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GROUP TREATMENTS FOR ADDICTION

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— Maya Angelou

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ABOUT THE INSTRUCTOR

Dennis C. Daley, Ph.D., is a Professor of Psychiatry, and Chief of Addiction Medicine Services at Western Psychiatric Institute and Clinic (WPIC) of the University of Pittsburgh Medical Center. He oversees a large continuum of care at Addiction Medicine Services (AMS), which includes over twenty-five treatment, prevention and intervention programs, training programs for psychiatric residents, medical students and graduate students in behavioral health.

Dr. Daley has been or is currently an investigator, trainer and/or consultant on numerous research studies at WPIC sponsored by the National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism related to treatment of individuals with substance use disorders and mood disorders. He is currently a trainer and consultant on a NIDA sponsored study of bipolar substance abusers at Harvard Medical School (Roger Weiss, MD, PI). Dr. Daley and colleagues at AMS are currently involved in seven research projects. His research interests are in the areas of addiction, mood disorders and addiction, and adherence to treatment.

Group Treatment for Addiction: Current Developments in Delivery, Structure, and Recovery Support

The structured group treatment approaches described in this course — from relapse prevention groups to psychoeducational sessions on specific substances — continue to form the backbone of addiction treatment programming. What has changed is how these groups are delivered, who facilitates them, and how the evidence base has expanded to include both traditional clinical settings and newer recovery support environments. The evolution of group treatment reflects broader shifts in the field: the integration of technology, the diversification of recovery support models, and the growing recognition that evidence-based group programs require deliberate organizational support to deliver consistent outcomes.

The most significant shift in group treatment delivery since this course was written is the integration of virtual and hybrid formats. A 2025 scoping review examined models that combine in-person and virtual participants in substance use disorder group therapy and found that hybrid approaches "yield comparable results to traditional in-person therapy and outperform fully virtual formats." The review identified two primary configurations — virtual facilitator with in-person participants, and in-person facilitator with mixed attendance — and noted that successful implementation requires deliberate attention to technology access, confidentiality in home environments, and managing group dynamics across modalities (Trimble et al., 2025). For programs implementing the structured group formats described in this course, the hybrid model opens access for clients with transportation barriers, childcare responsibilities, or geographic isolation without sacrificing the group cohesion that makes in-person sessions effective. The Trimble et al. finding that hybrid formats outperform fully virtual groups is an important clinical distinction. Fully virtual groups sacrifice the embodied, in-room interpersonal dynamics that drive many of the therapeutic factors described in this course: universality, interpersonal learning, group cohesion, and the corrective recapitulation of family dynamics. The hybrid model preserves these factors for in-room participants while extending access to those who cannot attend physically. For group facilitators, this means developing new competencies in managing split-modality dynamics — ensuring that virtual participants are not relegated to passive observer status, that confidentiality is maintained across both settings, and that the group norms established in the room extend seamlessly to those joining remotely. Practically, this may require adjusting seating arrangements so that the camera captures the full room, designating moments for virtual participants to share without competing with in-person cross-talk, and establishing clear protocols for what virtual participants should do if their home environment becomes non-confidential during a session.

The feasibility of delivering structured group CBT in acute clinical settings was demonstrated in a 2023 study of 419 psychiatric inpatients with substance use disorders. Participants in a group motivational enhancement therapy combined with CBT program showed high engagement — session satisfaction ratings averaged 8.3 out of 9. Patients with opioid misuse demonstrated "greater importance and confidence to change" compared to other participants (Buckner et al., 2023). For group leaders, this finding challenges the assumption that acutely ill or multiply-diagnosed clients cannot benefit from structured group formats — the same structured approach this course describes can work even in inpatient psychiatric settings with highly complex presentations. The 8.3 out of 9 satisfaction score reported by Buckner et al. among psychiatric inpatients is clinically noteworthy because this population is often assumed to be too unstable, too cognitively impaired, or too psychiatrically symptomatic to engage meaningfully in structured group work. The data contradicts this assumption directly. The

finding that opioid misuse patients showed greater importance and confidence to change suggests that structured group formats may be particularly well-suited for individuals whose substance use is intertwined with acute psychiatric distress — precisely because the group provides structure, predictability, and peer validation during a period of clinical instability. For practitioners facilitating groups in acute settings, this supports maintaining structured, evidence-based group curricula rather than defaulting to loosely facilitated process groups when working with complex or symptomatic clients.

The recovery support landscape has expanded well beyond traditional 12-step mutual aid. A 2024 study of 122 participants in Recovery Dharma — a Buddhist-inspired mutual aid program integrating meditation and emotion regulation — found that emotion regulation difficulty was the strongest predictor of recovery capital, more influential than mindfulness or demographics. The authors concluded that "the intentional cultivation and improvements in emotion regulation skills inherent in Buddhist practices" may support long-term recovery outcomes (Wang et al., 2024). For practitioners designing group curricula as described in this course, this research supports incorporating diverse recovery frameworks — not just the 12-step model — into group programming, particularly emotion regulation and mindfulness-based approaches. The Wang et al. finding that emotion regulation difficulty was the strongest predictor of recovery capital — outweighing mindfulness, age, gender, and other demographic factors — has direct implications for group treatment design. It suggests that groups focused specifically on building emotion regulation capacity may produce broader recovery benefits than groups focused on any single substance or behavioral target. For group leaders, this does not mean abandoning substance-specific psychoeducation or relapse prevention groups. Rather, it suggests that weaving emotion regulation skill-building into existing group formats — regardless of the group's primary focus — may enhance the overall effectiveness of the treatment programming. A relapse prevention group that includes a brief emotion regulation check-in, or a psychoeducational group that explicitly connects substance use information to emotional management strategies, addresses the factor that the Wang et al. data identifies as most predictive of recovery success.

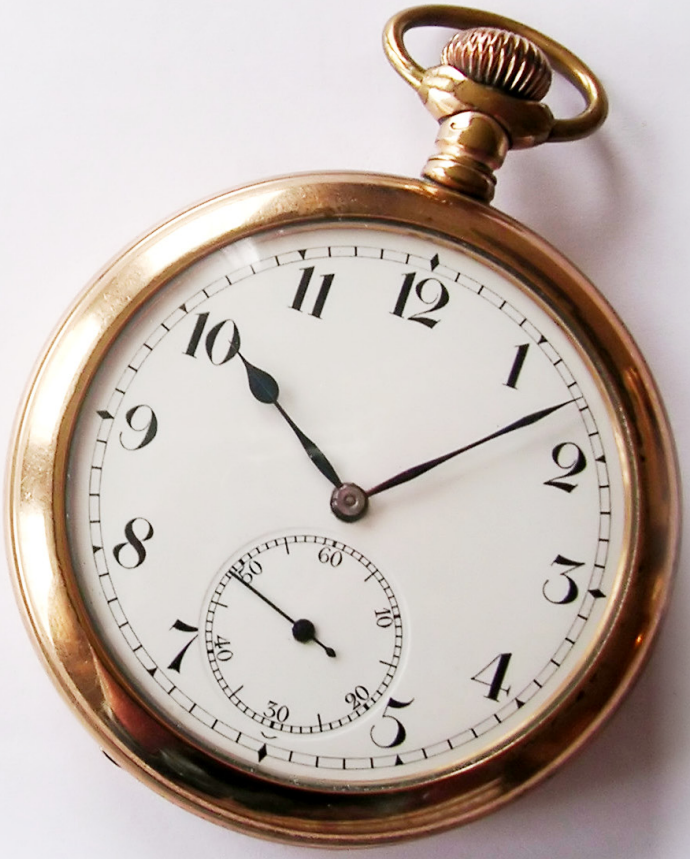
The challenge of implementing structured group programs in real-world recovery settings was documented in a 2026 study examining a three-year initiative to implement the SMART Successful Life Skills program — "a 12-session curriculum that uses a mix of behavioral tools and aspects of the social model of recovery" — across 100 rural recovery houses. The researchers identified barriers including recruitment challenges, inconsistent staffing, varying treatment approaches, technology gaps, and workforce instability. Successful implementation required diversified outreach, cooperative partnerships, resource provision, and programmatic flexibility (Ashworth et al., 2026). For treatment administrators using this course's structured group formats, the finding reinforces that evidence-based group curricula do not implement themselves — organizational infrastructure, staff training, and adaptive management are essential for translating a well-designed group protocol into consistent practice. The barriers documented by Ashworth et al. are not unique to rural recovery houses — they are present, to varying degrees, in virtually every community treatment setting. Workforce instability, in particular, poses a fundamental challenge to group treatment quality: when facilitators turn over frequently, the consistency, therapeutic alliance, and progressive skill-building that structured groups depend on are disrupted. Programs can mitigate this by investing in curriculum fidelity tools — detailed session guides, training videos, and supervision protocols — that allow new facilitators to deliver the program with reasonable consistency even without extensive prior experience.

A 2024 Cochrane systematic review of 64 randomized controlled trials with 8,241 participants confirmed that psychosocial group interventions for stimulant use disorder reduce dropout rates with

high-certainty evidence and reduce drug use frequency with high-certainty evidence, with contingency management identified as "the most extensively studied and promising approach" (Minozzi et al., 2024). For the structured group treatments described in this course, this provides the strongest available evidence that group-based interventions produce measurable clinical outcomes — particularly in retention, the prerequisite for all other treatment effects. The Minozzi et al. Cochrane review, synthesizing evidence from over 8,000 participants, provides the kind of definitive evidence base that group treatment practitioners can cite with confidence. The high-certainty finding on reduced dropout rates is especially meaningful because retention is the foundation on which all other treatment outcomes depend — a client who leaves treatment cannot benefit from the skills, insights, or peer connections that the group provides. Across all five studies reviewed here, a consistent picture emerges: group-based treatment for substance use disorders is effective, deliverable across diverse settings and formats, and responsive to the evolving needs of both clients and treatment systems. The structured approaches described in this course remain the clinical foundation — what the current evidence adds is clarity about how to adapt that foundation for hybrid delivery (Trimble et al., 2025), acute psychiatric populations (Buckner et al., 2023), diverse recovery philosophies (Wang et al., 2024), real-world implementation barriers (Ashworth et al., 2026), and the demands of evidence-based practice (Minozzi et al., 2024).

Treatment Manuals for professionals

Group treatments for addiction



counseling strategies for recovery and therapy groups

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Group Treatment for Substance Use Disorders

Table of Contents

1. Introduction to Substance Use Disorders 1
Prevalence of Substance Use Disorders
Substances of Abuse and Routes of Administration
Classification of Substance Use Disorders
Causes of Substance Use Disorders
Effects of Substance Use Disorders
Assessment Strategies
Measures to Aid in Treatment Planning and Monitoring Outcome
Evidenced-Based Treatments or Practices
Medication-Assisted Recovery for Addiction
Principles of Effective Treatment
Recovery from Substance Use Disorders

2. Overview of Group Treatments 15
Group Treatments of Substance Use Disorders
Research Basis of Group Treatments
Limitations of Group Treatment
Goals of Group Treatment
Content and Process of Groups
Orienting Clients to Groups
Adapting Groups for Co-Occurring Disorders
Measuring Outcome of Treatment

3. Training and Supervision of Group Leaders 25
Training
Supervision
Group Counseling Competencies
Use of Adherence Scales to Rate Group Interventions
Common Challenges of Group Leaders

4. Structured Recovery Groups 33
Group Format for Outpatient Settings
Group Format for Residential or Inpatient Settings
Structured Recovery Group Topics for Substance Use Disorders
Other Topics for Structured Groups
Choosing Topics for Group Sessions
Who Should Conduct Group Sessions?
Tools for Group Leaders

Documenting Group Sessions
Use of Homework Assignments with Group Members
Client Evaluation of Recovery Workbooks
Clinician Evaluation of Recovery Workbooks

5. Groups about Alcohol, Drugs, Substance Use Disorders and Addiction…51
Substance Use Disorders and Addiction
Addiction and the Brain
Overview of Substances (Alcohol and Drugs)
Alcohol and Sedatives
Cocaine and Other Stimulants
Heroin and Other Opioids
Cannabis
Nicotine
Effects of Substance Use Disorders

6. Groups about Treatment for Substance Use Disorders 75
Treatment of Substance Use Disorders
How to Get the Most Out of Treatment
Creating a Problem List and Treatment Plan

7. Groups about Recovery 83
The Process and Domains of Recovery
Stages of Change
Advantages of Recovery
People, Places, Things, Events, Holidays
Cravings and Triggers (Internal and External)
Barriers to Recovery

8. Groups about Medical and Physical Issues in Recovery 97
Medical and Physical Issues in Recovery
Withdrawal from Addictive Substances
HIV/AIDS and Substance Use Disorders
Viral Hepatitis and Substance Use Disorders

9. Groups about Psychological Issues and Psychiatric Disorders.....107
Overview of Psychological Issues in Recovery
Managing Feelings or Emotions
Anger
Anxiety and Worry
Boredom
Depression
Grief
Guilt and Shame

Sharing Positive Feelings in Recovery
Gratitude
Changing Thinking
Changing Self Defeating Behaviors
Personality Problems
Overview of Co-Occurring Disorders
Understanding Psychiatric Illness

10. Groups about Relationships in Recovery 141
Impact of Substance Use Disorders on the Family
Impact of Substance Use Disorders on Children
Refusing Substance Use Offers
Relationships in Recovery

11. Groups about Mutual Support Programs 151
How 12-Step Programs Can Aid Recovery
Step 1: Acceptance
Steps 2 and 3: Surrender
Using a Sponsor to Aid Recovery
Establishing a Recovery Support System

12. Groups about Relapse Prevention 163
Managing Relapse Warning Signs
Managing High Risk Factors
Maintaining Recovery by Using Tools in Daily Life
Setbacks: Stopping a Lapse or Relapse
Maintaining Recovery

13. Groups about Lifestyle Issues 173
Spirituality and Recovery
Financial Issues in Recovery
Non-Substance Related Addictions

14. Problem Solving or Therapy Groups 181

15. Family Groups 189

16. Appendices 193
Endnotes
References and Suggested Readings
Webpage Resources

Acknowledgements

During the past three decades I have been involved in developing and implementing numerous group treatment programs, supervising group therapists and conducting group sessions for clients with substance use disorders and co-occurring psychiatric disorders. I have also been involved in several studies as an investigator, consultant or trainer. I provided training programs to study group therapists, developed adherence scales to evaluate therapists' group interventions effectively and viewed hundreds of videotapes of treatment sessions. I also co-authored treatment manuals delineating group interventions for studies and clinical services. This work has occurred in both short and long-term programs and includes detoxification, rehabilitation, psychiatric hospital, outpatient and specialty settings. My work with group treatments has exposed me to a diversity of clients with all types and combinations of substance use and psychiatric disorders.

My work with group interventions has involved close collaboration with many researchers and clinicians at Addiction Medicine Services (AMS) at Western Psychiatric Institute and Clinic of the University of Pittsburgh Medical Center and at the National Institute on Drug Abuse (NIDA). NIDA funded several studies I was involved in that included group interventions.

I am grateful to, and wish to thank many colleagues for the opportunity to work together over the years in clinical and research programs on group interventions for addiction or co-occurring disorders. These include: (1) Delinda Mercer, PhD and Gloria Carpenter, M.Ed. with whom I co-developed the Group Drug Counseling intervention and treatment manual for the NIDA funded cocaine collaborative study (see *Therapy Manual for Drug Addiction*, manual #4). (2) Antoine Douaihy, M.D., Ihsan M. Salloum, M.D. and Michael E. Thase, M.D., all of whom I worked with in providing integrated treatment programs for clients with addiction and co-occurring psychiatric disorders. (3) Frances Campbell, MSN and many other colleagues from AMS where many group programs were provided in multiple treatment settings (residential, inpatient, ambulatory and specialty programs). In AMS we have provided extensive group services to tens of thousands of clients over the years. (4) My colleagues in the Appalachian Tri-State Node of the NIDA Clinical Trials Network Project at Meridian Community Services in Ohio, Southwestern Pennsylvania Health System, House of the Crossroads, West Virginia University Department of Psychiatry, and the Center for Psychiatric and Chemical Dependency Services. (5) Colleagues in the Clinical Trials Network of NIDA who worked with me on the multi-site study of a 12-step group counseling intervention for clients with cocaine or methamphetamine addiction (especially Dennis Donovan, PhD, Harold Perl, PhD, Greg Brigham, PhD, Candice Hopkins, PhD and Stu Baker, MA).

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About this Book

This book was written to help clinicians who conduct recovery or therapy groups in treatment programs for substance use disorders or co-occurring disorders. It provides an overview of group treatments, training and supervision of clinicians, structured recovery groups, therapy or problem solving groups and family groups. It includes curriculum for over 50 topics related to substance use disorders, treatment or recovery, covering all the domains of functioning. This book is also a reference for group treatments for addiction (see endnotes, references and suggested readings and web resources).

About the Authors

Dennis C. Daley, Ph.D. is Professor of Psychiatry and Chief of Addiction Medicine Services (AMS) at Western Psychiatric Institute and Clinic (WPIC) of the University of Pittsburgh Medical Center. Dr. Daley has provided services to individuals with addiction or co-occurring disorders for over 30 years. He a researcher, consultant and trainer on many studies funded by the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism including several studies of group treatment. Dr. Daley has published many books for professionals and recovery guides for clients and families on addiction or co-occurring disorders. He and colleagues co-developed an evidenced-based group treatment for addiction and a treatment manual for clinicians (see NIDA *Therapy Manuals For Drug Addiction, Manual #4)*. His materials are used throughout the U.S. and several have been translated to foreign languages.

Antoine Douaihy, M.D. is Associate Professor of Psychiatry, Medical Director of AMS and several clinical programs as well as an HIV clinic. Dr. Douaihy is involved in providing clinical services, teaching and research. He has many publications for professionals and individuals in recovery. Both Drs. Douaihy and Dr. Daley have worked together for many years in clinical programs, research, teaching and writing projects. They have been involved in several funded studies on the treatment of addiction.

About Daley Publications

We offer books and manuals for clinicians on treatment of addiction and co-occurring disorders. We also offer materials for clients and families in recovery such as workbooks and journals. These materials are brief, informative, user-friendly and useful for individuals with substance use disorders, psychiatric illness, and/or co-occurring disorders (psychiatric and substance use disorders combined). These materials can be used in addiction medicine, mental health programs and co-occurring disorders programs. Descriptions of materials are available on the webpage: **www.drdenniscdaley.com.**

CHAPTER 1
Introduction to Substance Use Disorders

Prevalence of Substance Use Disorders

Studies of community and clinical populations show that lifetime and current rates of substance use disorders (SUDs) are high and represent a significant public health problem in our country. The Epidemiologic Catchment Area study found a 13.7 percent lifetime prevalence of alcohol abuse or dependence and 6.1 percent of drug abuse or dependence among adults in the United States.[1] Study participants were mainly individuals in the community so prevalence rates were lower than rates found in medical, psychiatric or addiction treatment settings.

The National Comorbidity Survey found that 20 million people, or 11.3 percent of 15-54 year olds in the U.S. had a substance abuse or dependence problem within the past year.[2] Clinical studies of psychiatric clients indicate that significant numbers of clients also suffer from SUDs in addition to psychiatric disorders.[3] Hence, clients in treatment for SUDs have high rates of psychiatric disorders.

Substances of Abuse and Routes of Administration

A SUD refers to a clinical syndrome such as intoxication, withdrawal, abuse or dependence, each with specific symptoms according to the American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* DSM IV TR.[4]

Any substance may be used by individuals with SUDs. Substances of abuse or addiction include legal drugs such as prescription and over-the-counter medications as well as illicit or "street" drugs.

Types of legal substances or prescribed drugs include alcohol, nicotine, caffeine, amphetamines, certain opioids, sedatives, hypnotics and anxiolytics. Many of these are used to treatment medical or psychiatric conditions.

Types of illegal or street drugs include cannabis, cocaine, heroin, hallucinogens, inhalants and phencyclidine. While many clients abuse or are dependent on a single substance, substantial clients use and abuse multiple substances. For example, many people with opioid or cocaine dependence have problems with alcohol, anxiolytics or marijuana. Some clients mix drugs to boost the effects, others use anything or everything available without regard to what specific compound they are using or to what street drugs are "cut" with.

The effects of a substance depend on the type and amount of substance used, level of tolerance, expectations, social setting and route of administration. Substances may be taken orally (e.g.,

alcohol or pills), snorted (e.g., cocaine or heroin), smoked (e.g., marijuana or cocaine) or injected with a needle (e.g., opioids, cocaine or stimulants). Substances that are rapidly absorbed into the bloodstream through smoking, snorting or injecting have a more immediate effect than those taken orally and are more likely to lead to more intense intoxication as well as increased risk of developing a dependency on the substance. The client who ingests drugs through smoking, snorting or IV use often consumes large quantities and increases the risk of toxic effects or overdose. Rapidly acting substances such as diazepam (Valium) and alprazolam (Xanax) that produce immediate intoxication are more likely than slower-acting ones to lead to abuse or dependence.

Classification of Substance Use Disorders

Following are categories of substance-related diagnoses according to *Diagnostic and Statistical Manual of Mental Disorders*.[5]

Intoxication

This is a reversible syndrome caused by recent ingestion of a substance or exposure to certain substances. Physiological signs vary depending on the substances used and may include slurred speech, incoordination, unsteady gait, nystagmus, flushed face, and impairment in memory or attention. Behavioral or psychological signs also vary according to substances used and may include mood lability, elation, grandiosity, euphoria, dysphoria, apathy, belligerence, agitation or irritability, increased talkativeness, hypervigilance, impaired judgment, or impaired functioning at school, work, or in the family. The effects of intoxication may last hours or even longer and put the client at risk for accidents, medical problems or complications, or difficulty in any area of functioning.

Withdrawal

This is a substance-specific syndrome caused by reducing or stopping substance use that leads to significant distress or impairment. Withdrawal occurs when the client with physiological dependence stops or reduces heavy or prolonged substance use. Withdrawal symptoms vary greatly across the different classification of substances and are more easily observed or measured with certain drugs such as alcohol, opioids, and sedatives, hypnotics or anxiolytics.

1. *Symptoms of alcohol withdrawal* include coarse tremor of hands, tongue, and eyelids and one of the following symptoms: nausea and vomiting, malaise or weakness, tachycardia, sweating or elevated blood pressure, anxiety, depressed mood or irritability, or orthostatic hypotension.
2. *Symptoms of barbiturate or similarly acting sedative or hypnotic withdrawal* include three of the following: nausea and vomiting, malaise or weakness, tachycardia, sweating or elevated blood pressure, anxiety, depressed mood or irritability, orthostatic hypotension, or coarse tremor of hands, tongue, and eyelids.

3. *Symptoms of opioid withdrawal* include four of the following: lacrimination, rhinorrhea, pupillary dilation, piloerection, sweating, diarrhea, yawning, mild hypertension, tachycardia, fever and insomnia.
4. *Symptoms of stimulant withdrawal* include depressed mood, fatigue, disturbed sleep, or increased dreaming.

Substance Abuse

This involves a maladaptive pattern of substance use leading to distress or impairment with at least one of four symptoms occurring within a twelve-month period:

1. Failure to fulfill obligations at home, work or school
2. Recurrent substance use in hazardous situations, recurrent legal problems
3. Continued substance use despite the persistence of problems caused by such use.

Abuse does not include withdrawal, tolerance or compulsive use and instead refers to repeated use that includes only harmful consequences.

Substance Dependence (Addiction)

This involves a maladaptive pattern of substance use leading to distress or impairment with at least three or more of these symptoms occurring within a twelve-month period:

1. *Excessive or inappropriate use of substances (alcohol or other drugs)*: getting high or drunk and not being able to fulfill obligations at home, work or with others; feeling like substances are needed in order to fit in with others or function at work or home; driving under the influence of alcohol or other drugs.
2. *Preoccupation with getting or using substances*: living mainly to get high on alcohol or drugs; substance use becomes too important in life; being obsessed with using.
3. *Tolerance changes*: needing increased amounts of the substance to get high; or getting high much easier and with less of the substance than in the past.
4. *Withdrawal symptoms*: getting sick physically once the person cuts down or stops using (for example, having the shakes or feeling nauseous when stopping or cutting down on alcohol; having gooseflesh or a runny nose when cutting down or stopping heroin); or experiencing mental symptoms such as depression, anxiety or agitation.
5. *Difficulty cutting down or stopping once you drink or take drugs*: not being able to control how much or how often substances are used; using more alcohol or drugs than planned.
6. *Using to avoid or stop withdrawal symptoms*: using substances constantly to prevent withdrawal sickness (e.g., regular use of opioids or sedatives); drinking or using drugs in order to stop withdrawal symptoms once they've started.
7. *Using alcohol or other drugs even though they cause problems in life*: not taking a doctor's, therapist's or some other professional's advice to stop using because of problems substances have caused in life.

8. *Giving up important activities or losing friendships because of substance use:* stopping activities that once were important; giving up friends who don't get high; losing friends because of alcohol and drug use and how it affects relationships with others.
9. *Stopping use for a period of time (days, weeks or months), only to go back again*: making temporary promises to quit only to go back to getting high again; being unable to sustain abstinence.
10. *Getting into trouble because of alcohol or drug use*: losing jobs or being unable to find a job; getting arrested or having other legal problems; losing relationships or having trouble with family or friends; or having money problems.

Mood, anxiety and psychotic induced disorders

These refer to prominent psychiatric symptoms that are due to the physiological effects of substances. The acute or protracted effects of substances can cause symptoms that may remit when the client's system is free of substances. In some instances, symptoms may remit fairly rapidly where in other instances it may take several weeks or more of continuous abstinence before substance induced psychiatric symptoms remit.

Causes of Substance Use Disorders

Many physical, psychological and social or environmental factors interact to cause a SUD.[6] Addiction runs in families so some people are at higher risk than others. This is the same as it is for increased vulnerability for others illnesses like diabetes, heart disease or major depression, which also run in families.

Psychological factors contributing to SUDs include personality, coping skills, and a person's ability to manage problems and stresses. Social factors include access to substances, and the influence of family and friends.

Scientists refer to addiction (dependence) as a "brain disease" that disrupts the part of the brain responsible for experiencing normal pleasure, controlling thinking, solving problems, managing emotions and relating to others. These drugs change the brain. Addictive drugs are thought to interact with the brain's reward system. These substances provide the addicted person with "positive reinforcement," which then leads to continued use despite any problems caused by such use. Substances may become more important than "natural rewards" from eating, sex, socializing with friends, or other positive experiences or accomplishments.

Effects of Substance Use Disorders

Substance use disorders are associated with significant morbidity and mortality as affected individuals are at increased risk for medical or psychiatric disorders.[7] Such individuals are more likely to engage in high-risk behaviors such as driving under the influence, swimming alone, damaging property, provoking violent altercations, unprotected sex or multiple sexual partners,

and using or sharing needles, cotton, or rinsing water (for IV drug users). Some of the specific adverse effects on the client, family and society include: [8]

Medical

Medical and dental diseases; acquisition and transmission of HIV or sexually transmitted diseases; hepatitus; damage to the fetus and increased risk of infant mortality; sexual problems; and early death due to conditions caused or worsened by substance use, drug overdoses, vehicular accidents, industrial accidents, falls, drowning, fires, or homicide.

Psychiatric

Increased risk of psychiatric disorders, suicidality, violence, or visit to a psychiatric emergency room; or, poor adherence to treatment, which increases the risk of poor response to medications or therapy as well as psychiatric hospitalization.

Social and family

Accidents on the job, lost productivity, underemployment, unemployment, school dropout or poor performance, criminal behaviors and arrests, family and domestic violence, child abuse and neglect, family break-ups through separation or divorce, homelessness, physical and developmental disabilities of children, psychiatric or substance abuse among offspring or other family members; and lost or damaged social relationships or friendships.

Economic

Financial burden to families, employers, the government and insurance companies due to lost or reduced productivity, health care costs associated with medical or psychiatric disorders, social service costs (e.g., welfare), and costs associated with crime and the criminal justice system.

Spiritual

Feeling alienated or disconnected from others; feeling guilty and shameful about oneself; loss of faith or religious practices; or feeling a lack of meaning or direction in life.

SUDs can cause tremendous personal suffering and distress for the affected person as well as the family. While the personal, subjective experience may vary from one person to the next, it is clear that substance use disorders are associated with serious emotional and spiritual effects that cannot be adequately conveyed in data or an objective listing of problems. Books written about recovery, such as the "Big Book" of *Alcoholics Anonymous*[9] and the "Basic Text" of *Narcotics Anonymous*[10] contain a wealth of personal stories that convey the personal experiences and suffering of the person and family.

Assessment Strategies

Following is a summary of areas of assessment and methods. The American Society of Addiction Medicine's (ASAM) dimensions of functioning framework can be used to determine level of care need for a given client based on current symptoms of a substance use disorder.[11]

ASAM recommends assessing current level of intoxication and withdrawal potential, medical, psychiatric, and social functioning and problems, relapse potential and social support (recovery environment).

Client Interview

A comprehensive assessment includes a review of the following in one or more client interviews.

1. Quantity and frequency of all substances currently and previously used, methods of use (oral, smoking, intramuscular, intravenous), and preferred substance(s) of choice.
2. Changes in tolerance to specific substances (e.g., alcohol, opioids, etc.).
3. Withdrawal symptoms when the client reduces or stops use of addictive substances.
4. Medical (including dental and sexual) history to determine if there are current symptoms, diseases or viruses present (e.g., hypertension, diabetes, HIV, tuberculosis, hepatitis, etc.), past medical history, and current medications.
5. Psychiatric history to determine if there are current symptoms or disorders (e.g., mood, anxiety, psychotic, etc.) requiring monitoring or treatment, past history of treatment, and current medications.
6. Presence of obsessions and compulsions to use, attempts to cut down or to stop.
7. How the substance problem is perceived and motivation to change.
8. Negative consequences of substance use.
9. Participation in high risk behaviors (e.g., IV drug use, sharing needles or paraphernalia, unprotected sex, promiscuous sex, sex work, selling drugs, committing crimes to get money for drugs).
10. History of relapse and current potential for relapse based on motivation, current symptoms, support systems and presence of other problems.
11. Personal history: school, work, legal, interpersonal relationships, leisure interests, social support, involvement in religion or faith-based activities and financial status.
12. Family history of substance use and SUDs, medical problems or psychiatric disorders.
13. History of previous treatment attempts, adherence to treatment and outcomes.
14. Involvement in mutual support programs (AA, NA, other 12-step programs, and other mutual support programs such as Rational Recovery, SMART Recovery, Women for Sobriety, and others).

Informant or Collateral Interviews

Others (family, health care professionals, etc) can provide additional information about the client's history and functioning, and details of the substance use disorder (types and amounts used, frequency of use, effects of use, medical, psychological, social, spiritual or financial problems caused or worsened by the substance use) or history of treatment or participation in mutual support programs. Family and significant others can also play a role in the recovery

process by influencing the client to seek and comply with treatment and by providing support during recovery.

A Physical Examination and Medical History

These are used to identify medical problems that are being treated or those that need treatment. A medical exam also helps assess signs of substance intoxication or withdrawal, medical consequences of substance use, and to rule out medical problems that can complicate withdrawal for those addicted to substances. Alcohol withdrawal complications such as seizures or delirium tremens, for example, are more likely to occur in clients with compromised physical health problems.

Laboratory Tests

These help rule out the likelihood of alcohol or drug overdose. Breath alcohol levels or blood alcohol concentration (BAC) provide objective measurements of the intoxication state and the levels of tolerance. A BAC of 200-300 mg/ml in a client who shows only minor signs of intoxication indicates a high level of tolerance, and the client may be vulnerable to severe withdrawal when substances are reduced or stopped. A urine drug screen (UDS) helps identify recent drugs used by the client.

An initial test battery may include urinalysis, complete blood count with differential, blood chemistry, serology and liver enzymes. Tests such as CGT (gamma-glutamyl transferase) and mean corpuscular volume measure injury to the liver and cells that manufacture red blood cells.

Hepatitis screen and HIV testing should also be performed in high-risk groups, such as those with other drug use, especially intravenous drug users. These tests, conducted regularly and/or randomly, are also useful during treatment to monitor alcohol and other substance use.

Biological measures such as a BAC or UDS are helpful in monitoring progress during treatment episode. These should be combined with self-report measures for maximum use.

Measures to Screen and Identify Substance Problems

These measures are used to screen and identify substance problems, treatment planning and measuring progress in treatment over time. They include measures with a few questions that take a minute or two to complete to longer measures with many more questions requiring a much longer period of time. Some of these measures are completed either by clients or professionals while others are administered only by a professional.[12]

1. *Alcohol Use Disorders Identification Test (AUDIT):* this measures harmful alcohol use and consists of 10 questions that can be asked by a clinician or answered on a questionnaire by the client.
2. *CAGE Questionnaire*: this involves 4 questions asked by a clinician or completed as a self-report by the client.
3. *CRAFFT Questionnaire*: this involves 6 questions asked by a clinician or completed as a self-report by the adolescent client.

4. *Drug Abuse Screening Test (DAST):* this involves 20 or 28 questions asked by a clinician or completed as a self-report by the client to assess abuse or dependence on substances other than alcohol.
5. *Fagerstrom Test for Nicotine Dependence (FTND):* this involves 6 questions asked by a clinician or completed as a self-report by the client to assess dependence on nicotine from cigarette smoking.
6. *Michigan Alcoholism Screening Test (MAST):* there are several versions of the MAST, including one for geriatric clients. The MAST involves 10-25 questions asked by a clinician or completed as a self-report by the client to assess alcohol problems.
7. *Personal Experience Screening Questionnaire (PESQ):* this involves 40 questions completed as a self-report by the adolescent client to assess substance use problems.
8. *TWEAK Test:* this involves five questions asked by a clinician or completed as a self-report by the female client to assess current or past heavy drinking.

Measures for Treatment Planning and Monitoring Outcome

These measures help identify frequency and severity substance use, other domains of functioning, effects of the substance use disorder and motivation to change. Some can be administered in a few minutes while others such as the Addiction Severity Index (ASI) can take 45 minutes or longer (based on the version of the ASI used).[13]

1. *Addiction Severity Index (ASI):* this is a clinician administered instrument that involves 200 questions for an initial assessment or 133 questions for follow-up. It covers all the major domains of functioning and identifies the severity of problems in each domain. The ASI can also help monitor changes over time in any of these domains.
2. *Alcohol Dependence Scale (ADS):* this involves 25 questions completed by the adolescent client to identify the severity of alcohol dependence.
3. *Alcohol Expectancy Questionnaire (AEQ):* this has three versions, including one for adolescents, with 68-120 questions completed by the client. It identifies effects of using alcohol.
4. *Clinical Institute Withdrawal Scale for Alcohol (CIWA-AD):* this 8 item questionnaire is administered by a clinician to assess current severity of alcohol withdrawal. Results help determine if medications are needed to manage withdrawal symptoms.
5. *Drinker Inventory of Consequences (DrInC):* this involves 50 questions completed as a self-report by the client to identify problems or consequences of alcohol use
6. *Inventory of Drug Use Consequences (InDUC):* this involves 50 questions completed as a self-report by the client to identify problems or consequences of drug use.
7. *Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES):* this involves 19 questions completed as a self-report by the client to identify readiness to change an alcohol or drug problems.
8. *Timeline Followback (TLFB):* this uses a calendar to document quantity of alcohol or drug use on a daily basis during a specified period of time (1 week or longer).

9. *University of Rhode Island Change Assessment (URICA):* this involves 32 questions asked by a clinician or completed as a self-report by the client to identify stages of change for alcohol, illicit drug or nicotine problems.

In addition to these measures, there are many other measures that can be used to assess quality of life, satisfaction with treatment, involvement in 12-Step mutual support programs, or assess specific problems or symptoms such as anxiety or depression. Some can be used as part of the initial assessment and at follow-up points in time (e.g., depression or anxiety inventories) while others like satisfaction are usually used at the end of a treatment episode. Treatment programs can easily adapt questionnaires in quality improvement initiatives. Always keep in mind client burden when determining what measures to use with your clients.

Evidenced-Based Treatments or Practices (EBTs or EBPs)

Many evidenced-based psychosocial[13] and medication treatments[14] (EBTs, also called evidenced-based practices or EBPs) are available for substance use disorders. An EBT refers to a treatment tested scientifically in a randomized clinical trial in which an experimental condition is compared to a control condition (a comparison treatment or treatment-as-usual, TAU). When results show that the experimental condition is statistically superior to the control or TAU condition, the treatment has an evidence-base. EBTs are based on single site and/or multi-site clinical trials sponsored by the National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA) or other funding sources such as a foundation, pharmaceutical company, local or state government agency, or other source.[15]

Current day practice requires that clinicians integrate EBTs into their clinical practices. Many of these EBTs are described in treatment manuals available from NIAAA or NIDA.[14] In addition, SAMHSA has published many *Treatment Improvement Protocols* that describe EBTs (see webpages at end of this book for specific websites of NIDA, NIAAA and SAMHSA). Additional information about EBTs is available in the major textbooks on addiction published by the American Psychiatric Association, the American Psychological Association, and the American Society on Addiction Medicine. Other publishers (e.g., Hazelden, Oxford University Press, Guilford Press and others) also have books on pharmacologic, psychosocial, and combined EBTs for addiction. Hence, there is considerable clinical literature, much based on scientific studies, to inform providers who work with clients with SUDs.

Medication Assisted Recovery for Addiction

Medications are used for several purposes in treating addiction.[16] They can help clients safely and comfortably withdraw from addictive substances such as alcohol, opioids or sedatives, be used as replacement medications or help reduce cravings and severity of relapses.

Medications used for detoxification under the supervision of a physician depend on the type and severity of the addiction (opioids, alcohol, sedatives). Detoxification may occur in a hospital, residential program or ambulatory setting.

Medications are used to "replace" drugs a client is addicted to such as heroin or other opioids. Methadone helps opioid addicts transfer their addiction from street or non-prescribed drugs as this drug is closely monitored by medical and counseling staff. Nicotine replacement therapy in the form of Nicorette gum, NicoDerm patches® or Nicotrol® nasal spray helps those addicted to smoking.

Naltrexone is used to block the euphoric effects of heroin or other opioids. Buprenorphine (Buprenex®) and Bupronoprhine/Naloxne (Suboxone®) Have both replacement and antagonist effects and help the opioid addict withdraw and stay drug-free from opioids. This drug can only be administered by physicians who are trained and certified to provide it.

For alcohol dependence, disulfiram (Antabuse) serves as an aversive therapy causing the person to get sick if he drinks alcohol with the drug in his body. Since Antabuse may stay in the system up to 7-14 days after the last dose, it "buys" the alcoholic time when struggling with a strong desire to drink with the drug in the system. Other drugs like naltrexone (ReVia®) and acamprosate (Campral®) reduce the alcoholic's craving for alcohol. Buproprion (Zyban®) reduces the smoker's craving for nicotine as well as Varenicline (Chantix®).

It is recommended that medications be used with therapy or counseling and/or participation in mutual support programs that aid recovery. Ways that clinicians can help clients related to medications include:

1. Facilitating detoxification for clients physically addicted to drugs like alcohol, sedatives or opioids.
2. Encourage the client to consider a medication if other forms of treatment have only been partially successful or failed.
3. Encourage clients addicted to alcohol or drugs to consider detoxification through medical management. This may require facilitating a referral to a program that provides detoxification.
4. Monitor and assess adherence to medications used as part of a treatment plan for an addiction.
5. Anticipate and prepare for potential negative reactions from other members of support programs if the client decides to take a medication. For example, it is best that the client be discrete regarding who is told about medications such as an AA or NA sponsor.
6. Collaborate with the prescribing physician regarding problems responding to medications or adherence to taking them as prescribed.

Principles of Effective Treatment

A research-based guide published by the National Institute on Drug Abuse delineated the following principles for effective treatment of drug use disorders.[17]

1. *No single treatment is appropriate for all individuals.* A variety of different treatments have been used successfully for both alcohol and drug abuse problems. These include individual, group, family and combined approaches, as well as medications. In a large scale, multi-site study of cocaine treatment that my research group participated in, results showed that the combination of individual and group drug counseling had the best outcomes.[18]

2. *Treatment needs to be readily available.* Helping the client access treatment in a timely manner will improve outcome. The client who has to wait for an opening before being accepted into a treatment program can be encouraged to attend a mutual support program such as Alcoholics Anonymous, Narcotics Anonymous or Cocaine Anonymous.

3. *Effective treatment addresses other needs and problems in addition to substance use.* Substance abuse or addiction is seldom the only problem that the client has. Medical, dental, sexual, family, social, legal, occupational, spiritual, and financial problems are common. While these other problems are not usually the main focus of treatment, significant medical or psychiatric symptoms require stabilization before a client can benefit from addiction treatment. Long-term recovery requires focus on other problems as well since these can impact relapse to addiction.

4. *The treatment plan must be assessed and changed continually to meet the client's changing needs.* Treatment is a "dynamic" process and the focus may shift as the client's problems and needs change. The clinician must always ensure that the addiction receives proper attention, since too much focus on "other" problems can contribute to the client's lack of focus on the importance of abstaining from substances and changing self and lifestyle.

5. *Remaining in treatment for an adequate period of time is critical for treatment effectiveness.* For many people, substance dependence is a long-term, chronic condition. While professional treatment may be limited in terms of time, the client always has the option of continuing to receive support in self-help programs such as AA, NA and others. While brief treatments have been shown to be effective with alcohol use disorders, there are no demonstrated effective brief treatments for drug abuse. Evidence shows that at least ninety days in outpatient care is needed at a minimum for the drug abusing client to benefit. [19] Therefore, one of the early important treatment goals is retaining the client in treatment.

6. *Counseling and therapy are critical components of effective treatment for addiction.* While medications are sometimes helpful for certain types of addiction, individual, group or family treatments are often needed to help the client accept the substance use disorder, address problems contributing to and resulting from the substance abuse, and learn coping skills to stay sober and make positive lifestyle changes. A common complaint heard from hundreds of clients in focus groups discussing treatment is that they believe there are inadequate opportunities for individual sessions. Group-oriented programs should integrate some individual sessions so that clients are exposed to both types of interventions.

7. *Medications are an important element of treatment for many clients, especially when combined with counseling or therapy.* As mentioned in an earlier section, medications can be used to help detoxify an addicted client, to "replace" addictive drugs (e.g., using methadone to replace heroin), or to reduce cravings to drink or use drugs.

8. *Drug abusing or dependent clients with co-morbid psychiatric disorders need to have both disorders treated in an integrated way.* Treatment that focuses only on substance abuse or psychiatric illness is often inadequate since comorbid disorders are often linked in many ways.[20] Although treatment in two systems (mental health and addiction) can be effective, the more integrated treatment can be, the greater the likelihood of success.

9. *Medical detoxification is only the first stage of treatment and by itself does little to change long-term substance use.* Detoxification simply allows the client to withdraw safely from alcohol or other drugs. It paves the way for ongoing treatment and involvement in recovery. Clients referred for detoxification should be told that this is only one aspect of treatment, and that follow-up care in a residential, partial hospital, or outpatient program is needed in order to reduce relapse risk. A major problem with clients receiving detoxification is the failure to follow through with continued care upon completion of detox. Hence, facilitating the transition to rehab or an ambulatory program should be a major focus of detox in addition to stabilizing the client medically.

10. *Treatment does not need to be voluntary to be effective.* Most people with SUDs never receive treatment. Many clients enter treatment as a result of external pressure from employers, the legal system, or family members. Once the client participates in treatment, motivation may shift from external to internal. Since treatment effectiveness is correlated with the amount of time spent in treatment, involuntary clients who have to stay in treatment over a long period of time actually are in a good position to internalize the desire to change.

11. *Possible substance use during treatment should be monitored continuously.* While the majority of clients will be honest about substance use, some will lie, minimize, or deny any use, especially if they believe there will be an adverse outcome for using substances. Regular and random use of breathlyzers or urine drug screens can be used as an objective way to monitor substance use. Caregivers should also routinely ask substance abusing clients about episodes of use, strong cravings and close calls. Persistent strong cravings and frequent close calls often signal that a particular client is at high risk for relapse.

12. *Treatment programs should assess for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and provide counseling to help clients change behaviors that place them or others at risk of infection.* These diseases are common among substance abusers, particularly those who use drugs intravenously, share needles or paraphernalia, or engage in high-risk behaviors such as unprotected sex or sex with strangers, prostitutes, or multiple partners. Both acquiring and transmitting diseases are important issues to address with clients. It is not unusual for some substance abusing clients to react fatalistically when they discover they are HIV+ and use this as an excuse not to stay

sober or change. Anger, depression, and despair are common reactions and can be addressed in therapy.

13. *Recovery is a long-term process that frequently requires multiple episodes of treatment.* For many clients, substance use disorders are chronic and life-long disorders.[21] While some clients establish and maintain long periods of continuous sobriety, many experience periods of remission followed by episodes of relapse to substance use. Therefore, many clients need to return to treatment to stabilize from periods of relapse.

Recovery from Substance Use Disorders

Recovery from addiction encompasses all areas of functioning.[22] Abstinence from drugs and alcohol is usually the main goal of treatment. Personal and lifestyle changes are necessary to improve the chances of abstinence and to reduce the risk of relapse. Most clinicians are interested in substance use, functioning and quality of life so all three of these areas are important in recovery.

Recovery can be conceptualized as a process that occurs in phases. While there are several paradigms for stages of change, one that we find helpful is the model advocated by Marlatt.[23] The first phase involves making a commitment to change. For addiction, this means the client makes an agreement to participate in treatment even if abstinence is not the accepted goal. As long as the client acknowledges there is some problem associated with substance use, some commitment can be made. In the process of treatment, clients with weak commitments to recovery will have the opportunity to reassess their situations and develop motivation to change.

The second phase of change involves modifying a specific behavior. In the case of addiction, the primary change desired is cessation of drug and alcohol use (abstinence). While some clients achieve this change relatively easily, most struggle with it and experience multiple lapses and relapses over time. Many do not achieve ongoing abstinence during their first attempt at change. This is not a sign of failure. It implies that addiction is a chronic and complicated disease for many not unlike other chronic medical or psychiatric conditions that require multiple episodes of care over time.

The third phase of recovery is maintenance or relapse prevention. This refers to maintaining behavior change over time after it is initiated. In the case of addiction, relapse prevention (RP) refers to coping strategies to help clients identify and manage warning signs of relapse and high-risk relapse factors following a period of successful sobriety. RP strategies aim to help clients integrate changes into their daily lives after formal treatment has ended.

Recovery is best viewed as a process that is not linear. Many problems and resistances occur along the way and setbacks occur (lapses or relapses). This is to be expected and is not a sign that the treatment has failed or the client has failed. Many clients benefit from the cumulative effects of treatment experiences over time. The Counselor must keep a realistic perspective on change and maintain control over personal reactions to relapses, or burn-out will likely occur or frustration and anger will be high. Counselors must keep in mind that clients ultimately make the decision on whether or not to abstain from substances and engage in a program of recovery.

Counselors can influence and facilitate this process but the responsibility to change lies within the client.

CHAPTER 2
Overview of Group Treatments

Group Treatments for Substance Use Disorders

A widely used approach for substance use disorders is group treatment.[1] Many residential, intensive outpatient and outpatient programs rely heavily on group interventions for treatment of clients with substance use disorders.

Groups provide a mechanism for clients to acquire important information on addiction and recovery, gain support from others, and explore personal issues and concerns that are common among people recovering from an addiction. Types of groups used include any of the following:

1. *Milieu groups:* used in residential or hospital settings, usually at the beginning of the treatment day to review the schedule and identify goals for the day for each client, and used at the end of the day to review how the day went for each client.

2. *Psychoeducational recovery groups:* these are topic- or problem-oriented groups that focus on specific issues common among clients with SUDs. They provide information as well as an opportunity to learn recovery skills (e.g., how to manage cravings or resist social pressures to use alcohol or other drugs).

3. *Skill groups:* these focus on learning and practicing specific cognitive, behavioral or interpersonal skills. Examples include: how to refuse substance offers, how to refute depressed or anxious thinking that can lead to relapse, how to counter thoughts of wanting to use alcohol or drugs, how to manage cravings for drugs or alcohol, or how to ask an AA or NA member to be one's sponsor.

4. *Therapy or counseling groups (also called process or problem solving groups):* these address specific problems or issues of the clients who attend the group. Often, many of the problems and issues discussed are similar to the ones discussed in other types of groups only in a more personalized way in which members self disclosure more personal details of their problems, what they think and feel.

5. *Specialized groups:* these can be groups for specific populations (e.g, women, men, clients involved in the criminal justice system, clients with co-occurring psychiatric disorders, adolescents, etc.), for specific problems (e.g., parenting, anger management, mood management, family issues or relapse prevention groups) or group using a specific model of treatment (e.g., NIDA Group Drug Counseling model, MATRIX model, Integrated Treatment of Co-Occurring Disorders, etc.).[2]

Treatment programs with a large selection of groups often use a combination of these approaches so that clients have an opportunity to learn in psychoeducational or skills groups, as well as a chance to explore personal problems in a therapy or counseling group.

Research Basis of Group Treatment

Although there are fewer clinical trials of group treatment for substance use disorders compared to individual treatments, there is evidence from literature reviews and specific multi-site and single site clinical trials that group interventions are effective in reducing substance use, improving functioning of clients and improving treatment retention and completion rates. Most of the group treatment models (e.g., NIDA's Addict Aftercare and Group Drug Counseling models; the MATRIX model, and Coping Skills Models) also combine groups with individual and/or family sessions.

Weiss and colleagues reviewed 24 prospective, treatment outcome studies evaluating the effectiveness of group therapy for substance use disorders.[3] They concluded that group therapy is as effective as individual therapy, there are few differences among types of group therapy and that additional group therapy can enhance the effectiveness of usual treatment.

In a multi-site study of 978 outpatients participating in the MATRIX Intensive Outpatient Treatment model for clients with stimulant use disorders that utilized early recovery skills groups, relapse prevention groups, social support groups and family groups, researchers found significant improvements in drug use during treatment and at the 6-month follow up period. Although the usual treatment comparison group also showed significant improvements at the 6-month follow up period, clients in the MATRIX program had more drug free urines while in treatment, and had better retention and completion rates of treatment.[4]

In a multi-site study of 478 cocaine dependent outpatients researchers compared the outcomes of clients who received 24 weekly group drug counseling (GDC) with brief case management sessions (NIDA, 2002) to three individual treatments consisting of 39 sessions over 9 months: Individual Drug Counseling (IDC, NIDA, 1999) + GDC, Cognitive-Behavioral Therapy (CBT) + GDC or Supportive-Expressive Therapy (SEP) + GDC.[5] All four treatments showed significant improvements in drug use at the one-year follow-up period. GDC was just as effective as two of the individual treatments (CBT and SEP). Treatment outcomes were significantly better for IDC combined with GDC. This study supports the efficacy of a combined group and individual approach.

Sobell and Sobell reviewed four studies and reported results of their own study that compared the same behavioral treatment delivered in a group versus an individual formal.[6] They report that all five of these studies show that both group and individual treatments are effective with no one modality being superior to the other. They also report that no one type of group treatment is superior to another. Outcomes of all these studies showed improvements from baseline to follow-up period relevant to substance use.

Although this research shows that group treatments are effective, many patients benefit from a combination of individual and group sessions as well as medication-assisted treatment. And, since some patients do not want or will not participate in group treatments, it is good to have treatment options to offer.

Limitations of Group Treatments

There are several potential problems or limitations of relying solely or primarily on group treatments. I have conducted focus groups over many years with over a thousand clients in multiple treatment locations and the biggest complaint shared by them is that programs offer limited or no individual therapy or counseling sessions, especially in residential, inpatient or intensive outpatient programs. Clients often report benefits to groups, but many believe they need individual sessions as well. In individual sessions they may self disclose and explore problems or issues they aren't comfortable talking about in groups such as exposure to trauma like sexual abuse. Therefore, clinicians should consider offering individual sessions in combination with groups and/or medications (for addiction) to maximize the effects of treatment.

Other potential limitations relate to: (1) confidentiality, especially for groups in which members know each other; (2) lack of assertiveness of group members who feel it is hard to share when other members dominate the group discussion, which leads to limited self-disclosure or decreased interest in the group sessions; and (3) high levels of social anxiety making it hard for some members to talk in groups, In a quality improvement initiative in one of my treatment programs, we administered a scale to measure symptoms of social phobia to 120 outpatients. We found that more than one-third had high rates of social anxiety and avoidant behavior. As a result, they don't talk much in group sessions, miss sessions, drop out early, and do not engage in mutual support group programs as well. [7] What these clients do is simply miss group or drop out of group programs or mutual support programs without discussing their social anxiety with their counselor or group leaders.

Advantages of Group Treatments

There are many advantages of group treatments. One of the major ones is that clients learn that they share with others many similar problems related to their addiction and recovery. They can learn to rely on peers for help and support, which reinforces the importance of recovery being a "we" rather than an "I" process. By self-disclosing thoughts, feelings and behaviors to peers, clients learn the importance of social support in ongoing recovery.

Clients learn in groups to "give" help and support to peers, which can help them feel more connected to others and less self centered. This help and support can relate to many things such as: (1) help with something practical like a ride to an AA or NA meeting; (2) emotional support such as talking with a peer when feeling bored, angry or depressed; (3) giving or getting feedback on behaviors related to recovery; and (4) suggestions on how to cope with a specific recovery challenge such as managing a strong craving to drink or dealing with a child hurt by one's addiction.

Group members with more stable recovery can often serve as "role models" for clients new to recovery. With groups of clients, counselors have the opportunity to observe clients' in an interpersonal context to better understand their behaviors. And, they have more examples of behaviors (both positive and negative) to drawn upon when discussing specific ideas or issues related to recovery. This way, they can use group members' experiences to help each other learn. Finally, providing group treatment can be cost effective.

Goals of Group Treatment

Group Treatments provide the opportunity for clients to increase their understanding of their own problems by becoming educated on addiction and recovery. Clients also gain strength and hope from each other, learn to use and benefit from social support, and begin to feel valued because they are able to help others in a mutual problem-solving process. Although specific group sessions vary in their content and focus during treatment, the general purposes of group treatment for addiction are to provide members with an opportunity to:

1. *Acquire information* about substances, substance use disorders and effects, addiction as a disease, treatment, relapse and recovery from addiction. Learning about addiction as a brain disease may help reduce stigma and shame felt by clients who judge themselves harshly for having an addiction. Learning that alcohol or marijuana use substantially increases the relapse risk for cocaine addicts may influence a client to accept total abstinence as the most realistic goal of treatment. Or, learning that medications can help recovery from alcohol or opioid problems provides clients with more treatment options.

2. *Increase self-awareness* of their own specific problems and issues in relation to addiction and recovery. Clients may learn about their own personal relapse risk factors or how their personal decisions impact on relapse (e.g., a decision to cut down or stop mutual support program involvement without discussing this decision with a counselor or sponsor).

3. *Give and receive support* from each other by providing feedback and sharing problems, successes, hope and strength. Clients learn from each others by hearing about each other's struggles and problems, and use of positive coping strategies. Acceptance, understanding and empathy are shared as well, enabling clients to feel comfortable to self-disclose in an environment in which they are not judged.

4. *Learn coping skills* to deal with problems contributing to or resulting from the addiction, to reduce the chances of a relapse to addiction and to improve functioning. Clients may learn what others have done to successfully cope with a specific problem in recovery (e.g., managing a strong craving, resisting social pressure to drink or use drugs, managing a negative mood state, dealing with an interpersonal conflict, etc.). Clients learn not only by listening and sharing, but by practicing coping skills. Groups can integrate behavioral rehearsals as well as discussions of strategies to manage a specific problem or recovery issue.

The focus on these areas may vary depending on several factors. These include: 1) the setting of the group (detoxification unit, residential program, intensive outpatient, outpatient or aftercare program; 2) the length of the group session; 3) the number of groups members can attend over a period of time; and 4) the problems and needs of clients in treatment.

Content and Process of Groups

Both the content and the process are important aspects of group treatment. *Content* refers to the "what" of group, that is, the specific topics, problems or issues discussed in the session. The specific content areas covered during the twelve sessions of Phase I are delineated in a later section of this manual. Additional topics are also included for programs that want to provide more than 12 sessions (e.g., Intensive Outpatient Programs that meet several days per week).

Process refers to the "how" or the "method" of the group and how members interact. The process is the way the group leader facilitates the group in order to take into consideration the differences among group members. Group leaders should strive to maintain a balance among the three key elements of group: the individual member, the topic or theme, and the group as a whole. The leader should protect the group process by encouraging members to be on time, participate actively in discussions, listen to each other and provide support and feedback.

Group leaders need to use a variety of interventions in conducting group treatment sessions. These interventions include:

1. Providing educational information about addiction, treatment, recovery and relapse (e.g., using recovery groups based on specific topic areas).

2. Facilitating group discussion and interaction among clients.

3. Helping members relate to the psychoeducational concepts discussed in a personal way.

4. Validating issues or struggles presented by group members.

5. Using historical information shared by group members to illustrate issues discussed.

6. Helping members understand the connection between thoughts, feelings and behaviors.

7. Modeling healthy behaviors.

8. Challenging counterproductive behaviors or attitudes.

9. Monitoring alcohol or drug use or "close calls".

10. Encouraging continuing participation in treatment, and attendance at mutual support programs such as AA, NA, CA, CMA or other non 12-step programs.

11. Motivating members to talk directly to each other when sharing their opinions, discussing experiences or providing feedback.

12. Encouraging group members to identify and practice new coping skills or recovery skills.

Leaders should encourage members of the group to participate verbally by sharing their opinions, feelings and experiences as they relate to the topic covered. While respecting the right to remain silent, leaders should draw quiet members into the discussion by asking them direct questions or seeking their opinions (e.g. *"John, what is your experience with the issue of denial,"* or, *"Madge, how do you relate to what's been discussed about relapse warning signs?* or *LeVon, what is your experience in using a sponsor in NA?"*).

Leaders should not allow a member to dominate the group discussions and should set limits as needed (e.g., *"Carlton, I appreciate the fact that you have a lot of ideas to offer the group. Let's hear ideas or experiences from some other members now to see how they relate to..."* or, *"Lisa, it's great you have so many experiences or ideas to share, but we want to make sure others get a chance to share, too."*).

Group leaders can provide positive reinforcement to the group and individual members in order to foster group cohesion and trust. Reinforcement should be given even when a member talks about a lapse or relapse (e.g., *"Luwanda, it's good that you talked to the group about your recent relapse and asked for their input. "Jason, your suggestion to the group on paying attention to hidden or covert cravings for cocaine is good. You seemed to have learned from your own experience ignoring these in the past."*).

An important factor in group sessions is feedback on members' attitudes or behaviors. When possible, the group leader should encourage other members to provide feedback to another member who shows negative attitudes or behaviors (e.g., *"Mike, what do you think about Jackie's statement that NA meetings are a waste of time,"* or, *"Liz, what do you think about Jack's statement that a few beers or a joint won't hurt, that as long as he stays clean from cocaine he'll be OK?"*). Similarly, positive feedback can be elicited in order to support efforts made by group members (e.g., *"What do others think about how Pearl was able to resist her strong urge to smoke crack?"*). Or, *"What are reactions to how well Bill did controlling his anger at his wife and resolving their argument?"*

The group leader can also provide direct feedback to an individual client or the group by simply commenting on what is observed. This type of intervention serves as a "model" for the other group members to give feedback. It also provides members of the group with an opportunity to hear the leader's perspective as it relates to an individual member (e.g., *"John, I notice that when other members give you feedback, you interrupt them or argue with them"* or, *"Mary, you did a great job talking about how your addiction really messed up your life. It takes a lot of courage to be so honest"*) or the group (*"I notice that the discussion has shifted away from the topic of relationships in recovery to..."* or, *"your group did a nice job today talking about the ways AA and NA can aid recovery."*). Or, *"It looks to me like the group doesn't want to challenge Tony on why he still smokes pot even though it interferes with his ability to work."*

There will be times in which a group member is in a state of crisis as a result of a recent lapse or relapse. The group leader can use part of the group to help this member explore the lapse/relapse in order to learn from it and develop a way to stop it. Other life problems may create crises for some group members, as well. While the group leader can adhere to the principle of "disturbance takes precedence," in Phase I, the leader must guard against spending too much time on helping individual members resolve specific crises at the expense of the psychoeducational material pertaining to recovery. A member with a serious crisis can be seen briefly by the group leader before or after group. This member should be encouraged to talk over the current crisis with the individual counselor and/or an AA or NA sponsor or friends.

Most outpatient programs, especially structured group programs admit clients continuously so that group membership can change every week. These groups with an "open" or rolling admissions policy can have clients start at any session because a single recovery topic is covered completely within each meeting. Each recovery topic can be beneficial to all clients, regardless of where they are in their own recovery process.

Attendance at groups is strongly encouraged because groups provide the support and education that facilitates recovery. Clients are informed of the rules for group attendance and participation prior to entering the group session. Clients are requested to attend all group sessions and are asked to call if they must miss a session or will be late.

The counselor should discuss attendance problems with the client and the group if this becomes a problem. This enables to counselor to find out some of the potential reasons for missing sessions as the reasons are not always related to poor motivation. For example, one client became increasingly anxious when her therapy group discussed trauma issues. This triggered off bad memories and intense feelings. Rather than share these with group, this client failed to show for the next program day. When she returned and this issue became clear to the group, it triggered a discussion on how traumatic experiences can led to strong emotional reactions and a variety of thoughts, which can impact on decisions related to attending sessions. Many reasons for missing sessions can be "grist" for the therapeutic mill and discussed in the group. For some members, failure to attend regularly is one of many examples of difficulties they have being responsible in their lives.

One program uses a "10 minute" rule in which clients who show for group more than 10 minutes after the start of the session are not allowed to join the group in progress. Although some counselors criticize this procedure, the overwhelming majority of clients endorse this and feel it protects the group process. This group rule gives the clear message that members are responsible for being on time for group sessions.

Orienting Clients to Groups

Orienting clients to group programs (e.g., an Intensive Outpatient Program) or a single group treatment (e.g., a weekly aftercare groups) can help them prepare to get the most from groups. Orientation can include a review of any of the following in addition to questions or concerns of the client or clinician. The process can also include the client signing an agreement to abide by the rules of the group program.

1. Purpose and goals of the group program or treatment group.

2. Types of group sessions and how these are conducted (e.g., structured psychoeducational recovery groups, therapy groups, family groups, specialty groups, etc). Examples of topics of structured may be provided as well as examples of problems commonly discussed in therapy or problem solving groups.
3. Logistics of groups (location and time), length of time or number of sessions client will initially agree to attend.

4. How to participate in group sessions (e.g., come prepared with completed assignments or with specific problems to discuss, be honest during check-in periods, etc.).

5. The importance of self disclosure or talking about one's experiences, thoughts, feelings, behaviors and ideas relevant to topics, issues or problems discussed in group. Some programs use a "check-in" procedure in which all members share whether they have used since last session, experienced strong cravings for alcohol or other drugs, close calls or social pressures to use substances, and other information relevant to the group (e.g., meetings attended, current mood, etc).

6. Specific rules of the group program (these may vary depending on the program or treatment setting) such as coming on time, not leaving early, not coming to group sessions under the influence of alcohol or other drugs.

7. Other issues (e.g., combining individual or family sessions, when a client could be terminated from the group program and/or referred to a higher level of care based on poor compliance with treatment, lack of progress, a relapse etc.).

Adapting Groups for Co-Occurring Disorders

Many addiction medicine programs and mental health programs offer "integrated" treatment for clients who have both a substance use and psychiatric disorder combined. A number of approaches have been developed for use with clients who have co-occurring psychiatric disorders in addition to a substance use disorder. These include group approaches that can be used with any combination of co-occurring disorders as well as those designed for a specific clinical population such as clients who have a substance use disorder and PTSD, schizophrenia or bipolar disorder.[8]

Measuring Outcome of Treatment[9]

The primary outcome measure in the treatment of alcohol or drug addiction relates to substance use. While the ideal outcome is ongoing, continuous abstinence from all drugs and alcohol, any significant reduction of substance use can be seen as a positive outcome and evidence that treatment is effective. For example, if a polysubstance dependent client reduces drug or alcohol intake by 70% during the course of treatment and experiences periods of sustained abstinence with some periods of brief lapses or relapses, significant progress has been made. If an IV using

client stops using heroin and cocaine, or stops ingesting drugs with needles, this is a positive outcome even if this client still uses substances such as marijuana or alcohol. If a client with alcohol dependence who drank heavily on a daily basis drinks only a few days each month, this also is indicative of movement in the right direction. In addition, any reduction of harmful effects of substance use can be viewed as a positive outcome. This includes resolution or reduction of medical, family, psychological, interpersonal, social, leisure, legal, occupational, academic, spiritual, or financial problems.

Outcome on substance use can be documented by client self-report, collateral report (e.g., family members), administration of structured interviews such as the Addiction Severity Index urine drug screen (UDS) or alcohol breathalyzer. While at times there may be a discrepancy between objective measures such as UDS and client self-report, clients who attend treatment voluntarily are usually truthful about their lapses or relapses. Clients mandated to attend treatment by the courts or an employer and who are threatened with severe consequences for a positive urine (e.g., loss of job, jail time) may not report lapses or relapses due to fear of negative consequences.

Other ways of measuring outcome include evaluating compliance with treatment sessions, completion rates for the various phases of treatment, "active" involvement in mutual support programs (e.g., attending meetings, getting a sponsor, working the 12-steps, calling AA or NA members, using program slogans or literature, or attending program sponsored events such as holiday meals or celebrations), reduction of depression or anxiety symptoms, or reduction of use of more intensive levels of care such as detoxification or rehabilitation programs. Clinic logs, client interviews or brief questionnaires (e.g., anxiety, depression, 12-step involvement, etc.) can be used to document non-substance use outcomes such as attendance and adherence patterns, mood symptoms or involvement in 12-Step recovery programs.

CHAPTER 3
Training and Supervision of Group Leaders

Training

Training of group leaders is important to the success of group programs in the treatment of substance use disorders or co-occurring psychiatric disorders. I have consulted with or evaluated many treatment programs and found that training in conducting group sessions was often limited, and in some cases lacking. In some treatment programs staff were expected to conduct groups if they knew the "content or topic" or "disorder" of the clients in treatment regardless of their training in group treatment. This is not good clinical practice and puts clinicians in a situation that can be uncomfortable and for which they may not be qualified.

A variety of training strategies can be used but all group leaders should have access to training, supervision and consultation on conducting groups. Training strategies include:

1. Attending clinical workshops that cover the basics of conducting groups. This is best done in person although on-line group courses are available. It is good to learn one model of group treatment before expanding and using other models.

2. Observing more experienced clinicians conduct groups, then processing the experience after the group sessions end.

3. Co-leading groups with experienced clinicians, taking a secondary role in order to become comfortable in groups.

4. Co-leading groups with experienced clinicians, taking the lead role in the group.

5. Leading groups without a co-leader. You can have a supervisor or peer sit in group on occasion to observe you and provided feedback on how you are conducting groups.

6. Taping group sessions and reviewing the session with a supervisor or consultant. This strategies is much more time consuming than other strategies but can be very helpful as the observer of the group can make suggestions that may otherwise not be made during the group leader's verbal presentation of conducting a group session.

7. Use adherence scales for self-rating of groups, then reviewing these with a supervisor or consultant.

8. Reading a specific manual or book on group treatment of substance use disorders.

I recently conducted a survey of 80 addiction professionals on their experiences and opinions of group treatment. [1] This survey included questions on the types of groups they conduct, hours of formal training in specific models of group treatment, satisfaction with training received in group treatment, degree of comfort and competence in conducting groups using specific evidenced-based models of treatment, how often they observed or co-led groups with experienced clinicians, how often they receive clinical supervision that focused specifically on group treatment and level of satisfaction with their clinical supervision. Models of group treatment for which clinicians received the most hours of formal training were integrated treatment of co-occurring disorders, relapse prevention, coping skills training, twelve-step facilitation therapy, MATRIX model for stimulant addiction, NIDA Group Drug Counseling model, and NIDA addict aftercare and recovery training model. The fact that the highest number of training hours received were on the two areas of co-occurring psychiatric disorders and relapse prevention suggests that clinicians are increasing their knowledge and skills to address two of the most common issues and challenges in addiction treatment--providing care to clients with substance use disorders who also have mental health problems, and incorporating strategies to reduce relapse given the high rates of relapse and working with clients who engage in multiple treatment episodes.

Preferred Methods of Training

Participants of this survey rated the following methods of learning in order of importance (more than one method could be endorsed).

1. Watching experienced group leaders conduct groups in person or on video (67.1%).
2. Practicing group interventions (60.3%).
3. Reading group manuals or literature (52.9%).
4. Lectures with information (50%).

Respondents also rated their preferences in length and formats of formal educational training programs, workshops or conferences. The overwhelming majority (89%) preferred 1-day programs followed by ½ day programs (71.2%), 2-day programs (65.8%), and 3-5 day programs (46.6%). Almost all (91.7%) preferred multiple sessions over several months and would participate in ongoing consultation (84.1%).

These results show that clinicians prefer learning by watching experienced clinicians or "doing" groups through practicing the interventions. While gaining information from lectures is a helpful learning method, more "hands on" strategies seem to be preferred. Also formal training programs spread out over time followed by consultation are also preferred, which suggests that time is needed to integrate new learning and that access to experienced supervisors or consultants is valued by clinicians.

Supervision

Many treatment programs and clinics are so busy that that supervision is not regularly provided. For counselors learning to conduct treatment groups, regular supervision provides an opportunity for the counselor and supervisor to collaboratively evaluate the groups conducted, identify knowledge or skill deficits, and develop strategies to enhance group skills.

For new group leaders, the ideal way to provide training is to first have them observe more experienced counselors conducting group sessions. The new counselor can then co-lead groups and eventually take the main role in conducting the group sessions. Observing groups, co-leading groups, conducting groups, and participating in post-group consultations are excellent ways to help counselors develop and improve their group treatment skills.

Another more time-intensive method is to have group sessions videotaped and to review tapes in supervision sessions with the counselor or with a group of counselors. Reviewing and discussing tapes of sessions provides a different perspective than in discussions of group sessions that cannot be observed by the supervisor. In our treatment research study, all GDC sessions were videotaped and randomly selected for review by a supervisor. The supervisor used an adherence scale to rate the group sessions. The videotape review was used as the basis for the supervisory sessions which were initially held weekly, then tapered to biweekly and monthly as the counselor became more skillful using the GDC model. Since the GDC was part of a large research study, it was necessary to ensure that the counselors were actually using the model of treatment being studied; otherwise, the research results would be meaningless.

While some counselors will be open to these methods of supervision in which their work is closely scrutinized, others will feel anxious and threatened. So it is up to the supervisor to deal appropriately with any concerns about having one's group sessions observed and evaluated. Even highly experienced clinicians can feel anxious when their work is observed or videotaped, and then critiqued.

In my survey of 80 addiction professionals, only 20% reported receiving clinical supervision on their group work weekly or biweekly. The majority of respondents (61.3%) stated they "seldom or never" received clinical supervision for their group work. Regular supervision of group work can be beneficial even for experienced group therapists.

Only 44.6% of survey respondents reported they were "very satisfied" or "satisfied" with group supervision. And 45.2% reported they "didn't know" how knowledgeable their supervisor was in conducting groups or their supervisor was "somewhat" or "not very" knowledgeable. This may suggest some supervisors have limited group experience, which could mean group therapists do not get any group supervision.

Programs should evaluate their approach to supervision of group work to insure less experienced clinicians have a mechanism to review their work and improve their skills. More experienced group therapists can use supervision as a form of consultation to discuss any number of clinical issues in groups as well as issues related to the group process. If a program's supervisory staff

has limited or no group treatment experience, an outside consultant can be used to provide help to group therapists.

Group Counseling Competencies

A number of addiction counseling competencies for group leaders related to knowledge, skills and professional attitudes are delineated in the *Technical Assistance Publication Series* by SAMHSA.[2] Following is a brief summary of the six group counseling competencies for counselors with examples of knowledge, skills and attitudes of the group leader conducive for conducting effective group sessions.

1. Describe, select and appropriately use strategies from accepted and culturally appropriate models for group counseling. This involves knowledge of a variety of group interventions; skill in recognizing and accommodating individual client needs within the group; and openness and flexibility in the choice of counseling strategies used.

2. Carry out the actions to form a group such as determining group type, purpose, size, how to recruit and select group members, group goals and rules, outcomes of groups and methods for termination or graduation from the group. This involves knowledge of strategies that consider clients' age, gender and cultural backgrounds and how to select and screen clients for groups; skill in using the group process to set group goals and ground rules for members; and recognizing the importance of involving clients in establishing goals and rules for conducting group sessions.

3. Facilitating the entry of new members and transition of existing members. This involves knowledge of stages of therapeutic groups and characteristics of therapeutic group behavior; skill in addressing resistant behaviors; and recognizing the need to balance needs of individual group members and the goals of the group.

4. Facilitating group growth within rules of the group and movement towards goals of clients consistent with type of group provided. This involves knowledge of group development and counseling methods appropriate to each stage; skills in using counseling strategies to work towards measurable progress for the individual members' or group's goals; and appreciating the role and power of various group members in the group process.

5. Understand both process and content, and shift the focus of group when this helps the group move towards its goals. This involves understanding the difference between the process of the group and content of discussions; skills in observing and documenting process and content; and appreciating the appropriate use of interventions relevant to content or process of the group.

6. Describe and summarize the group member's behaviors within the group to document progress and identify needs and issues that may require a change in the treatment plan. This involves knowledge of how individual treatment issues may emerge in the group; skill in

changing an individual members' treatment plans based on the observation of group behaviors; and appreciating individual differences in progress towards treatment goals.

In the survey of clinicians mentioned earlier, the following items related to conducting groups or managing the group process were rated as "very important."

1. How to manage conflict among group members or disruptions (81.7%).
2. How to engage members in group discussions (78.9%).
3. How to deal with clients who do not "work" in group (78.9%).
4. How to manage disruptive clients in group (78.6%).
5. How to facilitate group members' self disclosure in group sessions (74.6%)
6. How to facilitate feedback within the group session (73.9%).
7. How to use "action" or experiential strategies in group sessions (73.5%).
8. How to structure a group session (64.8%).
9. How to stay on topic for structured group sessions (63.4%).

Use of Adherence Scales to Rate Group Interventions

The adherence scale used in one of the research studies I participated in is summarized below.[3] Each item was rated by a supervisor in terms of the quality of the intervention, using a scale of 0-7.

Some clinical trials use both supervisory review of sessions as well as clinician review of their own sessions. The latter adapts the adherence scale language to reflect the clinician's self rating of the sessions reviewed. Yet another option is to have peers review and rate group sessions. This activity of rating sessions can also serve as a *Quality Improvement* initiative and help programs improve their focus on a group leader's ability to conduct groups according to a manual.

1. **Supporting Recovery**
   - Encouraging clients to discuss episodes of use, near use or cravings for substances
   - Encouraging abstinence from all substances
   - Encouraging continued attendance in professional treatment
   - Encouraging clients to share problems and concerns regarding addiction and recovery
   - Giving clients feedback regarding their progress in recovery
   - Encouraging clients to state a concrete plan for dealing with cravings or other problems

2. **Encouraging 12-Step Participation (or Other Mutual Support Programs)**
   - Encouraging attendance and active involvement in 12-Step groups
   - Expressing positive opinions about the 12-Step approach and support groups
   - Encouraging clients to get and use a Sponsor

3. **Facilitating Group Participation**
   - Encouraging members to participate verbally

- Encouraging clients to give each other constructive, reality-based feedback
- Modeling and providing constructive feedback and positive reinforcement
- Creating an atmosphere of trust and confidentiality
- Facilitating group closings to create a sense of fellowship

4. **In Structured Recovery Psychoeducational Group**
   - Educating group about session topic
   - Discussing major points identified in session outline
   - Relating these points to clients' lives

5. **In Problem Solving or Therapy Group**
   - Assisting clients to identify and prioritize problems or concerns for discussion
   - Facilitating discussion among clients of problems and concerns
   - Assisting clients in exploring problems and coping strategies
   - Keeping discussion on the problems and issues identified by clients

One study conducted a survey to find out what group counselors liked most and least in conducting treatment groups as part of a research study.[4] Data from this survey indicated that counselors were very satisfied to be part of a major effort to study treatments for cocaine dependence. Group leaders were also very satisfied with the supervisory process that required them to tape all treatment sessions, have a selection of individual and group sessions reviewed and rated using an adherence scale and regularly receive feedback from a supervisor. Although this process of supervision was time intensive, it provided an excellent mechanism to assess whether or not counselors conducted group sessions according to the model of treatment used, and to help them identify areas of clinical strength and weakness.

Many addiction treatment clinics currently offer limited or brief supervision and may wish to reassess this given the positive benefits reported by counselors in this study. Critiquing tapes of counseling sessions as part of the supervisory process is rarely used in current clinical practice. This has implications both for clinical competence and for counselor morale.

Overall, counselors were very satisfied with participating in a treatment-research clinical trial and report more benefits than limitations to using a structured, manualized model of group treatment. Counselors found the structure of a manualized model helpful in conducting group sessions and engaging the clients in active discussion of recovery issues. They also believed that group rituals such as the check-in period in which clients reported their sobriety date, discussing close calls, cravings and relapses, and ending group sessions with the Serenity Prayer were helpful components of the group sessions. And, although groups had a specific format and structure, counselors felt they had sufficient freedom to use their own style of conducting groups.

Common Challenges of Group Leaders

I have conducted thousands of group sessions in detoxification, rehabilitation, inpatient dual diagnosis psychiatric programs and ambulatory programs. As part of my duties in managing treatment programs or functioning in several clinical trials, I have observed and rated hundreds

of group treatment sessions of other group leaders. In clinical programs these observations were in person whereas for clinical trials these observations involved watching videotapes of group sessions and rating these using an adherence scale specific to the study. From my extensive personal group experience and observation of other counselors I have noted a number of common challenges by group leaders. These include, but are not limited to the following:

1. *Boredom and burnout of the group counselor:* counselors can lose their motivation and energy when conducting too many group sessions per day or per week, or conducting groups on the same recovery topisc or problems over and over. Occasional time away from groups, using a variety of interventions, integrating "experiential" or "action" techniques in sessions to cover material in different ways, mentoring other group counselors by teaching how to conduct groups, and having a variety of topics to present in structured recovery groups can help reduce boredom or burnout. Signs of burnout can show in starting group sessions late, ending early, failure to come prepared (if covering a topic) or difficulty paying attention to discussions in the group.
2. *Not enough interaction among clients in group:* a major goal of groups limited in size is to engage members in discussions of problems or recovery material. This requires ensuring there is a balance between "I" (individual group members), "we" (the group as a whole) and "it" the topic covered or problem discussed in a therapy group.
3. *Boredom of clients with recovery issues or problems discussed:* clients who have had multiple treatment experiences sometimes get bored with the repetition of material in group sessions. Using a variety of teaching techniques to present material in more active ways, and encouraging them to use their experiences to help others learn about addiction and recovery may help reduce their boredom.
4. *Getting off track with "other" topics:* group members often have issues, problems or concerns they would like to discuss that are unrelated to the group topic. However, unless there is some serious issue or crisis that needs immediate attention (e.g., a group member is agitated, suicidal or under the influence of substances) stick to the group topic. Otherwise, group members will not have access to the information or coping strategies reviewed related to the group topic. Although specific group topics get different responses from clients in terms of their level of interest or desire to learn about the topic, group programs are developed based on the premise that all members should be exposed to certain material as part of their core recovery.
5. *Allowing too much time with members telling "stories" and not enough on the educational component of the group session:* many clients like to tell stories of things they did while under the influence or to get alcohol or drugs. Some get too stuck in the details that are not relevant to the group topic. Recovery groups aim to provide exposure to information on specific topics so make sure you focus on the content. If stories are brief and relevant, you can relate these to the topic of the group session. If stories are irrelevant, you can thank the member for sharing then state you want to discuss the topic of the group session with the members.
6. *Not spending enough time on positive coping strategies related to the problem or recovery topic:* I have watched many videos of group sessions and observed group sessions that would spend far too much time on problems or negative effects associated

with the substance use disorder only to rush through the final minutes of group time to cover positive coping strategies. A general rule of thumb is to make sure that as much time is spent in the group discussing or learning coping strategies as on discussing problems or struggles of group members.

7. *Rushing through material you are covering for a specific group session:* recovery material is most relevant and useful if digested and discussed with clients so they can share their experiences, opinions and ideas. Avoid rushing through the content of a group topic because you want to make sure you cover a lot of information.
8. *Not balancing the time needed for check-in, the recovery group topic, and check-out:* About 15% of group time can be spent in the check-in period and 15% on check-out or plans for continued recovery (if groups are conducted in ambulatory settings). For a group that meets an hour and one-half, this would mean a check in of 15-20 minutes, a check-out of 15-20 minutes, and covering material for 50-60 minutes.
9. *Focusing too much group time on the clients having trouble staying sober at the expense of not covering the group topic: in* ambulatory programs it is common to have groups with patients having difficulty getting sober or staying sober. There may be a natural desire to spend considerable time discussing lapses and relapses. However, it is best to review these briefly so that most of the group session can focus on the recovery topic. Otherwise, the group members who are managing their sobriety do not get exposure to the important recovery topics covered in group sessions.
10. *Not switching to the group process when the group gets bogged down***:** if the group is not doing much work, not paying attention, not showing an investment in the topic or just not working well, focus on the group process. Share your observations and inquire about what they think is happening and ask them why things have slowed down. Let group members help you solve the problem and get the group back on track.
11. *Not engaging quiet members or containing members who talk too much*: in groups of reasonable size (less that 12-14 clients), it is helpful to ask quiet members for their opinions about a specific topic or issue. Or, you can ask them to share their experience or ideas relevant to the topic being discussed in group. If a client talks too much, you can thank them for sharing but let the group know you want others to share as well.
12. *Not eliciting feedback from group members on how the groups are going:* you can regularly ask group members how they think the group (or group program) is going for them. Focus both on the content of the sessions (issues and problems discussed or taught), the methods used in structured groups (discussions, videos, speakers, workbooks and readings, powerpoint slides, creative media, etc.), the process of the group sessions or ways in which members interact. Ask members what they like best and find most helpful, what they like least, how they think the group can improve, how quiet members can get more active and any other area in which you think it would be helpful to elicit feedback from group members.

CHAPTER 4
Structured Recovery Groups

Structured recovery groups can meet for variable lengths of time (45-120 minutes), depending on the clinical population served, treatment setting and phase of recovery of the clients. In residential or inpatient settings groups often last 45-90 minutes whereas in ambulatory settings sessions may last 60-120 minutes or more. Recovery groups for clients with SUDS combined with chronic psychiatric disorders usually run less than an hour.

These groups introduce clients to a variety of issues relevant to substance use, psychiatric or co-occurring disorders. The goals of the group are to educate group members, provided opportunities to give and receive support from peers and learn recovery skills to manage the challenges of recovery. Groups also encourage continued participation in a mutual support programs such as AA or NA.

Group Format for Outpatient Settings

Following a format in conducting structured outpatient group that enables the clinician to use time wisely and engage all members in covering the agenda. Following is a format for outpatient groups:[1]

1. *Welcoming clients:* the group leader welcomes everyone to the group session, states the topic and goals of the session. Any pertinent announcements are made to members. It is best to start the group on time even if not all members are present. This conveys the message that time is important and members who show up on time will not lose valuable group time because others are late.

2. *Member introductions and check-in:* group members state their name, drug and alcohol problem, date of last use, any strong cravings or "close calls" since the previous group meeting, any lapse or relapse to use, and meeting attendance since last session. Many programs have a chart on the wall listing these "check-in" items to help group members stay focused during this process. Other check-in items can include current mood, problems clients are having that they would like to discuss in other groups (e.g., in an intensive outpatient program, clients attend several groups each day, which often includes a therapy or problem solving group in which clients can talk about any current problems or concerns). The check in should take 10-20 minutes so that the majority of time is spent on the topic of the session.

3. *Substance use:* if a group member has used since the last session the group will briefly process the event and discuss a plan to reduce relapse risk. The goal of total abstinence is emphasized. The group leader has to resist the tendency to spend extensive time on

members' relapses in psychoeducational recovery groups as this could easily consume most or all of the group time, which would lead to failure to cover the content of the recovery group topic.

4. *Handouts or assignments:* recovery-oriented handouts from a workbook, journal or other source or behavioral assignments are briefly reviewed if given to clients at the previous session. Since interactive recovery tasks take time, it is most efficient to assign these tasks prior to the group session so members can reflect upon the group session topic, and complete interactive tasks aimed at getting them to relate to the material. And, if members fail to complete an assignment it provides the group leader with "grist for the therapeutic mill."

5. *Topic introduction:* the group leader introduces the topic and reviews the major points noted on the outline for the specific topic. Questions and interactive discussions are used throughout the session. Members are asked to share their reactions to the material presented. They are encouraged to discuss how the topic relates to their personal situations. Group members are encouraged to interact and offer feedback to one another when appropriate. Most of the session is spent on an interactive discussion of the material related to the group topic. This part of the group should last 45-60 minutes in 90 minute sessions. If groups are 60 minutes, this section should last 40-45 minutes.

6. *Review of homework (optional):* each member is requested to briefly share his answers to questions on the handouts provided at the start of each session if homework was assigned. This is optional as some groups can discuss the questions without using written handouts.

7. *Group ending:* in the final 10-15 minutes of the group session, members are asked to state one thing they learned from the meeting and/or state their plans for recovery until the next session. In addition, they are encouraged to state mutual support meetings they plan to attend or other strategies such as find a sponsor, get phone numbers from other AA/NA members, or actually call these members. I have been in very few groups that could not have continued beyond the allotted time. However, you should stick to the time frame and end groups on time. You have to be aware that some members may wait until the end of the group to bring up important issues that require more time for discussion than is available. This is another example of an issue that can be discussed in the group—to use the time wisely to bring up issues and problems during the meeting rather than at the end of it.

8. *Serenity Prayer (optional):* the group joins hands and recites the Serenity Prayer aloud to end the session.

Group Format for Residential or Inpatient Settings

The group format depends on group size. Large groups conducted in auditorium are more likely to be a lecture format. However, ever large groups can incorporate some interactive with clients listening to the presentation by the staff member.

Since clients are in a supervised residential or inpatient environment, actual episodes of substance use are not likely (although possible) so focus can be more on what clients believe they are gaining from treatment and how they view their participation. Also, they will have plenty of time to complete recovery assignments (reading, writing, behavioral) so these do not have to be reviewed in group. Group endings can focus mainly on sharing something they gained from the meeting or one recovery goal they will work on during the rest of the day.

Structured Recovery Group Topics for Substance Use Disorders

Recovery group topics can be combined or expanded depending on the number and length of sessions provided in your treatment program (see discussion at end of this chapter). Chapters 5-14 provide information on the following topics of group sessions.

1. **Groups about Alcohol, Drugs, Substance Use Disorders and Addiction**
    - Substance use disorders and addiction
    - Addiction and the brain
    - Overview of substances (alcohol and drugs)
    - Alcohol and sedatives
    - Cocaine, methamphetamine and other stimulants
    - Heroin and other opioids
    - Cannabis
    - Nicotine
    - Effects of alcohol, drugs and addiction

2. **Groups About Treatment**
    - Treatment of Substance Use Disorders
    - How to Get the Most Out of Treatment
    - Creating a Problem List and Treatment Plan

3. **Groups about Recovery**
    - The Process and Domains of Recovery
    - Stages of Change
    - Advantages of Recovery
    - People, Places, Things, Events and Holidays
    - Cravings and Triggers (Internal and External)
    - Barriers to Recovery

4. **Groups about Health and Medical Issues in Recovery**
    - Physical Recovery
    - Withdrawal from Addictive Substances
    - HIV/AIDS and Substance Use Disorders
    - Viral Hepatitis

5. **Groups about Psychological Issues and Co-Occurring Psychiatric Disorders**
    - Overview of Psychological Issues
    - Managing Feelings or Emotions
    - Anger
    - Anxiety
    - Boredom
    - Depression
    - Grief
    - Guilt and Shame
    - Sharing Positive Feelings in Recovery
    - Gratitude
    - Changing Thinking
    - Self-Defeating Behaviors
    - Overview of Co-Occurring Disorders
    - Personality Problems
    - Understanding Psychiatric Illness

6. **Groups about Relationships, Family and Social Issues in Recovery**
    - Social Issues in Recovery
    - Impact of Disorders on the Family
    - Impact of Disorders on Children
    - Refusing Alcohol and Drug Use Offers
    - Relationships in Recovery (new friends; damaged relates; sexuality)

7. **Groups about Mutual Support Programs**
    - How 12-Step Programs Can Aid Recovery
    - Step 1: Acceptance
    - Steps 2 and 3: Surrender
    - Using a Sponsor to Aid Recovery
    - Establishing a Recovery Support System

8. **Groups about Relapse Prevention**
    - Managing Relapse Warning Signs of Relapse
    - Managing High Risk Factors
    - Maintaining Recovery by Using Tools in Daily Recovery
    - Setbacks: Managing a Lapse or Relapse

9. **Groups about Lifestyle and Personal Growth Issues**
    - Spirituality in Recovery
    - Financial Issues in Recovery
    - Other Addictions

Other Topics for Structured Groups

Group sessions can be developed on other topics relevant to the problems and needs of the clients a program serves. Examples include, but are not limited to:

1. *Medical and health issues:* pain, sleep, exercise, healthy eating, sex and recovery, healthy self care habits.

2. *Psychological issues:* trauma, grief, forgiveness, stress management, character defects, other compulsive or addictive behaviors (gambling, sex, internet use, etc).

3. *Psychiatric issues:* understanding and managing specific psychiatric disorders such as mood, anxiety, psychotic, personality or other disorders (causes, effects, treatment, recovery), self defeating or self destructive behaviors and suidicality.

4. *Family and relationship issues:* communication, making new friends, repairing damaged relationships, regaining trust, sexuality.

5. *Mutual support programs:* non-12-step recovery programs, any of the 12-Steps, specific readings from the "Big Book" of AA, "Basic Text of NA" or other recovery literature, using slogans to coach self.

6. *Lifestyle issues:* learning new hobbies, creating structure in daily life, lifestyle balance (family, work, play, recovery), work related issues (e.g., preparing for interviews, dealing with questions about gaps in employment history), financial issues in recovery, holidays and recovery.

Choosing Topics for Group Sessions

The specific topics chosen for group sessions depend upon the treatment setting, length of time of group sessions, and the total number of sessions that group members can attend during the course of treatment. Longer and more structured programs such as residential rehabs, partial hospitals or intensive outpatient programs often can usually provide a large number of group sessions over the length of treatment, especially if treatment lasts four weeks or longer. These programs have the opportunity to expose clients to a large number of group topics over time.

On the other hand, time-limited, weekly outpatient or aftercare groups can cover fewer topics due to the limited number of sessions provided. The group leader will have to choose topics that are most important and relevant to a specific cohort of clients.

Unless a clinician is using a specific model of group treatment in its original form in which a specified number of groups are offered over a designated time period, here are some guidelines for choosing topics for recovery group sessions or conducting groups.

1. *Choose "core" topics that need to be covered during the course of treatment.* These should be based on your clinical population and the number of sessions that you have available. For example, if you offer 12 weekly sessions over a 3 month period of time you will want to cover the topics that you, your peers and clients believe are important. You will want to stick with the basics and cover topics such as addiction and the brain, treatment, recovery, managing emotions, dealing with family issues, using support systems, relapse issues and lifestyle change.

2. *Choose "elective" topics that you believe will prepare clients for long-term recovery*. These also should be based on the clinical population and number of sessions available. For example, if relapse is a significant issues among a specific group of clients, groups related to relapse prevention would be important to offer.

3. *Maintain a biopsychosocial focus* since recovery involves multiple domains. Be sure to cover physical, psychological and emotional, social (interpersonal and family) and lifestyle issues in groups.

4. *Offer combinations of* groups. If your program offers several groups per week it is good to combine structured recovery groups with open therapy groups in which discussions are based on the specific needs, problems, concerns and issues of a particular group of clients.

5. *Use time creatively.* If your outpatient program offers only one group per week, you can divide the group time into several components: a check-in period, a structured recovery group, and open discussion of problems of members.

6. *Combine recovery topics.* Some group topics can be combined if you have a limited number of group sessions. Some examples of group topics that can be combined include: the process of recovery and stages of change; advantage of recovery and roadblocks to recovery; getting the most out of treatment and medication-assisted treatment; HIV/AIDS and Hepatitis; Acceptance and Surrender; etc.).

7. *Break some topics into multiple group sessions.* Some group topics can be provided in more than one session. For example, groups on managing emotions, depression, or recovery from co-occurring disorders can be expanded and covered in several rather than a single session.

Who Should Conduct Group Sessions?

Sessions should be conducted by clinical staff who have had training in conducting groups sessions and who have access to clinical supervision of their group group. I have observed many group leaders over the years and noticed that a significant minority lacked proper training. The assumption is erroneously made that if a clinician understandings substance use disorders, this person is competent to conduct a group. It is unfair and unethical to expect a clinician to conduct group sessions of this individual does not know knowledge or skills in group interventions.

While most groups can be conducted by therapy or counseling staff, it is helpful to include others in conducting some of these topic oriented groups. For example, groups about substances or medical aspects of substance use disorders can also be conducted by physicians, physician assistants, nurse practitioners, nurses or pharmacists. Psychologists, social workers, ministers and other religious professionals can conduct groups relevant to their discipline. Even individuals in recovery can contribute to groups relevant to recovery from addiction. For example, they can "tell their story of addiction and recovery" and this can be followed by a

If a counselor provides a large number of group sessions each week as part of a structured treatment program, it helps to invite a "guest presenter" to lead a discussion on a specific topic. This provides variety to group members and gives the group counselor another perspective on groups.

Groups can be co-led by two staff members if staff patterns permits. Co-leaders can agree ahead of time roles to assume within the group (e.g., one may take the lead role during the group session). In my experience, many agencies provide a single leader with the exception of a graduate level therapist in training as a co-therapist.

Tools for Group Leaders

Group leaders who use a broad repertoire of interventions can keep groups engaged, especially those that use a curriculum on a specific group topic. These strategies include but are not limited to:

1. *Brief lectures* in which interactive discussions are initiated to get members to relate to the material presented. For example, when presenting information on how the use of marijuana or alcohol significantly increases the risk of relapse to cocaine among cocaine addicted clients, the group leader can elicit examples from members on how use of alcohol or marijuana affected their recovery from cocaine addiction. Or, when presenting information on adverse effects of SUDs are discussion, the leader can ask group members to share specific examples of problems caused or worsening by their SUDs. These problems can related to physical, sexual, mental or spiritual health, or any other area of their functioning.

2. *Use of brief stories* to illustrate points discussed during the session. These stories can focus on failure and success experiences. For example, if a group leader is discussing the importance of clients reaching out for help and support when experiencing strong cravings for drugs or alcohol, examples can be shared of a client who kept cravings to self and eventually relapsed, and of a client who called an NA friend to talk about the strong craving. Or, when discussing the issue of motivation in recovery, the group leader can share a story about an "unmotivated client" who stuck with treatment only to find she gained from it substantially when she became motivated to get and stay drug free.

3. *Guest speakers* may include professionals with different perspectives on substance use problems or recovery (medical, psychological, family, spiritual focused). Or, they can

include others in recovery, especially treatment program graduates, who share their story of substance use problems and recovery. When using others in recovery, make sure the person spends more time on the "story" of recovery and less time on the "story" of addiction.

4. *Educational videos or audiotapes* can be used to provide information, stimulate discussion or provide "role models" of others in recovery who share their stories of using positive coping strategies. They should NOT be used to fill group time. Brief video or audio materials with interactive discussion is the most appropriate manner to use these to supplement other interventions. Group leaders should avoid using the majority of group time to show a video or play an audio. Most of the time in group should be spent discussing specific segments of these materials. For video or audiotapes longer than 15+ minutes, one strategy is to show or play a specific segment then follow this with a brief discussion before showing or playing another segment. Topics of videos or audios should be relevant to the treatment curriculum provided in a program.

5. *Use written recovery handouts, workbooks or journals* to educate clients and engage them in relating written materials to their own situation. These provide information, raise self awareness and help clients begin to learn coping strategies to manage problems or challenges of recovery. It is best to have clients complete written handouts prior to the group session so the group time can be used to discuss what they learned from this written material and how they relate it to their recovery. Since group size varies, it is not necessary to ask every member to share answers to every written assignment. The idea is to use the experience of group members to review specific materials assigned by having some members share their personal learning from completing a specific written assignment. If a member does not complete an assignment, you can explore this in group to find out the reasons. This may also lead to others discussing their experiences (positive or negative) with assignments and the importance of being responsible for following through with taking steps aimed at enhancing recovery.

6. *Use recovery readings* between sessions or have clients share brief readings during a session. Readings can come from many sources such as books, pamphlets, recovery guides, internet or even novels. Readings may come from the "Big Book" of AA, the "Basic Text" of NA, other 12-Step related readings, or other readings on specific addictions (alcoholism, cocaine) or other topics (anger, relapse, depression, cravings, family issues). Some structured rehab programs start the day with readings from meditation books relevant to recovery.

7. *Provide behavioral assignments* between sessions relevant to specific group members. As assignment can be something as simple as "introduce yourself to another person at an AA or NA meeting, call one peer you met in AA or NA to discuss something about recovery, talk to your spouse about how Al-Anon or Nar-Anon may help them." Or, it can relate to a behavior such as reaching out to another person (a confidante) and asking for help and support with a problem or emotional struggle, negotiating a conflict with another person or expressing upset feelings with an intimate partner.

8. *Use role plays or behavioral rehearsals* to address interpersonal problems to help clients develop skills. These can relate directly to recovery such as refusing an offer for alcohol or drugs, asking for a sponsor or talking with a family member about one's addiction and recovery. For example, a role play can be set up in which a friend offers alcohol (or drugs) to the person in recovery. The person being offered can be instructed to respond in any way that he or she wants. The person offering the substance can be instructed to exert some pressure on this other person.

   Role plays can also relate to other problems that could impact on recovery such as addressing an interpersonal conflict, reaching out to a friend for support when feeling depressed or learning to express anger in healthy ways that do not push others away or harm relationships.

   Interpersonal role-plays enable group leaders to engage clients not involved in the actual role play by asking to imagine it is them in the situation that is the focus of the role play. Group members can be asked to pay attention to what they would think and feel, and how they might handle the situation illustrated in the role play. Often, these role-plays lead to productive therapeutic discussions and additional behavioral rehearsal of positive coping strategies relevant to the specific problem or issue that is the role play focuses on.

9. *Use another group member to verbally serve as the client's "alter ego" in role-plays*. The clinician first gets the client's permission to do this. The person functioning as the alter ego speaks out loud during the role-play, saying what he thinks the client would like to say but is unable to. For example, in an actual role-play situation, a cocaine addict may be offered drugs by a friend. While he may say something such as "no thanks, I'm staying clean," he may be thinking, "I really want to get high. I really crave the drug." The alter ego expresses these inner thoughts or feelings, thus allowing conflicts to surface, be discussed, and hopefully be resolved. This process also helps the client understand the role of ambivalence in recovery, when mixed feelings surface.

10. *Use another group member to serve us the role playing client's "alter ego" by recording thoughts and feelings*. This is similar to the method above except that instead of the alter ego speaking out loud, thoughts or feelings are written down.

11. *Use dyads or triads to role-play problems identified by one or more clients*. This makes all group members active participants in the role-play, and is less threatening than when done in front of large groups.

    Role-plays usually work best when the clients choose the situations to practice. However, the clinician can have available several common scenarios--expressing anger, refusing substance use offers--that many clients identify with. Suggest these to the group if necessary.

    Another effective technique in role-plays with groups is to ask those not directly participating in the role-play to imagine that they are in the actual situation being enacted. They are told to pay close attention to their thoughts and feelings.

At the end of role-plays I have found it useful to give the client a chance to talk about what the experience was like. What did he think? How did he feel? How effective did he think his responses were? What did he dislike about his responses? What did he like? The other members of the audience can also respond with feedback. This often provides an excellent opportunity for the group to mutually explore issues and problems that are commonly faced in recovery.

If there is sufficient time and the situation permits, videotaping role-plays can be an effective tool for helping clients learn about themselves. They can dissect role-plays to learn what works best.

12. *Use monodramas.* This refers to a technique in which a problem or issue is "externalized" and the thinking of a client is explored. For example, when discussing obsession and compulsion related to addiction, the group leader can ask for a client to volunteer to participate in an "empty chair" experience. The client is asked to "imagine your addiction is sitting in this chair in front of you. Describe what it looks like, what it would say and how it would act."

    A variation of this would be to ask the client to have a discussion with the "addiction sitting in the empty chair." The client can go back and forth between being the "addiction" and being the client affected by the addiction.

    Other problems or issues can be adapted to monodramas. Another example is asking a client to do a similar experiment, but instead of having "addiction" sitting in the empty chair, "recovery" can be sitting in this chair. The client can then describe what it (recovery) looks like what it would say and how it would act.

13. *Use creative media (arts, crafts, music)***.** Many media can be adapted to express oneself related to the addiction or recovery. Specific "themes" can be the focus of a session using creative media. For example, one of our creative and expressive arts therapist asks clients to create drawings or collages to express their view of, and feeling towards their addiction. Essentially any topic related to addiction, recovery, relapse or recovery can be adapted for use with creative media. One clinician, for example, had group members create a collage to depict things they could have bought had they not spent so much money on alcohol or drugs. Another clinician had group members draw a picture of the "road to relapse" in which they identified triggers and signs of relapse.

14. *Use PowerPoint Slides.* The use of slides can provide visual support for educational presentations on any topic conducted in a group session. This can take the focus off the group leader as well as group members can shift from looking at the presenter to looking at the slides**.** One group member stated about the use of slides "it helped keep my attention and made it easier to stay awake as sometimes it is hard to concentrate in group and stay awake."

    Slides can integrate information as well as visual materials that support the information provided. The possibilities for visuals on a powerpoint slide are endless. Pictures of people, props (alcohol, drugs, places), cartoons, graphs and charts are just a few

examples. This is especially helpful in large groups (e.g., in an auditorium where a lecture is provided to a large group of clients in a residential treatment program), but can also be used in small groups (8-12 clients).

In a group in which I discussed "what research tells us about addition, treatment and recovery," I used pictures of MRIs of the brain to show how the brain looks during active addiction compared to how it looks after a period of abstinence from drugs. I also used illustrations of young children adversely affected by a parent's addiction that included real quotes from real children. These photos and quotes of children raised awareness among parents on the adverse impact of a SUD on children. One photo of a sad, depressed child can have more of an impact than sharing of information on the negative effects of SUDs on children.

Use of Homework Assignments with Group Members

Group treatment models all incorporate homework assignments such as readings, written workbook and journal assignments or behavioral assignments (e.g., ask for phone numbers of two AA or NA members; introduce yourself at an AA or NA meeting; call a peer in recovery every day for a brief discussion; etc).

1. The *MATRIX* model developed for clients with stimulation addiction includes a recovery handbook for clients that provides information and interactive activities on a range of topics in the various group modules and specific group topics offered as part of this Intensive Outpatient Program.[2] Examples of group topics and handouts include: 1) early recovery skills such as managing internal and external triggers, thoughts of using substances, and 12-Step sayings (slogans); and 2) relapse prevention such as managing boredom, avoiding relapse drift, anticipating and preventing relapse, relapse justification, 12-Step programs and repairing relationships.

2. The *NIDA Addict Aftercare: Recovery Training and Self-Help* model uses an informational and interactive recovery workbook to help group members relate to the information covered in different group sessions.[3] Examples of group topics with interactive handouts include addiction, recovery, cravings, people, places and things, emotions, relapse, and support systems in recovery.

3. The NIDA *Group Drug Counseling* model includes a patient recovery workbook with information and interactive activities related to the 12 psychoeducational group sessions provided during the first three months of outpatient treatment.[4] Examples of topics covered in group sessions with handouts include symptoms of addiction, recovery, managing cravings, establishing a support system and coping with warning signs of relapse.

4. The *Twelve-Step Facilitation Therapy* model, developed initially for use in individual counseling, but adapted to group sessions assigns readings from twelve-step literature such as the "Big Book" of Alcoholics Anonymous or the "Sober Living" book.[5] Other

readings and workbooks are also used to cover group topics such as the 12-Steps (especially Steps 1 on acceptance; Steps 2 and 3 on surrender), managing emotions and dealing with people, places and things.[6]

5. The *Stage-of-Change* model based on the Transtheoretical model of change offers handouts for the 29 different treatment groups that are relevant to various stages of change of clients.[7] For example, some of the topics covered in the precontemplation, contemplation or preparation stages of changes group include stages of change, effects of alcohol or drugs, and setting a goal and preparing to change. Some topics covered in the action or maintenance groups include managing stress, effective communication, managing thoughts, refusing substance offers and building social supports.

6. The *Coping Skills Training* model developed by Monti and colleagues for use with alcoholics in individual or group sessions includes "Reminder Sheets" for clients that contain practice recovery exercises, and "Therapist Tip Sheets" that focus on the topics covered in group sessions.[8] This model divides coping skills training into two broad categories: 1) interpersonal skills (e.g., assertiveness, drink refusing skills, resolving relationship problems, developing social support networks, etc); and 2) intrapersonal skills (e.g., managing urges, problem solving, managing negative thinking etc).

7. The *Motivational Cognitive-Behavioral* group treatment program developed by Sobell and Sobell[9] integrates motivational strategies with cognitive-behavioral strategies in a model called "Guided Self Change." Examples of materials used for homework assignments discussed in group sessions include self-monitoring logs (to monitor substance use during treatment, urges and context of use), choosing goals related to substance use, identifying high-risk situations and completing a decisional balance (to identify ambivalence and costs and benefits of changing and not changing).

In addition, many of the group models used for integrated treatment for substance use and co-occurring psychiatric disorders include client recovery materials to supplement groups conducted by counselors.[10]

It is recommended that homework assignments be explained and provided ahead of time so that the group session are not used to review material that members can work on between sessions. And, when reviewing homework assignments in group, not every member has to present every answer to every question or report on every recovery assignment. The idea on sharing homework is to have clients provide examples of how they related to the material in handouts. Completing homework assignments can have a positive impact on outcome for clients in treatment for an addiction.[11]

Since some clinicians may provide a psychoeducational or recovery group on the same topic many times during the course of a treatment program (e.g., residential or intensive outpatient program), it helps to have a variety of ways to present the material and engage group members in discussions. This helps reduce therapist boredom and encourages creative use of the group time to engage members in meaningful discussions of topics and issues covered.

If a group member fails to complete a recovery assignment, this is "grist for the therapeutic mill." Use this to engage the member and other members in a discussion of reasons the assignment was not completed. Look beyond superficial explanations such as "I forgot to do my assignment or lost my handouts." Tie this issue in to the concept of responsibility in recovery.

Educational videos can also be incorporated in group sessions, but should also include sufficient time for discussions of the material presented. Do not use these videos solely to keep patients busy. Show videos relevant to problems and issues discussed in treatment.

Documenting Group Sessions

Clinicians conducting groups are required to document sessions based on the policies of the program as well as regulatory requirements. Following is one suggested way of documenting group sessions with several examples using the D (discussion) A (assessment) and P (plan) format for notes.

1. Recovery group in a rehab program on the topic of "Managing Relapse Warning Signs."

    a. D: Jason attended group on relapse that discussed the difference between lapse and relapse, relapse as a process, and both obvious and subtle warning signs that often precede relapse in addiction.

    b. A: Jason completed his workbook assignment prior to group and was very active in the discussion, contributing excellent examples of his personal experience. He was able to identify several specific warning signs for his two relapses: "I abruptly stopped NA meetings and missed counseling sessions; I reconnected with old friends I used drugs with—I think I was looking for some action;" and I became more dishonest with my wife, son and friends in recovery. Jason was also able to see his buildup is fairly quick as he relapsed within a week or two of warning signs showing.

    c. P: Jason agrees to talk with his therapist and at least one NA peer if he feels like stopping meetings before making a decision to do so. He will also complete a daily RP inventory at the end of each day to determine if any of these, or other, warning signs are evident.

2. Recovery group in an intensive outpatient program on the topic of "Using Mutual Support Programs in Recovery."

    a. D: Melissa attended a group on mutual support programs that discussed barriers to using these programs, potential benefits and how to engage in AA, NA or other programs.

    b. A: Melissa was initially very critical of AA and NA referring to some male members as "hypocrites," who were out to "hustle me and other women." She only completed part of her workbook assignment stating "I didn't think it

mattered since I ain't getting involved again in AA or NA." She shared her experience hooking up with a man she met at a meeting, which led to a bad relationship. She received emotional support from the group, including other females who felt a similar pressure in the past. Melissa then softened her position and appeared open to reconsidering AA. Her peers encouraged her to attend meetings with other women in recovery, which she said "is a good idea."

c. P: Melissa agrees to attend a dozen AA or NA meetings with several female peers so she can be with supportive recovering friends. She agrees that she should not go out alone with any man in the program at this time, and will share any desire to do so with one of her recovering friends. She said "I know I have to do this or I'll let a man drag me down."

3. Therapy group in an outpatient clinic.

   a. D: Marcella talked about her changes in mood in recent weeks and told the group she missed last week's session because she felt too depressed to come. She shared her feelings of depression and thoughts about potential causes. Marcella also talked about how she has relapsed in the past when feeling this depressed.

   b. A: Marcella shows signs of an episode of clinical depression—depressed mood, decreased appetite, low energy, poor concentration and low motivation to get moving or attend her recovery activities. She denies suicidal thoughts or feelings. Given her past history of major depression, she understands she needs to take action now as she is at risk for relapse to alcohol or cocaine use.

   c. P: Marcella agrees to meet with the group leader after the session to complete a depression inventory and discuss the next steps to take. She agrees to call her individual therapist tomorrow and make an appointment to be seen ASAP as her therapist can facilitate a medication evaluation if needed.

4. Therapy group in a residential program.

   a. D: Phil attended daily therapy group today with most discussion focusing on difficulties several members have opening up and sharing their problems or struggles with others. Phil was able to express his difficulty asking for help and told the group he usually keeps problems and feelings to himself. He said "I like to work out things on my own."

   b. A: Phil and other members were able to delve more deeply into reasons for limiting self disclosure to others as well as how failure to reach out for support affects recovery. Some members were able to see a connection between "keeping secrets" and not sharing struggles or feelings with others, and the potential for relapse. Phil talked about how his last relapse followed a period of frustration and anger. During his relapse process, he failed to share his feelings with his NA sponsor, therapist or other peers in recovery.

c. P: Phil agrees to share something private with at least one peer in the rehab each day, and then to report to the group the next day whether he did this and how he felt about it.

Client Evaluation of Recovery Workbooks

As part of a quality improvement initiative, clinicians in several of my treatment programs asked hundreds of clients to complete written confidential surveys on their experiences and opinions related to using recovery workbooks in treatment. This survey was administered to clients being treated in: a detoxification unit in a hospital, an ambulatory detoxification program, an inpatient co-occurring disorders programs, a residential addiction program, several ambulatory programs (partial hospital, intensive outpatient and outpatient) and a narcotic addiction treatment program. Since I am the author of these workbooks, surveys were administered by clinical staff, and results were collated by research and administrative staff. Results were shared with clinical leaders so they understood how clinical staff view, and use, recovery materials in their work.

Following is a brief summary of findings from completed questionnaires of 95 patients being detoxified. These patients were provided a workbook entitled "Detox Recovery Workbook" that focused on issues pertinent to patients undergoing medical detoxification. Results show that:

1. 90% found this workbook to be very useful, useful or somewhat useful during detox.
2. 70% reported learning a great deal or a lot of information (addiction, detox, recovery).
3. 68% reported learning coping strategies to deal with their addiction.
4. 95% reported they were very likely or likely to continue treatment after detoxification.
5. 25 comments to open ended questions were mainly positive (n=20) with a few negative or neutral comments (n=5).
6. Examples of personal comments include:
    a. Helped me accept the need for long-term help.
    b. Helped me look at myself.
    c. Helped make me motivated.
    d. I learned about the importance of ongoing treatment and AA/NA.
    e. I learned how addiction hurts the family.
    f. It made me understand what's ahead for me in recovery.
    g. Taught me ways to cope with urges or cravings.
    h. Helped me understand how to cope with anxiety and depression.

Following is a brief summary of findings from a survey 195 patients being treated in several programs (residential and ambulatory).

1. Nearly 90% found workbooks very useful, useful or somewhat useful; only 6% found workbooks not useful at all.

2. Almost all learned a great deal, a lot or some information; less than 4% reported they didn't learn anything.
3. Almost all learned some coping strategies to manage their addiction; less than 6% reported they did not learn any helpful coping strategies.
4. 217 comments to open ended questions were positive (n=195), negative or critical (n=10) or neutral (n=12).
5. Personal comments fell into the following categories:
    a. Attitudes, self-awareness or motivation.
    b. Information learned.
    c. Coping strategies.
    d. Positive comments about format and content.
    e. Critical comments or suggestions.
6. Examples of comments related to attitudes, self-awareness or motivation include:
    a. Helped me accept my addiction or how troubled I was.
    b. Helped me realize there is no "quick fix" for my addiction.
    c. Gave me "hope" that there is recovery.
    d. Gave me something to work on at home between sessions.
    e. Gave me ideas on how to change.
7. Examples of comments related to information learned include:
    a. Learned about alcohol, drugs and addiction.
    b. Learned about mental illness (especially anxiety and mood disorders).
    c. Learned about the process of recovery.
    d. Learned relapse triggers.
    e. Learned ways to deal with my family who was hurt by my addiction.
8. Examples of comments related to coping strategies include:
    a. How to avoid or manage high risk situations.
    b. Ways to manage emotions and feelings
    c. How to think things through.
    d. How to manage psychiatric illness as well as addiction.
    e. Relapse prevention strategies to say sober.
9. Positive comments about the format and content of workbooks include:
    a. Consistent and easy to understand, yet not simplistic.
    b. Helpful suggestions and definitely helpful.
    c. Very educational, very useful too.
    d. Handy in time of crisis.
    e. These workbooks are phenomenal.

10. Examples of critical comments or suggestions include:
    a. Redundant.
    b. Need better preparation on how to use the workbook.
    c. Counselor needs to spend more time explaining the material in the workbook.
    d. I liked group sessions better than the workbooks.
    e. More CBT material would be useful (cognitive-behavioral).

The ratings of workbooks by a large cohort of clients treated in a variety of programs, their written comments and their verbal comments to staff show that they value workbooks, use them frequently, learn information and coping strategies, and believe these aid their recovery. Most of the criticism relates to the belief that better preparation from counseling staff is needed. This barrier can be easily overcome if the counselor explains to a client the purpose of a specific workbook assignment and discusses how this can aid the client's recovery, and then follows up with the assignment in individual or group sessions. In our programs, many clients ask for workbooks in addition to ones assigned by staff related to topics that interest them.

Clinician Evaluation of Recovery Workbooks

In addition to administering surveys to clients in treatment, I also had program managers administer confidential surveys to 41 clinical staff to ask them about their views of workbooks in treatment. This survey was supplemented by qualitative interviews of 8 staff members with one of our physicians completing an addiction fellowship. Since I am the author of these workbooks, surveys were administered confidentially by clinical staff, interviews were conducted with an M.D. who was part of this quality initiative, and results were collated by research and administrative staff.

Following is a summary of results of the written staff questionnaire on the use of recovery workbooks in clinical treatment programs.

1. Workbooks are used by all disciplines (nursing, social work, psychiatry, medicine, psychology) and degrees (MD, PhD, Master, Bachelor, and non-degreed residential aids).
2. Workbooks are used in all inpatient or residential (46% of respondents) and all types of ambulatory settings (54% of respondents).
3. The majority of patients workbooks were used with had co-occurring disorders (83%) compared to only a substance use disorder or psychiatric disorder (17%).
4. Workbooks are used by junior staff (19% of respondents have less than 2 years of experience) and senior staff (35% of respondents have over 10 years of experience).
5. During the past year, the majority of staff (80% of respondents) used 4 or more workbooks in their clinical work.
6. Staff rate the usefulness of workbooks as follows: a) 51% very useful; b) 34% useful; and c) 15% somewhat useful.
7. Staff recommend specific titles of workbooks to colleagues very often (24%) or often (37%).

8. Staff also provided comments on two open ended questions.
    a. All had positive comments.
    b. Many specific workbooks were mentioned (on specific combinations of co-occurring disorders; grief; relapse; and recovery from all types of substance addiction).
    c. Workbooks aid client learning about diagnosis, illness, treatment, recovery, and can serve as a reference.
    d. Workbooks facilitate self knowledge and impact on engaging in treatment or recovery. For example, a workbook can help a client self-disclose personal information in a group session. Workbooks help clients focus on recovery between treatment sessions.
    e. Workbooks can be tailored to client needs and used in individual or group sessions to help them learn coping skills to manage an addiction or co-occurring disorder and deal with the specific issues of recovery (e.g., cravings, grief, social pressures, relapse risk factors).
    f. Workbooks help clinicians structure some of the treatment groups by focusing on a specific problem, diagnosis, topic or recovery issue (anger, relapse, depression, co-occurring disorder, relapse, social support in recovery, etc.)
    g. Workbooks can also help clients focus on specific issues and problems in their individual therapy sessions.

Qualitative interviews of 8 staff members by an M.D. generally supported the aforementioned comments that workbooks help support the work of clinicians. However, a few staff in a specialty Narcotic Addiction Treatment program did not find workbooks all that useful and believed they could cover the information described in workbooks in their sessions. These clinicians appeared to want to focus on "therapy" rather than education or skills related to recovery. One factor that may account for this belief is that group sessions are used less in this program compared to other treatment programs, and group programs commonly rely on workbooks to help the members focus on specific problems, issues and recovery topics.

CHAPTER 5

Groups about Alcohol, Drugs, Effects of Substance Use Disorders and Addiction

Substance Use Disorders and Addiction
Addiction and the Brain
Overview of Substances (Alcohol and Drugs)
Alcohol and Sedatives
Cocaine and Others Stimulants
Heroin and Other Opioids
Cannabis
Nicotine
Effects of Substance Use Disorders

Group Topic
Substance Use Disorders and Addiction

Objectives of Group Session

1. Review continuum of substance use and substance use disorders (SUDs).
2. Define addiction or substance dependence as a no fault, biopsychosocial disease.
3. Review symptoms of substance abuse and addiction group members have experienced.
4. Identify factors contributing to addiction.

Points or Issues for Discussion.

1. Review prevalence of substance use disorders (SUDs) in the U.S. among adults.
   - More than 16% experience a SUD during their lives.
   - Alcohol problems are over twice as common as drug problems.
   - The most common drug problems are with nicotine, cannabis, opioids (illicit and prescription drugs), sedatives and hallucinogens.
   - Ask group members what substances they have used, which they prefer and why.

2. Review a continuum of substance use from no use to misuse, abuse and addiction.
   - Elicit examples of appropriate use of substances. For example, using medications only as prescribed; limiting the use of alcohol; not drinking to get buzzed up or drunk.
   - Elicit examples of misuse of substances. For example, taking more medication than prescribed; mixing medicine with alcohol; using illicit drugs; or drinking heavily

3. Ask members for examples of symptoms of substance abuse and dependence or addiction.
   - *Excessive or inappropriate use of substances (alcohol or other drugs):* getting high or drunk and not being able to fulfill obligations at home, work or with others; feeling like substances are needed in order to fit in with others or function at work or home; driving a vehicle or operating machinery under the influence of alcohol or other drugs.
   - *Preoccupation with getting or using substances*: living mainly to get high on alcohol or drugs; substance use becomes too important in life; being obsessed with using; thinking too much about getting or using substances.
   - *Tolerance changes*: needing more of the substance to get high; or getting high much easier or with less of the substance than in the past.
   - *Having trouble cutting down or stopping once you drink or take drugs*: not being able to control how much or how often you use; using more alcohol or drugs than planned.
   - *Withdrawal symptoms*: getting sick physically once the person cuts down or stops using (for example, having the shakes, feeling nauseous, having gooseflesh, having a runny nose, etc.); or experiencing mental symptoms such as depression, anxiety or agitation.
   - *Using to avoid or stop withdrawal symptoms*: using substances throughout the day to prevent withdrawal sickness; drinking or using drugs to stop withdrawal symptoms.
   - *Using alcohol or other drugs even though they cause problems in life*: not taking a doctor's, therapist's or some other professional's advice to stop using because of problems substances have caused in life.

- *Giving up important activities or losing friendships because of substance use*: stopping activities that once were important; giving up friends who don't get high; losing friends because of alcohol and drug use and how it affects relationships with others.
- *Stopping use for a period of time (days, weeks or months), only to go back again*: making temporary promises to quit only to go back to getting high again; being unable to sustain abstinence.
- *Getting into trouble because of alcohol or drug use*: losing jobs or being unable to find a job; getting arrested or having other legal problems; losing relationships or having trouble with family or friends; or having money problems.

4. State that the American Medical Association classifies addiction as a "disease." Read the following definition of addiction by the National Institute on Drug Abuse
   - "Addiction is a chronic, relapsing brain disease. It is caused by the complex interaction of genetic, social, environmental and developmental factors."

5. Ask group members what they think contributed to their substance use disorder. Review and discuss *physical factors* such as:
   - Repeated substance use over time changes the neurochemistry of the brain.
   - Addictive substances "hijack" the reward center of the brain. Pleasure felt from the high can surpass natural pleasures such as eating, sex, social interactions or accomplishments.
   - Over time, the brain gets conditioned to the presence of the drug and you may experience withdrawal if the drug is not present (when you cut down or quit).
   - Some drugs cause tolerance requiring use of more of the drug to produce the same effect.
   - Substance problems run in some families increasing your risk of becoming addicted.

6. Review and discuss *psychosocial factors* such as:
   - Drugs or alcohol make you feel good.
   - Family and friends influence you to use drugs or alcohol.
   - Using helps you feel like you belong to a peer group.
   - You use to cope with feelings (depression, boredom) or problems
   - You use to escape or forget about life's problems or challenges.
   - You use for excitement or to feel like they are "living on the edge."

7. Addiction usually progresses over time. Some become addicted quickly while others slowly develop an addiction over time. Many deny or minimize their addiction and come to treatment as a result of pressure from an employer, family or legal system. Over 80% of people with an addiction never receive help.

8. Motivation to change is often low during the early recovery period. Ask members to describe their current reasons for being in treatment and level of motivation to quit using. Emphasize the importance of staying in treatment when motivation is low.

9. Review and discuss clients' answers to any handout provided during the group session or as homework between group sessions (e.g., "Reviewing Addiction Symptoms").

Group Topic
Addiction and the Brain

Objectives of Group Session

1. Define addiction as a brain disease and behavioral disorder.
2. Review the structure of the brain.
3. Review how the brain communicates.
4. Review ways the brain is affected by alcohol, drugs and addiction.

Points and Issues for Discussion

1. State that "addiction is viewed as a brain disease" by doctors and scientists.
   - Ask what this means to group members that addiction is considered a brain disease.
   - Discuss other aspects of addiction related to behaviors, habits and thinking.

2. The American Medical Association, and the National Institute on Drug Abuse and others classify "addiction" as a brain disease.
   - Drugs mimic the action of one or more of the transmitters in the brain.
   - Drugs "hijack" the mesolimbic dopamine pathway or "reward pathway" of the brain.
   - Once this happens, according to some experts, a "switch" is thrown, causing the addicted person to lose the ability to make free choices about using drugs.
   - Addiction is much more than drug use as it seizes control of the brain and usurps the mind and the life of the addicted person (hence obsession/compulsion).
   - AA, NA and other twelve-step programs view addiction as a disease involving physical, mental, social and spiritual aspects.
   - This definition is broader than that focusing mainly on the addicted brain.
   - AA and NA recognize that these other factors play a significant role in addiction.

3. Your brain is the most complex organ in your body and is at the center of all human activity. Areas of the brain affected by drug use include:
   - *Brain stem*: controls functions basic to life such as breathing, heart rate, sleeping.
   - *Limbic system*: controls the reward circuit, regulating ability to feel pleasure. This system is responsible for positive and negative emotions, which is why drugs are "mood-altering."
   - *Cerebral cortex*: the frontal cortex or forebrain gives you the ability to think, plan, solve problems and make decisions. Other areas allow you to process information from your senses so you can see, feel, hear, taste and smell.

4. The brain's communication center consists of billions of neurons or nerve cells that pass messages back and forth with the brain, spinal column and peripheral nervous system.
   - Each neuron sends and receives messages in form of electrical impulses.
   - Neurotransmitters are the brain's "chemical messengers."
   - Receptors are the brain's "chemical receivers.

5. Dopamine is considered the "pleasure" neurotransmitter.
    - It is released in natural ways such as an athletic, intellectual or artistic accomplishment, a sexual experience or enjoying some experience such as listening to music that you find pleasurable.
    - Drugs cause release of dopamine in ways more explosive and pleasurable than natural methods; this can even surpass the pleasure of an orgasm.
    - A message is sent to the rest of the brain from the pleasure center "this (drug) is the most rewarding, exciting and important moment you could have."

6. The good feeling caused by the effects of drugs on the brain leads to cravings for the drug.

7. While you may have started using drugs by choice, once addicted, you may use compulsively and lose control over use due to the way your brain adapts to drugs.

8. Drugs can change or affect any of the areas below. Ask members for examples of how their substance use affected their mood, memory, thinking, motor skills and behaviors.:
    - The molecules and cells making up your brain
    - Your mood or how you feel (limbic system of brain)
    - Memory and thinking (cerebral cortex of brain)
    - Motor skills (cerebellum)
    - Any aspect of your behavior

9. Ask group members that if addiction is a disease involving the brain, social behaviors, thinking and spirituality, what does this imply about their recovery.

10. Mention the various domains of recovery, each involving specific challenges.
    - Physical recovery
    - Mental/emotional recovery
    - Social recovery
    - Spiritual recovery

Group Topic
Overview of Substances (Alcohol & Drugs)

Review Objectives of Group Session

1. Review types of substances a person can abuse or become addicted to.
2. Identify effects of substances.
3. Review treatments for substance abuse or addiction.

Points and Issues for Discussion

1. Ask members to give examples of substances they used, how they used them, why they used them and what they liked about them.
   - Substances used may be legal and socially acceptable such as alcohol or nicotine.
   - Substances may be illegal such as cocaine, meth, heroin, marijuana and LSD.
   - Drugs used may be prescribed by a doctor for a medical or psychiatric problem.
   - The most common of prescribed addictive drugs are pain pills and tranquilizers.
   - Drugs may be taken orally, snorted, smoked, or injected with a needle.
   - Many with an addiction use more than one substance.
   - There are many reasons (physical, mental, social) why people use substances; the reasons for initial use may vary from the reasons for current use, especially if person is addicted.
   - Users identify many physical, psychological or social effects of substances that they like.

2. **Depressants.** These include sedative-hypnotic, anti-anxiety, or tranquilizing drugs used for medical and psychiatric disorders. These drugs are used to induce anesthesia before surgery, control seizures, improve sleep, or reduce anxiety. These drugs include:
   - *Barbiturates (reds, red birds, barbs, phennies, yellows, yellow jackets)*: Pentothal, Brevital, Nembutal, Seconal, Amytal, Butisol, and Luminol.
   - *Antianxiety drugs or tranquilizers (candy, sleeping pills, downers, tranks):* Benzodiazepines such as Librium, Valium, Serax, Tranxene, Dalmane, and Ativan.
   - *Other depressant*s: Paraldehyde, Noctec, Placidyl, Meprobamate, Doriden and Nodular.
   - These drugs may disturb the natural sleep cycle or lead to depression.
   - They can be dangerous when mixed with alcohol.

3. **Opioids and Morphine Deriatives.**
   - Some of these drugs, such as heroin, have no medical use at all.
   - Others are used to reduce or stop pain or as cough suppressants.
   - Like alcohol and other depressants, these drugs produce drowsiness and mood changes.
   - They can cause difficulty with breathing and respiratory depression, confusion, sedation, unconsciousness, coma and poor judgment. These include the following drugs:
   - *Natural opioids (big O, black stuff, M, monkey, Cody):* opium, morphine and codeine.
   - *Semisynthetic opioids (dope, H, horse, junk, smack):* heroin, Dilaudid, Percodan, and OxyContin.
   - *Synthetic opioids:* Demerol, Darvon, Vicodin.
   - *Agonists and partial agonists:* Methadone, Narcan, ReVia®, Buprenex® and Suboxone®.
   - Some mix opioids with stimulants, or uppers, which is a dangerous practice as it can cause death.

- Others mix these with other depressants such as alcohol, barbiturates, or tranquilizers.
- Many develop addiction to alcohol or other drugs as well.

4. **Stimulants (uppers).** These drugs produce feelings of well-being or euphoria, decrease fatigue, the need for sleep or appetite, and increase energy and sexual desire
   - *Cocaine (C, coke, crack, rock, snow, toot)*: This is a powerful, destructive and addictive drug that can be smoked, snorted or injected with a needle.
   - Stimulants include *Amphetamines and methamphetamines (bennies, black beauties, crosses, speed, uppers, crank, crystal, ice, glass, meth)*: Benzedrine, Dexedrine and Methedrine.
   - Stimulant drugs have been used in the treatment of narcolepsy (a sleep disorder in which one may suddenly go to sleep at any time and have no control over this behavior), obesity (by helping to control the appetite) or hyperactivity (difficulty concentrating and paying attention, excessive fidgeting, acting before thinking and other symptoms).
   - The effects of crack cocaine are felt within seconds with the peak effect in 10 minutes or less.
   - Cocaine snorted in powder form can take up to a few minutes to produce the desired response with the peak effect occurring in half an hour or more.
   - Cocaine injected into the veins with a needle produces an effect in a half minute or more with the peak effect occurring in ten to twenty minutes.
   - *MDMA (ecstasy, Eve, lover's speed, peace, STP, X, XTC)*: this drug also has hallucinogenic effects in addition to stimulant effects.
   - *Other stimulants:* Preludin, Ritalin, and Plegine.
   - *Caffeine:* found in coffee, tea, colas, chocolate, aspirin, caffeine pills, and a number of other products.

5. **Cannabis (pot***)*. This drug can cause loss of appetite, an inability to fall asleep, mild anxiety or agitation, and nausea.
   - Types of cannabis include: *Marijuana (blunt, dope, grass, herb, joint, pot, reefer, weed, Mary Jane):* made from the leaves of the cannabis plant and smoked, usually in a joint or blunt.
   - *Hashish (hash, hemp, hash oil, chronic)*: comes from the resin of the plant and is more potent than marijuana, and is usually smoked in a pipe.
   - People addicted to marijuana often report depression and intense craving.
   - Many heavy users say that it makes them lose their ambition and they become lazy.

6. **Hallucinogens (psychedelics)** produce a change in your perception of the outside world or the internal world (that is, how you see, hear, smell, feel, or taste things).
   - Many hallucinogenic drugs are created in laboratories. These include: *LSD (acid, blotter, cues, microdot, yellow sunshine)*; m*escaline (buttons, cactis, mesc, peyote) and Psilocybin (mushrooms, purple passion) and synthetic hallucinogens*: DOM, STP, DMT.
   - Behavior following hallucinogenic use may resemble that found in psychotic disorders, which can led to treatment in a psychiatric setting.

7. **Phencyclidine (PCP)** is an animal tranquilizer that is one of the most unpredictable illicit drugs on the street as it affects people in a variety of ways.
   - Large doses can cause slowed breathing, convulsions, seizures, extreme stiffness or coma.
   - Some PCP users experience psychosis, paranoia, manic behavior and severe emotional changes accompanied by violent outbursts.

8. **Club drugs (or designer drugs).**
   - These include *Rohypnol, MDMA and Ketamine (special K, vitamim K)*, a drug used as an anesthetic, mainly by veterinarians.
   - *GHB (G, liquid ecstasy, easy lay, Georgia Home Boy)*: gamma-hydroxybutyrate. This is one of the "club drugs."
   - *Flunitrazepam (forget-me-not, Mexican Valium, roofies, rope, rophies, R2);* Rohypnol is another "club drug" sometimes used in cases of sexual assault.

9. **Other drugs.** Virtually any compound that has properties that a person thinks will create a high has been used for this purpose. Other types of substances include:
   - *Volatile or organic solvent:* these include gasoline or benzene; glues; cleaning solutions, nail polish removers; lighter fluids; paints and paint thinners; and aerosols.
   - *Amyl or butyl nitrites*: Amyl nitrite is sometimes used for heart clients to dilate blood vessels and make the heart beat faster.
   - *Deliriants*: nutmeg, mace, nightshades, amanita mushrooms, catnip, nitrous oxide, and morning glory seeds, along with the nitrates are sometimes classified as hallucinogens, but are usually less potent than the common hallucinogens such as LSD.
   - *Over-the-counter drugs*: these include non-prescription hypnotics, anti-anxiety drugs, analgesics, stimulants, diet pills and most laxatives.

10. Ask for examples and summarize the potential negative effects of substances, substance abuse and addiction on health and functioning. Relate these to any of these domains of functioning.
    - Physical, medical, dental, sexual.
    - Emotional, psychological, psychiatric.
    - Family, interpersonal and social relationships.
    - Social: activities, hobbies, use of time.
    - Spiritual: values, behaviors, beliefs, faith, meaning.
    - Lifestyle: habits, school, work, legal, financial

11. Ask for opinions about the importance of treatment for a substance use disorder, then summarize the group members' answers and briefly review the continuum of care.
    - Many professional treatments exist: programs, counseling, medications.
    - Mutual support groups (AA, NA, etc) play a major role in recovery.
    - Multiple episodes of treatment over time are needed by many people.
    - Treatment is effective to the extent you comply with it and follow through.
    - The best results occur when treatment is combined with mutual support programs.

Group Topic
Alcohol and Sedatives

Objectives of Group Session

1. Review the effects of alcohol and other depressants.
2. Identify medical problems associated with alcohol and other depressants.
3. Identify psychosocial and psychiatric problems associated with alcohol and other depressant abuse and dependence.

Points and Issues for Discussion

1. Ask group members about their experiences, both positive and negative, or using alcohol, sedatives or other depressants.

2. Central Nervous System (CNS) depressants include alcohol, hypnotics (barbiturates and barbiturate like drugs) and anti-anxiety drugs (tranquilizers) such as benzodiazepines.

3. The National Institute on Alcohol Abuse and Alcoholism states that "at risk" drinking is having 5 or more drinks per occasion or 14 or more drinks per week for men, and 3 or more drinks per occasion or 7 or more drinks per week for women.

4. Almost 14% of adults develop alcohol abuse or dependence at some point in their lives. It is the #1 drug problem in our country.

5. Review some facts about alcohol and ask group members how they relate to these.
   - Alcohol in beer has the same effect as alcohol in wine or liquor.
   - The legal limit for intoxication is a blood alcohol level (BAL) of .80 or .10 in most states.
   - The higher the BAL, the greater the likelihood of impairment, loss of physical or mental control, an accident or becoming unconscious.
   - Women absorb more alcohol into their bloodstream, resulting in higher BAL than men.
   - If you do not "feel drunk" after consuming a large quantity of alcohol it is due to a high tolerance. Even if you do not feel drunk, your judgment, behavior, and ability will be impaired. You can have a high BAL yet feel "normal" and believe you can drive safely.
   - Mixing alcohol with other depressant drugs potentiates their effects (2+2=5).
   - Even alcohol used in small qualities can lead to poor judgment, causing you to say or do things that would not occur if not drinking.
   - You may believe alcohol gives you "courage" to say what is on your mind. The "truth" that comes out can be greatly distorted or exaggerated. Mild irritation may be expressed as passionate hatred. Or, attraction may falsely be stated as deep love.
   - Victims and perpetrators of homicide and other forms of violence are often under the influence of alcohol during the episode.

6. CNS depressant drugs are used to treat medical and psychiatric disorders.
   - Prescription drug abuse and dependence are common among people with alcohol problems.

- Many develop problems with these drugs whether they are prescribed for some medical or psychiatric disorder or obtained from family members, friends or the street.
- Some of these drugs such as the benzodiazepines are more addictive than others.
- These drugs can be dangerous taken in large doses as they can cause death by coma or convulsions.
- Withdrawal is more severe with alcohol and depressants than other drugs.

7. Symptoms associated with excessive use of depressant drugs or withdrawal include anxiety, depression, sleep disturbance, impaired judgment, impaired coordination, slurred speech, tremors, weakness, sweating, increased pulse rate, nausea and vomiting, memory loss or blackouts, seizures, and confusion.

8. Hundreds of thousands of people die each year from the effects of alcohol. A person dependent on alcohol may lose 10-15 years of their expected life span.

9. Due to the effects of alcohol or other depressants, poor diet or health care practices, or concurrent use of tobacco, the risk of medical and psychiatric problems is higher among alcoholics compared to the general population.

10. Ask group members for examples of medical problems caused or worsened by substance use:
    - *Central nervous system*: impaired memory, seizures, slower reflexes, sleep disturbances, or deterioration of brain cells that can lead to organic brain damage.
    - *Digestive system:* cancers of the mouth, tongue, pharynx and esophagus, irritation or bleeding of intestines, inflammation of the pancreas (pancreatitis) or stomach (gastritis).
    - *Hepatic system (liver):* inflammation or destruction of liver tissue, fatty liver, or diseased or scarred liver (cirrhosis).
    - *Cardiovascular system (heart):* weakening of heart muscle, coronary artery disease, irregular heartbeat, heart pain, heart attack, stroke, or high blood pressure.
    - *Musculoskeletal system (bones):* broken bones from accidents or injuries, loss of calcium in bones, muscle cramps or weakness, painful swelling of the joints (gout), and damage to nerve tissue (polyneuropathy).
    - *Respiratory system (breathing):* many alcoholics smoke heavily and are increased risk for lung damage or disease, infections (pneumonia, bronchitis, emphysema), or cancers of the larynx and esophagus.
    - *Other problems for women*: increased risk of miscarriage for pregnant women, increased risk of birth defects, problems with menstrual cycle, or weight loss.
    - *Other problems for men*: decreased testosterone levels causing a lowered sperm count and impotence.

11. Ask for examples of family, social, psychological or psychiatric problems such as:
    - Accidents and impaired ability to drive or operate machinery.
    - Violence and other antisocial behaviors.
    - Anxiety and panic symptoms.
    - Depression, suicidal feelings or actual attempts.
    - Work, school, family, legal, financial, or other spiritual problems.

12. Ask group members if they have experienced withdrawal symptoms when stopping or cutting down alcohol or use of other depressants such as:
    - Insomnia (hard to fall or stay asleep)
    - Anxiety, irritability
    - Flushed face, sweating
    - Trembling ("shakes")
    - Nausea, vomiting
    - Headache
    - Tingling in fingers or toes
    - Increased heart rate or increased blood pressure.

13. Withdrawal symptoms usually begin within 6-48 hours after your last drink or when your blood alcohol level starts dropping close to zero. Symptoms may last between 3 and 10 days.

14. Due to the risk of seizures and other complications from withdrawal, it is often helpful to get detoxified in a hospital, residential or outpatient treatment program under the care of a physician and nurse. Medications and counseling are provided during detoxification.

15. Treatments for alcohol problems include:
    - Residential or intensive outpatient for alcohol dependence.
    - Individual, group or family therapy.
    - Medications to reduce cravings and the risk of relapse. These include naltrexone (Revia or Vivitrol), acamprosate (Campral) and disulfiram (Antabuse).

16. Treatment works best if you complete a treatment program, attend your sessions and use what you learn to make changes in your life.

17. Talk with your counselor about involving your family or significant other in treatment.

18. Active involvement in Alcoholics Anonymous (AA) can also help with long-term recovery.
    - Attend meetings regularly and get a home group. Go to meetings when you feel like it and when you don't feel like it—make it part of your weekly routine.
    - Get an AA sponsor and talk with him or her every day.
    - Get a list of phone numbers from other AA's who are sober and working a program.
    - Work the 12-Steps of AA.
    - Read AA recovery literature (e.g., the "Big Book" of AA).

Group Topic
Cocaine and Other Stimulants

Objectives of Group Session

1. Review the effects of cocaine and other stimulant drugs.
2. Identify medical problems associated with cocaine and other stimulants.
3. Identify psychosocial and psychiatric problems associated with cocaine and other stimulants.

Points and Issues for Discussion

1. Ask group members about their experiences, both positive and negative, of using stimulants.

2. Stimulant drugs include cocaine, amphetamines, caffeine and nicotine.
   - These drugs are prescribed to treat narcolepsy, attention deficit disorder with hyperactivity, obesity, and depression. Excessive use can cause psychiatric symptoms.
   - These drugs can be taken in the form of pills, injected with a needle, or smoked in the form of freebase cocaine or crack.

3. Cocaine is sometimes mixed with heroin and injected. Many people use alcohol to help cope with the "crash" when coming off of a cocaine or speed binge.
   - Crack/cocaine is a cheap form of smokeable cocaine that can be bought in the form of "rocks" for as little as $3 - $5.
   - The effects of cocaine usually last 20-30 minutes; effects of meth can last 8-24 hours.

4. Stimulants release neurotransmitters such as norepinephrine from nerve cells. These can cause a decrease in reuptake of the neurotransmitter dopamine.

5. Stimulant drugs cause feelings of euphoria, increase energy, decrease fatigue, decrease the need for sleep, decrease appetite, and sometimes increase sexual feelings and sexual energy.

6. Medical problems associated with stimulants include:
   - An increase in the heart rate that can cause an elevation of blood pressure. Elevated blood pressure can cause hemorrhaging in the cranium.
   - Increase in heart rate that can cause cardiac fibrillation, respiratory arrest, and death.
   - Pulmonary problems such as bronchitis.
   - Contaminated needles may cause complications such as hepatitis, abscesses, AIDS virus, or endocarditis.
   - Damage to the nasal septum (for those who snort cocaine).
   - Damage to unborn fetus in pregnant women.

7. Cocaine and other stimulants can cause a withdrawal syndrome. Symptoms include depression, fatigue, unpleasant dreams, sleep disturbance, increased appetite and psychomotor agitation or retardation.

8. These drugs may cause serious psychiatric and psychosocial problems. Ask group members for examples and add additional ones such as:
   - Depression, suicidal feelings and attempts.
   - Accidents.
   - Violence, antisocial behaviors and impulsive behaviors.
   - Psychosis, including paranoia.
   - Panic symptoms.
   - Work, family, legal, financial, and other problems.

9. Many with stimulant addiction have problems with alcohol or other drugs. Continuing to drink alcohol or smoke pot significantly raises the risk of relapse to cocaine use.

10. Treatments for cocaine problems include:
    - Short-term residential treatment (under 60 days) or an intensive outpatient program for more severe types of cocaine dependence or problems with cocaine and other substances like alcohol, marijuana, opioids or sedative drugs.
    - If you have made multiple attempts at recovery but continue to relapse, consider a long-term residential program such as a therapeutic community (TC). TC programs usually last 6 months or longer and help you maintain recovery, change yourself and begin to focus on goals related to job training, school or work.
    - Individual, group or family therapy.

11. No medications for cocaine dependence have been approved by the FDA yet. Modafanil (Provigil), Vigabatrin and a cocaine vaccine show promise and are being studied.

12. Treatment for stimulant abuse or dependence works best if you complete a treatment program, attend your sessions and use what you learn to make changes in your life.

13. Talk with your counselor about involving your family or significant other in treatment.

14. Active involvement in Cocaine Anonymous (CA), Crystal Meth Anonymous (CMA) or Narcotics Anonymous (NA) can help with long-term recovery.
    - Attend meetings regularly and get a home group. Go to meetings when you feel like it and when you don't feel like it—make it part of your weekly routine.
    - Get a CA, CMA or NA sponsor and talk with him or her every day.
    - Get a list of phone numbers from other CA's CMAs or NA's who are drug free and working a program of recovery
    - Work the 12-Steps of CA, CMA or NA with your sponsor.
    - Read recovery literature from CA, CMA or NA. Ask your sponsor other others for recommendations.

Group Topic
Heroin and Other Opioids

Objectives of Group Session

1. Review the effects of heroin and other opioids.
2. Identify medical problems associated with these drugs.
3. Identify psychosocial and psychiatric problems associated with opioid abuse and dependence.
4. Review treatment options for opioid problems.

Points and Issues for Discussion

1. Ask group members their experiences, both positive and negative, or using opioid drugs.

2. Opioids include street drugs like heroin or opium, or prescription narcotics such as Methadone, Dilaudid, Percodan, Darvon, Vicodin and Oxycontin.
   - Opioids can be ingested by using a needle, snorting, smoking, or in pill form. Some addicts mix cocaine with heroin ("speedball").
   - Prescribed opioids are used to reduce or control pain or as cough suppressants.

3. Effects of opioids depend on the types and amounts used and methods of use.
   - Opioids are dangerous when taken in large doses and can cause death by coma.
   - Heroin is "cut" with adulterants that can be dangerous when ingested.
   - Using "dirty" needles or works to prepare and shoot drugs can lead to infections.
   - Some die from overdoses, suicides, homicides, and medical problem.

4. Ask about withdrawal symptoms anyone has experienced such as:
   - Depression, nausea, vomiting, muscle aches, runny nose, yawning, tearing eyes, sweating, tremors, sleep and appetite disturbance, weakness, fever, chills, cramping and abdominal pain, diarrhea, gooseflesh, and strong drug cravings.
   - Withdrawal is not as severe or life threatening as with alcohol or barbiturates.

5. Elicit examples of medical problems caused or worsened by opioid use such as:
   - HIV infections and AIDS.
   - Skin and muscle abscesses and infections.
   - Liver disease, tetanus, malaria.
   - Gastric ulcers, kidney failure, endocarditis, heart arrhythmias.
   - Sexual dysfunctions.

6. Elicit examples of psychosocial or psychiatric problems caused or worsened by opioid use:
   - Depression, suicidal feelings or actual attempts.
   - Anti-social and criminal behaviors, including violence, committed to get money to buy the drugs.
   - Work, family, legal, financial, spiritual, and other problems.

7. Many with opioid addiction have problems with alcohol or other drugs. Abstinence from alcohol and all other drugs is important for recovery to progress.

8. Ask group members about their experiences in treatment for opioid problems. Treatments include:
   - Short-term residential treatment (under 60 days) or an intensive outpatient program for more severe types of opioid dependence or problems with opioids and other substances like alcohol, marijuana, stimulants or sedative drugs.
   - If you have made multiple attempts at recovery but continue to relapse, consider a long-term residential program such as a therapeutic community (TC). TC programs usually last 6 months or longer and help you maintain recovery, change yourself and begin to focus on goals related to job training, school or work.
   - Individual, group or family therapy. Encourage members to include their family when possible.
   - Medications to aid withdrawal or replace opioids like heroin (methadone or suboxone, buprenorphine).

9. Treatment for opioid addiction works best if you complete a program, attend your sessions and use what you learn to make changes in your life, and attend mutual support programs like NA.

10. Active involvement in Narcotics Anonymous (NA) can help with long-term recovery.
    - Attend meetings regularly and get a home group. Go to meetings when you feel like it and when you don't feel like it—make it part of your weekly routine.
    - Get an NA sponsor and talk with him or her every day.
    - Get a list of phone numbers from other NA's who are drug free and working a program.
    - Work the 12-Steps of NA with your sponsor.
    - Read recovery literature from NA. Ask your sponsor other others for recommendations.

11. Opioid addicts unable to get and stay drug free with rehabilitation programs, counseling, and/or NA, may benefit from Methadone Maintenance (MM).
    - MM "replaces" opioid drugs, allowing the affected individual to function.
    - MM is offered under medical supervision in conjunction with counseling.
    - Many take MM for 1-2 years, but others remain on it for years.
    - There is nothing wrong with taking this replacement medication for a long time if it helps you put your life together and stay in recovery.

12. Other medications for opioid addiction include buprenorphine and naltrexone.
    - Buprenorphine (Buprenex) is used to ease withdrawal and as a replacement drug in maintenance therapy.
    - Naltrexone (Trexan) blocks the euphoric high of opioid drugs so the addicted person does feel the usual "high" from opioids.

Group Topic
Cannabis

Objectives of Group Session

1. Review the effects of cannabis.
2. Identify problems associated with cannabis abuse or dependence.
3. Review treatment and recovery for cannabis problems.

Points and Issues for Discussion

1. Ask group about experiences, both positive and negative, of using marijuana: types used, effects and problems caused. Discuss what they liked about using this drug.

2. During this discussion review facts about marijuana and effects.
   - Marijuana is the most commonly used illegal drug in the U.S.
   - Slang terms: pot, grass, weed, MJ, reefer, boo, broccoli, ace, joint, ganga, blunt.
   - It is a mixture of leaves, stems, seeds and flowers of cannabis sativa, the hemp plant.
   - Hash and hash oil are the strongest forms of this drug.
   - It is smoked in cigarettes, pipes, blunts, or eaten.
   - Marijuana has over 400 chemicals.
   - TCH (delta-9-tetrahydrocannabinol) is the main active chemical in marijuana.
   - It can be detected in urine weeks after the last use for chronic users of this drug.

3. When smoked, THC travels throughout the body.
   - The effects depend on how much THC is in it, expectations of the user, setting of drug use, how it is ingested, and whether alcohol or other drugs are used with marijuana.
   - THC connects to cannabinoid receptors on nerve cells to influence memory, thought, pleasure, concentration, sensory and time perception and coordinated movements.
   - Peak level is reached in 10-30 minutes after smoking and intoxication lasts 2-4 hours.
   - Peak level is reached in 30-60 minutes after eating it and intoxication lasts up to 8 hours.

4. There are some medical uses of THC such as reducing nausea in cancer clients and stimulating appetite in AIDS clients.

5. Marijuana affects many regions of the brain such as the:
   - Cerebellum, which controls body movement and coordination.
   - Hippocampus, which affects learning and memory.
   - Cerebral cortex, which controls thinking and judgment.
   - Nucleus accumbens or the reward center.
   - Basal ganglia, which affects movement.
   - Amgdala, which affects emotions such as fear or panic.
   - These effects on the brain contribute to confusion, illogical thinking, increased appetite, impaired ability to concentrate or learn, impaired coordination and ability to drive.

6. Withdrawal from cannabis addiction is mild and includes nausea, insomnia, irritability and anxiety

7. Effects marijuana use, abuse or addiction on the heart include:
   - Increase in heart rate and blood pressure.
   - Increase risk of heart attack.
   - Reduces oxygen-carrying capacity of blood.

8. Effects of marijuana use, abuse or addiction on lungs include:
   - Increase in risk for cancer of head or neck.
   - Problems similar to those of smokers: cough, acute chest illness, risk of lunch infections, and obstructed airways.

9. There are effects on pregnancy and children. Infants of mothers addicted to marijuana have:
   - Lower birth weight.
   - Tremors and startle response.
   - Increased problems with memory, attention, language and behavior.

10. Other effects of marijuana use, abuse or addiction include:
    - Depressed or anxious mood.
    - Changes in personality.
    - Lower motivation at work or school.
    - Increase in absences from work or school or being late.
    - Use and abuse of other substances like alcohol.

11. There are many treatments for marijuana problems. These include:
    - Residential treatment or an intensive outpatient program for more severe addiction or problems with marijuana and other drugs or alcohol.
    - Individual, group or family therapy.

12. Treatment works best if you complete a treatment program, attend your sessions and use what you learn to make changes in your life. Involve your family or significant other.

13. Active involvement in Narcotics Anonymous (NA) can also help with long-term recovery.
    - Attend meetings regularly and get a home group. Go to meetings when you feel like it and when you don't feel like it—make it part of your weekly routine.
    - Get an NA sponsor and talk with him or her every day.
    - Get a list of phone numbers from other NA's who are sober and working a program.
    - Work the 12-Steps of NA.
    - Read NA recovery literature (e.g., the "Basic Text" of NA).

Group Topic
Nicotine

Objectives of Group Session

1. Provide information about nicotine and nicotine addiction
2. Understanding the link between nicotine and other substance abuse
3. Review strategies to prepare to quit smoking
4. Review challenges associated with stopping the use of nicotine.

Points and Issues for Discussion

1. Ask group members about experiences using nicotine, both positive and negative.

2. Nicotine is a highly addictive, natural compound found in the leaves of the tobacco plant
   - It is rapidly distributed throughout the body, reaching the brain within 8-10 seconds.
   - It can enter the bloodstream through inhalation (cigarettes) through the mucous membranes of the mouth (chewing tobacco) and the nose (when snuff is used).

3. Nicotine, like alcohol and other drugs of abuse has the ability to activate the dopamine system in the reward circuitry of the brain.
   - The younger people begin smoking cigarettes, the more likely they are to become addicted to nicotine
   - In young people who try smoking; up to one-third to one-half become daily smokers.

4. Ask group members how many smoke, how much they smoke, and how this interacts with the alcohol or other drug problem that brought them to treatment
   - Among clients seeking treatment for substance use disorders, 80-90% are smokers.
   - The act of smoking serves as a cue for drug and alcohol craving and nicotine serves as a primer for drug and alcohol abuse.

5. As for examples of consequences of smoking
   - Smoking is the leading cause of preventable death in the United States.
   - Smoking is the single highest contributor to mortality in clients with alcoholism.
   - Smoking kills 1 out 10 adults each year worldwide
   - Out of the 6.7 billion people in the world it is estimated that 500 million will die from tobacco consumption eventually
   - 430,000 Americans die each year from smoking related diseases, 40,000 deaths from heart disease caused by second hand smoking occur each year

6. Nicotine Addiction or Dependence involves:
   - Tolerance is developed when one must increase amounts of nicotine in order to achieve the desired effect of nicotine
   - Nicotine is often used in larger amounts than one has planned on
   - A large period of time is spent on obtaining, using or recovering from nicotine use

- Some social, occupational, or recreational activities are avoided or are less attended due to nicotine use.
- Continued use of nicotine despite knowing the negative effects of nicotine.

7. Ask group members if they have tried to quit, what methods they used, and what the outcome of these quit attempts were.
   - Nicotine dependence requires a comprehensive treatment approach including a combination of counseling, support and medication.
   - There are several medications and nicotine replacement products to help.
   - Nicotine patch, gum and lozenges are nicotine replacement products.
   - Varenicline, Buproprion and Clonidine are non-nicotine cessation medications.

8. Client surveys at substance use disorder treatment programs across the nation indicate:
   - A strong interest, readiness and willingness to participate in smoking cessation treatment while getting help for other alcohol or drug problems.
   - Clients that are smoke free during treatment and at follow-up are nearly twice as likely to have drug-free urine samples as those who are smoking.

9. Ask the group members to assess their nicotine dependence using the Fagerstrom Test (Score of 6 or greater-highly nicotine dependent; 5 or less-less nicotine dependent.)
   - How soon after you wake up do you smoke your first cigarette? within 5 minutes (3); 6-30 minutes (2); 31-60 minutes (1); after 1 hour (0)
   - Do you find it difficult to refrain from smoking where it is forbidden? yes (1); no (0)
   - Which cigarette would you most hate to give up? The first one in the morning (1); Any other (0)
   - How many cigarettes do you smoke a day? 31 or more (3); 21-20 (2); 11-20 (1); 10 or fewer (0)
   - Do you smoke more frequently during the first hours after waking than during the rest of the day? Yes (1); No (0)
   - Do you smoke when you are so ill you are in bed most of the day? Yes (1); No (0)

10. Ask the group members to identify the "5 R's associated with quitting.
    - Relevance: why is quitting personally relevant (important) to them at this time?
    - Risks; what are the risks associated with continued nicotine use?
    - Rewards: what are the benefits to stopping nicotine use?
    - Roadblocks: what are the barriers to quitting, how can treatment address these issues?
    - Repetition: what question or point of discussion can treatment or the therapist repeat to help them be motivated to quit or stay quit?

11. When a person decides to quit smoking the best thing to do is find a good time to quit.
    - Do not try to quit smoking during a stressful period, but rather a date you know you will not be tempted to smoke.
    - Identify a specific stop date.
    - Prior to stopping make a list of pros and cons to not smoking.
    - Keep a log of their cigarette use at least one week before your targeted stop date.

12. Ask the group members to discuss withdrawal symptoms they have experienced in the past, which symptoms they can expect now and ways to address these symptoms. Symptoms are:
    - Low or depressed mood, insomnia
    - Irritability, frustration and or anger, anxiety
    - Difficulty concentrating, restlessness
    - Decreased heart rate
    - Increased appetite or weight gain

13. Once you stop smoking it is not unlikely to relapse on nicotine. Almost 60-90% relapses within the first 2 weeks. Common relapse signs are:
    - *Behavior changes*: irritability, arguing with others for no reasons, being in a situation where smoking is common i.e., smoking section of restaurants, the smoking lounge
    - *Attitude changes:* Negativity about life and how your life is going
    - *Changes in thoughts*: thinking you can smoke one cigarette without getting hooked
    - *Changes in feelings or moods*: increased moodiness or depression, anger at yourself or others, increased feelings in boredom.

14. If relapse occurs, remind group members that it takes most smokers several attempts to stay quit but that cessation is possible.
    - Ask group members to identify what helped in their quit attempt, what worked against it?
    - Discuss what medication or nicotine replacement products are being used and if they are helping in cessation.
    - During the quit attempt, were the group members able to reduce the number of cigarettes smoked, or the places or situations in which they smoked?

15. Steps to prevent relapse or reduce the risk of relapse to smoking:
    - Identify high risk situations. These are situations that are internal and external that may increase the likelihood of you smoking again
    - Identify urges and desires to smoke
    - Talk with others when you feel the urge to smoke
    - Redirect yourself to another activity. For example, clean your house, work out, do work around your house, write in a journal, or walk your dog
    - Think positively. Turn negative thoughts in to positive thoughts.
    - Avoid high-risk or dangerous situations
    - Keep a daily log of your progress.

Group Topic
Effects of Substance Use Disorders

Objectives of Group Session

1. Identify effects of substance use disorders (SUD's).
2. Identify problems caused or worsened by substance use and SUDs.
3. Introduce "progression" and how problems caused by SUD's can worsen over time.
4. Review strategies to deal with negative effects and problems associated with SUD's.

Points and Issues for Discussion

1. Substance use disorders (SUD's) are associated with many negative effects.

2. SUDs can cause or worsen psychological, psychiatric, family, interpersonal, social, academic, occupational, legal, spiritual, and financial problems.

3. Elicit examples of problems caused or worsened by substance use or SUD's. Use examples of group members and add new ones to summarize problems associated with SUDs, methods of use (e.g., dirty needles), or a lifestyle centered around substance use. Example include:

4. **Health** problems include injuries, infectious diseases, medical disorders, dental problems, sleep problems, weight loss, sexual problems (loss of interest or ability to engage in sex).
   - These can result from poor health care habits.
   - These can also result from effects of substances and addiction on medical diseases.
   - Accidents

5. **Psychiatric** problems can result from acute and chronic use of substances, which can cause:
   - Cognitive, mood-related, physical or behavioral symptoms
   - Psychiatric disorders are more common among those with alcohol (37%) or drug abuse or dependence (53%) compared to the general population (22%).

6. **Psychological** problems include poor judgment, lowered motivation, poor emotional control, memory problems, low self-esteem and poor control over behavior when using substances.

7. **Family** problems include divorce and family break-ups.
   - Addiction is associated with many negative effects on family members, including children.
   - Children of substance abusers are more likely than other kids to have a SUD, psychiatric illness, academic or behavioral problems.
   - Many people with SUDs become disconnected from parents, siblings, children and other relatives. Much heartache is caused in families by substance problems.

8. **Interpersonal and social** problems are common as relationships can be harmed or lost.
   - Non-substance social activities may be given up due to the addiction.
   - Relationships can be harmed by in many ways.

9. **Occupational and academic** problems include underfunctioning at school or work, an inability to find or keep a job, poor grades, or flunking out of school.

10. **Legal** problems include criminal behaviors leading to incarceration or probation.
    - Many people are incarcerated for crimes caused by the effects of substances or to get money to pay for them.
    - Substance abuse and addiction are common problems among inmates in jails and prisons. Many would not be there if not for their addiction.

11. **Spiritual** problems include shame, guilt, feeling empty, and becoming disconnected from loved ones or church are common spiritual problems associated with SUD's.

12. **Financial** problems include debt, failure to pay bills and inability to meet living expenses.

13. Ask group members how remaining in treatment and engaging in recovery can help them reverse some of the negative effects caused or worsened by their substance use disorder.
    - Emphasize how staying in treatment leads not only to improvement in substance use, but improvement in different areas of life.
    - As problems improve, the quality of group members' lives can improve, too.
    - Trust can be regained in relationships.

14. Ask group members what else they can do to begin reversing some of the negative effects and problems associated with substance use disorders.
    - Emphasize how some negative effects or problems may be reduced when they get and remain sober over time.
    - State that some negative effects or problems cannot be reversed or changed. Elicit examples from group members.

15. Discuss the importance of resolving problems as recovery progresses.
    - Emphasize the need to limit the number of problems addressed in early recovery so that group members do not feel overwhelmed.
    - State that this can help "small" problems from getting worse.

CHAPTER 6
Groups about Treatment for Substance Use Disorders

Treatment of Substance Use Disorders
How to Get the Most Out of Treatment
Creating a Problem List and Treatment Plan

Group Topic
Treatment of Substance Use Disorders

Objectives of Group Session

1. Review types of psychosocial treatments and programs for SUDs
2. Review role of medication-assisted treatment
3. Review specific types of medications for SUDs
4. Discuss importance of compliance with treatment

Points and Issues for Discussion

1. Ask group members about experiences in treatment and what was most helpful.

2. Discuss the "continuum of care" of treatment services for SUDs and ask clients which they have participated in. As you review services, briefly review the goals of each and have clients give specific examples of how these programs helped them in the past.

3. **Detoxification Programs**: Goals of detox are to safely withdraw from addictive substances, stabilize medically, and engage in the next level of care. Detox has three levels.
   - Level 4A (medically managed in a hospital under the care of a doctor and nurses).
   - Level 3A (medically monitored in a rehab program under the care of a doctor and nurses).
   - Outpatient detox (under the care of a doctor and nurse).

4. **Rehabilitation Programs: These include both short and long term programs.**
   - *Short-term* residential programs last 30 days or less. These may involve individual, family and group therapy, recovery and other types of groups, mutual support programs (AA, NA, and others) and other activities aimed at helping manage the SUD. The goals of rehab are to: accept the SUD, develop a plan for ongoing recovery and engage in the next level of care.
   - *Long-term* residential programs are for 30 days to a year or longer. These include Halfway House, Quarterway House, and Therapeutic Community programs. The goals are to help continue recovery by learning skills to manage the addiction, improve relationships and support systems, manage emotions, work on vocational or occupational goals and prepare for living in the community as a responsible citizen.

5. **Partial Hospital and Intensive Outpatient Programs:** These vary in length from 3-7 days per week, 3- 8 hours per day, and last several weeks to months. These programs may involve services similar to those in residential rehab (therapy, mutual support meetings, and other services such as HIV education, testing and counseling).

6. **Outpatient Counseling (OPT)***:* This may involve regular individual, group or family sessions with a counselor to help deal with the SUD. Goals are individualized and depend on the severity of the SUD, motivation to change and personal problems.

- Some people use OPT only to learn they need detox or rehab or IOP programs. Others use these as a "step down" program from a higher level of care,
- Others use OPT as a way to get help with the SUD and related problems.
- At least 3 months or longer is usually needed to get benefits from outpatient counseling for drug problems.

7. Ask group members how best to take advantage of individual or group therapy. What can they do to make these treatments beneficial?
   - Go prepared to sessions with problems or concerns to discuss.
   - If in group, open up and share your thoughts, feelings, and problems with peers.
   - Elicit examples of how members benefited from treatment when they stuck with it, opened up to their therapist or group, followed through with making changes, and used "recovery skills."
   - Combining professional treatment with mutual support program participation often leads to better improvement.

8. Ask group members what has happened in the past when they dropped out of treatment early, missed sessions, came late or didn't take advantage of the help of professionals.
   - Recovery was more complicated.
   - Problems were less likely to get resolved.
   - Relapse was more likely.

9. As group members how medication-assisted treatment has helped them in the past in their recovery from addiction. Discuss the various ways medications are used:
   - To help detoxify from addictive substances.
   - As a "replacement" for opioid drugs like heroin or prescription pain medicine. Examples include methadone and buprenorphine.
   - To block the effects of opioid drugs (Trexan)
   - To reduce cravings for alcohol or other drugs.
   - To assist the person in recovery from an addiction.

10. Review how medications are used to help a person withdraw from physical addiction to alcohol or drugs like benzos or opioids.
    - Review examples of withdrawal symptoms.
    - Discuss length of withdrawal: acute and protracted.

11. Review medications used to help clients with alcohol, opioid, nicotine or other types of addiction. Ask group members for their experiences with these medications.

12. Discuss the importance of using counseling and participating in mutual support programs in addition to taking medication for any substance addiction.

13. Discuss the importance of compliance with medications. What happens when medications are not taken as prescribed?

Group Topic
How to Get the Most out of Treatment

Objectives of Group Session

1. Identify group members' expectations of treatment.
2. Review the importance of taking an "active" role in treatment and responsibility for change.
3. Identify the benefits and limitations of professional treatment.
4. Review attitudes and behaviors that promote a positive recovery.

Points and Issues for Discussion

1. Ask group members what they expect from professional treatment.
   - What are their goals and why is it important to set and prioritize goals for treatment?
   - How they see their role in treatment? What do they need to do?
   - How do they view their responsibility with treatment compliance?
   - What do they need to change in themselves or lifestyle to manage their substance problem?

2. Group members need realistic expectations about treatment and recovery.
   - Unrealistic expectations, especially those that are too high, will set group members up to fail, feel frustrated, or feel disappointed.
   - Treatment and recovery are only effective to the degree that clients work hard to change and deal with the many challenges facing them.

3. Stress the importance of group members taking an "active" role in treatment by working with their counselor or treatment team to:
   - Identify problems and goals, and strategies to reach these goals.
   - Practice and implement change strategies.
   - Evaluate progress with change plan.
   - Change ineffective strategies.

4. Review how treatment can help as well as limitations of treatment and the professionals providing it. For example:
   - Treatment can help you get sober, deal with problems caused or worsened by your substance use disorder, and learn ways to sustain recovery over the long-term.
   - Treatment can provide an understanding of how mutual support programs can aid long-term recovery and help prepare you for these programs.
   - A therapist will not always be available for phone discussions and may not be able to give counseling appointments as often as you would like.
   - Changing a therapist is not always advisable. You should not change a therapist or counselor without discussing the reasons and getting input from an objective person.
   - Group members may not always like the treatment they receive or the professionals providing their care.

5. Discuss attitudes and behaviors that aid involvement in treatment.
   - Being honest with professionals about problems, struggles, feelings, and thoughts.
   - Being patient and persistent regarding change.
   - Making a commitment to recovery.
   - Attending all treatment sessions and being on time.
   - Being self-reflective.
   - Setting realistic goals for change.
   - Sharing goals with others and asking for their feedback.
   - Knowing when and how to ask others for help and support.
   - Applying coping strategies to deal with problems.

6. Ask group members for examples of behaviors that sabotage or interfere with positive use of treatment or their recovery. Some examples include:
   - Missing or coming late to treatment sessions.
   - Dropping out of treatment early or leaving against medical advice.
   - Not following through with agreements made with group or counselor.
   - Keeping secrets from your counselor or group.
   - Lying about relapses and acting like things are OK when they are not.
   - Putting yourself in high-risk situations.
   - Cutting down or stopping mutual support groups meetings without discussing the reasons with someone you trust who knows you (e.g., a sponsor).
   - Focusing too much attention on the wrong priorities (e.g., not making recovery a high priority).
   - Focusing on a new relationship so much that recovery takes a back seat.

7. Discuss attitudes and behaviors that aid recovery.
   - Regular attendance at AA, NA, or other support groups.
   - Trying out different types of meetings and mutual support programs.
   - Connecting with a "home" group.
   - Getting and using a sponsor.
   - Getting telephone numbers and keeping in regular contact with members of mutual support programs.
   - Working the 12-steps and using other program tools.
   - Allowing room for mistakes and learning from them.

8. Discuss how members can evaluate their progress regularly and change their plans as needed.

9. Discuss how treatment can help members develop their "inner resources" and learn ways to help themselves.

Group Topic
Creating a Problem List and Treatment Plan

Objectives of Group Session

1. Review how to develop a problem list and treatment plan with specific recovery goals.
2. Review problems associated with substance use disorders.
3. Help group members identify personal strengths and resiliencies.
4. Review how to develop steps or methods to reach goals related to problems identified.

Points and Issues for Discussion

1. Ask group members why they came to treatment and what they hope to gain from it.

2. Emphasize the importance of keeping the addiction as the primary focus of treatment.

3. Briefly review problems associated with substance use disorders and why treatment should focus on helping address some of these problems.
   - Motivational, cognitive, emotional, spiritual
   - Interpersonal, social
   - Legal, financial, medical

4. Discuss the importance of prioritizing problems and limiting the focus on just a few in early recovery. The substance use disorders must remain the number one priority.

5. Emphasize that during the early stages of recovery, the main emphasis is on getting sober and learning how to work a program of recovery to help sustain long-term sobriety.

6. Discuss the importance of total abstinence. Ask how use of "other" substances can impact on the primary substance problem. Substance use can:
   - Affect motivation to change.
   - Cause problems in any area of life.
   - Have a negative impact on adherence to treatment and recovery.
   - Lower the effectiveness of some medications or cause interactions.

7. Every person has personal strengths and resiliencies. Ask members to identify their strengths and resiliencies that can aid recovery or add to quality of life such as:
   - Positive qualities such as being friendly, loving, sociable, kind, altruistic, committed, resourceful, or assertive.
   - Good relationships with family, friends, AA/NA members, caregivers, or others.
   - Positive attitudes about recovery and willingness to work hard.
   - Stable living, job, or economic situation.
   - Talents such as athletic, musical, artistic, mechanical, or other abilities.
   - Faith in God or a belief in a Higher Power.
   - Ability to bounce back from adversity and learn from problems or personal suffering.

8. Define goals as statements about what a person wants to achieve (i.e., to learn, do, accomplish). Goals imply action toward some end and are best described with "action verbs."
   - Goals may relate to the addiction (e.g., getting sober, managing cravings, avoiding high-risk people, places or things).
   - Goals may relate to a specific area of life (e.g., getting a job, engaging in new leisure interests not involving drugs or alcohol, developing sober friendships).

9. Ask group members why it is important to set goals.
   - Goals make treatment an active process by providing a focus for change.
   - Goals provide structure and a way to reach specific ends that are desirable.
   - Goals are a way to judge progress towards a desired end.
   - The process of working toward a goal can be as important as the goal itself.
   - Goals give a sense of direction and provide hope.

10. Define short, medium, and long-term goals as follows:
   - Short-term: less than three months.
   - Medium-term: four to twelve months.
   - Long-term: one year or longer.

11. Ask about the importance of having an "action plan" to reach goals. Ask for examples from group members. Emphasize the need for several coping strategies.
   - *Cognitive:* changing thoughts and beliefs, reflecting on oneself, recovery and life, and thinking through problems.
   - *Behavioral*: changing how one acts or copes with problems.
   - *Interpersonal*: using help and support from others, improving communication and relationships.
   - *Physical/lifestyle*: changing health care habits, exercising, following a diet, or changing lifestyle.
   - *Emotional*: changing how you manage feelings or mood states.
   - *Spiritual:*: using a Higher Power, prayer, meditation, forgiveness, helping others or focusing on contributing to the good of society.

12. Discuss the importance of "walking the walk," not just "talking the talk" of recovery.
   - Discuss the need to practice new behaviors and accept that mistakes may be made, and it may take time to make successful changes.
   - Elicit examples of successful changes and what was involved in making these changes (e.g., putting forth effort, taking time to change, having a plan, using support from others, and learning from mistakes).

CHAPTER 7
Groups about Recovery

The Process and Domains of Recovery
Stages of Change
Advantages of Recovery
People, Places, Things, Events, Holidays
Cravings and Triggers (Internal and External)
Barriers to Recovery

Group Topic
The Process and Domains of Recovery

Objectives of Group Session

1. Define recovery as a long-term process of "abstinence + change."
2. Review domain of recovery: physical, psychological, family, social and spiritual.
3. Review internal and external aspects of change.

Points or Issues for Discussion

1. Ask group members their view of the difference between "treatment" and "recovery."

2. Treatment involves:
   - Attending a program (e.g., detox, rehab or IOP), participating in counseling, taking medication for an addiction, or a combination of these.
   - It is provided by professionals and helps you get and stay sober and deal with problems caused or worsened by your addiction.
   - Treatment helps you understand and engage in recovery.
   - Treatment helps you learn recovery skills to sustain your sobriety over time.
   - Multiple episodes of treatment over time may be needed to help you sustain long-term recovery.

3. Recovery is a long-term process of **abstinence + change**. Ask group members what this means.

4. Ask members their view of the importance of abstinence from all substances.
   - Discuss why abstinence from all substances (alcohol, street drugs and non-prescribed drugs) is recommended not just the "primary" drug of choice (if there is one).
   - Any substance use can threaten recovery from the primary drug of addiction or lead to developing an addiction to another substance.

5. Ask group members to share their views of recovery as a "long-term" process.
   - Treatment may be short-term (e.g., 5 days of detox, 21 days of residential rehab), but recovery continues.
   - For addiction, it is best to view recovery as occurring for years. Many engage in recovery programs such as AA, NA for their entire life.

6. Encourage members to use strategies to deal with periods of low motivation.
   - Reminding oneself of the negative effects of addiction on self, family and others.
   - Reviewing the benefits of sobriety, both short and long term.
   - Repeating one's goals and how important sobriety is in reaching these goals.
   - Accepting motivational struggles as normal and remaining client.
   - Admitting motivational struggles and sharing them with others who understand.
   - Talking to AA, NA, CA friends or sponsor.
   - Reading inspirational literature or recovery literature.
   - Maintaining recovery disciplines even in the face of declining motivation.

7. Review the physical domain of recovery.
    - Good nutrition
    - Regular exercise
    - Getting adequate sleep
    - Relaxation
    - Taking care of medical or dental problems
    - Learning to cope with cravings to drink alcohol or ingest drugs.

8. Review the psychological domain of recovery.
    - Accepting the addiction.
    - Learning to cope with problems and stresses without relying on substances.
    - Changing distorted, negative or "stinking" thinking.
    - Managing emotions without relying on substances.
    - Getting help for psychological problems or psychiatric disorders.

9. Review the family domain of recovery.
    - Reviewing the effects of addiction on the family and individual members.
    - Involving the family in treatment and recovery.
    - Making amends when appropriate.
    - Improving relationships with family members.

10. Review the social domain of recovery.
    - Developing relationships with sober people.
    - Learning to resist pressures from others to use substances
    - Developing healthy social and leisure interests to occupy time.

11. Review the spiritual domain of recovery.
    - Relying on a Higher Power for help and strength.
    - Developing a sense of purpose and meaning in life.
    - Taking other steps to improve one's faith or "inner life."
    - Engaging in religious or faith based practices.
    - Praying, meditating, reading spiritual literature.

12. Discuss how recovery is best viewed as a "we" process in which you use the support of others, especially sober individuals who are actively working a program of recovery.

13. Ask for examples of change that may occur in recovery.
    - Internal change refers to changes within one self (how you think or manage emotions).
    - External change refers to changes in relationship and lifestyle.

Group Topic
Stages of Change

Objectives of Group Session

1. Identify stages of change in recovery and problems associated with these stages.
2. Have group members identify their stage of change related to their drug or alcohol problem.
3. Identify the short- and long-term benefits of recovery.

Points or Issues for Discussion

1. Introduce the concept of stages of change in recovery. As these stages are discussed, ask group members where they think are at this time in their lives related to these stages. Elicit personal examples related to each stage from their current or past experiences.

2. Precontemplation
   - In this stage you do not believe you have a problem or need help.
   - This may account for the fact that over 80% of people with substance abuse or addiction never get help.
   - Most who get help are pressured or encouraged to do so by family members, friends, medical professionals, other professionals or the legal system.
   - External pressure is common in the early stages of change.

3. Contemplation
   - In this stage you begin to admit you have a problem, and think you may do something about it in the future, but not now.

4. Preparation
   - In this stage you plan to take action to deal with your substance problem.
   - You make a commitment to change.
   - This may involve getting involved in treatment, a mutual support program or both.
   - You still have mixed feelings about your problem and whether you want to stop using.

5. Action
   - In this stage you work on changing your alcohol or drug problem.
   - This may involve getting involved in treatment, a mutual support program or both.
   - If you have a physical addiction, you may need detoxification under the supervision of medical professionals.
   - You become an active partner with your therapist or treatment team, and engage in an active process of recovery to stop using substances and make changes in your life.
   - You view "addiction" as your problem, not drugs or alcohol.

6. In this stage of change, you begin to address the common issues associated with recovery from addiction such as:
   - Managing cravings and thoughts of using
   - Avoiding high-risk people, places and things

- Learning to have fun without using substances
- Dealing with emotions (anger, anxiety, boredom, depression, loneliness, guilt or shame) in positive ways so you do not use substances.

7. For many people, this involves "active" participation in support programs such as AA, NA and other 12-Step programs or other mutual support programs (Rational Recovery, SMART Recovery, Women for Sobriety, etc). This means:
   - Attending meetings
   - Getting a sponsor to guide you in your recovery
   - Exchanging phone numbers
   - Keeping in daily contact with others in recovery
   - Working the 12-steps
   - Reading recovery literature
   - Using other "tools" of the program.

8. Maintenance
   - In this stage, you focus on strategies to reduce your risk of relapse.
   - You learn to identify and manage relapse warning signs.
   - You learn to identify and manage your personal high risk relapse factors.
   - You continue to focus on personal change and growth in recovery.
   - You also focus on the need to "balance" the various areas of your life.
   - You may continue participating in personal therapy, an aftercare group and/or ongoing mutual support groups.

9. Ask group members to identify short and long-term benefits of recovery.
   - *Short-term*: feel better physically, feel better mentally, reduce likelihood of getting in trouble related to alcohol or drug use, learn to manage cravings and desires to use, disengage from an addictive lifestyle, and begin to deal with aftermath or problems caused by a Substance Use Disorder.

   - *Long-term*: get life back on track, function better at work or in relationships, better able to reach goals in any area of life (work, family, social, spiritual, financial), undo damage caused by the Substance Use Disorder to loved ones like family (including children), and engage in a recovery lifestyle.

Group Topic
Advantages of Recovery

Objectives of Group Session

1. Review advantages and disadvantages of getting and staying sober.
2. Identify the advantages and disadvantages associated with ongoing recovery.

Points and Issues for Discussion

1. There are advantages and disadvantages associated with giving up alcohol and drugs, and initiating a program of recovery from substance use disorders.
   - These include short-term advantages and disadvantages.
   - These include longer-term advantages and disadvantages.

2. Points to emphasize and discuss include:
   - It is not easy to stop using substances and stay sober, especially in the early phases of recovery. A feeling of "loss" or "grief" is common with abstinence.
   - Many group members in early recovery are ambivalent about sobriety. Part of them wants to continue using substances while another part wants to get sober.
   - Motivation can change from day to day. Even within a single day, a group member's motivation can change.
   - Group members need to acknowledge and accept they have an "addicted side" that wants to use substances, and a "healthy side" that wants sobriety.
   - This ambivalence helps group members become able to focus on the advantages of giving up alcohol or drugs and changing.

3. Ask group members what they will miss about not using substances or living a lifestyle that is no longer centered on substance use.
   - Physical feelings related to alcohol or drug use.
   - Impact on moods and behaviors.
   - Temporary escape from problems, life, feelings.
   - Social aspect of alcohol or drug use.

4. Discuss the positive aspects of sobriety and recovery from the substance use disorder. These include improvements in:
   - Physical health: improved appetite or sleep, less pain, better overall health.
   - Psychological health: better control over emotions, thinking, impulses and behaviors; improved self-esteem.
   - Cognitive abilities: think more clearly, solve problems.
   - Family and social relationships: less family conflict; increasing family cohesion.
   - Ability to work or attend school.
   - Spiritual health.
   - Financial situation.
   - Quality of life.

5. Ask group members what they think are the advantages and disadvantages of involvement in ongoing recovery. Points to emphasize include:
   - Recovery requires patience, discipline, and hard work.
   - Recovery has rough spots; it is not always easy and at times you may want to give up or question the ability to change
   - A program of recovery helps you get and stay sober by making changes in yourself and lifestyle. Recovery gives a "focus" to your life and energy.
   - Although there may be disadvantages, these are outweighed by the potential advantages of recovery.

6. Elicit personal examples of advantages or disadvantages group members have experienced in the past, or expect to experience in recovery in the future.

7. Ask group members how they have used the support of other people or organizations such as:
   - Family members or friends they trust
   - Sponsors or members of AA, NA, or other 12-step programs
   - A therapist or counselor
   - Other mutual support programs
   - Church or faith based organizations
   - Other community organizations

Group Topic
People, Places, Things, Events and Holidays

Objectives of Group Session

1. Define the concept of "high-risk" people, places, things and events.
2. Help group members identify personal risk factors related to these areas.
3. Review strategies to manage high-risk people, places, things and events.
4. Emphasize the importance of using active coping strategies to safely enjoy holidays.

Points and Issues for Discussion

1. All group members have "high-risk people, places, events and things" that can threaten recovery if they are unprepared to deal with these.

2. In relation to addiction, high-risk people, places, things and events are referred to as "triggers" since they may precipitate cravings or increase vulnerability to using substances.

3. Emphasize that it is the group members' use of active coping skills that ultimately determines the impact of people, places, events, and things on their recovery.
   - Elicit examples of failure to use coping skills in the past.
   - Ask why positive coping skills were not used.
   - Discuss why using positive coping skills is necessary for recovery.

4. Ask group members for specific examples and add to their list to cover a broad range of high-risk people, places, events and things that can affect their recovery. Common examples include:
   - Associating with drug dealers, other active addicts, or others who use drugs or get high on alcohol, even if they are not addicted.
   - Living with a spouse or partner who gets high on alcohol or other drugs or has an addiction.
   - Maintaining a relationship with a significant other who is non-supportive of recovery, critical, violent, or unable to have a mutual "give and take" relationship.
   - Spending time at places or events where alcohol or drugs flow freely (i.e., parties, bars, concerts, other social, work or family events, etc.) or where alcohol is used even in moderation.
   - Associating sex with getting high or being unable to have sex unless high on drugs or alcohol.
   - Other places and things that trigger desire to use substances include: music, drug paraphernalia, money, the sight or smell of other substances, positive thoughts of getting high, certain sexual partners, etc.

5. Elicit examples of positive coping skills members have used in the past. Then, review and discuss strategies to manage high-risk people, places, events, and things such as:
   - Avoiding high-risk people, places, and things when possible and appropriate.
   - Preparing ahead of time to cope with an unavoidable high-risk situation.
   - Ending relationships that are abusive or emotionally damaging.

- Minimizing time spent with family members or significant others who are critical or non-supportive of recovery.
- Requesting a partner with a substance use disorder who represents a risk to your recovery get involved in treatment.
- Gaining interpersonal strength to deal with destructive relationships through ongoing involvement in counseling.
- Maintaining awareness of high risk people, places, events and things, and talking to a support person to bounce off ideas on how to manage these.

6. Ask group members about the impact of holidays on recovery. Which holidays are most difficult in their recovery and why?
   - This will vary. For example, New Years Eve and St. Patrick Day are days that many people with alcohol problems associate with drinking and partying.
   - Or, the Christmas season is a time that others associate with upset feelings, which can make you feel at risk for alcohol or drug use.

7. Ask which holidays are the most risky for ongoing recovery and discuss why this is so.

8. Discuss how group members can use recovery supports to help them during holidays

9. Discuss strategies to manage holidays such as:
   - Spending them with supportive family and friends who do not threaten your sobriety.
   - Remaining active in recovery program activities such as meetings or events.
   - Participating in special events sponsored my mutual support programs like AA or NA.
   - Being more vigilant about your sobriety and recovery.
   - Planning ahead to feel prepared for holidays perceived as the most risky for group members.

10. Ask group members why social support is so important during the holidays.

Group Topic
Cravings and Triggers (Internal and External)

Objectives of Group Session

1. Define cues, triggers, or precipitants of cravings to use alcohol or drugs.
2. Identify external and internal precipitants of cravings.
3. Review strategies to manage cravings

Points and Issues for Discussion

1. Ask group members to define and describe cravings for alcohol or drugs.
   - How do cravings show in physical symptoms?
   - How do cravings show in their thoughts?
   - How do cravings show in their behaviors?

2. Ask group members to identify external factors that trigger their cravings and ask for specific examples for each category.
   - **People:** friends or family members they used with, dealers, spouse or partner who uses or gets high.
   - **Places**: parties, clubs, bars, any location associated with drinking alcohol or using drugs to get high.
   - **Events**: family or work functions, concerts, or any social event in which alcohol or drugs are being used.
   - **Things or objects** (external): alcohol or things associated with drinking, drugs or things associated with using drugs (papers, pipes, needles, any drug paraphernalia).

3. Ask group members to identify internal factors that trigger their cravings and ask for specific examples for each category.
   - Thoughts: "I need a drink or drug; I'm dying to get high; I have to use to get through the day."
   - Feelings: boredom, anxiety, loneliness, depression, anger.
   - Physical pain or discomfort.

4. Discuss levels of intensity of cravings (from mild to severe). The level of craving will determine coping strategies to use.
5. Review how drugs "hijack" the reward system of the brain, which results in substances bringing more pleasure than food, sex, or other activities.
6. One result of this hijacking is the susceptibility to "cravings" when experiencing memories of substance use or exposed to external triggers.
7. This hijacking helps to partially explain the "compulsion" to use substances despite the damage they cause.
   - Ask group members to describe their experiences with a compulsion to drink alcohol or use drugs.
   - Ask members to discuss at what level of intensity they believe it is difficult to manage their cravings to use substances.

8. Discuss the importance of using multiple strategies to manage cravings since one strategy may not work in every instance of a craving.

9. Review coping strategies to manage cravings by asking group members to share examples of times in which they successfully managed a craving such as:
   - Recognize and label your craving for alcohol or drugs and accept these are normal in recovery.
   - Keep a daily craving log in early recovery in order to remain vigilant and track your triggers, cravings and intensity of them.
   - Talk about your craving and related thinking with a sponsor or confidante so you do not keep it a secret and overwhelm you.
   - Go to a mutual self-help meeting such as AA or NA.
   - Talk to others in recovery to find out what they do to manage their cravings.
   - Talk yourself through the craving ("this will pass," "I can resist using," "I control my craving, it does not control me" or "one craving at a time").
   - Remember how far you have come in your recovery and how good you will feel if you stick with it and don't give in to your craving for drugs or alcohol.
   - Accept that your craving will pass in time, and most last just a few minutes.
   - Redirect your activity to distract yourself temporarily from your craving.
   - Write your thoughts about your craving and your related feelings in a journal.
   - Get rid of booze, drugs, and drug paraphernalia (external triggers).
   - Avoid high-risk people, places, events and things when possible when you are craving alcohol or drugs.
   - Pray or use your Higher Power and ask for help and strength.
   - Read recovery literature to stay focused on your sobriety.

10. Ask group members to discuss why they sometimes have given in to cravings in the past and other times resisted them.
    - What can they learn from these experiences?
    - What determines "not giving in" to "giving in" to a craving?
    - How do they feel when they "give in?"
    - How do they feel when they "resist" their cravings?

Group Topic
Barriers to Recovery

Objectives of Group Session

1. Review common barriers to recovery from substance use disorders.
2. Have group members identify their personal barriers to recovery.
3. Review strategies to work through barriers so clients do not sabotage their recovery
4. Reinforce the importance of staying involved in treatment and support groups when motivation wavers.

Points and Issues for Discussion

There are many barriers that can interfere with recovery. Ask group members for examples of personal factors that can impede, mess up or sabotage their recovery.

1. Use their examples and add others to review the following barriers to recovery.
   - *Attitude and motivation:* such as low motivation to change, difficulty accepting the addiction, or not caring about recovery.
   - *Relationship:* such as living with a person who gets high or not having a confidant or someone to confide in.
   - *Personality:* such as being stubborn and not letting others help, giving up too easily when things are difficult, or difficulty opening up and sharing problems.
   - *Lifestyle:* such as lack of structure or routine in daily life, failure to plan for the future, or having no direction in life.
   - *Treatment participation:* such as missing counseling sessions, dropping out early, or failure to take medications as prescribed.
2. Emphasize that awareness of group members' personal barriers to recovery puts them in a position to overcome them.
3. Ask each group member to identify one example from these categories and several specific ways to overcome this barrier.
4. Emphasize commonalities in these barriers and positive coping strategies. Add additional coping strategies to ones provided by group members as the discussion unfolds.
5. *Attitude and motivation*: share negative attitudes or changes in motivation with others (sponsor, AA/NA friends, counselor, trusted friend or family member). Accept that changes in motivation are common. Stick with your program even when you don't feel like it.

6. *Relationship*: avoid high-risk people, stop dead end or harmful relationships, "stick with the winners" (in AA, NA and other mutual support programs); focus on relationships in which there is adequate "give and take." Learn to reach out to others you trust for help and support; get and use a sponsor in AA/NA.

7. *Personality*: use the 12-Step program to identify "defects of character" and ways to improve oneself; focus less on self and more on others; increase gratitude, kindness and positive behaviors towards others.

8. *Lifestyle*: develop discipline, routine and structure in your life; set goals; live for today but plan for the future; try to live a "recovery lifestyle" in which recovery takes a high priority as does relating to others in recovery ("fellowship").

9. *Treatment participation*: attend all of your counseling and treatment sessions; do not drop out early; take medications only as prescribed; take responsibility for change; and trust your counselor or others helping you.

10. Ask group members why they should stay in treatment when they want to drop out early.
    - Gives them the chance to learn about reasons to drop out (these are usually irrational or unhealthy).
    - It helps get through rough spots.
    - Treatment takes time to lead to benefits.
    - Impulsive behaviors (quitting often leads to negative outcomes).

11. Ask group members why they should continue mutual support recovery meetings (AA, NA and others) even when they do not feel like going.
    - A disciplined recovery increases the chances of doing well.
    - When a person least feels like attending a meeting may be the time he should attend.
    - Missing meetings can lead to missing more meetings, which can lead to dropping out or failure to use the "tools" of the program.
    - Longer time in recovery gives group members more opportunities to learn recovery skills to manage the challenges of recovery.

12. Discuss the importance of using support from other people to help overcome any of these, or other barriers to recovery and positive change.
    - Recovery works better as a "we" vs. and "I" program.
    - Other peers in recovery can share what has helped them.
    - Support from others helps you deal with difficult times.
    - Being connected to others provides opportunities to share meaningful experiences.

CHAPTER 8
Groups about Medical and Physical Issues in Recovery

Medical and Physical Issues in Recovery
Withdrawal from Addictive Substances
HIV, AIDS and Substance Use Disorders
Viral Hepatitus and Substance Use Disorders

Group Topic
Medical and Physical Issues in Recovery

Objectives of Group Session

1. Identify factors contributing to physical, medical, dental or sexual problems among individuals with substance use disorders (SUDs).
2. Identify physical, medical, dental or sexual problems caused or worsened by SUDs.
3. Review withdrawal symptoms and treatments to manage withdrawal from addictive substances.
4. Review components of physical recovery from SUDs.
5. Discuss the importance of good health care habits.

Points or Issues for Discussion

1. Physical, medical, dental or sexual problems can result from:
   - The acute or chronic effects of alcohol or drug use.
   - Methods of substance use (e.g., using needles to inject drugs, using "dirty" needles, or sharing needles with other addicts).
   - Poor diet or poor health care habits.
   - Failure to get regular exams or treatment for problems.
   - Poor compliance with treatment recommendations of doctors, dentists or other health care professionals.

2. Ask group members to identify some of the physical, medical, dental or sexual problems caused or worsened by their substance use disorder.
   - Physical
   - Medical
   - Sexual
   - Dental

3. Addiction to alcohol or drugs is associated with decrease in life span due to a variety of factors. Ask group members to give examples of people with SUDs they have known who have died prematurely and ask for examples of reasons. Make sure the following categories are covered to summarize factors reducing the lifespan.
   - Accidents or injuries caused by the effects of a SUD (e.g., automobile accident, or fall during a period of intoxication).
   - Alcohol or drug overdoses.
   - Illnesses and medical problems caused or worsened by a SUD.
   - Being a victim of violence from another person.
   - Suicide.

4. If appropriate to the group, review withdrawal from addictive substances. Ask group members what symptoms they have experienced when the cut down or stopped using alcohol or drugs after using regularly for a period of time.

5. Withdrawal symptoms vary greatly across the different classification of substances and are more easily observed or measured with certain drugs such as alcohol, opioids, and sedatives, hypnotics or anxiolytics.

   - *Symptoms of alcohol withdrawal* include coarse tremor of hands, tongue, and eyelids and one of the following symptoms: nausea and vomiting, malaise or weakness, tachycardia, sweating or elevated blood pressure, anxiety, depressed mood or irritability, or orthostatic hypotension.
   - *Symptoms of barbiturate or similarly acting sedative or hypnotic withdrawal* include three of the following: nausea and vomiting, malaise or weakness, tachycardia, sweating or elevated blood pressure, anxiety, depressed mood or irritability, orthostatic hypotension, or coarse tremor of hands, tongue, and eyelids.
   - *Symptoms of opioid withdrawal* include: lacrimination, rhinorrhea, pupillary dilation, piloerection, sweating, diarrhea, yawning, mild hypertension, tachycardia, fever and insomnia.
   - *Symptoms of stimulant withdrawal* include depressed mood, fatigue, disturbed sleep, or increased dreaming.

6. Ask group members to identify components of physical recovery such as:
   - Diet.
   - Exercise.
   - Good health care habits.
   - Cravings or obsessions for alcohol or drugs.
   - Medication-assisted treatment (for addiction to alcohol or opioids).

7. Ask group members to state what they believe are good health care habits.
   - Getting sufficient sleep and rest.
   - Relaxation and using strategies to reduce and manage stress.
   - Following a reasonable diet.
   - Getting sufficient exercise.
   - Managing cravings for alcohol or drugs.
   - Taking care of current medical or dental problems.
   - Getting regular physical, eye and dental examinations.
   - Taking medications for medical or psychiatric disorders only as prescribed.

8. Ask group members what they think are the barriers to using these good health care habits?

9. Ask each member to state one habit they can begin to work on changing now, and an example or two of specific steps to take to change this habit.

Group Topic
Withdrawal from Addictive Substances

Objectives of Group Session

1. Review the symptoms of withdrawal from alcohol and other drugs.
2. Review treatments to manage withdrawal.
3. Discuss the importance of ongoing treatment after withdrawing from addictive substances.

Points or Issues for Discussion

1. State that withdrawal symptoms associated with physical addiction are temporary and will gradually disappear as the person establishes more sober time.

2. Ask group members to identify symptoms they experienced when they first stopped using drugs and alcohol (acute withdrawal).

3. Ask group members to identify symptoms that emerged after being substance free weeks or longer (protracted withdrawal or post-acute withdrawal).

4. Review symptoms of withdrawal from alcohol, sedative-hypnotics or tranquilizers:
   - Tremors, nausea, vomiting, feeling weak, sweating
   - Elevated blood pressure
   - Irritability, anxiety or depression.
   - Seizures, severe agitation, delusions or hallucinations may occur in more serious cases of withdrawal.

5. Review symptoms of withdrawal from heroin or other opioid drugs:
   - Runny nose, tearing eyes, gooseflesh, dilated pupils, sweating, yawning, diarrhea, elevated blood pressure, fever and trouble sleeping.
   - While very uncomfortable, these are not life threatening.

6. Acute withdrawal symptoms associated with other substances such as cocaine, other stimulants or marijuana include:
   - Anxiety or depression.
   - Strong cravings to use substances.
   - Irritability.

7. While most acute withdrawal symptoms occur within the first several hours or days of cessation of substances, protracted withdrawal symptoms may occur much later, even weeks or longer after substance use has stopped. These include:
   - Anxiety
   - Depression
   - Strong cravings
   - Irritability.

8. Review detoxification services that can help addicted individuals safely withdraw from alcohol or drugs.
   - Medical detoxification in a hospital or residential rehabilitation setting.
   - Outpatient detoxification in an addiction treatment program.
   - Detoxification by a physician in a private or clinic practice (e.g., suboxone).

9. Medications are needed in some cases to stop or reduce withdrawal symptoms and reduce the risk of major complications such as seizures.

10. Clients with a history of serious withdrawal complications often need medication and strong social support to facilitate the withdrawal process. Complications include:
    - DT's
    - Seizures
    - Suicidality

11. Clients should be aware that it is becoming increasingly difficult to get insurance companies or the government to pay for hospital detoxification because it is so expensive.

12. Discuss the importance of ongoing treatment following completion of detoxification.
    - Detoxification has limited value if you do not follow-up with treatment and recovery.
    - Ask group members about experiences in the past when they <u>did not</u> follow-up after detox.
    - What was the outcome?
    - How long did they stay sober?
    - Did they have to get detoxed again?
    - If so, how soon?

13. Ask group members about experiences in the past when they <u>did</u> follow-up after detox.
    - What treatment did they receive?
    - What was the outcome?
    - How long did they stay sober?
    - What would get in the way of continuing treatment after detox?
    - How can they make sure they follow up with treatment following detox?

Group Topic
HIV, AIDS and Substance Use Disorders

Objectives of Group Session

1. Provide information about HIV/AIDS and substance use.
2. Review how HIV or AIDS are diagnosed.
3. Review strategies to reduce risk of HIV transmission or acquisition.

Points and Issues for Discussion

1. Ask group members for their understanding of HIV and AIDS: definition, causes, effects, who is at greatest risk for HIV/AIDS and treatment. Discuss the following points.

2. HIV refers to the Human Immunodeficiency Virus that attacks or disables the body's immune system.

3. HIV incidence rates in the U.S. in 2006 were highest among:
   - Gay and bisexual men who have sex with men: 53%
   - Those with high-risk heterosexual contact: 31%
   - IV drug users: 12%

4. HIV infection can progress slowly or quickly, depending on the strain of the virus, genetic factors, health habits and lifestyle.

5. HIV is a progressive disease; about half of those with untreated HIV progress to AIDS within 10 years of infection.
   - Without treatment for HIV, as the immune system becomes damaged, the body cannot fight off a variety of illnesses (opportunistic infections).
   - Opportunistic infections (pneumonia and cancers) can cause serious illness or death.

6. Since HIV infected individuals are living longer, mortality is increasing related to cardiovascular, hepatic and renal causes.

7. CD4 T cells are the main target of HIV infection.
   - This is a type of white blood cell that helps protect the body from infection
   - HIV destroys these cells, which weakens the immune system

8. An AIDS diagnosis is given if the person is HIV+ and has a CD4 T-cell count below 200 (the normal range is 500-1500), or an opportunistic infection is present.

9. Ways to monitor immune health include CD4+ Cell, Viral Load testing and basic blood tests.
   - CD4+ T-cell testing: monitoring cell count and percentage is the key; rapid rate of decline of CD4 count is an indication for therapy.

- Viral Load testing: measures HIV in the blood; lowered viral load levels indicate stability and reduce risk of progression.
- Complete Blood Count (CBC): most common test used; checks levels of white blood cells, red blood cells and platelets.

10. HIV monitoring is recommended every 3 – 6 months and helps to determine when to start antiretroviral therapy, assess immune response to drug therapy and assess need for preventive treatment for potential opportunistic infections.

11. Ask group members how they think HIV is transmitted. Discuss the following.
    - When HIV infected blood, semen, vaginal fluids or breast milk of an HIV+ person enters blood stream of another person.
    - Routes of transmission include sharing needs or needle stick, blood transfusions, sexual contact (through semen or vaginal secretions), and during pregnancy, childbirth or breast feeding.`
    - Survival of HIV outside the body depends on amount of HIV present in the fluid, and to what conditions the fluid is subjected.
    - Hot water, soap, bleach and alcohol can kill HIV outside the body; also, air can dry the fluid containing HIV, which reduces the viral amount by 90+%.

12. How HIV is not transmitted.
    - Through bodily fluids such as saliva, tears, perspiration or urine.
    - Through kissing, hugging, sharing food or drink, touching, being around someone coughing, insect bites or donating blood.

13. Risk of HIV transmission.
    - Unprotected vaginal and anal sex, and IV drug use are riskiest behaviors.
    - Oral sex is less likely, but has risk.
    - Masturbation, monogamy and abstinence are safest behaviors.

14. Ask group members why HIV testing is important and how they feel about having a test done (ie, what are their fears and worries?).

15. Ask group members how to reduce the risk of HIV transmission or acquisition.
    - Through safe sex: sex that does not let someone else's semen, blood or vaginal fluids get into someone else's body.
    - By not engaging in risky behaviors such as IV drug use.

16. HIV treatment can substantially increase life expectancy (30-50+ years after infection).
    - Goals of HIV treatment are prolonging survival, improving quality of life, restoring immune system, suppressing viral load, and preventing transmission of HIV.
    - There are over 20 approved antiretroviral drugs in 6 classes for HIV (NRTI; NNRTI; protease inhibitors fusion inhibitors; CCR5 antagonists; integrase inhibitors).
    - Combinations of drugs may be needed to treat HIV.

Group Topic
Viral Hepatitis and Substance Use Disorders

Objectives of Group Session

1. Provide information about Hepatitis and substance use.
2. Review how Viral Hepatitis is diagnosed.
3. Review strategies to reduce risk of Viral Hepatitis transmission or acquisition.
4. Understand the link between drug abuse and Hepatitis infection

Points and Issues for Discussion

1. Ask group members for their understanding of Viral Hepatitis:
   - Definition, causes, effects
   - Who is at greatest risk for it and treatment.

2. Discuss the following points.
   - Hepatitis is an inflammation of the liver. Viruses are the main cause of hepatitis.
   - Hepatitis A virus (HAV) is transmitted primarily by fecal-oral contamination.
   - Hepatitis B virus (HBV) is transmitted mainly by sexual contact and IV drug use.
   - Hepatitis C virus (HCV) is transmitted mainly by IV drug use.
   - Hepatitis contributes substantially to morbidity and mortality among IDUs.
   - Drug users who inject drugs with needles may transmit hepatitis to others with SUDS as well as others through sexual or close contacts.

3. Substance users are at high risk for infection with HAV, HBV, and HCV.
   - There are 200,000+ new cases of viral hepatitis B (HBV) infection each year in the U.S.
   - Type B hepatitis was at one time referred to as "serum hepatitis," because it was thought that the only way hepatitis B virus (HBV) could spread was through blood or serum (the liquid portion of blood) containing the virus.
   - It is now known that hepatitis B can spread by sexual contact, the transfer of blood or serum through shared needles in drug abusers, accidental needle sticks with needles contaminated with infected blood, blood transfusions.

4. There are about 150,000 new cases of hepatitis C each year.
   - The hepatitis C virus (HCV) usually is spread by shared needles among drug abusers.
   - Patients with chronic hepatitis C infection are at risk for developing cirrhosis, liver failure, and liver cancer.
   - There are about 3.5 million people with chronic hepatitis C infection in the United States.

5. There are at least six distinctly different strains of the HCV with different genetic profiles.
   - In the U. S., genotype 1 is the most common form of HCV. Even within a single genotype there may be some variations (genotype 1a and 1b, for example).
   - Genotyping is important to guide treatment because some viral genotypes respond better to therapy than others.

6. The presence of HCV in the liver triggers the human immune system, causing inflammation.
   - Over time (usually decades), prolonged inflammation may cause scarring.
   - Extensive scarring in the liver is called cirrhosis.
   - When the liver becomes cirrhotic, the liver fails to perform its normal functions, (liver failure), and this leads to serious complications and even death.

7. HCV is spread (transmitted) most efficiently through inadvertent exposure to infected blood. The most common route of transmission is needles shared among users of illicit drugs. Rates of HCV remain high among addicts (30% of younger users).

8. Transmission of HCV can be prevented in several ways.
   - Avoiding needle sharing or injection equipment sharing among drug addicts.
   - Needle exchange and educational interventions reduce high-risk behaviors.
   - HCV seems to be more easily transmitted parenterally than HIV.

9. It is important to realize that HCV is not spread by casual contact. Thus, shaking hands, kissing, and hugging are not behaviors that increase the risk of transmission.

10. About 75% of people have no symptoms when they first acquire HCV infection.
    - The remaining 25% may complain of fatigue, loss of appetite, muscle aches or fever.
    - Yellowing of the skin or eyes (jaundice) is rare at this early stage of infection.
    - Over time, the liver in people with chronic infection may begin to experience the effects of the persistent inflammation caused by the immune reaction to the virus.
    - As cirrhosis develops, symptoms increase and may include weakness, loss of appetite, and weight loss

11. Of 100 people infected with HCV, it is estimated that:
    - 75 to 85 will become chronically infected.
    - 60 to 70 will develop liver disease.
    - 5 to 20 will develop cirrhosis of the liver.
    - 1 to 5 will die from complications of liver disease like cirrhosis or liver cancer.

12. HCV testing should be done in people at high risk for infection including current and past IV drug users. Testing is recommended when exposure to the virus is suspected.

13. There is no vaccine available to prevent hepatitis C.
    - Combined Pegylated interferon and Ribavirin are the standard for treating hepatitis C.
    - Treatment is indicated depending on the stage of the illness and is best decided in a discussion between the patient and the treatment provider.
    - Treatment responses are mainly defined by results of the HCV testing.
    - Four patterns of response to antiviral treatment have been described: sustained virologic response, relapse, partial response, and non-response.

CHAPTER 9
Groups about Psychological Issues and Psychiatric Disorders

Overview of Psychological Issues in Recovery
Anger
Anxiety and Worry
Boredom
Depression
Grief
Guilt and Shame
Sharing Positive Feelings in Recovery
Gratitude
Changing Thinking
Changing Self-Defeating Behaviors
Personality Problems
Overview of Co-Occurring Disorders
Understanding Psychiatric Illness

Group Topic
Overview of Psychological Issues in Recovery

Objectives of Group Session

1. Review the components of the psychological domain of recovery.
2. Review how defenses like denial impact on addiction, and strategies to accept the SUD.
3. Discuss the importance of managing feelings and emotions in recovery and how mismanaged emotions can impact on relapse.
4. Provide examples of how thinking effects recovery and mental health, and ways to challenge unhealthy thoughts or beliefs.
5. Review co-occurring psychiatric illness and how this can impact on recovery from a SUD.

Points and Issues for Discussion

1. Discuss psychological defenses with a focus on denial. Give examples of denial. State that these defenses are "unconscious" and occur out of awareness.

2. Denial is common in substance use disorders and contributes to the low rates of treatment involvement. It is the refusal to believe a painful reality in life and serves to "protect" a person from the anxiety associated with facing the truth about a serious problem.

3. Families and others can deny the disorder. They have difficulty accepting the reality of a substance use disorder in a loved one.

4. Elicit examples of denial of the substance use disorder (SUD) and how this affects group members.
   - Minimizing the problem because substances are not used every day or you do not always lose control and get drunk or high when using.
   - Believing substance use is due to stress or psychological problems.
   - Acknowledging the SUD, but refusing help.
   - Failure to accept abstinence as a goal or, agreeing to give up the "main" substance of abuse but using "other" substances (i.e., giving up cocaine or heroin, but continuing to use alcohol or marijuana).

5. Review strategies to work through denial and accept the SUD.
   - Reviewing patterns of substance use, behaviors, and effects on self and others. Stress the importance of knowing the diagnoses related to the substance use disorder.
   - Emphasize the importance of thinking that "addiction" is the problem, not alcohol or drugs.
   - Getting feedback from professionals, family members or others regarding diagnoses, behaviors or symptoms related to the substance use disorder.
   - Completing Step 1 of AA, NA, CA (can use worksheet or workbook for this).

6. Emphasize the importance of managing feelings in recovery to:
   - Reduce the chances of relapsing.

- Help clients feel better about themselves.
- Help improve their relationships and deal with emotional reactions.

7. State that others in recovery have identified common "high risk" feeling states for drug addicts and alcoholics. For some these feelings are a "trigger" and raise the risk of relapse if not dealt with appropriately. Ask the group members which feelings are the most difficult to deal with in their experience in recovery to this point in time.
   - Anxiety
   - Anger
   - Boredom
   - Depression
   - Emptiness
   - Guilt
   - Loneliness

8. State that although people associate "negative" feelings such as anger or depression with relapse, "positive" feelings can also be a trigger to relapse.

9. Ask clients to identify and discuss various strategies they can use to manage their feelings and stay sober.

10. Remind clients who have previously relapsed to try to identify whether or not any changes in feelings represented relapse warning signs, as "upsetting emotional states" has been identified as the most common relapse precipitant in a number of studies.

11. Ask clients how their thinking impacts their behaviors and moods. Elicit examples of how thinking can impact on anxiety, depression, and decisions to use alcohol or other drugs. Discuss the concept of "stinking thinking" of 12-Step programs.

12. Review the relationships between substance use disorders and psychiatric illness.
    - A SUD can increase the risk of having a psychiatric illness.
    - A psychiatric illness can increase the risk of having a SUD.
    - Each disorder can affect the recovery of the other.
    - Addressing both disorders gives group members the best chance for recovery.
    - Discuss the importance of medications for more severe psychiatric disorders.

Group Topic
Anger

Objectives of Group Session

1. Define the three components of anger: feelings, thoughts, and behaviors.
2. Identify connections between anger and substance use disorder and recovery.
3. Review causes and effects of anger and the ways in which it is managed.
4. Review strategies to manage or cope with anger from other people.

Points for Discussion

1. Ask group members to define anger and discuss the degree to which it is a problem for them.
   - Some will report chronic problems with anger and state they have a "short fuse."
   - Others will state they have difficulty allowing themselves to feel angry or express it.

2. Relate their answers to anger having thress components.
   - Emotional (feelings).
   - Cognitive (thoughts and beliefs).
   - Behavioral (actions).

3. Discuss what group members learned from parents and others about anger and how to express it or deal with it in their relationships with others.

4. Review unhealthy and healthy ways of expressing anger:
   - *Unhealthy*: acting out and hurting others physically or verbally; hurting oneself; being passive and letting anger build up; drinking or using drugs; and acting in passive-aggressive ways.

   - *Healthy*: expressing it to others in a controlled manner when it is appropriate to do so; talking about feelings with a confidante; talking oneself out of being angry; engaging in activity that helps release or control anger; praying; or using anger as a motivator.

5. Ask group members to give examples of the effects of unhealthy anger management strategies on themselves and others.
   - *On self*: using substances, becoming enraged, depressed, or out of control.

   - *On others*: causing fear or worry, pushing others away emotionally, causing emotional damage in a relationship or causing it to end.

6. Discuss the connection between anger and methods of expression, and substance use disorders.
   - Anger can lead to substance use and be an excuse for relapse.
   - Anger that controls a person can lead to acting out in ways that hurt others emotionally or physically.

- Anger that is not dealt with and suppressed can contribute to depression, self-harm, anxiety, low self-esteem, or internal turmoil.

7. Review strategies for managing anger and elicit examples from group members on both positive and negative ways they have deal with their anger.

8. *Verbal strategies*: talking about it directly with the person one is angry at; talking with a confidante to release feelings in a safe context; or getting support and another person's perspective.

9. *Cognitive or self-talk strategies*: changing thoughts, internal dialogue, or core beliefs, or using "slogans" of AA, NA or DRA (e.g., "this too shall pass").

10. *Behavioral strategies*: going for a walk or exercising, redirecting one's activity, working around the house, praying or meditating, or going to an AA, NA, or DRA meeting to "drop off" anger.

11. *Medications*: when anger is intense, persistent, and acted upon impulsively or aggressively, a mood stabilizer may be useful. An evaluation by a psychiatrist can determine if medications are needed.

12. Review a process to deal with angry feelings:
    - Step 1: recognize anger in thoughts, feelings and behaviors.
    - Step 2: examine causes of anger.
    - Step 3: evaluate the effects of anger and coping strategies used.
    - Step 4: identify coping strategies to manage anger in each situation.
    - Step 5: rehearse or practice new coping strategies.
    - Step 6: put these into action, evaluate their effects, and change as needed.

13. Identify concerns of group members related to dealing with anger expressed by others.

14. Discuss strategies to cope with anger from other people.

Group Topic
Anxiety and Worry

Objectives of Group Session

1. Define anxiety, worry and anticipatory anxiety.
2. Review causes and effects of anxiety and worry.
3. Review anxiety and worry as symptoms common with substance use disorders.
4. Identify how substance use affects anxiety.
5. Review strategies for managing anxiety and worry.

Points for Discussion

1. Ask group members to define anxiety and worry, and how the two go together.
   - Anxiety is the physical side and shows in tension, tightness in stomach and rapid heartbeat.
   - Worry is the psychological side and shows in thoughts and beliefs, which affect behaviors.
   - Anticipatory anxiety is the fear of something happening and may lead to avoiding the situation feared (e.g., a speech or job interview).

2. Ask members to share some of their symptoms of anxiety and their psychiatric diagnosis if they have an anxiety disorder. Review types of anxiety disorders:
   - Phobias.
   - Social anxiety disorder.
   - Panic disorder.
   - Acute and post-traumatic stress disorders.
   - Generalized anxiety disorder.
   - Obsessive-compulsive disorder.

3. Discuss causes of anxiety and worry and how these are common in many psychiatric and substance use disorders.
   - Anxiety can be caused by substances or a symptom of withdrawal.
   - Anxiety is a symptom in generalized anxiety, obsessive-compulsive, panic, post traumatic stress, and phobic disorders.
   - These disorders are caused by multiple biological, psychological and environmental factors.
   - Anxiety is a common symptom among people with mood, psychotic and other psychiatric disorders.

4. Review effects of anxiety on:
   - Physical health
   - Emotional health
   - Relationships
   - Substance use, particularly the use of benzodiazepines and alcohol.

5. Ask group members for examples of both positive and negative ways they have coped with anxiety in the past.

6. Review strategies for managing anxiety and worry. Emphasize the need for a variety of cognitive, affective and behavioral strategies.
   - Identify and label anxiety and worry.
   - Find out what is causing anxiety and worry.
   - Get a physical examination.
   - Evaluate and change diet, especially the use of caffeine.
   - Evaluate lifestyle to identify sources of anxiety.
   - Change beliefs or thoughts that contribute to anxiety and worry.
   - Share anxious feelings and thoughts with others.
   - Learn to accept and live with persistent anxiety.
   - Set aside "worry" time each day.
   - Keep a written anxiety and worry journal.
   - Face the situations causing anxiety and worry. Do this gradually for situations that cause intense anxiety or fear.
   - Meditate and use relaxation techniques.
   - Practice proper breathing techniques.
   - Pray and ask for help from a Higher Power.

7. Discuss treatment for anxiety disorders.
   - Therapy, medications and combined treatments are used for anxiety disorders.
   - Cognitive, behavioral and supportive therapies are used with many of the anxiety disorders.
   - Specialized therapies are used with disorders such as OCD, PTSD or phobias.

8. The goals of therapy are to:
   - Eliminate or reduce symptoms of the anxiety disorder.
   - Increase accurate thinking to reduce anxiety and related symptoms.
   - Improve functioning.
   - Manage persistent symptoms of chronic anxiety disorders.

9. Medication is used for moderate to severe types of anxiety disorders.
   - The specific medicines used depend on the disorder, severity of symptoms and impairment caused by the disorder.
   - Be careful about using addictive medications such as benzos, especially for a prolonged period of time. These can lead to dependency on these drugs.

Group Topic
Boredom

Objectives of Group Session

1. Identify ways that boredom affects recovery and can impact on relapse.
2. Identify sources of boredom and "high-risk" times.
3. Review the importance of structure and routine in daily life.
4. Review strategies to manage boredom.

Points for Discussion

1. Ask group members to identify and discuss how boredom affects recovery from a substance use disorder. Problems associated with boredom include:
   - Relapse to alcohol or drug use.
   - Feeling depressed.
   - Getting involved in activities or relationships that may temporarily reduce boredom but create other problems.
   - Making major decisions not well thought out that are based on feeling bored (for example, with a relationships or job).

2. Discuss how group members feel about living without alcohol or drugs, or partying.
   - They may miss the action of bars or parties.
   - They may feel nothing can replace the high feeling produced by alcohol or drug use.
   - They may even feel "empty" at first, like life has little meaning or direction.

3. Identify and list leisure activities given up due to the substance use disorder.
   - Which of these do they miss the most?
   - Which of these could be regained?

4. Identify non-substance activities or situations that bring pleasure or are fun. Discuss how or why these activities bring pleasure, enjoyment or meaning.
   - Social events
   - Interpersonal relationships.
   - Athletic
   - Creative
   - Artistic
   - Musical
   - Spiritual
   - Collecting things
   - Fixing or repairing things (cars, furniture)
   - Other

5. Identify and discuss the benefits of having structure in daily life.
   - Reduces the chances of engaging in high risk situations causing relapse.
   - Gives a sense of direction and purpose.

- Forces you to focus on goals and methods to achieve these goals.
- Facilitates accountability with your time.

6. Review practical coping strategies to reduce boredom.
   - Recognize boredom, high-risk times for it and reasons for boredom.
   - Regain "lost" activities that are not substance-related.
   - Develop new leisure interests or hobbies.
   - Learn to appreciate the simple pleasures in life.
   - Build fun or pleasant activities into day-to-day life.
   - Change thoughts and beliefs about boredom.
   - Evaluate relationship or job boredom before making major life changes.
   - Deal with persistent feelings of boredom.
   - Participate in recovery support groups or recovery clubs.

7. Option: have group members complete a daily or weekly activities schedule to get them to practice building structure and activities into their lives.

8. Option: discuss the issue of "emptiness" and "joylessness" associated with giving up substances, and how this contributes to both boredom and an inability to experience pleasure in normal activities.

Group Topic
Depression

Objectives

1. Review prevalence, types and symptoms of depression.
2. Review causes and effects of depression.
3. Identify the relationships between substance use and depression.
4. Identify treatments for depression and recovery strategies to manage depression and improve mood.

Points for Discussion

1. Depression affects 10-20% of adults and is twice as common among women than men.
   - It is one of the leading causes of disability in the world and suicides.
   - About half who become depressed will experience a second episode.
   - For many, depression is a chronic or recurrent condition.
   - About one-third of those with depression have a substance use disorder.
   - Untreated, it can cause personal suffering, complicate recovery and contribute to relapse.

2. Review types of depressive illness.
   - Major depression (single episode or recurrent, with or without psychotic symptoms).
   - Seasonal depression.
   - Dysthymia (chronic, low-grade depression).
   - Bipolar depression.
   - Depression caused by substances or a medical condition.

3. Clinical depression shows in symptoms that are persistent and last several weeks or more.
   - Functioning is often impaired as a result.
   - You can have some symptoms of the disorder, but not enough to meet full criteria.
   - This is called "subsyndromal depression"

4. Ask group members to share symptoms of depression they have experienced such as:
   - Feeling depressed, sad, irritable, empty, helpless, hopeless or worthless.
   - Trouble experiencing pleasure or loss of interest in life.
   - Significant gain or loss of weight without trying; loss of appetite.
   - Falling asleep, waking up early, disrupted sleep, or sleeping too much.
   - Feeling agitated or slowed down.
   - Difficulty concentrating or remembering things.
   - Loss or decrease in sexual desire.
   - Thoughts of suicide, making a plan, or making an actual attempt.

5. Have group members identify factors that contributed to their depression. Use this to discuss biopsychosocial factors involved in depressive illness.
   - *Biological*: genetic vulnerability (runs in families), or dysregulation of transmitters in the brain.

- *Psychological*: beliefs, personality, and coping skills deficits.
- *Environmental*: family, job, economic or other social problems.
- *Interpersonal*: social skill deficits or unhealthy relationships.

6. Have group members give examples of how substance use and SUDs affect depression.
   - Both acute and chronic effects of drugs impact on mood.
   - Withdrawal states contribute to depressed mood.
   - Losses associated with addiction can impact on depression.

7. Have group members give examples of how a depressed mood affects their substance use.
   - Use substances to feel better, sleep better, increase energy.
   - Use of substances can increase suicidal risk and lead to an attempt.

8. Ask how substance use can affect recovery from depression. Discuss how substance use can:
   - Mask depressive symptoms or increase these symptoms.
   - Decrease motivation to recover or desire to change or work a recovery program.
   - Interfere with ability to make changes in self, lifestyle, or coping mechanisms.

9. Elicit examples of how alcohol and drug use affects psychiatric medications.
   - Substances can raise or lower the level of medications in the blood.
   - Substances may have a negative interaction with medications.
   - Substance use can lower motivation to comply with medications.

10. Review the professional treatments for depression.
    - Psychotherapy or counseling, medication, electroshock therapy (ECT).
    - Combined treatments (medications, ECT and therapy).
    - If one treatment does not work or is minimally effective, a second should be added.

11. There are many effective therapies for depression such as cognitive-behavioral (CBT) and interpersonal psychotherapy (IPT).
    - CBT and IPT may be used alone or in combination with anti-depressant medications.
    - The goals of therapy are to decrease or eliminate depressive symptoms, decrease inaccurate thinking, improve interpersonal skills, deal with role transitions, reduce suicidal risk, and improve functioning.
    - In cases of chronic depression, an additional goal is learning to manage persistent symptoms that do not totally remit.

12. Medication is used for moderate to severe types of depression.
    - There are different types of antidepressants: selective serotonin reuptake inhibitors or (SSRIs), tricyclics (TCAs) and monamine oxidase inhibitors (MAOs).
    - SSRIs are the most commonly used because they have less severe side effects.
    - MAOIs require a special diet.
    - For single episodes of depression, medications should be used for 6+ months or longer after the episode remits. Otherwise, symptoms may return.
    - For recurrent episodes of depression, medications should be used continuously to reduce the likelihood of a future reoccurrence.

- Most antidepressants take up to two weeks or longer to show the effects.
- Some people need more than one antidepressant for maximum benefit.

13. Ask members what strategies helped improve their mood or manage depression in the past.
    - Focus on non-substance use strategies.
    - Emphasize the importance of recovery from the addiction if mood is to improve.

14. Review *cognitive strategies* to manage depression.
    - Address problems contributing to depression and do something about them (problem solving).
    - Manage thoughts and beliefs contributing to depression (e.g., challenge faulty thinking).
    - Focus on positive experiences or successes.

15. Review *interpersonal strategies* to manage depression.
    - Participate in support groups with others in recovery.
    - Make amends to others hurt by the addiction or other behaviors.
    - Deal with loss, grief or trauma issues.
    - Deal with relationship problems or conflicts.

16. Review *emotional management* strategies to improve mood.
    - Talk about feelings and problems with others.
    - Identify other emotions that may contribute to depression (i.e., anxiety, guilt, anger).
    - Learn to soothe yourself.

17. Review *behavior changes* that improve depression.
    - Keep active and force yourself to engage in daily life tasks.
    - Participate in pleasant activities.
    - Keep a journal or log to monitor and rate your feelings.
    - Identify and plan social activities that do not evolve around substance use.

18. Review *health and lifestyle changes* to improve depression.
    - Use a daily and weekly schedule to introduce regularity into your daily life.
    - Engage in regular exercise.
    - Follow a reasonable diet.
    - Get sufficient sleep.
    - Follow a regular schedule in terms of when you get up and go to bed.
    - Meditate.
    - Take medications only as prescribed.
    - Do not stop taking anti-depressant medications without discussing this decision with your counselor or doctor.

Group Topic
Grief

Objectives of Group Sessions

1. Review grief issues common in recovery from an addiction.
2. Identify how unresolved grief can complicate recovery
3. Review strategies to manage grief and remain sober.

Points and Issues for Discussion

1. Grief issues are common in recovery from an addiction.
   - Grief is associated with the "loss" of addiction or a lifestyle.
   - Addiction leads to loss of significant relationships or status, which contribute to grief.
   - Many people with addiction have lost loved relationships through death, divorce or separation.
   - Addiction interferes with the process of mourning a loss of a love relationship.
   - While sobriety is healthier than active addiction, it can create a major adjustment.

2. Ask members to describe "losses" associated with "giving up" their addiction and/or lifestyle associated with substance use.
   - Acknowledge that this is a major change that can be difficult.
   - Loss of the high, loss of friends, loss of lifestyle can be overwhelming.
   - Loss of identity in the drinking or drug culture is common for some people.

3. Ask members to share losses caused by their addiction that have contributed to grief or other upset emotions.
   - Loss of marriage or primary relationship.
   - Loss of respect or trust of loved ones.
   - Loss of friendships.
   - Loss of jobs or financial stability.
   - Loss of physical health.
   - Loss of housing stability.
   - Loss of important values.
   - Other losses?

4. Ask for examples of how these losses and feelings of grief have affected their lives.
   - Physical health: sleep problems, poor appetite, not taking care of self.
   - Mental health: feeling anxious, angry, depressed or lonely.
   - Spiritual health: feeling empty or angry at God, decreasing involvement in faith based activities.
   - Relationships: resisting intimacy with another person due to fear of losing this person.
   - Lifestyle: major change in structure in daily life.

5. Discuss how inability to manage negative or upsetting emotions is one of the high-risk factors in relapse to addiction following a period of recovery.
   - It is not the emotion that leads to relapse, but the lack of using a positive coping strategy.
   - Ask for examples of how members have coped with grief or other feelings. Elicit both positive and negative coping strategies.

6. Discuss strategies group members to manage grief such as:
   - Keeping recovery from addiction as a high priority.
   - Sharing their story of loss with others (with sponsor, friends in AA, NA, a therapist, friend, family member or confidante).
   - Accepting and sharing feelings related to losses—grief, anger, depression, etc.
   - Listening to the experiences of others and how they have dealt with losses.
   - Seeking support from others who care about them, especially in times they struggle.
   - Reflecting upon lost relationships (what liked about person).
   - Being grateful for what others added to their lives.
   - Paying tribute to loved ones lost through death.
   - Using faith and spirituality to gain strength.
   - Reading, writing and talking about grief as often as needed, without putting a time frame on how long they should grieve.

7. Discuss treatment if grief persists and they can't seem to shake it or get on with life.
   - Sadness continues or becomes more intense despite their attempt to use coping strategies.
   - Activities, events and people are avoided due to feeling grief or related emotions.
   - They feel depressed or suicidal.
   - They worry they may use alcohol or drugs to escape or feel better temporarily

Group Topic
Sharing Positive Feelings in Recovery

Objectives of Group Session

1. Identify positive feelings and benefits of expressing these to others.
2. Identify strategies for sharing positive feelings.
3. Review potential benefits to relationships of sharing feelings.

Points and Issues for Discussion

1. An important component of emotional competence and health is being able to experience and express positive emotions or feelings towards others.

2. A new field of "Positive Psychology" has emerged that focuses on positive emotions, resilience and personal growth.

3. Ask group members to identify positive feelings that they have experienced and that they believe are important in their relationships.

4. Add to their examples as needed and cover a range of examples such as:
   - Love and affection.
   - Hopefulness
   - Joy.
   - Caring.
   - Glad, happy, thankful.
   - Passionate.
   - Playful.

5. Although recovery focuses on coping with negative feelings such as anger, guilt, or depression, it is also important to focus on positive feelings.
   - Such feelings are a source of satisfaction in relationships.
   - Others will appreciate you sharing positive feelings with them.
   - Your relationships may grow and deepen.
   - You may feel greater emotional connections to other people.
   - Positive emotions add to the quality of your life.

6. Similar to other feelings, positive feelings show in behaviors and what is said to others.
   - Stress that saying positive things without backing these up with actions will have limited impact.
   - You can tell another person "I love you" but treat them poorly. These words will have little impact as a result.
   - You can tell another "I love you" and do nice things for this other person and show this love in your actions as well as what you say.

7. Ask group members to share their thoughts on the benefits of expressing positive feelings. Add to their ideas to include some of the following examples of benefits of sharing positive feelings with others:
   - Helps build relationships and enhance connectedness to others.
   - Helps balance out negative feelings in relationships.
   - Contributes to satisfaction in life.
   - Promotes better mental health.
   - Promotes better spiritual health.

8. Ask group members to identify ways positive feelings can be shared in words.
   - Elicit specific examples such as making caring or loving remarks.
   - Expressing love or empathy.
   - Making a statement conveying appreciation of another person.

9. Ask members how position feelings can be expressed in actions:
   - Elicit specific examples such as taking care of another person.
   - Doing something nice for them.
   - Surprising someone with a card, letter or gift.
   - Spending time with others, visiting with them.
   - Helping them in time of need.

10. Discuss the idea of forgiveness and how this can impact on emotions and recovery.
    - Others forgiving the addicted person for things done that caused hurt.
    - The addicted person forgiving others to let go of anger or other emotions.

11. Ask group members to share something they feel grateful about related to the group or something else in recovery.
    - Discuss what it was like to share gratitude with peers.
    - Discuss barriers to expressing gratitude.

Group Topic
Gratitude

Objectives of Group Session

1. Define gratitude ("gifts") in daily life and recovery.
2. Identify areas of gratitude.
3. Review barriers to feeling or expressing gratitude.
4. Review strategies to increase gratitude in recovery.

Points and Issues for Discussion

1. Ask group members to define gratitude and state why it is important in recovery.
   - Gratitude is being thankful and appreciative for actions of others.
   - It is also feeling appreciative for having others in your life.
   - Gratitude can occur in response to kindness of other person (personal).
   - It can also occur in response to being thankful to God or a Higher Power (Transpersonal).
   - Gratitude enriches your life and relationships and contributes to happiness.
   - People who are grateful are less bitter and resentful than others.

2. Ask for examples of "gifts" received from others that led to feeling gratitude.
   - Gifts from others can be tangible or intangible.
   - Tangible includes objects, items, money, help with a task or project.
   - Examples: a friend helps you move, your parents help you in a time of financial crisis.
   - Intangible include time given to you by another, support, concern, help with a problem.
   - Examples: an AA or NA Sponsor stands by you during a period of depression or helps you stop a relapse.

3. Discuss *personal gratitude*.
   - Feeling thankful towards someone who has provided you some kindness or benefit.
   - Or, it can be feeling thankful just for their being in your life (parent, child, friend).

4. Discuss *transpersonal gratitude* such a being thankful for:
   - God or Higher Power that gives you strength, hope, connection or purpose in life.
   - The beauty of the world as in nature.
   - Having opportunities given to you by others (parents, teachers, coaches, bosses, friends).

5. Discuss barriers to expressing gratitude.
   - Lack of self reflection and inability to focus on positive actions of others.
   - Feeling entitled or you "deserve" things you get in life from others or God.
   - Focusing more on the negative than the positive in life.
   - Depression that clouds your thinking.

6. Ask group members for examples of "gifts" they have in various areas of life and how these have enriched their lives.
   - Recovery network: sponsor, friends in recovery, others who support you.
   - Family: close connections to family members.
   - Friends: mutually satisfying relationships with others.
   - Physical gifts: health, intelligence, athletic ability.
   - Psychological gifts: resilience, persistence, good coping skills, positive thinker.
   - Spiritual: belief in God or Higher Power, strength from faith or religion.
   - Other gifts: creative abilities, good job, financial security.

7. Discuss strategies to increase gratitude in daily life and recovery.
   - Look for your blessings or gifts in life on a regular basis.
   - Work on not showing ingratitude when others do things for you.
   - Challenge non-grateful thoughts.
   - Think gratitude thoughts.
   - Express gratitude in what you say to others.
   - Show gratitude in your actions or what you do (walk the walk).
   - Do not take others or your gifts in life for granted.
   - Do things for others they may feel grateful for.
   - Do not view yourself as a victim if you've had tough times, but a survivor who can cope with your past in a positive way.
   - Write about gratitude experiences in a journal.
   - Write a gratitude letter to someone who has influenced you in a positive way.
   - Read about gratitude or being thankful.

8. Ask group members to summarize the importance of gratitude in daily life and recovery.
   - How gratitude can enhance the quality of their lives.
   - How expressing gratitude can improve relationships.
   - How gratitude can become part of daily recovery.

Group Topic
Changing Thinking

Objectives of Group Session

1. Review the impact of beliefs and thoughts on feelings, behaviors, and substance use.
2. Identify "cognitive distortions" that impact on relapse.
3. Identify strategies to change cognitive distortions or inaccurate thinking.
4. Introduce the concept of "stinking thinking" of AA, NA, or other 12-step programs.

Points for Discussion

1. Elicit examples of inaccurate, distorted, negative or "stinking thinking." Ask how thinking impacts on group members' feelings and behaviors.
   - Thinking can lead to substance use.
   - Thinking can affect satisfaction in life.
   - Thinking can contribute to psychiatric symptoms such as anxiety or depression.
   - Thinking can impact on what you do, or don't do in recovery.

2. Provide additional examples of thinking associated with substance use that can lead to poor decisions regarding using alcohol or drugs.
   - I need a drink.
   - How can I have fun without using?
   - Sobriety is a drag.
   - Poor me, poor me, pour me a drink!

3. Provide additional examples of thinking contributing to negative emotions or moods.
   - My anxiety is killing me.
   - I'm going to have a bad day.
   - Nobody cares about me.

4. Provide examples of cognitive distortions or inaccurate thinking such as:
   - Black and white thinking or viewing situations in extremes, without accepting that there are "grey" areas.
   - Making things worse than they are such as exaggerating a problem to make it much bigger than it really is.
   - Making generalizations based on a single experience.
   - Expecting the worst to happen or expecting to fail.
   - Ignoring the positive and focusing only on the negative.
   - Jumping to conclusions without all the facts.

5. Strategies to change thoughts and beliefs include:
   - Be aware of your thinking patterns.
   - Check the evidence for your negative or inaccurate thoughts.
   - Challenge your cognitive distortions or stinking thinking.
   - Focus less on the negative and more on the positive.
   - Keep a journal to recall and dispute inaccurate thoughts.

- Regularly review benefits of recovery, progress, and appreciate efforts to change.
- Learn and use the slogans in AA or NA.
- Read materials written about how to improve thinking.

6. Review a process for challenging cognitive distortions and negative thinking.
   - *Step 1:* identify the belief or thought.
   - *Step 2*: state what is faulty or incorrect about it.
   - *Step 3*: identify 2-4 counterstatements for each belief or thought.
   - *Example*: "
     a. Step 1: "how can I have fun without drinking?"
     b. Step 2: "this presupposes that alcohol is needed to enjoy oneself."
     c. Step 3: "I can have fun without drinking; I will take action and do something I enjoy that does not pose a risk to my recovery; I'll ask friends in AA what they do for fun while sober; and I will not let boredom drag me down."

7. Have group members identify specific examples of their thinking to practice using these three steps. Ask for some examples. Other group members can add more ideas and counterstatements for the examples such as:
   - Change "I need a drink (or drug)" to "I sometimes would like a drink, but I don't need one. My desire to drink will leave in time if I'm client. I don't have to give in to it."
   - Change "my anxiety is killing me" to "it feels bad now, but I know it will get better. I don't have to let my anxiety control my life."

8. Discuss the importance of small changes.
   - For example, if you can reduce negative thinking by 10 percent, this is good progress.
   - Do not expect major changes to occur quickly as changing how you think require practice and more practice.

9. Encourage group members to continue their work by practicing changing thoughts and beliefs between group sessions.

Group Topic
Changing Self-Defeating Behaviors

Objectives of Group Session

1. Review self-defeating behaviors associated with recovery from substance use disorders.
2. Help group members identify their own self-defeating behaviors.
3. Review strategies to change these behaviors.

Points for Discussion

1. Ask group members for their definition of "self-defeating" behaviors or those behaviors that:
   - Threaten their sobriety.
   - Harm their physical health.
   - Upset their emotional well-being.
   - Create problems in relationships.
   - Lead to financial problems.
   - Contribute to their ability to get or keep a job.
   - Interfere with their ability to function in other areas of life.

2. Elicit specific examples of self-defeating behaviors from group members. Mention some of the following to provide concrete examples and have group members share how these behaviors create problems for them:
   - Putting self in high-risk situations that increase relapse risk.
   - Not keeping therapy appointments.
   - Dropping out of AA or NA without discussing reasons with a confidante.
   - Jumping from one relationship to the next.
   - Getting easily bored with a partner.
   - Moving in with a partner after knowing this person for a short period of time.
   - Picking up strangers and having sex with them.
   - Getting involved too quickly in a romantic relationship.
   - Getting involved in relationships that are physically or emotionally abusive.
   - Using intimidation and anger to keep people on their guard.
   - Quitting jobs impulsively or under performing at work.
   - Managing money poorly and getting deep into debt.
   - Gambling too much or compulsively.
   - Compulsive sexual behavior.
   - Getting involved in illegal activities or criminal behaviors.

3. Self-defeating behaviors can cause physical or psychological harm to you or another person. Discuss examples provided by group members to illustrate the impact of the following on group members and others.
   - Suicidal threats or acts.
   - Acts such as cutting or burning oneself or punching a wall.
   - Physical violence toward other people or threats of violence.

- Breaking or destroying property.
- Overdosing on drugs or alcohol.
- Any compulsive behaviors (gambling, sex, spending, etc).

4. Some self-defeating behaviors can be caused by poor judgment during an episode of psychiatric illness such as an episode of depression, mania or psychosis.
   - During a manic episode, a person can spend excessive amounts of money and accrue substantial debt.
   - During a psychotic episode, a person can decide to stop taking medications because of an unusual belief.
   - During a depressive episode, a person can quit a job because they hate it without having thought this decision through or discussed it with a confidante.

5. Changing these behaviors involves gaining an awareness of what they are, what causes them and how they affect you and others.
   - This puts you in a better position to devise action plans to reduce or stop them.

6. Have group members identify one self-defeating behavior they want to change.
   - Discuss ways they can change this behavior.
   - Discuss the relationships between thinking, emotions and behaviors.

7. Summarize strategies that may be used to change self-defeating behaviors. Use some of the examples of coping strategies given by group members.
   - Changing the way a person thinks about himself, other people and the world; accepting responsibility for problems; and making a commitment to change.
   - Completing an inventory of strengths and deficits or character defects. Working Steps 4 and 10 of the AA/NA/DRA program with a sponsor is an excellent way to identify and change behavior.
   - Decreasing or stopping behaviors that cause problems such as violence towards others, impulsive acting out or controlling impulsive behaviors associated with personality problems.
   - Increasing behaviors that are pro-social or helpful towards others (e.g., showing kindness, providing help or support, or being empathic towards others).
   - Increasing personal control over emotions and how these are expressed.
   - Some professional treatments such as cognitive therapy help you change thoughts, underlying beliefs and related behaviors.
   - Psychiatric disorders that involve behaviors such as hurting yourself or acting violently towards others often respond to medications, depending on the specific symptoms or diagnosis.

Group Topic
Personality Problems

Objectives of Group Session

1. Define personality, personality traits, personality problems and disorders.
2. Review the connection between personality problems and addiction.
3. Identify problematic traits that may hinder group members' recovery or well-being.
4. Review strategies to change one problematic personality trait identified.

Points for Discussion

1. Ask group members to define personality and personality traits and give examples.
   - Personality is your usual way of seeing the world and relating to other people.
   - Personality shows in how you think, your emotional reactions, how you act and relate to other people and how to manage your impulses.
   - It shows in a range of situations (work, home, friends, public).
   - Personality is sometimes referred to as "character."
   - Personality traits are specific patterns that show in your life.
   - Ask for examples of personality or character traits and discuss how these can be viewed on a continuum.
   - Examples include: prosocial vs. antisocial; controlling vs. non-controlling; aggressive vs. passive; empathic vs. indifferent.

2. *Personality "problems*" are common among people with substance use disorders. Twelve-step programs refer to these as "character defects."
   - For example, being impulsive (acting without thinking) can lead to poor decisions that cause problems for you or others.
   - Or, needing excitement can lead to drug or alcohol use, getting involved in unhealthy relationships or engaging in risky behaviors.
   - Personality traits or issues can cause problems but not be part of a personality disorder.

3. Elicit examples of personality problems.
   - Ask group members to talk about ways these have influenced drug and alcohol use.
   - Ask how these have caused problems in their relationship with other people.
   - Ask how these have caused personal distress.

4. Ask group members if they have heard the term "character defect" used in Twelve-Step programs.
   - Have them to define how they relate to it in terms of their own personality.
   - Relate this concept to changing problematic personality traits as part of ongoing recovery.

5. Discuss the importance of viewing personality traits on a continuum and that even some that are identified as negative or problematic may have positive aspects to them. Traits identified as positive can have negative aspects to them.

- For example, aggressiveness can get one into trouble if it is used to hurt other people or to put other people down. However, aggressiveness can be helpful in business situations, athletic situations, or situations where other people want to take advantage of you.
- Similarly, kindness can be a positive trait and help you develop mutual relationships. However, if you are too kind and always "give to others" you may harbor resentment on the inside or feel dissatisfied in your relationships.
- It is usually not the trait in and of itself but the degree that it effects the person in recovery that is important.

6. Have group members identify one personality issue they would like to change and discuss ways they can change. Use these examples to point out how people can change over time. Emphasize that change requires practice.
   - Change beliefs about the personality issue and associated behavior. For example, a group member who is too passive and unable to express anger can work on changing the belief that "anger is bad and should be avoided at all costs" into "anger is a normal part of life."
   - Change behavior associated with the trait. For example, a passive group member can practice being assertive and expressing ideas, thoughts, and feelings rather than holding these in.
   - The strategies reviewed in the previous section on changing self-defeating behaviors are also relevant to personality issues. These include using the 12-step program (especially steps 4 and 10), decreasing or stopping behavior that is harmful, increasing positive or prosocial behaviors and learning to control emotions.
   - Although mediations are not used to treat a specific personality disorder, they are used to treat symptoms that are associated with a disorder. For example, a mood stabilizer can decrease violence, or impulsivity or irritability.

7. *Personality "disorders"* are long-term conditions in which ingrained traits cause significant problems in your life or considerable personal distress.
   - About 11-23% of the general population has personality disorders.
   - Over 50% of those with addiction have a personality disorder.
   - Having one of these, or having another personality disorder, increases your risk of having depression or other psychiatric disorders.
   - It can also interfere with your recovery from addiction.
   - The more common personality disorders with addiction include borderline and antisocial.

8. Although antisocial behavior is common with addiction, an *antisocial personality disorder* (ASPD) is a more serious, ingrained pattern of behavior.
   - This affects about 3% of men and 1% of women in the general population.
   - Up to 20% of people with addiction meet criteria for ASPD disorder.
   - It is higher among those with drug addiction than alcoholism.
   - The person with ASPD disorder believes lying, cheating or breaking the law is OK if they don't get caught.
   - ASPD disorder involves violating the rights of other people, breaking the law and not being concerned with the effects of your actions.
   - Trouble with the law and jail time is common with those who have ASPD. Many are mandated to treatment as a result of involvement with the criminal justice system.

- ASPD may involve aggressiveness or intimidation towards others, manipulating, using or taking advantage of them.
- Aggressiveness can show in fights or assaults, domestic violence or explosive behaviors.
- Relationships may be superficial based on getting what you want from others.
- ASPD disorder is associated with thrill seeking, a lack of anxiety when breaking the law or and lack of remorse over hurting others.
- The person is self-centered and deceitful.
- Failure to plan ahead and acting impulsively are common.
- Behaviors related to ASPD often start during the teenage years and shows in poor school achievement, inconsistent work history and irresponsible behavior.
- Long-term therapy with a therapist you trust and can open up to, being willing to look within and alter antisocial behaviors, increasing positive behaviors towards others, become responsible and using an AA or NA sponsor are helpful strategies for change.
- Involvement in long-term programs such as a Therapeutic Community help many addicted people with ASPD disorder if they stick with the program long enough to make significant changes in thinking and behaviors.

9. *Borderline personality disorder* (BPD) is another serious personality disorder common with addiction.
   - BPD is much more common among women than men.
   - The person with BPD is more vulnerable to stress than others.
   - There are many areas of difficulty with BPD.
   - Mood problems include depression or suicidality.
   - Reality testing may be impaired and show in hallucinations or other psychotic symptoms.
   - Emotions are hard to control, which shows in intense anger or feeling empty.
   - Personal identity problems may show in confusion about self, sexual identity or joining a cult.
   - Poor judgment may show in involvement in high-risk relationships or behaviors or impulsive actions.
   - Self harm is common (cutting, burning or hurting self) among women with BPD who may direct aggression inward against the self.
   - Men with BPD may “act out” and get in fights or direct aggressions towards others.
   - Therapy, medications and mutual support groups all are helpful with BPD.
   - Goals are to decrease chaos in relationships, impulsiveness and self confusion.
   - Goals are to increase control over emotions, improve relationship skills, tolerate distress and use other self-awareness skills to manage symptoms and behaviors.

Group Topic
Overview of Co-Occurring Disorders

Objectives of Group Session

1. Define "dual" or "co-occurring" disorders and review their prevalence.
2. Identify types and causes of substance use +disorders.
3. Identify types and causes of psychiatric disorders.
4. Identify relationships between substance use and psychiatric disorders.
5. Review treatment approaches for dual disorders.

Points for Discussion

1. Define dual or co-occurring disorders.
   - A combination of a substance use disorder (SUD) and psychiatric (mental) disorder.
   - Either disorder can vary from mild to moderate to severe.

2. Review prevalence data for SUDs and co-occurring psychiatric illness.
   - Over 16% of adults will experience a SUD at some point in their lives.
   - Alcohol abuse and dependence are the most common SUDs.
   - Fifty-three per cent with a drug use disorder and 37% with an alcohol use disorder will have a psychiatric disorder during their lifetime.
   - Many have 3-5 disorders, hence the term "co-occurring."

3. Types of substance use disorders include:
   - Substance intoxication or withdrawal.
   - Substance abuse.
   - Substance dependence (also called addiction).
   - Substance induced mental disorders (depression, psychosis).

4. Ask group members for examples of symptoms of SUDs.
   - Physical: withdrawal when cutting down or stopping use or using to prevent withdrawal.
   - Physical: increase or decrease in tolerance (need for more to get high; get high with less).
   - Mental: obsessions to use or cravings to use.
   - Behavioral: compulsion to use, loss of control.
   - Behavioral: inability to stop, continued use despite medical or psychosocial problems.

5. Review prevalence data for psychiatric illness.
   - Over 22% of adults experience a psychiatric disorder during their lifetime. Many have more than one disorder. Depression and anxiety disorders are the most common.
   - There are high rates of co-occurring SUDs among people with psychiatric illness. The highest rates are with personality disorders, bipolar illness and schizophrenia.

6. Each psychiatric disorder has a cluster of symptoms relating to thinking, mood, behavior, and/or ability to function. Review the following DSM categories:

- *Mood disorders*: depression, mania and mixed states. About one-third with depression and 60% with mania have a SUD during their lifetime.
- *Anxiety disorders*: generalized anxiety, phobias, panic disorder, obsessive-compulsive disorder, and post-traumatic stress disorder. Up to one-third or more of those with an anxiety disorder have a SUD during their lifetime.
- *Psychotic disorders*: schizophrenia, schizoaffective disorder, and other psychotic disorders. Almost one-half of those with schizophrenia have a SUD during their lifetime.
- *Personality disorders*: antisocial, borderline, narcissistic, histrionic, paranoid, schizoid, avoidant, dependent, obsessive-compulsive, and "mixed." About 85% of those with an antisocial and over 65% with a borderline disorder have a SUD.
- *Other psychiatric disorders*: eating disorders, compulsive gambling, impulse control, attention deficit, and adjustment disorders.

7. Biological, psychological and social factors contribute to the development and maintenance of psychiatric and SUDs.

8. *Biological and physical factors* include hereditary predisposition, brain chemistry and medical conditions.
   - First degree relatives of those with a psychiatric or SUD have increased odds of having one of these disorders.
   - In the case of psychiatric illness, there may be disturbances in the way neurotransmitters work in the brain, or excesses or deficits of these brain substances.
   - Medical conditions such as cancer, diabetes or chronic pain can also contribute to psychiatric disorders.
   - In the case of addiction, drugs can "hijack" the reward center of the brain making substance use more pleasurable than eating, sex or social activities.
   - Cravings for substances can be intense, and cause the addicted person to repeat the behavior of ingesting alcohol or drugs.

9. *Psychological factors* include defense mechanisms, personality, sensitivity to stress or how you manage stress, and your beliefs and cognitive style.
   - Personality impacts on how you view the world and behave towards others or bounce back from adversity or problems.
   - Coping mechanisms how you manage stress and deal with problems.
   - Beliefs or how you view yourself, the world and your problems.

10. *Social factors and life experiences* impact on psychiatric illness. These include:
    - The influence of the family, other people and the culture.
    - Losses (e.g., relationships, jobs, financial stability), and life experiences.
    - Exposure to a single trauma (e.g., rape, assault, natural disaster or serious accident) or repeated traumatic experiences (e.g., violence, childhood abuse, sexual abuse, combat) can contribute to psychiatric illness.

11. Ask group members how their psychiatric disorders affected their substance use, and how their substance use affected their psychiatric symptoms.

12. Discuss the relationships between substance use and psychiatric disorders.
    - Each illness raises the risk of developing the other.
    - Each illness affects recovery from the other.
    - Chronic alcohol or drug use can cause or worsen psychiatric symptoms, mask them, or cause a psychiatric relapse.
    - Symptoms of psychiatric illness can contribute to relapse to alcohol or drug use.
    - Each illness can become closely linked with the other over time.
    - Each illness can develop at separate points in time.

13. *Option:* have group members discuss previous treatment experiences when only one of their disorders was addressed. Emphasize the importance of addressing both disorders in recovery.

14. Discuss approaches to treatment of dual disorders.
    - Parallel: you receive mental health treatment and substance abuse treatment in different agencies.
    - Sequential: you get one disorder treated, then the other.
    - Integrated: both disorders are treated by the same team in the same treatment setting. This is usually the recommended approach although other approaches may be used at different times.

15. A continuum of care is needed to treat dual disorders. This continuum includes both professional treatment, ancillary services and mutual support programs.
    - Inpatient psychiatric care.
    - Inpatient detoxification.
    - Short and long-term residential.
    - Partial hospital.
    - Intensive outpatient.
    - Outpatient treatment.
    - Medications and electroshock therapy are helpful treatments for certain disorders or symptoms that do not respond to medication or when medication cannot be taken.
    - Other services such as vocational rehabilitation or case management are often needed.
    - Mutual support programs for addiction (AA, NA, Rational Recovery, SMART recovery, Women for Sobriety, etc).
    - Mutual support programs for psychiatric illness (Recovery, Inc., Emotions Anonymous, or groups for a specific type of illness).
    - Mutual support programs for co-occurring disorders (DRA or Dual Recovery Anonymous).

Group Topic
Understanding Psychiatric Illness

Objectives of Group Session

1. Define and identify types of mental or psychiatric illness.
2. Review major symptoms associated with various types of illness.
3. Identify factors contributing to psychiatric illness.
4. Review treatments for psychiatric illness

Points for Discussion

1. Discuss psychiatric illness as a mental disorder or mental disease that involves mood, cognitive, physical or behavioral symptoms.

2. About 22.4% of adults in the United States experience an episode of psychiatric illness during their lifetime. Mood and anxiety disorders are the most common.

3. A significant number of people with psychiatric disorders also have a substance use disorder (SUD). SUDs are highest among those with antisocial or borderline personality disorders, bipolar illness and schizophrenia.

4. Ask group members to share disorders or symptoms that they are experiencing. Then, discuss the categories of psychiatric illness and types of symptoms associated with these illnesses (physical, cognitive, mood, behavioral).
   - *Mood disorders*: depression, mania and mixed states.
   - *Anxiety disorders*: generalized anxiety, phobias, panic disorder, obsessive-compulsive disorder, and post-traumatic stress disorder.
   - *Psychotic disorders*: schizophrenia, schizoaffective disorder, and other psychotic disorders.
   - *Personality disorders*: antisocial, borderline, narcissistic, histrionic, paranoid, schizoid, avoidant, dependent, obsessive-compulsive, and "mixed."
   - *Other disorders*: eating disorders, compulsive gambling, impulse control, attention deficit, and adjustment disorders.

5. There are several different presentations of psychiatric illness.
   - *Single episode*: some people suffer only one episode of illness and once the symptoms remit they do not experience another episode.
   - *Recurrent episodes*: some people experience several episodes over time. They may function well between episodes. Episodes may occur years apart.
   - *Chronic or persistent*: some group members experience some psychiatric symptoms more or less all of the time. Even though they can get well and improve functioning, they may always have to cope with some of their symptoms.

- *Su-syndromal symptoms*: some group members experience psychiatric symptoms but do not meet criteria for a "diagnosis." These symptoms can cause personal suffering and impairment in life, and often require treatment.

6. Stress that psychiatric disorders are best viewed as "no fault illnesses" and not a sign of "weakness." They are caused by a combination of factors such as:
   - *Biological factors:* these include hereditary predisposition, brain chemistry and medical conditions. First degree relatives of those with a psychiatric illness have increased odds of having one of these disorders. These disorders may also involve excesses or deficits of neurotransmitters in the brain. Medical problems such as cancer or other diseases, and substance abuse or addiction can contribute to psychiatric disorders.
   - *Psychological factors:* these include defense mechanisms, personality, sensitivity to stress and how a person manages it, and a person's beliefs and cognitive style (e.g., how a person views himself, the world and his problems).
   - *Social factors and life experiences:* these include family, social and cultural influences, as well as exposure to trauma. For example, a traumatic injury, rape, assault or exposure to a natural disaster such as hurricane or flood can contribute to psychiatric illness. So can exposure to persistent trauma such as violence, sexual abuse or child abuse.

7. A continuum of care is needed to treat psychiatric disorders. This continuum includes inpatient psychiatric, residential, partial hospital, intensive outpatient, and outpatient treatment.

8. For chronic and recurrent conditions, ongoing involvement in "maintenance" treatment is needed. The client may return to see a therapist or psychiatrist every several months once stabilized from the acute symptoms of the disorders.

9. Somatic treatments include medications and electroshock therapy.

10. Other ancillary services including vocational rehabilitation or case management are often needed as well.

11. Family involvement in treatment and recovery is helpful, too. Families can learn what to do to support their ill member as well as what not to do. And, family members can learn how to help themselves. In some instances, family members need help for their own psychiatric or substance use disorder.

12. Mutual support programs such as Emotions Anonymous, Recovery, Inc. or programs for specific psychiatric disorders are helpful as well.

CHAPTER 10
Groups about Relationships in Recovery

Impact of Substance Use Disorders on the Family
Impact of Substance Use Disorders on Children
Refusing Substance Use Offers
Relationships in Recovery

Group Topic
Impact of Substance Use Disorders on the Family

Objectives of Group Session

1. Review addiction as familial disorders and discuss the impact of the family
2. Review concerns and questions of families related to dual disorders.
3. Review the importance of involving the family in treatment and recovery.
4. Identify situations in which a family member may need help with their own substance use or psychiatric disorder.
5. Review recovery strategies for family members.

Points for Discussion

1. Addiction runs in families.
   - Prevalence rates are significantly higher among first degree relatives (children and siblings) of an addicted person than the general population.
   - This is no different than other medical or psychiatric disorders running in families.
   - This simply means that family members are at increased risk for addiction if a parent or sibling has an addiction to alcohol or other drugs.

2. Addiction is associated with many family problems.
   - The family unit is affected in many ways, sometimes in profound ways.
   - Individual family members including children are affected.

3. Effects of addiction on the family vary from mild to serious. The actual effects depend on the severity of the disorders, behaviors of the dual disordered member, and coping skills and support systems of family members.

4. Ask group members for examples of how their family unit and individual members were affected by their disorders. Expand on their list to include problems related to:
   - Family mood and atmosphere.
   - Communication and interaction in the family.
   - Psychological and emotional effects on family members (e.g., anger, depression, confusion, anxiety, frustration, guilt and shame).
   - Financial effects.
   - Family breakup due to divorce, separation, incarceration or having children taken by child welfare services.

5. Discuss family recovery issues for the dual disordered member:
   - Acknowledging the impact of disorders on the family.
   - Encouraging family involvement in treatment and recovery.
   - Making amends to family members hurt by these disorders.
   - Taking an active role in the lives of family members.

6. Discuss the importance of family involvement in assessment and treatment. There are a variety of types of sessions the family may attend (evaluation, education, and counseling). Family involvement can help in two general ways:
   - Supporting the dual diagnosed member's recovery.
   - Gaining help and support for the family and its members.

7. Discuss the possibility that other family members, including children, may have psychiatric or substance use disorders requiring treatment.

8. Discuss "red flags" for determining if a family member needs help. An evaluation should be sought when the family member has:
   - Symptoms of an anxiety, mood, psychotic, personality, eating or impulse control disorder (e.g., depression, mood swings or suicidality).
   - Threats of violence or suicide, or actual behaviors harmful to self or others.
   - Evidence of a substance abuse or dependence disorder.
   - Problems at home, school, or work caused by a psychiatric and/or substance use disorder.
   - Personal distress or suffering resulting from psychiatric symptoms or a substance use disorder.

9. Family members benefit from counseling and participation in support groups such as Al-Anon, Nar-Anon, and NAMI (National Alliance of the Mentally Ill). These help reduce the family burden and enable family members to become educated about dual disorders and learn coping skills.

10. Discuss recovery strategies for families and their members:
    - Acknowledging and accepting the dual disorders and the impact on everyone in the family.
    - Accepting the need for help and support for family members, not just the impaired dual disordered member. Help may come from professionals, other members of mutual support groups, or both.
    - Reducing behaviors that "enable" the affected family member.
    - Learning to "detach" and set limits, but in a kind, supportive manner.
    - Developing realistic expectations of the impaired family member, and acknowledging success, even when it occurs in small steps.
    - Developing a plan for psychiatric emergencies (suicidal threats or gestures, violence, poor treatment adherence, or relapse of either disorder).
    - Focusing on self (feelings, goals, dreams, and desired changes), not just the impaired family member.
    - Helping children in the family understand and deal with the impact of the disorders on them.

Group Topic
Impact of Substance Use Disorders on Children

Objectives of Group Session

1. Review effects of substance use disorders on children.
2. Identify how group members' children may have been affected by their substance use disorders.
3. Identify ways in which parents can help their children.
4. Recognize when children may need professional help.

Points for Discussion

1. State that substance use disorders effect children of all ages (including adult children) in many ways.

2. Ask group members to share examples of how their children have been affected by their substance use disorders. Let them know this discussion may make them feel guilty.

3. Studies of children of parents with a substance use disorder (SUD) show that, compared to children who do not have a parent with a SUD, these kids have higher rates of:
   - Alcohol or drug abuse.
   - Mood and anxiety disorders.
   - Oppositional disorders, delinquency, aggression and conduct disturbances.
   - Impulsivity, inattention, and irritability.
   - Academic problems (poorer performance in school, and lower scores on IQ tests).

4. Many of these children:
   - Worry about their parents
   - Feel unwanted, angry, anxious, depressed, lonely or hopeless
   - Act in defiant ways
   - Feel that a parent's substance abuse hurts relationships within and outside of the family.

5. Reiterate that these children are at increased risk for drug or alcohol problems.

6. Even adult children can feel the adverse effects of a parents' SUD.
   - Ask if group members are sons or daughters of a parent or caretaker who had (or still has) a substance use disorder.
   - If so, how were they affected when growing up?
   - How are they still affected in terms of how they think, feel and behave (e.g, do they avoid or minimize interactions with parents due to bad feelings still harbored)?
   - Are group members holding on to anger, hurt and pain?

7. Parents and adults can help children who have been exposed to a family member's substance use disorder by:
   - Educating the children about these disorders

- Encouraging children to ask questions and talk about their feelings and experiences related to a parent's disorders.
- Accepting that children often feel an emotional burden due to a parent's substance use disorder.
- Protecting the child from violence, intoxicating, and other high-risk behaviors.
- Providing the child with hope that things can get better in the family.
- Sharing activities with the child.
- Taking an interest in the child's activities and relationships.
- Focusing on the child's strengths and building resiliencies.
- Getting the child to attend treatment sessions with the parent(s).

8. Ask members if they are concerned that any of their children may have a substance use disorder or psychiatric disorder (anxiety, depression, suicidality, violence, problems at school or with the law).

9. If so, what have they done or what could they do to get help for their child with a serious problem in any of these areas of life?

Group Topic
Refusing Substance Use Offers

Objectives of Group Sessions

1. Teach group members to anticipate direct and indirect social pressures to use substances.
2. Identify the effects of social pressures on thoughts, feelings, and behaviors.
3. Teach group members about "relapse set-ups" or how they put themselves in high risk social pressure situations either consciously or unconsciously.
4. Review strategies to refuse social pressures to use alcohol or other drugs.

Points for Discussion

1. Social pressure to use substances is one of the most common relapse risk factors with substance use disorders.
   - Social pressure can be direct in which drugs or alcohol are offered to you.
   - Social pressure can be indirect when others around you are using and you feel some pressure to use in order to fit in.
   - However, it is not the social pressure itself, but your ability to manage it that determines if you will relapse and use alcohol or drugs.

2. Ask group members to provide examples of direct and indirect social pressures they have faced or expect to face in the future. These will fall in one of these categories:
   - **People:** family members or friends who use; people with whom group members drank or got high, and drug dealers.
   - **Places**: bars, parties or other places where substances were used.
   - **Events or situations:** weddings, graduations, holiday celebrations, sporting events, concerts, or family events.

3. Set up role-plays where a member is offered alcohol or drugs by another person.
   - Ask other group members observing the role-play to identify with the client being offered substances, and to pay attention to their thoughts and feelings.
   - Have the group members being offered drugs or alcohol to respond based on how they feel at the moment.

4. After the role-play, process it with the group. Focus on the following:
   - What do you feel when confronted by social pressures to use?
   - What thoughts come into their minds when offered alcohol or drugs.
   - How do social pressures impact on your motivation to stay sober?
   - What can you do to refuse offers of substances?

5. Option: have group members pair up in dyads. Each offers the other alcohol or drugs. After this experience, discuss the same questions listed above.

6. Option: use a male-female in the role play and instruct the individual offering alcohol or drugs to add an offer of a "good time" or sex.

- A male client might feel more vulnerable to an offer by a female to get high because of the association between sex and getting high with a woman (or vice versa).
- A variation is to use male-male or female-female scenarios in order to address social pressures experienced by gay men and lesbian women.

7. Discuss what could happen if the group member gives in to social pressure.
   - Could continue use and have relapse.
   - Could experience negative effects: medical, family, psychological, spiritual, legal, and financial.
   - Could lose desire to get back on track.

8. After the group processes the role-play, review positive coping strategies:
   - Avoidance of high-risk social pressure situations when appropriate.
   - Verbal (ways to say no).
   - Behavioral (ways to reduce or deal with unavoidable social pressures).

9. Also, discuss the issue of "ambivalence" ((i.e., this role play often helps group members realize that part of them that still wants to get high and they "miss the action").

Group Topic
Relationships in Recovery

Objectives of Group Session

1. Identify how addiction affected relationships with family, friends, coworkers, and others.
2. Identify ways to begin repairing damage done to family and interpersonal relationships.
3. Define enabling.
4. Identify components of healthy relationships.

Points or Issues for Discussion

1. Relationships with other people are often damaged by addiction.
   - When people are active in their addiction, their primary relationship is to the substance.
   - They may spend a lot of their time getting money to buy, obtain, use, or recover from the effects of alcohol or drugs.

2. Some recovering people want to continue to socialize with drug using friends. These relationships pose a threat to recovery, and each person in recovery must evaluate his relationships to determine which ones should be terminated.

3. Many people are lonely for meaningful relationships and use drugs or alcohol to facilitate socializing with others. They may feel uncomfortable or unable to interact without being under the influence.

4. Some people feel they express themselves better or function better sexually with alcohol or drugs.

5. Ask group members to identify the specific problem areas in their relationships caused or worsened by their addiction and draw from the following list.
   - Communication difficulties
   - Distrust from others
   - Manipulating others
   - Lying, stealing or conning others
   - Failure to assume parental or marital responsibilities
   - Sexual problems
   - Anger problems
   - Being irresponsible in the relationship
   - Inability to give and take
   - Financial problems
   - Difficulty meeting each other's needs
   - Broken relationships
   - Violence or threats of harm

6. Have clients identify ways to begin repairing some of the damage to relationships caused by their addiction.
   - Stopping hurtful behaviors.
   - Talk with those hurt by your addiction.
   - Apologize and make amends when appropriate.

7. Define enabling and ask group members to give examples of these behaviors in their relationships with family or significant others.
   - **Enabling** refers to behaviors such as shielding the dependent person from consequences of use, covering up or lying for them, or bailing them out of trouble that was caused by the alcohol or other drug use.
   - **Enabling** can be passive (they do nothing) or active (they shield you from consequences of your addiction).

8. Ask group members to identify the components of healthy relationships and review the following:
   - Support your sobriety and involvement in recovery
   - Allow for mutual love and respect
   - Involve a balance between "give and take"
   - Allow you to recognize and meet your own needs
   - Have mutual trust and respect
   - Can tolerate and appreciate differences
   - Can tolerate anger and other feelings
   - Can work through conflicts and disagreements
   - Are able to share positive and negative feelings
   - Are non-abusive (verbally or physically).

9. Ask clients to state why sobriety is important if they are to develop or nurture healthy interpersonal relationships.

10. Ask clients the importance of having relationships with “sober” people and where they can meet new friends in recovery.

11. Discuss how mutual support programs and recovery clubs can provide a context to develop new relationships with sober peers in recovery.

CHAPTER 11
Groups about Mutual Support Programs

How 12-Step Programs Aid Recovery
Step 1: Acceptance
Steps 2 & 3: Surrender
Using a Sponsor to Aid Recovery
Establishing a Recovery Support System

Group Topic
How 12-Step Programs Aid Recovery

Objectives of Group Session

1. Provide an overview of the 12-Step programs (AA, NA, and others)
2. Discuss experiences and beliefs about 12-Step programs
3. Emphasize the importance of "we" in the "Fellowship" of these programs.

Points and Issues for Discussion

1. Ask group members to share their experiences and beliefs about 12-step programs.
   - What types of 12-step programs and meetings did they attend?
   - What did they dislike or like about these programs?
   - What did they find helpful?
   - How can 12-step programs aid their long-term recovery?

2. Discuss how 12-Step programs are a major source of support in ongoing recovery from addiction. These programs involve many components such as:
   - Meetings (open, closed, leader, discussion)
   - Sponsorship
   - 12-Steps
   - Recovery events
   - Readings on addiction and recovery such as "Big Book of AA" "Basic Text" of NA.
   - Slogans such as "One day at a time," "This too will pass," or "Easy does it."
   - Service

3. Get group members to discuss experiences and beliefs about 12-Step meetings.
   - How often they attended or think they should attend.
   - Types of meetings they liked the most (or least) and why.
   - Why having a "Home Group" is important.
   - Why regular meeting attendance is important.

4. Ask group members to discuss experiences and beliefs about Sponsors.
   - Why get a sponsor.
   - How to get a sponsor.
   - How a sponsor can help.
   - Reservations about getting and trusting a sponsor.
   - How to actively "use" a sponsor to mentor them in recovery.
   - The difference between a sponsor and a therapist or counselor.

5. Get group members to discuss experiences and beliefs about the 12-Steps.
   - Purpose of the 12-Steps.
   - Focus on the "we" that is in all steps vs. the "I" to stress the "Fellowship."

- Which of the 12-Steps have members "worked" before and what was the outcome?
- Focus on the importance of "Step 1" during early recovery.

6. Ask members to share experiences attending events sponsored by the 12-Step Fellowship.
   - Types of events attended (social, recovery oriented)
   - What they gained from these events.
   - How these events aided their recovery.
   - How holiday related events can help them through difficult time periods.

7. Get group members to discuss experiences and beliefs about reading recovery literature.
   - What have they read?
   - How has recovery literature helped them?
   - Mention the "Big Book of AA" and the "Basic Text of NA" for drug addiction.
   - State there are many books, pamphlets and workbooks available related to the 12-Step program of recovery through AA, NA and other publishers.
   - Inform group members where they can get 12-Step recovery literature.

8. Ask group members to discuss some of the "Slogans" used in the 12-Step program.
   - What are slogans and how can they help?
   - Which slogans do they use in their daily recovery.
   - Review a few of the common ones that help in early recovery.
   - "Easy Does It; One Day at A Time; Let Go and Let God."
   - "Think Through the Drink/Drug; This Too Shall Pass."
   - Other slogans.

9. Get group members to discuss experiences and beliefs about "Service"
   - How do members "serve" each other?
   - Service can be formal (chair meetings)
   - Service can be informal (help set up and clean up after meetings).
   - Service gets recovering person to focus on others rather than self.

10. Emphasize the "Fellowship" is a "we" program and discuss what this means to group members to work "with" others in recovery rather than try to recover alone.

Group Topic
Step 1: Acceptance

Objectives of Group Session

1. Review Step 1 of the 12-Step program of AA and NA.
2. Identify examples of "Powerlessness."
3. Identify examples of "Unmanageability."

Points and Issues for Discussion

1. Ask group member to read Step 1: "We admitted that we were powerless over our addiction and that our lives had become unmanageable."

2. Ask members to share their view of what this Step means in their personal recovery.
   - Some may think it means that they are *helpless* over their addiction.
   - Some may insist that they are in control of their substance use.
   - Some may think this means that they cannot change.
   - Some may not see any connection between their substance use and problems in life.

3. Discuss with group members how to "work" Step 1.
   - Review addiction and negative effects with a Sponsor or therapist to "share" one's history of substance use and addiction.
   - Discuss specific details of the addiction and negative effects on self and others.

4. Break the Step down into three key words: we, powerlessness and unmanageability.

5. Discuss the "We" component and ask members how they view the "we" aspect of recovery.
   - The 12-Step program works on inter-dependence among recovering group members.
   - Each person is responsible to make the efforts to stay sober, but they have the support of other recovering persons.
   - Recovery works best when it is viewed as a "we" process rather than an "I" process.

6. Ask for examples of "Powerlessness" related to substance use or addiction.
   - How have substances or addiction controlled the person?
   - Have they ever used substances to stop or control withdrawal symptoms?
   - Have they ever used when they swore they would not use?
   - How does it feel to be controlled by the need or desire to use alcohol or drugs?
   - How does the compulsion to use substances affect group members' lives?
   - How do they feel about being "powerless" over substances or addiction?
   - Discuss how denial of the problem often leads to continued substance use.
   - Elicit examples of how group members have minimized or denied their addiction?

7. Ask members what "Unmanageability" means to them and to give some concrete examples. This can relate to amount or frequency of use of alcohol or drug use. Examples include:
   - Using more alcohol or drugs than intended.

- Using more often or frequent than one intended.
- Substances play too big of a role in their life.
- Life becomes centered around getting, using or recovering from the effects of alcohol or drugs.

8. Ask members for examples of behaviors shown under the influence of substances that the members would not show if not under the influence of drugs or alcohol?

9. Review specific effects of substances and/or the addiction on:
   - Physical health and personal hygiene.
   - Dental health and hygiene.
   - Diet and exercise habits.
   - Relationships with family members, including children.
   - Relationships to friends, colleagues or others.
   - Ability to function responsibly at work or school.
   - Mood or feelings.
   - Mental health.
   - Financial health.
   - Spiritual health.
   - Other negative consequences?

10. Discuss what it feels like to "give up" alcohol or drugs use or their "active" addiction.

11. Review how 12-Step programs view the disease of addiction:
    - There is no cure for addiction, only recovery.
    - Abstinence--*one day at a time*--is the only option that works.
    - Self-reliance and willpower are not enough.
    - The support of peers ("we") in 12-Step programs is vital to recovery.
    - The goal of 12-Step programs is to maintain abstinence by avoiding the first use, *one day at a time*.
    - The goal of working Step 1 is to accept the addiction and negative impact on life, and become willing to engage in recovery.

12. Emphasize how working Step 1 sets the foundation for recovery.

Group Topic
Steps 2 and 3: Surrender

Objectives of Group Session

1. Discuss the concept of "Surrender" in recovery from addiction.
2. Review Step 2 of the 12-Step program.
3. Review Step 3 of the 12-Step program.

Points and Issues for Discussion

1. Step 1, which deals with "powerlessness" and "unmanageability" can be phrased as "I can't handle it" (substance use and addiction).

2. Step 2 deals with belief that someone or something more powerful than the person can help.
   - Have a group member read aloud Step 2: "*Came to believe that a power greater than ourselves could restore us to sanity."*
   - Ask the group members what Step 2 means to them.
   - Reassure them that 12-Step fellowships are open to people of all beliefs and backgrounds, including atheists and agnostics.

3. As with the first Step, break Step 2 down into its key concepts.
   - *"Came to believe"*
   - *"Power greater than ourselves"*

4. Ask group members what *"Came to believe"* means to them.
   - What are their beliefs about God or a *"Higher Power"*?
   - Ask non-believers to approach this step with an open mind.

5. Ask group members how they define spirituality.
   - Discuss the difference between *spirituality* and *religious belief*.
   - Spirituality gives a person a sense of meaning or purpose in their life.
   - Some group members may feel ashamed and guilty about past behaviors.
   - Some members may be angry because of traumatic events in their life.
   - Since recovery is a process that takes place over time, group members who do not believe today may come to believe in the future—if they remain open-minded.

6. Ask group members what *"Power greater than ourselves"* means to them.
   - What forces outside of themselves have been more powerful than they?
   - Did they ever have people that they looked up to or admired?
   - What did they admire or respect about those people?
   - What "Higher Power" has been benign and loving?
   - Recovery from addiction works best when it is *with* other people. The appropriate slogan is, "We alone can do it, but we can't do it alone."

- Explore group members' relationship with their "Higher Power."
- Discuss how prayer or meditation can help recovery.

7. Ask members what *"Restore us to sanity"* means to them.
   - Briefly revisit examples of unmanageability" from Step 1 to illustrate how addiction led to insane behaviors on the part of group members.
   - Continuing old behaviors and expecting new results.
   - Ask group members who can help to "restore them to sanity."

8. Step 3 has to do with allowing someone or something to help:
   - Have a group member read aloud Step 3: "*Made a decision to turn our will and our lives over to the care of God--as we understood him*."
   - This is a step to help group members move away from the destruction, hopelessness and despair of addiction towards the hope and opportunity of recovery.

9. Group members' willingness to work this Step is demonstrated by their ability to accept and follow the suggestions of others about recovery.
   - This may mean going to meetings and changing old habits and routines.
   - Turning their will over to a Higher Power does not mean that God will take care of everything in life.
   - They have to work hard at changing their lives. The 12-Step program provides a venue to aid in the change process.

10. Ask group members what *"Made a decision"* means to them.
    - While Step 2 is a process of coming to believe, this Step is an action of decision.
    - The decision is to trust one's life to someone or something outside themselves.
    - This decision is made throughout recovery.
    - It is a conscious and deliberate decision on the part of group members.

11. Ask members what *"Turn our will and our lives over"*" means to them.
    - What is their experiences trusting God or trusting others?
    - Do they believe that the experience of others in recovery can help them?
    - Part of recovery involves following a "common wisdom" found in the 12 Steps.

12. Ask members what *"Care of God, as we understood Him*" means to them.
    - Some people have a more caring concept of God than others.
    - For those who do not believe in God or a Higher Power, suggest that they use the Fellowship of AA or NA as their "Higher Power" at first.

13. Summarize the importance of surrendering and looking outside of oneself in recovery.

Group Topic
Using a Sponsor to Aid Recovery

Objectives of Group Session

1. Define sponsorship in the 12-Step program of AA, NA and others.
2. Review ways in which a sponsor can help in recovery.
3. Identify how to get a sponsor.
4. Review specific ways to "use" a sponsor.
5. Review differences between a sponsor and a counselor or therapist.

Points and Issues for Discussion

1. Ask group members what they think the role of a Sponsor is in 12-Step programs.
   - The tradition of sponsorship started early in the days of AA.
   - Originally sponsors were people who visited alcoholics in the hospital and took them to AA meetings when they were discharged from the hospital.
   - Sponsors were used as resources for questions about material in the Alcoholics Anonymous literature.
   - Sponsorship has evolved into a way for newcomers to get practical advice and support from more experienced peers.
   - Sponsors serve as "mentors" and help new members use the 12-Step program.
   - Being a sponsor is both a privilege and a responsibility.

2. Discuss reasons why some members may not get a sponsor.
   - Hard to trust others and open up
   - Don't like being told what to do
   - Don't want accountability for recovery
   - Other.

3. Ask group members how a Sponsor can aid their recovery from addiction.
   - Promotes openness and self disclosure by sharing his/her own history of addiction and recovery, and how 12-Step programs aided recovery.
   - Provide information about the 12 Step program.
   - Suggest 12-Step meetings to attend (types of meetings or specific ones).
   - Introduce the newcomer to other recovering individuals.
   - Help them "work" the 12 Steps.
   - In short, the sponsor facilitates the newcomer's participation in 12-Step recovery.
   - A good sponsor can only share by example and make suggestions to the newcomer.

4. Get members to discuss what to look for in Sponsor.
   - Same gender to avoid potential for sexual attraction.
   - Similar age and background (although not always necessary).
   - Someone with substantial recovery (at least a year although several years or longer is better).

- A person "active" in working the program of AA, NA or other 12-Step program (they go to meetings, use the phone to stay connected with others in recovery, have their own Sponsor, work the 12-Steps and engage in other aspects of the program).

5. Discuss how to find a Sponsor in AA, NA or other 12-Step program.
   - You can ask the Chairperson at a meeting for a "temporary" Sponsor.
   - This person can help until a permanent Sponsor is found although you may keep this person as your Sponsor.
   - You can ask friends in recovery for recommendations on finding a Sponsor.
   - Counselors or therapists who know you may suggest ways to find a Sponsor.
   - Make a commitment to get a Sponsor by setting specific time frame (e.g., "I will get a Sponsor within the next 14 days" rather than "I'm going to get a Sponsor" without having any time frame in mind).

6. Ask members how they can "use" a Sponsor to benefit from their experience in recovery.
   - Talk regularly by phone, especially in early recovery, to discuss progress in recovery, challenges in recovery and any aspect of the 12-Step program of change
   - Call Sponsor when you need help and support (e.g., with strong cravings to use).
   - Call Sponsor when things go well to stay connected.
   - Attend recovery events together (e.g., sober dances, holiday celebrations).
   - Work the 12-Steps.
   - Elicit feedback on your progress ("how am I doing in my recovery?").
   - Attend meetings together.
   - Meet before and after 12-Step meetings to discuss recovery issues.
   - Focus on spiritual growth, gratitude, humility and positive aspects of change.
   - Reach out for help to get back on track after a relapse.

7. Discuss the differences between a Sponsor and a Professional Counselor or Therapist.
   - Both a counselor and sponsor offer support and advice, however, there are important differences.
   - A counselor knows the client for a prescribed period of time, with specific appointment times for counseling sessions that focus on agreed upon goals.
   - Once treatment is over, the counselor is no longer part of the client's life. A sponsor however, is available throughout the client's life, for as long as that relationship exists.
   - A sponsor does not use therapeutic techniques to treat the client, rather shares experience through self-disclosure and offers support. Whereas the roles of the counselor and the sponsor differ, it is not uncommon for each to give the client similar advice.

Group Topic
Establishing a Recovery Support System

Objectives of Group Session

1. Identify the benefits of having a recovery support system.
2. Identify supportive people and organizations to include in a recovery support system.
3. Identify reasons why it may be difficult to ask others for help or support.
4. Identify ways to approach others and ask for help or support.

Points or Issues for Discussion

1. In previous sessions, the focus was on using the 12 Step fellowship of AA, NA, and CA for help with ongoing recovery.
   - Meetings, sponsors, recovering friendships, the 12 Steps, slogans and recovery literature are all "tools" of recovery that can help you stay sober and make positive changes over time.

2. Other people and organizations can also provide you with help and support. These people don't have to necessarily be directly associated with a recovery program.

3. Then ask group members to give examples of people they might ask for help and support.
   - Specific family members
   - Specific friends
   - A boss or coworker
   - A neighbor
   - A priest, minister or rabbi
   - Other people?

4. Ask members of the group to give examples of organizations or groups that can play an important role in their efforts to stay sober and change their lifestyle.
   - Church or synagogue
   - Sports team
   - Club that evolves a specific interest
   - Volunteer organizations

5. Ask group members to give examples of how other people and organizations can play a role in their recovery.
   - Other people can listen to their problems or concerns.
   - Other people can be asked for specific help with a problem or situation.
   - Other people can participate in mutually-satisfying activities or events that do not evolve around alcohol or drug use (e.g., share a hobby, go to a movie together, etc.).
   - Organizations can give a sense of belonging.
   - Organizations can offer opportunities for social interaction, a chance to develop new friendships or interests, or a chance to learn new skills.
   - Church related organizations can provide an opportunity for spiritual growth.

6. Ask group members to give examples of people they <u>should not ask for help</u> or support.

- Others who still get drunk or high and have no interest in supporting them in recovery.
- People who are angry at the recovering person and may still be holding a grudge.
- People who don't want the recovering person to succeed at getting or staying sober or clean.
- Other

7. Ask the group to give reasons why it is difficult to reach out and seek help or support from others.
   - Fear of rejection.
   - Feeling unworthy to be helped by others.
   - Don't know how to be assertive and make requests from other people.
   - Feeling shy and awkward.
   - Embarrassed to have to ask another for something.
   - Fear of sounding inadequate.
   - Hard to trust others and open up.

8. Ask members to share ideas on how to "reach out" to others for help and support.
   - Make a list of people that they trust and feel they can rely on.
   - Choose one or two to start with in terms of asking for help or support.
   - Talk with them about recovery and the need for their support.
   - Communicate regularly, not just in time of trouble.
   - Talk face-to-face, by phone, email or text messaging.
   - Take a risk and open up to others.
   - Also, show an interest in their lives as well.

CHAPTER 12
Groups about Relapse Prevention

Managing Relapse Warning Signs
Managing High Risk Factors
Setbacks: Stopping a Lapse or Relapse
Maintaining Recovery by Using Daily Tools

Group Topic
Managing Relapse Warning Signs

Objectives

1. Teach group members that warning signs precede substance use relapse.
2. Introduce the idea that relapse is a process as well as an event.
3. Review *common warning signs* associated with relapse.
4. Review *subtle warning signs* that may be unique to each individual.
5. Identify strategies to manage relapse warning signs.
6. For those who have had one or more episodes of relapse, teach them to use this as a *learning experience* to help their future recovery.

Points for Discussion

1. Ask group members to define relapse as it relates to their substance use disorder. Give the following definitions:
   - Addiction relapse refers to the process of returning to alcohol or drug use after a period of sobriety.
   - A lapse refers to the initial period of use and may or may not progress to a full-blown relapse.

2. Ask group members who have relapsed to either disorder for examples of relapse warning signs from past experiences. Add additional examples as needed and state that warning signs will fall in the following categories:
   - *Changes in thinking*: "I don't need recovery, it's not worth the effort, I don't need medications anymore;" increase in severity of paranoid thoughts, delusions, or hallucinations.

   - *Changes in mood*: significant increase in anger, anxiety, boredom, or depression.

   - *Changes in health habits or daily routines*: not taking care of personal hygiene or changes in daily habits or rituals.

   - *Changes in behavior*: stopping or cutting down on treatment sessions, medications, or support group meetings without prior discussion with a professional or AA, NA or DRA sponsor; reducing social interactions or activities; or reduced use of the "tools of recovery."

3. For relapse to substance use, emphasize it seldom "comes out of the blue."
   - Discuss the context of relapses (who, where, when)
   - Help group members see that it may be days or longer between an emergence of warning signs and substance use.

4. Emphasize the importance of catching relapse warning signs early.
   - The earlier that group members intervene, the less likely that relapse will occur.
   - Ignoring warning signs is not a good strategy as they must be dealt with.

5. Discuss the importance of not keeping warning signs a secret as things can build up and end in a relapse. Failure to identify or deal with relapse warning signs invites problems.

6. Discuss the difference between "common" and "individual" warning signs.
   - Common warning signs include cutting down or stopping meetings.
   - Individual warning signs may include an increase in dishonestly, or depression during the holidays.

7. Ask group members to identify strategies to manage relapse warning signs. Their specific examples should fall in the following broad categories:
   - *Cognitive*: changing thoughts and beliefs (e.g., challenging the thought "I can't have fun without alcohol or drugs" or "just because I didn't get the job I wanted doesn't mean I have to get depressed and give up").

   - *Behavioral*: changing a behavior (e.g., resuming regular meeting attendance when one identifies cutting back as a warning sign; taking medications as prescribed after one identifies cutting down or stopping without first discussing this with a doctor or therapist).

   - *Interpersonal*: seeking help and support from others in AA, NA or DRA (e.g., talking with others about ways to manage warning signs).

8. Use this information to emphasize the importance of being aware of warning signs and having a plan to manage them.

9. Discuss the importance of seeking support from others to manage warning signs (e.g., AA/NA friends and sponsors, counselor, friends, family, etc.).

Group Topic
Managing High Risk Factors

Objectives

1. Review factors that increase the risk of relapse to addiction and label these as "high risk."
2. Teach group members that relapse risk factors fall into different categories, but it is usually a combination of factors, rather than just one, that contribute to relapse.
3. Emphasize the importance of learning coping skills to manage relapse risk factors.

Points for Discussion

1. Relapse is common with psychiatric, substance use disorders.
   - Relapse does not mean failure
   - It is common with chronic or recurrent diseases (medical, psychiatric or addiction).

2. There are a number of external and internal factors that increase group members' vulnerability to relapse. These are referred to as "high-risk" factors.

3. Ask group members to identify high-risk relapse factors in relation to their addiction
   - These are situations in which they used alcohol or drugs in the past.
   - These can occur regardless of how engaged you are in a recovery program.
   - These are situations that increase their desire to use.

4. Review the major categories of causes of relapse, eliciting and giving some examples from each category:
   - Intrapersonal or internal factors (thoughts, feelings).
   - External factors (relationships, support system, etc.).
   - Lifestyle factors (health habits, structure, etc.).

5. Group members need more than awareness of their high-risk relapse factors. They also need to actively use coping skills to manage these factors effectively.

6. The skills needed vary and depend on the group members' relapse risk factors.

7. Stress the importance of having a plan to deal with potential high-risk factors. The idea is to:
   - Identify (anticipate) high-risk factors.
   - Develop strategies to manage relapse-risk factors.
   - Implement coping strategies into daily recovery.
   - Change strategies that do not work and try new ones.

8. Reinforce the importance of making a commitment to long-term recovery using both professional counseling and self-help programs such as AA, NA, DRA groups.
   - This provides an ongoing mechanism to identify and manage high-risk factors.
   - It provides social support so that you can get help from others in recovery.

9. Some group members are more vulnerable to relapse than others, based on their history and severity of their illnesses and coping skills. For example:
    - A group member with a long history of addiction and multiple attempts at recovery is more vulnerable to relapse than a first-timer.
    - A group member with an untreated psychiatric disorder is at increased relapse risk.
    - A group member who lacks social support on a recovery network is more likely to keep problems to oneself and return to substance use.

Group Topic
Setbacks: Stopping a Lapse or Relapse

Objectives

1. Review the importance of being prepared to handle a setback, emergency or relapse.
2. Identify benefits of continued involvement in treatment and recovery.
3. Raise awareness that failure to comply with ongoing treatment increases the chance of relapse.

Points for Discussion

1. Ask members how they define a setback or emergency as it relates to recovery from addiction.

2. Group members who comply with treatment do better than those who do not. Failure to comply with treatment often contributes to relapse.

3. Stress the importance of keeping therapy appointments even after sobriety has been achieved and maintained for a while.

4. Ask group members who have failed to comply with treatment in the past, and those who did, to state how this affected their recovery.

5. Ask group members to identify the potential benefits of complying with treatment and recovery plans.

6. Many group members relapse so it helps to be prepared should this occur.
   - Relapse can occur even if group members comply with treatment.
   - It is less likely if treatment is complied with.

7. Discuss the benefits of preparing ahead of time for a setback or relapse.
   - Group members are better prepared to take action quickly and early in the relapse process.
   - Group members feel more hopeful about recovery if they know how to handle setbacks and potential problems.
   - Damage that occurs following a relapse is limited.

8. Ask group members what they could do if they felt their treatment plan was not working or not helpful instead of dropping out of treatment.
   - Talk to their treatment team about changing the plan.
   - Talk to a sponsor.
   - Figure out why the plan is not working.

9. Ask group members to identify steps to take if they relapse to substance use.
   - Stop using and get rid of booze, drugs and drug paraphernalia.

- Ask for help from a sponsor or other AA, NA, or DRA friends.
- Ask for help from the treatment team.
- Seek detoxification if physical addiction has reoccurred.

10. Review the following ideas about setbacks and emergencies:
    - Preparing ahead of time allows group members to catch setbacks early, which may help prevent a full-blown relapse.
    - Group members can ask for help with setbacks or emergencies from counselors, other professionals, sponsors, and friends in recovery.
    - When possible, your family should be involved.
    - Group members who get re-addicted physically and cannot stop alcohol or drug use will need detoxified under medical supervision.

11. Ask group members what they learned from previous relapses or setbacks.

Group Topic
Maintaining Recovery

Objectives of Group Session

1. Stress the importance of a daily plan for recovery.
2. Reinforce the helpfulness of continued participation in self-help programs after completion of professional treatment.
3. Review the "tools" of recovery that can be used in daily life to help one maintain sobriety and continue to make positive changes.

Points or Issues for Discussion

1. Ask group members why they think it is important to follow a daily plan in recovery. Add examples as needed to cover these benefits:
   - Helps keep group members focused and vigilant about recovery.
   - Keeps them busy and focused on using positive coping strategies.
   - Helps group members achieve their goals.
   - Helps them spot problems early.

2. Discuss the possible negative consequences of not following a recovery plan on a daily basis. Add examples as needed to cover the following potential problems:
   - Problems are not identified or addressed promptly.
   - Boredom and hopelessness are more likely.
   - Group members can lose focus on recovery.
   - Group members can become too passive about recovery and the actions needed to sustain recovery.
   - The risk of relapse may increase.

3. Ask the group members to identify the benefits of ongoing participation in a recovery program following completion of treatment. Some examples include:
   - Can receive continued help and support from others in recovery.
   - Actively working a program of recovery reduces relapse risk.
   - Involvement in recovery, especially support groups, is a constant reminder of the seriousness of addiction and the importance of following the "disciplines" of recovery.
   - Staying sober puts the recovering person in the position to continue to make positive changes in self and lifestyle.
   - Many problems and issues emerge over time, even if one is sober from alcohol or clean from drugs. Participation in a recovery program can make you feel better prepared to handle these issues or problems.

4. Discuss the length of time group members should stay involved in a recovery program such as AA, NA, or CA. This varies considerably among recovering individuals with many staying involved for years or even lifelong.

5. Ask members what happened to them in the past if they dropped out of treatment early.
   - How were they affected?
   - Why did they drop-out?
   - What does this say about addiction?

6. Ask the group what "tools" of recovery they can use on a regular basis once they are finished with the group sessions. They can also state how these various recovery tools can help their ongoing recovery.
   - Attending AA, NA, CA or other self-help meetings.
   - Spending time at a recovery club or clubhouse.
   - Talking with a sponsor or other members of self-help programs.
   - Sharing social or recreational activities with friends.
   - Avoiding high risk people, places, or situations when possible.
   - Using aftercare group counseling sessions or talking individually with a counselor or therapist.
   - Using techniques learned to fight off thoughts of drinking alcohol or using drugs, or to fight off strong cravings.
   - Using positive affirmations by reminding oneself of the benefits of sobriety and that all the time and effort put forth is worth it.
   - Getting physical exercise.
   - Attending religious services.
   - Praying or using one's Higher Power.
   - Focusing on one of the 12 Steps.
   - Repeating and thinking about a recovery slogan.
   - Reading specific recovery literature or a meditation guide.
   - Writing in a recovery journal or workbook.
   - Participating in pleasant activities that don't involve alcohol or drugs.
   - Doing something nice for someone else as a way of "giving back."
   - Reviewing the plan for recovery at the beginning of each day.
   - Evaluating how the day went at the end of it to review positive growth and identify problems needing attention.
   - Regularly reviewing relapse warning signs to catch them early.

7. Ask group members why recovery should be approached "one day at a time."

CHAPTER 13
Groups about Lifestyle Issues

Spirituality and Recovery
Financial Issues in Recovery
Non-Substance Related Addictions

Group Topic
Spirituality and Recovery

Objectives

1. Review spirituality as a domain of recovery.
2. Identify ways that spirituality can aid recovery and self-change.
3. Help client understand the "we" versus the "I" aspect of recovery.
4. Identify steps of the AA or NA program that address spirituality.

Points for Discussion

1. Recovery is multidimensional and involves physical, psychological, social, interpersonal and spiritual domains.

2. Ask group members to define spirituality and what it means to their recovery.

3. Discuss "values and meaning" as an aspect of spirituality. Ask group members to talk about which relationships, activities, or values give them the most meaning and purpose in their life.

4. Spiritual values include honesty, faith, hope, humility, courage, compassion, forgiveness and altruism or service to others.

5. Spiritual or faith based activities include self reflection, meditation, prayer, and participation in religious services.

6. Connectedness with a Higher Power is an important aspect of spirituality. While most choose to use God as their Higher Power, some use other sources of a Higher Power such as the fellowship of AA or NA.

7. Discuss recovery as a "we" rather than an "I" process. Emphasize the importance of looking beyond oneself, and reaching out for help and support.

8. As recovery progresses, serving others is one way of expressing spirituality. Helping others is the basis of Step 12. However, this is only done after a substantial period of recovery.

9. Steps 2, 3, 5, 6, 7, 11 and 12 of the 12-Step program address spirituality issues.

10. Ask group members to identify one area of spirituality they want to work on.

11. Discuss spirituality strategies to help recovery and personal growth. Strategies may include the following:
    - Rely on God or a Higher Power for strength, guidance, purpose in life, and understanding.

- Participate in religious or faith based services and activities.
- Make praying a regular part of the day or join a prayer group.
- Attend a religious retreat or spend time at a monastery or other spiritual place to get in touch with spiritual beliefs.
- Meditate.
- Read the Bible or other spiritual and inspirational guides to seek knowledge, guidance, and motivation.
- Discuss spirituality issues in therapy sessions or with an AA/NA sponsor.
- Focus on Steps 2, 3, 5, 6, 7, 11, and 12.
- Seek spiritual advice from a priest, minister, rabbi, or other spiritual person.
- Focus on the greater good of society and contributions that can be made to make the world a better place.
- Be of service to others (i.e., through volunteer work).
- Show love and compassion in daily life in interactions with other people.
- Be kind and forgiving to self and others.
- Accept one's weaknesses and limitations and be tolerant of shortcomings and mistakes.
- Stop hurtful behaviors toward others and make amends as needed.

Group Topic
Financial Issues in Recovery

Objectives of Group Session

1. Identify financial problems caused or worsened by substance use.
2. Identify strategies to reduce debt.
3. Identify strategies to manage money more effectively.

Points for Discussion

1. Financial problems are common among people with substance use disorders.

2. Financial problems can cause frustration, anger, and hopelessness for the client and the family.

3. Ask group members to give examples of financial problems caused or worsened by their substance use disorders.

4. Include financial effects on the family and children, as well as group members.

5. Discuss some of the more common problems such as:
   - Using a paycheck, disability or government check or other income to buy drugs or alcohol.
   - Loss of income due to inability to get or keep a job, or being underemployed.
   - Inability to pay bills on time (rent, utilities, etc.) or meet basic needs for food, clothing and shelter.
   - Inability to provide adequately for children or family (food, clothing, shelter, education, etc.).
   - Accumulating a drug debt, which can put you in danger due to retaliation by drug dealers.
   - Getting too many loans or loans at high rates of interest.
   - Making bad investments, going on spending sprees, spending retirement income.
   - Shopping excessively when high.
   - Getting into debt due to above problems, or due to borrowing money at high rates of interest from financial institutions or loan sharks.

6. Review strategies to address financial problems and manage money more effectively. Money-management strategies include:
   - Keeping track of money so group members know how they spend it.
   - Developing and following a budget to live within financial means.
   - Not spending impulsively (spending BEFORE thinking).
   - Not buying things you cannot afford because you want them.
   - Regularly reviewing progress and changing budget plan as needed.
   - Reducing debts on loans and credit cards.
   - Avoiding loan sharks and high interest loans.

- Shopping more effectively to stretch money.
- Figuring out "little ways" to save money here and there (all of which can add up to substantial savings).
- Reading books and magazines to learn new ways of managing money.
- Seeking help from a financial counselor for money problems or financial consultant for investment advice.

5. Some group members may have no income at all.
   - The goal with them is to find ways of financial support until they get back on their feet.
   - This support may have to come initially from the government in the form of welfare.
   - These group members may also benefit from information on food banks and other sources of help (i.e., help with utility payments).

Group Topic
Non-Substance-Related Addictions

Objectives

1. Define the terms excessive, compulsive and addictive as these relate to behaviors.
2. Identify specific behaviors that can be excessive, compulsive or addictive.
3. Review the relationship between substance use and other addictive behaviors.
4. Review strategies to manage behavior-related addictions.

Points for Discussion

1. Many people with substance addictions have other behaviors that they engage in excessively, compulsively or are addicted to. These can develop in the absence of substance use. Behaviors become addictive through self-reinforcing properties, self-medication effects, and/or creating physiological changes similar to those that result from substance use and abuse. Substance and behavioral addictions can occur simultaneously or sequentially.

2. Ask group members to provide their views of the following terms, and then review the definitions and discuss how members would know if any of their behaviors could be considered:
   - Excessive: more than necessary, normal or desirable.
   - Compulsive: an irresistible urge to behave in a certain way.
   - Addictive: becoming dependent on a certain behavior and being unable to stop it without experiencing negative effects.
   - Addiction also includes: a) obsessions (strong thoughts or desires); b) changes in tolerance or needing more of the behavior; c) spending too much time thinking about, engaging in, or recovering from the effects of the behavior; d) continuing the behavior despite negative consequences; e) inability to stop; and f) feeling uncomfortable when not engaging in the behavior (somewhat like withdrawal).
   - In our society too many behaviors are considered addictive and the term is overused.

3. Ask group members to give personal examples of behaviors they consider to be excessive, compulsive or addictive. Some examples are:
   - Eating (binging, overeating, compulsive eating)
   - Gambling
   - Sex and computer sex (cybersex)
   - Compulsive checking, hand washing, counting, hoarding, etc (these can be part of an anxiety disorder).
   - Investing, spending
   - Working
   - Playing videogames
   - Using the internet
   - Using of computer or technology
   - Sports
   - Exercise

- Collecting things
- Other activities

4. Review how some of these behaviors have both positive and negative aspects associated with it.
   - Some behaviors considered excessive or even addictive can have mixed effects.
   - For example, while workaholism can lead to career advancement, productivity, and making a good living, it can also lead to personal distress or family conflict.
   - Or, playing sports can help one stay in shape and watching sports can bring fun and excitement. However, if too much time is spent on sports, other parts of life may be affected such as a marriage or relationship with a child.

5. Discuss the relationships between substance use disorders and behaviors that group members believe are excessive, compulsive or addictive.
   - Substances can affect judgment and contribute to these other behaviors.
   - These other behaviors can cause distress, which can lead to substance use.
   - Relapse to substance use can follow engaging in another addiction.

6. Review effects of behavior-related addictions. Similar to substance addiction, these can cause problems in any area of life. Ask members for examples and relate these to:
   - Physical, mental, emotional and spiritual health (shame, guilt, feeling empty, suicidal behaviors).
   - Relationships to loved ones and social life (separation, divorce, lost relationship).
   - Financial stability and ability to provide for self or family.
   - Legal status as criminal behaviors may be caused by gambling or sex addiction.
   - Other.

7. Discuss help available for other addictions or compulsive disorders. Ask members to share any positive experiences they have had getting help with other addiction.
   - Therapy or counseling or a specialized program.
   - Medications can help with associated symptoms such as depression.
   - Mutual support (Gamblers Anonymous, Sex and Life Addicts Anonymous).
   - Other.

8. Ask group members to discuss what is involved in recovery from another addiction.
   - Accepting the problem and developing a desire to change.
   - Developing a plan of action (therapy, self-help, medications or a combination).
   - Dealing with the challenges of recovery from an addiction: cravings or desires; triggers in the environment; emotional distress; problems caused or worsened by the addiction; identifying and managing relapse warning signs or high-risk situations; and following a daily plan of recovery.

CHAPTER 14
Problem Solving or Therapy Groups

Purpose and Objectives of Groups

Therapy or problem solving groups provide clients an opportunity to discuss specific issues, concerns or problems that impact on their recovery and lives. Specific issues discussed may related to any domain of life: physical, psychological, social, family, interpersonal, spiritual, or other. Therapy groups allows members to discuss issues in greater detail to gain insight and make decisions to change. These groups can be used to:

1. Aid clients in learning how to prioritize their concerns and problems, and to work together on these as a group.

2. Support clients' dealing with difficulties faced in their new drug-free lifestyles.

3. Encourage the development of personal responsibility for ongoing recovery.

4. Help members learn to give and receive support.

5. Help clients develop healthy problem-solving strategies.

6. Assist clients in learning how to give and receive constructive feedback.

Group Format

Following a group format enables the leader to use the time wisely and engage members in productive discussions of their problems. One suggested format is as follows:

1. When the group meeting starts, members introduce themselves, admit to their addiction and state their dates of last use (this includes use of any type of drug or alcohol). Members are encouraged to briefly discuss how they are doing, any cravings, temptations, or "close calls" they have experienced since the previous group meeting. If there are clients in the group who have alcohol or drug problems, but who do not meet criteria for addiction or dependence, they can introduce themselves as "having an alcohol or drug problem" rather than as an "addict."

2. If someone has used since the last session, the group will help that member briefly process the event and develop a plan to prevent further relapse. The goal is total abstinence for all members.

3. Each member is then encouraged to identify a current problem or concern in his or her life and get feedback from the other group members. The group leader can go around the room and ask each member to verbally state a problem or concern. Or, each member can be asked to write on an index card or sheet of paper one problem or concern he would like to discuss in the session. Since not all members will have a chance to discuss their individual problems, the group leader should help the members prioritize problems for discussion. Problems can be listed on a chalkboard or flip chart before deciding which ones to discuss.

4. Common problems, concerns or issues discussed in therapy groups include:

    - Struggles with motivation, ability to stay sober, or inability to accept the need for total abstinence from all substances.
    - Lapses and relapses
    - Boredom with sobriety, "the straight life or straight friends."
    - Not caring about sobriety
    - Persistent obsessions or cravings to use
    - Difficulty coping with specific feelings (anxiety, boredom, depression, emptiness, guilt and shame, loneliness).
    - Lack of interest in, acceptance of, or ability to connect with, self-help programs such as AA, NA, CA or others
    - Specific interpersonal relationship problems or conflicts with family member, partner, friend or work associate (early recovery romances, separation or the threat of it, anger at family member, guilt over impact of addiction on children, etc.).
    - Specific interpersonal deficits such as lack of ability to trust others, control anger, assert self, or appropriately self-disclose thoughts and feelings.
    - Lifestyle change issues such as how to spend leisure time, how to have fun without using substances, how to maintain a structured recovery program, where and how to develop sober relationships, and how to cope with "other" addictions (gambling, sex, overeating, spending, work).
    - Job-related stresses
    - Spirituality issues, such as struggles with defining one's own spirituality, difficulty accepting the spiritual component of 12 Step programs, or lacking meaning in one's life.

5. In the final 10-15 minutes, members are asked to state their plans for the next week in an effort to help them structure their time. In addition, they are encouraged to mention which self-help meetings they plan to attend.

6. The group joins hands and recites the Serenity Prayer aloud to close the group session.

In each group session the leader will facilitate the group process by having each member identify a current problem or concern in his or her life and how to deal with it. Then, the group's feedback will be elicited on how to best resolve the problem. The focus of the group is on current life problems and developing healthy problem-solving strategies to deal with difficulties faced in recovery. In this type of group the members learn how to give and receive feedback from one another, how to prioritize their own concerns and how to work together as a group. The group

leader will model or teach members these skills as needed. The group functions as a support group and members will learn to allow other recovering people to support them.

Problems Discussed in Therapy Group Sessions

Any of the recovery issues and problems discussed in structured recovery groups may be explored The most common issues discussed are those related to staying free from alcohol or other drug use, relapses, relationships, managing emotions and making positive changes in self or lifestyle. Specific problems and issues discussed in groups include:

1. *Motivational struggles* such as loss of, or lowered desire to stay drug free or make personal and lifestyle changes. Related motivational problems show in denial or minimization of the substance use disorder, lack of acceptance of it, and failure to accept the need for abstinence. Motivational problems often lead to poor adherence with attending treatment sessions, self-help groups, or following the individualized recovery plan. Poor adherence in turn often contributes to substance use relapse.

2. *Strong desires, obsessions or craving to use substances.* These problems or recovery issues are more common among members who have not established any significant period of continuous abstinence

3. *Lapses or relapses to alcohol or other drug use.* Group members vary widely in their experiences with lapses or relapses. Some have none, others have one, and others have multiple relapses during the course of treatment. The focus is on trying to get the group member to develop a desire to initiate and maintain abstinence. Or, if a group member is unable to do this, then the group leaders should consider other types of treatment at a higher level of care.

4. *Giving up the main substance of use but continuing to use other substances.* Although total abstinence is the main goal of treatment, some group members will not accept this and may continue to use substances other than their primary drug of choice. The use of these substances increases the risk of relapse to the primary drug of choice. While the majority of cocaine dependent individuals have problems with alcohol abuse or dependence, some are able to successfully moderate their alcohol use.

5. *Problems in NA, CA and AA* or related to mutual support program participation. Members vary in their use of programs such as AA, NA, CA, CMA, other 12-Step programs or mutual support programs. While attendance is highly encouraged, some clients refuse to attend, attend only occasionally, or participate minimally in the nuts and bolts of the programs such as getting a sponsor, working the steps or attending social functions sponsored by NA, CA or AA. Some members discuss concrete problems such as conflicts with a sponsor or other members or being offered substances by a member of a mutual support program.

6. *Boredom with recovery* and the feeling that life isn't much better despite being off of drugs. Many individuals with an addiction like excitement, action and "living on the edge," and recovery is a major adjustment for them. It often is much less exciting the feelings produced by certain drugs wheeling and dealing on the streets, getting over on other people, and partying it up. Some members also experience boredom with relationships, their job or other aspects of life.

7. *Managing emotions such as anger, anxiety, depression or guilt and shame***.** Inability to use active coping strategies to manage emotions is a factor in relapse to alcohol or drug use following a period of recovery. Group members often benefit from learning basic emotional management skills such as being able to identify and recognize feelings, accept them, and learn to live with them without escaping to substance use. In some instances, an emotional state (e.g., anxiety or depression) can be part of a psychiatric disorder that may require treatment.

8. *Relationships problems or conflicts with family members, friends or colleagues at work.* Interpersonal problems run the gamut from mildly problematic ones to severe ones that pose a major threat to recovery or well being. Some specific interpersonal problems or issues often discussed include conflicts or disputes with others, anger or disappointment at others, emotional or physical violence, inappropriate sexual interactions (e.g., unprotected sex, sex with a stranger, sexual promiscuity). Involvement in relationships that are non-supportive or characterized by lack of reciprocity, difficulty saying no or setting limits with others, and difficulty asking others for help or support.

9. *Relationships within the group.* Group members may have strong feelings towards each other that impact on their participation in a therapy group and their recovery process. It is not unusual for group members to exhibit problems in interpersonal style in a therapy group, especially one that occurs over a long period of time and members get to know each other fairly well. These dynamics show in numerous ways. A few example include: criticizing a member, not responding to a member's emotional pain, showing anger towards a member, avoiding eye contact or direct conversation with a group member,

10. *Psychiatric disorders or other types of addictions.* In some instances, group members will have co-morbid psychiatric disorders or other compulsive disorders that contribute to difficulty with emotional states, interfere with recovery, cause personal distress, or contribute to suicidal feelings. Some members may also have other addictions or excessive behaviors such as compulsive gambling, sex, spending or work. While the group is not intended as a therapy group for mental health disorders unless part of a Co-Occurring Disorders program, these problems may be discussed in the context of recovery from addiction. The group leader should encourage members with psychiatric disorders to get an appropriate evaluation to determine if psychiatric treatment is needed in addition to addiction treatment. The leader can also offer to help facilitate this evaluation if needed.

11. *Other psychosocial problems* such as those related to school, work, housing, finances, the legal system, or how to structure leisure time.

Problems Encountered in the Group Process

In addition to specific problems related to recovery or the lives of the group members, problems are also commonly encountered in the group process. These problems require the Group Counselor to intervene to make sure the group addresses them. Following is a discussion of some of the more common group process problems and some suggested strategies for the Group Counselor:

1. *A group member dominates the discussion or always brings the discussion back to his own problems or issues.* The Group Counselor can thank the member for the contributions and then elicit opinions and experiences from other group members. If the group member persistently tries to dominate group discussions or always turns the discussion back to his own problems or issues, this behavior pattern can be pointed out by the Group Counselor to make this member and other group members aware of the behavior. The other members can be asked how they feel about the member's dominating the discussion, and how they want to deal with this in a way that is satisfying to everyone in the group. Even though this creates a problem on one level, on another level some group members find that it creates a safety net for them because they may believe they don't have to self-disclosure personal problems or feelings as long as another member is taking up the group time.

2. *A group member does not disclose any problem or open up in the group session.* The Group Counselor can share his observations about the member's behavior, generalize the issues by group members to talk about any difficulties that contribute to problems in self-disclosing (e.g., shame, shyness, social anxiety). Discussion can then focus on ways this member (or other group members who have trouble self-disclosing) can gradually learn to trust the group and self-disclose personal thoughts, feelings, problems or concerns

3. *A member rejects the input, advice or feedback of other group members.* The Group Counselor can point out this pattern and engage the group in a discussion of why this pattern is occurring. Members' who offer help and support only to have their attempts rejected can be asked to talk about what this feels like so that the member rejecting their help is aware of the impact of this behavioral pattern on others.

4. *A member can only pay attention when the discussion focuses on his problems or who interrupts others when they talk.* The Group Counselor can point out his observations of the group member and discuss the reasons for this behavior. The group can then engage in a discussion of the effects of this behavior (e.g., upsets other members, turns them off, makes them feel like their problems aren't important) and the importance of "giving and receiving" mutual support by listening to each other's concerns and problems.

5. *A member who wants easy answers to problems or is quick to provide easy solutions to others when they discuss personal problems.* The Group Counselor can share his observations of these behavioral patterns and ask the group to discuss the importance of taking responsibility to find solutions to their problems, and to identify more than one strategy to address a particular problem. The leader can emphasize that while there are

many different alternative ways to resolve specific problems, seldom are their easy or simply solutions, and that time, patience and persistence are needed for group members to adequately resolve problems. When a group member provides an easy solution, the Group Counselor can acknowledge this is one strategy that may help some people, but it is also helpful to have other strategies. The Counselor can then engage the group in a discussion of other strategies to resolve the problem under discussion. Finally, the Group Counselor can emphasize to the group that learning how to think about problem solving is just as important as dealing with specific problems since everyone in the group will continue to face multiple problems in their ongoing recovery.

6. *A member who tries to use the Group Counselor for individual therapy during the group session.* The Group Counselor can ask other group members to comment on the problems or issues presented by this member to engage the group in the discussion. Group members can also be asked how they relate to the problem or issue presented on a personal level. If the group member asks the Counselor how to handle a specific problem, he can encourage the member to directly ask peers in the group their ideas on dealing with this problem.

7. *Members who arrive late for the group session or want to leave during discussions.* The leader and group should decide on a rule regarding lateness to group. Sometimes, there are legitimate reasons for being late (e.g., the bus a member takes was running 15 minutes late, the member got a flat tire, etc.). Members may be given a break once or twice for being late. Or, the group may establish a rule in which the member cannot join the group after a certain amount of time (e.g., more than 10 minutes after the start of the group). If time limits are not set, the Group Counselor can predict that some members will often be late. Members who are persistently late can be asked to discuss this pattern of behavior, how it shows in other areas of life, and what they think needs to be done to change this pattern. Group members should never leave the session unless some emergency occurs (e.g., they have a minor illness and need to use the restroom). Routinely allowing people to walk in and out disrupts the flow of the conversation and gives the message that what members say is not important because people can leave at any time. Members may want to leave group due to boredom, feeling like the discussions don't related to them, or as a way to avoid personally discussing problems or concerns.

8. *The group talks in generalities and avoids exploring specific problems in depth.* The Group Counselor can point out this dynamic to the group and ask them to discuss why they aren't talking about specific problems or concerns in recovery. Members can then be asked to set the agenda in a concrete way so that specific problems or concerns are identified for discussion in group. It isn't uncommon for group members to view Counseling Groups as no different than free floating discussions held in some CA, NA or AA meetings. However, Phase II group sessions are designed to explore and solve problems and not simply be a repetition of 12 Step recovery meetings.

9. *The group avoids confronting a member who behaves inappropriately.* The Group Counselor can point out this dynamic and ask the group what they think about the inappropriate behavior, and what lead to their avoiding it.

Other problems may occur during the group time, but these are some of the ones that we've seen over the past several years reviewing hundreds of group sessions. We wish to stress again that while the "content" (i.e., problems and issues discussed) of the group is important, if the "process" bogs down, not much will get accomplished. In addition, some group members may miss sessions or drop out as a result of process problems that aren't addressed. Unfortunately, group members may avoid these issues directly so the Group Counselor won't always know the reasons for a member's poor attendance or early drop out from group. In our experience, it is not uncommon for members to be upset over process issues. A "preventive" strategy is to periodically engage the group in a discussion of the group process. The Group Counselor can ask what they think about the group sessions, what they like and dislike about how the group has been going, and what they would like to see different in the group.

CHAPTER 15
Family Groups

Introduction

Addiction contributes to a variety of family difficulties, affecting the family system as well as individual members. The burden and emotional pain can be great. Family members may exhibit behaviors with the intention of "helping" the addicted member but which ultimately have an adverse impact.

There is an association between relapse and social support across a range of addictions. Involving the family or significant other of the addicted client in individual or multiple family group sessions can reduce relapse risk. Such involvement has benefits to all involved:

1. It provides the counseling staff with an opportunity to learn about the family of the client, observe how family members interact, and gain input from the family.

2. It can facilitate compliance with treatment. If a client feels pressure to remain in treatment in order to satisfy the requests of the family, he may maintain this involvement even during periods of low motivation. This buys the client time for motivation to improve.

3. It provides the family with an opportunity to verbalize their concerns, questions, experiences and feelings related to the addicted family member.

4. It offers the client the opportunity to hear how the family experienced the addiction.

5. It offers the client the opportunity to receive support from the family.

6. The family can gain education and support from other families which may decrease the burden experienced. Anger, worry, confusion and other emotional reactions can be shared and strong, negative affect may be diffused.

7. Family members who appear to need help themselves with a psychiatric or addictive disorder can be encouraged to seek help, and referrals can be facilitated.

8. Family members can be educated about, and encouraged to attend, support groups such as NarAnon or Alanon.

9. Family members can learn about behaviors they should avoid that are considered "enabling."

10. Family members can learn about strategies that can help them better cope with an addicted member.

11. Family members can learn about strategies to take care of themselves so that all the focus is not directed at the addicted person.

Psychoeducational workshops have been used with all types of psychiatric and addictive disorders. Such workshops can have a positive impact on participants in learning information, decreasing family burden, increasing helpful behaviors and decreasing unhelpful behaviors.

There are a variety of formats that can be used for FPWs. These can be a one-time offering (several hours to several days). I advocate using a variety of family approaches including multiple family groups, family psychoeducational workshops, individual family sessions, sessions with individual family members based on a specific need, and referral to family-related self-help programs.

Format of Family Workshops

FPWs are semi-structured sessions in which specific information is provided to clients and families in the context of a group of multiple families. Support is also provided and families are encouraged to share their questions, concerns and feelings. Since this is not a therapy group, the leaders must make sure that it doesn't become a context for sharing deep-seeded emotional feelings. Strong affect is always present in these workshops and some sharing of emotion is necessary. However, opening up families too much can be counterproductive, so education and support are the main areas of focus. Interactive discussion is encouraged in the context of increasing participants' understanding of addiction and recovery.

Educational videotapes can be used to help present information and stimulate discussion. We also find it helpful to provide written literature to clients that relates to the workshop content. Usually after a FPW, one or more family members will have personal questions or concerns they wish to discuss with the workshop leader.

Workshop Content

The specific material covered in family psychoeducational workshops will depend on the amount of time available. Following are the topics or issues commonly addressed in family workshops:

1. *Overview of substance use disorders:* prevalence, symptoms, causes and basic concepts (e.g., various degrees of substance use problems, denial, obsession, compulsion, tolerance, comorbidity, etc.); substance use diagnoses.

2. *Effects of substance use disorders:* on the individual, family system and individual members, including children.

3. *Overview of recovery:* recovery issues for the affected person (physical, psychological or emotional, social, family, spiritual, other) and how to measure outcome.

4. *Overview of treatment resources:* treatment approaches for the affected individual and treatment resources.

5. *How the family can help:* enabling behaviors for the family to avoid and behaviors that are helpful in supporting the addicted family member's recovery.

6. *Family recovery issues:* how the family member can heal from adverse effects of addiction and involvement in a close relationship with an addicted member.

7. *Self-help programs:* programs available for addicted members and family members, how they can help, and how to access them.

8. *Relapse:* common warning signs of relapse, the importance of relapse prevention planning, how the family can be involved, and how to deal with an actual lapse or relapse of an addicted family member.

Family Educational Materials

Families benefit from written information on any of the topics listed above. Families can continue to read and learn about addiction and recovery if written materials are provided or recommended. In addition, educational videos also provide an excellent mechanism to provide information and insight, and often facilitate excellent discussions among families.

Appendices

Endnotes
References and Suggested Readings
Webpage Resources

Appendix 1:
Endnotes

Chapter 1: Introduction to Substance Use Disorders

1. Regier.
2. Kessler et al.
3. Daley & Moss; Daley & Thase; Mueser et al.
4. APA, 2000.
5. APA, 2000.
6. Many factors contribute to substance use disorders. For more details, see the major textbooks of addiction:
    a. Kleber & Galanter, Part 1, pp. 3-54.
    b. Lowinson et al., Part 2, pp. 33-120.
    c. Ries et al., Part 1, pp. 27-64.
    d. See also Cloninger; and Volkow & Fowler.
7. Daley & Marlatt (2006a); Kleber & Galanter; Lowinson et al; Ries et al.
8. Adverse effects of alcohol and drug problems on individuals, family and society are documented in many publications. For example, see:
    a. Textbooks on` addiction (e.g., Galanter & Kleber; Lowinson et al; and Ries et al).
    b. Clinical books for professionals (e.g., Daley & Marlatt 2006a).
    c. Publications by the U.S. Government (e.g., CSAT, NIAAA, NIDA & SAMHSA).
9. Alcoholics Anonymous.
10. Narcotics Anonymous.
11. See Ries et al., Appendix 3 for ASAM patient placement criteria for substance use disorders.
12. The APPI's *Handbook of Psychiatric Measures* (2008) includes a section on questionnaires used to screen and identify alcohol and drug and related problems. These can be used to help assess a substance problem, plan treatment and monitor progress by measuring outcome of treatment. See also McLellan, Kleber & O'Brien for a comparison of outcomes among drug abusers compared to outcomes of patients with three major medical disorders.
13. Behavioral treatments for substance use disorders are described in textbooks on addiction, clinical manuals, and publications of NIAAA, NIDA and SAMHSA. See the following:
    a. Galanter & Kleber, Parts 4 & 5, pp. 333-489
    b. Lowinson et al, Part VI, pp. 579-803.

c. Ries et al, Section 8, pp. 743-908).

d. Beck, Wright & Liese; Daley & Marlatt (2006a); Fals-Stewart et al; Miller & Rollnick; Monti et al; Nowiski & Baker; O'Farrell & Fals-Stewart; Project MATCH; Rawson et al.

e. NIAAA, NIDA and SAMHSA manuals, NREPP webpage, and NIDA (2008) "Science of Addiction" Dissemination kit.

f. The SAMHSA National Registry on Evidenced-Based Programs and Practices (NREPP) describes a large number of interventions and includes references based on clinical trials.

14. Medication-assisted-treatments for substance use disorders are described in textbooks on addiction, clinical manuals, and publications of NIAAA, NIDA and SAMHSA. See the following:

    a. Galanter & Kleber, Part 3, pp. 111-329.

    b. Lowinson et al, Section III, pp. 121-467 & Section VI, pp. 615-652.

    c. Ries et al, Section 7, pp. 629-642.

    d. Bouza et al; Carroll et al; Cornelius et al; Mann, Lehert & Morgan; NIAAA (2000); Rychtarik et al; Salloum et al; and Vocci, Acri & Elkashet.

    e. CSAT (Treatment Improvement Protocol, TIP manuals #40, 42,& 45); NIDA, 2008 and 2010.

15. The National Institute on Drug Abuse established the Clinical Trials Network (CTN) to conduct large, multi-site studies with a broad range of clients in diverse treatment settings. For a review of the work of the CTN during the past decade, see reference #40 (*Journal of Substance Abuse Treatment)*.

16. When medications are used to treat addiction they are usually combined with behavioral treatments such as Motivational Incentives or addiction counseling or therapy (e.g., Cognitive Behavioral Therapy, Individual Drug Counseling, Group Drug Counseling, Relapse Prevention Therapy, etc).

17. NIDA, 2009.

18. Crits-Cristoph et al, 1999; NIDA, 2002.

19. NIDA, 1997.

20. Daley & Moss; Daley & Thase; Kessler et al; Mueser et al; Regier.

21. Condon et al; Dennis & Scott; McLellan, Lewis & O'Brien.

22. Many books and papers describe recovery from alcohol and drug problems and recovery management. See CSAT; Daley & Douaihy; Daley & Marlatt (2006a,b); Dennis & Scott; Dennis, Scott & Funk; Hser; Laudet, McLellan et al; Nowiski & Baker; Scott, Foss & Dennis; and White, Kurtz & Sanders.

23. Daley & Marlatt (2006a).

Chapter 2: Overview of Group Treatments

1. Daley, 2011; Daley et al, 2009; Rawson et al, 2005; SAMHSA 2005a&b; Sobel & Sobel; Velaquez et al; Weiss et al, 2004.
2. NIDA, 2002; Daley & Thase; Rawson et al, 2005; SAMHSA, 2006; Mueser et al.
3. Weiss et al, 2004.
4. Rawson et al, 2005.
5. Crits-Cristoph et al, 1999.
6. Sobel & Sobel, 2011.
7. This quality improvement initiative evolved from discussions among several group therapists who identified some of the reasons clients are less compliant to group sessions than individual sessions. Results show that social anxiety is certainly a factor for some clients. However, clients usually do not express this unless asked specific questions.
8. Daley & Thase; Najavits; Roberts; Weiss et al, 2011.
9. I attended a 2-day conference on clinical outcomes sponsored by NIDA in December of 2010 during which time experts discussed the various ways of measuring outcomes of treatment. The primary outcome measure is usually substance use. And, the "gold standard" in measuring outcome is a combination of self report and biological measures (urine, blood, sweat, hair).

Chapter 3: Training and Supervision of Group Leaders

1. This was conducted via "Survey Monkey" on the internet so that clinicians could answer questions in a confidential manner. The majority of the 80 respondents were clinicians who currently provide group services in their clinical programs.
2. SAMHSA, 2005b.
3. Crits-Cristoph; NIDA, 2002.
4. NIDA, 2002.

Chapter 4: Structured Recovery Groups

1. Many of the group treatment models provide curriculum on structured recovery groups including a format for conducting these sessions. See the following.
    a. Bowen, Chawla & Marlatt.
    b. Monti et al.Cooney & Kaden.
    c. Daley & Thase, 2004.
    d. NIDA, 1993, 1994 & 2002.
    e. Rawson et al, 2005.

f. SAMHSA 2005a & b.
g. Sobell & Sobell.
h. Velaquez et al.

2. Rawson et al, 2005; SAMHSA, 2006.
3. NIDA, 1994.
4. NIDA, 2002.
5. NIAAA, 1995c; Nowinski & Baker.
6. Daley & Donovan.
7. Velaquez et al.
8. NIAAA, 1995b; Monti et al.
9. Sobell & Sobell.
10. Daley & Thase; Mueser et al.
11. Sobell & Sobell; L'Abate 2004a&b.

Appendix 3:
Webpage Resources

Al-Anon Family Groups	www.alanon.alateen.org
Alcoholics Anonymous	www.alcoholics-anonymous.org
American Psychological Association	www.apa.org
American Psychiatric Association	www.psych.org
Dennis C. Daley	www.drdenniscdaley.com
Dual Recovery Anonymous (DRA)	www.draonline.org
Guilford Publications, Inc.	www.guilford.com
Hazelden Educational Materials	www.hazelden.org
Herald House, Independence Press	www.heraldhouse.org/
Nar-Anon Family Groups	www.naranon.org
Narcotics Anonymous	www.na.org
National Alliance for the Mentally Ill	www.nami.org
National Clearinghouse for Alcohol & Drug Information	www.higherdcenter.org/resources/national-clearinghouse-alcohol-and-drug-information-ncadi
National Institute of Mental Health	www.nimh.nih.gov
National Institute on Alcohol Abuse and Alcoholism	www.niaaa.nih.gov
National Institute on Drug Abuse	www.nida.nih.gov
National Mental Health Association	www.nmha.org
Substance Abuse and Mental Health Services	www.samhsa.gov
U.S. Journal & Health Communications	www.hci-online.com

American Psychological Association: www.apa.org

The APA publishes many clinical and empirically-based books for clinicians, which cover a range of psychological disorders. Books are also available on topics such as spirituality, forgiveness and healing as well as treatment of a range of substance use, psychiatric and co-occurring disorders. APA, 750 First Street S.E., Washington, D.C., 20002.

American Psychiatric Association: www.psych.org

The American Psychiatric Association publishes the *Diagnostic and Statistical Manual of Mental Disorders (DSM IV TR)*, practice guidelines, a book on outcome measures, and many books with the most recent evidenced-based practices for psychiatric and substance use disorders. APA, 1400 K. Street N.W., Washington, D.C., 20005.

Dennis C. Daley: www.drdenniscdaley.com

This webpage of the author of this book includes descriptions of materials written for clinicians, clients and families on many topics related to substance use disorders, psychiatric illness, and co-occurring disorders. Dr. Daley was one of the first in the U.S. to write brief, interactive workbooks for recovery from addiction, and the first to write workbooks for recovery from co-occurring disorders. He and his colleagues wrote the first book for counselors on working with clients with substance use disorders and psychiatric illness. Several of his writings have been translated to foreign languages. Daley Publications, PO Box 161, Murrysville, PA 15668, (724) 727-3640.

Hazelden Educational Materials: www.hazelden.org

Hazelden is one of the largest publisher of recovery oriented literature for SUDs in the U.S. It also has books and treatment manuals for clinicians. Hazelden, Pleasant Valley Road, PO Box 176, Center City, MN: 55012, (800) 328-9000.

National Institute on Alcohol Abuse and Alcoholism (NIAAA): www.nih.niaaa.gov.

NIAAA has many excellent resources for medical and health professionals, researchers, clients, families and anyone interested in alcohol problems. Some examples of publications for professionals include: Alcohol Alert; Alcohol Research and Health; The 10th Annual Report to Congress on Alcohol and Health; Helping Patients Who Drink Too Much: A Clinician's Guide; many treatment manuals (e.g., manuals for clinicians from project MATCH and COMBINE); a "Graphics Gallery" with pictures used in NIAAA presentations (e.g., pictures of different systems of the body; and pictures related to Fetal Alcohol Syndrome).

Some examples of publications for people with alcohol problems, families or others interested in alcohol problems include: "Drinking and Your Pregnancy; Tips For Cutting Down on Your Drinking; A Family History of Alcoholism: Are You At Risk? and Frequently Asked Questions" (alcohol problems).

National Institute on Drug Abuse (NIDA): www.nih.nida.gov.

NIDA has many resources, including an extensive portfolio of publications, for medical and health professionals, researchers, clients, families, students and young adults, parents and teachers, and anyone interested in alcohol problems. Some examples include facts and information handouts for all drugs of abuse, treatment manuals for clinicians, brief updates on research, clinical resources on evidenced-based treatments (see "Science of Addiction"), an extensive list of publications (including some materials en Espanol) and news articles.

NIDA offers free subscriptions by mail or e-copy to "Addiction Science & Clinical Practice", a peer-reviewed journal for drug abuse researchers and treatment providers, and "NIDA Notes," a brief, 16-page summary of current research sponsored by NIDA.

This webpage has a link to resources on treatment and prevention for medical and health professionals "NIDAMED." This provides extensive information to caregivers and information that can be used with patients who have drug abuse. NIDAMED also includes a drug use screening tool (NM ASSIST), information for referrals for treatment and a link to NIDA's Clinical Trials Network (CTN). The CTN is a national network of medical centers and community treatment programs where research is conducted across a variety of settings with diverse clinical populations. The CTN link provides information on all participants in the CTN and a list of all the specific studies funded. Finally, NIDAMED provides links to other websites of interest to professionals. For example, the "MEDLINEplus Health Information on Substance Abuse" from the National Library of Medicine at NIH provides access to information to professionals and patients on a range of topics related to substance use, substance use disorders and co-occurring disorders.

Substance Abuse & Mental Health Services Administration (SAMHSA): www.samhsa.gov

SAMHSA has many publications on prevention and treatment of substance use, psychiatric and co-occurring disorders. Similar to the NIAAA and NIDA web pages, this website provides extensive information for medical and health care professionals, researchers, clients, families and anyone interested in substance use and mental health issues. Examples include sections for "Military Families," "Recovery Supports" that promote health and resilience, and a "Data, Outcomes & Quality" section that provides information about the "National Survey on Drug Abuse and Health."

A "**Find Help**" section on the right side of the SAMHSA home page provides information for help on suicide prevention (1-800-273-8255) and a link for "Treatment Locators" so you can find locations for services for substance abuse or mental health problems. A 24-hour helpline is available to aid in locating help with any of these problems (1-800-662-4357).

This webpage provides access to numerous resources for clinicians including the NREPP (National Registry of Evidenced Based Programs and Practices. In addition, 1) CSAT's Treatment Improvement Protocol (TIP) Series of manuals on numerous specific topics related to addiction or co-occurring disorders (e.g., adolescent treatment, older adult treatment, detoxification, group therapy, family treatment, medication treatments, etc); these are consensus-based guidelines developed by clinical, research and administrative experts in the field. 2) CSAT's Knowledge Application Program (KAP) gives knowledge about best treatment practices wings by putting it in the hands of providers who help individuals seeking substance abuse treatment. 3) Quick Guides for Clinicians based on the TIP Series. 4) Quick Guides for Administrators based on the TIP Series.

REFERENCES

Ashworth, M., Johnson, D., Thompson, R. A., Clancy, G. L., Baier, J., & Spielman, J. (2026). Barriers and facilitators to recovery support interventions in US rural recovery houses: Implementing the SMART life skills program. Evaluation and Program Planning, 114, 102717. https://doi.org/10.1016/j.evalprogplan.2025.102717

Buckner, J. D., Scherzer, C. R., Crapanzano, K. A., & Morris, P. E. (2023). Group cognitive behavioral therapy for substance use disorders among psychiatric inpatients. Public Health Reports, 138(1 Suppl), 90S-95S. https://doi.org/10.1177/00333549231170219

Minozzi, S., Saulle, R., Amato, L., Traccis, F., & Agabio, R. (2024). Psychosocial interventions for stimulant use disorder. Cochrane Database of Systematic Reviews, 2(2), CD011866. https://doi.org/10.1002/14651858.CD011866.pub3

Trimble, E. A., Bormann, N. L., Kalata, A. H., Gerberi, D., Arndt, S., & Oesterle, T. S. (2025). Hybrid virtual group model for substance use disorder therapy: A scoping review. Substance Abuse and Rehabilitation, 16, 137-146. https://doi.org/10.2147/SAR.S518266

Wang, V., Stone, B. M., Vest, N., & LaBelle, O. P. (2024). Emotion regulation predicts recovery capital beyond mindfulness and demographic variation in Recovery Dharma. Addiction Research & Theory, 32(5), 346-352. https://doi.org/10.1080/16066359.2023.2282531

Appendix 2:
References and Suggested Readings

1. *Alcoholics Anonymous* ("Big Book," 5th ed.) (2001). NY: AA World Services, Inc.

2. American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (DSM IV-TR). Washington, D.C: APA.

3. American Psychiatric Publishing, Inc. (APPI, 2008). *Handbook of Psychiatric Measures,* 2nd ed. *(*AJ Rush, MB First & D Blacker, eds). Washington, DC: APP.

4. Anton RF, O'Malley SS, Ciraulo DA, et al. (2006). Combined pharmacotherapies and behavioral interventions for alcohol dependence: The COMBINE study: a randomized controlled trial. *JAMA*, 295, 2003-2017.

5. Beck A, Wright F, Liese B. (1994). *Cognitive Therapy of Substance Abuse*. New York: Guilford Press.

6. Bowen S, Chawla N & Marlatt GA (2011). *Mindfulness-Based Relapse Prevention for Addictive Behaviors.* NY: Guilford Press.

7. Center for Substance Abuse Treatment (1999). Treatment succeeds in fighting crime. In: *Substance Abuse Brief*. Rockville, MD: CSAT, SAMHSA.

8. Center for Substance Abuse Treatment (2000a). Substance abuse treatment reduces family dysfunction, improves productivity. In: *Substance Abuse Brief*. Rockville, MD: SAMHSA.

9. Center for Substance Abuse Treatment (2000b). Treatment cuts medical costs. In: *Substance Abuse in Brief*. Rockville, MD: SAMHSA.

10. CSAT (2005a). Medication-assisted treatment for opioid addiction in opioid treatment programs . *Treatment Improvement Protocol (TIP) Series 43* (DHHS Publication No. SMA 05-4048). Rockville, MD: SAMHSA.

11. CSAT (2006). *National Summit on Recovery: Conference Report*. Rockville, MD: SAMHSA. From http://pfr.samhsa.gov/docs/Summit-Rpt.pdf.

12. Cloninger CR. (2005). Genetics of substance abuse. In: M Galanter & HD Kleber (Eds). *Textbook of Substance Abuse Treatment*, 3rd ed. Washington, D.C.: American Psychiatric Publishing, Inc., pp. 73-80.

13. Crits-Christoph P, Siqueland L & Blaine J et al (1999). Psychosocial treatments for cocaine dependence: Results of the NIDA Cocaine Collaborative Study. Archives of General Psychiatry, 56:493-502

14. Daley DC (2004). *Managing Anger: For Recovery from Mental Health or Substance Use Disorders*. Murrysville, PA: Daley Publications.

15. Daley DC (2005). *Sobriety Journal: Your Plan for Recovery in Year 01.* Murrysville, PA: Daley Publications.

16. Daley DC. (2006). *Mood Disorders and Addiction: A Guide for Clients, Families and Providers.* NY: Oxford University Press.

17. Daley DC (2009). *Relapse Prevention Workbook for Recovering Alcoholics and Drug-Dependent Persons,* 5th ed. Murrysville, PA: Daley Publications.

18. Daley DC (2011[a]). *Recovery from Co-Occurring Disorders: Strategies for Managing Addiction and Mental Health Disorders,* 4th ed. Independence, MO: Independence Press.

19. Daley DC (2011[b]). *Group Treatment of Addiction.* Murrysville, PA: Daley Publications.

20. Daley D & Donovan D (2009). *Using 12-Step Programs in Recovery: For Individuals with Alcohol or Drug Addiction*. Murrysville, PA: Daley Publications.

21. Daley DC & Douaihy A (2005). *Managing Emotions: Recovery from Mental health or Substance Use Disorders*. Murrysville, PA: Daley Publications.

22. Daley DC & Douaihy A (2010a). *A Family Guide to Addiction and Recovery: Coping Strategies for Familiy Members.* Murrysville, PA: Daley Publications.

23. Daley DC & Douaihy A (2010b). *Recovery and Relapse Prevention for Co-Occurring Disorders.* Murrysville, PA: Daley Publications.

24. Daley DC & Douaihy A. (2010c). *Sober Relationships and Support Systems in Recovery: For Substance Use or Co-Occurring Disorders.* Murrysville, PA: Daley Publications.

25. Daley DC & Douaihy A. (2010d). *Grief Journal: Living with the Loss of a Loved One.* Murrysville, PA: Daley Publications.

26. Daley DC, Douaihy A, Weiss R & Mercer D. (2009). Group treatment of substance use disorders. In Ries, R., Fiellin, D., Miller, S., Saitz, R. (Eds) Principles of Addiction Medicine (4th ed), Philadelphia, PA: Lippincott, Williams and Wilkins, pp 839-850.

27. Daley DC & Marlatt GA. (2006a). *Overcoming Your Alcohol or Drug Problem: Effective Recovery Strategies.* Therapist Guide. 2nd ed. NY: Oxford University Press.

28. Daley DC & Marlatt GA. (2006b). *Overcoming Your Alcohol and Drug Problem: Effective Recovery Strategies.* Client Workbook, 2nd ed. NY: Oxford University Press.

29. Daley DC & Miller J. (2001). *Addiction in Your Family: Helping Yourself and Your Loved Ones*. Holmes Beach, FL: Learning Publications.

30. Daley DC & Moss HM. (2002) *Dual Disorders: Counseling Clients with Chemical Dependency and Mental Illness,* 3rd ed. Center City, MN: Hazelden.

31. Daley DC & Ross JR. (2003). *Relapse Prevention Workbook for Sexually Compulsive Behavior*. Murrysville, PA: Daley Publications.

32. Daley DC & Spear J. (2003). *A Family Guide to Coping with Dual Disorders*, 2nd ed. Center City, MN: Hazelden.

33. Daley DC & Thase ME. (2004). *Dual Disorders Recovery Counseling: Integrated Treatment for Substance Use and Mental Health Disorders,* 3rd ed. Independence, MO: Independence Press.

34. Dennis M, Scott CK & Funk R. (2003). An experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders. *Evaluation and Program Planning, 26,* 339-352.

35. Dennis ML & Scott CK. (2007) Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, 4(1):45-55.

36. Dobkin PL, Civita M, Paraherakis A, et al. (2002) The role of functional social support in treatment retention and outcomes among outpatient adult substance abusers. *Addiction*, 97:347-356.

37. Douaihy A, Daley D, Stowell KR, et al. (2007). Relapse prevention: Clinical strategies for substance use disorders. In: Witkiewtiz K, Marlatt GA, eds. *Therapist's Guide to Evidence-Based Relapse Prevention*. Academic Press Publications, Elsevier, 37-71.

38. Douaihy A, Daley DC & Marlatt GA (in press, 2011). Relapse prevention. In: Lowinson JH, Ruiz P, Millman RB, et al., eds. *Substance Abuse: A Comprehensive Textbook*, 5th ed. Philadelphia: Lippincott, Williams & Wilkins.

39. Galanter M & Kleber HD (2008, eds). *Textbook of Substance Abuse Treatment*, 4th ed. Washington, DC: American Psychiatric Publishing, Inc.

40. Hser YI. (2007). Predicting long-term stable recovery from heroin addiction: Findings from a 33 year follow-up study. *Journal of Addictive Disorders*, 26(1):51–60.

41. Journal of Substance Abuse Treatment (JSAT, 2010). *A Decade of Research by the National Drug Abuse Treatment Clinical Trials Network*, 38(4):Supplement 1.

42. Kessler RC, Crum RM, Warner L A, et al. (1997). Lifetime co-occurrence of DSM-III-R alcohol abuse and dependence with other psychiatric disorders in the National Comorbidity Survey. *Archives of General Psychiatry*, 54, 313-321.

43. L'Abate L (Ed., 2004a). *Using Workbooks in Mental Health: Resources in Prevention, Psychotherapy, and Rehabilitation for Clinicians and Researchers.* NY: Haworth Press.

44. L'Abate L (2004b). *A Guide to Self-Help Workbooks for Mental Health Clinicians and Researchers.* NY: Haworth Press.

45. Ladouceur R & Lachance S (2007). *Overcoming Pathological Gambling: Therapist Guide*. NY: Oxford University Press.

46. Ladouceur R & Lachance S (2007). *Overcoming Pathological Gambling: Workbook*. NY: Oxford University Press.

47. Laudet AB, Morgen K & White WL. (2006). The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-Step Fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug problems. *Alcohol Treatment Quarterly, 24,* 33-73.

48. Lowinson JH, Ruiz P, Millman RB, et al. (in press). *Substance Abuse: A Comprehensive Textbook*, 5th ed. Philadelphia: Lippincott, Williams & Wilkins.

49. Marlatt GA & Donovan DM. (2005). *Relapse Prevention: A Self-Control Strategy for the Maintenance of Behavior Change*, 2nd ed. NY: Guilford Press.

50. Marlatt GA & Gordon J. (1985). *Relapse Prevention: A Self-Control Strategy for the Maintenance of Behavior Change*. NY Guilford Press.

51. McLellan A, Lewis DC, O'Brien CP, et al. (2000). Drug dependence, a chronic mental illness: Implications for treatment, insurance, and outcomes evaluation. *JAMA*, 284(13):1689–1695.

52. Miller WR, Rollnick S. (2002). *Motivational Interviewing: Preparing People for Change*, 2nd ed. NY: Guilford Press.

53. Monti P, Adams D, Kadden R, et al. (2002). *Treating Alcohol Dependence,* 2nd ed. NY: Guilford.

54. Moss HM, Vanyukow M, Majumder P, et al. (1995). Prepubertal sons of substance abusers: Influences of paternal and familial substance abuse on behavioral disposition, IQ and school achievement. *Addictive Behaviors,* 20:1-14.

55. Mueser KT, Noordsy DL, Drake RE & Fox L (2003). *Integrated Treatment for Dual Disorders: A Guide to Effective Practice.* NY: Guilford.

56. Najavits LM (2002). *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse*. NY: Guilford Press.

57. *Narcotics Anonymous* ("Basic Text") (1988). Van Nuys, CA: NA World Services

58. National Institute on Alcohol Abuse and Alcoholism (1995a). *Motivational Enhancement Therapy Manual*. Rockville, MD: DHHS.

59. National Institute on Alcohol Abuse and Alcoholism (1995b). *Cognitive-Behavioral Coping Skills Therapy Manual*. Rockville, MD: DHHS.

60. National Institute on Alcohol Abuse and Alcoholism (NIAAA, 1995c). *Twelve-Step Facilitation Therapy Manual*. Rockville, MD: DHHS.

61. National Institute on Alcohol Abuse and Alcoholism (2000). Highlights from the 10th special report to Congress. *Alcohol Res Health.* 24(1). Rockville, MD: DHHS.

62. National Institute on Alcohol Abuse and Alcoholism (2004). *Combined Behavioral Intervention Manual*. Bethesda, MD: DHHS.

63. National Institute on Drug Abuse (2009). *Principles of Drug Addiction Treatment: A Research-Based Guide*, 2nd ed. (NIH Publication No. 00-4180). Bethesda, MD: DHHS.

64. National Institute on Drug Abuse (1993). *Cue Extinction Techniques: NIDA Technology Transfer Package*. Rockville, MD: DHHS.

65. National Institute on Drug Abuse (1994). *Recovery Training and Self-Help*, 2nd ed. Rockville: DHHS.

66. National Institute on Drug Abuse (1997). Beyond the therapeutic alliance: Keeping the drug dependent individual in treatment. In: Simon Onken L, Blaine JD, Boren JJ, eds. *NIDA Research Monograph* 165. Rockville, MD: DHHS.

67. National Institute on Drug Abuse (1998a). *A Cognitive Behavioral Approach: Treating Cocaine Addiction*. Therapy Manuals for Drug Addiction, Manual 1. Rockville, MD: DHHS.

68. National Institute on Drug Abuse (1998b). *A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction.* Therapy Manuals for Drug Addiction, Manual 2. Rockville, MD: DHHS.

69. National Institute on Drug Abuse (1999). *An Individual Drug Counseling Approach to Treat Cocaine Addiction*. Therapy Manuals for Drug Addiction, Manual 3. Rockville, MD: DHHS.

70. National Institute on Drug Abuse (2002). *A Group Drug Counseling Approach to Treat Cocaine Addiction.* Therapy Manuals for Drug Addiction, Manual 4. Rockville, MD: DHHS.

71. National Institute on Drug Abuse (2008). *The Science of Treatment: Dissemination of Research-Based Drug Addiction Treatment Findings.* Rockville, MD: DHHS.

72. Noone M, Dua J & Markham R (1999). Stress, cognitive factors, and coping resources as predictors of relapse in alcoholics. *Addictive Behaviors,* 24:687-693.

73. Nowinski J & Baker S. (2003). *The Twelve-Step Facilitation Handbook: A Systematic Approach to Early Recovery from Alcoholism and Addiction.* MN: Hazelden.

74. Nunes EV, Weissman MM, Goldstein R, et al. (2000). Psychiatric disorders and impairment in the children of opiate addicts: Prevalences and distribution by ethnicity. *The American Journal on Addictions*, 9:232-41.

75. O'Farrell TJ, Choquette KA & Cutter HS (1998). Couples relapse prevention sessions after behavioral marital therapy for male alcoholics: Outcomes during the three years after starting treatment. *Journal of Studies on Alcohol,* 59:357-370.

76. O'Farrell TJ. (1993). Couples relapse prevention sessions after a behavioral marital therapy couples group program. In: O Farrell TJ, ed. *Treating Alcohol Problems: Marital and Family Interventions*. NY: Guilford Press:305–326.

77. Rawson RA, Marinelli-Casey P, Anglin MD, et al. (2004). A multi-site comparison of psychosocial approaches for the treatment of methamphetamine dependence. *Addiction*, 99(6):708-717.

78. Rawson RA, Obert JL, McCann MJ & Ling W. (2005). *The MATRIX Model: Intensive Outpatient Alcohol and Drug Treatment. Therapist's Manual*. Center City, MN: Hazelden.

79. Regier D (1990). Comorbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiologic Catchment Area Study. *JAMA,* 264:2511-2518.

80. Ries RK, Fiellin DA, Miller SC & Saitz R (eds., 2009). *Principles of Addiction Medicine*, 4th ed. NY: Lippincott Williams & Wilkins.

81. Roberts LJ, Shaner S 7 Eckman TA (1999). *Overcoming Addictions: Skills Training for People with Schizophrenia*. NY: WW Norton.

82. Substance Abuse and Mental Health Services Administration (2008). *National Registry of Evidence-based Programs and Practices,* from http://www.nrepp.samhsa.gov/.

83. Substance Abuse and Mental Health Services Administration (2004). *Substance Abuse Treatment and Family Therapy.* A treatment improvement protocol TIP 39. Rockville, MD: SAMHSA.

84. Substance Abuse and Mental Health Services Administration (2005a). *Substance Abuse Relapse Prevention for Older Adults: A Group Treatment Approach.* DHHS Pub No (SMA) 05-4053. Rockville, MD: SAMHSA.

85. Substance Abuse and Mental Health Services Administration (2005b). *Substance Abuse Treatment: Group Therapy.*. DHHS Pub No (SMA) 05-3991. Rockville, MD: SAMHSA.

86. Substance Abuse and Mental Health Services Administration (SAMHSA, 2005c). Substance abuse treatment for persons with co-occurring disorders. *Treatment Improvement Protocol (TIP) Series 42* (Rep. No. DHHS Publication (No. SMA 05-3992). Rockville, MD: SAMHSA

87. Substance Abuse and Mental Health Services Administration (2006). *Counselor's Treatment Manual: Matrix Intensive Outpatient Treatment for People with Stimulant Use Disorders.* DHHS Pub No (SMA) 07-4152. Rockville, MD: SAMHSA.

88. Substance Abuse and Mental Health Services Administration (1999). Enhancing motivation for change in substance abuse treatment. *Treatment Improvement Protocol (TIP) Series 35* (Rep. No. DHHS Publication No. (SMA) 99-3354). Rockville, MD: SAMHSA.

89. Substance Abuse and Mental Health Services Administration (2008). *NREPP: SAMHSA's National Registry of Evidenced-Based Programs and Practices*. See Relapse Prevention Therapy on http://www.nrepp.samhsa.gov/.

90. Scott CK, Dennis M L & Foss MA. (2005). Utilizing recovery management checkups to shorten the cycle of relapse, treatment reentry, and recovery. *Drug and Alcohol Dependence, 78,* 325-338.

91. Scott CK, Foss MA, Dennis ML. (2005). Pathways in the relapse-treatment-recovery cycle over 3 years. *J Subst Abuse Treat*, 28(Suppl 1):S63-72.

92. Sober LC & Sobell MB (2011). *Group Therapy for Substance Use Disorders: A Motivational Cognitive-Behavioral Approach*. NY: Guilford Press.

93. Velaquez MM, Maurer CG, Crouch C & DiClemente CC (2001). *Group Treatment for Substance Abuse: A Stages-of-Change Therapy Manual*. NY: Guilford Press.

94. Volkow NHD & Fowler JS (2000). Addiction, a disease of compulsion and drive: Involvement of the orbitofrontal cortex. *Cerebral Cortex*, 10, 318-25.

95. Weiss RD, Jaffee WB, DeMeril VP & Cogley CB (2004). Group therapy for substance use disorders: What do we know? *Harvard Review of Psychiatry,* 12(6): 339-350.

96. Weiss, RD & Connery HS (2011). *Integrated Group Therapy for Bipolar Disorder and Substance Abuse*. NY: Guilford Press.

97. White WL, Kurtz E & Sanders, M (eds., 2006). *Recovery Management*. Chicago: Great Lakes Addiction Technology Center, University of Illinois at Chicago.

98. Witkiewitz KA & Marlatt G. (Eds.) (2007). *Therapist's Guide to Evidence-Based Relapse Prevention.* Boston, MA: Elsevier Academic Press.

99. Yalom ID (2005). *The Theory and Practice of Group Psychotherapy*, 5th ed. NY: Basic Books.

Appendix A: Group Treatments for Addiction

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in the following manner:

Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

http://www.ceumatrix.com/studentcenter

Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'View Lesson Quiz' and you will be presented with the electronic exam.

To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. You will also receive a link to the Certificate of Completion. This is the final step in the process, and you may save and/or print your Certificate of Completion.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

NOTE: THE QUESTIONS AND/OR ANSWERS MAY BE IN A DIFFERENT ORDER ON THE ONLINE EXAM.

Answer the following questions by selecting the most appropriate response.

1. The effects of a substance depend on:
a) type and amount of substance used
b) social setting
c) level of tolerance
d) route of administration
e) all of the above

2. Addictive drugs are thought to interact with the brain's _____ system.
a) synaptic
b) reward
c) lymphatic
d) circulatory
e) routing

3. Current day practice requires that clinicians integrate _____ into their clinical practices.
a) hypnosis
b) positive reinforcement
c) role playing
d) evidence-based treatments
e) none of the above

4. Most clinicians and counselors are interested in substance use, functioning and quality of life so all three of these areas are important in recovery.
a) True
b) False

5. Potential limitations related to group treatment include:
a) social anxiety
b) confidentiality
c) emotional support
d) lack of assertiveness
e) all but (c)

6. Most outpatient programs, especially structured group programs, admit clients _____.
a) intermittently
b) weekly
c) continuously
d) monthly
e) daily

7. A survey concluded that this was the most important method of learning for group therapists.
a) Lectures with information
b) Watching experienced group leaders conduct groups in person or on video
c) Practicing group interventions
d) Attending college courses
e) Reading group manuals or literature

8. All but _____ have been noted as common challenges by group leaders.
a) Not spending enough time on coping strategies
b) Boredom of clients
c) Rushing through material
d) Abundance of client interaction
e) Not eliciting feedback

9. The goals of the group are to:
a) Learn recovery skills
b) Provide opportunities to give support
c) Encourage group discounts
d) Educate group members
e) All but (c)

10. The specific topics chosen for group sessions should have nothing to do with the treatment setting.
a) True
b) False

11. In order to provide variety to group members, a counselor can employ the use of _____ in his/her sessions.
a) slide presentations
b) handouts
c) guest presenters
d) testimonials
e) frequent breaks

12. Group treatment models all incorporate _____ in their programs.
a) homework assignments
b) sharing exercises
c) role playing
d) car pooling
e) religious principles

13. Clinicians conducting groups are required to document sessions based on _____ and _____.
a) content, outcome
b) patient status, efficacy
c) length, location
d) policies of the program, regulatory requirements
e) overall cost, licensing

14. Alcohol problems are over _____ as common as drug problems.
a) four times
b) three times
c) six times
d) ten times
e) twice

15. Among U.S. adults, more than _____% experience a substance use disorder during their lives.
a) 20
b) 16
c) 25
d) 40
e) 35

16. The following are areas of the brain affected by drug use:
a) limbic system
b) brain stem
c) cerebral cortex
d) hypothalamus
e) all but (d)

17. _____ produce(s) feelings of well-being or euphoria, decrease the need for sleep and appetite and increase energy and sexual desire.
a) PCP
b) Hallucinogens
c) Stimulants
d) Cannabis
e) Depressants

18. A person dependent on alcohol may lose 20-25 years of their expected life span.
a) True
b) False

19. All but _____ are medical problems associated with stimulants.
 a) gastroenteritis
 b) damage to the unborn fetus
 c) increase in heart rate
 d) pulmonary problems
 e) elevated blood pressure

20. _____ is the term used for the mixture of cocaine with heroin.
 a) fastball
 b) speedball
 c) slowball
 d) highball
 e) screwball

21. Worldwide, smoking kills ___% of adults each year.
 a) 5
 b) 2
 c) 20
 d) 10
 e) 15

22. Pyschiatric problems are no more prevalent in those with substance use disorders than with the general population.
 a) True
 b) False

23. Which of these is NOT a goal of detoxification programs?
 a) safe withdrawal from addictive substances
 b) engage in the next level of care
 c) improved relationships
 d) stabilize medically

24. _____ expectations, especially those that are too high, will set group members up to fail, feel frustrated, or feel disappointed.
 a) Great
 b) Realistic
 c) Low
 d) Future
 e) Unrealistic

25. Substance use can:
 a) Cause problems in any area of life
 b) Lower the effectiveness of some medications
 c) Affect motivation to change
 d) Have a negative impact on adherence to treatment and recovery
 e) all of the above

26. _____ involves attending a program, participating in counseling, taking medication for an addiction, or a combination of these.
a) Treatment
b) Recovery
c) Motivation
d) Discipline
e) Behavior

27. External factors that trigger cravings include:
a) Events
b) Places
c) People
d) Things or objects
e) all of the above

28. Symptoms of alcohol withdrawal include:
a) tachycardia
b) anxiety
c) elevated blood pressure
d) tremors
e) all of the above

29. Lacrimination, rhinorrhea, piloerection, diarrhea, tachycardia, fever and insomia are all symptoms of _____ withdrawal.
a) barbiturate
b) sedative
c) alcohol
d) opioid
e) stimulant

30. Most acute withdrawal symptoms occur within the first several hours or days of cessation of substances and protracted withdrawal symptoms may occur much later.
a) True
b) False

31. _____ cells are the main target of HIV infection.
a) Fibroblastic
b) CD4 T
c) Neuroblastic
d) Cholangiocytic
e) Nephritic

32. HIV is incapable of surviving outside the body for any length of time.
a) True
b) False

33. The Hepatitis viruses are spread by:
a) sexual contact
b) IV drug use
c) kissing
d) (a) and (b) but not (c)
e) all of the above

34. Although people associate "negative" feelings such as anger or depression with relapse, "positive" feelings can also be a trigger to relapse.
a) True
b) False

35. All but which are the three components of anger?
a) behaviors
b) thoughts
c) ideas
d) feelings

36. _____ is the fear of something happening and may lead to avoiding the situation feared.
a) Worry
b) Anxiety
c) Panic
d) Stress
e) Anticipatory anxiety

37. Problems associated with boredom include:
a) feeling depressed
b) getting involved in activities that create other problems
c) making major decisions not well thought out
d) relapse to alcohol or drug use
e) all of the above

38. Depression is _____ among women than men.
a) more debilitating
b) less common
c) twice as common
d) less severe

39. A new field of _____ has emerged that focuses on positive emotions, resilience and personal growth.
a) enlightened feelings
b) eternal hope
c) forever happy
d) positive psychology
e) blissful emotion

40. The concept of God or Higher Power should not be implemented in group therapy.
a) True
b) False

41. Personality problems or _____ is/are common among people with substance use disorders.
a) character defects
b) mental retardation
c) physical abnormalities
d) learning problems
e) immunodeficiency

42. With regard to borderline personality disorder (BPD):
a) more common among men than women
b) less vulnerability to stress
c) self harm is uncommon
d) none of the above
e) all of the above

43. Among abusers, ___% with a drug use disorder and ___% with an alcohol use disorder will have a psychiatric disorder during their lifetime.
a) 20, 33
b) 33, 20
c) 12, 24
d) 53, 37
e) 37, 53

44. The two most common psychiatric disorders are _____ and _____.
a) anxiety, schixophrenia
b) anxiety, bipolar illness
c) bipolar illness, depression
d) depression, schizophrenia
e) depression, anxiety

45. Psychiatric disorders are caused by things such as:
a) biological factors
b) psychological factors
c) social factors
d) life experiences
e) all of the above

46. Children of parents with a substance use disorder have higher rates of _____.
a) alcohol or drug abuse
b) mood and anxiety disorders
c) skin disorders
d) (a) and (b) but not (c)
e) (a), (b), and (c)

47. As part of a coping strategy an abuser should take on high-risk social pressure situations in order to build up confidence.
a) True
b) False

48. Step 1 of the 12-Step program: We admitted that we were _____ over our addiction and that our lives had become unmanageable.
a) nearly
b) happily
c) powerless
d) finally
e) never

49. Originally, sponsors in the 12-Step programs were people:
a) who visited alcoholics in the hospital
b) who paid for others' treatment
c) who were actual counselors
d) who were members of the clergy
e) who operated treatment facilities

50. Addiction _____ refers to the process of returning to alcohol or drug use after a period of sobriety.
a) recovery
b) follow-up
c) treatment
d) relapse
e) reality

51. Although thought to the contrary, relapse is not common with chronic or recurrent diseases.
a) True
b) False

52. Substance and behavioral addictions can occur _____ or _____.
a) frequently, infrequently
b) now, later
c) simultaneously, sequentially
d) simultaneously, frequently
e) now, sequentially

53. _____ problems often lead to poor adherence with attending treatment sessions, self-help groups, or following the individualized recovery plan; which can contribute to substance use relapse.
a) Physical
b) Mental
c) Societal
d) Financial
e) Motivational

54. Addiction is generally considered to only affect the individual, not family members.
a) True
b) False

55. A behavior that all family members should avoid with regard to the substance abuser is _____.
a) supporting
b) motivating
c) worry
d) enabling
e) referring