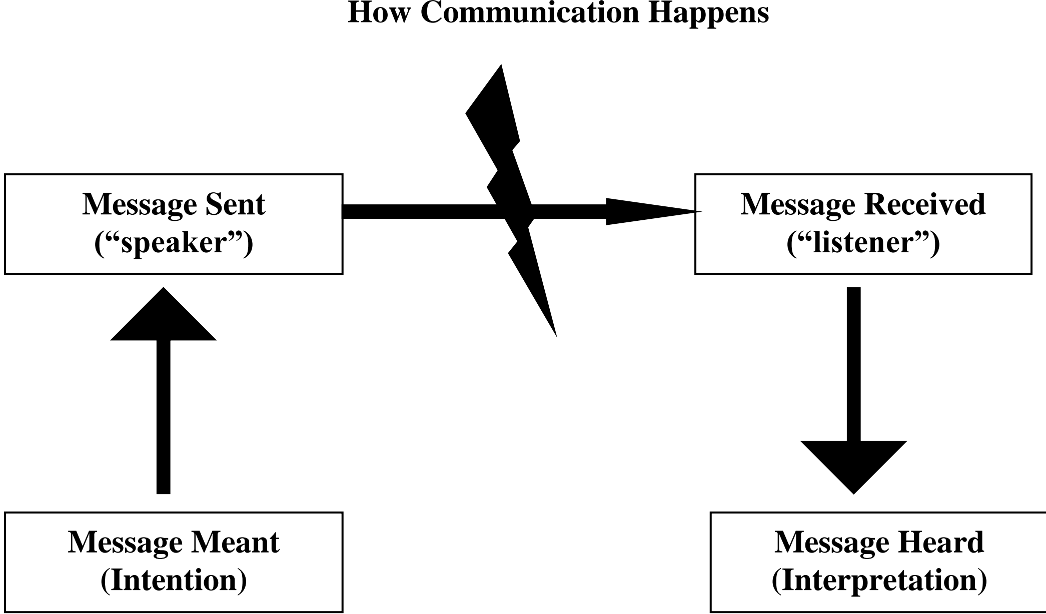
Key Interventions

This session contains a lot of material, so there's a danger that you will spend too much time teaching and not enough time practicing. The material in this chapter provides wonderful opportunities for role plays, so allow enough time for them. You may choose to select particular areas to cover based on what you already know about the patient. For instance, if the patient has difficulty clearly expressing feelings, then spend some time reviewing **Reminder Sheet: Feeling Talk and Listening Skills**. If, on the other hand, the patient tends to express him/herself using several negative patterns review the **Reminder Sheet: Patterns to Avoid in Effective Communication** and emphasize this information. The teaching points are divided into non-verbal and verbal skills. There are also sections on learning an assertive style of

communication and on giving and accepting criticism. Both sections contain very important skills to teach some patients.

Throughout this module you will be referring to the "speaker" (the person who is trying to make his/her point) and the "listener" (the person who is focused on understanding what is being said to them). Often what happens when there is miscommunication is that both people are trying to be heard and understood <u>at the same time</u>. This dynamic does not work well. Let the patient know that learning how to use the skills in this module will help him/her become a good speaker as well as a good listener, and that as a result, things will go more smoothly.

How Communication Happens



Be aware as you teach these skills that styles of communication are influenced by cultural differences. For instance, in some cultures, it would be considered extremely rude or even hostile to look directly into someone's eyes for a long period of time. In another culture, it is quite normal to use very direct eye contact. Body posture and position vary from culture to culture. Remember to ask the patient what is comfortable in his/her cultural experience rather than making assumptions and giving directions that might create discomfort or confusion.

Adolescents often don't understand that empathic listening and understanding someone else doesn't mean they are conceding their position. Instead, it means they are trying to understand the other person's position. Moreover, most adolescents don't understand that although it FEELS like their position is TRUTH with a capital T, the other person also usually feels he/she has TRUTH with a capital T on his/her side. Help the patient understand that most of us feel that we are right during times of disagreement and highly charged feelings. Explain that TRUTH with a capital T probably doesn't really exist; there are multiple truths. What is important in communication is for each person to be understood in order to create a win-win situation out of the conflict. Win-lose isn't an effective strategy in the long run; neither is lose-lose. If you lose, you may want to get even with the winner. It's not easy to come up with a win-win position. The first step is to LISTEN to what the other person is saying and to try to

see it from his/her perspective. (**Reflective Listening** is a very important skill to help defuse a hot conflict and will be taught later in the session.)

Verbal and Non-Verbal Communication Skills
Non-verbal and verbal communication styles convey many different messages; therefore, it is important to work on both. Point out that sometimes, one may not be aware of non-verbal messages because they are a habit, like not making eye contact when you are nervous or waving your hands wildly when you are angry. Inconsistent messages can be confusing, i.e. speaking with an angry tone, but saying you are not angry. In demonstrating the material for non-verbal and verbal communication skills, try to be entertaining without going overboard. Some exaggeration may be necessary (and you can state that as you demonstrate) in order to make a point. You will model how to do each skill first incorrectly and then correctly. If you know that one or more of these skills is a particular area of weakness for the patient, you can emphasize that skill without necessarily stating that it is a deficit. Likewise, when you have observed that patients are proficient in a skill, make sure you mention their ability, thereby reinforcing the behavior.

You will cover each of the skills (non-verbal and verbal) using the lists below to prompt for examples. Use real examples from situations in their lives whenever possible, e.g. if they have told you about an argument they have had or a time when they were unable to express themselves. It may feel more natural to combine the non-verbal and verbal skills as you demonstrate. However, it is useful to begin with some examples of non-verbal communication to warm them up. Often feeling a lack of empowerment in situations (e.g. criticized or punished for expressing their opinions), these adolescents have likely learned to revert to using passive body language to get their point across. By the time they reach therapy, most adolescents have already developed a lifetime of negative body language. Let them know it will take a while to correct negative body language, but that you are certain they can do it. You might say:

> *It is important to know what your body is doing before you say anything. Remember that a look can speak a thousand words, so you want to be aware of how you are sitting or standing* [posture] *and your facial expression. If you are feeling angry, then it's important to say that directly. Let's first work on what your body is saying.*

As you introduce the points below, state that these skills apply if you are <u>either the speaker or the listener</u>. In demonstrating, it is usually more effective to practice these skills with the patient as the listener. Go through each one, emphasizing the ones which may be difficult for the patient.

List of Strong Non-Verbal Communication Skills

1. **Posture:** Relaxed and looks natural; refrain from slouching, crossing arms, looking too stiff; practice standing with weight evenly distributed, face body towards others or at no more than a slight angle.

2. **Personal space:** If too close, speaker may begin to feel anxious; comfortable distance is at least two feet between you and the listener.

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3. **Eye contact:** Look directly at a speaker's face while trying to catch his/her eye. This helps speaker feel he/she is being listened to and you are following the conversation. Don't overuse direct eye contact; a person may feel like you are staring, making them uncomfortable.

4. **Head nods:** Lets the speaker know you are listening and perhaps agreeing.

5. **Facial expression:** Pleasant expression can help loosen up the conversation. Scowling and frowning may be misinterpreted as irritation or disapproval. Smiling and laughing appropriately can show that you are a pleasant person to be around.

6. **Nervous movements and hand gestures:** Playing with objects, tapping your feet, shaking your knee, swinging your leg indicate that you might be distracted or uncomfortable as someone is speaking. If you know your habits, you can try to do something else with your hands. Too many hand gestures can be distracting.

After going through the above list, ask the patient if he/she has any questions. You can prompt by asking some of these questions:

- *Can you see any skills that have been a problem for you in the past? What happened?*
- *How have you felt when you are trying to talk to someone and they start to* [use example of poor non-verbal communication]?
- *What kind of situations can you think of where it would be difficult for you to follow these? Why?*

Next you will go through the **List of Strong Verbal Communication Skills**. These skills are summarized in the **Reminder Sheet: Feeling Talk and Listening Skills** in the patient workbook. You will probably have several examples from the patient's own life, times when he/she has used negative and positive verbal skills. Accentuate the positive examples, and use the negative ones to teach alternatives. You might say:

> *You have really been able to tell me what you want to get out of therapy. You speak up when you don't like something in here. That's great. Now, I want to teach you how to do this with other people in your life. Doing this with your* [family or girlfriend/boyfriend] *would be a great start.*

List of Strong Verbal Communication Skills

1. **Speak up:** Talking about your ideas, needs, and opinions can help you avoid later explosions. However, remember that these adolescents may have been punished in the past for speaking up, so they may be quite hesitant to do so. Help patients learn to express themselves directly using all of the skills they will learn.

2. **Use "I" messages instead of "you" messages:** "I" messages confront without having a destructive effect. "You" messages emphasize blame, criticism, and judgment. (This is a good place to use examples, demonstrating the different effect of an "I statement" versus a "you statement.")

3. **Be specific:** Let the listener know exactly what you are asking for using a specific example rather than a vague, unclear statement. Example: *"I feel really angry when you nag me all the time about my homework. It would work much better if we talked about it one time, say, after dinner. I can tell you how I am doing."*

4. **Be brief:** Avoid being too long-winded as you may lose the listener and not make your point. Use short examples. Don't repeat points. Learn to paraphrase and summarize.

5. **Check to see that others are listening:** As you are trying to express yourself, ask the listener at certain times: *"Do you agree?" "Am I making sense?"* Communication becomes more of a dialogue when you ask questions.

6. **Find out what others are thinking:** Ask the listener: *"What do you think about that?"*, *"How would you like to do it?"* Ask how the listener is feeling about what you are saying and be prepared to listen to his/her answer calmly and respectfully. Always show interest in the other person's point of view.

7. **Reflective listening:** Emphasize that this is an important skill to use when trying to resolve a conflict. You will be "reflecting" back what the speaker is saying by summarizing or paraphrasing his/her statements. *"I think what you are saying is that you don't like it when I . . ."* or *"You get really mad when I don't tell you what I'm gong to do after school. It would help if I just called you. I can do that."* If you don't understand what the speaker is saying or need more explanation, ask him/her to tell you more. You might want to take this opportunity to demonstrate the **Mirroring Exercise** for positive communication (Hendrix, 1988). The point of mirroring is to listen to the other person with empathy, putting aside a need to be "right." The steps to the mirroring exercise are as follows:

   - Listen carefully to what is being said (take notes if necessary).
   - Repeat back what you heard using eye contact and watching tone of voice.
   - Ask the other person if you were accurate in repeating what he/she said.
   - If not, ask the other person to repeat the points you missed.
   - Repeat those points back to the other person.
   - Finally, say what makes sense to you about what the other person said and state what you think he/she is feeling.
   - Next, it's your turn to do the same exercise.

8. **Ask questions if you are confused:** As stated above, it is important to ask for more explanation when you don't understand what is being said to you. While being careful not to interrupt. Ask the speaker for clarification if you are confused. Remember to watch your tone when doing so.

9. **Stop and let others know when communication is breaking down:** Discussions sometimes need to be stopped, temporarily. Decide in advance how you will signal other people that you need to take a time out from the discussion. Make sure you set a time to resume the discussion. "Cooling off" periods should probably not be more than a day. You may only need a few minutes.

10. **Tone of voice:** Avoid using a weak, hesitant voice or a cold, superior, demanding voice. Also, a sarcastic style can lead to misinterpretation. Aim for a calm, warm, and relaxed tone, which can still be firm. Avoid mumbling, yelling, or whispering.

In wrapping up this section, ask patients if they have any questions or would like to share situations in which they have had difficulty using the above skills. Remind them of the rationale for teaching these skills in a treatment for substance use; say that these skills should help them to get their needs met and to have more satisfying relationships. Effective communication will lead to less frustration and should reduce experiences that trigger substance use.

Three Styles of Communication (Passive, Aggressive, Assertive)

This is a good time to introduce the differences between passive, aggressive, and assertive styles of communication. It is useful to point out the disadvantages of using passive or aggressive communication styles with the advantages of using assertiveness. (You may have done this comparison already if you have completed Module #5 Anger Awareness and Management.) First, define each style and give examples (Definitions adapted from Monti et al., 1989, pp. 46-48):

> ***Passive*** *people tend to give up their rights and usually do not let others know what they are thinking or feeling. They often bottle up their feelings. They often feel like they cannot get things done and feel hurt by others. People have no way of knowing what a passive person wants.*
>
> ***Aggressive*** *people run over other people, sometimes with their mouths and sometimes with their bodies, to get what they want. They don't think about how their aggression will make others feel and often think that they have the only rights which count. Others often look at these people and think of ways they can "get even" at another time. Aggressive people may get their needs met in the short run, but not always in the long run.*
>
> ***Assertive*** *people decide what they want and plan how to get what they want by working with other people to do so. Being assertive is the best way to let others know what is going on with you or what others are doing which you might not like. Being assertive can make you feel much more in control of your life. Assertive people usually don't feel like victims because they are speaking up about their needs. We will work on ways in which you can communicate assertively in some tough situations.*

Giving and Receiving Criticism Constructively

Criticism is often considered to be a negative or unpleasant event. It doesn't have to be. The skills taught to the patient will present criticism as a potentially constructive communication skill that can produce positive results for both the speaker and the listener. It is important for the patient to know how to give and to receive criticism.

Here are some suggestions for giving constructive, assertive criticism:

- Calm down first.
- State the criticism in terms of your own feelings, not in terms of absolute facts.
- Criticize the behavior, not the person.

- Request a *specific* behavior change.
- Be willing to negotiate a compromise.
- Start and finish on a positive note.
- Tone of voice should be clear and firm, not angry.

When you receive criticism, remember the following:

- Don't get defensive, don't debate, don't counter-attack.
- Try to find something to agree with in the criticism.
- Ask questions for clarification.
- Propose a workable compromise.

As adolescents will need concrete examples of each of these concepts, teach the concepts in role plays. You might begin by demonstrating a maladaptive (incorrect) communication strategy first, so patients can feel how it comes across negatively. Then, shift to the positive communication style, and have him/her comment on the differences between the two styles. You can have the adolescent role play the positive technique in response to therapist playing the maladaptive role. This role play gives the adolescent a chance to be in the mature, successful role. It should be satisfying for him/her to see how the newly acquired skill shifts the other person (therapist in role play) in a more positive direction.

In-Session Practice
Once you have taught the material above, it is time to practice what you have learned. Remember to make sure to leave enough time to practice, as this is when the effective learning should take place. The following are all options to use for in-session practice. The most effective practice for this module is role play. In choosing role plays, consider this patient's particular strengths and weaknesses and the situations they have identified which will be the most challenging. You will not have time to do each of these role plays, so choose one or two that will be most effective.

- **BEHAVIOR REHEARSAL ROLE PLAYS:** Have patient generate personally relevant scenes in which he/she would expect to have difficulty communicating with someone. Practice focusing on the nonverbal and verbal aspects. Possible role plays include: a friend offering him/her drugs; being asked to a party where there will be drugs and alcohol; a friend saying he/she was disappointed with the patient because the patient didn't come to party where there would be drug use.

- **ROLE PLAY DIFFERENT STYLES:** Role-play a scene of potential conflict using 3 styles of nonverbal communication with the same verbal content.

  1. **Passive:** Hesitant speech (fidgety, poor eye contact, apologetic tone, slouched posture)

  2. **Aggressive:** Loud, hostile (demanding tone, scowling expression, hands on hips)

  3. **Assertive:** Relaxed and firm (good posture, direct eye contact)

- Do a **ROLE PLAY** intentionally using **PATTERNS TO BE AVOIDED** (handout)**.** When modeling negative behaviors, make sure you normalize and elicit patient's personally relevant examples. Then, have patient role play more effective ways of saying the same thing. Take turns.

  1. **Putdowns** (Name-calling, insults, inappropriate laughter, rude remarks. Can be subtle, like rolling eyes.)

  2. **Blaming** (Say or imply the problem is the other person's fault. Includes transferring the blame to another person, i.e. "I've done everything I can.")

  3. **Denial** (Dismissing the other person's issue. Even if you don't see something as a problem, recognize that it is for the other person.)

  4. **Defensiveness** (Can be displayed by becoming angry or argumentative, making excuses, becoming silent and refusing to participate. Self talk can play a big part in becoming or not becoming defensive.)

  5. **Communicating hopelessness** ("Nothing works," "What's the point," "It won't do any good." Communicated non-verbally with heavy sighs and rolling of eyes. Giving short replies like, "Whatever," "I guess.")

  6. **Mind reading** (Implying that you know what another person's opinions or motives are. Ask what other people are thinking instead of telling them.)

  7. **Talking for others** (For problems to resolve, everyone needs to say how they are feeling, how they are affected, and commit to working on a solution.)

  8. **Sidetracking (**Talking about things not relevant to the subject. Bringing up new problems before the original one is resolved.)

At-Home Practice
There are several options for practice exercises. Each of these exercises has something to offer so it is worthwhile to review them with the patient. However, you might not expect the patient to do them all. You can suggest particular ones for the patient to do, depending on strengths and weaknesses in his/her communication skills. They are:

- **Feeling Talk and Listening Skills Practice Sheet**
- **Nonverbal Communication Practice Sheet**
- **"I" Statements Practice Sheet**
- **Introduction to Assertiveness Practice Sheet**
- **Receiving Criticism Practice Sheet**
- **Giving Criticism Practice Sheet**

It is important to emphasize that patients will learn the most from real-life practice. Therefore, the two exercises below should be assigned to all patients.

- **EXERCISE #1:** Between now and next session, observe someone else and list the positive things you noticed about his/her use of verbal and non-verbal communication. (What you notice could be a conversation or discussion in which you were involved or one in which you were not involved.) How did the other person's use of good communication skills have a positive effect on the communication?

- **EXERCISE #2:** Start a conversation with someone. Notice your non-verbal behaviors as well as your use of the verbal skills you learned. Afterwards, note the nonverbal and verbal behaviors that you liked and those behaviors you thought you could improve on. Did you choose a passive, aggressive or assertive style? If it was either passive or aggressive, what could you have done differently?

Optional Exercise: Have patients practice using **Mirroring Exercise for Positive Communication** with another person. They should review the steps with the other person. At first, they should practice this activity when they are not having an actual argument in order to get used to the sequence of steps.

GETTING YOUR POINT ACROSS: SPEAKING AND LISTENING SKILLS

Being able to get your feelings and thoughts heard and understood by other people is not easy! However, it's really important. Good communication skills will help you get what you need at home, school, work and in your relationships. When we don't feel like people are listening to us, we start to feel unimportant, discounted, and possibly sad and angry. When we don't listen and respect other people, they start to feel the same way. This cycle leads to problems in relationships, usually with arguments, "cold wars," or just avoiding the situation.

There are different styles of communicating (Passive, Aggressive and Assertive—see below). Work on being assertive in situations whenever possible. Lots of people fall into the trap of being either passive or aggressive when they are upset by something. It is important to be prepared for how to give and receive criticism as that is often when we are tempted NOT to use good communication skills. We express ourselves both with our words and with our body language. A dirty look sometimes can speak 1,000 words! We will practice both verbal and non-verbal communication skills during this session.

Styles of Communicating

Passive: You avoid saying what you want, think or feel. Voice is weak, hesitant, soft. Posture: stooped, slumped over, head down, and/or hand on face. You might say things like, *"I'm not sure. I'm sorry…but, Gee…I don't know, I kind of think that."*

Aggressive: You say what you want, think and feel, but at the expense of other people's rights and self esteem. Voice: tense, loud, cold, or demanding. Posture: macho-fight stance, leaning over, hands on hips, or inches from the other person. *"You better give me that!"*

Assertive: Standing up for your rights as a person without taking away another person's rights. You say what you honestly want, think, and feel in direct and helpful ways ("I" messages). Voice: firm, warm, relaxed, and expressive. Eyes: You look directly at the other person, but you don't stare. Posture: You face the person with head erect and with a relaxed, balanced posture. "*I need to speak with you about what's bothering me."*

The materials in this session will focus on skills to help you have more success with communication. Remember that good communication means using excellent speaking AND listening skills. We will learn where your trouble spots are and practice ways to improve them.

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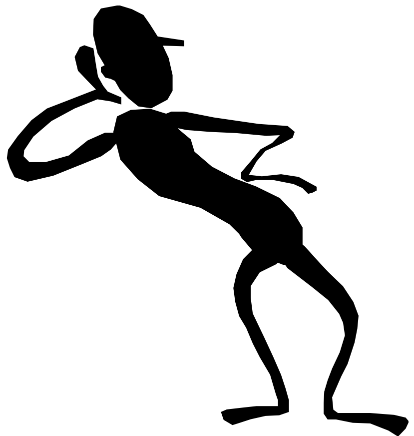
REMINDER SHEET
Feeling Talk and Listening Skills

- **Sharing your feelings with other people:**
    - *It's OK* to talk about your feelings (both positive and negative ones). Choose a person who it feels safe to talk to and let that person know how you are feeling. You could share positive or negative feelings.

- **Listening to other people:**
    - Use "body language" to show that you are listening to the other person (leaning forward, eye contact, head nods, etc.).
    - Pay attention to the tone of voice, facial expression, and body language of the other person to help you "tune into" his/her feelings.
    - Listen for the right time to talk.
    - Show interest and understanding by asking questions and adding comments of your own.
    - Share similar experiences or feelings that you have had.



PRACTICE EXERCISE
Feeling Talk and Listening Skills

Practice expressing your feelings and listening to the feelings of others.

Exercise 1: Practice Expressing Feelings
Start a conversation with someone and share a feeling during the conversation.

1. Whom did you talk with? ____

2. What feeling(s) did you share?

____

3. How did he/she respond?

____

____

Exercise 2: Practice Listening to Feelings
During a talk you have with someone, notice a feeling that he/she is expressing both verbally and nonverbally.

1. What feelings did he/she express verbally?

____

____

2. What nonverbal behaviors did you notice?

____

____

3. What feeling was he/she expressing nonverbally?

____

____

4. How did you show you were listening?

____

____

REFLECTION SHEET

I practiced listening with (person):____

On (date and time):____

The other person knew I was practicing my listening skills: □ Yes □ No

This is how I think I did as a listener:	**Not well**		**OK**		**Really Well**
1. Paying complete attention to the entire conversation	1	2	3	4	5
2. Keeping my own "stuff" out of it (advice, opinions, intentions, wants, etc.)	1	2	3	4	5
3. Making understanding statements	1	2	3	4	5
4. Repeating back what the other person said and asking the person if you were accurate in what he/she said (reflection)	1	2	3	4	5
5. Asking for clarification if unsure about what the other person said or felt	1	2	3	4	5
6. Using non-verbal communication skills:					
Eye Contact	1	2	3	4	5
Head nods	1	2	3	4	5
Neutral/positive facial expressions	1	2	3	4	5

Notes (what we talked about, how I felt, what happened afterwards, any details you want to discuss with your therapist):

____

____

____

____

____

____

Adapted with permission from Miller, W.R., ed. *COMBINE Monograph Series, Volume 1. Combined Behavioral Intervention Manual: A Clinical Research Guide for Therapists Treating People with Alcohol Abuse and Dependence.* DHHS Publication No. (NIH) 04-5288. Bethesda, MD: NIAAA, 2004.

REMINDER SHEET
Patterns to Avoid in Effective Communication

1. **Putdowns** (name calling, insults, inappropriate laughter, rude remarks. These signals can be subtle, like rolling eyes.)

2. **Blaming** (saying or implying the problem is the other person's fault. Includes transferring the blame to another person, i.e. "I've done everything I can.")

3. **Denial** (dismissing the other person's issue. Even if you don't see something as a problem, recognize that it may be a problem for the other person.)

4. **Defensiveness** (can be displayed by becoming angry or argumentative, making excuses, becoming silent and refusing to participate. Self-talk can play a big part in becoming or not becoming defensive.)

5. **Communicating hopelessness** ("nothing works," "what's the point," "it won't do any good." Communicated non-verbally with heavy sighs and rolling of eyes. Giving short replies like, "Whatever," "I guess.")

6. **Mind reading** (implying that you know what another person's opinions or motives are. Ask what other people are thinking instead of telling them.)

7. **Talking for others** (for problems to resolve, everyone needs to say how they are feeling, how they are affected, and commit to working on a solution.)

8. **Sidetracking** (Talking about things not relevant to the subject. Bringing up new problems before the original one is resolved.)

REMINDER SHEET
Nonverbal Communication

"Body language" can be very useful in helping to get your point across.

- Posture
- Eye contact
- Facial expression
- Tone of voice
- Head nods
- Hand movements and gestures
- Personal space

Practice Exercise #1
Between now and the next session, notice what you like about the nonverbal behavior of some of the people you see. List some of the positive things you observe. Briefly describe how those things may have a positive effect on the communication process.

____

____

____

____

Practice Exercise #2
Start a conversation with someone. As you are talking, try to notice some of your nonverbal behaviors. Then, after the conversation is over, jot down the nonverbal behaviors that you thought you did well and some that you would like to improve.

Person you talked with: ____

I did these nonverbal behaviors pretty well: ______________________________________

____

____

____

I could use some improvement on these nonverbal behaviors: ___________________________

____

____

____

<u>"I" STATEMENTS</u>

When you want to be assertive and to get your point across, try to use one of these phrases in your statement:

- I think/don't think . . . .
- I feel/don't feel . . . .
- I want/don't want . . . .
- I can/cannot . . . .
- I agree/disagree . . . .
- I will/won't . . . .
- I like/don't like . . . .

Practice Exercise
Think about some conflict situations (family, friends, etc.) and decide what you want to say and how you want to say it. First, write down what you would say to the person using a "you" statement. Then write it again as an "I" statement using the above phrases.

Example: *"**You are never** going to understand what I am telling you!"*
---changes to--
*"**I don't think** you understand what I am trying to say to you."*

1. ____

____

2. ____

____

3. ____

____

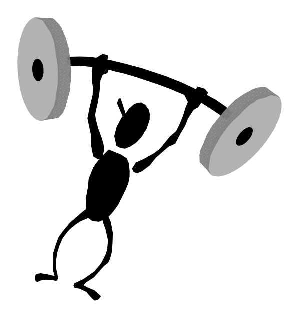
4. ____

____

5. ____

____

REMINDER SHEET and PRACTICE EXERCISE
<u>Introduction to Assertiveness</u>



Remember the following points in practicing assertiveness:

- Take a moment to think before you speak.
- Be specific and direct in what you say.
- Pay attention to your body language.
- Be willing to compromise.
- Restate yourself if you feel that you're not being heard.

Practice Exercise
This exercise is to help you become aware of your style of handling various social situations. The three common response styles are passive, aggressive, and assertive.

Pick three different situations prior to the next session. For example, these situations could include interactions with family, friends, your boyfriend/girlfriend, or your boss. Write brief descriptions of them and of your response to them. Then, decide which of the three common response styles best describes your response.

Situation 1: ____

Your response: ____

____

Circle response style: passive, aggressive, assertive

Situation 2: ____

Your response: ____

____

Circle response style: passive, aggressive, assertive

Situation 3: ____

Your response: ____

____

Circle response style: passive, aggressive, assertive

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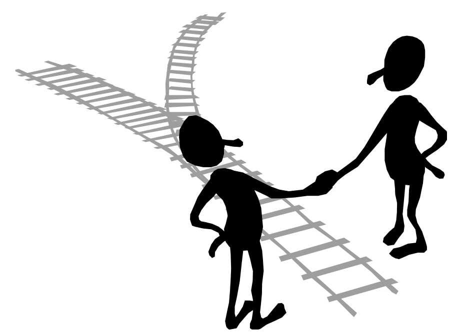
REMINDER SHEET AND PRACTICE EXERCISE
<u>Receiving Criticism</u>



When you receive criticism, remember the following:

- Don't get defensive, don't debate, don't counterattack.
- Try to find something to agree with in the criticism.
- Ask questions for clarification.
- Propose a workable compromise.

Practice Exercise
Stay alert until our next session for any criticism you may receive. It may come from a family member, boyfriend/girlfriend, or teacher. For one criticism that you receive, record the following:

Describe the situation: ____

____

____

____

____

Describe your response: ____

____

____

____

____

Communication Checklist:

	YES	**NO**
1. Did you behave as if the criticism was nothing to get upset about?	____	____
2. Did you find something to agree with in the criticism?	____	____
3. Did you ask questions to clarify the criticism?	____	____
4. Did you propose a workable compromise?	____	____

REMINDER SHEET AND PRACTICE EXERCISE
<u>Giving Criticism</u>

Here are some suggestions for giving constructive, assertive criticism:

- Calm down first.
- State the criticism in terms of your own feelings, not in terms of absolute facts.
- Criticize the behavior, not the person.
- Request a *specific* behavior change.
- Be willing to work on a compromise.
- Start and finish on a positive note.
- Tone of voice: clear and firm, not angry.

Practice Exercise
Approach a person to whom you have been meaning to tell something negative. Provide that person with some constructive criticism.

Identify the problem: ____

____

____

____

Your goals: ____

____

____

____

After speaking to the person, describe what happened:

What did you say to him/her? ______________________________________

____

____

____

How did he/she respond? ____

____

____

____

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MODULE 6: Anger Awareness and Management

Summary of Tasks

- Normalize anger
- Distinguish between *feelings* and *behavioral consequences*
- Present cognitive-behavioral model of anger
- Build anger awareness skills
- Construct anger management plan

Presenting Session Rationale

During this session, you will explain how to recognize anger (awareness) and how to control it so that it can be used constructively (management). The patient will learn that anger is a normal emotion with destructive (makes things worse) and constructive effects (helps you). Destructive effects can include:

- Mental confusion
- Poor decision-making
- Impaired communication
- Reduced self-esteem
- Feelings of resentment
- Anger "blackouts"
- Relapse to drug use

Constructive effects can include:

- Signal for problem-solving
- Increase in feelings of personal power
- Ability to communicate negative feelings
- Avoidance of future misunderstandings
- Stronger relationships

You will explain the difference between anger as a feeling and the behavioral consequences of anger, such as violence, loss of relationships, and other life disruptions. In presenting a rationale for this session, you might say:

> *Anger can really cause problems when we are trying to quit using.* (Refer to the patient's internal triggers from functional analysis if they included responding to anger on his/her Functional Analysis.) *There's nothing wrong with feeling angry—it's what we do when we get angry that gets us in trouble. Let's look closely at what it feels like when you are angry and learn some ways to recognize when it's coming on quickly. Then, we'll come up with some strategies to help you cope better with anger.*

With a resistant patient who has not identified a desire to change his/her substance use and who does not acknowledge serious problems, you might say:

> *Let's look at your goals to see how you are doing.* [You are looking for anything that relates to anger as a barrier to one of their goals.] *Get along better with my parents . . . Get off being on probation at work. . . Let's see if there is any connection between getting frustrated and angry and getting what you want here.*

For all patients, let them know that the goal of this module is to help them learn to communicate angry feelings in a way that doesn't hurt themselves or other people. Many users report that they use substances when they feel angry or upset with another person. Several studies of people who have completed treatment have shown that there is a strong relationship between episodes of anger and substance relapse. Let patients know that their chances of staying sober will be greater if they learn and practice these skills.

You will be presenting a cognitive-behavioral model of anger. In this model, anger is not caused by the trigger event, but by our thoughts or beliefs about the event. You might want to draw this concept on a board to describe what you mean using an example.

Trigger event >>> Angry thoughts and feelings >>> Behavior

Refer them to the introduction sheet to the anger management module in their workbook (**Know Your Hot Buttons: Skills for Managing Anger**).

Key Interventions
The module is divided into two sets of skills—anger awareness, followed by anger management. Let the patient know that he/she must become skilled at recognizing signs regarding the presence and intensity of his/her anger. Learning how to measure anger takes great practice, but is well worth the effort, as it can save one from making costly mistakes. In general, you are trying to get him/her to recognize "signal" anxiety (which might be expressed as anger or other feelings) at an earlier stage, so it can be regulated before it becomes too hot to handle.

Anger Awareness
First, you will teach the patient how to increase his/her awareness of the personal events that trigger anger for him/her. You might say:

> *It's really important to know what kinds of situations or triggers make you feel angry (more than a little irritated). Once you know what they are, it will make it a lot easier to stay away from those situations. But that's not always possible, so later in the session, I'll teach you some skills to help cool things down when you are really mad. It's usually a certain trigger that really gets you mad* [see list below].

Some common triggers for anger are:

- A direct attack (verbal or non-verbal attacks)
- Seeing an attack on someone else
- Feeling threatened
- Inability to reach a goal

- Unfair treatment (feeling you are being blamed)
- Excessive demands on you
- Feeling disapproval by others

Use this list to have patients identify the types of situations that trigger them. Reassure them that it is perfectly normal for them to become angry under these circumstances. In having this discussion, you may become more aware of the types of distorted thinking which influence their management of moods, not just anger. Knowing more of their distorted thinking will be important information to store and to use during other sessions, particularly when you teach Module #6 Negative Mood Regulation.

Next, you will teach the patient to become very familiar with the internal reactions that signal anger. These internal reactions can be measured in a number of different ways. You should mention each of these reactions to the patient and have him/her endorse which ones are relevant. It is often best to start with physical reactions as most patients will be able to describe their physical reactions to feeling angry. It might take some prompting for the patient to articulate these reactions, so you can use some of these examples:

> *It is very common to have your body react to your anger. Have you experienced any of these physical reactions when you have been angry?*

- Physical reactions: feeling hot, muscle tension, headache, pounding heart, sweating, rapid breathing, adrenaline rush, clenched teeth or jaw, beginning to yell, anger "blackouts."

Help the patient find words to describe his/her anger. Many patients will never have had the opportunity to talk about what it feels like when they experience anger. The list below can be used to help start this discussion.

> *You may feel entirely overwhelmed by lots of different emotions when you get angry. It is not unusual for people to feel confused, sad, almost without words when they feel anger.*

- Feelings related to anger: frustration, irritation, annoyance, aggravation, feeling "on edge" or "wound up," sadness with feelings of helplessness, poor concentration, being obsessed with a situation (unable to think about anything else).

At this point, you will introduce an in-session exercise specifically on anger awareness to make sure that the patient is following the concepts outlined above.

In-Session Practice (Awareness)

You will have patients think of a particular recent situation during which they became angry (more than slightly irritated). Ask them to describe this situation to you including when and where it happened and who was involved. Have them explain why they were feeling angry. Have patients list personal anger triggers and their internal reactions to them. Help them identify physical reactions as well as feelings and thoughts. You will probably have to help them identify the thoughts and beliefs related to the situation.

You must have been feeling very frustrated. Can you help me understand what was going through your head [thoughts] *when that happened? What were you saying to yourself? It can feel really confusing. Sometimes feelings come first, followed by angry thoughts. Sometimes thoughts come, followed by feelings. Sometimes you're seeing red and you just do something like punch the wall. The point is that you want to work on being aware of your feelings and your thoughts so that you don't do something to hurt yourself or someone else. You have to make yourself aware of what you are thinking. You might be thinking, 'Boy, I screwed up, I can't believe I smoked tonight! I feel really mad at myself.'*

Explain that there is *always* a connection between thoughts, feelings and behavior. The goal is to be more conscious of how they interact with each other. Use this example to help the patient identify patterns in their internal reactions to anger. For instance, do they often respond to criticism by feeling angry? Understanding patterns in becoming angry will be helpful as you move into the next section on anger management.

Anger Management

Let the patient know that there are many techniques for managing anger. The important thing to know is what works for him or her individually. The remainder of the session will focus on finding strategies to calm angry feelings so that patients can think more clearly and rationally, and subsequently, make better decisions. Remind them that anger can result from the way we think about things:

Trigger event >>> Angry thoughts and feelings >>> Behavior

Below are the steps to teach the patient for managing anger. Refer patients to their **Reminder Sheet on Anger Management** as you review these steps. Encourage them by stating that the outcome of using these steps will be that they will feel greater control of a situation:

1. **Learn to calm down or keep your cool** so you can be in control of the situation. (Identify which self statement(s) work best for you: slow down, take it easy, chill out, take a deep breath, stop and think, relax, count to 10, take a time out, let it go.)

2. **Review the situation point by point.** After you have slowed down, think about the situation. What's getting me angry? Is someone trying to get me angry? What will be the consequences if I act aggressively? Is there anything positive about this situation?

3. **Think about your options**. What is in my best interest? What can I do? Which option seems best?

4. **Choose an assertive response to resolve the problem**. Assertive responses increase the chances that your goals will be met and that you will feel better about your role in the situation. (If necessary, review **Assertive/Passive/Aggressive** responses found in Module #4 Communication Skills.)

5. **After trying to resolve the problem**, you may feel you were:
   a) Unable to resolve the conflict. Remember you cannot fix everything. Try to shake it off.
   b) Successful in resolving it. Congratulate yourself.

In-Session Practice (Management)
It can feel somewhat artificial practicing these skills during the session when a patient is not feeling angry. (You may want to choose this module if the patient has arrived at the session angry due to some recent or current interpersonal conflict he/she is experiencing.) Nevertheless, it is important to try the different options for managing anger that the patient has learned. If the patient seems uncertain about how to use these new skills, you may want to begin with some modeling:

- **Modeling**: Present patient with a scenario. Demonstrate an appropriate response to the situation and articulate self-statements for anger management aloud. Review cool down phrases, thoughts about the situation, and different options on how to handle the anger. Ask the patient if he/she has any questions or comments about what was demonstrated.

Some patients will be ready to move directly to a role play for practice:

- **Behavior rehearsal role play:** Ask the patient to choose a recent situation which generated angry feelings. Ask the patient to describe this situation to you including when and where it happened and who was involved. Have the patient explain <u>why</u> he/she was feeling angry. Guide him/her on how to choose positive thinking alternatives to this situation. Have the patient "think out loud," using the calming reminder phrases. You may need to model this for the patient by demonstrating new self talk he/she can use for the situation:

  It is so unfair that she is always telling me what to do and criticizing me in front of other people. I hate that! I could hit something, I am so angry. I better take a time out or someone is going to get hurt. [Breathe slowly for 30 seconds while visualizing calming images.] *I suppose I must have really made her mad for her to do that. We haven't had a fight like this in a long time. I guess I could talk with her about it when I'm feeling calmer.*

- **Demonstrate assertive, aggressive and passive response to situation.** For the above situation or another one, ask the patient to comment on the effectiveness or ineffectiveness of his/her responses. Have the patient identify which style of communication they were using and how he/she might change it to become assertive.

<u>**Option:**</u>
To summarize all the concepts learned in both sections of this module (awareness and management), you can complete the following exercise (Feindler and Ecton, 1986):

Trigger (antecedent) ⟶ Behavior ⟶ Consequence

- First, instruct the adolescent to identify at least 3 triggers that without fail lead to a loss of anger control and to elaborate on the triggers that provoke the greatest amount of anger. Write these down on the board.
- Next, have the adolescent talk about how he/she reacts to each of the triggers listed on the board. Ask these questions to categorize the different reactions (thoughts, feelings, behaviors).

What do you <u>think</u> about when your anger is triggered? [thoughts]
What do you <u>feel like</u> when your anger is triggered? [affective-physiological]
What do you <u>act like</u> or what <u>do you do</u> when your anger is triggered?[behavior]

- Finally, cue the adolescent to talk about the consequences that immediately follow the angry behavior. After listing these consequences on the board, place a plus or minus sign next to each consequence indicating his/her perception of the consequence.
  Example:
  "Hit the wall and broke my hand." (rated as a negative consequence by adolescent)
  -OR-
  "Talked to my mother and we worked out a plan for me to borrow the car" (rated as a positive consequence)
- Score each of these consequences. The positive consequence represents a scored point for the adolescent; a negative consequence represents a scored point for the trigger.
- In most cases, if the adolescent's perception of the consequences is accurate, then the trigger usually is the winner, at least until the patient learns to have better control over his/her behavior. This exercise can lead to a valuable discussion of the constructive and destructive effects of anger.

At-Home Practice

Have the patient complete the worksheets for **<u>Anger Awareness</u>** and **<u>Anger Management</u>**. You can also have the patient complete the **<u>Coping with Anger</u>** worksheet. Each of these worksheets will help the patient practice real-life situations to reinforce the skills he/she learned.

REMINDER SHEET

Anger Awareness

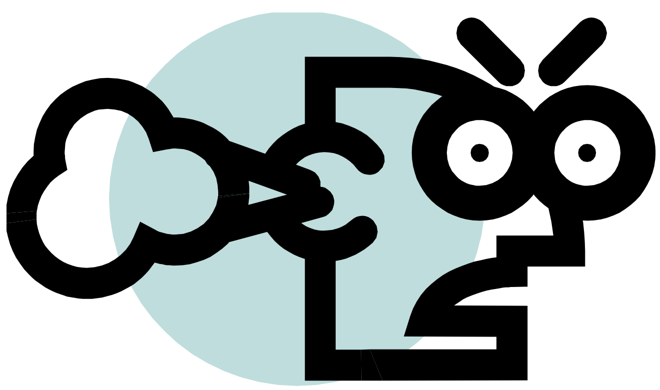
Anger is a normal human emotion. Increased awareness of angry feelings will make it possible for you to cope with them so that they don't get out of hand and lead to negative consequences such as violence and/or arrest. Increase your awareness of the following:

Events that trigger anger:

- Direct attack on you
- Feeling threatened
- Inability to reach a goal
- Unfair treatment
- Seeing an attack on someone else
- Excessive demands on you

Internal reactions that signal anger:

- Feelings: frustration, annoyance, aggravation, feeling on edge or wound up.
- Physical reactions: muscle tension, headache, sweating, rapid breathing, adrenaline rush, clenched teeth or jaw, beginning to yell.
- Difficulty falling asleep, thinking too much about a situation.
- Depression or feelings of helplessness.



(Adapted from: Monti et al., 1989)

PRACTICE EXERCISE
Anger Awareness

Pay attention to your negative feelings. For one situation involving anger or what led to the feeling of anger (e.g. frustration, annoyance, or irritation), record the following:

When and where? ____

____

____

____

Who else was involved?

____

____

____

What happened that provoked your reaction? ________________________________

____

____

____

Any physical sensations? ____

____

____

Thoughts and feelings? ____

____

____

____

Anger Scale

1	2	3	4	5
Mildly Irritated				**Burning Mad**

(From: Monti et al., 1989)

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REMINDER SHEET
Anger Management

Anger can result from the way we think about things:

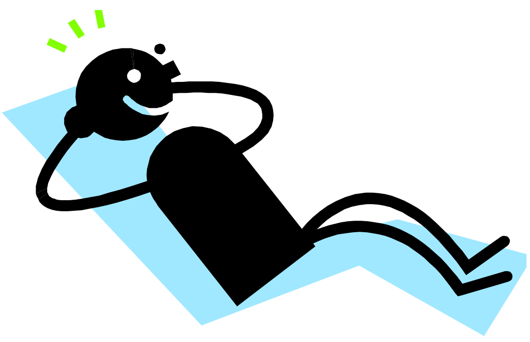
Events > > Angry Thoughts and Feelings > > Behavior

Use phrases like these to help you calm down in a crisis:
Chill
Relax
Take a TIME OUT
Cool it

Next, think about what's getting you so angry. Review the situation point by point:
What's getting me angry?
Is this a personal attack or insult?
Am I angry because I'm expecting too much of myself or someone else?
What are the positives here?

Then, think about your options:
What can I do?
What will be the consequences of my action?
What is in my best interests here?
Anger should be a signal to start problem solving.
Communication skills, problem solving, or other coping skills may be helpful.

If the problem won't go away:
Remember that you can't fix everything.
Try to shake it off.
Don't let it interfere with your life.
Talk with someone who is supportive of you.



If you resolve the conflict, congratulate yourself:
I handled that pretty well.
I'm doing better at this all the time.
I didn't blow my cool.

If you didn't resolve it, think about how you can do something differently in the future.

(Adapted from: Monti et al., 1989)

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PRACTICE EXERCISE
Anger Management

Until the next session, pay attention to your response to anger-provoking situations. Try to identify and change your thoughts in those situations. Pick one occasion before the next session involving angry feelings (or feelings of annoyance, frustration, irritation) and record the following:

Trigger situation:____

____

____

Calm-down phrases used: ____

____

____

Anger-increasing thoughts (e.g. *She always treats me unfairly.)*: ________________________

____

____

Anger-reducing thoughts. May include reminder of consequences (e.g. *If I lose my cool, I'll hit someone and that will make things worse.)*: ____

____

____

What other thoughts might have helped you cope with this situation? (e.g. *I can get out of here soon. Then I can calm down.):*____

____

____

(From: Monti et al., 1989)

COPING WITH ANGER WORKSHEET

Directions: It's best to fill out the worksheet while you are angry, but it's also OK to fill it out after you have coped with the anger.

1. What event or problem is making me angry?

2. What are the signals that tell me I'm angry?

   a. Body signals

   b. Thought signals

   c. Action signals

3. What can I do to relax my body?

4. What coping self-talk can I use to control my thoughts?

5. What effective action can I take to deal with the situation or solve the problem?

Coping with Anger Rating Scale (circle one)

1. Didn't try to cope with anger at all.
2. Sort of tried to cope with anger, but it didn't really work.
3. Tried hard to cope with anger, but it didn't really work.
4. Tried hard to cope with anger, and it worked.

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MODULE 7: Negative Mood Regulation

Summary of Tasks

- Explore symptoms of negative mood states and depression to build awareness
- Describe connections between negative affect and substance use
- Explain and demonstrate the 3 A's cognitive model for mood regulation
- Introduce thought stopping
- Identify errors in thinking and generate new answers to negative thinking

Presenting Session Rationale

It is common to experience negative moods (irritability, depression, anxiety, anger, boredom) during recovery. Negative moods are often related to the depressant effects of the substance of abuse, but can also be related to losses experienced in life. Some of these losses may have been results of the substance use, such as family problems, school failure, and relationships ending. Experiencing negative moods can be a major reason for relapse and can put a patient in high risk situations. Returning to the use of drugs or alcohol is not an effective way to cope with negative mood states and can make things worse. As one learns to be more effective in managing life problems throughout the course of treatment, negative moods can improve.

In presenting a rationale for this session to the patient, you might say:

> *Everyone gets in a down (negative) mood sometimes. Usually we are thinking things that make us feel worse. When this happens, it's tempting to go back to using to feel better.* **(Refer to their internal triggers from the functional analysis if they included that they responded to mood shifts or negative feeling states, including sadness, boredom, or disappointment by using substances.)** *The problem with going back to using is that it's a temporary solution to the problem. I would like to teach you some helpful tools to figure out what's bothering you and to find other ways of looking at the situation.*

With a resistant adolescent who has not identified a desire to change his/her use, you can use a similar approach, downplaying somewhat how substance use may be involved:

> *Everyone gets in a down (negative) mood sometimes. Usually we are thinking things that make us feel worse. It helps to find other ways of looking at the situation. It usually feels better to get high when you're bothered by something. I would like to teach you some other tools to help you get through these rough times and to figure out what's bothering you.*

Key Interventions

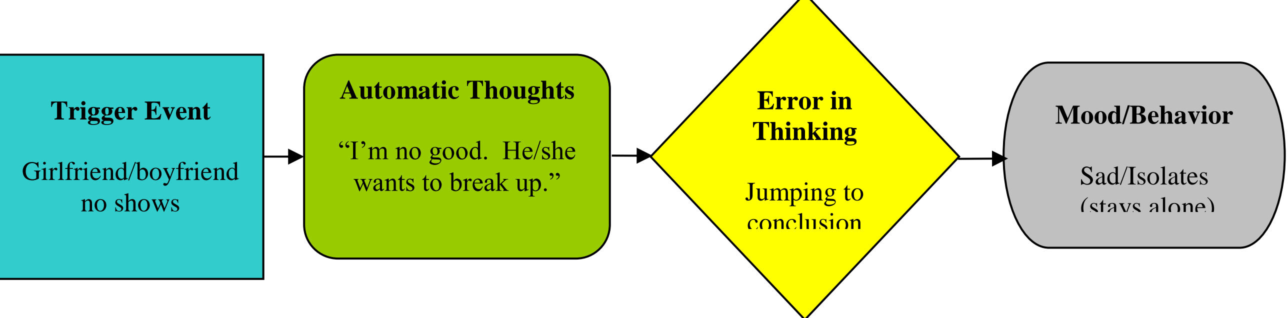
Basic Concepts of Cognitive Mood Regulation

A significant skill to learn in managing negative moods is that changing the way one thinks about a situation can lead to a change in the way one feels and behaves. These are complex concepts to teach, so you will want to break them down into components. First, you will want to demonstrate the point that there are *many* ways of viewing (perceiving) any situation.

Before giving real-life examples of this point, you can use the two **ILLUSION DRAWINGS** in the patient workbook to explain.

Ask the patient to look at the **OLD WOMAN/YOUNG WOMAN** picture and quickly tell you what he/she sees. Some patients will be able to identify both a young woman and an old woman in the picture, but many patients will see only one or the other. The exercise is to point out both images in order to demonstrate that with new information one's perception can change. If you prefer, you can use the other "illusion" (**SILHOUETTE OF FACE/WORD "LIAR"**) or show them both pictures to demonstrate the point.

The next step will be to introduce the connections between the perception of the event and one's subsequent negative mood and behavior. It is important to explain that it is not the event itself, but how one interprets the event. Until people learn the difference, most people believe the event causes the reaction. Use an example to review how the patient could have other perceptions of the same event, leading to a different emotional response. Let the patient know that initially, it is difficult to recognize how one's thoughts affect feelings, because thoughts happen quickly, as in an **automatic thought.** You might want to have the patient follow your explanation by looking at the diagram below that is in his/her workbook. At this time, elicit examples from his/her own life and/or model with one from your own experience:



3 A's Cognitive Model for Mood Regulation

Once you have reviewed the concepts above, you will teach a straightforward model (3A's) so that the patient can practice how to change his/her ways of thinking on a daily basis (Emery, 1981). Before beginning, let the patient know that it takes time and practice to recognize negative thoughts and to develop positive thinking to change moods and feelings. This is a complex module with many sophisticated concepts. It takes most normal adults, capable of abstract thought process, several weeks to months to become skilled at cognitive restructuring. This model has been simplified to make it easier for adolescents to learn. However, cognitive restructuring will be challenging, and it's important to let them know that fact beforehand. You might say:

> *I am going to teach you how to change your ways of thinking about yourself and the world. I know that sounds like a lot, but I'll go over the steps with you and we'll practice. When you are feeling bad, it's easy to start seeing things in a really distorted way* [not as they are]. *Remember that the way you think affects how you feel. If I think no one wants to be my friend, I'm going feel very sad. I'll then probably feel like giving up and stop trying to talk to people at school. Let's go over the 3 A's.*

- *The **First A** stands for building **AWARENESS** of the self-defeating thoughts you are having.*

- *The* ***Second A*** *stands for* ***ANSWERING*** *these self-defeating thoughts with more realistic and positive thoughts.*
- *The* ***Third A*** *is taking* ***ACTION*** *on your new thoughts.*

  We'll go over each of these steps in more detail. The thing to remember, too, is that it isn't easy to learn this, so be patient. It usually takes several weeks of practice to get the hang of doing this. If you don't notice feeling much better instantly, that doesn't mean it isn't working. Try to stick with it. So here's the first step. . .

AWARENESS:
In order to learn how to manage negative mood states, one must first recognize what they are. Patients may not know how to label moods or feelings. The **FEELINGS WHEEL** and **IDENTIFYING FEELINGS** handouts are useful tools to help patients learn how to identify and label feelings. You will teach patients to be aware of situations that influence their mood and to watch for fluctuations in the way they feel (e.g. a change from happy to sad, excited to bored, feeling confident to feeling a lack of confidence). One should learn to be aware of changes in the way the body feels (somatic complaints), when activities take great effort, or when it is difficult to concentrate. In addition to changes in physical sensations and mood, teach the patient to recognize what he/she is thinking (self talk).

Once the self talk is identified, it can be examined for errors in thinking (cognitive distortions). Patients will have a sheet titled **LIST OF ERRORS IN THINKING ("STINKIN' THINKIN")** in their workbook. Go through each Error in Thinking with them, one by one, emphasizing ones which seem typical of their thinking. Check to make sure they understand cognitive distortions:

1. **Black and white thinking (Either/Or):** You see things as perfect or awful, or you see people as all good or all bad. *"Either I'm a loser or a winner."*

2. **Catastrophizing:** You react to a disappointment or failure as though it means the end of the world. *"I know something terrible happened."*

3. **Jumping to Conclusions:** You assume the worst without checking the evidence. Or, you decide that terrible things will happen even when there is no proof of this. *"He didn't call me; it must mean he thinks I'm a loser."*

4. **Missing the Positive:** You don't pay attention to positive experiences, or you say they "don't count." *"That home run was a fluke. I'm no good at baseball."*

5. **My Fault:** You blame yourself for things that are not your responsibility or not in your power to control. *"It's my fault that my parents are getting divorced."*

6. **Shoulds:** You feel you "should" think or do something or criticize other people for what you think they should or shouldn't be thinking or doing. *"I should always be nice to everyone,"* or *"You shouldn't ever upset anyone."*

ANSWERING:

Once patients learn to recognize their negative moods and the thoughts associated with them, they can begin to answer their ingrained thoughts by generating new, positive self talk. You can remind them of how to use empowering self talk to manage cravings as taught in Module #3. Answering means considering a wide range of possible interpretations for the situation, not just the negative ones. Remind patients of the **ILLUSIONS** exercise. When they did this exercise, they were able to see more than one image by widening their perspective. They can widen their perspectives cognitively as well. You will teach the patient to look for the evidence (or lack thereof) for a particular thought and examine possible distortions (use **LIST OF ERRORS IN THINKING**). When distorted thinking is corrected, feelings and negative moods will change**.** Go over the list of **KEY QUESTIONS** below. These questions can be used to develop alternative thoughts. They are:

- Is this thinking all-or-nothing?
- What evidence do I have that this is true?
- What's the worst case scenario?
- Do I know for certain that something bad is going to happen?
- Is this thinking getting me what I want? What do I want? What are my goals?
- Am I overlooking my strengths?
- Am I close enough or too close to the situation to judge?
- Am I confusing a thought with a fact?
- What are the advantages and disadvantages of thinking this way?
- What difference will this make in a week or a year?

Different questions from the above list will be used to challenge the negative thoughts. Let patients know that some of these questions will work better than others in particular situations. It is important to review the list when you are first learning how to challenge negative thoughts. Make sure that you provide an example.

> *When you felt embarrassed by what happened* [caught shoplifting], *what were you thinking?* ["I'm a loser and no one will ever trust me again. I won't be able to become a probation officer now."] *What errors in thinking do you think you might have been using?* [black and white, jumping to conclusions] *Sounds like you are using some all-or-nothing thinking. It might be good to know the facts and get some advice about what the real consequences of your action will be. That way, you can best plan what to do next.*

ACTION:
Although it's a very important step toward feeling better, let the patient know that just answering thoughts won't be enough to change one's mood. You will now have to make opportunities to act on new thoughts and beliefs. There are several things you can do. Below are three categories of action that you can take:

1. **Increasing involvement in positive activities** has been shown to improve mood. Develop a schedule of daily activities, which is flexible and has alternatives. Anything is worth doing, with the exception of using, which may be the activity a patient thinks about first. You will help the patient develop a menu of activities. These activities can be characterized by:

    - Things that must be done daily (eat, dress, sleep)

- Things that <u>bring pleasure</u> (movie, shop)
- Things that <u>bring a sense of mastery</u> (finishing projects)

2. **Problem solving** will help you feel you have more control over your life. If Module #7 has been completed, the steps to problem solving will have already been learned. Do not attempt to teach these steps in this module as there will not be adequate time to do so. However, it is worth mentioning that doing <u>something</u> about a problem will always feel better than doing nothing. Let the patient know that you will be teaching him/her how to resolve the issues and problems in their lives.

In-Session Practice

The in-session practice should focus on applying the <u>cognitive model for mood regulation</u>. Using a real-life example to demonstrate thought management is effective. With thought management, you are interrupting the flow of negative thoughts and then challenging and rewriting the negative thoughts (Answering). The exercise will deliver the message that patients have the power to shift their own thinking. The exercise will incorporate each of the concepts of the 3 A's model and will utilize the materials available in their workbook.

Have the patient follow these steps:

1. Ask the patient to get into a comfortable, relaxed position. He/she could close his/her eyes if he/she is comfortable doing so. Have him/her imagine an event that led to bad/upset feelings. (This could be an instance in which the feelings led to a substance using episode, but it doesn't have to be.) Examples of events often leading to negative thoughts are family arguments, conflicts with friends, school difficulties, slips or relapses (see Module #11). You may need to prompt the patient if he/she is unable to think of a recent event.

2. Assist patients with using all five senses to create images of what happened recalling exactly what happened, what was said, what the final outcome was (<u>Awareness</u>). They do not need to articulate these images at this time. Have them concentrate on remembering the experience.

3. Ask them to identify the negative thoughts that led to the bad feelings and have them repeat these thoughts to themselves for several seconds (<u>Awareness</u>).

4. Wait for several seconds allowing the patient to recall the thoughts and feelings associated with those thoughts. You can remind the patient that there may different feelings with several different negative thoughts simultaneously.

5. You will then state out loud, **"STOP"** (with a volume loud enough to surprise, but not to shock). This exclamation will <u>distract</u> the patient, breaking the flow of negative thoughts at least temporarily.

6. Next, have the patient use the skills from the <u>Answering</u> step to challenge his/her negative thoughts. First, have the patient review the **LIST OF ERRORS IN THINKING** to identify cognitive distortions. If the patient is having difficulty identifying the type of distortion, reassure him/her that the important step is to be aware

that there is a distortion and to move ahead with challenging the negative thoughts by using the **KEY QUESTIONS.**

7. Correct the distortion using **KEY QUESTIONS** to examine the evidence. You will most likely need to help patients with this offering some examples.

8. Have the patient outline actions they will take to maintain new perspectives (Answering) and/or to take Action.

At-Home Practice
There are several options for the at-home practice in this module. These options allow you and the patient to decide which areas need the most practice.

Patients do not need to memorize, but they should be familiar with the material in:

- **ANSWERING NEGATIVE THOUGHTS: KEY QUESTIONS TO USE**
- **LIST OF ERRORS IN THINKING ("STINKIN' THINKIN'")**
- Encourage all patients to complete the **PRACTICE EXERCISE: KNOW YOUR MOODS AND WHAT YOU'RE THINKING**.
- They should review the **REMINDER SHEER: MANAGING NEGATIVE THINKING** and complete the **PRACTICE EXERCISE: MANAGING NEGATIVE THINKING** worksheet.
- Encourage them to know what they are feeling by reviewing the **FEELINGS WHEEL** and completing the **IDENTIFYING FEELINGS** worksheet for at least 4 days between now and the next session.

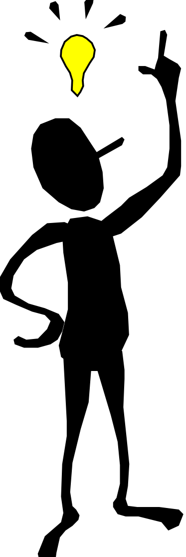
REMINDER SHEET
Managing Negative Moods

Use the **Three A's** to *help overcome your negative moods:*

- Be **AWARE** of how you feel (emotionally and physically) **AND** your self-defeating thoughts.
    - Be aware of your moods and the situations that influence them.
    - Be aware of your errors in thinking.
    - Use the Feelings Wheel and Identifying Feelings sheets to help you know what you are feeling.
    - Use the List of Errors in Thinking ("Stinkin' Thinkin'") to help figure out what kind of error in thinking you are using.

- **ANSWER** these thoughts.
    - Use the sheet Answering Negative Thoughts: Key Questions to Use to challenge the assumptions behind these errors in thinking.
    - Replace the negative thoughts with positive ones.
    - Use the Managing Negative Thinking worksheet.
    - Use the Positive Thinking Worksheet.

- **ACT** differently.
    - Increase your positive activities.
    - Use the Finding Activities You Enjoy worksheet.
    - Decrease your involvement in unpleasant activities.
    - Use your problem-solving skills to deal with issues that give you worries and concerns.
    - **Reward yourself for the positive steps you are making.**



(Adapted from: Kadden et al., 1992)

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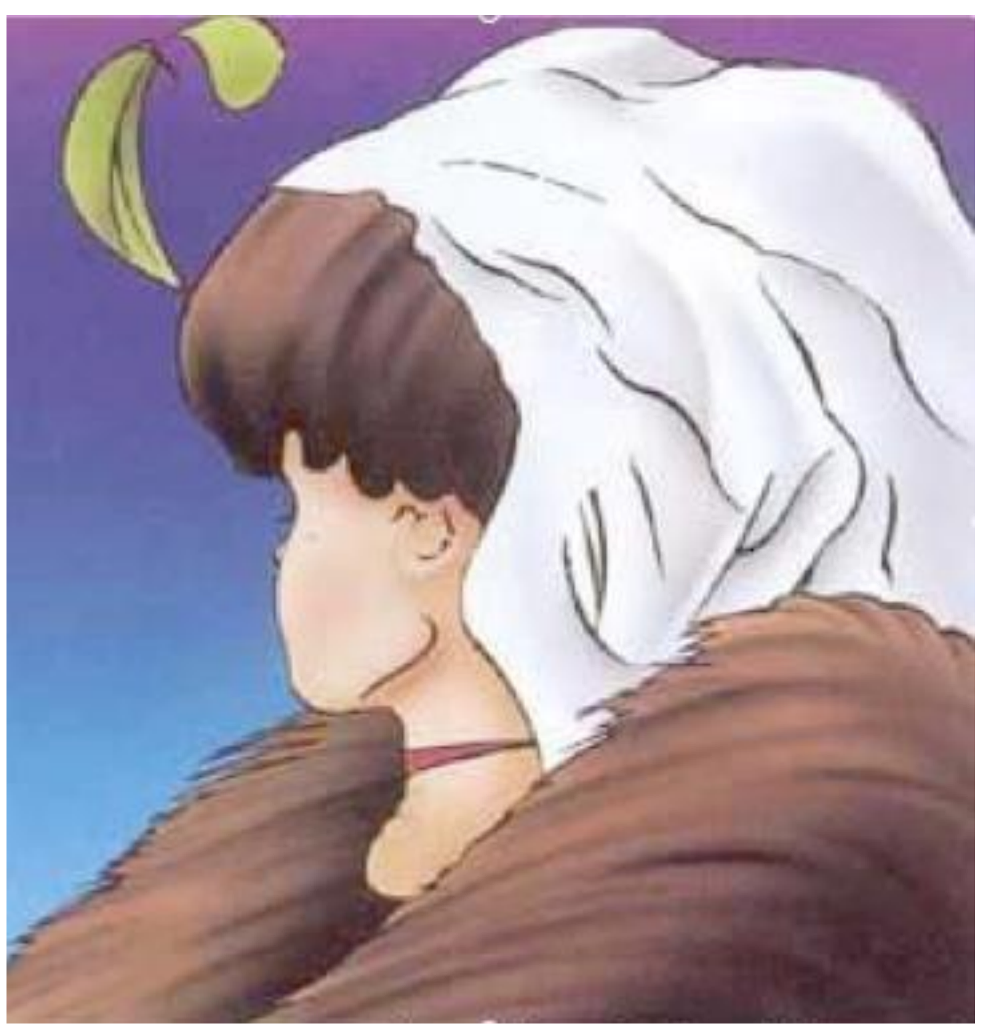
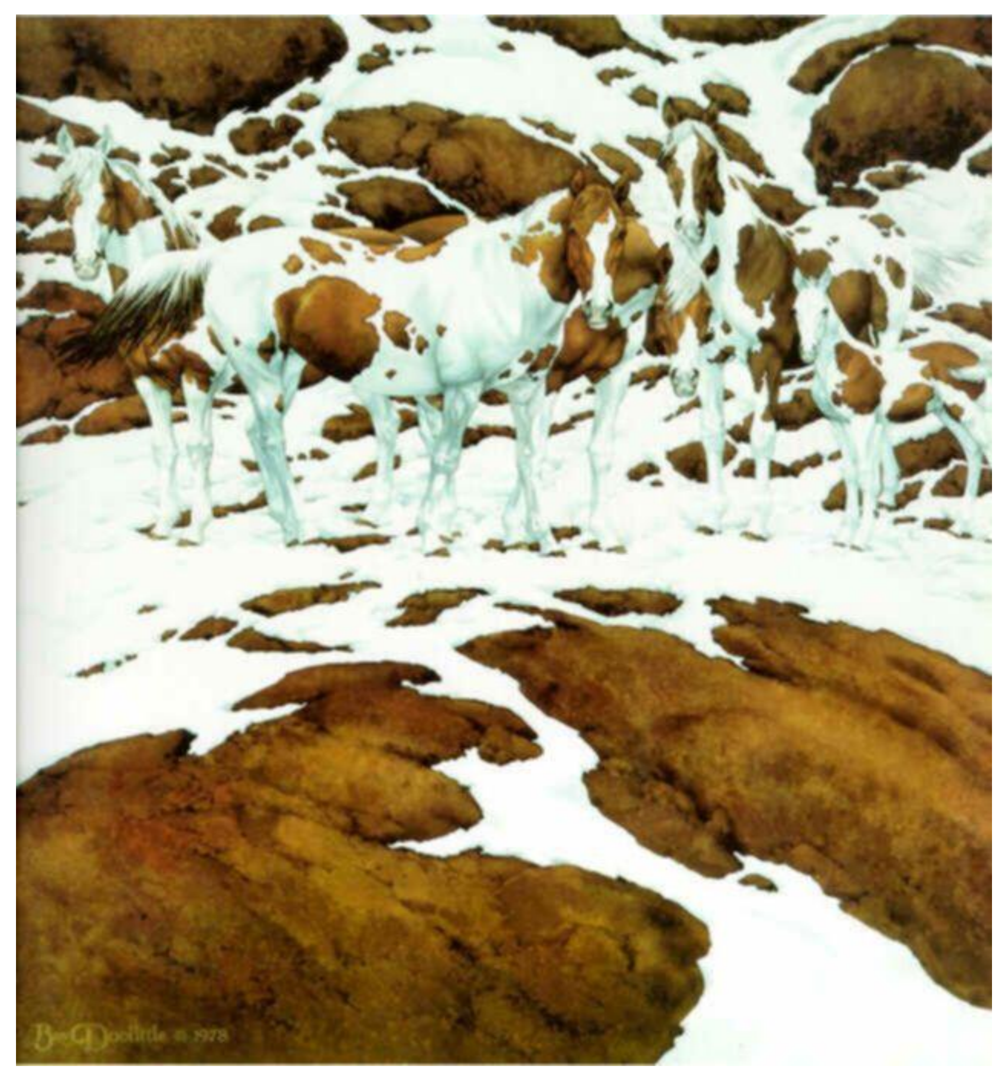
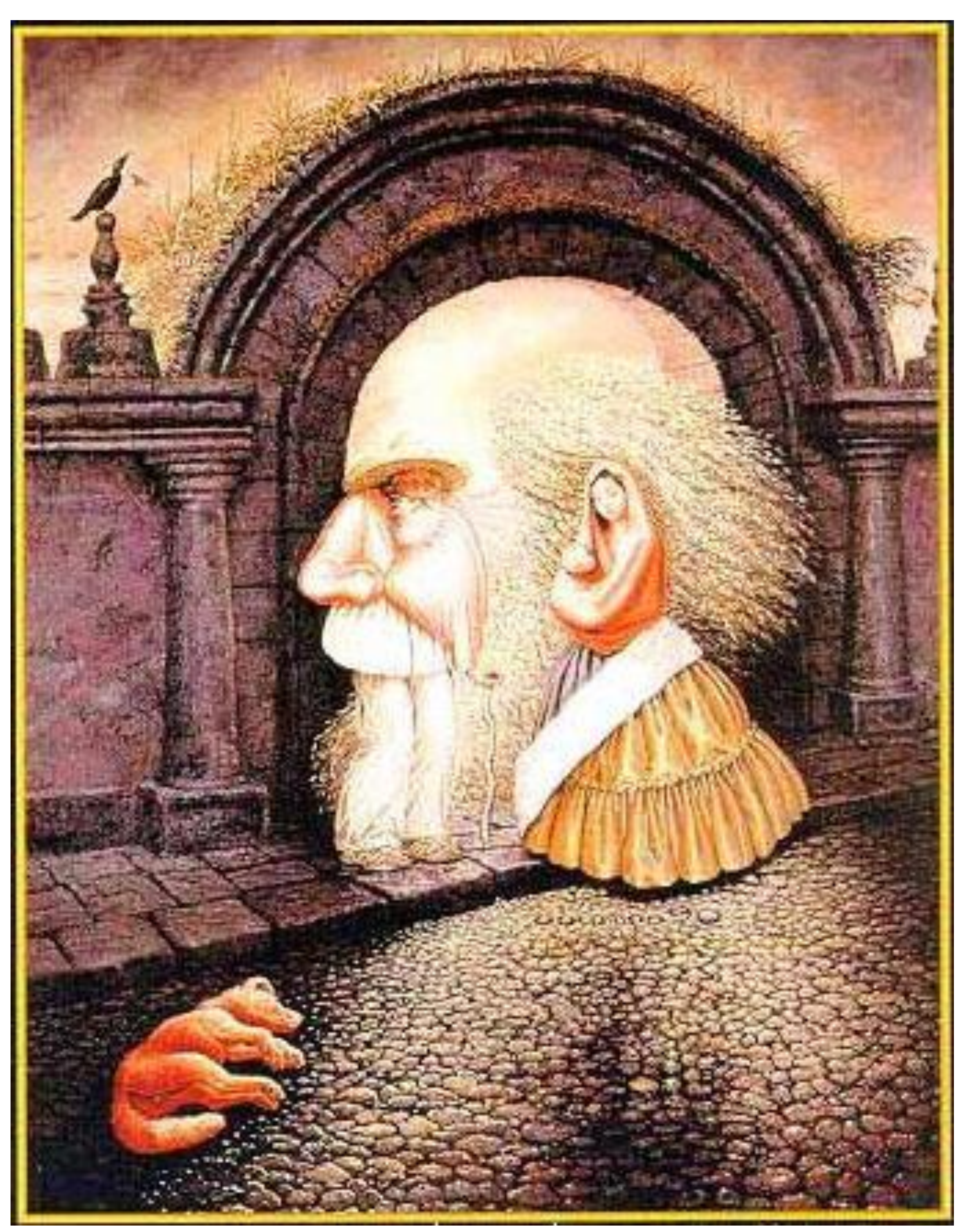


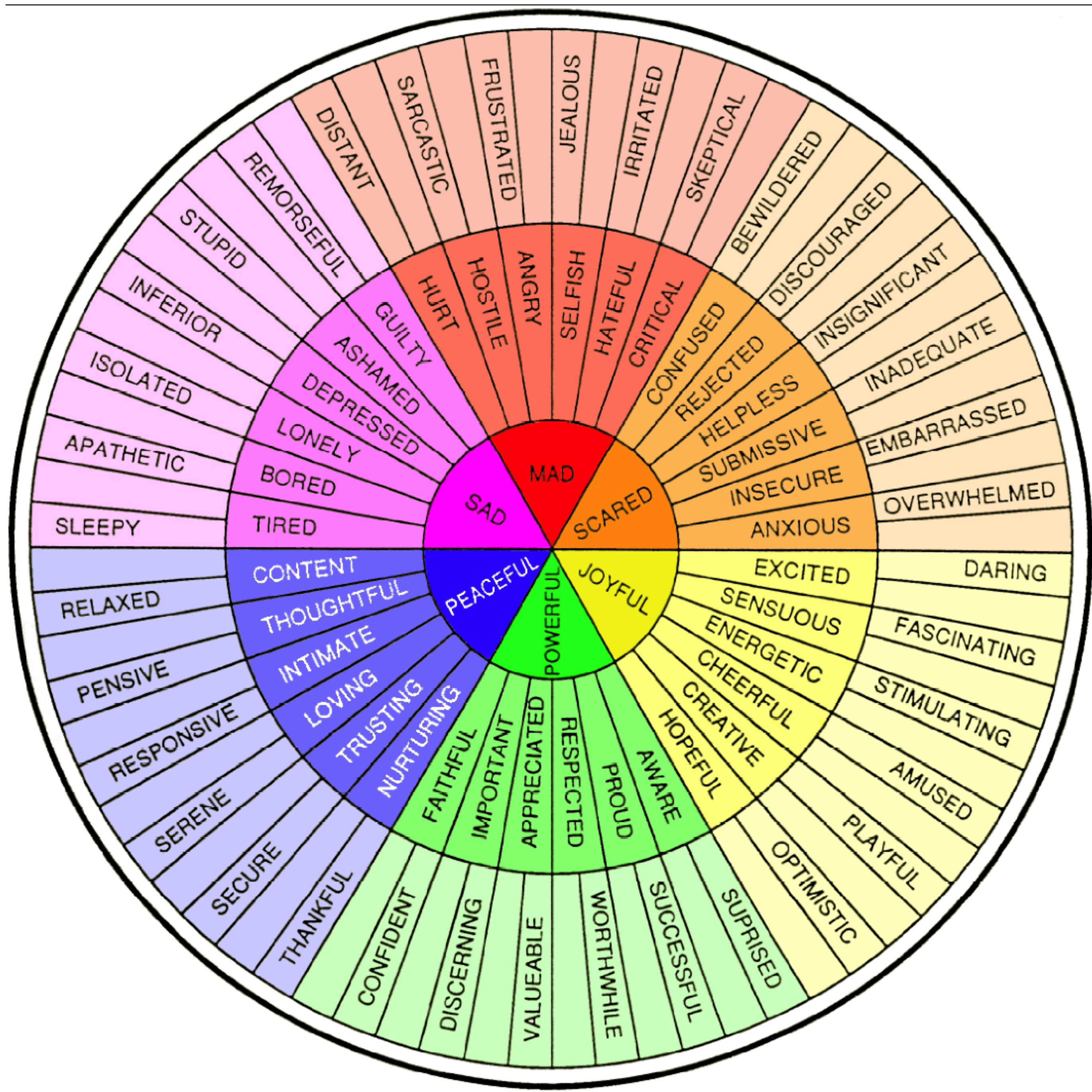
What do you see in this picture?

What did you see first in this drawing?
What did you see next?

You can look at the same thing and see it different ways.
The same is true of our thoughts and beliefs.


Bev Doolittle © 1978





This simple wheel can help you identify different feelings you might be experiencing at any time. Take a look at the center of the wheel and then look outward on the different spokes to discover ***all*** of your feelings. Remember, you can have more than one feeling (***and lots of different thoughts***) at one time.

<u>**IDENTIFYING FEELINGS**</u>

People often live in fear of their feelings. It is helpful to explore what your feelings mean to you so that you can begin to view feelings as a part of you to be listened to and not to be feared. The first step in allowing your feelings to work for you is to begin to identify the feelings you experience in the course of a day. At the end of the day (on the checklist below), check off the feelings you experienced. After a few days of doing this exercise, you will find it much easier to identify specific feelings.

FEELINGS	Mon	Tue	Wed	Thurs	Fri	Sat	Sun
angry							
sad							
guilty							
lonely							
embarrassed							
happy							
afraid							
anxious							
disappointed							
hate							
frustrated							
disgusted							
love							
lust							
compassionate							
confident							
jealous							
affectionate							
excited							
bored							
confused							
numb							
hurt							
calm							
secure							
silly							
playful							
shy							
remorseful							
ashamed							
nostalgic							
worried							
desperate							
resentful							

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LIST OF ERRORS IN THINKING
("STINKIN' THINKIN'")

1. **Black and white thinking (Either/Or):** You see things as perfect or awful, or you see people as all good or all bad. There is nothing in between. *"Either I'm a loser or a winner."*

2. **Emotional Reasoning:** You assume that the way you feel reflects the way things are. You feel tired and inadequate and assume that things are useless and require too much effort. *"I am really angry—it is impossible for me to get my point across with my girlfriend."*

3. **Blowing things up (catastrophizing):** You react to a disappointment or failure as though it means the end of the world. A small disappointment (a bad grade on a homework assignment) becomes a huge catastrophe (you'll never pass high school). *"I will never pass math class because I cannot figure out the solution to this math problem." "I know something terrible happened."*

4. **Jumping to Conclusions:** You assume the worst without checking the evidence. Or, you decide that terrible things will happen even when there is no proof. *"He didn't call me, it must mean he thinks I'm a loser."*

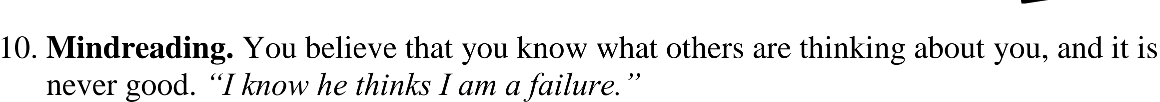
5. **Missing the Positive:** You don't pay attention to positive experiences, or you say they "don't count." *"That home run was a fluke. I'm no good at baseball."*

6. **My Fault:** You blame yourself for things that are not your responsibility or not in your power to control. *"It's my fault that my parents are getting divorced."*

7. **Magnifying or Minimizing:** You exaggerate the importance of certain things (such as your mistakes or someone elses' successes) and minimize other things (such as your own desirable qualities or other's imperfections). *"I failed that test! I will never get into college."* (magnifying) *"You would think I just robbed a bank! I just got caught with a pipe."* (minimizing)

8. **Fortune Telling:** You anticipate that things will turn out badly, and feel convinced that your prediction is a fact. *"I shouldn't bother trying out for the team. There's no way I will be able to* qualify."

9. **Shoulds:** You feel you "should" think or do something or criticize other people for what you think they should or shouldn't be thinking or doing. *"I should go home now." "You shouldn't ever have gone out with him!"* As a result, everything that you do and everything that others do disappoint or bother you.



10. **Mindreading.** You believe that you know what others are thinking about you, and it is never good. *"I know he thinks I am a failure."*

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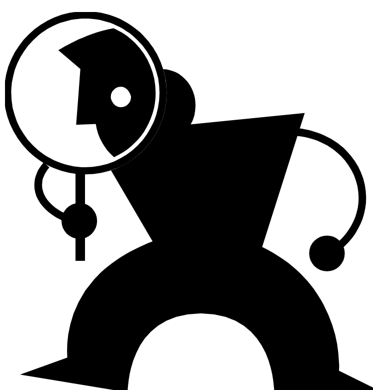
ANSWERING NEGATIVE THOUGHTS: KEY QUESTIONS TO USE

When you are aware that you are having negative thoughts, use these questions to challenge these thoughts and to come up with new, realistic ways of seeing the situation (self talk).

- Is this thinking all-or-nothing?
- What evidence do I have that this is true?
- What's the worst case scenario?
- Do I know for certain something bad is going to happen?
- Is this thinking getting me what I want? What do I want? What are my goals?
- Am I overlooking my strengths?
- Am I close enough or too close to the situation to judge?
- Am I confusing a thought with a fact?
- What are the advantages and disadvantages of thinking this way?
- What difference will this make in a week or a year?



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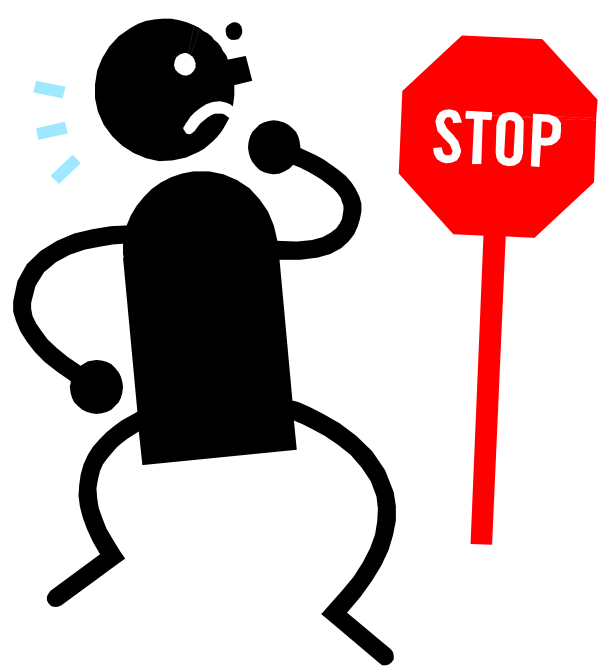
PRACTICE EXERCISE
Managing Negative Thinking

- Catch negative self-talk whenever you feel upset by an event or have a craving.
- Shout "STOP" to yourself quietly in your head.
- Challenge your negative self-talk and write down new thoughts which are more accurate and make you feel better.
- Remind yourself of good things you have done.
- Notice how you feel better once you have done this.
- Believe in the positive things you are saying to yourself. If you need to check in with a friend or some other supportive person to help with this, do it! You deserve to feel good about yourself, even when things are going badly.



PRACTICE EXERCISE
Positive Thinking Worksheet

Use this worksheet to write down one or two events that occur before the next session, your negative thoughts or self-talk, and then your positive thoughts or constructive challenges to the negative self-talk.

(A) EVENT OR SITUATION (who, where, when)	(B) THOUGHTS/SELF-TALK		
	Negative Thoughts →	**STOP! →**	***Challenge*** **the negative thoughts and write down** ***new*** **thoughts**
Fight with my parents over using the car.	*They never let me do anything by myself.*	**STOP! →**	*They said I could use it as long as I call 1x during the night and come home by 11:00 p.m. Not so bad.*
		STOP	
		STOP	

(Adapted from: Monti et al., 1989)

PRACTICE EXERCISE
Know Your Moods and What You're Thinking

Use this worksheet to help you become aware of the issues involved in your negative moods and the active steps you can take to change your moods.

1. What are the ways in which I show my negative moods, attitudes, and actions? (Examples: *I don't want to see or talk to people, I feel irritable and snap at people, I want to sleep all the time, etc.*)

___

___

___

___

2. What are the automatic negative thoughts (errors in thinking) that go along with my negative moods? What do I think about myself, my current situation, and my world in general?

___

___

___

___

3. What can I do to challenge these automatic negative thoughts? (Examples: *Ask other people what they think, decide I'm making a big deal about something, let it go, etc.*)

___

___

___

___

4. What steps am I going to take to act differently? What pleasant activities might I increase? What unpleasant activities might I avoid or minimize?

___

___

___

___

(Adapted from: Kadden et al., 1992)

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FINDING ACTIVITIES YOU ENJOY

It is really important to have ideas about the kinds of things you enjoy doing (besides using) as it's easy to get bored when there's not much to do. A pleasant activity can really help switch your mood from bad to good mood.

Circle any activities that you think you would enjoy AND which you would plan and actually do. Feel free to add different activities at the bottom of the page:

Skateboard
Go out to eat
Go shopping
Rent a movie
Walk around the mall
Watch TV
Go camping
Lift weights
Ride a dirt bike
Play baseball
Ride a bike
Join a youth group
Play hockey
Go on a picnic
Play volleyball
Go for a walk
Listen to music
Go to a sporting event
Play football
Skydive
Play cards
Play softball
Travel
Ride horseback
Rollerblade
Go bowling
Work at a craft
Walk the dog
Play a video game
Use a computer
Play pool
Boxing
Talk on the phone
Go to a museum

Play a board game
Go to a concert
Learn to cook
Write a letter
Read a book
Go skiing
Go snowboarding
Visit a relative
Go to a library
Learn something new
Draw

Paint
Write a poem
Shoot a video
Take photos
Rearrange your room
Get a job
Help a neighbor
Go for a hike
Play miniature golf
Garden
Paint your room
Start a journal
Write a story
Sing or play music

Start a band
Do your nails
Make a scrap book
Organize your closet
Go dancing
Go fishing
Take an art class
Go to batting cages
Swim
Go to amusement park
Play Ping Pong
Ride go carts
Try karate
Try paintball
Get ice cream
Take a class
Play basketball
Join a sports team
Study for driver's test
Wash the car
Fix a car
Babysitting
Help family food shop
Ride a bicycle
Go to a science center
Go to a gallery
Run track
Learn to sew
Hug someone
Smile
Laugh

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MODULE 8: Problem Solving

Summary of Tasks

- Explain importance of problem-solving skills for sobriety
- Draw connections between maladaptive problem solving and substance use behaviors
- Present and practice model for problem-solving approach

Presenting Session Rationale

A situation becomes a problem if a person has no effective coping response available to handle it. Substance users who are reducing/stopping their use are likely to encounter new problems they had previously ignored while they were using. The problem situations could include peer pressure, managing family relationships, school, legal, employment, and finding new activities to maintain sobriety. It will be difficult to face these problems, and you will want to remind patients that they will have your support as they do so. It is important to let patients know that if they don't find a good solution, the problem can build up over time. Effective problem-solving strategies must be a part of everyone's abstinence program.

In presenting a rationale for this session to the patient, you might say:

> *When you can't figure out what to do about something, it's really frustrating. When you don't deal with things, the problems usually get bigger and bigger. At times like this, it's easy to fall into the trap of wanting to use. Let's go through the steps of how to solve a problem so that you don't fall into that trap.*

Almost anyone will recognize that life is "full of problems," so it is usually not difficult to state a rationale for completing this module. With a resistant adolescent who has not identified a desire to change his/her use, you might say something very similar to the above, downplaying to some extent the connection with his/her use:

> *Life seems to present lots of problems. It's not always clear what to do, and that can be really frustrating. When you don't deal with things, the problems usually get bigger and bigger. Let's go through the steps of how to solve a problem so that you have different options.*

For the adolescent who expresses "too many problems to work on just one," try using the Problem Bank Worksheet. The adolescent is encouraged to write down all the problems s/he is having. He/she then reviews the list and chooses the top 1 or 2 problems. After narrowing down the problems in this way, counselor and patient can focus on the most troubling, persistent problem that presents itself to use for teaching/learning the problem solving approach.

Key Interventions

Problem-solving approach (5 steps)

You will present a straightforward model for problem-solving which consists of five steps (D'Zurilla and Goldfried, 1971). Before beginning to explain these steps, inform the patient

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that effective problem solving requires recognizing the problem and resisting temptations either to respond on first impulse or to do nothing. The steps are outlined below:

1. **Problem recognition:** Is there a problem? What are some of the clues that there is a problem? The very act of sitting down, analyzing a problem situation, and coming up with a range of solutions can be used as an alternative to using. Problems may be drug-specific, related to family, financial, job-related, or other interpersonal issues.

   To help begin this process, you might say:

   > *You may be used to feeling troubled about something, but instead of doing something about it or. realizing you have some options, you've gone out and used* [substance]. *That makes sense. But remember that it's normal to feel bothered by things. When you can learn to say to yourself, "Hey, that's a problem, but I can deal with it," things will start to feel less overwhelming. You will learn to recognize when you are bothered by something and stopyourself from using. It will be easier once you know what to do next. Let's move on to step #2.*

2. **Identify the problem:** Gather as much information and as many facts as you can to help clarify the problem. Be concrete, and define the problem in terms of behavior, whenever possible. Break it down into specific parts such as, "Who, When, and Where," whenever possible. Being directive and concrete will help the patient feel less hopeless, as he/she can set actual objectives.

   Prompt the patient to be very specific by saying:

   > *It's really important to know exactly what problem you are trying to resolve. So take the time to break it down into, "who, when, where." For instance, if you are trying to solve the problem of "using with my old friends," then what you want to determine is what might be getting in the way of making those changes* [pressure from old friends to get together, worrying that you will let them down, not having opportunities to meet new friends, lack of resources, etc.] *Once you understand the barriers to the changes you want to make, we can address each of these barriers. If you don't do that first, the whole thing can seem overwhelming. So let's say that the problem you are trying to resolve is, "Making time in my life to find new activities so that it's easier to stay away from old, using friends." This sounds pretty specific to me and will help a lot as we move on to the next step.*

3. **Consider various approaches to the problem:** It is tempting to try out the first solution that comes to mind. However, that may not be the best approach. It is important to develop a number of possible options. To find other options, try the following things:

   a. Brainstorming: Write down all of the ideas you can come up with. More is better.

For the problem we've been talking about, we could come up with a number of ideas. When you are brainstorming, don't throw out any ideas until later. Even one that might sound silly or useless may turn out to be a good idea. So let's begin…. You could let your old friends know that you can't see them at the park anymore, but perhaps a movie would be o.k. You could join the urban league basketball team. You could get a part-time job after school. Do you get the idea? What ideas do you have? Let's get them all down. [It is a good idea to have the patient write these ideas down on a sheet of paper or on a board in the therapy room.]

b. Change your point of view or frame of reference: It helps to step back and to get a little distance from the situation. Ask the patient to imagine that he/she is advising a friend on what to do.

Is there anyone you can think of who would give you good advice on this problem? What do you think they would say?

c. Adapt a solution that has worked before. Think of something that has worked in a similar situation or ask someone else about solutions that have worked for him or her in the past.

What's already worked for you with this problem? Have you been able to find some time already to get out and do something new that you've enjoyed [that didn't involve using]? [If so] *That's great. There's no reason you won't be able to do that again. Let's make sure that nothing will get in the way of doing that again. Wonderful progress.* [If not] *It's really hard to try new things. It can feel easier to do it the same old way.* [Continue to problem solve around any barriers.]

4. **Select the most promising approach:** Once you have come up with a good list of approaches and options, go through that list and eliminate ones that may seem weak or unrealistic. To make this list with effective options, you must think ahead. Identify the most probable outcomes for each possible approach and be sure to include both positive and negative outcomes, as well as long- and short-term consequences. Arrange all potential solutions according to their consequences and desirability, ranking them from highest to lowest.

Well, we have a number of different options listed here. Some will clearly work better than others. Let's first get rid of ones that you don't think will help fix the problem and also ones that might not be realistic, at least for right now. Then, we'll put the ones that are left in order from highest to lowest . There may be more than one that you can do right away so we can put those in the same rank of importance. It's important to know what you are going to do right away and also to have a future plan for what you might also try. It seems like what would be good to do right away is to talk with your family about your problem and to make a list of the activities you want to try. Remember, you can't do everything at once. One step at a time.

5. **Take action and assess the effectiveness of the selected approach:** The next step is for the patient to implement his/her chosen best approach. This is the action stage in which the patient must be encouraged to carry out the different approaches that he/she has identified. During the session, help patients identify one thing which they will do right away. This is similar to the part of goal setting in which they identify the "first steps they are going to take" (objectives) in reaching their goal. Choosing at least one thing should be familiar to them. Remind them that, unless they try something, they will not know if anything can change. Another important part of this step is to evaluate immediately the strengths and weaknesses of the action taken. Encourage the patient to ask himself/herself: *"Am I getting the results I expected?"* Let patient know that after he/she has given the plan a fair chance, and it doesn't seem to be resolving the problem, he/she should move onto the second-choice solution and follow the same procedure. You will want to check in with him/her about how his/her approach worked (or didn't) as a review of homework during the next session.

In-Session Practice

It is important to have the patient select a real-life problem and, with your assistance, work through the first four steps of the above problem-solving process during the session. Some patients will have difficulty selecting a problem to address. You will want to make use of everything they have shared with you about their lives, including family and home, work, finances, relationships, and, of course, substance use, to help them choose something that has importance and relevance.

- Have patient describe the problem in behavioral terms (e.g. who, when, and where).
- Have patient brainstorm solutions (write them down). You will likely need to get patient started by sharing some ideas. Trade off in the process of sharing ideas.
- Have the patient articulate both advantages and disadvantages for every alternative. Together, weigh the alternatives of each solution to select the most promising one. Prioritize these alternatives (rank order).
- Role plays can be used to evaluate the effectiveness of the most promising one. For instance, you could include a role play of the patient practicing with his/her family how he/she is going to ask for more support. The role play allows for opportunities to practice other skills learned such as effective communication.
- Have patients articulate an action plan (steps). They will not be able to implement the action plan during the session. However, they should choose exactly what they plan to do outside of the session as the next step. They should also be prepared to discuss the strengths and weaknesses of their approach when they come in for the next session.

At-Home Practice

Have your patients continue to work on the problem they have identified, completing step 5 (action and evaluation). They can use the **Problem Solving Practice Exercise** in their workbook to write this out and/or to choose another problem to work on.

You may also choose to have your patient fill out the **Problem Bank** worksheet if he/she is feeling overwhelmed with many problems. When your patient comes in for the next session, you can then go over the problem-solving steps based on his/her number one problem.

PROBLEM BANK

Use this sheet to list all of the problems you are currently facing. List them in no particular order. Then, review the problems and try to determine the most troubling problem and the least troubling problem. Place a "1" by the most troubling problem, then a "2" by the next most troubling problem, and so forth. A "10" will be placed by your least troubling problem. Remember, by placing your problems in this bank and identifying the most troubling one, you can start to work on your most troubling problem. The remaining problems will be here for you to work on when you're ready. In the meantime, let's put some of them aside and work on the most troubling, persistent problem.

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____

7. ____

8. ____

9. ____

10. ____

REMINDER SHEET
Problem Solving

These, in brief, are the steps of the problem-solving process:

1. Recognize that a problem exists. "Is there a problem?" We get clues from our bodies, our thoughts and feelings, our behavior, our reactions to other people, and the ways that other people react to us.

2. Identify the problem. "What is the problem?" Describe the problem as accurately as you can.

3. Consider various approaches to solving the problem. "What can I do?" Brainstorm to think of as many solutions as you can. Try taking a different point of view, try to think of solutions that have worked before, and ask other people what worked for them in similar situations.

4. Select the most promising approach. "What will happen if . . .?" Consider all the positive and negative aspects of each possible approach, and select the one likely to solve the problem with the least hassle.

5. Assess the effectiveness of the selected approach. "How did it work?" After you have given the approach a fair trial, does it seem to be working out? If not, consider what you can do to improve the plan, or give it up and try one of the other possible approaches.

(Adapted from: Monti et al., 1989)

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PROBLEM SOLVING WORKSHEET[4]

❶ **Identify the problem.** • Who? When? Where? • Be specific. Use details.		
❷ **Consider several approaches:** • Brainstorm. • Take a different point of view. • Consider familiar solutions.	1.	5.
	2.	6.
	3.	7.
	4.	8.
❸ **Think ahead.** • Pick the most promising approaches. • Identify possible positive and negative outcomes for each.	Approach #____	Positive outcomes: Negative outcomes:
	Approach #____	Positive outcomes: Negative outcomes:
	Approach #____	Positive outcomes: Negative outcomes:
❹ **Select the best one**: Most likely to solve the problem with the least amount of hassles. ➡		
❺ **Do it.** • **Evaluate: Did it get me what I wanted?**	**If so, congratulations!** Nice job! **If not, re-evaluate the plan:** Improve the initial plan or try another approach.	

[4] Credit: Jennifer Wyatt, LMHC, MT-BC, CDPT Cognitive Behavioral Therapist, Therapeutic Health Services, Seattle, WA

MODULE 9: Substance Refusal Skills

Summary of Skills

- Explain importance of substance refusal skills
- Describe direct and indirect types of peer pressure
- Present non-verbal and verbal skills
- Model and practice responding to high-risk situations

Presenting Session Rationale
As substance use develops over time during childhood and/or adolescence, people tend to start spending time with friends and acquaintances that use, forming a peer group of people who support and reinforce drug use. This increases risk of relapse. There are two forms of social or peer pressure: direct and indirect. **Direct** occurs when someone directly offers the patient drugs; **indirect** involves returning to the same environment, with the same people, doing the same things, and experiencing the same feelings associated with substance use. In teaching this module, you will emphasize that the first strategy should be to avoid situations and people associated with drug use. However, avoidance is not always possible. It is important to know how to turn down the offer of substances.

To remain abstinent in the face of pressure from peers requires the use of assertiveness skills. This session will largely be a review of skills learned in the communication module (assertiveness) as well as a blend of different skills, such as managing cravings and problem-solving. Some patients will resist the idea that they are influenced by their peers stating, *"Well, it's up to me to stop!"* You can agree with statements like that, at the same time letting the patient know how important it is to be able to respond quickly to these situations by practicing for them.

In presenting a rationale for this session to the patient, you might say:

> *You have been doing so well with your abstinence. Let's make sure that your progress doesn't get thrown off by getting into situations where it's hard to say "No." Realistically, it's not always possible to avoid these situations. It can be uncomfortable to tell people that you aren't going to use. We will come up with some strategies you can use when you haven't been able to avoid a situation* [where substances are present].

With a resistant patient who has not identified a desire to change his/her use, you might say:

> *It's good to have some ways to say "no"*"[to using] *when you are ready* [to abstain]. *There will be times when you need to tell your friends you aren't going to use. We'll practice this so you can get comfortable with it.* [Try to connect a reason for not using to one of their goals, such as needing a clean urinalysis.]

Key Interventions

Refusal training is a very important skill to facilitate and may need to be revisited several times during the therapy (Godley et al., 2001). After years of using in social situations, a patient may feel a strong lack of confidence in his/her abilities to handle these situations. The goal is to learn to say *"No"* in a convincing manner and to have this response ready immediately. The more quickly a patient is able to say "no" to a request to use, the less likely he/she is to relapse. This is true for two reasons. First, it gives the other person more time to work on convincing the patient to use. Secondly, it gives the patient more time to rationalize using, such as, *"One beer won't be so bad."* Remind the patient of the skills learned in Module #4 Communication Skills, striving for assertive behavior in these situations. A few important things to remember are:

- Speak in a clear, firm, and unhesitating voice.
- Make direct eye contact.
- Don't act guilty (if you are feeling that way, challenge your negative self talk—see Module #3 Managing Cravings).
- Avoid the use of excuses and vague answers.

Review each of the skills below with the patient:

Say, *"No, thanks,"* assertively. You must be firm and positive when refusing. If an explanation is needed, then it is acceptable to offer one. Casual acquaintances usually will not ask for an explanation. Close friends or family members are more likely to ask for any explanation for a refusal. A prepared excuse (even a false one) may be helpful at this time, but may create the need to refuse again later. The most assertive thing you can do is to state your preference directly without offering an explanation. *"No, I don't want to."* You can always end the conversation and leave.

Watch body language and tone of voice. It is important to refuse substances using both words and body language indicating that you are serious and confident. It is very important to be sure that your tone of voice and non-verbal messages, like posture and eye contact, match what you want to communicate. You should practice standing up straight, facing an individual, and stating firmly, *"No, thanks."* Not projecting assertive nonverbal messages may project the message that your decision to refuse is not a firm one.

Suggest alternatives: You can suggest something other than substances. *"Let's go grab some food."* Or, *"No, thanks. Let's shoot some hoops."*

Change the subject. Changing the subject indicates that you are not interested in the offer. For example, you could say, *"No, thanks. What do you think of that new CD by. . . ?"* This may feel awkward at first, but with practice, it will feel more natural. Remember that it is your right to take action to control the situation.

Confront an aggressor. If someone persists in offering you substances despite receiving a refusal, you may need to confront the individual. This confrontation should be a last resort, because it may lead to a counterattack or loss of a friend. You can say, *"Do you understand that I have stopped using . . . ? Why is it so important to you that I use when I don't want to?"*

Dealing with group pressure. A particular type of pressure situation involves being with a group of people. It is best to be clear about your decision not to use before entering into a group

situation in which substances will be present. Think about what the group may want you to do and why. Decide what you want to do. Do a role play in your head (or with someone else if available), practicing what you want to say to the group about your decision.

In-Session Practice
This session offers many opportunities for role plays so plan to do this as often as possible once you have identified the key problem areas for the patient.

Options:

- Some patients will have difficulty identifying problem situations, times when they might feel pressured to use. To help them with identifying these situations, review **"External Triggers"** on the **FUNCTIONAL ANALYSIS FOR DRUG USING BEHAVIOR** to identify "Locations" and "Social Situations" in which using behavior takes place. Have the patient sort these triggers from most to least frequent using setting/situation. This exercise will help patients anticipate the settings and the people in their social network(s) who promote the highest risk for using.

- **Behavior rehearsal role plays:** Use the locations and situations categories identified in the **FUNCTIONAL ANALYSIS** (high risk situations/settings) for different role plays. Encourage the patient to think ahead to potentially risky situations, including those in which there is a group of people. Therapist plays the role of the person being pressured to use and demonstrates an effective and assertive way to handle the situation. Then, switch roles. It may be useful to elicit the patient's fantasies about how the other person will respond to her/his refusal to use and process these beliefs.

At-Home Practice
The following worksheets are in the patient workbook. These sheets will be useful in pointing out different scenarios that might present challenges. The patient should review and/or complete each of these.

- **Drug/Alcohol Refusal Methods**
- **Checklist of Social Pressure Situations**
- **Substance Refusal Skills**
- **My Social Triggers**
- **Alternatives To Drug Use**

Optional Exercise:
Real-life practice will be useful to build confidence. While you won't encourage the patient to seek out situations in which substances will be present, many patients will still be spending time with using friends and acquaintances. Ask the patient to practice using the skills in a situation in which there has been **direct** pressure to use and report on that during the next session. If this situation does not happen, ask the patient to observe how he/she handled a situation in which he/she experienced **indirect** pressure to use and report on that experience during the next session.

REMINDER SHEET
Drug/Alcohol Refusal Methods

1. The most assertive thing you can do is to state your preference directly without offering an explanation. *"No, I don't want to."* If you choose this method, it is also very important to be sure that your tone of voice and other non-verbal messages, like posture and eye contact, match what you want to communicate.

2. Another direct way to assert your preference is to say, "NO," and also offer an explanation.

   a. You can give an excuse. *"No, I'm driving....My parents will kill me. I want to keep my driver's license."*

   b. You can give a consequence. *"My boss will fire me.... If I fail another drug test, I'm back in residential."*

   c. You can mention treatment. "*I'm quitting and I'm in treatment now."* If you choose this method, this is a good time to ask for support from friends. Ask them to help you out by not offering stuff to you.

3. One indirect way to refuse is to give an alternate suggestion for an activity that doesn't involve using. *"I'm hungry, let's go get something to eat . . . I'd rather play some basketball."*

4. Change the subject.

5. End the conversation and leave.

6. The easiest way of refusing is to stay away from situations in which you know you will be tempted.

(Adapted from: Monti et al., 1989)

CHECKLIST OF SOCIAL PRESSURE SITUATIONS

To what extent do you expect that the following situations could be a problem for you in becoming or staying clean?

		✘ No Problem	✘ Some Problem	✘ Significant Problem
1.	I am around other people who frequently use drugs/alcohol	_______	________	_______
2.	Someone very close to me frequently uses	_______	________	_______
3.	Someone I live with uses drugs or alcohol	_______	________	_______
4.	I make other people uncomfortable because I am not drinking/using drugs	_______	________	_______
5.	People often offer me alcohol/drugs	_______	________	_______
6.	I feel awkward telling people that I am trying to not use drugs or drink alcohol	_______	________	_______
7.	Most of my friends drink or use drugs	_______	________	_______
8.	I am around drugs/alcohol at school/work	_______	________	_______
9.	People give me a hard time for not using	_______	________	_______

Adapted with permission from Miller, W.R., ed. *COMBINE Monograph Series, Volume 1. Combined Behavioral Intervention Manual: A Clinical Research Guide for Therapists Treating People with Alcohol Abuse and Dependence.* DHHS Publication No. (NIH) 04-5288. Bethesda, MD: NIAAA, 2004.

REMINDER SHEET AND PRACTICE EXERCISE
Substance Refusal Skills

When you are urged to use drugs, keep the following in mind:

- Say “no” first.
- Voice should be clear, firm, and unhesitating.
- Make direct eye contact.
- Suggest an alternative, something else to do.
- Ask the person to stop offering you a “hit,” for example, and not to do so again.
- Change the subject.
- Avoid the use of vague answers.
- Don’t feel guilty about refusing to use.
- If necessary, create a possible excuse as to why you cannot use now.

Practice Exercise
Listed below are some people who might offer you drugs in the future. Give some thought to how you will respond to them and write your responses under each item.

Someone close to you who knows your drug problem: ________________________________

____

Someone from school: ____

____

Girlfriend/boyfriend: ____

____

New acquaintance: ____

____

Host at a party: ____

____

A relative: ____

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MY SOCIAL TRIGGERS

1. Are there any people with whom you are more likely to use drugs? **Yes No** (circle)

Who? (initials only) __________

2. Could you take a "vacation" from (avoid) any of these people? **Yes No** (circle)

Which ones? ____

3. Are there any people in your life whom you don't use drugs with? **Yes No** (circle)

Who? (initials only) __________

4. Are there any people you can say "no" to about drugs? **Yes No** (circle)

Who? ____

5. Do you ever feel more like using drugs when you are angry with someone? **Yes No** (circle)

When was the last time? ____________________________________

6. Do you ever feel more like using drugs when you have just had a fight with someone? **Yes No** (circle)

When was the last time? ____________________________________

7. Do you ever feel like using drugs when you are lonely? **Yes No** (circle)

When was the last time? ____

ALTERNATIVES TO DRUG USE

1. Dealing with social (external) pressures:

a. Develop supportive relationships with individuals and peer groups; spend time with people who support your sobriety.

b. Stop spending time with using friends.

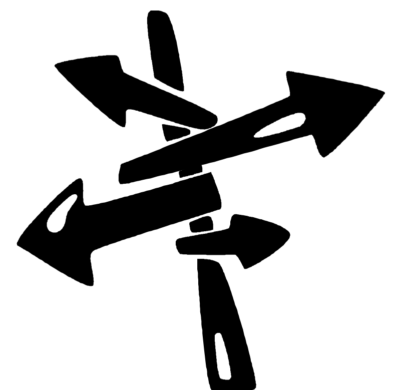
c. Avoid social situations you don't think you can handle.

d. If an uncomfortable situation comes up, give yourself permission to leave.

e. Prepare in advance what you will say if someone offers you a chance to use/drink.

f. Don't expect the world to quit using/drinking because you have. Your friends won't understand why you quit. They may think they are doing you a favor by giving you drugs.

2. Dealing with psychological (internal) pressures:



a. Physical exercise, relaxation exercises.

b. Talking about your situation or feelings with someone you trust.

c. Go see a movie.

d. Read a good book.

e. Listen to music.

f. Sit and feel hurt.

g. Pay attention to tension signals and use this as a signal to think about changes you may need to make in your life. Tension sometimes appears through churning stomach, sore back, tight neck, headache, grinding teeth.

h. Leave an uncomfortable situation.

i. Have a discussion with someone you are at odds with.

j. Get advice from friends and/or family.

MODULE 10: Enhancing Social Support Network

Summary of Tasks

- Explain importance of social support in maintaining abstinence
- Explore current level of social support and areas of need
- Discuss barriers to enhancing support system and problem solve
- Develop plan to enhance social supports

Presenting Session Rationale

There are many stresses associated with substance use: emotional, interpersonal, financial, and medical among others. Sometimes support systems have broken down because of social withdrawal or interpersonal conflicts resulting from substance use. A social support network can include family, friends, teachers, and acquaintances. Staying abstinent, dealing with problems related to substance use and triggers, and pressures to use are far more difficult without support from others. Let the patient know that people with support usually feel more confident about their ability to manage their lives and to cope with problems. Furthermore, he/she should be thinking about how to replace some of the support he/she has been getting in therapy after it is completed. Building a new support system is an important skill for life, as patients will likely be asked to return the support at one time or another.

In presenting a rationale for this session to the patient, you might say:

> *Throughout our treatment so far you have learned many skills to help you stop using substances. However, we know getting and staying sober can be difficult to do alone. We will decide whom you can ask for help. We will also help you figure out what kind of help you may want or need and how to get it.*

With a patient who has not identified lack of support as an issue you might say:

> *It's hard to ask for help when you really need it. Everyone needs help at one time or another. And people like to help out when they can. Let's look at what you might need and how to ask for it. Remember being supportive is a two way street. When you help out others, they want to help you in return.*

Key Interventions

A social support network can include family, friends, acquaintances, co-workers, and support groups, such as 12-step or other programs. The patient may expect you to tell them that they *must* give up friendships with using friends. While it might be to patients' advantage in some cases to do so, this is not always the case. These peers can be engaged in supportive activities, such as being available for calls during cravings or for trying other activities. Help patients identify criteria for a supportive friend versus one who is not, e.g. a supportive friend will listen and comply with a request not to use around you. Sometimes their using friends are also interested in becoming abstinent. You can ask patients if there are friends in their current peer group who would consider going through treatment also. (Some friends may qualify for the study and they can call for a pre-screening.) Let the patient know that people often don't feel they have the support they need. Some people don't know how to seek it out or think they are

not supposed to ask for help. Communication strategies previously learned will help patients build and maintain supportive relationships.

Identify WHO Might Be Helpful To You
It is important that patients think carefully about who is in their support system already and whom they could add. In considering their supports, they may realize they have overlooked important people, as well as depended on people who are unreliable. Ask patients to identify these people, writing them down in their workbook or on the board:

- **People who are already important in your life.** (You may already have an idea about who these people are, but ask the patient to list them anyway.)

- **People who could offer a more supportive role.** (Prompt them by asking about school staff, co-workers/bosses, places of worship, sports teammates, coaches, etc.)

- **People who are presently hindering your efforts to make changes in your life, such as sobriety.** (Don't assume that all using friends will hinder efforts to become sober. Ask patients to identify people who would either sabotage or support their work.)

Consider What TYPES Of Support You Would Like
Knowing what you would like may seem to be a simple concept; however, it is unlikely that the patient has ever stopped to think about what other people can offer in their lives. Developmentally, adolescents are struggling to become independent, to rely less on others. Therefore, you may need to build an argument for the different types of support that everyone needs, no matter what age. It will be helpful to provide an example of how you use support in your life. List these examples, highlighting ones that you know will be particularly relevant:

- **Problem solving.** (If you have completed Module #7 Problem Solving, refer to the brainstorming process, which greatly benefits from more than one perspective.)

- **Moral support.** (Define this as the help you would need when trying to make a difficult decision, involving an ethical dilemma. Adolescents often face these decisions, e.g. whether or not to be involved in illegal activity and what to do when they have knowledge about this activity. Let them know it is helpful to identify people who will be able to help them look at what is in their best interest, even when it may put them at odds with others.)

- **Helping with tasks.** (These tasks might be simple things, like a ride to their therapy visit, a job interview, or to school. Adolescents may feel awkward asking for these things if they are not used to getting such help from family members. Or, if they are used to getting what they want, they might need to learn how to ask for help *without* an entitled tone. See "How to Get the Help You Need" below.)

- **Information and resources.** (They may know people who can help them identify available jobs, school programs, or other important resources to help them meet their goals. If not, brainstorm with them to identify these resources. If available, get on the Internet together to help them search for information. Remember that most adolescents are seeking new ideas and information. Sometimes, they are looking for information to support why it is alright to be using substances. It is best to take a neutral stance and let

them discover through available resources what the dangers are and where they can get help.)

http://teens.drugabuse.gov/ (National Institute on Drug Abuse has developed a site specifically for adolescents; it cites scientific research on all substances of abuse.)

http://www.teenquit.com/index2.asp (A free, comprehensive online program to help adolescents quit using nicotine. Its concepts and exercises are an excellent adjunct to material in this manual. This website has been developed by Danya International, a private sector organization providing research-based tools to promote health and education solutions.)

http://www.al-anon.alateen.org/ (Many of these adolescents will be living with family members who are also substance-dependent. Let them know how difficult it is for them to quit under these circumstances and that there is support for family members.)

http://www.niaaa.nih.gov/faq/faq.htm (Sponsored by the National Institute on Alcohol Abuse and Alcoholism, this site gives answers to several frequently asked questions about alcoholism.)

- **Emergency help.** (Adolescents rarely plan for emergencies, as they don't typically think ahead. Encourage them to be prepared for times when they might need to ask for help and need a quick response, e.g. list whom they would call in the middle of the night if they needed to. This list could also include names of professionals they could go to for medical advice and referral. In addition, there might be an opportunity to discuss what sort of help they might need after this therapy ends.)

- **Help with not using.** (Review "Talk it Through" from Module #3 Coping with Cravings and Urges to Use. Here, the patient identified friends and other people whom they could call during a craving. Take this opportunity to refresh and expand that list.)

- **Encouragement.** (Many of these adolescents will be accustomed to hearing negative statements by others about their lack of school success, their substance use, and other problems in their lives. You will suggest that not everyone sees them as unsuccessful, and they should seek out people who can see their accomplishments, however small. You can list yourself as a person who can see the patient's value and successes, if that feels comfortable, as well as other study personnel who know the patient. Let patients know that the more they are able to use the skills they have learned in therapy, the more likely they will be to get encouragement rather than discouragement. Help them think of examples in which they have already received encouragement because of their efforts.)

Consider HOW You Can Get the Help You Need

The skills that you will teach in this section are mostly a review of skills learned in Module #5 Communication, particularly tips on how to be assertive. Remind patients of the importance of being direct, without being pushy, when asking for help. Let them know that people in their lives cannot read their minds when they need help, so they will have to be clear and direct. Acknowledge that asking for help is not easy, especially when they are not used to doing it or

have been rejected in the past. If they seem to have a strong sense that it is not "*right*" to seek help, ask what makes them believe that. You may need to do some brief cognitive restructuring to address these thoughts (see Module #7 Negative Mood Regulation). Remind the patient of each of the elements below:

- Figure out what you need and who will be the best person to ask. Then, be direct and specific in your request.
- Lend your support to others, as this will ensure that help keeps coming your way when you need it.
- When you have asked for help, such as advice, be an active listener even when you do not agree with what you are hearing.
- Give feedback. Friends and family need your guidance on what was or wasn't useful.
- Remember to say thank you whenever you receive support.

In-Session Practice
Options:

- **BEHAVIOR REHEARSAL ROLE PLAYS:** Have patients identify an area in which they need support currently. Demonstrate ineffective and effective ways of asking for that help and for different types of support. This exercise is a good opportunity to practice an assertive (versus passive or aggressive) communication style.

- Have them begin the **SOCIAL NETWORK MAP** during the session. Instruct the patient to put himself/herself in the center. Place the people who are already important in his/her life in the next circle, and the people who are neutral a little farther away. Write in their roles (family member, friend) and what kind of support they do (or could) offer. Circle the people who will be of most help in efforts to stay abstinent. What kind of support could you (or do you) provide to others? Ask them to look carefully at their map and have them reflect on who they would like to spend more time with. Ask if there are particular areas of support in which they think they need to add people.

- Introduce the **PRACTICE EXERCISES** by reviewing the questions with patients, as it may be difficult for some patients to identify: problems, who to ask support from, and what to ask for. Send them home with these questions to complete.

At-Home Practice
Conclude the module by asking the patient to observe and write down times over the next week when he/she did and did not ask for support when he/she needed it. Have him/her complete:

- **PRACTICE EXERCISES (#1 and #2)**
- **SOCIAL NETWORK MAP**

REMINDER SHEET
Social Support Networks

WHO might be able to support you? Consider which people have in the past been:

- Usually supportive
- People who could offer support if you asked them
- People who are getting in the way

WHAT types of support will be most helpful?

- Problem solving
- Moral support
- Information and resources
- Helping with tasks
- Emergency help
- Help with not using
- Encouragement

HOW can you get the support or help you need and maintain that support over time?

- Ask for what you need. Be specific and direct.
- Lend your support to others; it helps you strengthen your own skills.
- Be an active listener when giving or receiving support.
- Give feedback about what was or wasn't helpful.
- Thank the person for her/his support.

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PRACTICE EXERCISES
Enhancing Social Support Networks

Exercise #1
Think of a current problem that you would like help with. Describe the problem:
____
____

Who might be helpful to you with this problem? ___________________________________

What might he/she do to lend you the support you would like? ________________________
____
____

How can you try to get this support from him/her? _________________________________
____
____

Now, choose the right time and situation and try to get this person to support you. Describe what happened: ____
____
____

Exercise #2
Name a friend or family member who is currently having a problem and who could use some more support from you. ____

Describe what you could do to lend him/her some support: ___________________________
____

Now choose an appropriate time and setting and give support to this person. Describe what happened: ____
____

(Adapted from: Monti et al., 1989)

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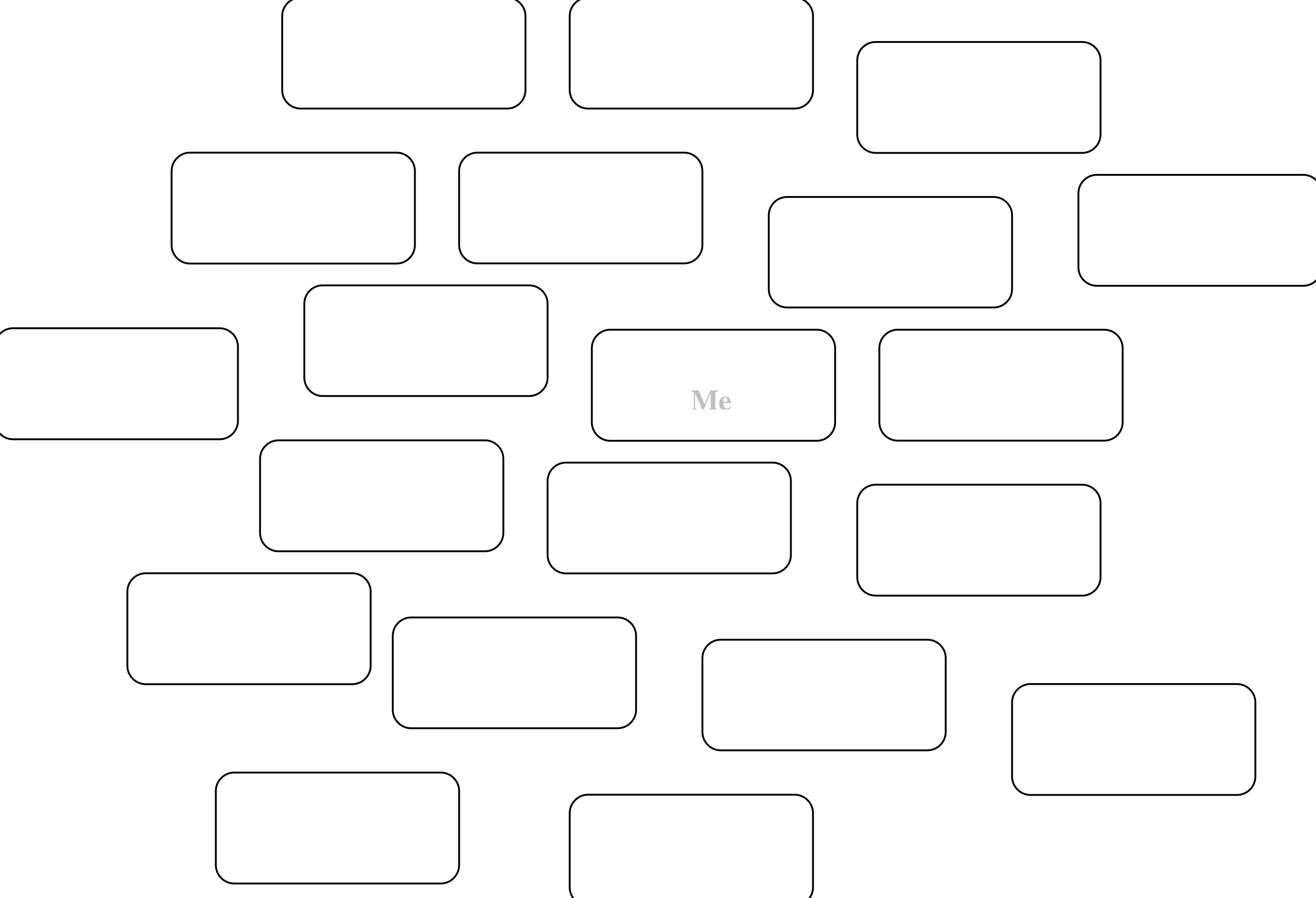
INSTRUCTIONS FOR THE SOCIAL NETWORK MAP

Below are twenty rectangles. Place your name in the centermost rectangle (“Me”). Then, in the surrounding rectangles, write the names of the people in your social network. The names in the rectangles closest to the center should be the people whom you consider closest to you. The further away from the center, the less close to you that person is. If you run out of rectangles, make your own; the more the better!

After you have finished writing names in the rectangles, look back over the names.

- Put a circle around the names of people who use substances
- Put a square around the names of people who do not use substances
- Put a triangle around the names of people involved in crime
- Put a star next to the names of people who you believe would support or encourage you in your goal to stop using. For example, include people who would refrain from offering you drugs or using around you, be available for a phone call, or spend time with you.

Now, let’s look over your network map!



MODULE 11: Job-Seeking and Educational Skills

Summary of Skills

- Define short-term goals for employment and/or education (focus varies by patient)
- Determine priorities for employment and education
- Explore barriers to employment and school success
- Identify plan to resolve barriers using learned skills (opportunity for review of other skills)

Presenting Session Rationale

School and vocational failure often co-occurs with substance problems and almost always exists when a person is untreated for ADHD. There are very high rates of school drop out among adolescents with ADHD. The teens who stay in school have commonly been funneled into less –rigorous, remedial programs by the time they reach high school, where there are greater chances of consorting with other users, beginning a downward spiral of academic success. School and vocational problems often get overlooked in treatment when there are so many other significant issues, such as the substance use itself and family/relationship problems. This session offers opportunities to refine academic and vocational goals, and to practice skills to reach specific objectives.

Patients will often request this module (particularly Job-Seeking Skills), as they recognize its applicability to their current goals. These adolescents are likely getting negative messages from others about their need to finish school (or to get their GED), and they might be reluctant to bring up this topic, fearing more criticism. On the other hand, they are usually fairly motivated to talk about finding work. A job signifies an increase in status and more independence for an adolescent. At this point, they may be feeling fairly hopeless about their chances to succeed in either education or employment. Whatever the case may be, bring a positive and hopeful approach to the topics. The focus of the session should be targeted to their strengths, as well as to areas in which they need to develop skills. You can tailor your rationale statement to cover one or both topics. You might say:

> *I bet you're sick of people nagging you about school and getting a job* [mention one or both depending on needs and goals set previously]. *I think we can get a lot done to meet your goals. We should have time to cover both topics* [skip if there is no need to cover one of the topics]. *Let's talk specifically about what you want to accomplish in school and for work* [mention one or both]. *These things can always change, but it's important to know what you are thinking right now. Let's talk about all the things you are already doing in school and to find a job* [mention one or both]*, and then figure out what could make it easier.*

Key Interventions

Job Skills (adapted from Godley et al., 2001)

Provide an Overview of a Job-Seeking Approach
Introduce the topic by stating that it usually takes a lot of effort to get a job, and that you may not start out getting exactly the job you want. However, starting somewhere will pay off in the long run, as eventually the patient will be able to work his/her way toward a job that he/she finds satisfying. This process is one of those times when it really helps to keep a long-range perspective. To start out, keep in mind the following points:

- Being rejected is part of the job-seeking process. Do not be discouraged if it happens.
- A first step is to generate a list of job areas that interest you.
- Research shows that the more interviews you have, the better your chances of finding a job.
- It is important to make a lot of contacts to generate job leads.
- You need to know how to: fill out an application; practice how to approach employers; and interview.

Explore Job Categories
Often adolescents are focused on getting *any* job. Realistically, job possibilities will be limited because of age, educational level, and experience. However, you can encourage them to think about their particular interests, even at an early age. Many of these adolescents may never have had anyone pay attention to their vocational goals, having been largely written off in academic circles. These questions can help identify interest areas:

- What kind of work have you done? (Ask about paid and unpaid work, such as taking care of siblings or helping family members.)
- What kinds of volunteer jobs have you done?
- What job training have you had?
- What type of place would you like to work in?
- What would you like to do?

Prepare a Working Resume
Potential employers will typically not expect an adolescent to have a professional resume. However, it is good to prepare for the time when a resume would be requested. You can have the patient prepare a simple, typed document that contains the following information:

- Full legal name
- Address
- Telephone where patient can be reached or a message can be left
- Level of education completed (include any special courses or certificates, if applicable)
- Past work experience
- Relevant skills

- Names and phone numbers of 3 people for the employer to call as references

When computer resources are available, you could have the patient work on their resumes at your clinic. Or, preparing a resume could be an at-home practice. If patients don't have a computer at home, they could go to their local library. In any case, review the finished resume with the patient and make suggestions as necessary.

Develop a List of Contacts for Job Leads
The best source of jobs is the people one knows, including friends, acquaintances, and family members. Other important sources of leads are past employers or coworkers. The *Yellow Pages* and/or online searches for particular types of companies are also useful. Help-wanted ads in the newspaper and job-wanted postings are important but should not be solely relied on.

How to Make Job Inquiries
Although the exact approach may vary somewhat depending on the type of job lead, there are some common aspects to approaching a potential employer about work. Azrin and Besalel recommend the following approach (1980):

- Tell the person you are looking for a job and why.

- State why you are asking that person for help (e.g. he or she has a job or knows where a lot of other teens work).

- Describe your skills briefly.

- Don't be afraid to "network" (get other leads). Ask for information on any places he or she has heard may be hiring or about any position opening signs.

Refer patient to the sheet in his/her workbook titled **FINDING A JOB** for a sample script on how to request an interview.

Preparing for Interviews
Some adolescents have never had a job interview. You can help them develop their skills in this area by role playing interviews during the in-session practice. You can take the role of the employer, asking typical job interview questions and coaching them on their answers. Questions could include:

- What interested you in this job?
- Tell me about the skills you could offer for this position.
- Describe your previous work experience.
- What are your expectations for working here?

The patient may not be asked these questions in the interview; however, the practice will help him/her to feel more comfortable sharing personal information. Prepare the patient to describe positive attributes in a way that sounds confident and natural.

Track Job-Seeking Efforts
It is important to track job contacts made each day and their results. Have the patient track this information using the **JOB LEADS LOG**. This log will be helpful in maintaining a record of

what to do for follow-up, e.g. reminders to stop by a store or to call a manager the next day. Encourage the patient to keep accurate records of names and telephone numbers. For adolescents with ADHD, it is very important to organize this information. By having this information written down in one place, the patient will be able to follow up on leads easily.

Educational Skills

Define Your Goals

The patient may have set an educational goal during Core Module #1 Motivation and Goal Setting. If so, follow up on that goal, determining reasonable, short-term objectives. If not, let patients know that having educational goals will help them prepare for jobs that will be enjoyable and rewarding throughout their lives. Adolescents often have grandiose thoughts about their future and sometimes have unrealistic expectations, e.g. not thinking through all that is involved in becoming a mechanical engineer or for becoming a DJ. While encouraging optimism, have them look realistically at how to get from one point to the next in a vocation or career. You can ask these questions to help them identify their educational goals:

- What are your future plans?
- What are your educational interests?
- What subjects do you enjoy? Which subjects do you find challenging?
- Do you intend to seek further education? If so, what type of programs are you considering?
- Who supports you continuing in school? Who doesn't?

Prepare To Meet Your Goals

Remind the patient that meeting educational goals will require patience and effort. He/she may need to take classes to prepare for college entrance exams or learn a necessary skill, such as bookkeeping or typing. You may want to take time during the session to identify and locate vocational training programs, certificate programs, etc. Encourage the patient to think about all of the skills he/she has learned so far, particularly communication, using support systems, and problem solving. If a patient seems to be uncertain about what steps to take in meeting his/her goal, use the problem solving steps in Module #8 to define what to do next.

Complete Your Homework

These adolescents may be lacking good study habits. Some patients will also have inadequate support at home to get their work done. Problem-solve barriers to completing work, including the impact that their current substance use might have. Encourage them to develop a routine to complete school assignments. You might say:

> *Being abstinent from substances will make it easier to concentrate on homework. However, you will still need to develop a routine to sit down and complete assignments. It's a good idea to set aside the same time each day to do homework, such as before dinner, or immediately when you get home from school.*

They may also want to ask teachers for special assistance or to start a study group with non-using peers. You may want to role play with them how to ask for this help.

Everyone at some point has difficulty with assignments. You may not understand the instructions or you may not be able to solve a problem. Ask your teacher for help. If you don't ask for help, you won't get it, so it's up to you to seek it out.

In-Session Practice

The patient will be actively involved in discussing each of the vocational and educational skills outlined above; therefore, practice is occurring throughout the session. **Behavior rehearsal role plays** should be chosen individually with the patient based on his/her particular needs and requests. These role plays could include practice of:

- Telephone skills with potential employer
- Job interview skills
- Asking for support at school (e.g. teacher, school counselor)

At-Home Practice

- Each day during the next week, develop three to five job leads either through friends, the newspaper, or the *Yellow Pages*. Follow-up on these. Maintain **JOB LEADS LOG**.
- Write out plan for school goal(s) using steps on **SETTING GOALS WORKSHEET** in Module #1 Motivation/Goal Setting (in patient workbook).

FINDING A JOB

- Make a list of what you're interested in and what you'd like to do.
  - Think of what kind of work you've done in the past. ANY experience you've had matters!
  - Think about what you're good at or places you'd LIKE to work. Examples: computers, retail (mall), maintenance, waiter (restaurant work), typing, filing.

- Develop a list of contacts for job leads.
  - Talk to family members, friends, past bosses
  - Look in the *Yellow Pages* to find businesses in the job categories you want to work in.
  - Look for help-wanted ads posted in windows of stores or restaurants.
  - Examine help-wanted ads in the newspaper every day.

- Ask about job openings, and ask for an application.
  - Introduce yourself.
  - Ask for the manager.
  - Ask whether you can come in and talk about any openings. Ask for an interview.
  - Set up a time the same day or the day after.
  - Tell the person about the work you have done in the past. If he/she is not currently hiring, ask whether you can turn in an application and come back in a couple of weeks.
  - Ask whether he or she knows of any other businesses that are hiring.
  - Respond in a positive and polite manner.

- Develop a resume that includes:
  - Your name
  - Address
  - Telephone where you can be reached
  - Work you've done in the past
  - Skills you have
  - Names and phone numbers of 3 people for the employer to call a references

- Set goals when looking for a job.
  - Make at least five contacts a day.
  - Be motivated.
  - Make a lot of appointments.
  - Call employers back to check whether a position has opened up.
  - Turn in applications to as many places as possible.

Sample request for an interview*: Hello, my name is ______. I would like to talk to the manager. Can you tell me his or her name, please? I'm looking for a job in ______* (e.g. restaurant work), *and I'm wondering whether I could come in to talk about a possible job opening. I can make it at 2 this afternoon; would that be convenient for you? I have experience in _______, and I'd like to talk to you about any openings now or later. Would you have time this afternoon?* (If not) *When is a good time to come back?*

WRITING A RESUME

When you apply for work, employers usually expect you to bring a resume - a short, typed summary of your qualifications. Your resume should draw attention to your skills and accomplishments, and motivate an employer to interview you. Look at the job advertisement to check what it is the employer seeks in terms of qualifications. If you have what the employer needs, then submit a resume that shows you have the necessary skills to meet the criteria. Save all other information for the interview. Keep your resume short and sweet. Do not list employers that you do not want a prospective employer to contact.

Many books have been written about how to write a resume. The advice given is not always consistent. Don't let this lack of agreement trouble you. The bottom line is that there is no "perfect" resume style or format. *The best resume for* ***you*** *is one that markets your skills effectively for the type of work you want.*

Use a resume format that brings your strongest qualifications to the employer's attention first. In other words, use a format that puts your most impressive qualifications at the beginning.

Here are a few tips:

- If you want to emphasize how you have progressed to increasingly complex and responsible positions, use a **chronological format** that lists your work experience from most recent to least recent.
- To emphasize the skills you have developed, use a **combination format** that groups your experience according to skill categories and then provides a brief chronological account of your background.
- If you don't have much work experience, but your education is directly related to the work you are applying for, list your education first.

When you have a draft resume prepared, ask yourself the following questions.

- Is it short and to the point - preferably one page long and definitely no more than two pages? (Busy employers won't take the time to sift through a lot of information.)
- Is it printed on good quality, white or off-white, standard, business-size bond paper? Does it look professional and inviting to read? Are items listed in point form? Is there lots of "white space" on the page? Margins at least one inch?
- Is it well organized and readable? Do key points and headings stand out? Is your eye drawn immediately to the information you want employers to notice first - your most relevant accomplishments and achievements?
- Is the language clear, simple and concise? Does every statement emphasize a skill or ability? Have you eliminated unnecessary words or sentences?
- Is all of the information relevant and positive? (**Never** include anything negative!) Does everything you say about your qualifications relate to the requirements of the type of work you are applying for?
- Does every item start with an action verb? (Avoid the pronoun "I" and inexpressive phrases such as "I was responsible for . . ." or "My duties involved . . .")
- Is the information accurate? (Don't exaggerate or misrepresent yourself. Most employers check. On the other hand, don't sell yourself short by being too humble.)

- Are you sure there are no spelling, grammatical, or typing errors? (If you are not absolutely sure, ask a friend to proof-read your draft.)
- If you have listed your references, are they people who can verify the skills you have chosen to emphasize? (Always find out if the people you list are willing to provide a positive reference **before** you distribute your resume!)

If you answered "no" even once, revise your draft. When you can confidently answer "yes" to all of the above questions, find out if other people agree with you. Show your draft to people who will give you feedback, such as your parents, a friend who has gone through the same process, or a teacher or guidance counselor at school. Accept their suggestions without argument, and then make up your own mind about what you will and will not change.

(Adapted from website of the Career Centre, Alberta, Canada)

JOB LEADS LOG

DATE	COMPANY	PERSON'S NAME	PHONE	ADDRESS	RESULTS OF 1ST CONTACT	RESULTS OF 2nd CONTACT

MODULE 12: Planning For Emergencies and Coping with Slips And Relapses

Summary of Tasks

- Explain importance of being prepared for slips
- Identify role of stress in triggering a slip
- Discuss difference between a slip and a relapse
- Explore how negative thinking can impact a slip or relapse
- Develop plan for dealing with a slip

Presenting Session Rationale

It is not uncommon for people to experience a **slip** (a single substance use event) once they become sober. Major life events and life changes, such as health problems, new responsibilities, school changes, or family problems, can be very disruptive and can lead to either a slip or a **relapse** (returning to former patterns of using substances). Positive life changes such as starting a new relationship, getting a job, and starting high school or college can also pose risks for a slip or relapse. It is important to plan ahead and to be prepared for ways to handle crisis situations or times when the patient may be vulnerable. If a slip happens, it is likely to be accompanied by feelings of guilt and shame, which may be covered over with an attitude of "I don't care." It is important to help the patient recognize automatic negative thoughts, such as, "I guess I'll never change." These negative automatic thoughts can lead to feeling demoralized and increase the risk for relapse. In this module, previous skills training will be reviewed including: **problem solving, decision making, managing automatic negative thoughts, anger management, creating a social support network, and increasing pleasant activities.** All these skills can help prevent relapse. Experiencing a slip or a relapse does not mean all is lost and that one must start at the beginning. The patient has learned many skills and he/she can review and reapply the skills to regain sobriety. This module will teach skills to help prevent slips or a relapse, as well as what to do when one does occur.

In presenting a rationale for this session to the patient, you might say:

> *As one is working toward maintaining abstinence, it is not uncommon to have a slip or even relapse. It might help to think of a slip as different from a relapse. Think of a* ***slip*** *as a single time of using, perhaps at a party or after you have a big fight with your boyfriend/girlfriend. Most people in recovery take a fall now and then. It's serious and needs to be looked at so we can learn from it. Think of a* ***relapse*** *as when you go back to the same patterns of use as before recovery. You might be using all the time and reacting to the same triggers you had before you entered treatment. You might also be saying to yourself that you are "right back where you were before." Your thinking can become very hopeless when this happens. Major life events, both positive and negative, can create situations where the urge to use can be strong. You will learn how to develop a plan to handle emergency situations. Don't expect yourself to be perfect, but be prepared.*

With a resistant patient who has <u>not</u> identified a desire to change his/her use, you might say:

> *You have not yet made the decision to become abstinent, but understanding how major life events, both positive and negative, affect your wish to use will help when you do decide you want to change. All of the skills you have been learning in therapy will help you manage difficult life situations. As you gain control in these areas, you may see that there is a benefit to changing your substance use.*

Being Prepared for High-Risk Situations: Using the Functional Analysis (FA) to Avoid Slips
To begin the module, let patients know that they have been working on relapse prevention from the very beginning of treatment as they engaged in exploring their substance use in Module #2 Functional Analysis. Godley at al. wrote (2001, p. 96): "Relapse prevention begins with the functional analysis of substance use to understand the antecedents and consequences of using." Remind them that the functional analysis is a vital, working tool that will help them identify high-risk situations that might increase the likelihood of relapse. The key concept of this module is <u>preparedness</u>, so offer one or more examples of where they might be at risk based on what you have learned doing the FA. This is an excellent opportunity to review the triggers that they identified (external and internal) in the functional analysis. For example, the patient who has persistent cravings before he/she goes to a party (anxiety) can arrange to go to the event with a good friend instead of alone. (Later in the session, you could practice what he/she will do when he/she walks into the room, e.g. get a soda or water to drink, stay away from the keg, etc.)

Skills for Emergency Situations
This module offers opportunities to weave in several previously taught skills. <u>Refusal techniques</u>, <u>assertive communication skills</u>, and how to <u>problem solve</u> will provide a strong foundation for handling high-risk situations. Remind patients that the first line of defense to avert a slip is to <u>avoid</u> situations that will put them at risk. Realistically, patients will often put themselves in harm's way of having a slip. You might say:

> *Stressful situations will arise unexpectedly and so you want to be really prepared. You've got a lot of tools to use now. You will have to think quickly to figure out exactly what tools to use. Let's make it easy by having an automatic list. You probably want to think first of <u>refusal skills</u> –what you are going to say and do if* [drugs/alcohol] *are around. You'll need to remember the basics of communicating assertively, too. A strong "I" statement about what you plan to do* [to not use] *will keep you pretty safe, if you follow through with it. Your problem solving skills will help you get out of a jam, too. Remember that there is always more than one option. This is a lot to think about. But I know you can do it. We're also going to practice some tough situations that might come up in a few minutes.*

This discussion can reinforce many of the concepts that have been taught and will help to build confidence.

If a Slip Occurs
It is valuable to go over steps that the patient should take when a slip occurs. If these steps are followed, a full relapse may be prevented. The steps are outlined on the <u>**Reminder Sheet:**</u>

Personal Emergency Plan for Slips (Jaffe et al., 1989). Review these steps during the session.

- Get rid of drugs and get away from the setting where the slip happened.

- Examine the slip with someone, exploring all of the possible triggers, including the "Who," "When," and "Where" of the situation. This is called a behavioral chain analysis. By closely examining the events/feelings leading up to the use incident, the patient can learn to interrupt the chain as it begins and before it leads to using.

- Watch out for automatic negative thoughts, such as *"I guess I'll never change," "I'm a failure,"* or *"I'll never be able to quit."* Remind the patient how to rewrite negative self talk (cognitive restructuring) to protect from all-or-nothing or hopeless thinking. *"I realize that one hit or even one day of drug use does not have to result in a full -blown relapse. I will not give in to thoughts of guilt or blame, because I know these thoughts will pass in time."*

- Call for help from someone else.

Functional Analysis for Drug-Use Behavior (Relapse Version)

During this module, you will review how to do a special functional analysis for a slip (relapse version). This FA is located in the patient workbook. (This exercise is not relevant for patients who are still using regularly.) While it might seem difficult to do immediately following a slip, let the patient know that it is extremely worthwhile. If he/she takes the time to do the FA, he/she will have a wealth of information about situations and circumstances that put him/her at risk in the future. The relapse version FA will answer questions about what he/she was thinking and feeling preceding the slip as well as about dangerous circumstances that led to the use episode (who, when and where).

In-Session Practice

Preventing a slip:

- Ask the patient to describe one or more life events that might lead to craving drugs or to a slip. Write these events down and ask patients how they might change their behavior (action items) to prevent the slip from happening. It is helpful to have the patient write down these ideas, e.g. call a friend, stay home, go to a movie, etc.

- **Behavior Rehearsal Role Play:** Set up and complete a role play to practice necessary skills to avert a slip. You could use the event(s) described above to generate the role play. Have the patient articulate what it is he/she is trying to do to prevent a slip and guide him/her to communicate effectively, e.g. use of refusal skills, expressing feelings, etc.

Handling a slip if it occurs:

- **Behavioral Chain Analysis:** Have patient describe sequence of events leading up to the use, prompting for details about the persons involved, setting, and feelings. This analysis can be written out on the board as a time line.

- Have patients begin the **Personal Emergency Plan: High-Risk Situation** during the session, writing down at least one to two names. (They can include you, if they would

like.) It may be difficult for some to identify people they can call when they are in trouble. They may feel embarrassed or think they can do it on their own. Help them understand how important it is to have support.

- **Behavior Rehearsal Role Play:** Set up a role play with patient asking for support from someone on his/her contact list. You could practice having the patient make a telephone call to you or to someone else. If he/she has identified someone in his/her family, this is an excellent opportunity to practice what he/she would say to the family member.

At-Home Practice

The at-home practice should emphasize being prepared for any circumstance which might lead to a slip, as well what to do if a slip occurs. Don't shy away from giving assignments to patients who are not trying to be abstinent. It is important to reinforce the message that, even if they are not interested in stopping now, they can learn and use skills to manage their behavior in the current context. The skills will be available for them to use when they are ready, and they should practice now.

- Have patients review the materials in their workbook and complete the **Personal Emergency Plan: High-Risk Situation,** writing down the names and phone numbers of people in their life whom they can call for help if they feel at risk. In completing this plan, they should consider who would be a good person to call if they do have a slip and need to get some support.

- To build awareness of triggers and high-risk situations, have them review their copy of the written functional analysis (found in workbook, Exploring Your Use), as well as any sheets they have completed in Coping with Cravings and Urges to Use. In particular, they should review their **DAILY RECORD OF URGES TO USE** and **SELF MONITORING RECORDS**.

- Complete a **Functional Analysis for Drug-Use Behavior (Relapse Version)** for any slips that occur in the next week.

FUNCTIONAL ANALYSIS FOR DRUG-USE BEHAVIOR
(RELAPSE VERSION)

EXTERNAL TRIGGERS	INTERNAL TRIGGERS	DRUG USING BEHAVIOR	POSITIVE CONSEQUENCES	NEGATIVE CONSEQUENCES
1. **Who** were you with when you used?	1. What were you **thinking** about right before you used?	1. **What** were you using?	1. What did you like about using with ____________________? (who)	What were the negative results of your using in each of these areas:
			2. What did you like about using _________________________? (where)	**a.** Interpersonal
				b. Physical
			3. What did you like about using _________________________? (when)	
2. **Where** were you when you used?	2. What were you **feeling physically** right before you used?	2. **How much** did you use?		**c.** Emotional
			4. What were some of the pleasant thoughts you had while you were using?	**d.** Legal
				e. Job
			5. What were some of the pleasant physical feelings you had while you were using?	
3. **When** did you use?	3. What were you **feeling emotionally** right before you used?	3. Over **how long** a period did you use?		**f.** Financial
			6. What were some of the pleasant emotional feelings you had while you were using?	**g.** Other

(From: Godley et al., 2001)

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REMINDER SHEET
Personal Emergency Plan for Slips

A slip is a major crisis in recovery. Returning to abstinence will require an all-out effort. Here are some things that can be done.

If I experience a slip:

1. I will get rid of drugs and get away from the setting where I slipped.

2. I will realize that one hit or even one day of drug use does not have to result in a full blown relapse. I will not give in to thoughts of guilt or blame because I know these thoughts will pass in time.

3. I will call for help from someone else.

4. At my next session, I will examine this slip with my therapist, discuss the events prior to my slip, and identify triggers and my reaction to them. I will explore with my therapist what I expected alcohol/drug to change or provide. I will work with my therapist to set up a plan so that I will be able to cope with a similar situation in the future.

REMEMBER: THIS SLIP IS ONLY A TEMPORARY DETOUR ON THE ROAD TO ABSTINENCE.

(Adapted from: Jaffe et al., 1989)

REMINDER SHEET

Personal Emergency Plan: High-Risk Situation

If I encounter a life event that puts me in a high-risk situation:

1. I will leave or change the situation or environment.
2. I will put off the decision to use for 15 minutes. I will remember that most cravings are time-limited and I can wait it out—not use.
3. I will challenge my thoughts about using. Do I really need to use? I will remind myself that my only true needs are for air, water, food, and shelter.
4. I will think of something unrelated to using.
5. I will remind myself of my successes to this point.
6. I will call my list of emergency numbers.

I will speak to each of these people in advance to let them know that I might call them if I am feeling at risk for using. **I also know that I can call someone on this list if I do have a slip to get some support.**

	Name	**Phone Number**
1.	______________________________	___________________
2.	______________________________	___________________
3.	______________________________	___________________
4.	______________________________	___________________
5.	______________________________	___________________
6.	______________________________	___________________

(Adapted from: Jaffe et al., 1989)

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MODULE 13: Seemingly Irrelevant Decisions

Summary of Tasks

- Describe *seemingly irrelevant decisions* and their relevance to slips or relapses
- Provide examples in which minor decisions can lead to a use outcome
- Explore types of thinking that can contribute to lapses
- Identify strategies for choosing low-risk options

Presenting Session Rationale

In this module, the patient will learn how small decisions which seem unimportant and trivial, **seemingly irrelevant decisions** (SID's), can lead to high risk situations in which the urge to use may become stronger and stronger. Through a series of minor decisions, one may move gradually closer to the point at which using becomes very likely. Explain to the patient that when some people relapse, they often think of themselves as victims. They might think, *"It just happened."* It can be difficult to recognize how perhaps dozens of little decisions bring one closer to high risk situations that could be avoided. In a study looking at different characteristics of relapse following substance treatment, Brown et al. found that approximately one-third of the major relapse episodes were considered "impulsive or externally related" (1989). In these relapses, the individual had no prior thoughts of using before relapsing and did not initiate efforts to acquire the alcohol or drug.

In presenting a rationale for this session to the patient, you might say:

> *Understanding how even small decisions can lead to situations where you did not expect to face an urge will help you control your substance use. People often think "things just happen," and that they have no control. But actually, you have more control than you think. If you plan things out ahead of time and make definite decisions about things, you will be at low risk for having a slip. This is true for any situation. You will have a lot more control over things if you look ahead.*

With a resistant patient who has not identified a desire to change his/her substance use, you will also teach how to plan ahead and make decisions that will lead to accomplishing goals:

> *It is possible you are not aware of how the decisions and choices you make have an impact on how things go in your life. People often think "things just happen," and that they have no control. Let's look at your goal sheet to figure out if there are some small decisions that you could be making to help you accomplish your goals.*

Key Interventions

Look Before You Leap

While the concept of planning ahead appears to be a fairly simple one -look before you leap, so to speak-, adolescents rarely premeditate their actions. Adolescents typically take action and think about the consequences of their actions later. Acting and not thinking about the consequences can be particularly relevant with adolescents who have Attention Deficit Hyperactivity Disorder (ADHD) due to heightened impulsivity. The purpose of this module is

to help patients see that every decision (or lack of decision) has some consequence. It is important to mention that sometimes not making a decision at all, holding back on doing something that is important, is also making a decision. Looking ahead at all of the possible consequences prevents unpleasant surprises. Of course, looking ahead applies to more than substance use (e.g. unprotected sex, school truancy, etc.). However, for this session, you will be focusing on risks related to substance use. You might say:

> *It's often the small decisions we make that get us into trouble. To prevent yourself from having a slip, you want to think through what you are doing and why. Each decision is like a link in a chain. Some are weak, leading to a break in the entire chain. A good example of this might be when you are planning for your free time, like the weekend. When you leave things to chance, you often end up being bored. Choose ahead of time what you want to do, and you will probably have more fun. Remember that not making a decision at all really is making a decision. We are totally responsible for our actions and behaviors, including times when we are avoiding making a decision. We always have a choice, and it's up to us.*

It is normal for adolescents to externalize or blame others ("fate") for their circumstances and missteps (external locus of control). The message to deliver is that they have the power to take active steps in their lives. They can make choices in their best interest even in the face of difficult environmental conditions. Your job is to help them find realistic options and to act on them (versus reacting to them).

Choosing Low Risk Options –In this section, the text sometimes uses "you" as if the manual is written for the patient instead of for the therapist. Should parts of it be italicized, as examples of how to talk with patients?
Planning ahead is not always easy, especially if you don't have transportation and are short on money. However, it can be done with some practice. The best way to plan ahead is to think about every option you have. Remember that sometimes, the safest choice is to do nothing. (An example of this would be if you are feeling very angry with your parents after an argument, you could go out driving with some of your using friends, or you could stay home in your room listening to music). Decisions can be characterized as high risk or low risk and should be considered within the context of the patient's coping skills for cravings. For example, choosing to go to a party where you know there will be a keg would be a high risk decision, especially if you had recently stopped drinking. It is better to make a low risk choice, such as finding another activity for the night. When faced with a decision, choose the low-risk option. If, for some reason you choose a high-risk option, be prepared by reviewing your **URGES TO USE** strategies. It may feel awkward at first to have to consider everything so carefully, but it will give you increased control over your life, including sobriety. When making any decision, large or small, do the following:
Again, the text after the following bullet point fluctuates between addressing the patient and addressing the therapist.

- Consider all the options you may have. You can use the brainstorming skills you learned in Module #8 Problem Solving. Generate a list of options for the situation you are in. Remind them that there is always more than one choice in any situation. They should take into account all the facts about the situation. Once you have identified choices or options, then you have moved out of a passive position and are moving toward a decision.

- Think ahead to the possible outcomes of each option. What positive or negative consequences can you anticipate, and what are the risks of having a slip?

- Select one of the options. Choose the one that will minimize your relapse risk. If you decide to choose a risky option, plan how to protect yourself while in the high-risk situation.

Same issue below as above.

Dangerous Thoughts Can Lead to a Seemingly Irrelevant Decision

As you become more comfortable evaluating seemingly irrelevant decisions, you will begin to recognize certain kinds of thoughts that might lead to using, i.e. "I should" go to the party tonight, "I have to" get that weed for a friend, or "it's only" one shot. Remind the patient how to use the cognitive restructuring skills taught in Module #4 Coping with Cravings and Urges to Use. This module will allow for corrected self talk and provide for the ability to manage a potential urge to use. You might say:

> *Once you learn to recognize when you are about to do something without thinking it through, stop for a moment to ask yourself what you are thinking. It's not uncommon to hear in your thoughts something like, "It doesn't matter if I go out and party tonight, school starts next week, and I'll have to stop then." Is that accurate thinking? What's the evidence that this is true? What are the advantages and disadvantages of thinking this way? Watch out for those kinds of thoughts. You may not even be consciously aware of thinking that way, but this often happens right before making some poor decisions.*

Teaching this module is an excellent opportunity to review the connections between thoughts and behaviors. It teaches awareness about conflicting desires: wanting to use and wanting to be clean at the same time. Most patients will feel ambivalence about becoming clean. In emphasizing that they must be aware and active regarding the decisions they make, you are teaching them that a passive approach ("no decision at all") is avoidance and will likely lead to a slip.

In-Session Practice

It can feel somewhat awkward practicing these skills, as you are focusing largely on hypothetical situations. The most effective way to practice during the session is to dissect an example of a recent slip to examine what may have gone wrong. If the patient says, *"I just wanted to use,"* ask him/her to look at the situation more closely, examining each of the events leading up to using (**behavioral chain analysis**).

- Have the patient think about the last time he/she used. Trace back along the decision-making chain. What was the starting point (trigger, automatic thoughts)? Have the patient recognize the choice points at which he/she made risky decisions. What decisions led up to using? List choices or decisions on a blackboard or flip chart. This is a very sophisticated and difficult exercise which can take adults many sessions to learn. Let patients know that the work they are doing to analyze and think ahead is very difficult. You may also want to talk about ways in which they may feel cheated or deprived, because they aren't in a position like most of their peers to "do what they want" (use) and "get away with it." Patients may not feel that way, but if they do, make sure you empathize.

- Review plans that the patient has made for the weekend (or other time period). If none, why? Sometimes <u>not planning</u> means planning to use. What plans could be made? Identify high risk versus low risk options.

At-Home Practice

<u>Options:</u>

- Have patients carry out the safe decisions they made regarding the upcoming weekend (or some other time period). Have them report on the consequences related to the decisions they made. When discussing patients' decisions and their outcomes during the next session, you could ask what they might have done differently.

- Review and complete the **MAKING SAFE DECISIONS PRACTICE SHEET**.

REMINDER SHEET and PRACTICE EXERCISE
Making Safe Decisions

When making any decision, large or small, do the following:

- Consider options you may have
- Think ahead to the possible outcomes of each option. What positive or negative consequences can you anticipate, and what are the risks of relapse?
- Select one of the options. Choose the one that will minimize your relapse risk. If you decide to choose a risky option, plan how to protect yourself while in the high-risk situation.

Practice Exercise
Think about a decision you have made recently or are about to make. The decision could involve any aspect of your life, such as your job, recreational activities, friends, or family. Identify "safe" choices and choices that might increase your odds of relapsing.

Decision to be made:

Safe alternatives:

Risky alternatives:

(From: Monti et al., 1989)

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MODULE 14: HIV Risk Assessment and Safe Decision Making

Summary of Tasks

- Provide accurate information about condom effectiveness and HIV transmission
- Complete **Decisional Balance Exercise** for condom use/non-condom use.
- Strategize ways to resolve barriers for condom use.

Presenting Session Rationale

Because HIV with adolescents is largely transmitted through sexual behavior, it can be prevented through appropriate behavioral changes. Sexual abstinence is the most effective way to remain uninfected. HIV risk reduction is important even in adolescents who are abstinent or who have never been sexually active. It is important to address accurate knowledge, as well as attitudes and cognitions about safe sexual practices. Addressing perceptions regarding change efficacy and developing cognitive problem solving skills for change implementation are considered two critical elements in changing HIV risk behavior (Kelly, 1995). This module is intended to increase comfort levels for talking about sex and exploring options for how to handle internal and peer pressures to be sexually active. For adolescents who are not celibate, correct and consistent use of condoms is the most effective strategy to reduce their risk of exposure to HIV. HIV is also transmitted through the sharing of contaminated drug injection equipment. Safer injection practices, including avoiding or reducing needle reuse or sharing and cleaning injection equipment, may help reduce HIV risk.

This module will review facts and myths about HIV risk, as well as assess a patient's attitudes and risk behaviors with respect to HIV. . HIV risk from intravenous drug use (IVDU) is relatively low, since it is an infrequent behavior among adolescent drug users. While risks from IVDU are taught, the in-session practice focuses on unsafe sexual practices, e.g. non-condom use. Because HIV prevention is likely to be a sensitive and difficult topic, developing therapeutic rapport is particularly important for the session. The therapist needs to consider the developmental readiness of the adolescent to address sexually explicit content. However, the module can easily be adapted to those adolescents who are not yet sexually active by focusing on *how they have chosen abstinence* in specific circumstances. The session could also involve role plays to explore specific ways patients have managed difficult peer pressure situations. These discussions will reinforce the decisions they have already made to protect themselves. The content of this session provides an opportunity to practice other learned skills, such as assertive communication, problem solving, and seemingly irrelevant decisions. There is an opportunity to apply these skills to making safe decisions with sexual behaviors. To introduce the session, you might say:

> *You may be familiar with some of the things we are going to talk about today, like how HIV is transmitted and the best ways to protect yourself. We'll go over those facts and some of the myths that people believe about HIV. It's important that you know the facts about HIV transmission and risk behaviors, whether you are sexually active or not. We'll spend most of our time talking about what you can do to make sure that you don't put yourself at risk now or at any time in the future. We've been talking a lot about*

ways to plan ahead and avoid risky situations. We'll do the same thing today. This time, though, we'll be talking about sexual behaviors instead of substance use.

For teens who seem reluctant to talk about sexual behaviors, let them know that the reason you are addressing the topic is to expand their tools (make new choices), just as you have been doing when you plan ahead for risky drug using situations. Many teens will tell you up front that they "always use condoms" (and, for some, that is true) and that this issue is "not a problem". They may be expecting a lecture from you or simply feel uncomfortable talking about something so private. Start by letting them express their reason(s) for discomfort to avoid overselling the topic. (Such an approach would likely move the discussion backward rather than forward.) As you listen, you are more likely to hear something from them about their behavior in this area and you can proceed. At the same time, it will also be important to communicate to the patient that it is okay if he or she wants to listen to the information about HIV prevention without disclosing much about his or her own sexual history – past or present. A patient may have experienced sexual trauma, and may not feel comfortable talking about his or her sexual history or history of abuse, especially with a therapist with whom the patient may still be in the process of building trust.

I know this can feel awkward to talk about, and it sounds like you are in good shape on using condoms all the time. Tell me more about why you don't want to talk about it.

If that approach doesn't open up the discussion, then don't force it. Do, however, go over the materials in the module, such as the **Facts about HIV Risk**.

Key Interventions

Building Knowledge on HIV and its Prevention
Before beginning the decisional balance exercise (see below), you will review information about HIV, focusing on its transmission and prevention. You can review information on the **Facts about HIV Risk** sheet in the patient workbook. You can also answer questions to fill in gaps of knowledge and correct misinformation regarding the transmission of HIV. This activity should not be presented as a "test;" it is simply as an opportunity to learn new information. While filling in the gaps, make sure to give lots of praise for the information patients have already acquired and their safe sex practices. Let them know that there is new research being done all the time on HIV and that you would be happy to help them find answers to questions that you might not have addressed. This is an excellent opportunity to help them feel some mastery in a topic. You will also increase compliance with safer sexual practices by building their sense of self-efficacy.

The primary intervention in this session is to conduct a decisional balance exercise using the **Exploring Personal Risks: Decisional Balance for Condom Use** worksheet. You will explain that the purpose of this worksheet is to explore patients' vulnerabilities in particular situations leading to non-condom use. As you will be gathering very personal information, you will want to be sensitive to their feelings as they answer the questions. As a patient exposes risky behavior in which he/she has already engaged in, reassure him/her that it is important to change those behaviors now. Convey that you believe that talking about what to do in future situations will be helpful. Provide information about testing centers in your community. It is useful to have a list of clinics and other resources available.

Let patients know that what often gets in the way of making good (safe) decisions about sexual practices is what we are thinking (self talk). This would be a good time to elicit some participation from them about instances in which their self talk might have influenced them to make either a safe or unsafe decision. You might say something like this:

> *We're going to explore what you might have been feeling and thinking during an episode when you didn't use a condom as well as when you did* [if they can share an example of each]. *Just like we've done when we've talked about your substance useand different moods, including anger, it will be important for you to tell me what you were thinking at the time. That way we will know what you can do to take care of yourself in the future. We'll do lots of problem solving to make these situations easier for you in the future.*

Complete the Decisional Balance for Condom Use Exercise

Research shows that adolescents may have strong positive beliefs about using condoms and intentions to do so. However, these attitudes do not always lead to behavior change (actually being prepared and using condoms when having intercourse). The most important part of this intervention is to problem solve any barriers to changing the specific behavior of using a condom in ALL situations. Sometimes these barriers are related to poor planning and decision-making (e.g., presence of drugs and alcohol) and sometimes to faulty thinking (e.g., the belief that he/she is not vulnerable to infection). We will look at both factors in this exercise, emphasizing what you and the patient identify to be the most crucial barriers to change.

During this exercise you will be working together to identify high-risk situations so that safer decisions can be made in the future (or safe decisions already being made are reinforced). It is often most productive to begin with having patients describe particular high-risk situations that they have already encountered and then having them talk about the kind of thoughts and feelings these situations invoked (building self awareness). It is useful to write down current risky behaviors on a board or sheet of paper as they are identified. Use MI strategies to encourage them to identify these situations themselves (open-ended questions and reflections). One of the riskier situations is when drugs and/or alcohol have been used.

> *You're right! Getting out a condom and using it when you are high or drunk is hard. We will figure out some of the things that make it difficult and problem-solve. What kinds of things have you thought about that might make using a condom easier?*

On the worksheet, patients will be asked to list the positive (PROS) and negative (CONS) consequences of **using a condom.** In this way, the therapist is more likely to uncover particular beliefs that might affect behavior in the future (e.g. *"It's too much of a pain to use a condom." "I don't think there's any chance that I can get HIV."* "*I don't want my girlfriend to think I don't trust her*." *"He'll think I'm a slut if I ask him to wear a condom*.") Then, emphasize the pros. You can have the patient identify his/her STRONGEST REASON for using a condom. The purpose of this part of the exercise is to reinforce new self talk. In addition, identifying a situation in which condom use might be particularly challenging (and why) can be practiced by doing a role play. This exercise will provide important information about the patient's sexual behavior as well as about self-efficacy and assertiveness.

You can perform the decisional balance with adolescents who have not been sexually active by asking them to identify pros and cons of safe sex (condom use). (These patients will likely

identify more pros than cons. Affirm those self-statements.) In addition, you can explore situations in which they chose abstinence under pressure. This conversation can be an opportunity for you to affirm personal decisions they have made in the area of sexual activity. Talking about sex with adolescents may also lead to discussions about sexual orientation and "coming out." Exploring sexual identity is a normal task of adolescence, and it is important that the adolescent feel complete acceptance from you as he or she discusses sensitive topics that he/she may never have shared with an adult.

In-Session Practice

- Use the **Exploring Personal Risks: Decisional Balance for Condom Use** worksheet as described above.
- Review instructions on how to use a condom.
- Provide a condom for the adolescent and have him/her practice putting it in and taking it out of a purse or wallet. Demonstrate the ease and minimal time commitment that using a condom requires. You can even use a timer to show how little time it takes!

At-Home Practice

Any of the above **In-Session Practice** exercises could be continued during the week to follow. In addition, the patient could:

- Review the **Facts about HIV Risk** sheet and choose an area for additional research. Locate information and bring it in to the following session. Share this information with a friend.

- Make a list of any situations that could lead to non-condom use (e.g. getting drunk, leaving the house without condoms, etc.). Write a list of things you can do to ensure that you will have and use condoms whenever you are sexually active.

- Agree to talk with at least one friend about HIV/AIDS. This dialogue can be in the form of discussing beliefs, providing facts, or forming pacts for getting tested. Provide support and encouragement!

FACTS ABOUT HIV

What is HIV?
The **H**uman **I**mmunodeficiency **V**irus is a virus that kills your body's "CD4 cells." CD4 cells help your body fight off infection and disease. You can have HIV without having AIDS; HIV progresses into AIDS over time.

What is AIDS?
The **A**cquired **I**mmuno**D**eficiency **S**yndrome is a disease you get when HIV destroys your body's immune system. Your immune system normally helps you fight off illness. There is no cure for AIDS.

How does a person get HIV?
HIV spreads through contact with four fluids in our bodies: blood, semen, vaginal fluid, and breastmilk. HIV enters our bodies through the lining of the vagina, penis, rectum, or mouth. Having unprotected sex (sex without a condom) ONE TIME either vaginally or anally with someone who has HIV puts you at risk. Pulling out before a male ejaculates does NOT decrease the risk of contracting HIV. Sharing a needle with an infected person also puts you at risk of contracting HIV.

You cannot get HIV:
- By working with, hugging, or being around someone who has HIV/AIDS
- From sweat, spit, closed mouth kissing, tears, clothing, drinking fountains, phones, toilet seats, sharing a meal, or insect stings/bites
- From donating blood

How does this affect me?
Of all the new cases of HIV in the United States in 2007, **over half occurred in people ages 15-24.** HIV/AIDS is NOT gender or sexually biased. Of all the people in the United States who have HIV, one in three (32%) who contracted HIV did so heterosexually. Women can spread HIV to men, too.

How can I make sure I don't get HIV/AIDS?
- Abstinence from sexual activity is the safest, most effective way to ensure that you do not get HIV.
- If you are sexually active, use a condom **every time.** You can get HIV from having unprotected sex ONCE. You cannot tell if someone has HIV by the way he/she looks. Have the discussion with your partner. Check the expiration date on the condom you use. Expired condoms risk rupturing, and that can spread HIV. Use lubrication to prevent condom breakage. Do not use lambskin condoms, and do not use any oil-based product, like baby oil or Vaseline for lubrication, as oil erodes latex.
- Do not share needles used for drug injection, steroids, vitamins, tattoos, or body piercings.

Know your HIV/AIDS status: Get tested!
Your counselor can give you information on free, confidential HIV testing.

EXPLORING PERSONAL RISKS: DECISIONAL BALANCE FOR CONDOM USE

Sometimes it's hard to figure out exactly why we make risky decisions such as having sex without a condom. Just like with using substances, there are "reasons" (pros and cons) that we make certain choices even if they are not good for us. The exercise below will help you identify things about condom use that you may never have considered. Putting these down on paper will help us figure out what you need to do in the future to keep yourself safe by **always using a condom** whenever you have sex. When we think about making changes, most of us don't really consider all the "sides" in a complete way. Instead, we often do what we "want" or avoid doing things we don't feel like doing, or just feel confused or overwhelmed and give up thinking about it at all. Thinking through the pros and cons of both changing and not making a change is one way to help us make sure we think things through. Thinking things through now can help us hold onto a plan in times of stress or temptation.

Things to ask yourself…

- What might get in the way of you using a condom whenever you have sex (e.g., trouble getting/affording them, feeling uncomfortable bringing it up with a partner, thinking that you are not at risk)?
- How might your use of drugs and alcohol affect your decision to use a condom?
- What are some possible bad things that could happen if you do not use a condom?
- What are some positive things that you can think of if you use a condom every time you have sex?

	BENEFITS/PROS	COSTS/CONS
Using a condom	o *Protects against HIV/AIDS and other STD's.* o ____________ o ____________ o ____________	o *It's hard to ask my partner ahead of time.* o ____________ o ____________ o ____________
	BENEFITS/PROS	**COSTS/CONS**
Not using a condom	o *It feels better.* o ____________ o ____________ o ____________	o *I'm really worried about getting an STD.* o ____________ o ____________ o ____________

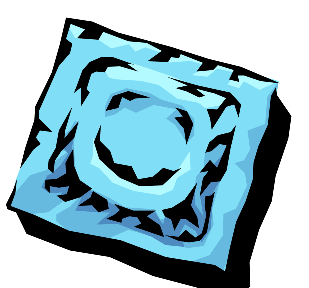
Use your PROS about using a condom list to help you with NEW SELF TALK!

From the upper PROS column, circle the strongest reason on the list for using a condom.
Identify a situation where this might be difficult for you to use this self talk: Why?

Let's role pla

THE RIGHT WAY TO USE A CONDOM

What to look for in a condom to make sure it will work right:



1. It should be made from latex.
2. The date on the condom package should not have expired.
3. The condom should be in good condition, not torn, dried out. or yellowed.
4. It's best to buy condoms that are already lubricated.
5. If you add lubricant, make sure it is water based (like KY Jelly), not oil based (like Vaseline).

The steps to correctly putting on a condom are:

1. Before you open the condom package, move the condom inside the package to the side, so you don't tear the condom when you open the package.
2. The condom is put on the man's penis at the start, as soon as the clothes come off and the penis is erect.
3. Find the side that rolls down by putting your fingers inside the condom (unless you have long fingernails or sharp rings) and put that side on top.
4. Pinch the tip of the condom to keep out air.
5. Roll the condom down the shaft, being careful of rings and fingernails.
6. Roll the condom all the way down—don't stop half way.

The steps to correctly taking off a condom are:

1. Take the condom off as soon as ejaculation has occurred, while the penis is still erect.
2. Hold the condom on the base of your penis until you are away from your partner's body so that the condom doesn't end up being left inside the partner.
3. Remove the condom carefully to avoid spilling the semen that's inside.
4. Tie the open end of the condom to avoid spilling the semen that's inside.
5. Throw away the tied condom in the trash—never reuse a condom.

MODULE 15: Termination

Summary of Tasks

- Observe and comment on new strengths and skills
- Anticipate potential events/circumstances which pose risks for relapse
- Encourage active use of support networks (including continued therapy, when appropriate)
- Give and receive feedback regarding the therapy
- Allow time to say goodbye

Presenting Session Rationale

Despite its here-and-now focus, issues concerning termination are as important in a cognitive-behavioral treatment as they are in any therapy. Through the course of the therapy, you have built a strong and active working relationship with the patient, and your relationship needs to be acknowledged as you prepare to say goodbye. In anticipating the patient's departure, at minimum 2-3 sessions leading up to termination, the therapist should accentuate examples when the patient used new skills successfully on his or her own. These successes, however small, should be highlighted whenever they occur during the therapy. The patient needs to be reassured that he/she has the skills to solve life's problems without having to rely on the therapist for support. Overall, the patient's self-efficacy can be enhanced by reinforcing the active use of skills, such as problem solving and decision making. Emphasize that the patient will have the new skills he/she has learned for the rest of his/her life. Termination is also a time when the patient can give important feedback to the therapist. The session is an opportunity to underscore the patient's successes in *all areas*, not just his/her substance use behavior.

Be encouraging to all patients, regardless of the level of success they have had in staying abstinent. Assume that all patients have tried their very best:

> *You can feel very proud of yourself for sticking with treatment. It is not easy to come in every week and share your struggles and learn new skills. I hope you will be able to use the skills you learned in here for the rest of your life. Remember, they apply to lots of different situations. The key will be practicing, so don't get frustrated if it doesn't feel like they are working right away. Stick with them, and you will continue to have success.*

Key Interventions

This module is less structured than the preceding ones. It will not include a formal in-session practice, and you will not be assigning at-home practice at the end. However, don't forget to review the skills and homework from the immediately preceding session. Touch on each of the topics below, if they are relevant to your patient and his/her treatment:

To Ease a Patient's Transition out of Therapy

There are several things you can do to help a patient feel ready to use the skills on his/her own. You will have been encouraging throughout the treatment, so it will seem quite natural to tell the patient that you believe that he/she is ready to work independently. Emphasize two areas in this final session:

1. Developing an "emergency plan" to deal with unanticipated life crises that may arise. This "emergency plan" will have been started during Module #12 Planning for Emergencies and Coping with a Slip. Make sure that patients have completed this plan. Tell them how important it is for them not to feel like they are "doing this alone" after they leave therapy. Encourage them to pay special attention to self-care during times of high stress in their lives, pointing out that at these times, one is more vulnerable to relapse. As they learned in Module #13 Seemingly Irrelevant Decisions, it is important to anticipate times when they might need extra support, perhaps in another treatment. Help them to frame seeking support as a sign of strength, not of weakness (as discussed in Module #10 Enhancing Social Support). It is important to review the individual signs or symptoms that they might need additional treatment. Let them know that seeking additional treatment does not mean that this therapy was a failure. Refer them to the handout **Saying Goodbye** in their workbook.

2. Coping with unresolved problems. Remind them of the skills they have learned in Module #8 Problem Solving. They should expect to experience difficulties in different areas of their lives after treatment, even if they are abstinent. Having problems is normal and should be a signal to get out the manual and to practice the skills they have learned.

Review Successes

This session is a good time to review the goal sheet from the beginning of treatment. (You and the patient will have been reviewing the goal sheet periodically throughout the treatment.) Have patients assess progress on their goals. Ask patients to describe some of the problems they had at the beginning of treatment, and the success they had in resolving these problems. Ask the patient to describe the skills they have used to overcome or cope with these problems. Identify persistent problems and how they impact current goals. Some patients may take this opportunity to set new goal for themselves. To enhance self-efficacy, all patients should be reassured that they have the skills to resolve life's problems without having to rely on the therapist for support. It is important to be quite specific about the skills they have learned and used, such as effective communication, problem solving, refusal skills, and other areas. Enumerating the patients' skills will help patients internalize their therapy experience. By identifying instances when adolescents have used their new skills, perhaps to manage a craving or to abstain from using, you will help build self-efficacy and allow them to recall positively examples in which they were successful. Vague discussions about skills learned without concrete examples may become lost on the patients, particularly for ones who are still moving from concrete to abstract operational thinking.

Feedback to the Therapist

During this session, encourage the patient to provide comments, both positive and negative, regarding the therapy experience as a whole and the therapist in particular. You can ask:

- *What would they change about the therapy?*
- *What practice helped the most? What practice helped the least?*
- *What motivated them to complete at-home assignments? What factors stood in the way?*

Allow plenty of time for the patient to say goodbye in his/her own way.

In-Session Practice
There is no formal in-session practice. You should take the opportunity to ask your patient if there are any particular skills that he/she would like to practice. Asking patients this question will foster their confidence, as it gives the message that you believe they know what they need at this point. As you review the material covered during the treatment, you will be able to comment on areas that could use further practice. However, the overall parting message should be positive and encouraging, stating that you believe they will have success in choosing when and how to use the skills. With patients who have not made strong progress in using the skills, encourage them to hold onto the material and to review it sometime during the next 2-3 months, as it might have more relevance at a later date. Ask them to keep an open mind and to look for instances in which particular skills might be helpful. Let them know that you are available should they have questions about the material or wish to have a referral for further treatment. For all patients, congratulate them on staying in treatment and wish them success for the future.

At-Home Practice
There is no assignment given at this session.

SAYING GOODBYE

When it's time to finish therapy, you will have many tools to use to solve life's problems and to reach your goals. Problem solving and decision-making will come much easier as you continue to practice. In looking back over the therapy, we will have an opportunity to review what you have learned and to determine where you might need to do some extra practice. The skills you have learned will become part of what you use for the rest of your life. It's also important to keep reviewing your goals and adding new ones as you meet your past ones. You can use the goal sheet included in this workbook. You probably haven't met all of your goals yet, which is alright. Write goals you still want to meet and your next steps for each one below:

	Goal:	**Next steps to take:**
1.	________________________	______________________________________
2.	________________________	______________________________________
3.	________________________	______________________________________

At this time, you may feel completely ready to go out on your own, or perhaps you feel you need more help. If you do, that's fine and does *not* mean that your time in therapy was unsuccessful! One of the most important things to know in life is when you do need help. Together, we will develop a list of signs that you might need to seek additional professional help for your substance use or for other problems. These signs might include:

Examples: Dropping out of school; hanging out with using friends; increased arguments at home

1. ____

2. ____

3. ____

4. ____

You want to be able to anticipate events and situations which might put you at risk for slipping back to old use patterns. Such circumstances may include life changes (positive or negative). Most of all, remember to highlight (and to point out to others!) all of your successes. It's okay to show pride in what you have accomplished so far and what you do in the future. **Congratulations!!!!!!!**

TAKE SOME TIME TO THINK ABOUT YOUR EXPERIENCE IN ENCOMPASS

1. What did you like about it?

    a. ______________________________

    b. ______________________________

    c. ______________________________

2. What didn't you like about it?

    a. ______________________________

    b. ______________________________

3. How will the skills you learned help you in the future?

____

____

4. What are you going to do next?

____

____

5. What other comments do you have that might make the program better?

____

____

____

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RESOURCE TRACKING SHEET

The following sheet will help you keep track of resources that you and your therapist discuss during your therapy. The sheet will help you keep track of places and people you can call or go to for support outside of therapy. You will see below the name of the organization, the contact number, and sometimes a person to contact there. You and your therapist can brainstorm ideas of what you want to say when you make this contact. If you feel uncomfortable communicating with this person(s), please let your therapist know so you can talk about what might be getting in the way (or perhaps do a role play to prepare). It is very important that you and your therapist have discussed a plan for what you will do after you stop seeing each other.

Contact Agency: ____
(Name) (Address)

Contact Phone Number:____

Contact Name/Person:____

I called them on ____________________, and they said________________________
____
____

Contact Agency: ____
(Name) (Address)

Contact Phone Number:____

Contact Name/Person:____

I called them on ____________________, and they said________________________
____
____

Adapted with permission from Miller, W.R., ed. *COMBINE Monograph Series, Volume 1. Combined Behavioral Intervention Manual: A Clinical Research Guide for Therapists Treating People with Alcohol Abuse and Dependence.* DHHS Publication No. (NIH) 04-5288. Bethesda, MD: NIAAA, 2004.

MODULE 16: Family/Significant Other Therapy

Summary of Tasks

- Improve relationships within the family (caregivers)
- Provide information about substance use, in particular cognitions and reinforcers related to use
- Motivate participation of family in treatment
- Teach family relevant skills, in particular effective communication and problem solving

Background

Many researchers have looked at the risk factors predicting adolescent substance use, both intrinsic and extrinsic (Bry et al., 1998). Lack of family support and drug use within the family are highly associated with adolescent substance use. These findings suggest the critical importance of addressing family factors in treatment with adolescent substance users. As the family interventions in this therapy are limited to three sessions, they are designed to impact some of the most salient protective factors. Godley summarizes five protective factors found to be significant in preventing adolescent substance abuse (2001). For caregivers, these are:

- Be a role model by refraining from using drugs or alcohol in front of the adolescents in their care.
- Increase positive communication with the adolescents in their care.
- Monitor adolescents' activities, including knowing where they are and with whom they are spending time.
- Become involved in adolescents' lives outside the home by encouraging and promoting pro-social activities.
- Teach and practice positive communication and problem solving skills in the family.

Research on resilience demonstrates that another important protective factor against substance abuse occurs when adolescents receive family support to develop their dreams, goals, and purpose in life (Kumpfer, 1999). With this in mind, having family members hear about the patient's short- and long-term goals is an important activity in the family therapy. To promote mutual respect and reciprocity, family members should also be encouraged to explore areas for change. This concept will be further discussed in the outline for the First Family Session below.

Adolescents greatly benefit when they receive rewards or acknowledgment for their achievements and talents (positive reinforcement). Interventions in this module are designed to promote positive interactions by offering the adolescent and family praise and encouragement whenever possible and modeling positive behavior. In doing so, you will model positive interactions for the caregivers. At all times during family meetings, the focus is on the gains made by the adolescent and family, however small they may be in some cases. Another vital protective factor which adolescents can receive from their families is guidance in making critical life decisions. These decisions have a long-term impact on developmental trajectories,

such as choices about school, relationships, and career or vocation (Rutter, 1996). While past difficulties in the family are not to be ignored, interventions are intended to have patients "look forward" rather than backward, when times may have been very painful and difficult for all.

Presenting Session Rationale

As you will have already discussed the importance of family sessions with the patient and family at the beginning of treatment *(see **Preparing the Patient for Family Therapy** and **Family Involvement: Resistance to Involvement*** in **What to Know Before You Start** section), it shouldn't be necessary to provide more than a brief rationale for family therapy as an introduction. Attendees will want to know what you are going to do and what you are hoping to accomplish with them present. Your opening statements in each family session should be reassuring and positive, despite whatever might be going on with the patient in his or her family at that time. You should thank them for coming and set a positive tone by saying:

> *It is so helpful in this therapy to have the involvement of people who care about* [name of patient]. *He/she has been working hard every week. Having family members come in to share ideas, and for us to practice the skills together, makes a huge difference. Thank you for coming. These sessions will be very similar to the kinds of things we have been doing in our sessions. This therapy is based on learning new skills to manage substance use problems and for coping with day-to-day issues and relationships. Having the support of people in* [name of patient] *life will make a big difference. Every time you come in we will learn and practice a new skill.*

Another way to reduce blame and to increase safety for the patients attending the sessions is to normalize the problems and to be optimistic. Without minimizing the seriousness of the substance abuse, you will provide education on the prevalence of substance abuse among adolescents and praise the family and adolescent for taking steps to address the problem early, before consequences become more serious.

Remembering to Use Motivational Interviewing Strategies

People respond more positively when there is an atmosphere of mutual respect. These meetings are an opportunity to put blame aside and for all parties to identify what they would like to change. Some families are immediately ready to mobilize their energy to help their child in therapy, and others have a difficult time doing so. It is important not to get mired in the hopelessness that people may be feeling. Perhaps they are talking about the substance abuse issues face-to-face for the first time. Apply Motivational Interviewing to promote behavior change. Drive the desire for behavior change by asking questions which help the family and patient perceive a discrepancy between common goals--*where they are* and *where they want to be* (e.g. reduce family conflicts and substance use behavior). Express empathy for the family and patient through reflective listening. Family members may be accustomed to discussions with their child leading to arguments. Model how to roll with resistance, by empathizing with the family and patient about their ambivalence to change things. In families in which there is substance abuse, people are used to feeling upset and angry. It isn't easy to recognize or act on opportunities for change. However, let everyone know that there are other ways to extinguish family conflicts besides the no-win tactics of forcing demands or making threats. Finally, point out to the family any instances in which they *do* exercise self-efficacy (e.g. stopping an argument by using a new skill, solving a problem on their own, doing more activities with each other). There will be a tendency for family members to look back at all that

has gone wrong. It is your job to highlight all positive change talk communicated during the session.

To keep the sessions on a positive track, it might be useful to write these guidelines down on a board:

FAMILY/SIGNIFICANT OTHER THERAPY SESSIONS . . .

ARE* FOR*:

- Reviewing common goals & resolving barriers
- Getting/giving constructive feedback
- Practicing successful communication
- Developing problem solving skills to use together
- Identifying new kinds of support

ARE NOT* FOR*:

- Dictating commands without discussion
- Name calling
- Shouting
- Threatening
- Criticizing
- Pointing out past failures

Key Interventions

Following are three separate outlines for each family session. These outlines are organized by topic and contain in-session and at–home practice exercises. You will choose from the topics, **Family Goal Setting**, **Family Communication Skills**, and **Family ProblemSolving Skills & Supporting Sobriety**), based on the particular needs of the patient and family at the time you are conducting the session. These session outlines are meant to be guidelines. In reality, you may want to combine topics and the practice skills from different sessions according to the family's strengths and weaknesses. You may do these topics in any order or repeat a topic. However, you should begin with a goal setting exercise (see Family Session #1). It is important that you maintain a structure for the session and stay focused on teaching skills, rather than digressing into a free-for-all discussion. It might be helpful to review the self-rating criteria in advance of a session. In summary, these criteria are:

- Explain and answer questions about the therapy process.
- Review the patient's progress in therapy.
- Elicit participation from all attendees.
- Teach and model positive communication and problem-solving skills
- Involve all attendees in practicing of new skills.

Family/Significant other Session #1
FAMILY GOAL SETTING

Materials needed for session:
- Extra copy **RELATIONSHIP HAPPINESS SCALE** (Teen Version)
- Extra copy **RELATIONSHIP HAPPINESS SCALE** (Caregiver Version)
- Extra copy **FAMILY GOAL SETTING SHEET**
- White board or flip chart with markers

Establishing Rapport and Providing Information
The focus of this session is for the therapist to establish a rapport with the family and for everyone to work constructively toward setting goals and objectives. Begin this session by welcoming family members and asking if they have any questions before you begin. Share general information from your work with other families, affirming that these sessions have helped other families in similar situations.

Before you start, it's important to provide the family with a simple but thorough definition of cognitive-behavioral therapy for substance use. You might want to refresh yourself on some key points by reviewing the section ***Explain the CBT Model: How This Therapy Might Help Them*** in Core Module #1. Family members may not be used to hearing their child's problems described in cognitive-behavioral terms and will likely have some questions about how this kind of therapy works. Be prepared to explain the basic concepts using definitions and examples of triggers, automatic self talk, positive and negative consequences (behavior reinforcers), and coping skills for high-risk situations. Reassure family members that the strategies of CBT will become clear as you work together in these sessions. Family members may have very scanty and inaccurate information about the science of substance abuse. Refer family members to the National Institute on Drug Abuse website for parents and teachers. On this website they will find scientifically-researched information on physical and emotional signs of drug abuse, effects of substances of abuse, the brain and addiction, and other topics. You may also provide information on written materials educating families on the process of substance abuse treatment and the effects of different substances, such as *Educating Yourself about Alcohol and Drugs: A People's Primer* (Schuckit, 1998).

http://teens.drugabuse.gov/parents/index.asp

In-Session Practice: Setting Family Goals
It is important to set goals for the family interventions. As you will have limited time to work on these goals, it is important to get started right away.

1. Exploring areas for change: After introductions are made, have the adolescent and each family member complete their version of the **RELATIONSHIP HAPPINESS SCALE (Teen Version and Caregiver Version**). Introduce this exercise by saying how important it is to have targeted goals in a skills-based treatment. Explain that by setting goals, they should feel more hopeful about the future and will be able to measure their progress. **THE HAPPINESS SCALE** covers several domains in their family life and

relationships and will help them set a direction for behaviors they would like to change. Give them a few minutes to complete the worksheet.

2. Model for them: Before they do the next portion of the exercise, share a hypothetical example from a made-up family or from your own life. Demonstrate how to make a change statement about an interpersonal behavior and how to set a goal. Modeling in this way normalizes their family's difficulties, e.g. "Lots of people have these kinds of problems, including me." In your example, use "I" statements and positive language. Write the sample goal on the board.

   Sample statement/goal: *"I don't like that we always argue whenever you come home late. I would like it if you could call when you know you are going to be late."*

3. Presenting goals: Ask them to take turns answering the questions below to help frame a goal and an action plan. Have each person focus on one area to prevent overwhelming requests and an increasing a sense of hopelessness.

   - What one thing would you like to change in the family/your relationship? (Ask them to be specific. Help them to phrase the goal in positive language. Write the goal on the board.)
   - Why is this important to you?
   - What would be the first step you could take in this area?
   - What would you like to ask (other person) to do?

4. Have the other person take his/her turn answering the same questions. Everyone should have a turn.

5. Emphasize the positive: Once these have been completed, have each person share positive feelings for the other by stating three things that they appreciate about ______________________. Have them write these affirmations down on the board.
   (each person present)

You may need to coach patients during the exercise. Step in whenever you sense that there is confusion by providing examples. Always use positive language. Make sure that you gently interrupt when someone is being flagrantly critical and/or is using hopeless, negative talk. Redirect the person to use assertive language. This exercise may lead to either a heated discussion (a fight response) or silence from one party or both (a flee response). If either response should happen, reassure everyone that this is to be expected, as no one likes to hear anything "negative." Explain that the only way to have things change is for everyone to be clear about what each person wants and why. Mind reading never works very well. During the exercise, you might want to take notes, observing strengths and weaknesses in communication style. Your notes will be useful in later family sessions.

At-Home Practice
It is very important that each person leave the session with one behavioral goal and at least one immediate step that he/she could take toward achieving that goal. Suggest that family members write down their answers on the **FAMILY GOAL SETTING SHEET** during the session.

For at-home practice, ask the family members and the adolescent to continue work on the **FAMILY GOAL SETTING SHEET** between now and the next family session. As there will be at least one month between this family session and the next, encourage them to write down the specific steps they are taking, as well as any positive steps they observe being taken by the other person. Remind them to bring these sheets to the next family session so that they can be discussed.

Conclude by congratulating them on their hard work. Remind them that change comes from being open, honest, and willing to listen to all sides of a situation.

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Family/Significant Other Session #2
BUILDING COMMUNICATION

Materials needed for session:

- Extra copy **PATTERNS TO AVOID IN EFFECTIVE COMMUNICATION (Module #5)**
- Extra copy **FAIR FIGHTING RULES**
- Extra copy **MIRRORING EXERCISE FOR POSITIVE COMMUNICATION (Module #5)**
- White board or flip chart with markers

Check-In and Review At-Home Practice

It is important to spend the first few minutes or longer checking in with the family and adolescent before you begin teaching the next skills. Make sure that you answer any questions they might have about the therapy. Next, ask about their success with the at-home practice assignment. Praise all efforts to complete the assignment. If no work was done, make sure that you discuss why. Then review the assignment and complete as much as you can together. Encourage them to try the assignment again before the next session.

Present Positive Communication Skills

This session is focused on teaching skills for positive and effective communication. Research demonstrates that when families change their patterns of communication from aggressive/negative to assertive/positive patterns, overall family functioning improves. Let them know that people can learn to change these patterns, and that's what you will be focusing on today.

Begin by going over the list of **PATTERNS TO AVOID IN EFFECTIVE COMMUNICATION** summarized below.

1. **Putdowns**
2. **Blaming**
3. **Denial**
4. **Defensiveness**
5. **Communicating hopelessness**
6. **Mind reading**
7. **Talking for others**
8. **Side tracking**

As you go over these patterns, give examples of positive and negative communication styles and elicit comments about their personal communication patterns, both strengths and weaknesses. Ask them if they recognize any of these "don'ts" in their communication with each other.

It's O.K. to Fight If You Play by the Rules!

It is important to normalize anger. Tell them, *"Everyone feels angry at times, and there is nothing wrong with feeling angry. It's* <u>*what you do*</u> *when you become angry. Anger can be very destructive or very constructive."* Give a few examples of how anger can hurt relationships or help them. Talk about "button pushing," which is when someone learns what makes another person upset and uses that information <u>intentionally</u> to make the other person angry. Once people become angry, they usually "lose" the battle because they become out of control or frustrated. The other person "wins." However, really no one wins because you are no closer to finding a solution to the original issue. It is important to figure out the ways in which family members push each others' buttons. You can ask them: *"What are common button-pushing tactics that each of you use?"* Point out that it is hard to undo the verbal "zingers" (insults, threats, and demands) that we throw out when we are angry. Explain to patients and family members that it's important to learn how to hold your tongue when you are angry. Remind them that there will be opportunities at another time to express their views and needs calmly and clearly.

At this point, introduce the **FAIR FIGHTING RULES** listed below. It might be useful to have these rules written on a board present in the therapy room as reminders.

- Fights should be held in order to REACH A SOLUTION not to gain a victory.
- You cannot refuse a fight. If something is important enough to one person, it is worth "fighting over."
- You may state a gripe about BEHAVIOR, not about the person's character or values.
- The basic outline of a fight should be:
    1) State your gripe. (Remember to use "I statements.")
    2) Suggest and discuss alternatives. (Remember brainstorming skills.)
    3) Reach a solution.
- Fight about ONE THING AT A TIME.
- DON'T MAKE SPEECHES. State your gripe, and then let your partner respond.
- State your gripe in the form of a POSITIVE REQUEST, not a demand.
- DON'T PLAY ARCHEOLOGIST. Fight about your present gripe. DON'T dig things out of the past.
- DON'T MINDREAD. It is impossible to know what someone is thinking, so ask instead.
- NO NAME CALLING.

In-Session Practice: Behavior Rehearsal Role Plays

Have one person volunteer to describe a situation that might lead to a conflict. (It could be something that was argued about recently or something made up.) Ask the person who volunteered the topic to play themselves while you <u>model by playing the other person</u>. Initially, demonstrate an ineffective style of communication. Use several different examples from the list of **PATTERNS TO AVOID.** Then, staying in the same roles, demonstrate an effective style of communication, using "I" statements and reflective listening skills. After concluding, ask the person doing the role play with you how he/she was feeling during each of these role plays. Accentuate the different responses the person had to each style, negative and positive. Ask the observer(s) what they noticed during the role plays.

Next, have patient and family do a role play together using the same topic or another one. You can either have them switch roles or play themselves. Ask what they would like to do. Remind

them that the object of the role play is to keep the other person listening and engaged, not necessarily to persuade him/her of anything or for the speaker to "get his/her way." Encourage participants by nodding positively as they remain engaged in using positive communication strategies. Gently interrupt the role play if they digress into negative communication patterns, giving them feedback about what you observed. If there is time, have them switch roles.

At-Home Practice Options

Remind them that practice makes all the difference in building confidence when you are learning a new skill. Therefore, they will want to continue the work they did in the session by practicing at home. Have everyone read the instructions for **MIRRORING EXERCISE FOR POSITIVE COMMUNICATION** during the session**.** Demonstrate how to do this exercise by asking one person to volunteer to be the "speaker." Use reflective statements to model positive verbal and non-verbal communication strategies (see Module #5 Communication Skills). Suggest that they review their goal sheets for possible topics. They might want to practice asking the other person to help them with something or to stop doing something. Ask them to practice the **MIRRORING EXERCISE FOR POSITIVE COMMUNICATION** with each other at least twice a week until you meet again.

Conclude by reminding them that it takes lots of hard work and practice to change patterns of communication that may have been used for many years. In fact, some of these negative patterns will have been something caregivers inherited from their own families. Remind participants to be kind to themselves and keep trying!

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Family/Significant Other Session #3
<u>FAMILY PROBLEM SOLVING & SUPPORTING SOBRIETY</u>

Materials needed for session:

- Extra copy **<u>REMINDER SHEET: PROBLEM SOLVING (Module 8)</u>**
- Extra copy **<u>PERSONAL EMERGENCY PLAN: HIGH-RISK SITUATION (Module 12)</u>**
- White board or flip chart with markers

Check-In and Review At-Home Practice
Spend the first few minutes or longer checking in with the family and adolescent before you begin teaching the next skills. Make sure that you answer any questions they might have about the therapy at this time. Next, ask about their success with the at-home practice assignment. Praise <u>all efforts</u> to complete the assignment. If no work was done, make sure that you discuss why. Then review the assignment and complete as much as you can together. Encourage them to keep working on the assignment on their own.

Present Problem Solving Skills
This session is focused on using problem solving skills to enhance family functioning. When caregivers are effective problem solvers, they are positive role models for the entire family. Point out how important it will be for the adolescent's recovery for him/her to be able to come to family members for help in the problem solving process. Briefly go over the five steps for effective problem solving. It might be helpful to write these on the board:

1. **Recognize that a problem exists.**
2. **Identify the problem.**
3. **Consider various approaches to solving the problem ("brainstorming").**
4. **Select the most promising approach.**
5. **Assess the effectiveness of the selected approach.**

Support after Treatment
Due to high rates of relapse, it is important to know where you can go for help. Let the family know that you will be available to make additional referrals, if that is necessary. Discuss the adolescent's plans for continued support after treatment. This would be a good time to review the concepts of triggers and the role of stress in relapses. Encourage the adolescent to talk about particular high-risk situations and have him/her identify ways that his/her family may be able to support him/her with these situations. Remind everyone that there are many different ways in which the adult caregivers can support their child toward abstinence. These ways could include helping him/her become involved in activities, spending time with him/her, getting to know their child's friends, and problem solving difficult situations together.

In-Session Practice: Problem Solving & Asking for Support

- Ask the adolescent and family members if there is a particular problem that they would like to work on in the session. If they are unable to identify a problem to work on, have them review the FAMILY GOAL SHEETS and help them identify a problem, using this

material. Remember to have them identify the "who, what, where, and when" of the problem. Use the five-step approach for problem solving.

- Have the adolescent identify a high-risk situation for relapse and have him/her identify what his family could do to help. Have the participants do a role play of that situation.

At-Home Practice

- Use the problem-solving approach to work collaboratively on a problem identified by the adolescent.
- Have the family and adolescent work together on a list of Emergency Contacts for the **PERSONAL EMERGENCY PLAN: HIGH-RISK SITUATION**.

Recognize that it can feel "easier" to keep doing the same thing, even when it's not working. If this is the final family session, make sure you spend time reviewing the FAMILY GOAL SHEETS. Elicit their ideas on what they might do next to support change in the family and offer suggestions. Thank everyone for their strong efforts to learn new skills and encourage them to keep practicing.

RELATIONSHIP HAPPINESS SCALE
(Teen Version)

This scale is intended to estimate your current happiness with your relationship with your parent or caregiver in each of the areas listed below. You are to circle one of the numbers (1 to 10) beside each area. Numbers toward the left end of the 10-unit scale indicate various degrees of unhappiness, whereas numbers toward the right end of the scale reflect increasing levels of happiness. Ask yourself this question as you rate each life area: "How happy am I today with my parent in this area?" In other words, indicate according to the numerical scale (1 to 10) exactly how you feel today. Try to exclude feelings of yesterday and concentrate only on the feelings of today in each of the life areas. Also, try not to allow one category to influence the results of the other categories. If an area does not apply, please skip it.

	Completely Unhappy									**Completely Happy**
1. Time spent with me	1	2	3	4	5	6	7	8	9	10
2. Allowance	1	2	3	4	5	6	7	8	9	10
3. Communication	1	2	3	4	5	6	7	8	9	10
4. Affection	1	2	3	4	5	6	7	8	9	10
5. Support of school/work	1	2	3	4	5	6	7	8	9	10
6. Emotional support	1	2	3	4	5	6	7	8	9	10
7. General happiness	1	2	3	4	5	6	7	8	9	10
8. General home activities	1	2	3	4	5	6	7	8	9	10

(Adapted from: Godley et al., 2001)

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RELATIONSHIP HAPPINESS SCALE
(Caregiver Version)

This scale is intended to estimate your current happiness with your relationship with your adolescent in each of the eight areas listed below. You are to circle one of the numbers (1 to 10) beside each area. Numbers toward the left end of the 10-unit scale indicate various degrees of unhappiness, whereas numbers toward the right end of the scale reflect increasing levels of happiness. Ask yourself this question as you rate each life area: "How happy am I today with my adolescent in this area?" In other words, indicate according to the numerical scale (1 to 10) exactly how you feel today. Try to exclude feelings of yesterday and concentrate only on the feelings of today in each of the life areas. Also, try not to allow one category to influence the results of the other categories. If an area does not apply, please skip it.

	Completely Unhappy									Completely Happy
1. Household responsibilities	1	2	3	4	5	6	7	8	9	10
2. Communication	1	2	3	4	5	6	7	8	9	10
3. Affection	1	2	3	4	5	6	7	8	9	10
4. Job or school	1	2	3	4	5	6	7	8	9	10
5. Emotional support	1	2	3	4	5	6	7	8	9	10
6. General happiness	1	2	3	4	5	6	7	8	9	10
7. Time spent with adolescent	1	2	3	4	5	6	7	8	9	10
8. General happiness	1	2	3	4	5	6	7	8	9	10

(Adapted from: Godley et al., 2001)

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FAMILY GOAL SETTING SHEET

I would like to change this one thing in the family/our relationship. (Use **RELATIONSHIP HAPPINESS SCALE** to choose a goal):

____

____

____

The reasons I want this to change are:

____

____

____

The steps I could take immediately toward my goal are:

____

____

____

I would like ____________________________ to help by:
(teen or caregiver's name)

____

____

☼ ☼ ☼

This week I did these things toward my goal:

____

____

____

This week I noticed that __________________________ did these positive things:
(teen or caregiver's name)

____

____

____

FAIR FIGHT RULES

Fights should be held in order to REACH A SOLUTION, not to gain a victory.

You cannot refuse a fight. If something is important enough to one person, it is worth fighting over.

You may state a gripe about BEHAVIOR, not about the person's character or values.

The basic outline of a fight should be:

- State your gripe. (Remember to use "I statements.")
- Suggest and discuss alternatives. (Remember brainstorming skills.)
- Reach a solution.

Fight about ONE THING AT A TIME.

DON'T MAKE SPEECHES. State your gripe, and then let your partner respond.

State your gripe in the form of a POSITIVE REQUEST, not a demand.

DON'T PLAY ARCHEOLOGIST. Fight about your present gripe. DON'T dig things out of the past.

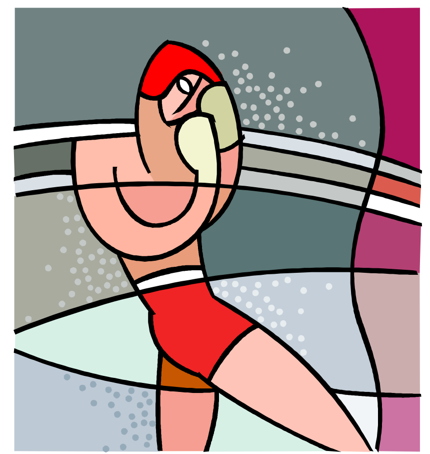
DON'T MINDREAD. It is impossible to know what someone is thinking, so ask instead.

NO NAME CALLING.

NO THREATENING.

NO HITTING.

No fighting about these rules!



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PARTICIPANT'S WORKBOOK

ACKNOWLEDGMENTS

This manual was adapted in 2007 by Constance Klein, LCSW and Paula Riggs, MD from one developed by Holly Waldron, PhD and colleagues at the University of New Mexico (Waldron et al 2001). The *Encompass©* Participant Workbook was extensively revised and updated by Jennifer Wyatt, LMHC, MT-BC, CDP and Julia Timmerman, LCSW, CACIII in 2016 to incorporate new material and concepts consistent with the third edition of *Motivational Interviewing: Helping People Change* published in 2013.

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INTRODUCTION TO *ENCOMPASS©*

Welcome! This workbook belongs to you and will be a useful guide for learning different skills. *Please bring it with you when you come to your sessions each week.*

There are a few things to know about *Encompass©:*

- You are the most important part of it. Right now, there might be things about your life that you don't want to change and things you do want to change. You might feel two ways about changing, where you see reasons to stay the same as well as reasons to change. It is natural to feel this way as you are thinking about making changes. Ultimately, the decision to change is up to you.
- We use cognitive behavioral therapy (CBT), which is focused on building skills that you will have with you whenever you need them. CBT is the most researched treatment for substance use and mental health disorders meaning that it has a lot of evidence to support its effectiveness.
- The *Table of Contents* lists the skills. The *core modules* are covered with everyone; you and your counselor will prioritize the rest based on your individual strengths and needs.
- We will follow a structure in each session:
    - Set agenda topics, including those important to you or related to your goals
    - Brief check in
    - Review of previous home practice
    - Past-week substance use (TLFB) and high risk situations
    - Skillbuilding module
    - Future high risk situations
    - Set prosocial activities and home practice assignment
- Measuring progress is one way we know if the treatment is working. We use a variety of methods, including session attendance, urine drug screens, and questions about mental health symptoms. We'll review this information and share all results with you.
- There are opportunities to involve a family member or significant other in up to 3 sessions. These sessions would be structured and focused on ways in which the person can support the changes you are making. No decision has to be made today; we will discuss this again later.

Please feel free to ask questions. Let us know if there's something you need that we haven't addressed yet along the way. This treatment is not done "to you", but in partnership "with you". We want you to get the very most out of our time together.

TABLE OF CONTENTS (*CORE MODULES)

***Motivation & Engagement:** Introduction to this treatment and discussing how you feel about changing your substance use right now; getting to know what is important to you.

Personal Feedback Report: Summary and discussion of what you reported about your drug and alcohol use; provides information on how your use compares with other people your age.

***Setting Treatment Goals:** Creating a road map for treatment by setting goals about your use, and other important areas of your life, like with family, school, work, and fun.

***Functional Analysis**: Exploring your patterns of drug and alcohol use with a focus on what you like about it, as well as your concerns. You'll also identify possible people, places, thoughts, and feelings that might be triggers for use.

***Coping with Cravings:** Offering skills to help you cope with urges to use and deal with discomfort.

Communication: Practicing skills to get your point across; letting others know what you think and feel assertively.

Anger Awareness and Management: Finding insight into what makes you angry and offering skills to help you manage anger.

***Negative Mood Regulation:** Learning skills to deal with the inevitable bad mood.

Problem-Solving: Discussing a process to help you solve problems effectively and successfully.

***Refusal Skills:** Developing practical ways to turn down offers to use.

***Social Support:** Talking about what kinds of help you can offer to others, and how people in your life might affect your choices.

Job Seeking/Education: Tips to get what you want out of school and work.

***Coping with a Slip:** Exploring what works for you to prevent relapse.

Seemingly Irrelevant Decisions: Learning how to take control over situations you face.

HIV/STI Prevention: Teaching facts about HIV/STI prevention and looking at risky situations.

Family Sessions: Bringing in supportive people to treatment.

***Saying goodbye:** Wrapping up therapy and providing resources for future support.

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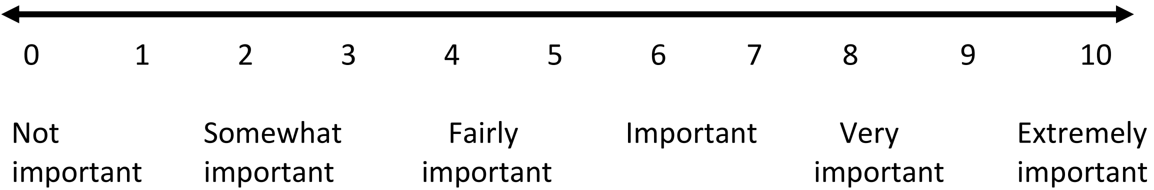
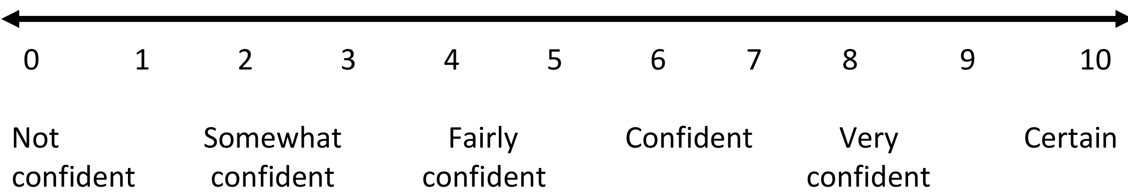
PERSONAL RULERS

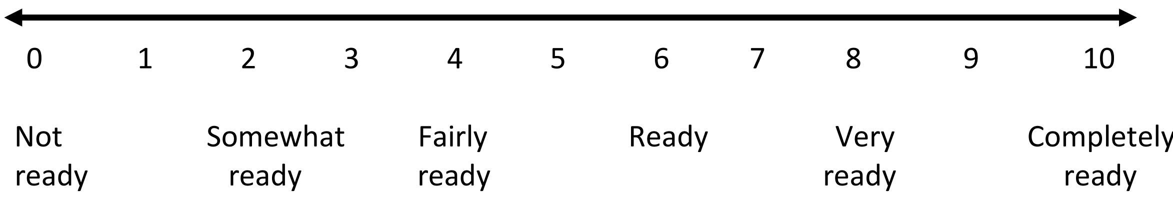
Importance Ruler: How important is it that you change your substance use?



Confidence Ruler: How confident are you that you can change your substance use?



Readiness Ruler: How ready are you to change your substance use?



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FINDING *PROSOCIAL ACTIVITIES* YOU MIGHT ENJOY

People who spend their free time pursuing enjoyable and substance-free activities tend to lead happier healthier lives. One of the goals *Encompass©* is to help you discover, or re-discover, *prosocial activities* you might enjoy.

Sometimes people give up activities they used to like when they spend more of their time using substances. For example, maybe you used to take Aikido classes, play on a basketball team, create art projects, or play in a band. You might have stopped these activities when you began to use substances more frequently. Or maybe there are activities you've always wanted to try but haven't yet such as getting a job.

Some qualities of a *prosocial activity*:

Structure → Fun → Social → Substance free → Goal oriented

Let's talk about what types of *prosocial activities* might appeal to you. They might be physical, creative, educational, job-related, or something else.

What are you good at? What *prosocial activities* did you used to enjoy in the past?	
What *prosocial activities* have you thought about trying?	
What activities might help you to achieve your goals in life?	
Thinking big, what *prosocial activities* would you like to do if there were no barriers?	

FINDING *PROSOCIAL ACTIVITIES* YOU MIGHT ENJOY

Some examples of prosocial activities are:

Each week, you and your counselor will plan two prosocial activities plus an alternate. For up to two of the planned activities that you complete and provide proof for, you will get a draw from the fishbowl. Examples of proof could be:

- A photo of your work schedule
- A program from an art exhibit, play, or concert you were involved in
- An email confirming submission of a job or school application
- A picture of you doing the activity
- Anything else you and your counselor agree on

The idea is to support you in developing your own skills and abilities so you have fun, social, goal-oriented, structured, and substance-free ways to spend your free time.

HOME PRACTICE:
FINDING *PROSOCIAL ACTIVITIES* YOU MIGHT ENJOY

Instructions: List three prosocial activities that you might consider trying below. Then, write out the pros and cons of participating in each. You'll discuss this at your next session.

ACTIVITY	*PROS*	*CONS*

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PERSONAL FEEDBACK REPORT

This session will help you to compare how your drug or alcohol use stacks up with other people your age. Sometimes, we get the idea that *everyone* uses. It might feel like this when we spend time with people who drink or get high a lot. We are going to look at rates of substance use in larger groups of people, beyond your close friends, such as all students in your grade at school.

You might have a range of reactions to this information. Some of this might seem surprising or even unbelievable. It might confirm things you've already thought. When you think about everyone in your school, for example, it starts to make sense that there are people who don't use drugs or alcohol. Whatever your reactions, you and your counselor will talk about it.

Instructions: Fill in your grade and how frequently you use substances: Daily, once in the past month, or once in the past year. Next, use the table provided by your counselor to compare your numbers.

SUBSTANCE	MY GRADE & USE	PERCENTAGE OF OTHERS' USE
EXAMPLE: Marijuana	12th grade; daily use	6% of 12th graders used marijuana daily in 2015
Marijuana		
Alcohol		
Tobacco		
E-cigarettes		

Note: From NIDA's website, locate the current year table titled, "Monitoring the Future Study: Trends in Prevalence of Various Drugs". Results from 2015 are available at the following link: https://www.drugabuse.gov/trends-statistics/monitoring-future/monitoring-future-study-trends-in-prevalence-various-drugs

- Detailed data, such as rates of use in specific states and among demographic characteristics, may be available in the YRBSS (http://www.cdc.gov/healthyyouth/data/yrbs/index.htm) or through state surveys.

PERSONAL FEEDBACK REPORT

Another way people assess their substance use is to check off how many of the criteria below apply to them. You may have done something similar at the beginning of the program; if not, you and your counselor will check off the items that apply to you for each substance you used in the past 12 months.

DSM-V CRITERIA	*Cannabis*	*Alcohol*	*Tobacco*	*Nicotine*	_______
Recurrent use in physically hazardous situations (e.g., driving under the influence; buying drugs in a dangerous area)					
Unable to carry out obligations at school or home (e.g., skipping class; low grades; not doing chores)					
Persistent & recurring social or interpersonal consequences (e.g., a pattern of arguing with friends and family; losing trust; losing privileges)					
Tolerance (needing more of the substance to get the same effect)					
Withdrawal (emotional or physical discomfort after stopping or reducing use)					
Greater amounts taken over a longer time than intended (e.g., using more than you planned)					
Persistent desire or unsuccessful efforts to cut down or control (e.g., trying to reduce or stop using without success)					
Spending a lot of time obtaining, using, or recovering from drugs or alcohol					
Stopping or reducing important social, occupational, or recreational activities					
Continued use despite physical or psychological consequences					
Craving or strong desire to use					
Total symptoms					

Severity rating key: Mild = 2-3; Moderate = 4-5; Severe = 6+

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GOAL-SETTING: HAPPINESS SCALE

This scale is intended to estimate your current happiness with different parts of your life. Numbers toward the left end of the scale represent various degrees of unhappiness, while numbers toward the right reflect increasing levels of happiness.

Ask yourself this question as you rate each area: *"How happy am I with _____ today?"* In other words, select the number on the scale (1-10) that best fits exactly how you feel **TODAY**. Try to exclude yesterday's feelings and concentrate only on the feelings of today in each of the life areas. Try *not* to allow one category to influence the results of the other categories. If any area doesn't apply to you, please skip it.

		Unhappy									**Happy**
1	Substance use or non-use (choose one)	1	2	3	4	5	6	7	8	9	10
2	Alcohol use or non-use (choose one)	1	2	3	4	5	6	7	8	9	10
3	Nicotine and tobacco use or non-use (Cigarettes, e-cigs, dip, hookah)	1	2	3	4	5	6	7	8	9	10
4	Relationships with friends	1	2	3	4	5	6	7	8	9	10
5	Relationship with partner	1	2	3	4	5	6	7	8	9	10
6	Relationship with parents or caregivers	1	2	3	4	5	6	7	8	9	10
7	School performance	1	2	3	4	5	6	7	8	9	10
8	Social activities	1	2	3	4	5	6	7	8	9	10
9	Recreational activities	1	2	3	4	5	6	7	8	9	10
10	Personal habits (e.g., getting up in the morning, being on time, finishing tasks)	1	2	3	4	5	6	7	8	9	10
11	Legal issues	1	2	3	4	5	6	7	8	9	10
12	Money management	1	2	3	4	5	6	7	8	9	10
13	Emotional life (feelings)	1	2	3	4	5	6	7	8	9	10
14	Communication	1	2	3	4	5	6	7	8	9	10
15	General happiness	1	2	3	4	5	6	7	8	9	10

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GOAL-SETTING

	GOAL #1: Related to substance use	GOAL #2: Something else	GOAL #3: Your choice
I would like to change this thing in my life…			
The reasons I want to make this change are…			
Specific things I can do <u>right now</u> to meet my goals…			
What might interfere…			
Who can help me and how…	Who: How:	Who: How:	Who: How:
The first signs I am reaching my goals; be specific…			

PERSONAL RULERS FOR GOAL-SETTING

Importance Ruler: How important to you is it that you reach your goal of

____?
(write goal here)

0	1	2	3	4	5	6	7	8	9	10

Not important — Somewhat important — Fairly important — Important — Very important — Extremely important

Confidence Ruler: How confident are you that you can reach your goal?

0	1	2	3	4	5	6	7	8	9	10

Not confident — Somewhat confident — Fairly confident — Confident — Very confident — Certain

Readiness Ruler: How ready are you to work toward reaching your goal?

0	1	2	3	4	5	6	7	8	9	10

Not ready — Somewhat ready — Fairly ready — Ready — Very ready — Completely ready

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EXPLORING YOUR PATTERNS OF USE

When we are trying to change a behavior or habit, it is important to look carefully at what is happening right **before** and **after** that behavior. During this session, we will complete a *Functional Analysis* of your substance use. Doing this together will help us come up with a plan to change your substance use. If you know what your personal triggers are, you can take more control over the behavior. For example, smoking marijuana **after** you have had an argument with your parents, thinking *"I need it"* (to calm down), will help you realize that feeling angry and upset may be a trigger for using. Knowing this, you can take other steps to help you with anger, for instance, choosing a different activity to calm yourself down.

We will look at what you use, how much and how often, and any patterns connected with people, places, and things. While it is sometimes difficult to know what you are **thinking** and **feeling** before you use, doing the Functional Analysis will help.

Some Words to Know

Craving: A strong feeling or urge for something like a drug, food, sex, or a thrill, which feels uncomfortable and sometimes uncontrollable.

Triggers: Thoughts, feelings, or behaviors that come before you use and which can lead to wanting to use. They can be external (people, times of day, places, things) or internal (thoughts, emotions, physical feelings).

Substance of Choice: While you might use several substances, there is usually one you like the most, as it has the greatest positive effects (calming, pleasurable, etc.) for you.

Functional Analysis: A tool used to explore substance use patterns; looks at your triggers and what you like and dislike about using drugs and alcohol.

Consequences: Something that happens as a result of substance use. It can be either positive (feeling calm after using) or negative (drug or alcohol hangover).

It's also important to understand **WHY** we are doing something in order to change that behavior. We will look at the things you **LIKE (positive consequences)** about using as well as all of the things you **DON'T LIKE (negative consequences)** about using. It is expecting a lot of yourself to give up something you enjoy or which helps you feel better. We can look for other ways to make you feel this way. Understanding patterns often helps us make good decisions about what we want to do in the future.

The information that is gathered in the *Functional Analysis* is meant to help **YOU** know your triggers as well as the "pros and cons" of using and will not be shared with anyone else. It is our tool to keep us on track with the therapy.

FUNCTIONAL ANALYSIS FOR SUBSTANCE-USING BEHAVIOR

EXTERNAL TRIGGERS	INTERNAL TRIGGERS	SUBSTANCE-USING BEHAVIOR	POSITIVE CONSEQUENCES	NEGATIVE CONSEQUENCES
1. **Who** are you usually with when you use drugs or alcohol? **2.** **Where** do you usually use substances? **3.** **When** do you usually use drugs or alcohol (times of day, days of the week)? **4.** What **things** are usually around when you use substances (music, paraphernalia)?	**1.** What are you usually **thinking** about right before you use substances? **2.** What are you usually **feeling physically** right before you use drugs or alcohol? **3.** What are you usually **feeling emotionally** right before you use substances?	**1.** **What** substances do you usually use? **2.** **How much** do you usually use? **3.** Over **how long** a period of time do you usually use substances (hours, days, weeks, etc.)?	**1.** What do you like about using substances with ___________________? (who) **2.** What do you like about using substances ______________________? (where) **3.** What do you like about using substances ______________________? (when) **5.** What are some of the <u>pleasant thoughts</u> you have while you are using drugs or alcohol? **6.** What are some of the pleasant <u>physical feelings</u> you have while you are using substances? **7.** What are some of the pleasant <u>emotional feelings</u> you have while you are using drugs or alcohol?	What are the negative results of your substance use in each of the areas below? **a.** Family members **b.** Friends **c.** Physical feelings **d.** Emotional feelings **e.** Legal situations **f.** School situations **g.** Job situations **h.** Financial situations **i.** Unprotected sex (e.g. unwanted pregnancy, HIV/STDs) **j.** Victim or perpetrator of violence (e.g. date rape, sexual assault, unwanted sex, theft) **k.** Other situations

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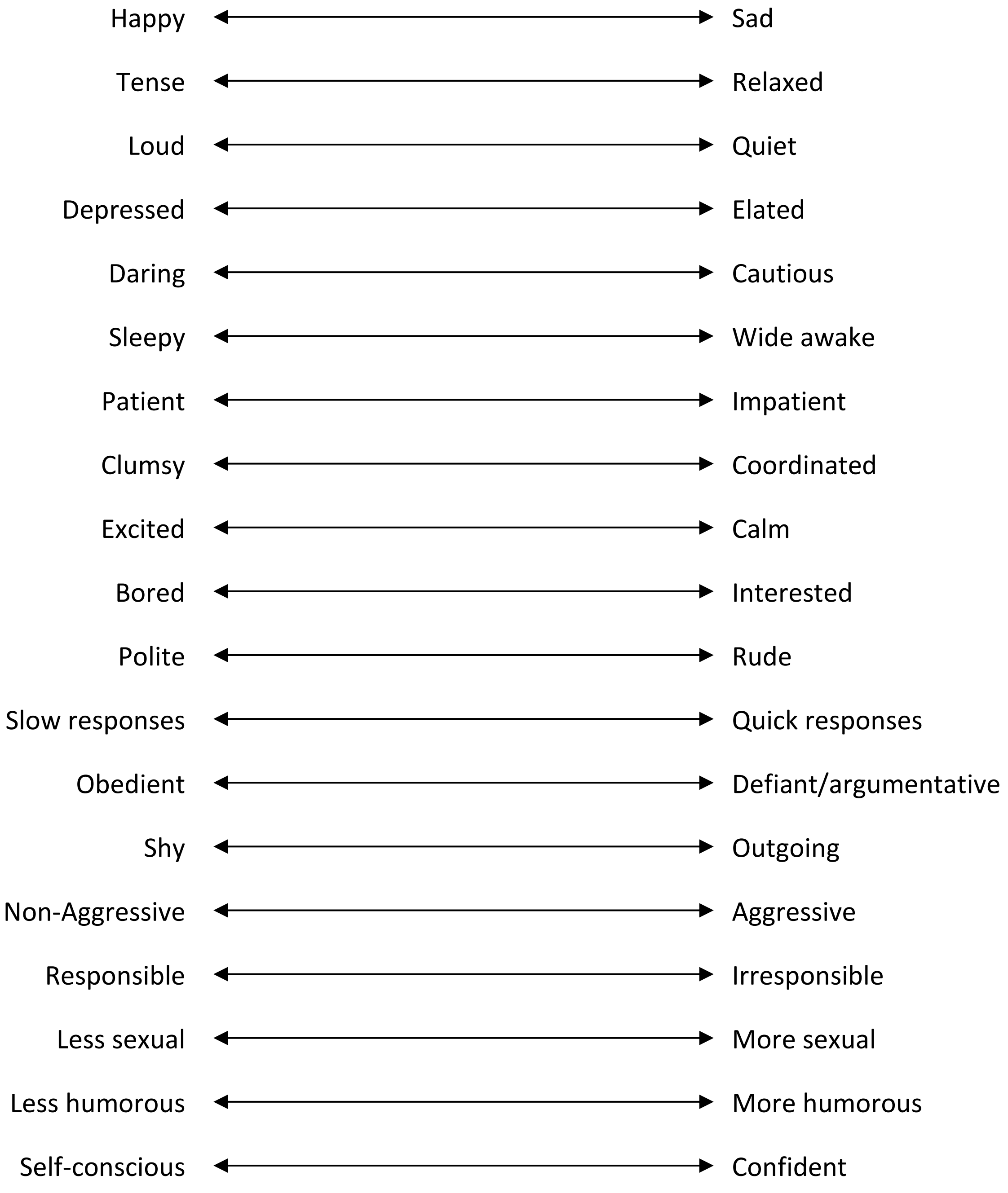
EXPECTATION OF EFFECTS

Directions: Below are listed a number of ways that drugs or alcohol can affect people. Indicate how the drugs you preferred generally affected you by putting a line in the appropriate place on the scale between each descriptor. For example, on the “happy-sad” scale you would place a check mark by “happy” if drugs would make you happier, by “sad” if they would make you sadder and between “happy and sad” if the drugs you take would have neither effect. Do not worry about right or wrong responses.

How would a moderate use of your substances of choice generally affect you?



SOME CONSEQUENCES OF SUBSTANCE USE

Questions to ask yourself:

- What not-so-good things have you experienced due to drug or alcohol use?
- Which ones are most concerning to you?
- Which ones would be most likely to motivate you to change your substance use?

A. Legal

1. Engaging in illegal activities to obtain drugs (e.g. stealing, buying/selling)
2. Receiving a ticket or charge
3. Losing license
4. Probation/Diversion
5. Incarceration

B. Family

1. Changes in relationships with family members, such as spending less time with them
2. Loss of trust
3. Arguments about drug use
4. Spending money needed by family on drugs
5. Drug-induced mood changes that create suspicion or uncertainty in family members

C. Social

1. Loss of friendships
2. Feeling judged by others
3. Neglected hobbies, interests, or school activities because of drug use
4. Conflicts with teachers, peers, or others

D. Emotional

1. Irritability
2. Guilt
3. Nervousness
4. Sadness
5. Emptiness

E. School or job problems

1. Frequent tardiness or absences
2. Difficulty in performance (Low grades, reduced motivation to do school work, memory problems)
3. Suspension or expulsion
4. Interrupted education
5. Threat of job loss or loss of job

F. Physical

1. Damage to body organs because of substance use
2. Withdrawal symptoms
3. Avoiding medical attention
4. Accidents due to drug use
5. Sexual dysfunction (Reduction in desire or arousal, problems with orgasms, pain)

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HOME PRACTICE: Understanding High Risk Situations

At the time I was tempted to use:

1. I was (where?): ____

2. I was with (whom?): ____

3. What was happening in the situation just before I felt tempted to use?

____

4. Right before I felt tempted, I was feeling: ______________________________________

____

5. Right before I felt tempted, I was thinking: _____________________________________

____

6. What tempted me the most to use in this situation? ________________________________

____

____

7. I believed that the pros of using would be: _____________________________________

____

8. I believed that the cons of using would be: _____________________________________

____

9. ☐ My **pros** proved to be true ☐ My **cons** proved to be true

10. ☐ I decided to use ☐ I decided not to use

11. I decided to use: What else might I have done to avoid using?________________________

____

12. I decided not to use: What exactly did I do to help me avoid using?___________________

____

13. Describe any bigger problems or concerns in my life that may have influenced my decision in this situation:

____

____

____

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COPING WITH CRAVINGS

Cravings can feel pretty out of control, especially when you have just changed your use of drugs or alcohol. The purpose of this session is to help you understand what cravings are and to teach you skills to manage them. Cravings or urges usually get weaker and happen less often when you don't give into them. Triggers are wired in our brains like computer circuitry; our brains will remember triggers and respond to them for weeks or even months, after you stop using.

For example, if you used to smoke marijuana behind the baseball diamond at a park, you may experience a craving for weeks or months later if you walk by or think about being at that spot. Remember, this craving will lose its strength as time passes. The skills in this module will help you deal with cravings and, over time, rewire your brain circuits.

Distracting Activities

- Think of other things you like to do, such as reading, a hobby, going to a movie, talking to a friend, playing basketball, or exercising. Once you get interested in something else, you will find that the cravings usually go away. Think about activities you used to enjoy, but have stopped or reduced because of using, or for other reasons. Others find it helpful to involve themselves in brand new activities they haven't tried yet.

Self Talk

- Self-talk becomes so automatic that you may not even notice how the way you think impacts the cravings. For example, "I can't get through the day without smoking. It's impossible." Alternative self-talk can make the urge easier to handle: "This urge is uncomfortable, but in 15 minutes, it will pass. I got this!"
- Remind yourself of the "cons" of using. Tell yourself that you really won't "feel better if you just have one hit," and that you stand to lose a lot by using.

Talk it Through

- Talking to a supportive friend or even a family member about a craving can sometimes help relieve the discomfort. Cravings are nothing to be ashamed of or to feel bad about. You want to make good decisions about who you ask for help. It should be someone who won't make you feel worse about having a craving and who might understand what it feels like.

Urge Surfing

- Some urges, especially when you are in the beginning stage of recovery, are just too strong to ignore. When this happens, it can be useful to stay with your urge until it passes. This technique is called urge surfing. The idea behind urge surfing is similar to the idea behind many martial arts—one overpowers an opponent first by going with the force of the attack. You surf the urge until it passes.

Remember, cravings may be uncomfortable but are a very common experience; having them does not mean something is wrong. You can be ready to cope with them when they happen.

USING *SELF-TALK* TO MANAGE A CRAVING

1. Pinpoint what you tell yourself about a craving that makes it harder to cope. These might be *craving-increasing thoughts* that strengthen the desire to use.
    a. Example: *"I won't feel better until I get high."*
2. Use self-talk (thoughts you say to yourself) to help challenge the belief that you "*won't be able to feel better if you don't get high*". If you can think *craving-reducing thoughts* (*"I'll be OK if I don't get high"),* it will make you feel better (less tense, anxious, panicky) although it may not make the feelings disappear entirely. Below is a list of different questions and statements to ask yourself to find new self-statements (think different thoughts). If you try these, your craving may get weaker.
    a. **What is the evidence?** What is the evidence that I will die if I don't get high immediately? What's the evidence that people who are recovering from a problem with substance use don't experience the feelings I have? What is the evidence that there is something the matter with me that will never improve?
    b. **What is so awful about feeling bad?** Of course, you can survive it. Who said that changing your substance use would be easy? What's so terrible about experiencing an urge? If you hang in there, you will feel fine. These urges are not like being hungry or thirsty; they are more like a craving for food and will pass in time.
    c. **You are a human being and have the right to make mistakes.** Maybe you worry about being irritable or hard to get along with. What's so bad about that? We all make mistakes and there is not a right or perfect way to get along.
3. Use these *alternate craving-decreasing thoughts* as long as you need to until you start feeling less panicky and distressed. They will serve as good distractions from the craving itself. This will also help you change your beliefs about life and substances. For instance, you might now be saying to yourself, *"I am just as good of a friend when I don't use as when I am high." "I'll be OK if I don't smoke weed at the party."* Using substitute statements is more than the power of positive thinking; you must actually believe in what you are saying to yourself.

IN-SESSION EXERCISE:
Learning New Self-Talk for Managing Cravings

One way to cope with thoughts about using substances is to remind yourself of the *benefits of not using* and the *unpleasant consequences of using*. On this sheet, make a list of reminders in each category. Then, create new self-talk to use when a craving happens.

TIP: *It might be helpful to put this list in your phone or somewhere else where you can read it, to get you through urges and cravings as they come up.*

Positive benefits of not using: ____

____

____

____

____

Unpleasant effects or negative consequences of using: __________________________

____

____

____

____

Now, circle the strongest motivators for you in both sections above. Write two alternate *craving-decreasing statements* below so you're prepared the next time an urge arises.

1 ____

____

____

2 ____

____

____

TALK IT THROUGH: Supportive People Checklist

This worksheet will help you to consider people you could "talk it through" with when you're having a craving. Rank each person below according to the statements on the left. Use a scale from 1 to 5:

1 = Not at all   2 = I don't think so   3 = Maybe   4 = Probably   5 = Without a doubt

	Person One ______________	Person Two ______________	Person Three ______________
Supportive of Treatment:			
Supports me in changing substance use	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Supports my goals	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Supportive of Me:			
Listens to me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Accepts me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Respects me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Understands me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Is honest with me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Readily Available to:			
Talk with me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Spend time with me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5
Willing to come to treatment with me	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

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URGE-SURFING: PRACTICING MINDFULNESS

Urges tend to disappear by themselves, often in 15 minutes. They are like ocean waves that rise, crest, and subside. Urges might start out small, temporarily grow in size, and then break up and disappear, just like a wave crashing on the beach.

As you practice mindfulness, pay special attention to any impulses or urges that appear. Then you will be well-prepared by using mindfulness to ride these waves without giving in to the urge.

Practice:

- Sit in a comfortable position, which might be in a chair, or on a pillow on the floor.
- Turn your attention toward your breath. Don't change it. Just notice as you breathe in and out.
- Scan your body for any discomfort, which may be a feeling of restlessness, an itch, or a craving.
- Note any desire to move, and turn your attention back to your breath.
- Notice thoughts that enter your mind. They might be thoughts like:
    - "I wish this would go away!"
    - "It's driving me crazy!"
    - "This isn't working!"
    - "It's not getting better!"
    - "I need to use right now!"
- They are just thoughts. Without judging, feeding, or fighting them, ***gently*** bring your attention back to your breath.
- Notice how your craving affects your body.
    - Is it in your stomach or your hands? Your mind or your feet? Somewhere else?
- Focus on one area of your body where you can feel the physical sensations associated with the urge, and notice what's happening.
    - If it had a shape, what would it be? Are the borders firm like a football, or fuzzy like wool?
    - If it had a size, how big or small would it be?
    - If it had a color, what would it be?
    - If it had a temperature, what would it be?
    - What kind of sound would it make?
- Be curious about your experience, and notice how it changes over time as you breathe in and out.
    - What happens to the urge? Does it get larger or smaller, more or less intense, or does the quality of it change?
- When you find your mind being distracted by thoughts, notice the thoughts, and direct your focus back to the physical sensations of the urge.

The key to Urge Surfing is to understand that we can have an urge AND not act on it. When we do this, we notice the discomfort change, crest, and subside, like waves in the ocean. In this way, urges become manageable and we don't feel the need to act on them, like we did in the past. The urges will become fewer and weaker the better we get at practicing mindfulness.

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IN-SESSION PRACTICE: Cravings Plan

It is important to have a strong plan that you can use when a craving or urge happens. Each of these skills will be useful at one time or another. You may rely on one in particular skill to get you through cravings. That's a good place to start. Then you can consider the others and might even try them out in different situations. Using more than one skill at a time might give you the best results.

Distracting Activities	Self-Talk	Talking it Through	Urge Surfing
Think of activities that might make you feel the same way **WITHOUT USING,** such as the need to feel excitement or to manage boredom by going snowboarding instead.	**CRAVING-REDUCING** self-statements remind you of the benefits and reasons for changing your substance use. They can be connected with your **PERSONAL GOALS OR VALUES:** *"I am going to get this job, but not if I get high tonight."*	It's important to let your **SUPPORT PEOPLE** know you might be relying on them to help. Think about specific things you would like from these people, such as to talk about the craving, *not* to talk about it, or go for a walk.	At first, this may feel a little uncomfortable, but with practice, you'll notice how empowering it feels to be able to **FLOW THROUGH A CRAVING**. Let the thoughts, and physical and emotional sensations pass through you until they diminish.
What kinds of activities might keep you from focusing on the cravings? 1. 2. 3.	What **HELPFUL** self-statements can use to get through a craving? 1. 2. 3.	Who could you talk to if you were having a craving to use? 1. 2. 3.	When might you use Urge Surfing to help you manage a craving? 1. 2. 3.

HOME PRACTICE REMINDER SHEET: Coping with Cravings and Urges

- ➲ Urges are common in the recovery process--not a sign of failure.
- ➲ Urges are like ocean waves; they get stronger only to a point and then they start to go away.
- ➲ You win every time you defeat an urge by not using. Urges only get stronger if you give in and feed them. An urge will eventually weaken and die if you do not feed it.

REMEMBER: Stopping a substance can cause cravings TEMPORARILY. It is common to experience a variety of different uncomfortable sensations and feelings when your body and mind are getting used to not having the drug in your system. These can include: Irritability, sleeplessness, decreased appetite, anxiety, restlessness, headaches, stomach aches and drug craving, all of which can present challenges. Hang in there. They will eventually go away.

Skills you can use:

1. **Distracting Activities**
2. **Talk it Through**
3. **Urge Surfing**
4. **Self-Talk**

For the next week, make a daily record of urges to use drugs or alcohol, the intensity of those urges, and the coping behaviors used.

Fill out the **DAILY RECORD OF URGES** on the next page.

- **a.** *Date*
- **b.** *Situation:* Include anything about the situation or your thoughts or feelings that seemed to trigger the urge to use.
- **c.** *Intensity:* Rate your craving, where 1 = none at all, 10 = worst ever.
- **d.** *Coping behavior:* Use this column to note how you attempted to cope with the urge to use. Note how well your coping behavior worked to withstand the craving and perhaps what might work better next time.

Examples:

Date	**Situation (include your thoughts and feelings)**	**Intensity of craving (1-10)**	**Coping skills used**
2/29/16	Was feeling stressed. Had a disagreement with my dad.	**7.5**	Shut myself in room and listened to music. Felt better after 20 minutes.
3/2/16	Antsy at bedtime. Trouble getting to sleep.	**6.0**	Played hoops. Took a hot shower. Hoops better than shower.

HOME PRACTICE: DAILY RECORD OF URGES TO USE

Date	Situation (include your thoughts and feelings)	Intensity of craving (1-10)	Coping skills used

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PERSONAL TRIGGERS LIST (HOME PRACTICE OPTION)

Instructions: Many people develop regular habits about when and where they use drugs and also when they don't use drugs. Common drug use situations include when you first wake up, before, during or after school/work, with a particular friend, and at parties. We are going to look at the times you are least likely and most likely to use.

A. Times you are LEAST likely to use:

	SITUATION/ACTIVITY	DAY	TIME
1.	Therapy sessions	Tuesday	5:00 p.m.
2.	___________________________________	___________	___________
3.	___________________________________	___________	___________
4.	___________________________________	___________	___________
5.	___________________________________	___________	___________

B. Times you are MOST likely to use:

	SITUATION/ACTIVITY	DAY	TIME
1.	___________________________________	___________	___________
2.	___________________________________	___________	___________
3.	___________________________________	___________	___________
4.	___________________________________	___________	___________
5.	___________________________________	___________	___________

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GETTING YOUR POINT ACROSS: Speaking and Listening Skills

Being able to get your feelings and thoughts heard and understood by others is not easy. Good communication skills will help you get what you need at home, school, work, and in your relationships. When we don't feel like people are listening to us, we start to feel unimportant, discounted, possibly sad and angry. When we don't listen and respect others, they start to feel the same way. This leads to problems in relationships, usually with arguments, "cold wars," or just avoiding the situation.

There are different ways of relating to others. The goal is to build assertive communication skills that will help you in a variety of situations. Lots of people fall into the traps of being either passive or aggressive when they are upset by something. It is important to be prepared for giving and receiving constructive criticism as that is often when our communication skills are most challenged. We express ourselves both with our words and with our body language. *A dirty look can speak 1,000 words*. We will practice both verbal and non-verbal communication skills during this session.

Passive	Assertive	Aggressive
• You avoid saying what you want, think, or feel. • Voice is weak, hesitant, soft. • Posture: Stooped, slumped over, head down, and/or hand on face. • You might say things like, "I'm not sure" or "It doesn't matter to me" or "Whatever; I don't know."	• Standing up for your rights as a person without taking away another's rights. • You say what you honestly want, think, and feel in direct and helpful ways. You use "I messages." • Voice: Firm, warm, relaxed, and expressive. • Eyes: You look directly at the other person, but you don't stare. • Posture: You face the person with your head up and with a relaxed, balanced posture. • "I need to speak with you about what's bothering me."	• You say what you want, think, and feel, but at the expense of other's rights and self-esteem. • Voice: Tense, loud, cold, demanding, possibly threatening. • Posture: Pointing your finger, shaking your fist, macho-fight stance, leaning over, hands on hips, or inches from the other person. • "You better give me that!"

The materials in this session will focus on skills to help you have more success with communication. Remember that good communication means using effective speaking AND listening skills. You will practice ways to be more assertive in relationships that are important to you.

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REMINDER SHEET and PRACTICE EXERCISE: Introduction to Assertiveness

Remember the following points in practicing assertiveness:

- Take a moment to think before you speak.
- Be specific and direct in what you say.
- Pay attention to your body language.
- Be willing to compromise.
- Restate yourself calmly if you feel that you're not being heard.

Practice Exercise

This exercise is to help you become aware of your style of handling various social situations. The three common response styles are passive, aggressive, and assertive.

Think of three different situations in which you related to other people. For example, these could include interactions with family, friends, your partner, or your boss. Write brief descriptions of them and of your response to them. Then decide which of the three common styles best describes your response.

Situation 1: ____

Your response: ____

____

Circle response style: passive, aggressive, assertive

Situation 2: ____

Your response: ____

____

Circle response style: passive, aggressive, assertive

Situation 3: ____

Your response: ____

____

Circle response style: passive, aggressive, assertive

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REMINDER SHEET: Patterns to Avoid in Effective Communication

1. **Putdowns**: Name calling, insults, inappropriate laughter, rude remarks. These can be subtle, like rolling eyes.

2. **Blaming:** Saying or implying the problem is completely the other person's fault; includes transferring the blame to another person, as in saying, "I've done everything I can."

3. **Denial:** Dismissing the other person's issue. Even if you don't see something as a problem, recognize that it may be a problem for the other person.

4. **Defensiveness:** Can be displayed by becoming angry or argumentative, making excuses, becoming silent and refusing to participate. Self-talk can play a big part in becoming or not becoming defensive.

5. **Communicating hopelessness:** "Nothing works." "What's the point?" "It won't do any good." Can be communicated non-verbally with heavy sighs and rolling of eyes. Giving short replies like "Whatever" or "I guess."

6. **Mind-reading:** Implying that you know another person's opinions or motives without checking with them. The assumptions are usually negative.

7. **Talking for others:** For problems to resolve, everyone needs to say how they are feeling, how they are affected, and commit to working on a solution together.

8. **Sidetracking:** Talking about things not relevant to the subject. Bringing up new problems before the original one is resolved.

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“I” STATEMENTS: IN-SESSION AND HOME PRACTICE EXERCISE

Read the two statements below. How are they different?

- *“**You are never** going to understand what I am telling you!”*
- *“**I don’t think** you understand what I am trying to say to you.”*

When getting your point across assertively, use one of these phrases in your statement:

- I think/don’t think. . .
- I feel/don’t feel. . .
- I want/don’t want. . .
- I can/cannot. . .
- I agree/disagree. . .
- I will/won’t. . .
- I like/don’t like. . .

Practice Exercise

Think about some recent conflict situations you have had with family, friends, or others in your life. Write down a few options to communicate what you want to say.

It might be helpful to add a request to your *I statement*. Here’s what it might sound like:

“I feel frustrated when I have to wait for you. It would help me greatly if you texted to let me know you are running late.”

1. ____

____

2. ____

____

3. ____

____

4. ____

____

5. ____

____

For Home Practice, try out the “I Statements” and tell your counselor how it went.

IN-SESSION AND HOME PRACTICE EXERCISE: Nonverbal Communication

"Body language" can be very useful in helping to get your point across.

- ✪ Posture
- ✪ Eye contact
- ✪ Facial expression
- ✪ Tone of voice
- ✪ Head nods
- ✪ Hand movements and gestures
- ✪ Personal space

Home Practice Exercise #1

Between now and the next session, notice what you like about the nonverbal behavior of some of the people you see. List some of the positive things you observe. Briefly describe how those things may have a positive effect on the communication process.

____

____

____

Home Practice Exercise #2

Start a conversation with someone. As you are talking, notice some of your nonverbal behaviors. Then, after the conversation is over, jot down the nonverbal behaviors that you thought you did well, and some that you would like to improve.

Person you talked with: ____

I did these nonverbal behaviors pretty well: ____

____

____

____

I could use some improvement on these nonverbal behaviors: __________________________

____

____

____

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IN-SESSION AND HOME PRACTICE EXERCISE: Expressing Constructive Criticism

Here are some suggestions for expressing constructive criticism in an assertive way:

- Calm down first.
- State the criticism in terms of your own feelings, not in terms of absolute facts.
- Focus on the behavior, not the person.
- Request a *specific* behavior change.
- Be willing to negotiate a compromise.
- Start and finish on a positive note.
- Tone of voice: Clear and firm, not angry.

Home Practice Exercise

Approach a person you have been meaning to give feedback to about a situation. First, plan out what you want to say.

Identify the problem: ____

____

____

____

Your goals and requests: ____

____

____

After speaking to the person, describe what happened:

What did you say to the person? ____

____

____

____

How did they respond? ____

____

____

____

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IN-SESSION AND HOME PRACTICE EXERCISE: Receiving Constructive Criticism

When you receive criticism, remember the following:

- Don't get defensive, debate, or counterattack.
- Try to understand the person's perspective.
- Ask questions for clarification.
- Propose a workable compromise.

Home Practice Exercise

Stay alert until our next session for any constructive criticism you might receive. This may come from a family member, significant other, or teacher. For one criticism that you receive, record the following:

Describe the situation: ____

____

____

____

____

Describe your response:____

____

____

____

____

Communication Checklist:

	YES	NO
1. Did you behave as if the criticism was nothing to get upset about?	☐	☐
2. Did you try to understand the other person's perspective?	☐	☐
3. Did you ask questions to clarify?	☐	☐
4. Did you propose a workable compromise?	☐	☐

REMINDER SHEET: Feeling Talk and Listening Skills

- **Sharing your feelings with other people:**
  - *It's OK* to talk about your feelings (both positive and negative ones). Choose a person who it feels safe to talk to. You'll share more with people you feel (or want to feel) closer to than with new people you meet.
- **Listening to other people:**
  - Use "body language" to show that you are listening to the other person (leaning forward, eye contact, head nods, etc.).
  - Pay attention to the tone of voice, facial expression, and body language of the other person, to help you "tune in" to their feelings.
  - Listen for the right time to talk.
  - Show interest and understanding by asking questions and adding comments of your own.
  - Share similar experiences or feelings that you have had.

HOME PRACTICE EXERCISE: Feeling Talk and Listening Skills

Practice expressing your feelings and listening to the feelings of others. Describe the situations below.

Exercise 1: Practice Expressing Feelings
Start a conversation with someone and share a feeling during the conversation.

1. Who did you talk with? ____

2. What feeling(s) did you share?

____

3. How did they respond?

____

____

Exercise 2: Practice Listening to Feelings
During a talk you have with someone, notice a feeling that they are expressing both verbally and nonverbally.

1. What feelings did they express verbally?

____

____

2. What nonverbal behaviors did you notice?

____

____

3. What feeling did they express nonverbally?

____

____

4. How did you show you were listening?

____

____

HOME PRACTICE: Reflection Sheet

I practiced listening with (person):____

On (date and time):____

The other person knew I was practicing my listening skills: ☐ Yes ☐ No

How I think I did as a listener:	Not well		OK		Really well
1. Paying complete attention to the entire conversation	1	2	3	4	5
2. Keeping my own "stuff" out of it (e.g., advice, opinions, intentions, wants)	1	2	3	4	5
3. Making understanding statements	1	2	3	4	5
4. Repeating back what the other person said	1	2	3	4	5
5. Asking the person if I was accurate in my reflection	1	2	3	4	5
6. Asking for clarification if I was unsure about what the other person said or felt	1	2	3	4	5
7. Using nonverbal communication skills:					
8. Eye contact	1	2	3	4	5
9. Head nods	1	2	3	4	5
10. Neutral or positive facial expressions	1	2	3	4	5

Notes (what we talked about, how I felt, what happened afterwards, any details you want to discuss with your therapist):

____

____

____

____

Adapted with permission from Miller, W.R., ed. *COMBINE Monograph Series, Volume 1. Combined Behavioral Intervention Manual: A Clinical Research Guide for Therapists Treating People with Alcohol Abuse and Dependence.* DHHS Publication No. (NIH) 04-5288. Bethesda, MD: NIAAA, 2004.

KNOW YOUR HOT BUTTONS: SKILLS FOR MANAGING ANGER

Anger can really mess us up when we are trying make changes or get anything done in our lives. Many people report they use or relapse when they feel angry or upset. There's nothing wrong with feeling angry—it's what we do when we get angry that might get us in trouble. There's a big difference between **feeling angry** and **angry behavior**, like becoming impulsive and violent with our actions.

It is very important to know how to recognize when you are feeling angry. We will look closely at what it feels like when you are angry (how hot you are getting) and learn some ways to recognize when it's coming on quickly. Then we'll come up with some strategies to help you cope better when you feel angry. The goal of anger management is to learn to communicate angry feelings in a way that doesn't hurt you or others.

It is important to keep in mind that anger is not caused by **trigger events** (circumstances making you angry) alone, but by our **thoughts** about those events. In turn, our thoughts and feelings affect what decisions we make about how to handle the situation (**behavior**). This is what happens:

TRIGGER EVENT

- Fight with partner
- Argument with parents
- Being dissed by a friend
- Losing job

ANGRY THOUGHTS & FEELINGS

- "They're being unfair. They never cared about me anyway."
- "They never let me do anything! I'm outta here!"
- "There's no point in trying to make friends; they're all two-faced."
- "My boss is such a jerk!"

Constructive Effects (helps you):

- Tells you there's a problem
- Signal that problem-solving is needed
- Feel powerful
- Able to communicate negative feelings
- Prevent future conflicts
- Stronger relationships

Destructive Effects (makes things worse):

- Mental confusion
- Poor decisions that you might regret
- Emotional distance or resentments
- Poor communication
- Masked or stuffed feelings
- Reduced self-esteem
- "Anger blackouts"
- Relapse to using substances

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REMINDER SHEET: Anger Awareness

Anger is a normal human emotion. Increased awareness of angry feelings will make it possible for you to cope with them so that they don't get out of hand and lead to negative consequences such as violence, broken relationships, or legal problems. Increase your awareness of the following:

Which events trigger anger for you?

- ❒ Direct attack on you
- ❒ Feeling threatened
- ❒ Inability to reach a goal
- ❒ Unfair treatment
- ❒ Seeing an attack on someone else
- ❒ Excessive demands on you

What internal reactions signal anger for you?

- Physical reactions:
  - Muscle tension; headache; clenched teeth or jaw; upset stomach
  - Hot, flushed skin; feeling shaky; trembling; sweating
  - Adrenaline rush; rapid breathing; raising your voice; beginning to yell
- Emotions: Frustration, annoyance, aggravations, feeling on edge or wound up.
- Difficulty falling asleep, thinking too much about a situation
- Depression or feelings of helplessness
- What else?

HOME PRACTICE EXERCISE: Anger Awareness

Over the next week, watch out for a situation involving anger, or a similar emotion such as frustration, annoyance, or irritation. Answer the following questions:

When and where?

____

____

____

Who else was involved?

____

____

____

What happened that provoked your reaction? ____

____

____

____

What were your physical sensations? ____

____

____

____

Thoughts and feelings? ____

____

____

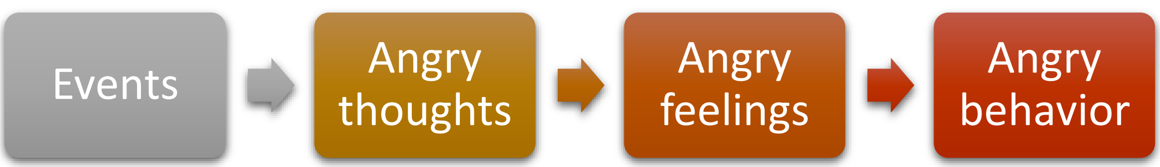
____

On a scale from 1 – 10, how angry were you?

1	2	3	4	5	6	7	8	9	10
Bothered, irritated			Frustrated, mad, pissed off				Irate, furious, enraged		

REMINDER SHEET: Anger Management

Anger can result from the way we think about things, especially if we think ***anger-increasing thoughts***:



Use short phrases like the ones below to help you calm down in a crisis. You can't think straight when you're angry.

"Chill."
"Relax."
"I need a time out."
"Cool it."
"It's not worth it."

Next, think about what's getting you so angry. Review the situation point by point:

What about the situation is bothering me so much?
Is this a personal attack or insult?
Am I angry because I'm expecting too much of myself or someone else?
What are the positives here?

Then, think about your options:

What can I do?
What will be the consequences of my action?
What is in my best interest here?
Communication skills, problem solving, or other coping skills may be helpful.
➲ Remember: *Anger is a signal to start problem-solving.*

If the problem won't go away:

Remember that you can't fix everything.
Try to shake it off.
Don't let it ruin your day.
Talk with someone who is supportive of you.

If you resolve the conflict, congratulate yourself:

"I handled that pretty well."
"I'm doing better at this all the time."
"I didn't blow my cool."
"I didn't let anger get me."

If you didn't resolve it, think about how you can do something differently in the future. If you're stuck, it might be helpful to seek some ideas from a trusted friend or family member.

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ANGER MANAGEMENT: IN-SESSION PRACTICE
Coping With Anger Plan

Directions: With help from your counselor in session, come up with a plan to manage anger and give it a try. The more you practice, the more you'll learn what works for you.

1. What events or problems tend to make me angry?

2. What are the signals that tell me I'm angry?

    a. Body signals

    b. Thought signals

    c. Action signals

3. What can I do to relax my body?

4. What coping self-talk can I use to control my thoughts? Think *anger-reducing thoughts*.

5. What effective action can I take to deal with the situation or solve the problem?

HOME PRACTICE EXERCISE: Anger Management

Until the next session, pay attention to your response to anger-provoking situations. Identify and change your thoughts in those situations. Pick one occasion before the next session involving angry feelings (or feelings of annoyance, frustration, irritation) and record the following:

Trigger situation:____

____

____

Calm-down phrases used: ____

____

____

Anger-increasing thoughts (e.g. "*She* <u>*always*</u> *treats me unfairly.")*: ______________________

____

____

Anger-reducing thoughts: May include reminder of consequences (e.g. "*If I lose my cool, I'll hit someone and that will make things worse.")*: _____________________________________

____

____

What other thoughts might have helped you cope with this situation? (e.g. "*I got this. I can calm myself down. I'll get out of here soon.") :*_____________________________________

____

____

HOW TO FEEL BETTER: MANAGING NEGATIVE MOODS

Feeling irritable, depressed, anxious, and bored are common when people first start to change their substance use. During these times, we are more vulnerable to feeling bad as we are used to having a substance to make us feel better.

The way we think about things can make us feel worse. This kind of thinking is self-defeating. When this happens, it's tempting to go back to using to feel better temporarily. The problem with going back to using is that it's a short-term solution to the problem and usually just makes things worse.

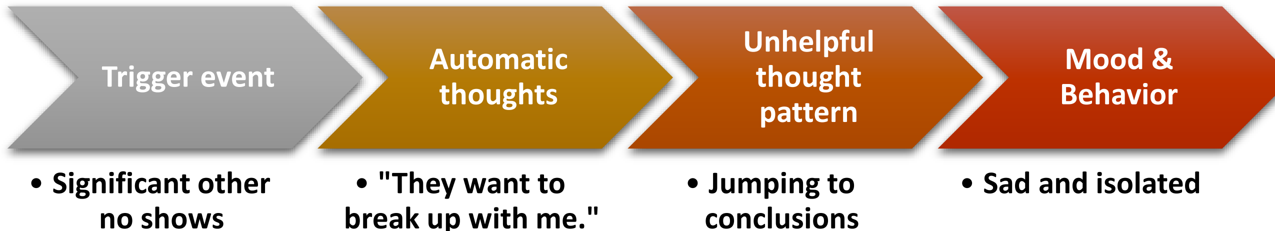
When we are **thinking** things that make us feel worse, it's not easy to recognize what those thoughts are, because they are automatic and quick. For example, if your partner doesn't meet you at the concert when they are supposed to, you might feel sad, angry and disappointed. You might **jump to conclusions** (unhelpful thought pattern) that they don't want to go out anymore; however, there are other ways of looking at this situation and at what happened. What are some other possible explanations?

____

____

____

Below is a model which can explains the connection between events, thoughts, moods, and behavior:



Generating other explanations that are more reasonable is not an easy thing to do when you are feeling bad. Just remember, there's always more than one way of looking at something. It's important to have tools to help you when these bad moods hit. These materials will help you to identify your feelings, know what you are thinking, and find new ways of looking at situations.

What do you see first?

Taking another perspective, what else do you now?

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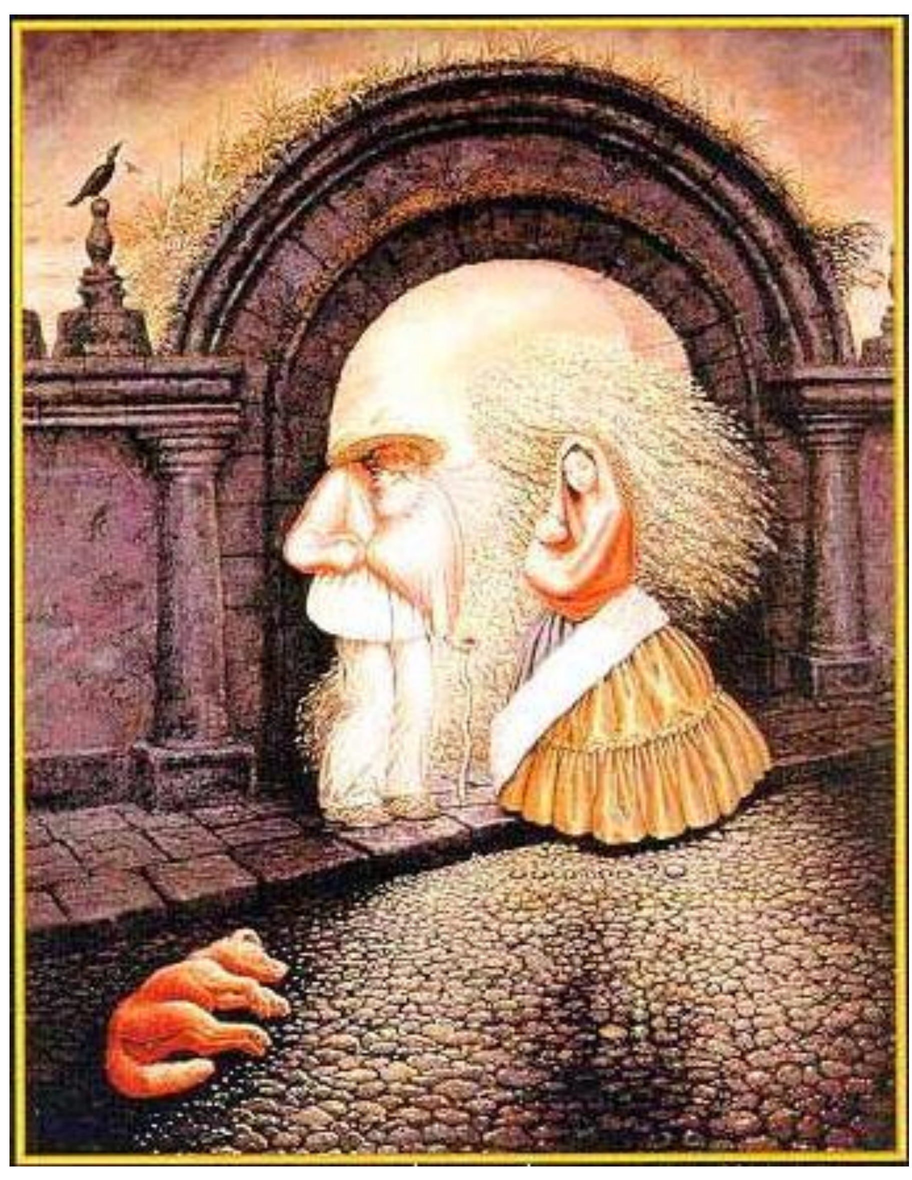
What do you see first in this picture?

Look again. Take a different perspective.

What do you see next?

Is the cat going up or down the stairs?



What did you see first in this drawing?
What did you see next?

You can look at the same thing and see it different ways.
The same is true of our thoughts and beliefs.
The situation does not change; how we choose to see it does.

UNHELPFUL THOUGHT PATTERNS: Increasing Your Awareness of How Thoughts Might Impact You

1. **Black and white thinking (Either/Or):** You see things as perfect or awful, or you see people as all good or all bad. There is nothing in between. *"If I can't go to the party, I won't go out at all." "I already had one beer; might as well keep going."*

2. **Emotional Reasoning:** You assume that the way you feel reflects the way things are. You feel tired and inadequate and assume that things are useless and require too much effort. *"I am really angry—it is impossible for me to get my point across with my partner."*

3. **Blowing things up (Catastrophizing):** You react to a disappointment or failure as though it is the end of the world. A small disappointment, like a bad grade on a test, or not getting called for a job interview after you turn in an application, becomes a huge catastrophe. "*I will never pass math class because I failed that test!" "I'll never get a job!"*

4. **Minimizing:** You diminish the importance of certain things, such as your own desirable qualities or others' imperfections. *"You would think I just robbed a bank! I just got caught with a pipe." "It's better than other things I could be doing instead!"*

5. **Jumping to Conclusions:** You assume the worst without checking the evidence. Or, you decide that terrible things will happen even when there is no proof. *"He didn't call me; it must mean he thinks I'm a loser."*

6. **Mental filter:** You dismiss the positive experiences as if you got lucky or they "don't count." Or you dwell on only negative events as if one drop of ink darkens the entire beaker of water. *"That home run was a fluke. I'm really not good at baseball."*

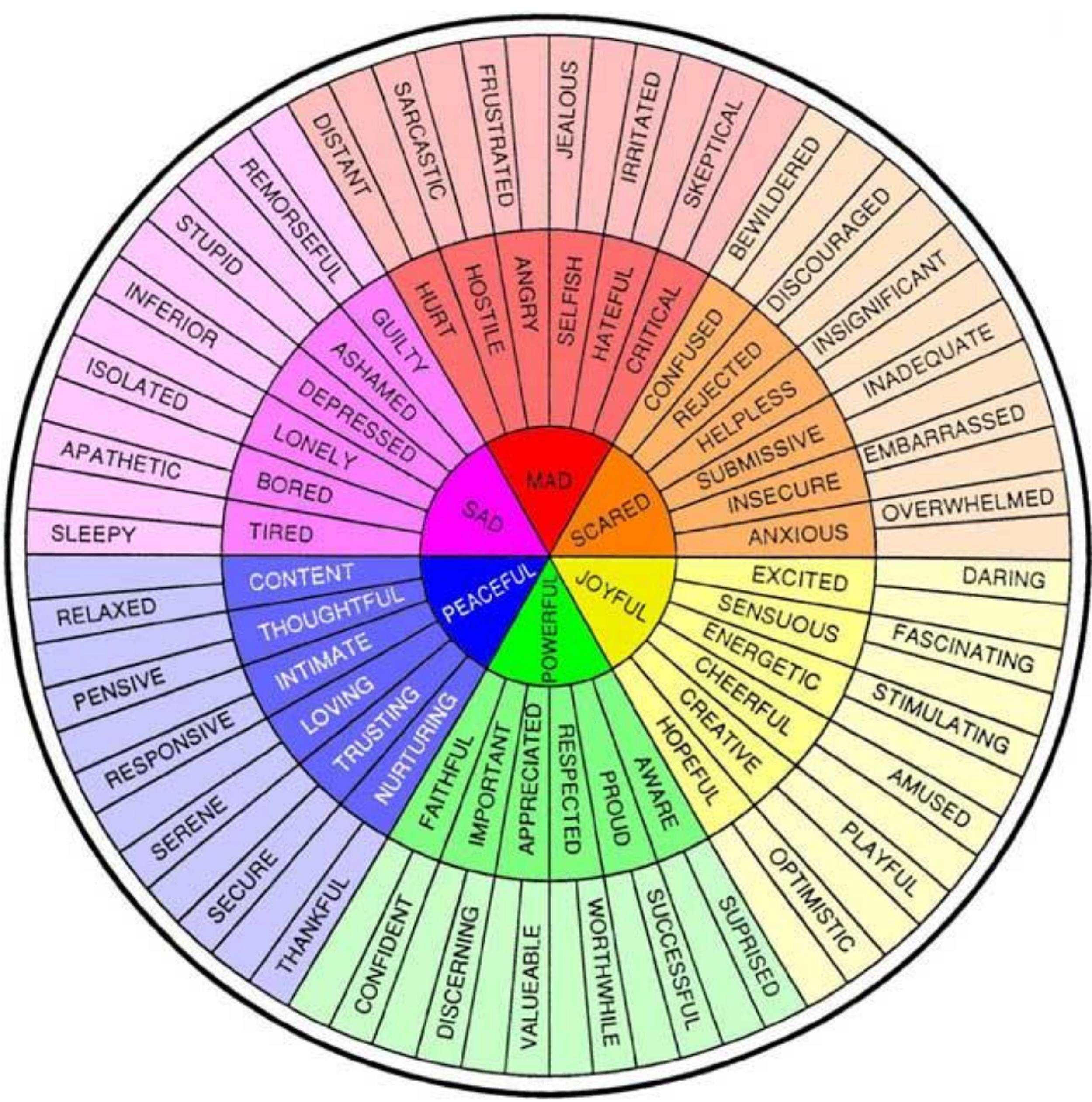
7. **Blaming:** You fault yourself for things that are not in your power to control. Or you focus on blaming others instead of taking responsibility for your part in the situation. *"It's my fault that my parents are getting divorced." "If my parents would let me smoke weed, we wouldn't fight as much."*

8. **Personalizing**: You think the things that others' do or say are in direct reaction to something you did or said. *"I know John talked about dating Maggie in front of me because he knew it would piss me off."*

9. **Fortune Telling:** You anticipate that things will turn out badly, and feel convinced that your prediction is a fact. *"I shouldn't bother trying out for the team. There's no way I'll be picked*."

10. **Shoulds:** You feel you "should" think or do something, or criticize other people for what you think they should or shouldn't be thinking or doing. *"I should have known better." "You shouldn't have gone out with him!"* As a result, everything that you do, and everything that others do, disappoints or bothers you.

11. **Mindreading.** You believe that you know what others are thinking about you, and it is never good. *"I know my boss scheduled me when she knew I had practice to make me quit; she never liked me."*



This simple wheel can help you identify different feelings you might be experiencing at any time. Take a look at the center of the wheel and then look outward on the different spokes to discover ***all*** of your feelings. Remember, you can have more than one feeling **(*and lots of different thoughts*)** at one time.

IDENTIFYING FEELINGS (HOME PRACTICE OPTION)

People often live in fear of their feelings. It is helpful if you can explore what your feelings mean to you so that you can begin to view feelings as a part of you to be listened to and not to be feared. The first step in allowing your feelings to work for you is to begin to identify the feelings you experience in the course of a day. At the end of the day (on the checklist below), check off the feelings you experienced. After a few days of doing this, you will find it much easier to identify specific feelings.

FEELINGS	Sun	Mon	Tue	Wed	Thur	Fri	Sat
angry							
sad							
guilty							
lonely							
embarrassed							
happy							
afraid							
anxious							
disappointed							
hate							
frustrated							
disgusted							
love							
compassionate							
confident							
jealous							
affectionate							
excited							
bored							
confused							
numb							
hurt							
calm							
secure							
silly							
playful							
shy							
remorseful							
ashamed							
nostalgic							
worried							
desperate							
resentful							

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HOME PRACTICE EXERCISE: Know Your Moods and What You're Thinking

Use this worksheet to become aware of how you experience negative moods and the active steps you can take to change your moods.

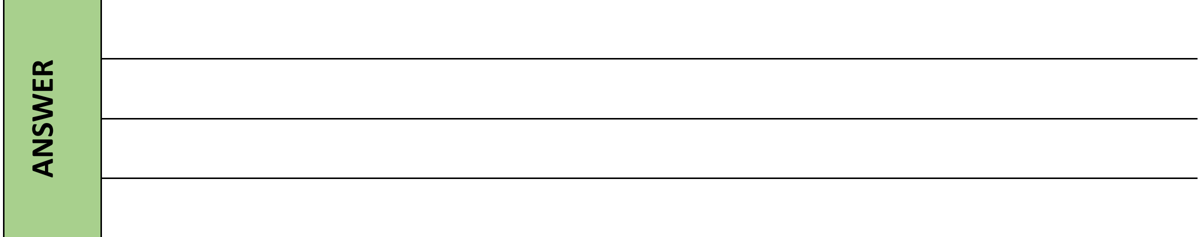
1. What are the ways that I show my negative moods, attitudes, and actions? (Examples: *I don't want to see or talk to people; I feel irritable and snap at people; I want to sleep all the time, etc*.)

AWARE

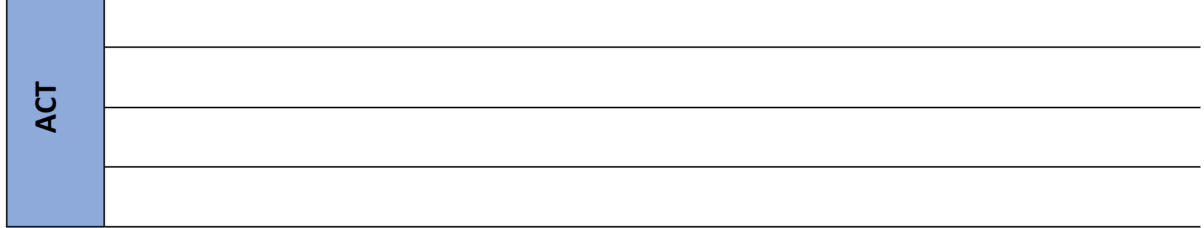
2. What are the automatic unhelpful thoughts that go along with my negative moods? What do I think about myself, my current situation, and my world in general?

AWARE

3. What can I do to challenge these automatic unhelpful thoughts? (Examples: *Ask other people what they think; separate my feelings from facts; let it go)*



4. What steps am I going to take to act differently? What pleasant activities might I increase? What unpleasant activities might I avoid or minimize?



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REMINDER SHEET: Managing Negative Moods

Use the **Three As** to overcome your negative moods:

AWARE

- Be aware of your moods and the situations that influence them.
- Be aware of automatic thoughts.
- Use the *Feelings Wheel* and *Identifying Feelings* sheets to help you know what you are feeling.
- Be on the lookout for *Thought Patterns to Challenge*.

ANSWER

- Use the sheet, *Answering Unhelpful Thoughts: Key Questions to Use,* to challenge unhelpful thought patterns.
- Replace the unhelpful thoughts with alternate helpful ones as you notice them pop up.
- Use the *Managing Unhelpful Thinking* worksheet.

ACT (differently)

- Increase your positive activities.
- Get ideas from *Activities to Shift Your Mood*.
- Decrease your involvement in unpleasant activities.
- Use problem-solving skills to deal with issues that give you worries and concerns.
- Reward yourself for the positive steps you are making.

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ANSWERING UNHELPFUL THOUGHTS: Key Questions To Use

When you are aware that unhelpful thoughts might be getting in the way, use these questions to challenge the thoughts and to come up with new, realistic ways of seeing the situation (self-talk).

- Is this thinking all-or-nothing?
- What evidence do I have that this is true?
- What's the worst case scenario?
- Do I know for certain something bad is going to happen?
- Is this thinking getting me what I want? What do I want? What are my goals?
- Am I overlooking my strengths?
- Am I close enough or too close to the situation to judge?
- Am I confusing a thought with a fact?
- What are the advantages and disadvantages of thinking this way?
- What difference will this make in a week or a year?
- How might [someone whose opinion you respect] view this situation?
- What are some alternative ways of looking at this?
- What might be the reason I am thinking this way?

PRACTICE EXERCISE: Managing Unhelpful Thinking

- Watch out for automatic unhelpful thoughts whenever you feel upset by an event or have a craving.
- Shout “STOP” to yourself in your head.
- Challenge those unhelpful thoughts and write down new thoughts which are more accurate and make you feel better.
- Remind yourself of good things you have done.
- Notice how you feel better once you have done this.
- Believe in the helpful and realistic things you are saying to yourself. If you need to check in with a friend or some other supportive person to help with this, do it! You deserve to feel good about yourself, even when things are going badly, temporarily.

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IN SESSION PRACTICE EXERCISE: Managing Unhelpful Thinking

Let's try this out. Think of an event that happened that led to negative feelings. Write down the automatic thoughts you had. Next, challenge those thoughts using the key questions. Then, write down a possible alternative helpful thought. We'll do a few in session and ask you to try some on your own over the next week.

(A) EVENT OR SITUATION (who, where, when)	(B) THOUGHTS/SELF-TALK Unhelpful Thoughts →	STOP! →	***Challenge*** **the unhelpful thoughts and write down** ***new*** **thoughts**
Fight with my parents over using the car.	*"They never let me do anything by myself."*	STOP	*"They said I could use it as long as I call 1x during the night and come home by 11:00 p.m. Not so bad."*
		STOP	

HOME PRACTICE EXERCISE: Managing Unhelpful Thinking

Let's try this out. Think of an event that happened that led to negative feelings. Write down the automatic thoughts you had. Next, challenge those thoughts using the key questions. Then, write down a possible alternative helpful thought. We'll do a few in session and ask you to try some on your own over the next week.

(A) EVENT OR SITUATION (who, where, when)	(B) THOUGHTS/SELF-TALK Unhelpful Thoughts →	STOP! →	*Challenge* the unhelpful thoughts and write down *new* thoughts
Didn't hear back after submitting a job application.	*"I'll never get a job. I give up."*		*"I have to keep trying. I really need a job so I can make money."*

ACT: ACTIVITIES TO SHIFT YOUR MOOD

A pleasant activity can help you to “shift gears,” whether you want to “shift down” to relax and do something calming, or “shift up” to do something exciting and active. At other times, you might want to “shift into neutral” until you can figure out what mood you’re in.

Circle the activities below you might be interested in.

Soothing, Calming, or Neutral Activities

Take slow deep breaths
Find a comfortable place to go
Drink herbal tea
Read a book or magazine
Wrap up in a soft blanket
Take a bubble bath or shower
Practice mindfulness
Do your nails
Put on lotion
Listen to music
Get a massage
Write or say self-affirmations
Read inspirational books
Find relaxation exercises online
Pet a friendly animal
Celebrate your accomplishments
Go for a walk
Look up at the stars
Stand up and stretch
Do progressive muscle relaxation
Get ice cream
Get some fresh air
Listen to an audio book
Use a computer
Go to a library
Give a hug or ask for one
Go out to eat

Entertaining or Energizing Activities

Shoot a video
Take photos
Rearrange your room
Smile and laugh
Build something
Work on a car
Wash the car
Work on a craft or hobby
Clean the house or your room
Play with a baby or child
Go for a run
Teach your pet a trick
Skateboard
Fly a kite
Play a board game
Play a video game
Swim
Paintball
Go camping
Pick some flowers
Go to church
Lift weights
Ride a dirt bike
Skydive
Volunteer
Play cards
Ride horseback
Play a sport
Go skiing or snowboarding
Learn to sew or knit
Go for a hike
Play miniature golf
Garden
Paint your room
Go fishing
Go to the batting cages
Go to an amusement park
Ride go-carts
Ride a bicycle
Go to a science center
Run track
Explore a new place
Rollerblade
Walk the dog
Yoga

Expressive Activities

Talk to a supportive person
Play a musical instrument
Sing
Write in a journal
Write stories or poetry
Color, draw, paint, sculpt
Make a scrapbook
Start a blog
Do something nice for someone

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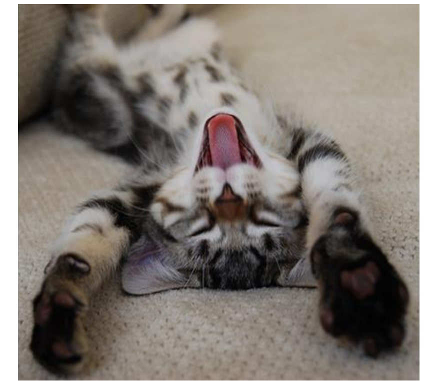
SOME RELAXATION TECHNIQUES

Here are a few exercises that may be helpful when you are stressed, nervous, or having trouble falling or staying asleep. There are many others in addition to the two presented here.

Body Scan



Get into a comfortable position, whether you are sitting in a chair, or lying down. Let your arms rest at your sides. Uncross your legs. Become aware of your breathing, and notice how your abdomen rises and falls with each breath. When you find your mind turning to thoughts, notice the thoughts and let them float by like a leaf might float downstream.

Now focus your attention on your feet. Let the muscles in your feet grow limp and relaxed. Notice how they begin to feel heavy. Now move your attention to your lower legs. Let the muscles in your lower legs grow limp and relaxed. Take as long as you need to relax these muscles. Don't force it, but allow your body the time it needs to relax itself. Your legs may begin to feel like warm candle wax, dripping down to the floor and off your body.

Now move your attention to your upper legs. Let the muscles in your upper legs relax and grow limp. Give your muscles all the time they need to completely relax. Focus next on your hips and buttocks. Allow these muscles to relax and grow limp. Now your entire lower body will feel heavy, limp, and relaxed.

Keep moving up your body, one section at a time. Relax your stomach and back. Take a deep breath to relax your chest and shoulders. Release any tension or stress from your shoulders. Next, focus on your arms. Let your elbows feel heavy and limp. Once they are completely relaxed, focus on your hands. Notice how your fingertips start to feel heavy, like they are warm wax melting off your body, completely relaxed.

Move your attention to your neck, releasing any tension by gently turning your head from side to side. Bring your head back forward. Relax the muscles in your neck and allow them to grow limp. Next take a big yawn but don't allow your jaw to close completely when you are done. Let it hang limp and comfortable with your mouth slightly open. Finally, shift your attention to your forehead. Imagine it is smooth with no worry creases or lines. Allow your forehead to grow limp and relaxed.

Now allow yourself to notice how relaxed your entire body feels. It may feel like you are floating. It may feel like you are sinking into the ground. Take as long as you'd like to enjoy the feeling of total relaxation. If you have the time, feel free to fall asleep. If you would prefer not to sleep, simply wiggle your fingers and your toes. This will gently wake up the rest of your body.

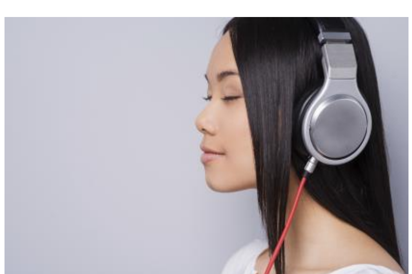
Equal Breathing

You can practice this technique anywhere, while you are walking, sitting, or waiting for the bus, for example. Breathe in deeply and evenly to the count of 4, and then breathe out deeply and evenly to the count of 4. You can increase the count to 5s and 6s.

Belly Breathing (Diaphragmatic Breathing)
With one hand on your chest and the other on your belly, breathe in deeply through your nose and down into your belly. Notice how your stomach, not your chest, expands. Breathe in for 5 seconds and out for 5 seconds. Pay attention to filling your belly with air. Practice for a few minutes each day.

This technique has been shown to reduce your heart rate and blood pressure, and helps you think more creatively and clearly. Try it before an exam, presentation, or any time you are feeling tense.

Match your Breathing to Relaxing Music
As you listen to a song you find calming, breathe in and out along with the rhythm. Some characteristics of relaxing music include:



- Tempo between 60-100bpm
- Consistent volume with few dynamic shifts from soft to loud
- Instruments the person finds pleasing to their ear
- Familiar song structure
- Could be instrumental or vocal

Note that what sounds relaxing to one person might not be to another. It is important to learn what type of music is soothing to you. Questions to ask yourself to figure out your personal relaxing music:

- Do I prefer electronic or acoustic music?
- Do I like to hear singing when I'm trying to relax, or would instrumental music be better?
- What instruments do I like? (e.g., piano, guitars, flutes, saxophone, cello, drums)
- Do I like the sound of low resonating bass?
- How about classical music?

Progressive Muscle Relaxation
This is similar to the Body Scan technique in that you will focus on each area of your body. Start from one end of your body and work toward the other. You can begin by tensing your toes, noticing how it feels to be tense and tight. Then, release your toes, noticing the difference, and how it feels to be relaxed. Pay special attention to the difference between tension and relaxation. Then move on to the next body part. Keep going until you've reached the other end of your body and notice how you feel calm and relaxed.

Practicing these techniques for a few minutes each day will make it easier for you to produce the *Relaxation Response*. Benefits include reduced stress, better sleep, enhanced creativity, less illness, decreased blood pressure, lower heart rate, and a quieter mind.

Which one might you like to try first?

TAKING CARE OF BUSINESS: Problem Solving Skills

Using drugs or alcohol can lead to difficult situations and, sometimes, it seems like there are no solutions. Eventually, problems with your family, friends, school, money, and other areas of life, are the result.

When you can't figure out what to do about something, it's really frustrating. When you don't deal with things, problems usually get bigger and bigger. At times like these, it's easy to fall into the trap of using to get away from the problems. This can turn into a vicious cycle where, in order to "forget" about problems, you keep using. But, the problems don't go away, and they might even get worse.

You can learn to use effective problem-solving strategies when you need them. The trick with problem-solving is neither to act too impulsively, nor to ignore the problems as if they don't exist. When changing your substance use, at first you may encounter new problems, such as managing cravings, dealing with peer pressure, and finding new activities and friends. That's a lot to deal with; if you follow the steps outlined in these materials, you can manage the problems and try out possible solutions.

PROBLEM BANK

Use this sheet to list all of the problems you are currently facing.

1. Start by writing down problems in no particular order.
2. Then, rank the problems, with *1* being the most troubling or important, and *10* being the least.

Remember, by placing your problems in this bank and identifying the most concerning ones, you can start to prioritize which to work on first. The remaining problems will be here for you to work on when you're ready. In the meantime, let's put some of them aside and focus on the most troubling problems.

PROBLEMS	RANK

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REMINDER SHEET: Problem-Solving

These are the steps of the problem-solving process:

1. Recognize that a problem exists: Is *there a problem?*

We get clues from our thoughts, feelings, and behaviors; our reactions to other people; and the ways that other people react to us.

2. Describe the problem: *What is the problem?*

List out all aspects of the problem in detail as accurately as you can.

3. Consider various approaches to solving the problem: *What can I do?*

Brainstorm as many solutions as you can. Take a different point of view. Think of solutions that worked before. Ask people you trust what worked for them in similar situations.

4. Think through the most promising approaches and select one to try: *What might happen if...?*

Consider all of the positive and negative outcomes of each possible approach, and select the one most likely to solve the problem with the least hassle.

5. Assess the effectiveness of the selected approach: *How did it work?*

After you have given the approach a fair trial, does it seem to be working? If not, consider improving the initial plan, or trying one of the other solutions.

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IN SESSION: Problem-Solving Worksheet

<table>
<tr><td>❶ Describe the problem.
⌘ Who? When? Where?
⌘ Be specific. Use details.</td><td colspan="3"></td></tr>
<tr><td rowspan="4">❷ Consider several approaches:
⌘ Brainstorm.
⌘ Take a different point of view.
⌘ Consider familiar solutions.
⌘ What would someone you trust do?</td><td colspan="2">1.</td><td>5.</td></tr>
<tr><td colspan="2">2.</td><td>6.</td></tr>
<tr><td colspan="2">3.</td><td>7.</td></tr>
<tr><td colspan="2">4.</td><td>8.</td></tr>
<tr><td rowspan="3">❸ Think ahead.
⌘ Identify possible positive and negative outcomes for the most promising approaches.</td><td>Approach
#_____</td><td colspan="2">Positive outcomes:

Negative outcomes:</td></tr>
<tr><td>Approach
#_____</td><td colspan="2">Positive outcomes:

Negative outcomes:</td></tr>
<tr><td>Approach
#_____</td><td colspan="2">Positive outcomes:

Negative outcomes:</td></tr>
<tr><td colspan="4">❹ Select the best one:
Most likely to solve the problem with the least amount of hassle. ➡</td></tr>
<tr><td colspan="2">❺ Do it.
⌘ Evaluate: Did it get me what I wanted?</td><td colspan="2">If so, congratulations! Nice job!
If not, re-evaluate the plan: Improve the initial plan or try another approach.</td></tr>
</table>

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HOME PRACTICE: Problem-Solving Worksheet

<table>
<tr><td colspan="2">❶ Describe the problem.
⌘ Who? When? Where?
⌘ Be specific. Use details.</td><td colspan="2"></td></tr>
<tr><td colspan="2" rowspan="4">❷ Consider several approaches:
⌘ Brainstorm.
⌘ Take a different point of view.
⌘ Consider familiar solutions.
⌘ What would someone you trust do?</td><td>1.</td><td>5.</td></tr>
<tr><td>2.</td><td>6.</td></tr>
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</table>

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MANAGING PRESSURES TO USE: Refusal Skills

People who use drugs or alcohol begin to spend more and more time around others who use substances. People who decide to change their substance use can face challenging situations as continuing to spend time with the same people, in the same places, and doing the same things, can make it difficult to succeed.

To make it easier to achieve your goals, you should *FIRST* avoid situations where people will be using. This may require staying away from or carefully planning your activities with using friends, acquaintances, relatives, and others.

Avoidance is not always possible so being able to turn down drugs requires you to use assertiveness skills. It is important to know *HOW* you will handle many different situations *BEFORE* they happen. Practice in refusing substances will help you to respond more quickly and effectively when the situation arises, so it doesn't catch you off-guard.

CHECKLIST OF SOCIAL PRESSURE SITUATIONS

Think about situations you are usually in with your friends, family, peers, or co-workers. To what extent do you expect the following situations to be challenging for you?

	No challenge	Some challenge	Big challenge
1. I am around other people who frequently use drugs or alcohol			
2. Someone very close to me frequently uses			
3. Someone I live with uses drugs or alcohol			
4. I make other people uncomfortable because I am not drinking or using drugs			
5. People often offer me alcohol or drugs			
6. I feel awkward telling people that I am trying to not use drugs or drink alcohol			
7. Most of my friends drink or use drugs			
8. I am around drugs or alcohol at school or work			
9. People give me a hard time for not using			

Adapted with permission from Miller, W.R., ed. *COMBINE Monograph Series, Volume 1. Combined Behavioral Intervention Manual: A Clinical Research Guide for Therapists Treating People with Alcohol Abuse and Dependence.* DHHS Publication No. (NIH) 04-5288. Bethesda, MD: NIAAA, 2004.

MY SOCIAL TRIGGERS

1. Are there any people with whom you are more likely to use drugs or alcohol? ☐ Yes or ☐ No
   Who? (initials only) ____

2. Could you take a "vacation" from, or avoid, any of these people? ☐ Yes or ☐ No
   Which ones? ____

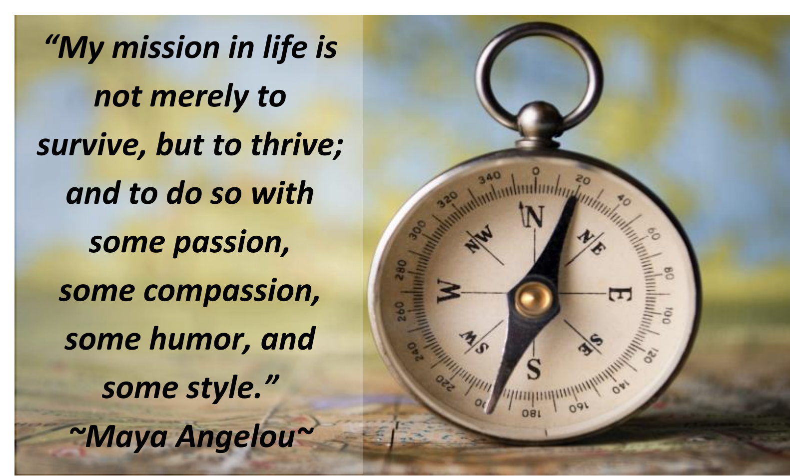
3. Are there any people in your life who you don't use drugs or alcohol with? ☐ Yes or ☐ No
   Who? ____

4. Are there any people you can say "No" to about drugs or alcohol? ☐ Yes or ☐ No
   Who? ____

5. Do you ever feel more like using drugs or alcohol when you are angry with someone? ☐ Yes or ☐ No
   When was the last time? ____________________________________

6. Do you ever feel more like using drugs or alcohol when you have just had a fight with someone? ☐ Yes or ☐ No
   When was the last time? _____________________________________

7. Do you ever feel like using drugs when you are lonely? ☐ Yes or ☐ No
   When was the last time? ______________________________________



REMINDER SHEET: Drug & Alcohol Refusal Methods

1. The most assertive thing you can do is to state your preference directly without offering an explanation: *"No, I don't want to."* If you choose this method, it is also very important to be sure that your tone of voice and other non-verbal messages, like posture and eye contact, match what you want to communicate.

2. Another direct way to assert your preference is to say "No" and offer an explanation. As you read through the options below, think about which ones might work for you.
   a. You can give an excuse: *"No, I can't; I'm driving" or "No, I've have to be at work early tomorrow" or "No thanks, I have a headache".*

   b. You can give a consequence: *"My boss will fire me" or "My parents will ground me" or "If I fail another drug test, my PO will send me back to court".*

   c. You can mention treatment: "*I'm quitting and I'm in treatment now."* If you choose this method, this might be a good time to ask for support from friends. Ask them to help you out by not offering drugs or alcohol to you.

3. One indirect way to refuse is to give an alternate suggestion for an activity that doesn't involve using: *"I'm hungry. Let's go get something to eat instead" or "I'd rather play some basketball."*

4. Change the subject.

5. End the conversation and leave.

The easiest way to refuse is to stay away from situations in which you know you will be tempted. Recognizing these High Risk Situations gives you a head start in either avoiding them altogether, or planning for how you will deal with them.

IN-SESSION AND HOME PRACTICE EXERCISE: Substance Refusal Skills

When you are offered drugs or alcohol, keep the following in mind:

- Say "No" first.
- Voice should be clear, firm, and unhesitating.
- Make direct eye contact.
- Ask the person to stop offering you drugs or alcohol.
- Don't feel guilty about refusing to use.
- Avoid the use of vague answers as best you can.
- Suggest an alternative or change the subject.
- If necessary, make up an excuse and leave the situation.

Instructions: Listed below are some people who might offer you drugs in the future. With help from your counselor, write your possible responses under each item.

Someone close to you who knows about the changes you are making: ______________________

____

Someone from school: ____

____

Partner: ____

____

New acquaintance: ____

____

Host at a party: ____

____

A relative: ____

____

Take this list home with you and try out the responses over the next week.

ALTERNATIVES TO DRUG & ALCOHOL USE

1. Dealing with social (external) pressures:

- **a.** Develop supportive relationships with individuals and peer groups; spend time with people who support your sobriety.
- **b.** Stop spending time with friends who use substances.
- **c.** Avoid social situations you don't think you can handle, especially early on.
- **d.** If an uncomfortable situation comes up, give yourself permission to leave.
- **e.** Prepare in advance what you will say if someone offers you drugs or alcohol.
- **f.** Don't expect the world to quit using and drinking because you have. Your friends might not understand why you quit. They may think they are doing you a favor by giving you drugs.

2. Dealing with psychological (internal) pressures:

- **a.** Get some physical exercise.
- **b.** Practice relaxation exercises.
- **c.** Talk about your situation or feelings with someone you trust.
- **d.** Go see a movie.
- **e.** Read a good book.
- **f.** Listen to music.
- **g.** Sit and feel hurt. Remember this feeling will pass with time.

- **h.** Pay attention to *tension signals* and use them as signals to think about changes you may need to make in your life. Tension sometimes appears through churning stomach, sore back, tight neck, headache, or grinding teeth.
- **i.** Leave an uncomfortable situation.
- **j.** Have a discussion with someone you are at odds with.
- **k.** Get advice from friends and/or family.

GETTING HELP: Support Systems

It is important to know WHO to call for help and HOW to ask. There are many stresses associated with substance use, among these are strained relationships, school failure, legal problems, and medical issues. Changing your substance use and dealing with problems related to drug and alcohol use, including triggers and pressures to use, are far more difficult without support from others.

Many of us have never practiced directly asking for help, and sometimes we feel uncomfortable doing so. Asking for help is not easy, especially if you have difficulty with trusting people. This module will help you to identify areas where you could use some help and to practice how to ask for support. We want to make sure that you have plenty of support to maintain the progress you have made after you've finished treatment. Your social support network may include family, friends, teachers, and acquaintances. It is a two-way street, in that you will want to offer others support as well. When this happens, your support system will grow and grow.

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INSTRUCTIONS FOR THE SOCIAL NETWORK MAP

Below are twenty rectangles. Place your name in the centermost rectangle ("Me"). Then, in the surrounding rectangles, write the names of the people in your social network. The names in the rectangles closest to the center should be the people you consider closest to you. The further away from the center, the less close to you that person is. If you run out of rectangles, draw in some extras; the more the better.

After you have finished writing names in the rectangles, look back over them.
▪ Put a circle by the names of people who use substances.
▪ Put a square by the names of people who do not use substances.
▪ Put a triangle by the names of people involved in crime.
▪ Put a star next to the names of people who would support or encourage you in your goal to change your substance use. For example, include people who would refrain from offering you drugs or using around you, or be available for a phone call, or spend time with you.

Now, let's look over your network map.

Me

REMINDER SHEET: Social Support Networks

WHO might be able to support you? Consider...

- People who have been usually supportive of you
- People who could offer support if you asked them
- People who are getting in the way

WHAT types of support will be most helpful?

- Problem-solving
- Moral support
- Information and resources
- Helping with tasks
- Emergency help
- Help with not using
- Encouragement

HOW can you get the help you need and maintain that support over time?

- Ask for what you need. Be specific and direct.
- Lend your support to others; it helps you strengthen your own skills.
- Be an active listener when giving or receiving support.
- Give feedback about what was or wasn't helpful.
- Thank the person for their support.

IN-SESSION AND HOME PRACTICE EXERCISE: Enhancing Social Support Networks

In-Session Exercise #1
Think of a current problem that you would like help with. Describe the problem:
____

____

Who might be helpful to you with this problem? ____________________________________

What might they do to lend you the support you would like? _________________________

____

____

How can you try to get this support from them? ____________________________________

____

____

Home Practice Exercise #1: Now, choose the right time and situation and try to get this person to support you. Describe what happened:

____

____

In-Session Exercise #2:
Name a friend or family member who is currently having a problem and who could use some more support from you. ____

Describe what you could do to lend them some support: ______________________________

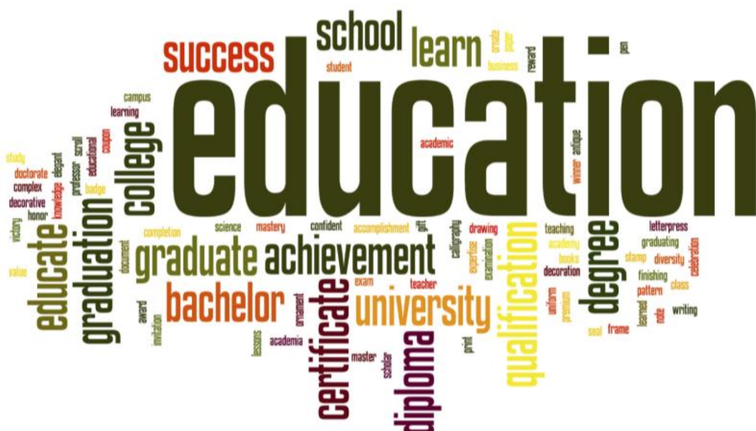
____

Home Practice Exercise #2: Now choose an appropriate time and setting and give support to this person. Describe what happened:

____

____

SCHOOL SUCCESS & SEEKING EMPLOYMENT



You can have success in school *IF* you are able to get *YOUR* particular needs met. You may feel that it's too difficult to catch up or you might have lost interest in school. While you won't always have choices to pick your classes or teachers in middle or high school, eventually you will later on, should you decide to pursue college or a vocational program.

Some people choose to get their GED instead of a high school diploma. In either case, you will have to get through required courses with one of the benefits being that you will be able to choose a course of study, which is of interest to you, whether it be in the arts, humanities, sciences, technology, or any other field.

It is never too late to define your school and vocational goals. Once you're clear on what you want, you can begin to work toward them. School and work can be satisfying and rewarding when you are working toward something you would like to do. It is critical for your future success to look at ways you can make your educational experience more worthwhile and enjoyable *in the present time.*

The materials in this module will assist with setting short-term goals for school and work. To accomplish these goals, it will be useful to remember all the skills you have learned so far, such as goal-setting, communication, and problem-solving.

REMINDER SHEET: Evaluate How You're Doing in School

Sometimes school can be challenging. Many people have subjects that come easy to them while they struggle in other areas. Grades are a big part of how people assess their school success. There are other markers of school success, too, such as playing on a school sports team, writing for the school paper, performing in the school's guitar ensemble, or having your work displayed in an art show. Becoming aware of your strengths and challenges can help you to develop a plan for school success.

Below, start thinking about your particular strengths and challenges in school. Think about grades, tests, homework, organization, planning, after-school activities, and relationships with peers and friends.

MY STRENGTHS	MY CHALLENGES

Knowing what you want to accomplish in school is also helpful. Sometimes people want to focus on short-term goals, such as getting a B in Algebra, and others might want to focus on long-term goals, like graduating. What are your goals for school?

____

____

____

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FINDING A JOB

- Make a list of what you're interested in or what you'd like to do.
  - Think of what kind of work you've done in the past. ANY experience you've had matters!
  - Think about what you're good at or places you'd LIKE to work. Examples: Computers, retail (mall), electronics, coffee shop, maintenance, server in a restaurant, car repair.

- Develop a list of contacts for job leads:
  - Talk to family members, friends, or past bosses.
  - Look for "help wanted" signs in the windows of stores or restaurants.
  - Use the Google Maps app to find businesses close to your school or home. Then, stop by or call to see if they are hiring.
  - Look online to find job postings. *What are some websites you've already heard of?*

- If you go into a store with a "help wanted" sign, ask about job openings, and get an application.
  - First, introduce yourself as someone looking for a job.
  - Ask to speak with the manager.
  - Inquire about available jobs and the interview process. Keep in mind that you might need to schedule an interview for another day.
  - Thank the manager, or whoever helped you, for their time.
  - Leave on a positive note and be polite. Remember that you could be talking to your future co-workers or boss!

- Develop a résumé that highlights your skills and experience.
  - You probably have more skills than you realize. A trusted friend or family member might be able to help you with this.
  - There is a sample format you can use in this module.

- Set goals when looking for a job.
  - Be motivated. Remember why you want to get a job.
  - Set a number of applications you want to submit each week.
  - **Follow up.** This is perhaps the most important thing to remember when you are looking for a job. Remember to check your voicemail and email daily; potential employers will contact you to set up interviews.

Sample request for an interview: *Hello, my name is ______. I would like to speak with the manager about your job openings. I'm wondering whether I could come in this afternoon at 2. Would that be convenient for you?* (If not) *When is a good time to come back?*

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WHERE DO I LOOK FOR A JOB? Some ideas to get you started…

List places close to where I live and go to school:	
❒	❒
❒	❒
❒	❒

List places where I like to shop:	
❒	❒
❒	❒
❒	❒

List places involving activities I am interested in doing, or might be related to a future career:	
❒	❒
❒	❒
❒	❒

Now, check the boxes of places you'd like to learn more about. What do you need to know to help you decide whether or not you'd like to apply?

- ____
- ____
- ____

What might be the next step?

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WRITING A RÉSUMÉ

When you apply for work, employers usually expect you to bring a résumé--a short, typed summary of your qualifications. Your résumé should draw attention to your skills and accomplishments, and motivate an employer to interview you. Look at the job posting to check what the employer seeks in terms of qualifications. If you have what the employer needs, then submit a résumé that shows you have the necessary skills to meet the criteria. Keep your résumé short and sweet. Do not list employers that you do not want a prospective employer to contact.

Many books have been written about how to write a résumé. The advice given is not always consistent. Don't let this lack of agreement get in your way. The bottom line is that there is no "perfect" résumé style or format. *The best* résumé *for* ***you*** *is one that markets your skills effectively for the type of work you want.*

Use a résumé format that brings your strongest qualifications to the employer's attention first. In other words, use a format that puts your most impressive qualifications at the beginning.

Here are a few tips:

- If you want to emphasize how you have progressed through increasingly complex and responsible positions, use a **chronological format** that lists your work experience from most to least recent.
- To emphasize the skills you have developed, use a **combination format** that groups your experience according to skill categories and then provides a brief chronological account of your background.
- If you don't have much work experience but your education is directly related to the work you are applying for, list your education first.

When you have a draft résumé prepared, ask yourself the following questions.

1. ***Is it short and to the point—preferably one page long?*** Busy employers won't take the time to sift through a lot of information.
2. ***Does it look professional and inviting to read?*** Is it printed on good quality, white or off-white, standard, business-size bond paper? Are items listed in point form? Is there a fair amount of "white space" on the page? Margins at least one inch?
3. ***Is it well organized and readable?*** Do key points and headings stand out? Is your eye drawn immediately to the information you want employers to notice first—your most relevant accomplishments and achievements?
4. ***Is the language clear, simple and concise?*** Does every statement emphasize a skill or ability? Have you eliminated unnecessary words or sentences?

5. ***Is all of the information relevant and positive?*** **Never** include anything negative. Does everything you say about your qualifications relate to the requirements of the type of work you are applying for?
6. ***Does every item start with an action verb?*** (Avoid the pronoun "I" and inexpressive phrases such as "I was responsible for . . ." or "My duties involved . . .")
7. ***Is the information accurate?*** Don't exaggerate or misrepresent yourself—most employers check. On the other hand, don't sell yourself short, either.
8. ***Are you sure there are no spelling, grammar or typing errors?*** If you are not absolutely sure, ask a friend to proofread your draft.
9. ***If you have listed your references, are they people who can verify the skills you have chosen to emphasize?*** Always find out if the people you list are willing to provide a positive reference **before** you distribute your résumé. Let them know a potential employer might be contacting them and confirm their preferred method of contact, whether it be through email or phone.

If you answered "no" even once, redo your draft. When you can confidently answer "yes" to all of the above questions, find out if other people agree with you. Show your draft to people who would give you feedback. This could be your parents, a friend who has gone through the same process, a teacher or guidance counselor at school. Accept their suggestions without argument then make up your own mind about what you will and will not change.

(Adapted from website of the Career Centre, Alberta, Canada)

RÉSUMÉS FOR HIGH SCHOOL STUDENTS: Highlighting Your Skills and Abilities

As a student, you may not think you have many job skills. You may not have held a job before, and aren't sure how to describe your abilities to employers. Developing a résumé can help you become aware of the skills you already have that might be attractive to employers.

Look at the categories below and select the ones that are most relevant to the job you are seeking. Consider, also, which categories will showcase your unique talents and strengths.

First name Last name
Address
Phone:
Email:

EDUCATION
(High School)
(Dates attended)

EXPERIENCE
(Job title, Company)
(Dates worked)
Bullet job duties

Include this format for each prior job held

INTERESTS & ACTIVITIES
(Bullet interests)

VOLUNTEER EXPERIENCE
(Bullet organizations)

COMPUTER SKILLS
Proficient with [relevant insert programs]

ACHIEVEMENTS
(Bullet specific achievements)

PERSONAL QUALITIES
(List your personal characteristics that apply to the job. Qualities including loyalty, reliability, or having a desire to learn are all positive characteristics that managers look for in a potential employee.)

REFERENCES
(List up to 3 people, how you know them, their current contact phone numbers or email addresses)

PREPARING FOR THE JOB INTERVIEW: Get Ready to Put Your Best Foot Forward

1. Decide what you will wear. What kind of impression do you want to make?
2. Figure out how you will get there and how long it might take. Plan to arrive 15 minutes early.
3. Bring 2 copies of your résumé: One for you to use as a reminder of your skills, and one for the manager interviewing you.
4. It is OK, and even expected, to be nervous. Take your time in answering questions, and remember to breathe.
5. Have some answers ready for common interview questions that managers ask. See the list below for ideas.

COMMON INTERVIEW QUESTIONS

1. Tell me about yourself.
2. Why do you want to work here?
3. What are your strengths?
4. What are your challenges?
5. Tell me about a time when you worked on a team.
6. If you had a problem with a co-worker, how would you solve it?
7. What would you do is you saw a co-worker stealing?
8. How long do you see yourself staying at this job?
9. When are you available to work?
10. When can you start if you were hired?

Often managers will ask if you have any questions. It might be helpful to think about this in advance. Some possibilities:

- What qualities are you looking for in the ideal candidate?
- What do you like most about working here?
- When do you plan to make a decision about the job?
- How will you contact me?
- What is the pay range for the position?
- What benefits are offered to employees?
- When do you want the person you hire to start?

Remember to check your email and voicemail when you are applying for jobs. You don't want to miss an important message!

JOB LEADS LOG

Company:	**Notes**
Date application submitted:	
Date of interview:	
Interviewer name:	
Follow up date to check application status:	
Outcome or next steps:	

Company:	**Notes**
Date application submitted:	
Date of interview:	
Interviewer name:	
Follow up date to check application status:	
Outcome or next steps:	

Company:	**Notes**
Date application submitted:	
Date of interview:	
Interviewer name:	
Follow up date to check application status:	
Outcome or next steps:	

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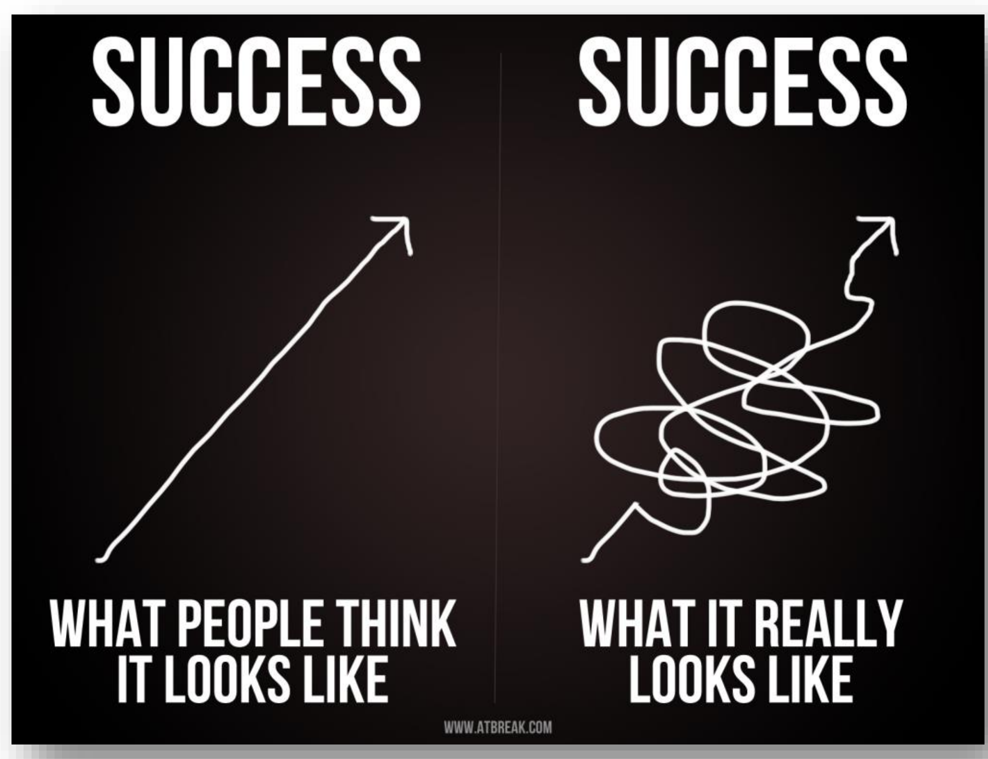
PLANNING FOR EMERGENCIES & COPING WITH A SLIP

It is not uncommon for people to have a ***slip*** (a single substance use event) once they have started working on changing their substance use. This can happen at any point along the way, not just at the beginning. Major life events and changes, such as a new job, switching schools, family problems, or health issues, can be very disruptive and might lead to either a slip or a ***relapse*** (returning to former patterns of using substances). Positive life changes, such as graduation, going away to college, or getting in a new relationship, can also make you more at risk for a *slip* or *relapse*. Keep in mind that all of the skills you are learning in therapy can prevent a full relapse if you continue to practice them.

Don't expect yourself to be perfect when it comes to changing your drug or alcohol use. Remember to AVOID situations where substances might be present. You want to be prepared for what you might think and feel if you do have a *slip*. If a *slip* happens, you might feel guilty or ashamed. Sometimes these feelings will be covered over with an attitude of, *"I don't care".* Watch out for automatic negative thoughts, such as *"I guess I'll never change"* or "This is impossible."

Remember a few things: It might help to take one day at a time and it's *always* possible to change. These materials will help you identify high risk situations that might increase the likelihood of a *slip* and to develop an emergency plan for these situations.



REMINDER SHEET: Personal Emergency Plan for Slips

A slip is a speedbump in recovery, not a personal failure. Staying in recovery will require an all-out effort. Here are some things that can be done.

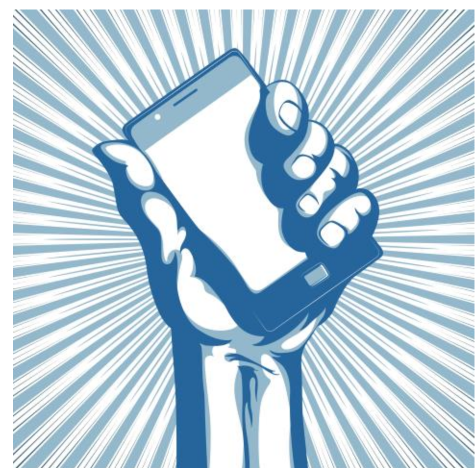
If I experience a slip:

1. I will get rid of drugs or alcohol and get away from the place where I slipped.
2. I will remember that one hit, one drink, or even one day of substance use does not have to result in a full blown relapse.
3. I will not give in to thoughts of guilt or blame because I know these thoughts will pass in time. Instead, I will view this as a temporary setback that sometimes happens when people make changes in their lives.
4. I will call for help from someone else.
5. At my next session, I will examine this slip with my counselor, discuss the events prior to my slip, and identify triggers and my reaction to them. I will explore with my therapist what I expected drinking or using to do for me. I will work with my therapist to set up a plan so that I will be able to cope with a similar situation in the future.

REMEMBER: THIS SLIP IS ONLY A TEMPORARY DETOUR ON THE ROAD TO RECOVERY.

REMINDER SHEET: Personal Emergency Plan - High-Risk Situation

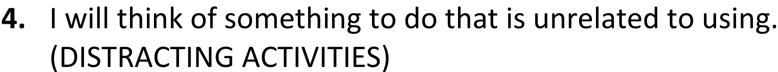
If I encounter a trigger that puts me in a high-risk situation:



1. I will leave or change the situation or environment.

2. I will put off the decision to use for 15 minutes. I will remember that most cravings are time-limited and I can get through it without using. (URGE SURFING)

3. I will challenge my thoughts about using. Do I really need to use? I will remind myself that my only true needs are for air, water, food, and shelter. (SELF-TALK)



4. I will think of something to do that is unrelated to using. (DISTRACTING ACTIVITIES)

5. I will remind myself of my successes to this point. (SELF-TALK)

6. I will contact supportive people. (TALKING IT THROUGH)

I will speak to each of these people in advance to let them know that I might call on them if I am feeling at risk for using. **I also know that I can contact someone on this list if I do have a slip to get some support.**

	Name	Best ways to contact
1	______________________________	______________________________
2	______________________________	______________________________
3	______________________________	______________________________
4	______________________________	______________________________
5	______________________________	______________________________

COMMON SITUATIONS THAT LEAD TO A SLIP OR RELAPSE:

- **Stress**: Upsetting life events, daily hassles
- **Negative emotions**: Anger, sadness, hopelessness, boredom, frustration, fear, feeling overwhelmed
- **Positive emotions**: Celebration, reward; birthdays, anniversaries and other significant life events
- **Arguments with other people** including family, friends, strangers, or co-workers
- **Social pressure**: Being offered drugs or alcohol at a party or school, or being with friends who are using
- **Using other substances**: Using one substance can trigger cravings for another or impair your ability to make decisions
- **Being around drugs**: Being close to the sights, smells, paraphernalia, people, or places associated with substance use can bring on strong cravings

Reference: *NIDA Clinical Report Series: Relapse prevention*. 1994. NIH Publication No. 94-3845

➥ List below, the skills you will continue to use in your recovery. Think about successful ways you have changed your substance use and other areas of your life.

- List three High Risk Situations. Anticipating helps you plan to avoid or deal with them. Think about specific people, places, situations, and negative thoughts.

  1. ____________________
  2. ____________________
  3. ____________________

- What **positive benefits** have you noticed since making changes in your life?

  - ____________________
  - ____________________
  - ____________________

- What specific **self-talk** will you use? Consider statements that remind you of the positive benefits of not using, the negative consequences of using, and your overall progress.

  - ____________________
  - ____________________
  - ____________________

- What **positive prosocial activities** will you do to have fun and relieve stress?

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- ______________________________
- ______________________________
- ______________________________

- What **productive activities** will you engage in to make progress in your life? Think about work, school, or other useful activities.
  - ______________________________
  - ______________________________
  - ______________________________

- Which **people** in your life will support your recovery and help you to make good decisions?
  - ____________________
  - ____________________
  - ____________________
  - ____________________

- What else will help you to be successful? Think of things that are specific to you, and could include taking medication, continuing in therapy, attending sober support meetings, or other activities that support your positive development.
  - ______________________________
  - ______________________________
  - ______________________________

Now try out your plan.
Be flexible.
Adjust it as you learn what works for you.

FUNCTIONAL ANALYSIS FOR SUBSTANCE USE BEHAVIOR (RELAPSE VERSION)

EXTERNAL TRIGGERS	INTERNAL TRIGGERS	SUBSTANCE-USING BEHAVIOR	POSITIVE CONSEQUENCES	NEGATIVE CONSEQUENCES
1. **Who** were you with when you used? **2.** **Where** were you when you used? **3.** **When** did you use? **4.** What **things** were around when you used? (music, paraphernalia)?	**1.** What were you **thinking** about right before you used? **2.** What were you **feeling physically** right before you used? **3.** What were you **feeling emotionally** right before you used?	**1.** **What** substances did you use? **2.** **How much** did you use? **3.** Over **how long** a period of time did you use?	**1.** What did you like about using drugs or alcohol with ___________________? (who) **2.** What did you like about using substances ______________________? (where) **3.** What did you like about using drugs or alcohol ______________________? (when) **5.** What were some of the <u>pleasant thoughts</u> you had while you were using? **6.** What were some of the pleasant <u>physical feelings</u> you had while you were using? **7.** What were some of the pleasant <u>emotional feelings</u> you had while you were using?	What were the negative results of your drug or alcohol use in each of the areas below? **a.** Family members **b.** Friends **c.** Physical feelings **d.** Emotional feelings **e.** Legal situations **f.** School situations **g.** Job situations **h.** Financial situations **i.** Unprotected sex (e.g. unwanted pregnancy, HIV/STDs) **j.** Victim or perpetrator of violence (e.g. date rape, sexual assault, unwanted sex, theft) **k.** Other situations

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SEEMINGLY IRRELEVANT DECISIONS: PLANNING AHEAD

It’s often the small decisions (*seemingly irrelevant or unimportant decisions*) that can lead us into high risk situations. Sometimes it seems like things just happen to us. When we look closer, we start to notice how a chain of decisions, or indecisions, bring us closer to situations we are trying to avoid—like using.

Each decision is like a link in a chain; some are weak and others are strong. Think about how you spend your free time on the weekend. If you plan things to do, instead of waiting for friends to invite you to do something, you end up feeling less bored and having more fun. ***Planning in advance is the key***. Below you will see the difference between planning and just letting things happen:

STRONG LINKS usually involve planned events:

WEAK LINKS tend to involve unplanned events:

Planning ahead is not always easy, especially if you don’t have transportation or are short on money. You can start by thinking through every choice you have to make by planning ahead. For example, when faced with a decision, choose the *low-risk option*. If, for some reason you choose a *high-risk option* (like a place where you know people will be drinking and using*)*, be prepared by reviewing all of your skills for recovery. It may feel awkward at first to have to consider everything so carefully, but it will give you increased control over your life, including your recovery.

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REMINDER SHEET and PRACTICE EXERCISE: Making Good Decisions

When making any decision, large or small:

- Consider all of your options.
- Think ahead to the possible outcomes of each option. What positive or negative consequences can you anticipate? What are the risks of relapse?
- Select one of the options: Choose the one that will minimize your relapse risk. If you decide to choose a “weak link” option, plan how to protect yourself while in the high risk situation.

Practice Exercise

Think about a decision you are about to make or a goal you want to achieve. The decision or goal could involve any aspect of your life, such as your job, recreational activities, friends, or family. For example, you might want to decide how to spend time with a friend you’ve smoked marijuana with before without using together. A weak link could be going to the friend’s house when their parents are not home, and a strong link could be meeting your friend in a public place where you will be less likely to use. Identify “strong link” choices and “weak link” choices that might impact your odds of using. *Links can be thoughts, feelings, or actions.*

Decision to be made or goal to be achieved:

____

____

____

“Strong link” choices (usually involve planned events):

____

____

____

____

“Weak link” choices (usually involve unplanned events):

____

____

____

____

BE SAFE: HIV/STI PREVENTION

Sexual abstinence is the ***most*** effective way to remain uninfected from HIV. If you are sexually active, using condoms ***every*** time you have sex (vaginal or anal) is the best way to protect yourself. You can also get HIV from having unprotected oral sex. The #1 method HIV is transmitted is through exposure to HIV-infected blood. The fact sheet included in these materials will answer many questions you may have about the disease, how it is spread and how you can protect yourself. We encourage you to read this carefully.

It isn't easy to share personal information about your sexual activity, and it can be an uncomfortable topic. There is no cure for HIV/AIDS; people still die from the disease. It's important to look at what you do (or don't do) to protect yourself from this deadly disease and other STIs (sexually transmitted infections). Staying safe requires using different skills, such as assertive communication, problem-solving, and planning ahead. We will explore situations where you have taken personal risks and find good solutions to decreasing these risks in the future.

FACTS ABOUT HIV

What is HIV?
The **H**uman **I**mmunodeficiency **V**irus kills your body's "CD4 cells". CD4 cells help your body fight off infection and disease. You can have HIV without having AIDS. HIV progresses into AIDS over time; treatment with effective medications can slow the progression.

What is AIDS?
The **A**cquired **I**mmune **D**eficiency **S**yndrome is a disease you get when HIV destroys your body's immune system. Your immune system helps you fight off illness. There is no cure for AIDS.

How does a person get HIV?
HIV spreads through contact with four fluids in our bodies: Blood, semen, vaginal fluid, and breast milk. HIV enters our bodies through the mucous lining of the vagina, penis, rectum, or mouth. Having unprotected sex (without a condom) ONE TIME either vaginally or anally with someone who has HIV puts you at risk. "Pulling out" before a male ejaculates poses a risk of contracting HIV as well as sharing a needle with an infected person.

You cannot get HIV:

- By working with, hugging, or being around someone who has HIV/AIDS
- From sweat, spit, closed mouth kissing, tears, clothing, drinking fountains, phones, toilet seats, sharing a meal, or insect stings/bites
- From donating blood

How does this affect me?
Young people ages 13-24 accounted for **1 in 4 new HIV infections** in 2010, making them one of the most at-risk groups for getting HIV**.** Most do not know they are infected, are not receiving treatment, and can unknowingly pass the virus on to others (www.cdc.gov/hiv).

How can I make sure I don't get HIV/AIDS?

- Abstinence from sexual activity is the safest and most effective way to avoid getting HIV.
- If you are sexually active, use a condom **every time.** You can get HIV from having unprotected sex ONCE. You cannot tell if someone has HIV by the way they look. Have the discussion with your partner. Check the expiration date on the condom you use. Expired condoms risk rupture, and that can spread HIV.
- Use lubrication to prevent condom breakage. Do not use baby oil or Vasoline, as these materials quickly break down latex, and can cause the condom to break.
- Do not share needles for drug injection, steroids, vitamins, tattoos, or body piercings.
- Ask your therapist for a list of strategies you can use to reduce your risk.

Know your HIV/AIDS status: Get tested!
Your counselor can give you information for free confidential HIV testing, or connect you with a doctor who can prescribe PrEP (Pre-exposure prophylaxis), which is medication taken by people at very high risk for HIV to lower their chances of becoming infected. They can help you get medical care if you've been told you are HIV Positive. Early and effective treatment is crucial.

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HOW TO USE A CONDOM

What to look for in a condom to make sure it will work right:

1. It should be made from latex unless you are allergic to latex. Talk to your counselor if you need to identify other prevention options.
2. The date on the condom package should not have expired.
3. The condom should be in good condition; not torn, dried out, or yellowed.
4. It's best to buy condoms that are already lubricated.
5. If you add lubricant, make sure it is water-based (e.g., KY Jelly or Astroglide). Never use oil-based lubricants (e.g., Vaseline, cooking oil, baby oil, hand lotion).

The steps to correctly putting on a condom are:

1. Before you open the condom package, move the condom inside the package to the side, so you don't tear the condom when you open the package.
2. The condom is put on the man's penis when it is erect.
3. Find the side that rolls down by putting your fingers inside the condom (unless you have long fingernails or sharp rings) and put that side on top.
4. Pinch the tip of the condom to keep out air.
5. Roll the condom down the shaft, being careful of rings and fingernails.
6. Roll the condom all the way down—don't stop half way.

The steps to correctly taking off a condom are:

1. Take the condom off as soon as ejaculation has occurred, while the penis is still erect.
2. Hold the condom on the base of the penis until it is away from the other person's body so that the condom doesn't end up being left inside the partner.
3. Remove the condom carefully to avoid spilling the semen that's inside.
4. Tie the open end of the condom to avoid spilling the semen that's inside.
5. Throw away the tied condom in the trash—never reuse a condom.

EXPLORING PERSONAL RISKS: Pros and Cons for Condom Use

Sometimes it's hard to figure out exactly why we make risky decisions, such as having sex without a condom. Just like with using substances, there are "reasons" (pros and cons) that we make certain choices even if they are not good for us. The exercise below will help you identify things about condom use that you may never have considered. Putting these down on paper will help us figure out what you need to do in the future to keep yourself safe by **always using a condom** whenever you have sex.

When we think about making changes, most of us don't really consider all sides in a complete way. Instead, we often do what we "want" or avoid doing things we don't feel like doing, or just feel confused or overwhelmed and give up thinking about it at all. Thinking through the pros and cons is one way to help us make the best and safest decision. This can help us hold onto a plan in times of stress or temptation.

Things to ask yourself…

- What might get in the way of you using a condom whenever you have sex? (e.g., trouble getting/affording them, feeling uncomfortable bringing it up with a partner, thinking that you are not at risk?)
- How might your use of drugs and alcohol affect your decision to use a condom?
- What are some possible bad things that could happen if you do not use a condom?
- What are some positive things that you can think of if you use a condom every time you have sex?

PROS AND CONS OF USING A CONDOM	
PROS	*CONS*
1. Protects against HIV/AIDS/STIs	1. It's awkward to bring up the subject
2.	2.
3.	3.
4.	4.
5.	5.

Use your PROS list to help you with NEW SELF TALK. From the PROS column, circle the strongest reasons on the list for using a condom and write new self-statements:

____

____

____

BE SAFE:
PROTECT YOURSELF FROM DISEASES & UNPLANNED PREGNANCY

There are a lot of myths floating around out there about pregnancy and diseases. It can be difficult to figure out what is true and what is false. People need reliable places where they can get their questions answered. Here are some websites that might help you get some of *your* questions answered:

Centers for Disease Control: http://www.cdc.gov/std/life-stages-populations/adolescents-youngadults.htm

- Customizable HIV Risk Reduction Tool on the CDC website: https://blog.aids.gov/2015/12/new-cdc-efforts-offer-individuals-vital-information-to-reduce-personal-hiv-risk.html

Planned Parenthood: https://www.plannedparenthood.org/

National Institute on Drug Abuse: http://www.drugabuse.gov/related-topics/viral-hepatitis-very-real-consequence-substance-use

Talk to your doctor to discuss your specific concerns. The two of you can work together to discuss prevention and treatment options based on your individual needs.

If you don't have a doctor, your counselor can connect you with local organizations in your community that provide medical care.

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SAYING GOODBYE

You've gained many new tools to solve life's problems and to reach your goals. Problem-solving and decision-making will come much easier as you continue to practice. In looking back over our time together, we will have an opportunity to review what you have learned and to determine where you might need to keep working. The skills you have learned will be there when you need them for the rest of your life.

It's also important to keep reviewing your goals and adding new ones as you make progress. You can use the goal sheet included in this workbook. You probably haven't met all of your goals yet, which is fine. Write below goals you still want to meet and your next steps for each one:

	Goal:	**Next steps to take:**
1.	______________________________	____
2.	______________________________	____
3.	______________________________	____

At this time, you may feel completely ready to finish treatment, or perhaps you feel you need more help. ***One of the most important things to know in life is when you do need help.*** Together we will develop a list of signs that might signal a need for to seek additional professional help for your substance use or for other problems. These signs might include:

Examples: Dropping out of school; hanging out with using friends; increased arguments at home; a slip or relapse

1. ____

2. ____

3. ____

You want to be able to anticipate events and situations which will put you at risk for slipping back to old use patterns and for jeopardizing the other progress you have made in your life. Such circumstances may include life changes (positive or negative). Most of all, remember to highlight (and to point out to others!) all of your successes. You can build on what you started in treatment to help you achieve your future goals.

SAYING GOODBYE: Take some time to think about your experience in *Encompass©.*

1. What did you like about it?

____

____

____

2. What didn't you like about it?

____

____

____

3. How will the skills you learned help you in the future?

____

____

____

4. What are you going to do next?

____

____

____

5. What other comments do you have that might make the program better?

____

____

____

RESOURCE TRACKING SHEET

The following sheet will help you keep track of resources that you and your therapist discuss during your therapy. This sheet will help you keep track of places and people you can call or go to for support outside of therapy. You will see below the name of the organization, the contact number, and sometimes a person to contact there. You and your therapist can brainstorm ideas of what you want to say when you make this contact. If you feel uncomfortable communicating with this person(s), please let your therapist know so you can talk about what might be getting in the way (or perhaps do a role play to prepare). It is very important that you and your therapist have discussed a plan for what you will do after you stop seeing each other. This sheet will help you stay organized as you plan for future support.

Contact agency: ____

Contact phone number: ____

Contact name/person: ____

I called them on ___________________________ and they said _________________

____

____

Contact agency: ____

Contact phone number: ____

Contact name/person: ____

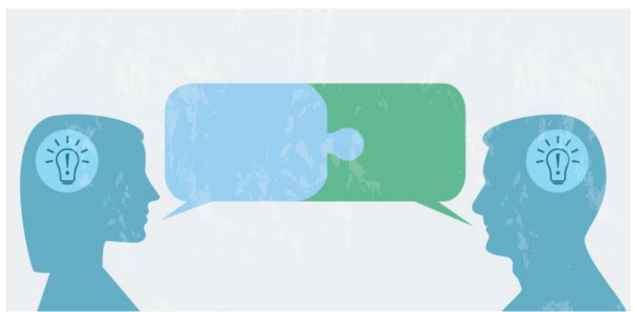
I called them on ___________________________ and they said _________________

____

____

Adapted with permission from Miller, W.R., ed. *COMBINE Monograph Series, Volume 1. Combined Behavioral Intervention Manual: A Clinical Research Guide for Therapists Treating People with Alcohol Abuse and Dependence.* DHHS Publication No. (NIH) 04-5288. Bethesda, MD: NIAAA, 2004.

BRINGING IN THE FAMILY



Including family members or significant others in therapy can be extremely helpful as you work toward your personal goals. *Encompass©* allows for up to three family sessions during the time you are in the program. We will work together to schedule them when they are most convenient for everyone.

As you learn more and more skills and start to practice them in your daily life, the people around you will start to notice some positive differences in your outlook, mood, and actions. This may not happen right away or all at once. Therefore, it's important to include family members or significant others in the process to help explain what you are working on, how they can support you, and any barriers you might be facing. We will prepare together for these sessions, just like we would with any other new skill. During each of these sessions, family members will be introduced to goal-setting, communication, and problem-solving skills.

While it may be difficult to communicate with your family about your substance use, it is worthwhile to practice this in treatment. You will have support from your therapist to explain your personal goals and your substance use—why you started, your triggers, what makes it difficult to stop, and your achievements in recovery. While you won't be required to talk about your use, we strongly encourage you to be open as it is an opportunity to rebuild trust with your family and to develop a better understanding of each other. You and your therapist can practice ways to make it easier to discuss uncomfortable topics.

FAMILY SESSIONS…

ARE FOR:

- Reviewing YOUR goals & resolving barriers
- Getting/giving constructive feedback
- Practicing successful communication
- Developing problem-solving skills to use together
- Identifying new kinds of support

ARE NOT FOR:

- Name-calling
- Shouting at each other
- Pointing out past failures
- Predicting lack of future success
- Dictating commands without discussion

If they are not already, keep in mind that family members may become very important in your support system, particularly after you finish treatment. They may have some things that they can share with you that will make it easier to meet your goals. We will explore this together.

RELATIONSHIP HAPPINESS SCALE
(Teen Version)

This scale is intended to estimate your current happiness with your relationship with your parent or caregiver in each of the areas listed below. Please circle one of the numbers (1 to 10) beside each area. Numbers toward the left end of the scale indicate various degrees of unhappiness, whereas numbers toward the right end of the scale reflect increasing levels of happiness.

Ask yourself this question as you rate each life area: "How happy am I today with my parent or caregiver in this area?" In other words, indicate according to the numerical scale (1 to 10) exactly how you feel today. Try to exclude feelings of yesterday and concentrate only on the feelings of today in each of the life areas. Also, try not to allow one category to influence the results of the other categories. If an area does not apply, please skip it.

	Unhappy									**Happy**
1. **Time spent with me**	1	2	3	4	5	6	7	8	9	10
2. **Allowance**	1	2	3	4	5	6	7	8	9	10
3. **Communication**	1	2	3	4	5	6	7	8	9	10
4. **Affection**	1	2	3	4	5	6	7	8	9	10
5. **Support of school/work**	1	2	3	4	5	6	7	8	9	10
6. **Emotional support**	1	2	3	4	5	6	7	8	9	10
7. **General happiness**	1	2	3	4	5	6	7	8	9	10

(Adapted from Godley, et al., 2001)

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RELATIONSHIP HAPPINESS SCALE
(Caregiver Version)

This scale is intended to estimate your current happiness with your relationship with your adolescent in each of the eight areas listed below. Please circle one of the numbers (1 to 10) beside each area. Numbers toward the left end of the scale indicate various degrees of unhappiness, whereas numbers toward the right end of the scale reflect increasing levels of happiness.

Ask yourself this question as you rate each life area: "How happy am I today with my adolescent in this area?" In other words, indicate according to the numerical scale (1 to 10) exactly how you feel today. Try to exclude feelings of yesterday and concentrate only on the feelings of today in each of the life areas. Also, try not to allow one category to influence the results of the other categories. If an area does not apply, please skip it.

	Unhappy									**Happy**
1. **Time spent with me**	1	2	3	4	5	6	7	8	9	10
2. **Household responsibilities**	1	2	3	4	5	6	7	8	9	10
3. **Communication**	1	2	3	4	5	6	7	8	9	10
4. **Affection**	1	2	3	4	5	6	7	8	9	10
5. **Job or school**	1	2	3	4	5	6	7	8	9	10
6. **Emotional support**	1	2	3	4	5	6	7	8	9	10
7. **General happiness**	1	2	3	4	5	6	7	8	9	10

(Adapted from Godley, et al., 2001)

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MIRRORING EXERCISE FOR UNDERSTANDING

When we are talking with another person, sometimes we can be so focused on what *we're* going to say next, that we miss an opportunity to understand the other person's perspective. This is especially challenging if we have strong reactions to the conversation topic. The exercise below asks you to mirror, or repeat back, what you heard the person say before sharing your own thoughts and opinions. The goal is for both people to understand each other's position so that everyone feels heard.

Listen carefully to what is being said; take notes if it will help you.

Repeat back what you heard using eye contact in a calm manner.

Ask the other person if you were accurate in summarizing what they said.

If not, ask the other person to repeat the points you missed.

Repeat those points back to the other person.

Then, say what makes sense to you about what the other person said, and state what you think they are feeling.

Next, switch roles to give the other person has a chance to practice.

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FAMILY GOAL SETTING SHEET

I would like to change this one thing in the family/our relationship. (Use **RELATIONSHIP HAPPINESS SCALE** to help you choose a goal):

____

____

____

The reasons I want this to change are:

____

____

____

The steps I could take immediately toward my goal are:

____

____

____

I would like ___________________________ to help by:
(teen or caregiver's name)

____

____

☼ ☼ ☼

This week I did these things toward my goal:

____

____

____

This week I noticed that _________________________ did these positive things:
(teen or caregiver's name)

____

____

____

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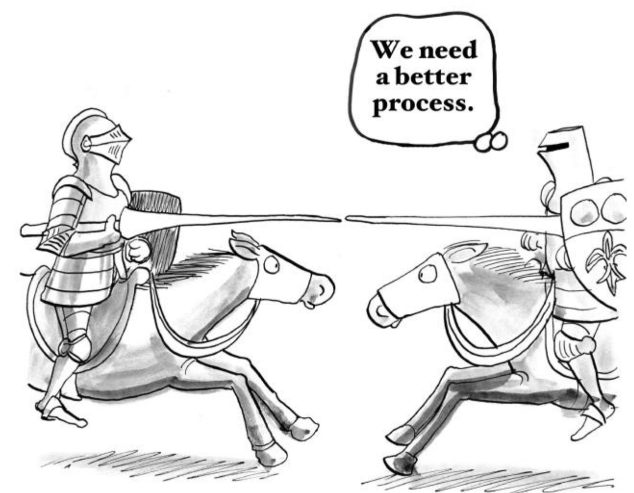
FAIR FIGHT RULES

Fights should be held in order to REACH A SOLUTION not to gain a victory. When done effectively, airing conflict can strengthen relationships, as both people can make changes to accommodate one another.

You cannot refuse a fight. If something is important enough to one person, it is worth fighting over.



The basic outline of a fight should be:

- Each person listens to the other's criticism. Remember to use "I statements" and to include a specific request.
- Suggest and discuss alternatives together. Use brainstorming skills.
- After discussing the options, choose a solution that is agreeable to both people.

DON'T CRITICIZE. You may state constructive criticism about BEHAVIOR; not about the person's character, values, or personality.

> *Example*: "I was angry when I came home to find that you hadn't emptied the dishwasher. We agreed that I would load it and you would empty it."

Fight about ONE THING AT A TIME.

DON'T PLAY ARCHEOLOGIST. Fight about your present gripe. DON'T dig things out of the past.

DON'T MAKE SPEECHES. State your gripe, and then let the other person respond.

DON'T MINDREAD. It is impossible to know what someone is thinking, so ask instead.

NO NAME CALLING, THREATENING, OR HITTING.

No fighting about these rules!

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DATE	HOME PRACTICE DESCRIPTION
1	
2	
3	
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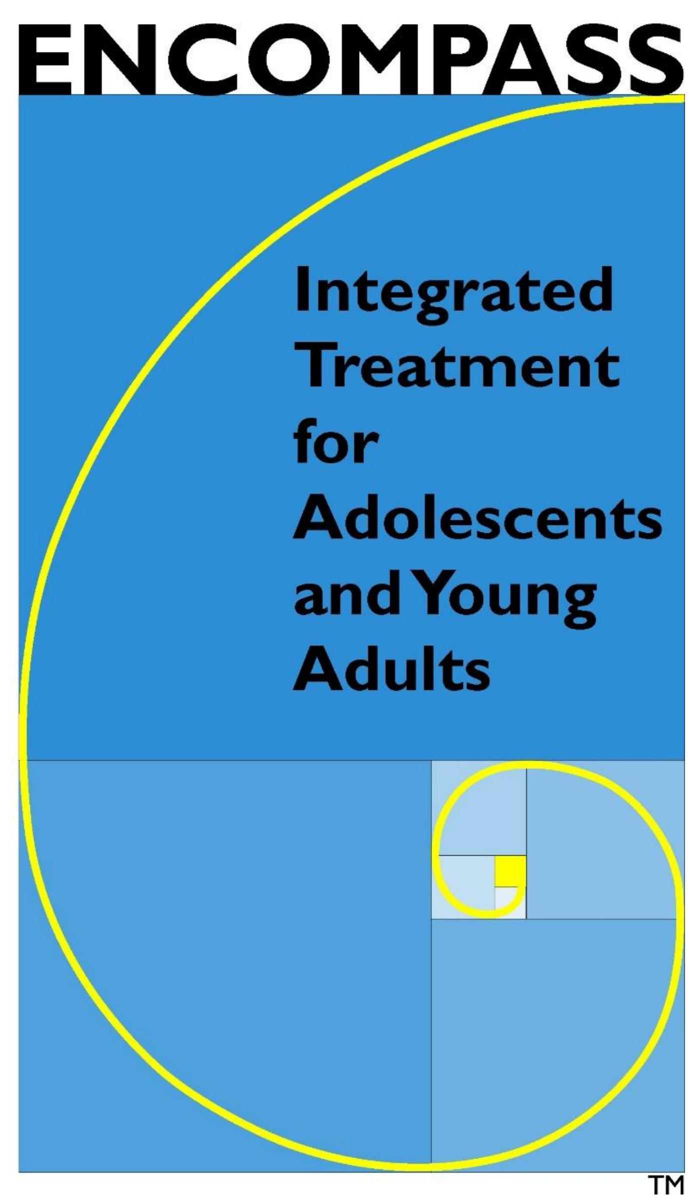
17	

CONTINGENCY MANAGEMENT/ MOTIVATIONAL INCENTIVES



Background and Procedures

Ample research shows that the addition of CM/motivational incentives increases the effect size of many psychosocial /behavioral substance treatment interventions. The history of basic principles in the use of contingency management interventions in the treatment of addictive disorders have been outlined by A.E Kazdin (1978) and were first tested scientifically by B.F Skinner (1983) and Thorndike (1998). Drug use is maintained by the effects of the substance, and use can be seen as a form of conditioned behavior. Treatment involves changing the reinforcement structure currently operating in the patient's life in which drug reinforcement is dominant to one which, in most cases, will involve the reinforcement of abstinence of behaviors that are thought to compete with drug use. The intent is to reduce and eliminate drug use through a shift in the overall reward structure of the individual's life (Bigelow et al., 1984).

Stitzer et al., 1993 demonstrated that during-treatment use of opiate and sedative drugs could be reduced by offering desirable rewards based on drug abstinence. Dr. Stephen Higgins at the University of Vermont achieved extraordinary effectiveness of reinforcement programs in helping patients curtail the use of cocaine and "crack" cocaine during the 1980's (2004). Dr. Nancy Petry's work at the University of Connecticut Health Center went on to create the "fishbowl" method of incentive delivery model which reduces the cost of reinforcing patients some, but not all, of the time, and by varying the value of reinforcements that they can receive (Petry et al., 2000). This work allowed for significant reduction in cost without corresponding loss in effectiveness, and helped make these incentive models more acceptable to community-based treatment programs.

Also in 2000, the National Institute on Drug Abuse (NIDA) formed the Clinical Trials Network. The Motivational Incentives to Enhance Drug Recovery (MIEDAR) study was conducted as a multi-site trial aimed at reducing cocaine use in patients receiving treatment in either methadone or medication-free community-based clinics. Success of this study (Pierce et al., 2006; Petry et al., 2005b) lead to the dissemination of this model through the web-based Promoting Awareness of Motivational Incentives (PAMI) of the National Addiction Technology Transfer Centers (www.nattc.org/pami).

Olmstead et al., 2007 has reviewed voucher-based and prize-based contingency management studies which indicate that prize-based CM is relatively inexpensive and effective incentive for continued attendance in treatment sessions.

Building on the work of Kazdin, 1994, Petry has identified seven core issues that all behavior modification or token economy systems need to address in terms of altering substance use behaviors (Petry et al., 2000). These are 1) target behavior; 2) the target population; 3) the type of reinforcer or incentive; 4) the magnitude or amount of incentive; 5) the frequency of the incentive distribution; 6) the timing of the distribution or the reinforcement; and 7) the duration of the reinforcement intervention.

Encompass CM/Motivational Incentives

Encompass utilizes well-established principles of behavioral reinforcement, or contingency management (CM), to reward or reinforce three behaviors:

1) treatment compliance--MET/CBT session attendance (or may require on time session attendance --within 5 minutes of scheduled appointment)—one prize draw for each session attended;

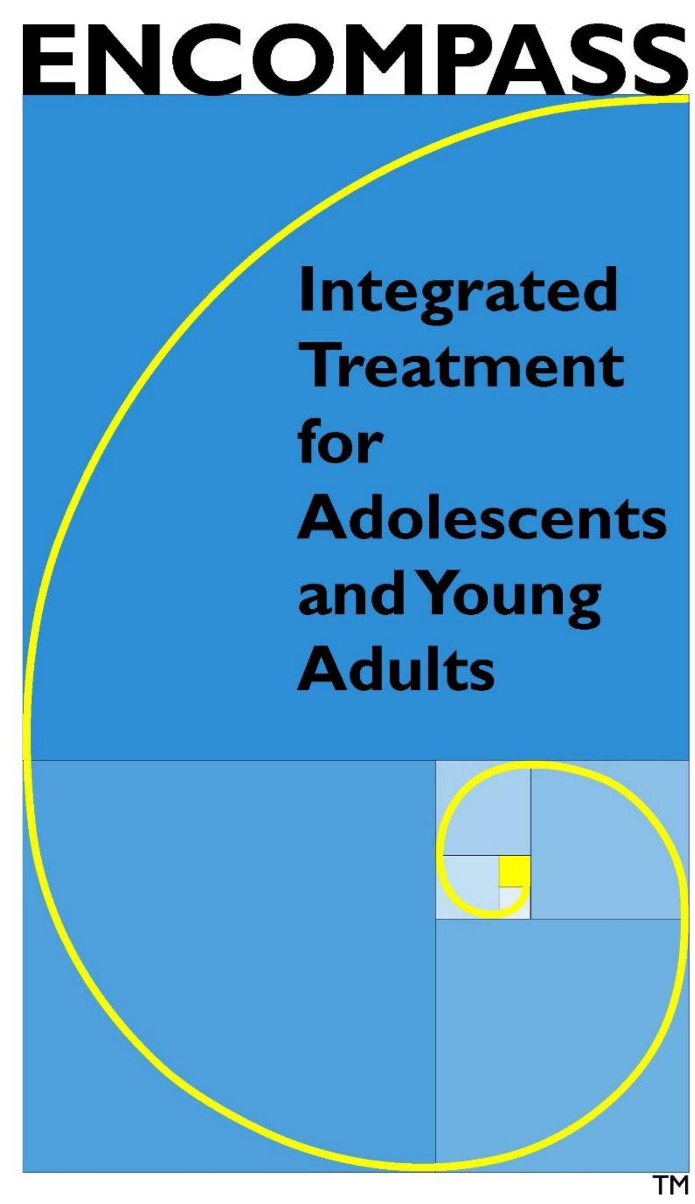
2) abstinence—one prize draw for each consecutive week of abstinence based on negative urine drug screen results collected weekly. If a patient produces a positive UDS after one or more consecutive negative UDS, prize drawings are 'reset' to zero until the next negative UDS. The patient is not able to resume prize draws for UDS results until the next negative UDS. This schedule of behavioral reinforcement is referred to as an escalating scale with resets;

3) non-drug pro-social activities—one prize draw for each of 2 activities completed (with documentation). Each week the therapist and patient negotiate and decide on two pro-social /goal-related activities (alternatives to drug use). Ideally, the activities selected should be a. enjoyable (to the patient) and/or goal-directed, b. pro-social, inconsistent or incompatible with substance use; c. enhance self-mastery/self-esteem ; d. increase patients' association with non-using peers and/or pro-social adult role models; and e. at least some of the activities selected should be those that the patient can remain involved with long term and which support a drug-free lifestyle facilitate maintaining treatment gains and sustained recovery.

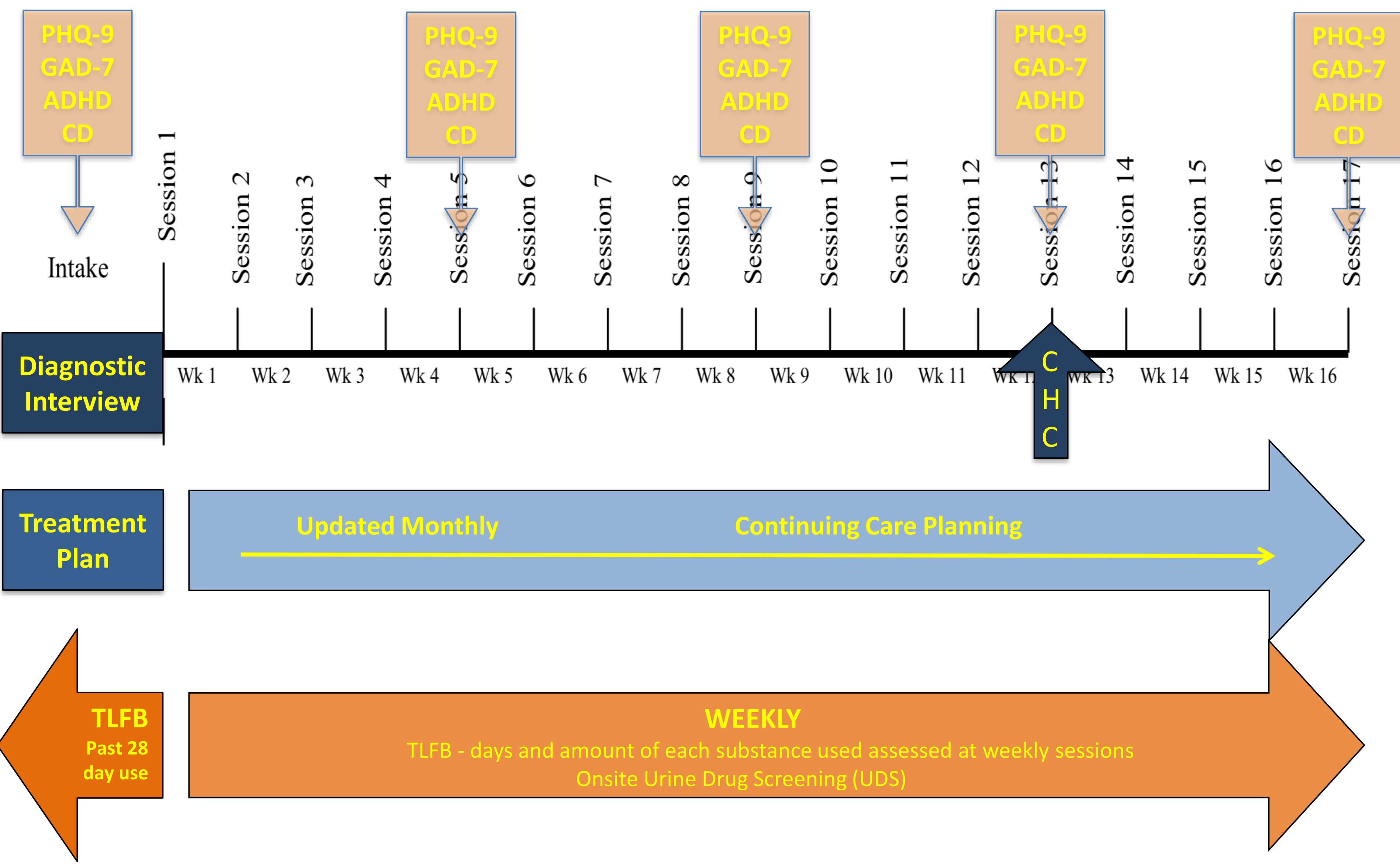
Encompass uses a variable reinforcement schedule to reinforce these behaviors, which means that patients have opportunities to draw for a prize (or a chance to win) using the "fishbowl" method, rather than automatically awarding a prize each time the specified behavior is demonstrated or documented.

Prizes used as behavioral reinforcers can be merchandise purchased in bulk from Costco or other discount stores or gift certificates (e.g. Amazon cards). Prizes should be kept in a locked cabinet or storage area with limited access by authorized clinic staff. The clinic will need to develop procedures for stocking, re-stocking, and prize inventory tracking. and re-stocking. The "fishbowl" contains 500 laminated cards or chips in the following specific ratio: 250 -- "Good Job"; 209 "Small" ($1-$3), 40 "Large" ($20-$25) and 1 "Jumbo" ($100). A small opaque covered trash bin with a swivel top works very well as a fishbowl. Whatever you use, be sure that the material is opaque and that access is restricted to a single hand reaching in for a draw. On average the total cost of incentives is about $100 per patient per 12 week *Encompass* treatment episode.

ASSESSMENTS AND REPEATED MEASURES



OVERVIEW OF ENCOMPASS



ENCOMPASS WEEKLY TEAM CALLS: Implementation Support; Case-Driven Clinical Consultation; MET/CBT Fidelity/Adherence; Data/Outcomes

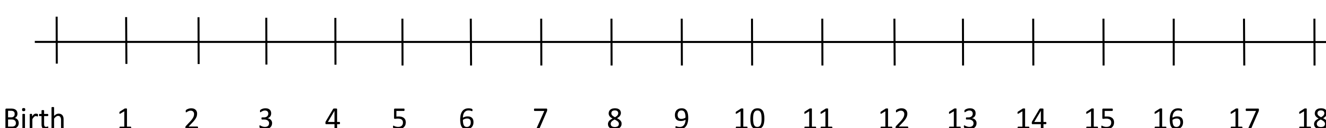
ENCOMPASS DIAGNOSTIC INTERVIEW

Instructions for Administration

The format and content of the *Encompass* history and semi-structured diagnostic interview can be flexibly modified to accommodate site-specific requirements and preferences but must still retain systematic evaluation to determine and document each patient's current SUD and psychiatric diagnoses at baseline or intake. Use of the "Lifetime Timeline" is not required, but highly recommended for clarifying the temporal relationship between the onset and progression of psychiatric symptoms and substance use. Only current SUD/psychiatric diagnoses are entered into the Encompass Data Entry Template.

Lifetime Timeline

Anchor significant events on timeline from the following life realms: (a) developmental history, including abuse/neglect or other trauma; (b) family issues, including changes in living situation; (c) school history noting significant changes in academic performance, peer affiliations, truancy, suspensions, expulsions (d) changes in peer affiliation; (e) onset and progression of psychiatric symptom severity/diagnosis (e.g. ADHD, CD, PTSD, MDD etc.); (f) onset and progression of substance use (i.e. initiation to regular to daily use) for each substance used => 5x lifetime; also note any significant periods of abstinence after initiation; SUD diagnoses(CUD, moderate; AUD, mild). Remember to assess abuse of OTC medications (e.g. cough medicine; "triple C") and non-medical use/abuse of prescription opioids/other medications.



A SAMPLE TEMPLATE FOR THE SEMI-STUCTURED DIAGNOSTIC INTERVIEW IS INCLUDED ON THE FOLLOWING PAGES.

First Name, Last init: ________________ MRN:________________ Clinician: ___________ Date: _________

II. BRIEF SEMI-STRUCTURED DSM-IV DIAGNOSTIC ASSESSMENT (ADAPTED FROM SCID)

DISORDER	Current Dx y/n	Mild	Mode-rate	Severe	Other *(e.g. seasonal, rapid cycling)*	Lifetime y/n
MOOD DISORDERS						
MDD: • 5 + of the following (must include either dep mood or anhedonia) •**dep mood => 2 wks** •tearful/sensitive •wt loss/gain •**anhedonia** •Sleep change •dec/inc appetite •irritability/agitation •energy •psychotic features •Suicidal ideations •guilt •worthless • Causes clinical significant distress/impairment in social/occupation • Not mixed episode, bereavement • Not better accounted for by schizoaffective disorder	***If yes, admin Ham-D** Ham-D score:					
Dysthymia: Depressed mood most days for **at least 2 years** (during 2 years never without sx for more than 2 months at a time) • 2 or more of the following: •poor appetite •Low self esteem •Hopelessness •Low energy/fatigue •insomnia/ hypersomnia •Poor concentration • No major depressive or manic episode or during chronic psychotic disorder, not due to substance use • Causes clinical significant distress/impairment in social/occupation	***If yes, admin Ham-D** Ham-D score:					
Depressive Disorder NOS: Clinically significant depressive sx that do not meet criteria for MDD/DD/Adjustment disorder and not better accounted for by bereavement • Not due to physiological effects of substance or medical condition	***If yes, admin Ham-D** Ham-D score:					
BIPOLAR I: •Presence of 1 manic/mixed episode and +/- major depression •Mania/manic episodes/3+ of following: •Inflated self - esteem/grandiose •Increase in goal directed activity •Pressured speech/talkative •Dec. sleep •Excessive involvement in activities w/painful consequences •Flight of ideas/racing thoughts •Not better accounted for by schizoaffective disorder, not superimposed on schizophrenia, schizophreniform disorder, delusional disorder, psychotic disorder NOS •Not due to physiological effects of medical condition or substance use						
BIPOLAR II: •At least 1 hypomania episode and presence of 1+ major depressive episode •Never had a manic or mixed episode •Hypomanic episode not due to direct physiological effects of medical condition or substance use •Not better accounted for by schizoaffective disorder						
ANXIETY DISORDERS						
Generalized Anxiety Disorder: • Excessive worry/anxiety for 6+ months with difficulty controlling the worry • Does not occur exclusively during mood, psychotic or pervasive development disorder • 3+ of following •Restlessness •Irritability •Easily fatigued •Muscle tension •Difficulty concentrating •Sleep disturbances • Anxiety not confined to features of Axis I disorder • Anxiety, worry, or physical sx cause clinically significant impairment • Disturbance not due to direct physiological effects of a substance or medical condition	***If yes, admin Ham-A** Ham-A score:					
Social Anxiety: • Marked fear/anxiety about social or performance situations when exposed to unfamiliar people or scrutiny of others • Exposure to feared social situation almost invariably provokes anxiety • Recognition that fear is excessive/unreasonable • Social situations avoided/out of proportion fear						

First Name, Last init: ________________ MRN:________________ Clinician: ____________ Date: _________

DISORDER	Current Dx y/n	Mild	Mode -rate	Severe	Other (e.g. seasonal, rapid cycling)	Lifetime y/n
Social Anxiety: (Continued) • Avoidance/distress in feared situation interferes with normal routine • Fear is not due to direct physiological effects of medical condition or substance use						
Specific Phobia: • Marked and persistent fear that is excessive cued by presence or anticipation of specific object or situation • Exposure to phobic stimulus almost invariably provokes immediate anxiety response • Recognition that fear is excessive/unreasonable • Phobic situation is avoided or endured with intense anxiety/distress • Avoidance or distress interferes significantly with person's normal routine, occupation, social activities • Not better accounted for by other mental disorder						
Panic Disorder: • Recurrent unexpected Panic attacks: Discrete period of intense fear or discomfort when 4+ of following develop abruptly and reach peak within 10 minutes • Palpitations • Sweating • Trembles/shakes • Shortness of breath • Feeling of choking • Pain in chest • Nausea • Attack followed by 1 month or more of either: • persistent concern about having additional attack • Worry about implications of attack • Significant behavior change related to attack • Not due to physiological effects of substance or medical condition • Not better accounted for by other mental disorder With agoraphobia • Anxiety about being in places/situations when escape might be difficult/embarrassing • Agoraphobic situations are avoided or endured with marked distress • Anxiety not accounted for by other illness						
OCD: Either Obsessive or Compulsive A. Obsessive • Recurrent/persistent thoughts/images • Thoughts/impulses, images not excessive worries about real-life problems • Attempts to suppress thoughts/impulse/ image or neutralize with other thought or action • Recognition that obsessive thoughts are products of own mind B. Compulsive • repetitive behaviors that feels driven to perform in response to obsession • Behavior aimed at preventing or reducing distress • Obsession/compulsion recognized as excessive or unreasonable • Obsession or compulsions cause marked distress, time consuming or interferes with normal routine • If another Axis I disorder is present, the content of the obsession or compulsion is not restricted to it • Not due to direct physiological effects of substance or medical condition						
Anxiety Disorder NOS: • Clinically significant anxiety or phobic avoidance that does not meet criteria for any specific anxiety or adjustment disorder • Example includes mixed anxiety-depressive disorder-clinically significant sx of anxiety and depression but criteria for specific mood or anxiety disorder • Clinically significant social phobic sx that are related to social impact of having a general medical condition or mental disorder • Not due to direct physiological effect of a substance or medical condition						
Adjustment Disorder: • Development of clinically signif. emotion/behavioral sx in response to stressor w/in 3 months of stressor • Symptoms are clinically significant with either • Marked distress that is in excess of what would be expected • Significant impairment in social or occupational functioning						

First Name, Last init: ________________ MRN:________________ Clinician: ____________ Date: _________

DISORDER	Current Dx y/n	Mild	Mode-rate	Severe	Other (*e.g. seasonal, rapid cycling*)	Lifetime y/n
Adjustment Disorder: (Continued) • Stress related disturbance does not met criteria of for other Axis I disorder and not exacerbation of preexisting Axis I or II disorder • Symptoms do not represent bereavement						
Post-Traumatic Stress Disorder PTSD: (If yes, admin PCL) "Sometimes things happen to people that are extremely upsetting—things like being in a life threatening situations like a major disaster, very serious accident or fire; being physically assaulted or raped; seeing another person killed or dead, or badly hurt, or hearing about something horrible that has happened to someone you are close to. At any time during your life, have any of these kinds of things happened to you?	Brief Description: ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________				Date: Mo/Yr: ____/________ ____/________ ____/________ ____/________ ____/________ ____/________ ____/________	Age: ____ ____ ____ ____ ____ ____ ____

Post-Traumatic Stress Disorder PTSD: (continued)
• Exposure to traumatic event present with following present
  • Person experience/witness/confronted with event involving threatened death/serious injury to self or others
  • Response involves intense fear, helplessness, horror
• Re-experienced in 1+ ways:
  • recurrent and distressing recollections of event (image, thoughts, perceptions)
  • recurrent dreams of event
  • acting or feeling event recurrently
  • intense psychological distress at exposure of internal/external cues
  • physiological reactivity on exposure to internal/external cues
• Persistent avoidance of stimuli associated with event, as indicated by 3+ of following:
  • avoid thoughts, feelings or conversations associated with event
  • avoid activities, places or people that arouse recollection of trauma
  • inability to recall important aspects
  • Diminished interest or participation in significant activities
  • Feelings of detachment or estrangement from others
  • Restricted range of affect
  • Sense of foreshortened future
• Persistent symptoms of increased arousal (not present before trauma) as indicated by 2+ of following:
  • Difficulty falling or staying asleep
  • Irritability or outburst of anger
  • Difficulty concentrating
  • Hyper-vigilance
  • Exaggerated startle response
• Duration of disturbance lasts more than 1 month
• Disturbance cause clinically significant impairment in social, occupational or other important areas of functioning
	***If yes, admin PCL**
	
	PCL score:					

PSYCHOTIC DISORDERS						

Brief Psychotic Disorder:
• Presence of one+ of following
  • Delusions
  • Disorganized speech
  • Hallucinations
  • Grossly disorganized or catatonic behavior
• Duration at least 1 day but less than 1 month and not better accounted for as mood disorder with psychotic features, schizophrenia, schizoaffective disorder
• Not due to the direct physiological effects of a substance or medical condition						

Schizophrenia:
• 2+ present for significant period of time during
• 1 month period impacting work, interpersonal relations or self-care
  • Delusions
  • Disorganized speech
  • Hallucinations
  • Grossly disorganized or catatonic behavior
  • Negative sx-affective flattening, alogia, or avolition
• Duration 6+ months with 1 month of above sx
• Exclude schizoaffective and mood disorder, exclude substance use or medical induced						

Schizoaffective Disorder: • Uninterrupted period of illness which either Major depressive episode, manic episode, mixed episode was concurrent with symptoms of schizophrenia						

First Name, Last init: ________________ MRN:______________ Clinician: ___________ Date: ________

DISORDER	Current Dx y/n	Mild	Mode-rate	Severe	Other (e.g. seasonal, rapid cycling)	Lifetime y/n
Schizoaffective Disorder: (Continued) • During same period, delusions or hallucinations for at least 2 weeks in absence of prominent mood symptoms • Symptoms that meet criteria for mood episode are present for substantial portion of total duration of illness • Disturbance not due to direct physiological effects of a substance or medical condition						
Delusional: • Non-bizarre delusions for at least 1 month involving situations that occur in real life, such as being followed, poisoned, infected, loved at distance, deceived by spouse, having disease • Criteria for Schizophrenia not met • Apart from delusions, functioning not markedly impaired/not obviously odd • If mood episodes have occurred concurrently with delusions, total duration brief relative to duration of delusional periods • Disturbance not due to direct physiological effects of a substance or medical condition						
SOMATOFORM DISORDERS						
Somatization Disorder: • Hx of many physical complaints beginning before age 30 occurring over a period of several years resulting in treatment sought or sig. impairment in social/occupational/important areas • Each of following must be met: • 4 pain sx –Pain related to 4 different sites-head, back, joints, etc. • 2 gastrointestinal sx- Nausea, bloating, vomiting, etc. • 1 sexual sx-Sexual indifference, erectile dysfunction, irregular menses, excessive bleeding, etc. • 1 pseudo-neurological sx • Either each of the sx cannot be fully explained by known medical condition **or** when there is a related medical condition, physical complaints or resulting social or occupational impairment are in excess of expectation						
Pain Disorder: • Pain in one or more anatomical sites is predominant focus of clinical presentation and is of sufficient severity to warrant clinical attention • Pain causes clinically significant distress/impairment in social, occupational, or other important areas of functioning • Psychological factors are judged to have an important role in onset, severity, exacerbation, or maintenance of pain • Symptom or deficit is not intentionally produced or feigned • Pain is not better accounted for by a mood, anxiety or psychotic disorder						
Hypochondriasis: • Preoccupation with fears of having or had a serious disease based in misinterpretation of bodily symptom • Preoccupation persists despite medical eval/reassurance • Not of delusional intensity, not restricted to body appearance • Duration 6+months • Causes significant distress/impairment in social, occupational or other important area of functioning • Not better accounted for by GAD, Panic disorder, OCD, MDD, Separation anxiety or other somatoform disorder						
Body Dysmorphic Disorder: • Preoccupation with an imagined defect in appearance, if slight physical anomaly is present the person's concern is markedly excessive • The preoccupation causes clinically significant distress/impairment • Preoccupation is not better accounted for by another mental disorder						
EATING DISORDERS						
Anorexia: • Refusal to maintain body weight at or above minimally normal weight for age and height (weight loss leading to maintenance of body weight less than 85% of expected; failure to make expected weight gain during period of growth • Intense fear of gaining weight or becoming fat • Disturbance in way in which one's body weight is experienced/ denial of seriousness of current weight • In postmenarcheal females, Amenorrhea-absence of at least 3 consecutive menstrual cycles						

First Name, Last init: __________________ MRN:_________________ Clinician: ____________ Date: _________

DISORDER	Current Dx y/n	Mild	Mode -rate	Severe	Other (e.g. seasonal, rapid cycling)	Lifetime y/n
Bulimia Nervosa: • Recurrent episodes of binge eating, characterized by both of following: • Eating in discrete period of time an amount of food definitely larger than most would eat **and** • A sense of lack of control over eating during the episode • Recurrent inappropriate compensatory behavior in order to prevent weight gain (vomiting, laxatives, diuretics, excessive exercise) • Binge eating and inappropriate compensatory behavior both occur on avg. at least twice a week for 3 months • Self-evaluation unduly influenced by body shape/weight • The disturbance does not occur exclusively during episodes of Anorexia						
Binge Eating: Recurrent episodes with 3+ of following ▪ Eating more rapidly than normal ▪ Eating until feeling uncomfortably full ▪ Eating large amounts of food when not feeling physically hungry ▪ Eating alone because of being embarrassed by how much on eats ▪ Feeling disgusted with oneself, depressed or very guilty after over eating • Marked distress regarding binge eating • Behavior occurs on average 2+days a week for 6 months • of binge eating in the absence of regular use of inappropriate compensatory behaviors characteristic of anorexia/bulimia nervosa						

DSM-IV Attention Deficit Hyperactivity Disorder (ADHD)

(To be completed with modified SCID after AISRS is administered-AISRS on back page of packet)

---

1. AISRS score > 24? Yes/No

If NO, discontinue, no ADHD Dx

If **YES**,

a) Total number of AISRS questions 1-9 (Inattentive symptoms) with a score of 2 or 3 _______

b) Total number of AISRS questions 10-18 (Hyperactive-Impulsive symptoms) with a score of 2 or 3 _______

If ≥ 6 Inattentive symptoms, or ≥ 6 Hyperactive-Impulsive symptoms, or ≥ 6 in both, continue:

Additional ADHD Criteria:

A. Onset of at least 2 symptoms in childhood Yes/No

B. Some impairment from symptoms is present in two or more situations (school, work, home) Yes/No

C. Symptoms cause clinically significant impairment Yes/No

Meets DSM IV Diagnostic Criteria for ADHD?

(If AISRS score > 24 AND "Yes" to A-C (above)) Yes/No

Last Name, First Init: ____________________MRN: _________________ Clinician: ___________Date: _________

DSM5 SUD Screener and Diagnostic Tool

For each substances used 5+ in lifetime: mark (√)the symptom for each substance use category and then add number of √	Nic		Alc		Can		Sed/ Hyp/ Anx		Stim		Opi		Coc		Hal		Poly		Other	
C=Current/ L=Lifetime	C	L	C	L	C	L	C	L	C	L	C	L	C	L	C	L	C	L	C	L
Recurrent use in physically hazardous situations																				
Recurrent use resulting in a failure to fulfill role obligations at school/home																				
Continued use despite persistent or recurring social or interpersonal consequences																				
Tolerance a. Increase amount to achieve same effect b. Diminished effect with same amount																				
Withdrawal a. Characteristic w/d syndrome b. Substance taken to relieve or avoid w/d symptoms																				
Often taken larger amounts over longer time than intended																				
Persistent desire or unsuccessful efforts to cut down or control use																				
Spending a lot of time in activities obtaining, using, or recovering from effects of substance use																				
Important social, occupational, or recreational activities given up or reduced																				
Continued use despite recurrent physical or psychological consequences																				
Craving or strong desire to use																				

Summary SUD Dx and Severity Rating: Count √ for each drug category, need at least 2 to make a SUD diagnosis. 2-3 = Mild 4-5 = Moderate 6+ = Severe																				

Last Name, First Init: ____________________MRN: _________________ Clinician: ___________Date: _________

SCID DSM-IV Current Diagnostic Summary

Instructions: Circle Yes or No for each diagnosis

Psychiatric Disorder	**Present: Yes/No (circle one)**	**Psychiatric Disorder**	**Present: Yes/No (circle one)**
Major Depressive Disorder *	Yes/No	**Post-Traumatic Stress Disorder*****	Yes/No
Dysthymic Disorder	Yes/No	Brief Psychotic Disorder	Yes/No
Depressive Disorder NOS	Yes/No	Schizophrenia	Yes/No
Bipolar I Disorder	Yes/No	Schizoaffective Disorder	Yes/No
Bipolar II Disorder	Yes/No	Delusional Disorder	Yes/No
Generalized Anxiety Disorder **	Yes/No	Somatoform Disorder	Yes/No
Social Phobia	Yes/No	Pain Disorder	Yes/No
Specific Phobia	Yes/No	Hypochondriasis	Yes/No
Panic Disorder	Yes/No	Body Dysmorphic Disorder	Yes/No
Agoraphobia	Yes/No	Anorexia Nervosa Disorder	Yes/No
Obsessive Compulsive Disorder	Yes/No	Bulimia Nervosa Disorder	Yes/No
Anxiety Disorder NOS **	Yes/No	Binge Eating Disorder	Yes/No
Adjustment Disorder	Yes/No	**ADHD *******	Yes/No

****Administer Hamilton Rating scale for Depression***
*****Administer Hamilton Rating scale for Anxiety***
******Administer PTSD Checklist (PCL-C) for PTSD***
*******Administer AISRS for ADHD***

Substance Use Disorder	**Present: Yes/No (circle one)**	**Substance Use Disorder**	**Present: Yes/No (circle one)**
Alcohol Use Disorder	Yes/No	Cocaine Use Disorder	Yes/No
Sedative/Hypnotics/Anxiolytics Use Disorder	Yes/No	Hallucinogens/PCP Use Disorder	Yes/No
Cannabis Use Disorder	Yes/No	Poly-substance Use Disorder	Yes/No
Stimulant Use Disorder	Yes/No	Other Substance Use Disorder	Yes/No
Opioid Use Disorder	Yes/No	Nicotine Use Disorder	Yes/No

Timeline Follow Back Screenshot

Patient ID:
Baseline Date:
Visit 1 Date:

1st drug category	Cigarettes or Tobacco
Select drug category	Cannabis Smoked-Vapor
Select drug category	Alcohol
Select drug category	None
Select drug category	None
Select drug category	None
Select drug category	None
Select drug category	None

For 1st drug category: Only select tobacco, or none, if no tobacco use, start with next drug catetgory

*** Must enter a value for each endorsed drug category for each day assessed: IF no use, MUST enter a 0**

Standard Marijuana Conversion:

1 gram= 1 unit — count each dab as 1, enter dabs/day

Standard Tobacco Conversion:

1 pack =20 units, 1 cigarette=1 unit

Standard Drink Conversion: Beer/Wine

one 12 oz. beer = 1 unit
one pint/16 oz. beer = 1.3 units
40z beer= 3.4 units
one 5 oz wine= 1 unit
750 ml = 25 oz. = 6.25 units

Hard Liquor

1 oz = 1 unit
1 shot = 1.5 units
1/2 pint= 8 units
1 pint=16 units
1/5th=26 units

All Other Drug Categories Conversion:

Code if they used that day: 0= no use, 1=used

28 day pre treatment

		SUN	MON	TUE	WED	THURS	FRI	SAT
4 weeks before baseline		#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!
	Anchor points/notes							
	Cigarettes or Tobacco							
	Cannabis Smoked-Vapor							
	Alcohol							
	None							
	None							
	None							
	None							
	None							
3 weeks before baseline		#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!
	Anchor points/notes							
	Cigarettes or Tobacco							
	Cannabis Smoked-Vapor							
	Alcohol							
	None							
	None							
	None							
	None							
	None							

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING ___0___ + ______ + ______ + ______

=Total Score: ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

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GAD-7

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

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***Encompass©* DSM V ADHD Symptom Checklist (Repeated measures = Past 1 week)** Date:

Name of Rater: Participant ID:

Administered: ☐ Intake Session: ☐ 5 ☐ 9 ☐ 13 ☐ 17 Follow-up (mon): ☐ 3 ☐ 6 ☐ 9 ☐ 12 ☐ Other

SCALE		
	0	Symptom is not present
	1 Mild	Symptom present, but only noticeable by the patient, or the patient has developed a way to manage it
	2 Moderate	Symptom is present frequently and interferes with functioning
	3 Severe	Symptom occurs frequently and results in negative consequences (school failure, disciplinary actions)

SYMPTOM	SCORE	SYMPTOM	SCORE
1 Carelessness • Make a lot of mistakes in school/work • Rush through work or activities • Trouble with detailed work		10 Squirms and fidgets • Always moving your hands and feet, tapping your pencil, or playing with hair or clothing • Do people notice?	
2 Difficulty sustaining attention • Trouble paying attention in class, fun activities, sports, watching movies • Having to re-read the same passage • Taking longer than usual to finish tasks		11 Can't stay seated • Trouble staying in your seat in class, at home or work, or while watching TV or eating dinner • Have to force yourself to remain seated • Avoid places where you have to sit	
3 Doesn't listen • Others complain that you don't listen (don't respond when spoken to or when asked to do tasks • People have to repeat directions		12 Can't play or work quietly • Agitated when doing quite things on your own like reading, listening to music, or playing a board game • Need to be busy after work or on vacation	
4 No follow through • Trouble finishing things like work or chores • Leave projects half-done and start another • Trouble following complex instructions		13 Runs/climbs excessively • Feel physically restless • Feel restless inside • More agitated when you cannot exercise daily	
5 Can't organize • Trouble with time management • Need others to plan for you • Difficulty planning leading to procrastination • Trouble organizing tasks into ordered steps		14 Talks excessively • Talk a lot, all the time • People complain about your talking • Are you often louder than other people you talk to?	
6 Dislikes tasks requiring sustained mental effort • Avoid tasks that are challenging or lengthy because it's hard to stay focused • Have to force yourself to do these tasks		15 On the go, "driven by a motor" • Have a lot of energy, always have to move • Hard for you to slow down • Unable to relax	
7 Loses important items • Lose things, such as backpack, keys, phone, wallet • Constantly looking for important items		16 Blurts out answers • Answer before people finish asking a question • Say things that don't fit in the conversation • Say things without thinking	
8 Easily distractible • Easily distracted by surroundings including noise, conversation, TV, movement, clutter • Need relative isolation to get work done • Hard to get back to a task once you stop		17 Can't wait your turn • Hard to wait your turn in conversations or waiting in line • Frequently frustrated with delays • Avoid situations where you have to wait	
9 Forgetful in daily activities • Forget things in your daily routine such as chores, tests, appointments, obligations • Forget to bring things to work or school • Need to write regular reminders to yourself to do most activities or tasks		18 Intrudes or interrupts others • Talk when others are talking • Butt into other' conversations before being invited • Interrupt others' activities	
Inattention subtotal		Hyperactivity or Impulsivity subtotal	
		TOTAL SCORE (Sum subtotals)	

***Encompass©* DSM V Conduct Disorder Symptom Checklist**
(Repeated measures = Past 4 weeks)

Date:

Rater:

Participant ID:

Administered: ☐ Intake Session: ☐ 5 ☐ 9 ☐ 13 ☐ 17 Follow-up (mon): ☐ 3 ☐ 6 ☐ 9 ☐ 12 ☐ Other

	IN THE PAST 4 WEEKS HAVE YOU:	
1	Stayed out late despite parental/guardian prohibitions?	YES or NO
2	Run away from home overnight?	YES or NO
3	Been truant from school?	YES or NO
4	Often lied to obtain goods or favors, or to avoid obligations?	YES or NO
5	Initiated any fights?	YES or NO
6	Used a weapon in a fight like a bat, brick, broken bottle, or gun?	YES or NO
7	Deliberately damaged property belonging to others?	YES or NO
8	Intentionally set fires to cause damage?	YES or NO
9	Been involved in a burglary/theft/shoplifting incident (or stole WITHOUT confrontation)?	YES or NO
10	Broken into a house, building, or car?	YES or NO
11	Been physically cruel to people?	YES or NO
12	Bullied or threatened others?	YES or NO
13	Forced someone into sexual activity?	YES or NO
14	Been physically cruel to animals?	YES or NO
15	Held someone up or robbed someone WITH confrontation?	YES or NO
	TOTAL SCORE (Sum “Yes” items)	

ENCOMPASS URINE DRUG SCREENING (UDS)

Sample Collection and Validation

The *i*Cup Drug Screen is recommended for Encompass rapid-drug testing. *i*Cup Drug Screens include adulterant tests for urine sample validity. Complete information and order forms can be found at www.usscreeningsource.com/icup_drug_test.htm. Look for the iCup test kits with adulteration test strips. There are two versions of the 3-panel tests; COC, THC, mAmp ($4.75) **OR** COC, THC, OPI, and a 4-panel test which includes COC, THC, mAmp, and OPI ($5.95). Selection decisions should be informed by regional patterns of drug use, i.e., there is much higher use of opioids on the east coast, while there is a much higher use of methamphetamine in the west and southwest. Therefore, select the appropriate panels for your region. This website also includes the package insert, directions for use, and *i*Cup Accuracy data.

Coordination with Clinical Urine Testing

Judicial and other contracts may require lab certified urine testing procedures. When possible we encourage outside agencies to continue to obtain their own UDS samples and certified lab test results rather than obtaining in the context of *Encompass* treatment and asking patient to sign a third party release. *Encompass* uses an MI approach to address UDS results and to determine the number of prize drawings (rewards) patients can earn each week. The only "negative consequences" of a positive UDS is no prize draw until the patient produces a negative UDS or a "reset" to zero (prize draws) if a positive UDS breaks a consecutive sequence of negative UDS.

Sometimes, the outside lab tests will read differently than the *i*Cup results. This discrepancy may be related to different cut off values for assigning a sample positive vs. negative. In other words, some tests are simply more or less sensitive. Different tests may also screen for different metabolites of drugs. A discrepancy may also occur if samples are collected on different days, and patients used on the intervening day, or a sample became clean over an additional 24-hour period.

Because different testing procedures may produce different results, it is important that the patient (and the clinical staff) understand that for the purposes of the fishbowl incentive program, use only *i*Cup results (immediate) which cannot be released to outside agencies (e.g. probation officer) because results are non-CLIA approved.

FIDELITY AND ADHERENCE MEASURES

INDIVIDUAL THERAPY SESSION RATING SCALES: MI AND CBT

As noted, *Encompass©* combines MI, MET, and CBT. The MET/CBT Consultant will rate counselors on a scale from 1 to 5 (Low to High) in terms of how well they demonstrated each specific skill when listening to a recording. The goal is for counselors to achieve a minimum and consistent standard rating of 3 on each of the 12 items.

Below, each of the criteria listed on the *Master Treatment Adherence Checklist* are described in detail. Use these descriptions to rate yourself after each session regarding how well you exemplified each of the counselor behaviors. These counselor behaviors are the areas of focus of development and training in *Encompass©*. Narrative feedback from the MET/CBT Consultant will emphasize specific examples illustrating high levels of skill, and provide suggestions for improvement.

	MI RATING SCALE
1	**COLLABORATION BALANCED WITH AUTONOMY (The Spirit of MI):** To what extent did you foster a collaborative feeling in the conversation and reach decisions together with a sense of purposeful partnership? To what extent did you support the participant's independence about whether to make the change and how to go about it?
2	**EVOCATION:** To what extent did you encourage the participant to articulate their own motivations for change rather than attempting to inform, advise, or direct? How much did you facilitate or increase the participant's awareness and expression of they want to be in the future (personal values) by emphasizing *Change Talk*?
3	***CHANGE TALK*:** To what extent did you maintain the movement toward change by recognizing and reinforcing different types of *Change Talk* (DARNCATs)? D=Desire; A=Ability; R=Reason; N=Need; C=Commitment; A=Activation; T=Taking steps.
4	**DIRECTION:** To what extent did you navigate the conversation so that discussion of the behavior change target and/or focal problem remains largely at the center? How much did you find a "safe" route to travel in the conversation avoiding discordance or rolling with resistance from the participant?
5	**EMPATHY:** To what extent did you demonstrate an accurate understanding of the participant's thoughts and feelings through the use of reflective statements? How much did you demonstrate genuine concern and an awareness of the participant's perspectives?
6	**OARS:** To what extent did you use Open-Ended Questions, Affirmations, Reflections and Summaries to support the participant's learning process? How much did you use these strategies to explore awareness and to reinforce small or large steps in the direction of change?

CBT RATING SCALE	
1	**PREVIOUS HOME PRACTICE:** To what extent did you review the previous assignment with the participant (e.g., review of skills taught in last session and/or explore any difficulties in carrying out the assignment)? Did you give the participant an opportunity to complete the assignment during session if it was not done?
2	**PAST/FUTURE HIGH RISK SITUATIONS:** To what extent did you explore any high-risk situations the participant encountered since the last session or anticipates prior to the next session? Did you explore any specific actions that were taken to avoid or cope with the situations or formulate appropriate coping strategies for upcoming situations?
3	**AGENDA SETTING/PROVIDE RATIONALE:** To what extent did you articulate and implement a specific agenda and structure for the session (e.g., a skill to be learned and practiced) and provide a rationale to the participant for why these skills are being covered during this session?
4	**COPING SKILLS TRAINING:** To what extent did you attempt to teach, model, review, and rehearse specific skills (e.g., explaining new skill step-by-step using relevant examples from the participant's life)?
5	**PRO-SOCIAL ACTIVITIES:** To what extent did you help the participant identify pro-social activities and discuss realistic steps toward engaging in these activities? Did you review the activities that the participant chose to complete during the previous week and discuss their effectiveness in avoiding or handling *High Risk Situations*?
6	**ASSIGNING HOME PRACTICE:** To what extent did you elicit the participant's input to identify one or more specific home practice assignments? To what extent did you explain the rationale of the assignment and answer any questions from the participant?

ENCOMPASS© MET/CBT MASTER TREATMENT ADHERENCE CHECKLIST

Compliance Codes
0 – Did not attend
1 – Attended

Non-Attendance Codes
2 – Pt cancelled
3 – Pt no show
4 – Therapist vacation
5 – Therapist sick

Skill Level Rating Scale:
1 ------- 2 ------- 3 -------- 4 ------- 5
Low High

0= Not Completed 9 =Not Applicable

Key to CBT Modules (* denotes Core Modules)

1 – Engagement*
2 – PFR/Goal Setting*
3 – FA/High Risk Situations*
4 – Coping with Cravings*
5 – Communication
6 – Anger Awareness/Mgmt
7 – Negative Mood Regulation*
8 – Problem Solving
9 – Refusal Skills*
10 – Social Support*
11 – Job Seeking/Education
12 – Coping with a Slip*
13 – Seemingly Irrelevant Decisions
14 – HIV Risk
15 – Saying Goodbye*
16 – Family Session (1,2,3)
17 – Other/Emergency

CBT SESSION #	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**
Client ID: Date:																	
MODULE # (use key above):																	
COMPLIANCE CODE (0 or 1)																	
NON-ATTENDANCE CODE (codes 2-5 above)																	
Motivational Interviewing/*Family Criteria**	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL
Collaboration balanced with Autonomy/ *Explore and answer questions about tx*																	
Evocation/ *Provide specific examples of pt's progress*																	
Reflecting & Reinforcing Change Talk/ *Elicit participation in selecting topic or issue*																	
Direction/ *Involve all in practice of skills*																	
Expressing Empathy/ *Provide summary of change talk*																	
OARS/ *Develop specific at-home practice*																	
Cognitive Behavioral Therapy	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL	SL
At-home practice review																	
Agenda setting/providing rationale																	
Review and assign pro-social activities																	
Teaching and rehearsing skills																	
Past week and/or future high-risk situations																	
Assigning at-home practice																	
UDS results (e.g., THC, Coc, Meth, Amph, Opi)																	

***** Use criteria in italics ONLY for family session ratings; put line through CBT cells.

Encompass **Data Entry Template**

Patient ID	ENCOMPASS Iteration	School or Clinic-Based	Site	Court mandated?	Referral source	Medications	Scheduled Session	Age	Gender	Patient ID	ENCOMPASS Iteration
1							Intake/KSADs			2	
							Session 1				
							Session 2				
							Session 3				
							Session 4				
							Session 5				
							Session 6				
							Session 7				
							Session 8				
							Session 9				
							Session 10				
							Session 11				
							Session 12				
							Session 13				
							Session 14				
							Session 15				
							Session 16				
							Session 17				

Patient ID	ENCOMPASS Iteration	School or Clinic-Based	Site	Court mandated?	Referral source	Medications	Scheduled Session	Age	Gender	Patient ID	ENCOMPASS Iteration
							Intake/KSADs				
							Session 1				
							Session 2				
							Session 3				
							Session 4				
							Session 5				
							Session 6				
							Session 7				
							Session 8				
							Session 9				
							Session 10				
							Session 11				
							Session 12				
							Session 13				
							Session 14				
							Session 15				
							Session 16				
							Session 17				

Patient ID	ENCOMPASS Iteration	School or Clinic-Based	Site	Court mandated?	Referral source	Medications	Scheduled Session	Age	Gender	Patient ID	ENCOMPASS Iteration
							Intake/KSADs				
							Session 1				
							Session 2				
							Session 3				
							Session 4				
							Session 5				
							Session 6				
							Session 7				
							Session 8				
							Session 9				
							Session 10				
							Session 11				
							Session 12				
							Session 13				
							Session 14				
							Session 15				
							Session 16				
							Session 17				

Patient ID	ENCOMPASS Iteration	School or Clinic-Based	Site	Court mandated?	Referral source	Medications	Scheduled Session	Age	Gender	Patient ID	ENCOMPASS Iteration
2							Intake/KSADs			3	
							Session 18				
							Session 19				
							Session 20				
							Session 21				
							Session 22				
							Session 23				
							Session 24				
							Session 25				
							Session 26				
							Session 27				
							Session 28				
							Session 29				
							Session 30				
							Session 31				
							Session 32				
							Session 33				
							Session 34				