Counselor's Manual for Relapse Prevention With Chemically Dependent Criminal Offenders

Technical Assistance Publication Series

19

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Introduction

This publication is intended for use by people who are interested in working with criminal offenders who are chemically dependent (addicted to alcohol and/or drugs). It focuses on chemical dependency and the criminal offender, and will present you with information you may not have been exposed to before.

Research tells us that most criminal offenders have alcohol or drug problems. It also tells us that traditional forms of treatment for chemical dependency are not very successful with these

offenders. Many of them return to using alcohol or drugs after treatment. When this happens, most of them become repeat offenders. This publication is designed to help you teach criminal offenders how they can stay sober and clean.

This publication is designed for the paraprofessional counselor. A paraprofessional counselor is someone who wants to help others, but who has little or no professional counselor training. This publication explains basic counseling information in simple terms. It is also designed to help you work with people who are using the Appendix—Relapse Prevention Workbook for Chemically Dependent Criminal Offenders. It explains the purpose of each exercise in this workbook and tells you how to help the patient use and understand the exercises.

This publication is based on information that has had better than average results in treating chemically dependent criminal offenders. This information is called *relapse prevention therapy*. Relapse prevention therapy is based on experience with patients who generally fail in traditional treatment. The techniques in this publication were developed through experience with these patients.

Relapse prevention therapy breaks down the recovery process into specific tasks and skills. Patients must learn these skills in order to recover. It also shows patients how to recognize when they are beginning to relapse, and how to change before they start using alcohol or drugs again.

It is important that you read the entire publication to understand the basic information and how it all fits together. When you read the section that explains how to use the exercises from the Appendix—Relapse Prevention Workbook for Chemically Dependent Criminal Offenders, read the workbook at the same time. If you are a recovering person yourself, fill in the workbook as you go through it. This will help you understand how the exercises work.

It is important to tell your patients (the offenders with whom you are working) that they may get frustrated or discouraged at times when they are completing the workbook. The main reason for this is that chemically dependent people, especially criminal offenders, want immediate payoffs and results. Recovery doesn't give immediate results. Encourage them to continue with the exercises, and give them positive feedback for each step they complete along the way.

It is also important for you not to get discouraged. Talk with other people who are doing the same kind of work. Find out what is working and what is not working for them. Tell them the same things. Encourage one another.

How will you know when patients are making progress? You will know by seeing how they change the way they think, feel, and act toward themselves and others. If you try to control your patients, they will either drop out of treatment or simply manipulate you by telling you what they think you want to hear.

It is important that you view your patients as people whose disease of chemical dependency and way of thinking prevent them from acting in a socially acceptable manner. These patients may want to be full members of society, but they do not have the skills to do so. In some cases, they have given up hope.

It is your job to help your patients understand more about themselves and the world, help them learn new skills, and give them hope, so that they are motivated to change. You cannot do this by telling them what they are or what they must be. It is one thing for you to know, but unless the patient comes to an understanding based on changes in his or her own thinking, treatment will fail.

You do not have all the answers. Even professional counselors do not have all the answers. Most answers come from listening carefully to what patients say and how they think. If you do not know something, be honest. Patients will respect you for this and be more willing to work with you if you are honest about what you do and don't know. When you don't know an answer, try to find the information and share it with the patient.

Most of all, give patients your best effort. If you do this and learn from your mistakes, you will become a better counselor. Read as much as possible about chemical dependency and counseling for chemically dependent people. Get all the training you can. Remember, your best source of information is your patients. When you make a mistake, admit it and learn from it. Even if you don't succeed with one patient, what you will learn will help other patients in the future.

You may never know for sure if you have helped most of your patients. Some patients will not use information you give them now, but will use it at some point in the future. Also, remember that every patient you help will have a positive impact on everyone with whom they come in contact.

Part I of TAP 19: Counselor's Manual for Relapse Prevention

Part I: General Information on Drug and Alcohol Dependency, Recovery, and Relapse

Chapter 1—What is Chemical Dependency/Addiction?

Chemical dependency is a disease caused by the use of alcoholand/ or drugs, causing changes in a person's body, mind, and behavior. As a result of the disease of chemical dependency, people are unable to control the use of alcohol and/or drugs, despite the bad things that happen when they use. Chemical dependency occurs most frequently in people who have a family history of the disease. As the disease process progresses, recovery becomes more difficult. Chemical dependency may cause death if the person does not completely abstain from using alcohol and other mood-altering drugs.

Effects

The problems of chemical dependency that affect people when they use alcohol or drugs, and even after they have stopped using, include the following.

Malnutrition and metabolic dysfunction. The addict's ability to function normally is damaged by the effects of alcohol and/or drugs on the brain and body. Only after a period of proper diet and taking supplements can normal body chemistry be restored. This process affects the way the addict thinks, feels, and acts.

Liver disease and other medical complications. The addict's liver enzymes may be far above normal. This can cause poisonous effects within the body and may lead to infections and illnesses that need to be treated before normal functioning can resume.

Brain dysfunction. Alcohol and drugs damage brain cells, interrupt the production of certain brain chemicals called neurotransmitters, and alter the way the brain functions. Some of these changes may be permanent.

Addictive preoccupation. A chemically dependent person's thinking patterns are altered by chemical dependency as the disease progresses. These changes cause the person to have strong thoughts, desires, and physical cravings for alcohol or drugs. These processes also change the way the person sees the world. They lead the person to believe that using is better than not using, despite the bad things that result from using.

Social consequences. As the physical and psychological problems identified above get worse, the person's behavior becomes more antisocial and self-destructive. Frequent social consequences of addiction are job loss, money problems, car accidents, domestic violence, criminal behaviors, illness, and death.

Criminal behaviors. Chemical dependency can cause a person to commit crimes. People who are chemically dependent commit crimes related to their use of alcohol or drugs (drunk driving, public drunkenness, assault, etc.), the support of their addiction (selling drugs, committing crimes to get drugs or money for drugs, etc.), and secondary consequences of drug or alcohol use (not paying child support or court fines, failing to follow through with probation requirements, etc.). Some people do not commit crimes until they become chemically dependent. Others have personality problems that initiate their criminal behavior. Most of those who have personality problems either become chemically dependent on or abusive of alcohol and drugs. Any relapse into behavior that leads to criminal actions is likely to cause a relapse into the use of alcohol or drugs. Any relapse into chemical use is likely to cause a relapse into criminal behavior.

The conditions just described combine and interfere with the ability to think clearly, control feelings, and regulate behaviors, especially under stress. Alcohol and drug dependency damages the basic personality traits that are formed before the addictive use of alcohol or drugs. Dependency on alcohol or other drugs systemically destroys meaning and purpose in life as the addiction gets worse and worse.

Treatment

Because dependency on alcohol or other drugs creates problems in a person's physical, psychological, and social functioning, treatment must be designed to work in all three areas. The worse the damage in each area, the greater the chance of relapse and return to old behaviors (criminal actions and/or the use of alcohol or drugs). Total abstinence (not using any alcohol and drugs) plus personality and lifestyle changes are essential for full recovery.

- The type and intensity of treatment depend on the patient's:
- Current physical, psychological and social problems
- Stage and type of addiction(s)
- Stage of recovery
- Personality traits and social skills before the onset of addiction
- Other factors in life that cause stress.

Chemical dependency is a chronic condition that has a tendency toward relapse. Abstinence from alcohol and other mood-altering drugs is essential in the treatment of chemical dependency. It is also an important part of relapse prevention therapy. There is no convincing evidence that controlled drinking or drug use is a practical treatment goal for people who have been physically dependent on alcohol or drugs.

Many chemically dependent people who exhibit criminal behaviors were raised in families that did not provide proper support, guidance, and values. This caused them to develop self-defeating personality styles that interfere with their ability to recover. Personality is the habitual way of thinking, feeling, acting, and relating to others that develops in childhood and continues in adult life. Personality develops as a result of an interaction between genetically inherited traits and family environment.

Growing up in a dysfunctional family causes a person to have a distorted view of the world. He or she learns coping methods that may be unacceptable in society. In addition, the family may not have been able to provide guidance or foster the development of social and occupational skills that allow the person to fully participate in society. This lack of skills and distorted personality functioning may cause addictive behaviors to occur. These problems may also contribute to a more rapid progression of the addiction, make it difficult to recognize and seek treatment during the early stages of the addiction, and make it hard to benefit from treatment.

There are four goals in the primary treatment of dependency on alcohol and other drugs:

- Recognition that chemical dependency is a bio/psycho/social disease
- Recognition of the need for life-long abstinence from all mind-altering drugs
- Development and use of an ongoing recovery program to maintain abstinence
- Diagnosis and treatment of other problems or conditions that can interfere with recovery.

Traditional treatment has taken one of two general approaches:

The Medical Model.

This approach tries to help the patient meet the first three goals listed above.

The Social/Behavioral Model.

This approach focuses on the fourth goal listed above.

The lack of a model that includes all of the components has led to high relapse rates, especially in criminal justice populations. Relapse prevention therapy is a model that uses an approach that works with all four components.

Chapter 2—What Is Recovery?

A comprehensive model of chemical dependency treatment effectively combines the best of the medical and social/behavioral treatment models. It is based on the idea that recovery is a process that takes place over time, in specific stages. Each stage has tasks to be accomplished and skills to be developed. If a recovering person is unaware of this progression, unable to accomplish the tasks and gain the skills, or lacks adequate treatment, he or she will relapse.

The following is a description of this comprehensive model. It is called the Developmental Model of Recovery (DMR).

The Developmental Model of Recovery

The DMR has been devised to help recovering people and treatment professionals identify appropriate recovery plans, set treatment goals, and measure progress. The DMR describes six stages or periods of recovery.

Transition Stage

The transition stage begins the first time a person experiences an alcohol or drug-related problem. As a person's addiction progresses, he or she tries a series of strategies designed to control use. This ends with recognition by the person that safe use of alcohol and/or drugs is no longer possible.

The struggle for control is a symptom of a fundamental conflict over personal identity. Alcoholics and drug addicts enter this phase of recovery believing they are normal drinkers and drug users capable of controlled use. As the progression of addiction causes more severe loss of control, they must face the fact that they are addictive users who are not capable of controlled use.

During the transition stage, chemically dependent people typically attempt to control their use or stop using. They are usually trying to prove to themselves and others that they can use safely. This never works for very long. Controlled use is especially tough for people who are participating in criminal behavior because the high level of alcohol and drug use among their peers makes their lifestyle and use seem normal.

The major cause of inability to abstain during the transition stage is the belief that there is a way to control use.

Stabilization Period

During the stabilization period, chemically dependent people experience physical withdrawal and other medical problems, learn how to break the psychological conditioning causing the urge to use, stabilize the crisis that motivated them to seek treatment, and learn to identify and manage symptoms of brain dysfunction. This prepares them for the long-term processes of rehabilitation.

Traditional treatment often underestimates the need for management of these issues, focusing instead on detoxification. Patients find themselves unable to cope with the stress and pressure of the symptoms of brain dysfunction and physical cravings that follow detoxification. Many have difficulty gaining much from treatment and feel they are incapable of recovery. The lack of a supportive environment for recovery that many criminal offenders experience adds stress and undermines their attempts to stabilize these symptoms. They often use alcohol and drugs to relieve such distress. It takes between 6 weeks and 6 months for a patient to learn to master these symptoms with the correct therapy.

The major cause of inability to abstain during the stabilization period is the lack of stabilization management skills.

Early Recovery Period

Early recovery is marked by the need to establish a chemical-free lifestyle. The recovering person must learn about the addiction and recovery process. He or she must separate from friends who use and build relationships that support long-term recovery. This may be a very difficult time for criminal justice patients who have never associated with people with sobriety-based lifestyles.

They also need to learn how to develop recovery-based values, thinking, feelings, and behaviors to replace the ones formed in addiction. The thoughts, feelings, and behaviors developed by people with criminal lifestyles complicate and hinder their involvement in appropriate support programs during this period. Major intervention to teach the patient these skills is necessary if he or she is to succeed. This period lasts about 1B2 years.

The primary cause of relapse during the early recovery period is the lack of effective social and recovery skills necessary to build a sobriety-based lifestyle.

Middle Recovery Period

Middle recovery is marked by the development of a balanced lifestyle. During this stage, recovering people learn to repair past damage done to their lives.

The recovery program is modified to allow time to reestablish relationships with family, set new vocational goals, and expand social outlets. The patient moves out of the protected environment

of a recovery support group to assume a more mainstream and normal lifestyle. This is a time of stress as a person begins applying basic recovery skills to real-life problems.

The major cause of relapse during the middle recovery period is the stress of real-life problems.

Late recovery period

During late recovery, a person makes changes in ongoing personality issues that have continued to interfere with life satisfaction. In traditional psychotherapy, this is referred to as self-actualization. It is a process of examining the values and goals that one has adopted from family, peers, and culture. Conscious choices are then made about keeping these values or discarding them and forming new ones. In normal growth and development, this process occurs in a person's mid-twenties. Among people in recovery, it does not usually occur until 3B5 years into the recovery process, no matter when recovery begins.

For criminal offenders, this is the time when they learn to change self-defeating behaviors that may trigger a return to alcohol or drug use. These self-defeating behaviors often come from psychological issues starting in childhood, such as childhood physical or sexual abuse, abandonment, or cultural barriers to personal growth.

The major cause of relapse during the late recovery period is either the inability to cope with the stress of unresolved childhood issues or an evasion of the need to develop a functional personality style.

Maintenance Stage

The maintenance stage is the life-long process of continued growth and development, coping with adult life transitions, managing routine life problems, and guarding against relapse. The physiology of addiction lasts for the rest of a person's life. Any use of alcohol or drugs will reactivate physiological, psychological, and social progression of the disease.

The major causes of relapse during the maintenance stage are the failure to maintain a recovery program and encountering major life transitions.

Stuck Points in Recovery

Although some patients progress through the stages of recovery without complications, most chemically dependent people do not. They typically get stuck somewhere. A Astuck point" can occur during any period of recovery. Usually it is caused either by lack of skills or lack of confidence in one's ability to complete a recovery task. Other problems occur when the recovering person encounters a problem (physical, psychological, or social) that interferes with his or her ability to use recovery supports.

When recovering people encounter stuck points, they either recognize they have a problem and take action, or they lapse into the familiar coping skill of denial that a problem exists. Without

specific relapse prevention skills to identify and interrupt denial, stress begins to build. Eventually, the stress will cause the patient to cope less and less well. This will result in relapse.

The Developmental Model of Recovery Compared With Traditional Models

Traditional models of treatment are based on the idea that once a person is detoxified, he or she can fully participate in the treatment process. Although this is true for many patients in the early stages of addiction who have had functional lives before their addiction progressed, it is not true for most of the criminal justice population. In addition, most traditional programs have a program format that is applied to all people regardless of their education, personality, or social skills. Patients whose needs fit within the program usually do well. But those whose needs do not fit, such as criminal justice patients, generally do not do well.

The DMR recognizes that there are abstinence-based symptoms of addiction that persist well into the recovery process. These symptoms are physical and psychological effects of the disease of chemical dependency. In the DMR, these symptoms must be stabilized and the patient must be taught how to manage them before general rehabilitation can take place. This model identifies the specific symptoms that a patient needs to overcome.

This model also contains methods and techniques that recognize the learning needs, psychological problems, and social skills of the patient.

Post Acute Withdrawal

Some of the symptoms of withdrawal from alcohol or drugs are the result of the toxic effects of these chemicals on the brain. These symptoms are called Post Acute Withdrawal (PAW). PAW is more severe for some patients than it is for others. Other factors cause stress that aggravates PAW. Below is a list of conditions affecting the criminal justice population that tend to worsen the damage and aggravate PAW.

Physical conditions that worsen PAW through increased brain damage or disrupted brain function:

- Combined use of alcohol and drugs or different types of drugs
- Regular use of alcohol or drugs before age 15 or abusive use for a period of more than 15 years
- History of head trauma (from car accidents, fights, falling, etc.)
- Parental use of alcohol or drugs during pregnancy
- Personal or family history of metabolic disease such as diabetes or hypoglycemia
- Personal history of malnutrition, usually due to chemical dependence
- Physical illness or chronic pain.

Psychological and social conditions that worsen PAW:

- Childhood or adult history of psychological trauma (participant in or victim of sexual or physical violence)
- Mental illness or severe personality disorder
- High stress lifestyle or personality
- High stress social environment.

Addictive Preoccupation

The other major area of abstinence-based symptoms is addictive preoccupation. This consists of the obsessive thought patterns, compulsive behaviors, and physical cravings caused or aggravated by the addiction. These behaviors become programmed into the patient's psychological processes by the addiction. They are automatic and can cause the recovering patient to return to use unless he or she has specific training to identify and interrupt them.

Addictive preoccupations are activated by high-risk situations and stress. Because of the environment surrounding most criminal justice patients, they often experience high-risk situations and stress. These situations and stresses can include

- Exposure to alcohol or drugs or associated paraphernalia
- Exposure to places where alcohol or drugs are used
- Exposure to people with whom the patient has used in the past or people the patient knows who are actively using
- Lack of a stable home environment
- Lack of a stable social environment
- Lack of stable employment.

Traditional treatment focuses on either detoxification alone or detoxification with movement into a rehabilitation program aimed at changing the patient's lifestyle. Programs are similar for all patients. Many programs omit teaching the specific stabilization skills that are necessary before lifestyle rehabilitation can take place.

The DMR first stabilizes patients so that they can take advantage of lifestyle rehabilitation. It then places the patient into a group that contains patients in similar stages of recovery and works on tasks and skills for that stage of recovery. Specific skills are taught to identify and manage relapse warning signs.

Chapter 3—What Is Relapse?

Relapse is not an isolated event. Rather, it is a process of becoming unable to cope with life in sobriety. The process may lead to renewed alcohol or drug use, physical or emotional collapse, or suicide. The relapse process is marked by predictable and identifiable warning signs that begin long before a return to use or collapse occurs. Relapse prevention therapy teaches people to recognize and manage these warning signs so that they can interrupt the progression early and return to the process of recovery.

Studies of life-long patterns of recovery and relapse indicate that not all patients relapse. Approximately one third achieve permanent abstinence from their first serious attempt at recovery. Another third have a period of brief relapse episodes but eventually achieve long-term abstinence. An additional one third have chronic relapses that result in eventual death from chemical addiction.

These statistics are consistent with the life-long recovery rates of any chronic lifestyle-related illness. About half of all relapse-prone people eventually achieve permanent abstinence. Many others lead healthier, more stable lives despite periodic relapse episodes.

Classification of Recovery/Relapse History

For the purpose of relapse prevention therapy, chemically dependent people can be categorized according to their recovery/relapse history. These categories are as follows:

- Recovery-Prone
- Briefly Relapse-Prone
- Chronically Relapse-Prone.

These categories correspond with the outcome categories of continuous abstinence, brief relapse, and chronic relapse described above. Relapse-prone individuals can be further divided into three distinct subgroups.

Transition patients fail to recognize or accept that they are suffering from chemical addiction in spite of problems from their use. This failure is usually due to the chemical disruption of the patient's ability to accurately perceive reality, or to mistaken beliefs.

Unstabilized relapse-prone patients have not been taught to identify the abstinence-based symptoms of PAW and addictive preoccupation. Treatment fails to provide these patients with the skills necessary to interrupt their disease progression and stop using alcohol and drugs. As a result, they are unable to adhere to a recovery program requiring abstinence, treatment, and lifestyle change.

Stabilized relapse-prone patients recognize that they are chemically dependent, need to maintain abstinence to recover, and need to maintain an ongoing recovery program to stay abstinent. They usually attend Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or another 12-step program in addition to receiving ongoing professional treatment. They also make protracted efforts at psychological and physical rehabilitation and recommended lifestyle changes during abstinence. However, despite their efforts, these people develop symptoms of dysfunction that eventually lead them back to alcohol or drug use.

Many counselors mistakenly believe that most relapse-prone patients are not motivated to recover. Clinical experience has not supported this belief. More than 80 percent of relapse-prone patients admitted to the relapse prevention program at Father Martin's Ashley in Havre de Grace, Maryland, had a history of both recognition of their chemical addiction and motivation to follow aftercare recommendations at time of discharge. In spite of this, they were unable to maintain

abstinence and sought treatment in a specialized relapse prevention program. he or she became aware of during this exercise.

Part II of TAP 19: Counselor's Manual for Relapse Prevention

Part II: Relapse Prevention Treatment

Chapter 4—What Is Relapse Prevention Treatment?

Relapse prevention is a systematic method of teaching recovering patients to recognize and manage relapse warning signs. Relapse prevention becomes the primary focus for patients who are unable to maintain abstinence from alcohol or drugs despite primary treatment.

Recovery is defined as abstinence plus a full return to bio/psycho/social functioning. As previously noted, relapse is defined as the process of becoming dysfunctional in recovery, which leads to a return to chemical use, physical or emotional collapse, or suicide. Relapse episodes are usually preceded by a series of observable warning signs. Typically, relapse progresses from bio/psycho/social stability through a period of progressively increasing distress that leads to physical or emotional collapse. The symptoms intensify unless the individual turns to the use of alcohol or drugs for relief.

To understand the progression of warning signs, it is important to look at the dynamic interaction between the recovery and relapse processes. Recovery and relapse can be described as related processes that unfold in six stages:

- Abstaining from alcohol and other drugs
- Separating from people, places, and things that promote the use of alcohol or drugs, and establishing a social network that supports recovery
- Stopping self-defeating behaviors that prevent awareness of painful feelings and irrational thoughts
- Learning how to manage feelings and emotions responsibly without resorting to compulsive behavior or the use of alcohol or drugs
- Learning to change addictive thinking patterns that create painful feelings and self-defeating behaviors
- Identifying and changing the mistaken core beliefs about oneself, others, and the world that promote irrational thinking.

When people who have had a stable recovery and have done well begin to relapse, they simply reverse this process. In other words, they

- Have a mistaken belief that causes irrational thoughts

- Begin to return to addictive thinking patterns that cause painful feelings
- Engage in compulsive, self-defeating behaviors as a way to avoid the feelings
- Seek out situations involving people who use alcohol and drugs
- Find themselves in more pain, thinking less rationally, and behaving less responsibly
- Find themselves in a situation in which drug or alcohol use seems like a logical escape from their pain, and they use alcohol or drugs.

A number of basic principles and procedures underlie the CENAPS Model of Relapse Prevention Therapy. Each principle forms the basis of specific relapse prevention therapy procedures. Counselors can use the following principles and procedures to develop appropriate treatment plans for relapse-prone patients. Following a description of each principle is the relapse prevention procedure for that principle.

Principle 1: Self-Regulation

The risk of relapse will decrease as a patient's capacity to self-regulate thinking, feeling, memory, judgment, and behavior increases.

Relapse Prevention Procedure 1: Stabilization

An initial treatment plan is established that allows relapse-prone individuals to stabilize physically, psychologically, and socially. The level of stabilization is measured by the ability to perform the basic activities of daily living. Because the symptoms of withdrawal are stress-sensitive, it is important to evaluate the patient's level of stability under both high and low stress. Many people who appear stable in a low-stress environment become unstable when placed in a more stressful environment.

The stabilization process often includes

- Detoxification from alcohol and other drugs
- Solving the immediate crises that threaten sobriety
- Learning skills to identify and manage Post Acute Withdrawal and Addictive Preoccupation
- Establishing a daily structure that includes proper diet, exercise, stress management, and regular contact with treatment personnel and self-help groups.

Because the risk of using alcohol or drugs is highest during the stabilization period, steps must be taken to prevent use during this time. The patient needs to be in a drug-free environment. Any irrational thoughts (thoughts that don't make sense to a healthy person) that are creating immediate justification for relapse need to be identified and discussed. The patient should then be helped to remember the consequences of past chemical use and to develop new coping strategies.

An early relapse intervention plan can be developed by the counselor and patient to decide what action to take if the patient begins to use alcohol or drugs. This early intervention plan motivates the patient to stay sober and provides a safety net should chemical use occur.

Principle 2: Integration

The risk of relapse will decrease as the level of conscious understanding and acceptance of situations and events that have led to past relapses increases.

Relapse Prevention Procedure 2: Self-Assessment

Self-assessment first involves a detailed reconstruction of the presenting problems (problems that caused the patient to seek treatment) and the alcohol and drug use history. A careful exploration of the presenting problems identifies critical issues that can trigger relapse. This allows the counselor to design intervention plans that help to solve crises that can be used for relapse justification in the early treatment stages. The next step is a reconstruction of the recovery and relapse history. This helps identify past causes of relapse.

In reconstructing the recovery/relapse history, it is important to identify the recovery tasks that were completed or ignored, and to find the sequence of warning signs that led back to drug or alcohol use. The assessment is most effective if the counselor reconstructs the relapse history using exercises (done as homework assignments), such as making a list of all relapse episodes and identifying the problems that led to relapse. These assignments should be reviewed in group and individual sessions.

Principle 3: Understanding

The risk of relapse will decrease as the understanding of the general factors that cause relapse increases.

Relapse Prevention Procedure 3: Relapse Education

Relapsers need accurate information about what causes relapse and what can be done to prevent it. This is typically provided in structured relapse education sessions and reading assignments, which provide specific information about recovery, relapse, and relapse prevention planning methods. This information should include, but not be limited to

- A bio/psycho/social model of addictive disease
- A DMR
- Common Astuck points" in recovery
- Complicating factors in relapse
- Warning sign identification
- Relapse warning sign management strategies
- Effective recovery planning.

The recommended format for a relapse education session is as follows:

- Introduction and pretest (15 minutes)
- Educational presentationClecture, film, or videotape (30 minutes)

- Educational exercise conducted in dyads or small groups (15 minutes)
- Large group discussion (15 minutes)
- Post-test session and review of correct answers (15 minutes).

It is important to test patients to determine their retention and understanding of the material. Many relapsers have severe memory problems associated with Post Acute Withdrawal that prevent them from comprehending or remembering educational information.

Principle 4: Self-Knowledge

The risk of relapse will decrease as the patient's ability to recognize personal relapse warning signs increases.

Relapse Prevention Procedure 4: Warning Sign Identification

Warning sign identification is the process of teaching patients to identify the sequence of problems that has led from stable recovery to alcohol and drug use in the past and then recognizing how those steps could cause relapse in the future. The process of developing a personal relapse warning sign list is (1) reviewing warning signs, (2) making an initial warning sign list, (3) analyzing warning signs, and (4) making a final warning sign list.

The patient develops his or her own individualized warning sign list by thinking of irrational thoughts, unmanageable feelings, and self-defeating behaviors. Most final warning sign lists identify two different types of warning signs: those related to core psychological issues (problems from childhood) and those related to core addictive issues (problems from the addiction). Warning signs related to core psychological issues create pain and dysfunction, but they do not directly cause a person to relapse into chemical use. *When patterns of addictive thinking that justify relapse are reactivated, a return to using alcohol and drugs occurs*.

Principle 5: Coping Skills

The risk of relapse will decrease as the ability to manage relapse warning signs increases.

Relapse Prevention Procedure 5: Warning Sign Management

This involves teaching relapse-prone patients how to manage or cope with their warning signs as they occur. The better they are at coping with warning signs, the better their ability will be to stay in recovery.

Warning sign management should focus on three distinct levels. The first is the situational-behavioral level, where patients are taught to avoid situations that trigger warning signs. At this level, they are taught to modify their behavioral responses should these situations arise. The second level is the cognitiveBaffective (thoughts and feelings) level, where patients are taught to challenge their irrational thoughts and deal with their unmanageable feelings that emerge when a

warning sign is activated. The third level is the core issue level, where patients are taught to identify the core addictive and psychological issues that initially create the warning signs.

Principle 6: Change

The risk of relapse will decrease as the relationship between relapse warning signs and recovery program recommendations increases.

Relapse Prevention Procedure 6: Recovery Planning

Recovery planning involves the development of a schedule of recovery activities that will help patients recognize and manage warning signs as they develop in sobriety. This is done by reviewing each warning sign on the final warning sign list and ensuring that there is a scheduled recovery activity focused on each sign. Each critical warning sign needs to be linked to a specific recovery activity.

Principle 7: Awareness

The risk of relapse will decrease as the use of daily inventory techniques designed to identify relapse warning signs increases.

Relapse Prevention Procedure 7: Inventory Training

Inventory training involves teaching relapse-prone patients to complete daily inventories. These inventories monitor compliance with the recovery program and check for the emergence of relapse warning signs. A daily recovery plan sheet is used to plan the day, and an evening inventory sheet is used to review progress and problems that occurred during that day.

A typical morning inventory asks the patient to identify three primary goals for that day, create a to-do list, then schedule time for completion of each task on the to-do list on a daily calendar. During the evening review inventory, the patient should review his or her warning sign list and recovery plan to determine whether he or she completed the required activities and experienced any relapse warning signs.

Whenever possible, these inventories should be reviewed by someone who knows the patient and who can assist him or her in looking for emerging patterns of problems that could cause relapse.

Principle 8: Significant Others

The risk of relapse will decrease as the responsible involvement of significant others in recovery and in relapse prevention planning increases.

Relapse Prevention Procedure 8: Involvement of Others

Relapse-prone individuals cannot recover alone. They need the help of others. Family members, 12-step program sponsors, counselors, and peers are just a few of the many recovery resources available. A counselor should ensure that others are involved in the recovery process whenever possible. The more psychologically and emotionally healthy the significant others are, the more likely they are to help the relapse-prone patient remain abstinent. The more directly the significant others are involved in the relapse prevention planning process, the more likely they are to become productively involved in supporting positive efforts at recovery and intervening on relapse warning signs or initial chemical use.

Principle 9: Maintenance

The risk of relapse decreases if the relapse prevention plan is regularlyupdated during the first 3 years of sobriety.

Relapse Prevention Procedure 9: Relapse Prevention Plan Updating

The patient's relapse prevention plan needs to be updated on a monthly basis for the first 3 months, quarterly for the remainder of the first year, and twice a year for the next 2 years. Once a person has maintained 3 years of uninterrupted sobriety, the relapse prevention plan should be updated on a yearly basis.

Nearly two thirds of all relapses occur during the first 6 months of recovery. Less than one quarter of the variables that actually cause relapse can be predicted during the initial treatment phase. As a result, ongoing outpatient treatment is necessary for effective relapse prevention. Even the most effective short-term inpatient or primary outpatient programs will fail to interrupt long-term relapse cycles without the ongoing reinforcement of some type of outpatient therapy.

A relapse prevention plan update session involves the following:

- A review of the original assessment, warning sign list, management strategies, and recovery plan.
- An update of the assessment by adding documents that are significant to progress or problems since the previous update.
- A revision of the relapse warning sign list to incorporate new warning signs that have developed since the previous update.
- The development of management strategies for the newly identified warning signs.
- A revision of the recovery program to add recovery activities to address the new warning signs and to eliminate activities that are no longer needed.

Chapter 5—Basic Counseling Skills

Although the workbook is intended to be used in a group counseling session, occasionally you will need to do individual counseling. This chapter discusses some basic counseling skills that can be used in individual and group counseling. It also explains some of the concepts and terms used in relapse prevention counseling that you will need to help patients with the workbook.

Helping Traits

People who are effective at counseling have developed eight behaviors that they use during counseling sessions. It is important to develop these traits if you are to improve your ability to help others. The counselor is a role model (someone whom patients tend to imitate). Therefore, you want to model behaviors that will be helpful to patients' recovery. The following are some of these traits.

Empathy. Empathy is the ability to understand how another person sees and interprets an experience. It is different from sympathy (feeling sorry for someone). When you are empathetic, you can look at and understand a situation from another person's perspective. It does not mean you have to agree with that person.

Genuineness. Genuineness is the ability to be fully yourself and express yourself to others. It is the lack of phoniness, faking, and defensiveness. When you are genuine, the way you act on the outside matches your thoughts and feelings on the inside.

Respect. Respect is the ability to let another person know, through your words and actions, that you believe that he or she has the ability to make it in life, the right to make his or her own decisions, and the ability to learn from the outcome of those decisions.

Self-Disclosure. Self-disclosure is the ability to disclose information about yourselfCthe ways you think and feel, the things you believeCin order to help other people.

Warmth. Warmth is the ability to show another person you care about him or her. Behaviors that show warmth include touching someone, making eye contact, smiling, and having a caring, sincere tone of voice.

Immediacy. Immediacy is the ability to focus on the "here and now" relationship with another person. You can express immediacy by saying things like: "Right now I am feeling _____." "When you said that, I began to think _____." "As you were speaking, I sensed that you felt _____."

Concreteness. Concreteness is the ability to identify specific problems and the steps necessary to correct them. When a problem, situation, behavior, or set of actions is defined in concrete terms, you could draw a picture or make a movie about it if you were able.

Confrontation. Confrontation is the act of honestly telling another person your perception of what is going on without putting them down. Confronting someone can include:

- Giving an honest evaluation of the person's strengths and weaknesses
- Saying what you believe the person is thinking and feeling
- Stating how you see the person acting
- Telling the person what you believe will happen because of their actions.

Active Listening

When a patient is talking about a problem or presenting an assignment, it is important to listen actively. Active listening is a basic counseling skill that helps you clarify for yourself and the patient what is really going on. Patients in recovery are not always clear in their thinking. This lack of clarity can confuse them and those around them. Active listening will help them clarify their thinking.

Active thinking consists of several skills. These include the following:

Clear listening. When you are listening to a patient, it is important to *just listen*. The most common problem for new counselors is that they think while they listen. If you are thinking about what you are going to say, you will not accurately hear what the person is saying. It is important that you listen without judging what the patient is saying and without immediately trying to correct his or her thoughts.

Reflecting. When someone talks to you, reflecting is summarizing and repeating that person's thoughts andfeelings in a simple, clear manner. Reflecting helps clarify the issues for both of you. If you misunderstand the patient, he or she can correct you. When you repeat thoughts and feelings back to the patient, use statements instead of questions.

Example: Patient—"I try and try to stay straight but everything goes wrong and I end up using again."

Counselor-"You seem to feel hopeless about recovering." Reflecting gives a patient the sense that you are really listening. He or she will tend to open up more and talk about problems he or she hasn't talked about before.

Asking-open ended questions. Do not ask questions that can be answered with a "yes" or a "no." Instead, ask questions that require patients to explore the reasons they think, feel, and act the way they do.

Example: "What happens when you try to recover?" "What do you do when you feel hopeless?"

Not asking "Why?". Most new counselors make the mistake of asking "Why?" The patient does not know why, or else he or she would have changed. If you ask "Why?" the patient will give you an excuse. By asking "What?" you are getting the patient to focus on what he or she has done that can be changed.

Using effective body language. How you physically position yourself tells a patient a lot about how you feel about him or her. When you are working with patients, it is best to sit with your legs and arms uncrossed, to lean forward and to make eye contact. This body position shows that you are interested in what the patient has to say and that you are paying attention.

Watching for nonverbal cues. When you are working with a patient, listen and watch carefully. Does the person tense up, tap his or her foot, shift around, etc.? When you see these cues, make the patient aware of them and let him or her know what this might mean the patient is feeling.

Basic Relapse Prevention Techniques

There are a number of techniques that are used when doing relapse prevention counseling.

Centering

When you begin a group or an individual session or when you want a patient to calm down and get in touch with thoughts and feelings, you can use a technique called *centering*. This is basically a relaxation technique. Instruct the patient to do the following:

- Put both feet on the floor, sit up straight and close your eyes.
- Breathe in through your nose and out through your mouth.
- Breathe in deeply, hold it for a second, then breathe out.
- Do this again and feel your lungs fill with air, then empty.
- Slow your breathing to a steady rhythm.
- See if any thoughts are entering your mind.
- Ask yourself if you are feeling any body tensions.
- Open your eyes when you are ready.

Speak slowly as you give the instructions. This will help the patient calm down.

Sentence completion

Sentence completion is a technique used to help patients identify thoughts that they have that may not be true. These thoughts are called mistaken beliefs. Many times when a patient is acting in a self-defeating way, it is a result of mistaken beliefs he or she has about the world and himself or herself. When a patient is behaving in a way that hurts himself or herself and others, it is because the patient believes that this is the only choice he or she has. Sentence completion is a way to help a patient identify and correct mistaken beliefs. You do this by doing the following.

- Have the patient form a sentence stem: A sentence stem is the beginning of a sentence that has meaning for the patient. You can form these stems based on topics the patient is talking about. Examples are:
  "I know my recovery is in trouble when . . ."
  "When I think about drugs, I . . ."
  "Right now, I am feeling . . ."
- Have the patient write down the sentence stem.
- Have the patient repeat it out loud and end it differently six to eight times or until he or she cannot think of new endings.
- Have the other group members write down the endings. If you are in an individual session, do this yourself.
- Have the group members read the endings back to the patient as they write them down. Have them use the following form: A(patient's name), I heard you say (sentence stem)(first ending)." Repeat the exercise until all the endings have been read.
- Look for a common theme in the endings. You may form a new sentence stem from the common theme and repeat the exercise, or stop here if the mistaken belief is identified.

- Have the patient identify the mistaken belief if he or she can and write it down.

Sentence repetition

Sentence repetition is a way for a patient to become conscious of mistaken beliefs and the thoughts, feelings, and actions they cause. Identify the mistaken belief and ask the patient to write it down.

- Ask the patient to repeat it out loud, slowly.
- After each repetition, ask the patient to take a deep breath, let it out, and report any thoughts, feelings, or urges that surfaced.
- Have the patient write down these thoughts, feelings, and urges.
- Ask the patient if he or she can remember who caused this mistaken belief or where it came from.
- Ask the patient if the person could have been wrong.
- Ask the patient if there are other ways to believe that could be true. You may have to ask the group to help.
- Ask the patient to complete the following sentences:
  "If I continue to believe this, the best that can happen is . . ."
  "The worst that can happen is . . ."
  "The most likely to happen is . . ."
  "If I change what I believe, the best that can happen is . . ."
  "The worst that can happen is . . ."
  "The most likely to happen is . . ."
- The probable outcomes can be discussed and a course of action decided by the group. The most important decision is to identify a rational thought that the patient can substitute when the mistaken belief occurs. Example are as follows.

Mistaken belief—I can't tell others what I feel or they will look down on me.

Chapter 6—Group Counseling

Group counseling has proved to be the most effective way of treating chemical dependency. This chapter explains how to do group counseling. Patients in chemical dependency treatment programs learn best in group counseling, where patients learn about themselves by interacting with others. They also come to understand that they are not alone in their problems. In addition, they learn social and communication skills that allow them to make better use of self-help programs such as Alcoholics Anonymous and Narcotics Anonymous.

How Is Group Work Different From Individual Counseling?

Group counseling and individual counseling are both important tools for treating chemical dependency. Group counseling uses many of the same intervention strategies as individual counseling. There are, however, some important distinctions between the two modalities. A

common mistake for beginning group counselors is to focus an entire group meeting on one patient, while the others in the group simply look on.

Group counseling is different from individual counseling in the following ways:

- Group counseling focuses on the present; the here and now. In group counseling, patients do not delve into long accounts of personal history that preceded the problems of chemical dependency. Group counseling provides a forum to understand current behavior, to learn about chemical dependency, to discuss new ways of behaving, to learn new ways to solve problems, and to develop relapse prevention skills.
- Group counseling makes use of the interactive process within the group. That is, the counselor focuses on how the group members act toward one another, communicate with one another, and how they behave in the group.
- The counselor and group members offer individuals feedback about their behavior. In individual counseling patients simply disagree with their counselor. In group counseling the counselor's feedback is combined with positive peer feedback from the group members. This makes messages more powerful.
- The group provides a place for the counselor to help individuals practice new skills such as problem solving, communication, and managing stress.

In group counseling, the counselor uses a peer group to influence individual patients and change behavior in a positive way.

Group Counseling Theory

Stages of Group Development

When a group first begins, counselors and group members alike will feel very uncomfortable. The members may not know the counselor or one another. As people become familiar with the group, feelings and behavior begin to change. These changes follow predictable patterns. In fact, groups have a clear developmental life cycle, that is, a group goes through different stages. As the group leader gains experience, he or she learns to anticipate these changes and work with them.

There are many models for the stages of group development. The following is a composite of several models:

- Stage 1—Preaffiliation
- Stage 2—Power and control
- Stage 3—Intimacy
- Stage 4—Differentiation
- Stage 5—Separation.

In the preaffiliation stage, members feel uncomfortable, anxious, or fearful with the newness of the experience. In this stage, members look to the leader for direction. Initially, the group should be leader-focused, with the leader helping members adjust to the new experience.

Once group members are more comfortable, it is predictable that they will challenge the authority of the leader and will pursue power and control. It is important for the leader to remember that this is a normal style in the group's development, not unlike the challenges that face the parents of an adolescent. This phase may be uncomfortable, with group members expressing anger and frustration. The leader should be careful not to personalize these challenges to authority. The leader should be consistent, avoid fighting with the group, and allow the group to become more autonomous without sacrificing his or her position of authority.

In the next stage, some degree of intimacy is established. It is very important for the leader to move members to a common level of intimacy before allowing too much self-disclosure by the group members. The setting and type of the group will determine the overall level of intimacy. As members feel safer in the group, they can better engage in activities and take risks necessary for change. At this stage, the leader can give less direction, allowing the members to work together more spontaneously and more independently.

Differentiation is the stage at which members have a strong sense of identification with the group and feel trusting. This is the most productive stage of group development.

Finally, at the point of termination or separation, members experience a range of feelings and display a range of behaviors in anticipation of leaving the group. It is important to remember that chemically dependent people typically have experienced a lot of loss over their lifetimes. Many have lost family members and friends to violence and illness. They do not handle the ending of relationships well. Termination of the group or loss of a group member presents an important opportunity to deal with this problem. The leader should begin to prepare the group for ending well in advance and do so gradually. The leader can expect members to use denial or to regress. It is important to predict these behaviors and to identify them as they occur.

These stages of group development are very predictable. Virtually all groups go through them. However, depending upon the circumstances a group may regress to an earlier stage at any time. For example, if a group adds new members, the level of intimacy will decrease. The group may return to a stage of preaffiliation. It is hard to predict how long a group will stay in a particular stage of development. The type of group (i.e., mandatory or voluntary), the setting (i.e. institution or community), and other factors can all influence the process. With experience, the group leader develops the skills to promote the group developmental process or alter.

Communication in Groups: Content and Interactive Process

The terms "content" and "interactive process" refer to the patterns of communication among group members. "Content" refers to the *substance* of a communication. The content is the subject matter, including issues, questions, or problems on which the group is focused. "Interactive process" refers to *how* members communicate and act with one another. The process includes not only the spoken words, but also the nonverbal messages expressed by tone of voice, posture, and

facial expression. Process provides the "present focus" or "here and now" raw material for group treatment.

The content of a group meeting sometimes symbolizes the group process. In the same way a client might talk about "a friend who has a problem," group members may talk about prior events and issues that reflect current experiences. Often as group leaders, we get caught up in the content. We are very interested in the what, when, where, who, how, and why. In group counseling, this content has relevance in a way that can be different from its relevance in individual counseling.

The Counselor as Group Leader

Many techniques used in group counseling are similar to those used in individual counseling. The general approach of the group leader, however, must work to create a group culture that focuses on the Ahere and now" behavior. An active and dynamic approach along with an empathic style are needed to do this.

The group leader's focus should:

- encourage group and individual recovery
- teach members about chemical dependency, recovery, and relapse prevention
- build members' self-esteem.

The group leader's approach should:

- be empathic
- instill hope
- model desired behaviors
- treat all members consistently, equally, and fairly
- be active and directive
- use appropriate interventions to keep the group moving.

The group leader should:

- maintain control in a nonauthoritative way
- be firm but not punitive
- be assertive in setting limits
- provide appropriate rewards (activities, trips, etc.) to the group.

Planning for Group Work

Logistics

All logistical arrangements should be planned well in advance of beginning the group. In order for the preplanning to go smoothly, group counselors should seek the support of appropriate administrative and support staff. Establish the following before getting started.

Group Size

Groups typically range in size from 6 to 12 people. The size should be determined by such factors as the type of group and the capacity of the patients. "Capacity" refers to the level of individual functioning. Can the patient concentrate, focus, and pay attention? Some substance abusers, particularly those in the early stages of recovery, cannot make use of all their mental functions. Others may have mental/emotional problems that interfere with these abilities. Low-functioning individuals will need a smaller group. Educational groups can handle more members, whereas process oriented-groups should be smaller.

Time

Time is an important boundary. The length of group sessions should be preplanned if the group is to be time limited. A schedule of sessions should be established that considers holidays and other commitments.

Sessions should be of equal length. The ideal length depends on the capacity of the patients, the setting, and the type of group. More functional patients can handle longer sessions than less functional or younger patients. The materials presented in this manual are intended for two-hour group sessions.

Once the time boundaries have been established, it is very important to begin and end group sessions on time.

Space

The space chosen for group meetings will make a statement about the importance given to this activity. The space should be psychologically positive and provide a safe environment for the emotional risks that go with treatment. The space should be well lighted, well ventilated, and an appropriate size for the size of the group. A private location that is accessible, free from interruptions, and physically safe should be chosen.

Types of Groups

Different types of groups serve different purposes. The following is a review of some options to help you decide what type of group is most practical and useful for the setting.

Mandatory or Voluntary Group?

You might assume that voluntary groups are best, but research and practice indicate that both voluntary and mandatory groups have their advantages and disadvantages.

Mandatory groups ensure that members will attend. With regular attendance the group process can develop with little disruption. Unfortunately, mandatory requirements often increase hostility and resistance and intensify denial. No one likes to be told they must go to a counseling group, and few counselors like being confronted with such hostility, particularly by a group of eight or more people.

When the counselor is well prepared, the situation can be managed. Patients will attempt to engage you in battle. The best tactic is to avoid these battles. One way to do so is to join with the group by saying something like, "You have to be here and I have to be here. I understand and appreciate your anger but it is not my fault. How can we both make the best of things?" Offering concrete rewards for cooperation may also help. Setting rules for attendance can eliminate overt resistance but seldom reduces passive resistance.

The disadvantages of the mandatory group become the advantages of the voluntary group. Members of voluntary groups identify with one another, denial is less potent, there is less hostility, and one can move on more quickly to group goals. However, the voluntary group does not have some major disadvantages. When participation is voluntary, members often find excuses to be absent when there is pressure on them to face problems. Without a "captive" audience, leaders find that it is hard to ensure member attendance and that it is difficult for the group process to evolve with absent members.

Which type of group is best? Research indicates that mandatory treatment works as well as voluntary treatment with substance abusers. In a criminal justice setting, required attendance can be useful for all.

Open or Closed Group Membership?

One issue to be decided in advance is whether or not to add members after the group has started. The terms Aopen membership" and "closed membership" are used to describe the two options.

Open membership can reach more clients and is easier to keep going over time because lost members can be replaced. However, adding new members can cause a loss of group intimacy and cohesiveness. Development may regress. Although this may not be ideal, depending on the goals of group, adaptations can be made. Closed membership allows for greater individual progress but is impractical in some settings.

Time-Limited or Open-Ended Group?

It may be practical to place a time limit on a group depending on the patients' stage of recovery. This way patients graduate together to another group with another specified goal. If the setting allows, an open-ended, closed membership group can be ideal. Such a group can achieve high levels of intimacy and differentiation that allow for greater risk taking. The goals can advance while the membership remains the same.

Educational Groups?

For patients to succeed in recovery, they must learn certain things about chemical dependency. This information helps them to cope with the challenges of recovery and avoid relapse. Educational groups also help *engage* the client in treatment and recovery. The overt or covert expectation of individual or group therapy is "change." People find this threatening. An educational group is much less threatening because it is easier to Alearn" than to Achange."

Educational sessions can be offered in 60- to 90-minute blocks. The educational sessions should offer basic information on

- Chemical dependency as a bio/psycho/social disease
- The recovery process
- Symptoms that appear after beginning abstinence
- Relapse warning signs
- Recovery planning.

These sessions should consist of a lecture and an exercise, presented with media supplements. Some programs have an educational curriculum available, and such programs may be available through your State Alcohol and Drug Abuse Agency. One prepackaged educational program that can be ordered is the *Staying Sober Educational Modules* (see the bibliography).

Group Goals and Principles

It is important for the group leader to be clear about what is to be accomplished in the group. It is best to have a written goal with a step-by-step plan for reaching the goal. Having both a written goal and a plan will help to keep the group on track.

The goals of group treatment with addicted patients should be:

Self-assessment. The patients should be able to talk about and understand the meaning of different exercises to their recovery.

Communication training. The group leader should teach patients basic techniques for talking about their thoughts, feelings, and reports of life events. This training should focus on teaching patients how to reveal things about themselves and how to give and receive feedback.

Cognitive restructuring. Patients should relearn how to think so that they can accurately examine and report information and understand how it pertains to their recovery.

Effective counseling. Group treatment should teach patients how to identify, express and self-regulate their emotions and moods.

Memory retraining. Treatment should help patients restore short-term and long-term memory.

Treatment monitoring. Group sessions should provide a vehicle for monitoring and holding the patient accountable for progress and problems encountered when pursuing treatment goals.

Support. The group leader should provide peer and professional support throughout the recovery process.

Opportunity for dialogue. Group sessions should give the patient a chance to talk about recovery issues in a supportive environment where feedback from and discussion with people both more and less advanced in the recovery are available.

Involvement of others in problem solving. The group process should involve the patient in problem solving with other recovering people. The group leader can tell patients that others can and will help in problem solving if they are allowed to, that they too are capable of helping others, and that they can help themselves by helping others.

The principles of group counseling for patients recovering from addictions should be:

Addiction groups. In order to be successful, groups must consist of only recovering alcoholics and drug addicts.

Group treatment goals with addicted patients. The addicted patient is suffering from chemical dependency. This is an illness causing specific physical, mental and social impairments. Group treatment must be directed at helping the patient with these impairments.

Structured and directive group process. The group process should be structured rather than free-floating. Patients must focus on concrete, specific problem solving relating to accepting their addiction and achieving a comfortable recovery. Feelings should be dealt with in the context of these concrete problems. All problems dealt with in the group must be related to recovery from chemical dependency.

The role of the group counselor. The group counselor should be directive, yet permissive and supportive. The counselor is responsible for establishing and maintaining direction for each patient and for the group as a whole. The group counselor gives direction and supervision to the group. He or she must provide a consistent group format; set the pace of the group and see that it is maintained; assign, follow, and review assignments; and manage group problems as they develop.

The abstinence goal. The first focus of group treatment should be for each patient to establish and maintain abstinence from alcohol and mood-altering drugs. This goal of recovery involves the identification of concrete problems and situations that could jeopardize abstinence, the development of specific plans for managing these problems, and the completion of skills training and assignments designed to develop skills in coping with these problems and situations.

Reliance on group support. Patients need to develop a strong substitute dependency to replace their old dependency on alcohol and drugs. Patients will tend to develop a strong dependency on the counselor as this substitute dependency. Group treatment should be used to transfer this dependency from the counselor to the group. Group counseling for addicted patients should be designed to support the patient's ongoing involvement in AA, NA, and other support groups. It

should also focus on building strong, positive, supportive relationships among the group members.

Admission and discharge criteria. There should be specific admission criteria that describe the type of patient that is appropriate for treatment in group counseling. There should also be specific discharge criteria that describe when a patient is ready to responsibly Agraduate" from the group.

Issues that are inappropriate for group treatment. There are certain issues that are best dealt with individually. This is due to the need for extreme confidentiality or a patient's inability to deal with the issues in a group setting. Care needs to be taken, however, not to support a patient's continuing denial by allowing him or her to avoid talking about routine recovery issues in group sessions.

Role modeling by the counselor. The counselor should model the behaviors that he or she expects from the patients.

Supportive counseling. The early efforts of the group counselor should be directed toward allying himself or herself with the addicted patient's needs rather than with attacking defenses. Addicted patients need basic support, education, communication training, and direction in recovery. These should be provided with support rather than harsh confrontation.

Group involvement. Eighty percent of the benefits of group treatment comes from becoming actively involved in utilizing the group process to help other group members to recover. This involvement interrupts chemically dependent self-centered behavior and provides training in the processes of problem solving and recovery. Many patients will automatically identify and discover solutions to problems in their lives by helping other patients cope with similar problems. Only 20 percent of the benefits of group counseling comes from working on personal problems.

Note taking and tape recording in group. Addicted patients suffer from severe memory impairments. It is recommended that all patients take notes on important issues. Patients can also tape record portions of the group sessions where they work on an issue and receive feedback. Listening to these tapes later often speeds up the counseling process.

The intoxicated patient in group treatment. It is unproductive to allow a patient to attend group sessions while actively intoxicated with alcohol or drugs. The patient should be asked to leave the group and an individual appointment should be made to motivate the patient to enter appropriate detoxification treatment.

Rules and Contracting

Contracting is a tool that many groups use to help get members to attend meetings and follow rules. Because it is very important that all members agree to the requirements and rules of the group, a document can be written up and copied for each member and the group leader. Each

member and the leader will sign this contract. The contract sets forth the day or dates of meetings, time, location and group rules.

Clearly stated and enforced rules are critical for a successful group. They can free members to deal with recovery issues. For example, when a rule of no violence is clearly stated and enforced, it allows the patient to feel and express anger, knowing that the group will not allow any one person to get out of control. Rules also offer limits to patients who have very few internal controls and who cannot set their own limits. Many substance abusers grew up in situations that did not teach them controls and limits. Establishing and enforcing group rules can help correct this.

Use the following guidelines in setting group rules.

- Do not make a rule that you or the agency cannot enforce.
- All rules must be enforced fairly and anytime they are violated.
- Rules should be clear and understood by all.
- Many substance abusers have memory problems; therefore, rules should be restated periodically and whenever a new members joins the group.

Group Rules

The following rules are designed to be used as part of the problem-solving group process.

- You can say anything you want, any time you want to say it. Silence is not a virtue in this group and can be harmful to your recovery.
- You can refuse to answer any question or participate in any activity except the basic group responsibilities. The group cannot force you to participate, but group members do have the right to express how they feel about your silence or your choice not to get involved.
- What happens in the group stays among the members with one exception: Counselors may consult with other counselors in order to provide more effective treatment.
- No swearing, putting down, physical violence, or threat of violence.
- No dating, romantic involvement, or sexual involvement among the members of the group. Such activities can sabotage the treatment of those involved and others. If such involvements develop, members should bring it to the attention of the group or individual counselor at once.
- Anyone who decides to leave group treatment must tell the group in person prior to termination.
- Group sessions are 2 hours in duration. Patients should be on time and plan on not leaving the session before it is over. Smoking, eating, and drinking are not allowed in group sessions.

Responsibilities of patients in the group include the following:

- Listen to other group members' problems.
- Ask questions to help clarify problems or proposed solutions.

- Give feedback about what you think and feel about a problem and the personal strengths you see in the person that will help him or her solve the problem. Also give feedback about the weaknesses you see that may set the person up to fail to solve the problem.
- Share personal experiences with similar problems when appropriate. Self-disclosure must be carefully managed to keep the primary focus on the patient who is working on the issue.

Problem-Solving Group Counseling Format

The Preparation Session

Before the group session begins, the counselors must prepare. Counselors meet as a group. A brief written description of each patient (a Athumbnail" sketch) is presented, and the patient's progress is reviewed. An attempt is made to predict the assignments and problems that patients will present.

The Opening Procedure (5 Minutes)

During the opening procedure, the counselor sets the climate for the group, establishes leadership, and helps patients warm up to the group process.

- The counselor enters the group room. He or she makes sure that the room is set up with a circle of upright chairs arranged close enough for the members to touch each other. The counselor greets each member informally by talking to them before the group starts.
- The counselor asks the members to touch the person on either side and while doing this make eye contact with each person in the group. He asks them to make sure the other person sees them by nodding or giving another response.
- The counselor completes a centering technique (see Counseling Techniques). This is designed to get the patient in touch with himself or herself and leave nonrelated problems outside the group room.
- The counselor then takes attendance. During the attendance procedure, the counselor makes eye contact with each patient, engages in a brief social greeting, and tries to get an idea of each patient's attitude and mood before going on.

Reactions to Last Session (15 Minutes)

A reaction is a brief description of (1) what each group member thought during the last group session, (2) how the group member felt during the last group session, and (3) identification of the three persons who stood out from the last session and why they were remembered.

All group members are required to give a reaction to the last session. This accomplishes a variety of goals:

- It forces each patient to talk in the first phase of the group session.

- It breaks the tendency toward isolation and self-centeredness by forcing the patient to notice and comment on at least three other group members. This reaction forces group involvement.
- It provides training in basic communication and on how to give feedback.
- It provides feedback to other group members about who stood out from the last session and why.
- It puts pressure on group members to recall important events from previous group sessions. As a result, it serves as a memory training device.
- It tests a group member's motivation. Members who refuse to give reactions or repeat what others say generally have problems cooperating with other aspects of treatment.
- It provides an opportunity for the counselor to reflect on the last group and compare his or her personal memory with the group members' memories.

It is important to remember that a reaction is a one-way communication. Other group members are not permitted to comment on the reactions. If someone is upset by what another group member says, it is that person's responsibility to volunteer to work on the issue when the agenda is set.

A reaction is also a no-fault communication. There are no right or wrong reactions. The only feedback the counselor and other group members generally give is on the format and completeness of the reaction. In other words, the group member is reporting on his or her thoughts, feelings, and at least three persons who stood out to them in the last session.

A typical reaction should have three parts:

- What I thought about during the last group session.
- How I felt during the last group session.
- Three people that stood out to me in the last group session.

A counselor must help patients by coaching their responses.

Typical problems that patients will have are

- They will say what they thought about or felt about the last session, instead of what they thought or felt during the last session.

  Example:
  Patient—I thought last week's session was good. (Incorrect)
  Counselor—You misunderstand. What I would like you to do is tell what conversations or pictures went on in your head.
  Patient—What I thought about during last week's session was how my drinking and drug use has affected my life. (Correct)

- They will confuse thoughts and feelings.

  Example:

Patient—I think I was angry. (Incorrect)
Counselor—You felt angry? (Explain the difference between a thought and a feeling.)
Patient—I felt angry. I was thinking about going to jail. (Correct)

- `They will talk about a group member instead of to them.

  Example:
  Patient—Joe stood out because his life history was a lot like mine. (Incorrect)
  Counselor—Please say this again and this time speak directly to Joe. Look at him and say, "Joe, you stood out because . . ."
  Patient—Joe, you stood out because your life history was a lot like mine. (Correct)

Examples of Good Responses. A typical reaction made by a group member to the last group might be as follows:

- I thought a lot about how I deal with anger and frustration. There was a lot of good feedback when I talked about my problem.
- I had a feeling of accomplishment as I worked on my problems. I was surprised. I got excited instead of depressed for the first time in a long time.
- Joe, you stood out to me because you understood what I was talking about.
- Mary, you stood out to me because you told me you cared. I'm not sure if I believe you. A part of me thought you were telling the truth and I felt good. Another part of me said, "Why should she care—no one else does."
- Pete, you stood out because you did not seem to pay attention to me when I was talking.

Learning To Give Good Reactions

It takes time for the average person to learn how to give good reactions in group session. This learning takes place as a result of instruction and imitation. The counselor and other group members should explain the components of a good reaction to each new group member. A written handout should be provided that describes the components of a reaction and gives examples.

The group member will also learn by observing and imitating the reactions of other group members. Counselors can speed up this progress by acknowledging good reactions. This is done by saying, "Good" or another positive response to encourage and reward the person. The counselor gives positive feedback for doing the reaction correctly, not based on agreement with the content of what the person says.

Report on Assignments (10 minutes)

Assignments are exercises that patients are working on in their workbook or in addition to their workbook. Additional assignments are often given to help a group member solve a problem that is being worked on in the group. Some of these assignments will be completed in group, and others will need to be completed in between group sessions. Immediately following reactions,

the counselor will ask all group members who have received assignments to briefly answer six questions.

- What was the assignment and why was it assigned?
- Was the assignment completed? If not, what happened when you tried to do it?
- What was learned from the completion of the assignment?
- What feelings and emotions did you experience while completing the assignment?
- Did any issues surface that require additional work in group?
- Is there anything else that you want to work on in group today?

Patients should be asked to rate how important their assignment or problems are in the group session by labeling them with a number from 1 to 10, with 1 being not very important and 10 being extremely important.

Setting the Agenda (3 Minutes)

After all assignments have been reported on, the group counselor will identify all persons who want to work, and announce who will work and in what order. Group members who do not have time to present their work in this group session will be first on the agenda in the following group session. It is best to not plan on over three patients working in any group session.

The Problem-Solving Group Process (70 Minutes)

The problem solving group process is designed to allow patients to present issues to the group, clarify these issues through group questioning, receive feedback from the group, receive feedback from the counselor (if appropriate), and develop assignments for continued progress.

The problem solving process is guided in two ways. A series of exercises are assigned and then processed in group. Special problems that come up are discussed by the group. One goal of group counseling is to teach problem solving skills that will enable the recovering patient to handle difficult situations when they arise.

When dealing with problems that are not assignments, a standard problem solving process is recommended. This process consists of the following steps:

Step 1: Problem Identification.

First, have the members ask questions to identify what is causing difficulty. What is the problem?

Step 2: Problem Clarification.

Encourage them to be specific and complete. Is this the real problem or is there a more fundamental problem?

Step 3: Identification of Alternatives.

What are some options for dealing with the problem? Ask the patient to list them on paper so they can readily see them. Try to have the group come up with a list of at least five possible solutions. This will give them more of a chance of choosing the best solution and give them some alternatives if their first choice doesn't work.

Step 4: Projected Consequences of Each Alternative.

What are the probable outcomes of each option? Have the group ask the person the following questions:

- What is the best possible thing that could happen if you choose this alternative?
- What is the worst possible thing that could happen?
- What is the most likely thing that will happen?
- What is your reaction (thoughts, feelings, memories, and future projections) when you think about implementing that alternative?

Step 5: Decision.

Have the group ask the person which option offers the best outcomes and seems to have the best chance for success. Ask them to make a decision based upon the alternatives they have.

Step 6: Action.

Once they have decided on a solution to the problem, they need to plan how they will carry it out. Making a plan answers the question, "What are you going to do about it?" A plan is a road map to achieve a goal. There are long range goals and short range goals. Long range goals are achieved along with short range goals. One step at a time.

Step 7: Followup.

Ask the person to carry out his or her plan and report on how it is working.

Most problems will not be solved by presenting them one time in group session. Personal problem solving is a process that requires time. It may require three to six presentations of a problem, accompanied by specific assignments completed between group sessions to bring a problem to full resolution. Patients should be given a limited time to present a problem or the summary of an assignment. As a general rule, patients should not work in group for more than 20 minutes.

Not every person will work on a problem during each session. There is an 80/20 rule for group treatment. Eighty percent of the benefit of group treatment occurs from learning how to become responsibly involved in helping others to solve their problems. Only 20 percent of the benefit is derived from working on personal problem issues.

Feedback

When you reach a point where part of the problem solving process is completed or an assignment is presented, group members and the counselor should give feedback. The counselor should go last. Feedback should be given by having the members complete the following:

- My gut level reactions is . . . (A feeling, thought, or how members can identify with the patient who presented)
- I think that how this affects your recovery is . . .
- What I think of you as a person is . . . .

The purpose of this feedback exercise is to practice communication skills, learn to give and take feedback, and use the group for problem solving. The counselor may give an assignment to the patient if it would be helpful to continue to learn more about how to solve this issue.

The Closure Exercise (15 minutes)

When there is approximately 15 minutes left in the group session, the counselor will ask the members the following:

- What is the most important thing you learned in group this evening? It is important to write this down in your notebook.
- What are you going to change about your behavior? Write this down in your notebook.
- Share with the group what you learned and what changes you are willing to make.

Each participant will then briefly review his or her answers to those questions with the group. The counselor then adjourns the group.

The Debriefing Session

The debriefing session is designed to review the patient's problems and progress, prevent counselor burnout, and improve the group skills of the counselor. If this can be done with other counselors running similar groups, it is especially helpful. A brief review of each patient is completed, outstanding group members and events are identified, progress and problems are discussed, and the personal feelings and reactions of the counselor are reviewed.

Outline for Group Counseling Sessions

Opening Procedure—Format (5 minutes)

- Form a tight circle.
- Do physical and eye contact exercises.
- Do centering (breathing) exercise.
- Take attendance to identify moods.

Opening Procedure—Purpose

- Establish control.

- Get group members in contact with one another.
- Get group focused.
- Check members' attitude and mood.

Reactions to Last Sessions—Format (15 minutes)

- Ask what patients thought about during last session.
- Ask how they feel during last session.
- Ask which three people stood out from last session and why.

Reactions to Last Session—Purpose

- Communication training.
- Memory training.
- Tie together group experience.
- Force interest in other group members.
- Initiate high quality group interaction.
- Test motivation.
- Create opportunity for "no fault" communication.

Report on Assignments—Format (10 minutes)

- Find out who had an assignment.
- Ask whether they completed it.
- If yes, ask what they learned.
- If no, ask what happened when they tried to complete it.
- Ask how important is it for them to present this in group tonight. (Rate 1-10.)
- Discuss any other problems that need to be worked on in group. (Rate 1-10.)

Report on Assignments—Purpose

- Accountability (getting only what you expect and inspect).
- Continuity (ensuring that all assignments are completed).

Setting the Agenda—Format (3 minutes)

- DECIDE and announce: The order of presentation by the group members.

Setting the Agenda—Purpose

- To identify the members who need to work in group.
- To review a brief description of the issue the member wants to work on.
- To establish priorities based on:
    - Problem severity
    - History of participation

Problem Solving Process—Format (70 minutes)

- Problem presentation.
- Questioning by the group.
- Feedback from group members.
- Feedback from the group counselor, if appropriate.
- Closure by the therapist.

Problem Solving Process—Purpose

- To present issues.
- To clarify the issue through questioning by the group.
- To receive feedback from group members.
- To develop assignments for continued progress.

Presenting a Problem in Group

- "The problem I want to work on is . . ."
- "This first became a problem when . . ."
- "The relationship of this problem to my addiction is . . ."
- "I have tried to solve this problem in the past by . . ."

Goals of Group Questioning

- To establish rapport by active listening.
- To encourage group members to know and understand the member who is working on a problem.
- To convey the message, "You are listened to, understood, taken seriously, and affirmed as a person."

Types of Questions

- Open—Cannot be answered with a "yes" or "no."
- Focus—Forces a choice between limited options.
- Closed—Forces a "yes" or" no" answer.
- Leading—Forces consideration of a new point of view.

The "EIAG" Method.of Questioning

- **E**—EXPERIENCE: "What exactly did you experience and why is it a problem?"
- **I**—IDENTIFICATION: "Can you identify what the important parts, elements, or outcomes of the experience were for you?"
- **A**—ANALYZE: "Why was this experience important? What is its meaning or significance?
- **G**—GENERALIZE: "What did you learn from this experience and how will you apply what you learned to other experiences?"

Addiction-Focused Questions

- How did this problem or experience contribute to the development of your addiction?
- How did this problem or experience affect your willingness or ability to recognize or seek treatment for your addiction?
- How did this problem or experience affect your willingness or ability to stay sober or maintain your recovery program?
- How did this problem or experience set you up to relapse in the future?

Giving Feedback in Group

- "My gut level reaction to your problem or assignment is . . ."
- "I believe your problem is . . ."
- "How I feel about you as a person is . . ."

The Timing of Change

- No problem is ever solved in one group presentation.
- To solve a single problem requires three to six group presentations.
- Each problem will need to be broken down into pieces that can be worked on in 20- to 30-minute sessions.
- Limit each presentation to 20–30 minutes.
- Allow time for two to four patients to work in each group.

The Problem Solving Process

- Problem identification
- Problem clarification
- Identification of alternatives
- Projecting the consequences of each alternative (best, worst, most likely)
- Decision
- Action
- Followup

The Closure Exercise—Format (15 minutes)

- Write down the most important thing you learned in group today.
- Write down what you will do differently as a result of what you learned.
- Explain to the group the most important thing you learned in group and what you will do differently as a result.

The Closure Exercise—Purpose

- To ensure that each group member understands and integrates the group experience.
- To assist in documenting the group process.

Adjournment

- Ask group members to report if they are not going to be in the next group session.
- Confirm the day, date, and time of the next group.
- The group is officially ended.

The Debriefing Session—Format

- Patient review: Review the progress and problems of each patient.
- Outstanding group members: Think about and record which group members stood out the most in today's group and why.
- Outstanding events: Think about and record any outstanding positive or negative events in the group.
- Problems—Progress: Think about and record any problems or progress observed in the overall management of the group.
- Personal feelings and reactions: Think about and record any personal feelings and reactions about the group.

The Debriefing Session—Purpose

- To review patient progress and problems.
- To prevent counselor burnout.
- To train and develop the skills of the counselor team.
- Debriefing is critical to long-term group success.

Part III: Helping Patients With the Relapse Prevention Workbook for Chemically Dependent Criminal Offenders

General Instructions

Read the Appendix—Relapse Prevention Work book for Chemically Dependent Criminal Offenders.

If you are a recovering person, you may want to complete the workbook in order to get a better understanding of it. In general, the workbook is in a format that a patient should be able to complete on his or her own. However, a patient's ability to complete the workbook, fully benefit from it, and increase chance of recovery will be much higher if done in a group counseling

experience. A separate educational session with a counselor will also increase the patient's ability to recover.

When using the workbook in a group counseling session format, patients complete the exercises on their own, in between group sessions. Patients then present a summary of what they learned by doing the exercises in group sessions. The patients are questioned by the group to ensure that they really understand each exercise and have done it correctly. They receive feedback from the group and then complete the next exercise for the next group session.

If a patient has trouble understanding and completing an exercise, the counselor and the group can help. When assisting a patient in group, it is helpful to complete the assignment on a blackboard so other patients can participate and learn from the exercise.

In some cases it may be necessary for the counselor to help a patient with an exercise in an individual session. This is especially true for the Alcohol/Drug/Legal Calendar (Exercise No. 3) and the Life and Addiction History (Exercise No. 6). Memory problems can interfere with these exercises in some patients. An individual session can be helpful in ordering the recall of old memories.

It is important to have patients bring their workbooks to group, as well as a pad of paper for taking notes. Patients who have reading problems should be teamed with a patient who can read. It is also helpful for these patients to tape record the sessions.

The rest of this part of the book consists of an exercise-by-exercise explanation and instructions to help you assist the patient in using the exercises in an individual or group session.

Chapter 7—Self-Assessment

Alcohol and Drug Addiction Test

Purpose. The first section of the patient workbook has two self-tests. The first is the Alcohol and Drug Addiction Test. This test is to identify whether the patient has a problem with alcohol or drugs. It is necessary for the patient to recognize that he or she has a problem before the workbook can help him or her.

Instructions. The primary goal of this test is to get the patient to examine his or her symptoms of addiction and start to make a connection to his or her other legal problems. The patient should complete this test and report the results in group. The group leader should then ask the patient if he or she agrees with the results of the test. Ask the patient how he or she thinks this is related to his or her criminal problems and how he or she has tried to change things.

If the results of the test clearly show that the patient is addicted, but the patient denies it, the counselor should challenge the patient as to why he or she believes the test results are not true. The first three exercises can help the patient connect his or her use with the things that happen to him or her. If, at this point, the patient continues to deny that he or she has a problem with

alcohol or drugs, that patient is probably not appropriate for this group and should be referred to a group that deals with basic education about addiction.

If the patient does not show any signs of chemical abuse or addiction, he or she should be referred for non-addiction focused counseling.

Offender Personality Self-Test

Purpose. The second test is for the purpose of helping the offender to see how he or she is similar to other criminal offenders. By helping the offender to see the similarity between himself or herself and others in the group, the person will begin to believe that there is hope. The test will also help the patient to understand the relationship between the use of alcohol or drugs and criminal behavior.

Instructions. The primary goal is to get the patient to start looking at his or her history of criminal behavior and how it is connected to the use of alcohol or drugs. The patient should complete the test and report the results in group. The group leader should then ask the patient whether he or she agrees with the results, and what his or her thoughts and feelings are about the results. Ask the patient how he or she thinks these thoughts and feelings are related to his or her criminal problems and what he or she has tried to do to change things.

Exercise No. 1: Why Do I Want To Change?

Purpose. In this exercise, patients explore why they want to participate in treatment and how motivated they are. This is an opportunity for the group leader to help patients understand that if they are going to recover, they have to make a commitment to long-term change. Long-term change means more than just getting out of their current situation.

Instructions. The goal is to have the group have questions that clearly point out that the patient must have a commitment to long-term abstinence and to a recovery program to successfully stay free of chemical dependency and out of trouble. Have the patient share the contents of this exercise in group. Ask the group to ask the patient if he or she is serious about recovery. If the patient is just trying to get out of a current situation, ask the group to ask the patient what he or she has tried before to get free from different problems and how that has worked.

Exercise No. 2: Reasons for Relapse?

Purpose. The purpose of this exercise is to help patients determine where they are in the recovery process, and to help you as the counselor decide what a patient should focus on. Patients fall into one of four basic groups.

Transition Patients: These patients do not accept their disease. They believe they can still use alcohol or drugs and learn to control their use. Focus. Connect negative events with alcohol and drug use so that patients can recognize that they need to abstain and begin recovery.

Stabilization Patients: These patients are unable to remain in recovery. Every time they try to stay clean and sober, they get sick, feel crazy, can't think of anything except alcohol or drugs, and encounter many problems. Focus. Identify and learn to manage the thoughts and feelings that make patients return to using alcohol or drugs. Get the patient to ask, "What thoughts and feelings will cause me to use today?"

Early Recovery Patients: These patients cannot get comfortable in their recovery. When they quit, they don't know how to change the way they live so they can enjoy being sober. Focus. Identify and change the things in the patients' lives that interfere with their desire to stay in recovery. Most often, these are things associated with a using lifestyle (friends, family, neighborhood, etc.) that they don't want to give up.

Relapse Patients: These patients get sober and clean, use AA or NA, and enjoy sobriety. However, something happens to make them begin to use again. Focus. Identify what kind of problems make them unhappy with recovery.

Instructions. Have patients report the results of this exercise in their group. Have the group ask each patient what these results meanCwhat do they have to learn in order to recover? Encourage patients to keep their answers in mind as they do the next few exercises, which focus on their history.

Exercise No. 3: Alcohol/Drug/Legal Calendar

Purpose. The purpose of this exercise is for the patient to begin to get a clear picture of his or her history of drug or alcohol use and criminal behavior. The exercise paints this information in picture form on a calendar. Most patients (especially those in early recovery) do not have a clear understanding of their own history and how events or situations in their lives cause other things to happen.

Instructions. Ask patients to present their story (with a calendar) in group. If the patient is unable to do the exercise alone, help him or her in an individual counselor's session or help the patient do the exercise on a blackboard in group. When the calendar is on the blackboard, the patient can copy it into his or her workbook. Have the group ask patients what they learned from the exercise about their history that they previously did not realize.

Exercise No. 4: Relapse Episode List

Purpose. The purpose of this exercise is to help patients identify things they did and did not do in trying to abstain from alcohol or drug use. By beginning to identify the causes of relapse, patients begin to learn how to refocus their thinking on what they can do to change.

Instructions. Have each patient review the worksheets of this exercise in group. Ask the group to question what, if anything, changed after each relapse episode, what was similar each time, and if the patient can identify why attempts to stay clean and sober failed.

Exercise No. 5: Summary of Relapse History

Purpose. This exercise helps patients to start to identify patterns that repeat themselves during periods of abstinence. It also helps patients understand that there is a series of events that happen before they relapse. This understanding helps the patient start to see hope of stopping the pattern.

Instructions. Have the patient present the summary worksheet in group. Then ask the group to ask the patient whether there is any pattern that begins to show up, and whether he or she sees any ways the pattern could be changed.

Exercise No. 6: Life and Addiction History

Purpose. Patients use this exercise to begin to get a clear picture of their life. The goal is to identify how their criminal behavior and alcohol and drug use developed over time.

Instructions. Have the patient give a 10-minute talk summarizing his or her life. The talk should track the progress of both criminal behavior and alcohol or drug use in the patient's life. Then ask the group to question the patient about what he or she thinks the major life turning points were and why.

Exercise No. 7: Life History Summary

Purpose. This exercise helps patients point to their most important life events and see how they used alcohol and drugs to cope with them.

Instructions. Ask each patient to present the major events in his or her life and describe how alcohol or drugs were used to cope with them. Ask the group to question the patient on how alcohol or drugs helped or did not help the patient to cope.

Chapter 8—Warning Signs and Recovery Planning

This chapter lists the exercises that are needed to help patients identify and manage relapse warning signs and develop their own recovery plan.

Warning Sign Identification

Exercise No. 8: Alcohol and Drug Relapse Warning Signs

Purpose. The purpose of this exercise is to help patients identify their alcohol and drug relapse warning signs before they relapse.

Instructions. Because this is a long exercise, it is best to complete it in two or three separate sessions. Have the patients take turns reading the warning signs and their descriptions, as listed in the exercise, out loud in group. After each description, ask the patients to underline words that strike them and that they identify with. Then have the patients talk about any thoughts or feelings that they experienced during the reading.

Exercise No. 9: Offender Relapse Warning Signs

Purpose. This exercise is to help patients identify their offender relapse warning signs before they return to criminal behavior.

Instructions. Again, it is best to devote two or three sessions to this exercise. Have the patients take turns reading the warning signs and their descriptions out loud in group. After each description, ask the patients to underline words that strike them and that they identify with. Then have the patients talk about any thoughts or feelings that they experienced during the reading.

Exercise No. 10 (A and B): Initial Warning Sign List

Purpose. The purpose of this exercise is to help patients identify what is most important about their three major alcohol and drug warning signs and three major offender warning signs.

Instructions. Ask each patient to summarize for the group the warning signs they identified. Then ask the group members to question the patient about whether there is any relationship between the two sets of warning signs. Have the group ask the patient about what he or she became aware of during this exercise.

Exercise No. 11: Warning Sign Analysis

Purpose. The purpose of this exercise is to help patients recognize how each of the six warning signs looked at in the last exercise happens to them. This exercise also asks patients to look at how the signs might happen in the future. The occurrence of warning signs varies from patient to patient.

Instructions. If necessary, demonstrate how to complete one of these worksheets on the blackboard and ask the patient to complete the rest before the next group session. Ask the patient to review the warning sign analysis worksheets in group, allowing about three minutes for each warning sign. Ask the group members to question the patient about what similarities the patient saw between warning signs, how they were different, and what they learned from the exercise.

Exercise No. 12: Combined Warning Sign List

Purpose. This exercise combines the warning signs that were evident in the last exercise sheets. The patient will begin to see common warning signs that appear over and over again.

Instructions. It is not necessary for patients to review this exercise in group unless they are having trouble identifying similar warning signs from Exercise No. 11.

Exercise No. 13: First Ordered Warning Sign List

Purpose. Patients put the warning signs in the order that they happen.

Instructions. Patients go back to the combined warning sign list in Exercise No. 12 and put the signs in order. It is not necessary for patients to review this exercise in group unless they are having difficulties with the exercise.

Exercise No. 14: Final Warning Sign List

Purpose. Patients rewrite the First Ordered Warning Sign List, adding new warning signs in the order they belong. Tell patients that it is important to obtain a new and more complete list.

Instructions. Patients go back to the First Ordered Warning Sign List and add new warning signs in the order that they belong. It is not necessary for patients to review this exercise in group unless they need encouragement or are having difficulties with the exercise.

Exercise No. 15: Critical Warning Sign

Purpose. The purpose of this exercise is to help the patient identify which warning signs are the critical ones. Critical warning signs are ones that the patient would recognize when they are happening. These would happen early enough that the patient would be able to do something about them.

Instructions. Have the patient read the three critical warning signs to the group. Ask the group to question the patient about how the patient could recognize these warning signs when they happen, why they occur soon enough to do something about them, and what the patient could do to change the outcome.

Obsession. A thought (usually about alcohol or drugs) that a person has over and over again despite efforts to stop it.

Recovery. The process of rehabilitation that begins with abstaining from alcohol and drugs and continues with changing thoughts, feelings, and actions, which results in major lifestyle and value changes.

Relapse. A series of internal and external events after starting a recovery program that cause a person to collapse physically and/or mentally, return to using alcohol or drugs, or commit suicide.

Relapse justification. A particular thought that a person has to make it okay to return to using alcohol or drugs after starting a recovery program. Example. My life is so miserable anyway, I might as well use.

Warning Sign Management

Exercise No. 16: Warning Sign Management Strategy

Purpose. This exercise allows the patient to look at different ways of handling warning signs. This can help to prevent relapse.

Instructions. Ask the patient to read his or her list of warning sign management strategies to the group. Then have the group challenge the strategies by asking "what if" questions.

Exercise No. 17: Identifying High-Risk Situations

Purpose. This exercise helps the patient identify the kinds of high-risk situations that may trigger the warning sign on the final warning sign list.

Instructions. Ask the patient to review this exercise in group. Ask the group to question the patient about what the high-risk situations have in common, whether they are on the list of critical high-risk situations, and whether the situations are related to things that happened previously in the patient's life.

Exercise No. 18: Identification of Core Beliefs

Purpose. The purpose of this exercise is to help the patient identify the core or mistaken beliefs that cause the high-risk situation to trigger the warning signs.

Instructions. Have the patient summarize the worksheets in this exercise to the group. Then ask the patient to read aloud the sentence completion portion of the exercise (No. 3). Ask the group members to report any other core beliefs that the patient did not identify.

Exercise No. 19: Combined Mistaken Belief List

Purpose. This exercise helps the patients break down mistaken beliefs into specific mandates and injunctions that come up in their lives.

Instructions. Ask the patient to write his or her core beliefs, along with the mandate and injunction lists, on the blackboard. Ask the group to give the patient feedback about any mandates or injunctions that they see in the core belief list that are not already identified, and have the patient add them to the list.

Exercise No. 20: Challenging Mandates and Injunctions

Purpose. This exercise helps the patient to identify mandates and injunctions that they are using that are not true.

Instructions. Ask the patient to read the list of mandates and injunctions one at a time to the group. For each item, ask the patient's opinion as to why it is or is not true. Have the group give the patient feedback on why they believe the item is or is not true and if it is false, what is true instead.

Exercise No. 21: Challenging Mandates

Purpose. This exercise allows the patient to take the information about mandates obtained from the group and identify different ways to handle the mandates in the future.

Instructions. The patient should read the mandate, realize other ways that he or she can think instead, and state what he or she thinks the possible outcomes of thinking in these ways would be. The leader should encourage the group to question the patient on the probability of the outcomes. The patient should reevaluate any unrealistic expected outcomes.

Exercise No. 22: Challenging Injunctions

Purpose. This exercise allows the patient to take the information about injunctions obtained from the group and identify different ways to handle the injunctions in the future.

Instructions. The patient should read the injunction, realize other ways that he or she can think instead, and state what he or she thinks the possible outcomes of thinking in these ways would be. The group should be encouraged to question the patient on the probability of the outcomes. The patient should reevaluate any unrealistic expected outcomes.

Exercise No. 23: Improved Reactions to Mandates and Injunctions

Purpose. This exercise helps the patient find new ways to handle those mandates and injunctions that are true and create situations where the patient does not see alternative reactions.

Instructions. Have the patient read aloud in group the mandates and injunctions, the alternative behavior, and the possible outcomes of both scenarios. Ask the group members to question the likelihood of the patient being able to carry out the alternative, the reality of the outcomes of this plan. The group should then ask what skills the patient must gain and what tasks he she must complete in order to carry out this plan.

Exercise No. 24: Management of High-Risk Situations

Purpose. Exercise No. 24 helps the patients to pull together all the material that has been worked on so far. Critical high-risk situations that were identified in Exercise No. 17, part 5, are analyzed. The patient then describes different ways of handling the high-risk situations. The patient also lists mandates and injunctions that are associated with these high-risk situations.

Instructions. The patient makes four copies of the exercise to fill out, one for each of the four high-risk situations identified in Exercise No. 17, part 5. The group should give feedback to the patient on the accuracy of the situations and how feasible they think the patient's solutions to handling high-risk situations are. The group should also give feedback to the patient about the mandates and injunctions.

Recovery Planning

Exercise No. 25: Relapse Prevention Strategies

Purpose. The purpose of this exercise is to pull together a set of personal relapse prevention strategies for each personal high-risk situation identified. The patient develops one card for each high-risk situation. The patient will have four cards if he or she identified four high-risk situations, but some patients may want to develop more cards. The patient starts off each day reading the cards and also carries the cards around. This exercise builds on the situations identified in Exercise No. 24, as well as on insights gained in the group process.

Instructions. The patient makes four copies of the exercise to fill out, one for each worksheet completed in Exercise No. 24. The patient also transfers information from the exercise onto cards that are carried around with the patient. Patients may fill out more than four worksheets and four cards if they wish.

Exercise No. 26: Daily Recovery Plan

Purpose. In this exercise, the patient starts to fill out a daily recovery plan based on what he or she has learned. The purpose of this exercise is to put into action all of the information patients have learned from the previous exercises.

Instructions. Between group sessions, the patient should fill out a daily recovery plan for each day. He or she should review with the group what is working well as part of recovery, and what is not. The group should give feedback on the plan and suggestions to make it work better. (This exercise and Exercise No. 27 should be done simultaneously.)

Exercise No. 27: Evening Inventory Sheet

Purpose. This exercise has the patient fill out an evening inventory sheet reviewing what he or she has learned each day. The purpose of this is to put this information into action.

Instructions. The patient should fill out an evening inventory sheet for each day between group sessions. He or she should review with the group which strategies are working and which are not. The group should give feedback on the strategies and suggestions to make them work better.

Concluding Remarks

When a patient completes the workbook (see the appendix), a closure ceremony should be held as part of a regular group session. During the ceremony all the group members tell the patient how they felt when they first met him or her, how they feel now, and what they wish for him or her in the future. The patient then tells the group members the same. The patient should be encouraged to continue to attend AA or NA and a relapse prevention self-help group.

Each time you work with a patient as a counselor, you will learn more. Every patient after that will be helped by what you have learned. Working with recovering patients can be both frustrating and rewarding. The authors hope that you will grow in your desire and ability to help people recover. Every time you help a person in recovery, you help yourself in some way, too.

As you read these materials, it is hoped that you will see more ways that you can use them. After you become comfortable with the information and techniques, reach out and try new things with this material. Read whatever you can and apply it. Get input and supervision from professionals, if you can do it. You may decide because of your experience that this is something you want to do professionally. If so, look into further education in addiction and general counseling. Everything you learn will help you, and potentially others.

Definitions

There are a number of words that are used in this manual and in the accompanying patient workbook that you may not be familiar with or that have different meanings than you are used to. The following is a list of terms and definitions as they are used in this publication.

Abstain or Abstinence: To not use any mood-altering substance, including alcohol and drugs.

Addiction: A physical dependence on a drug (alcohol, drugs, nicotine, and caffeine) that is marked by an increased intake, continued use despite consequences, and in many cases, physical withdrawal when use of the drug is discontinued.

Alcoholics Anonymous: An organization of recovering alcoholics who work together to help themselves and others recover from alcoholism.

Awfulizing Sobriety: The belief that living without alcohol or drugs is worse than suffering the consequences of using.

Belief: An idea that a person has about himself or herself and the world, whether it is true or not.

Bio/Psycho/Social: Having to do with the biological or the body, the psychological or the mind, and the social or interactions among people.

Chemical dependency: The same as addiction.

Compulsion: An overwhelming urge to take a certain action despite possible bad consequences.

Core addictive issues: Problems resulting from the period of addictive use that cause problems in sobriety. These include the inability to separate from friends who use, and a lack of acceptance of the need to abstain.

Core psychological issues: Problems resulting from beliefs formed in childhood that continue even though they are no longer true. These beliefs cause a person to act in a self-defeating manner.

Counseling: The process of helping a person understand his or her patterns of thinking, feeling, and acting, and helping that person to make conscious choices to change.

Craving: A powerful physical desire that demands satisfaction.

Detoxification: The process of safely stopping all alcohol and drug use when a person is physically addicted. This may be done by using other drugs and/or by helping the person through social support.

Dysfunctional: Unable to function in a normal manner.

Euphoric recall: The memories of using alcohol and drugs that are associated with pleasant experiences, even if these happened a long time ago.

Feeling: 1. An emotion, such as anger, sadness, or frustration. 2. A body sensation, such as tenseness, stiff neck, or knotted stomach.

Injunction: A mistaken belief in the form of a negative statement to oneself. Injunctions are often not conscious. Example. I can't let myself cry or show my feelings because men don't cry.

Irrational thoughts: Thoughts that do not make sense to a healthy person.

Magical thinking: The belief that alcohol and drugs can help a person do something he or she cannot do without them.

Mandate: A mistaken belief in the form of a compelling statement to oneself. Mandates are often not conscious. Example. I must be in control at all times.

Mistaken belief: An incorrect belief learned in childhood or because of a particular situation that a person continues to believe even though it is not true. This causes the person to feel and act in a way that is inappropriate to the current situation.

Narcotics Anonymous: An organization of recovering drug addicts who work together to help themselves and others recover from addiction.

Obsession: A thought (usually about alcohol or drugs) that a person has over and over again despite efforts to stop it.

Recovery: The process of rehabilitation that begins with abstaining from alcohol and drugs and continues with changing thoughts, feelings, and actions, which results in major lifestyle and value changes.

Relapse: A series of internal and external events after starting a recovery program that cause a person to collapse physically and/or mentally, return to using alcohol or drugs, or commit suicide.

Relapse justification: A particular thought that a person has to make it okay to return to using alcohol or drugs after starting a recovery program. Example. My life is so miserable anyway, I might as well use.

Relapse prevention: The counseling process that helps a person to identify and change thoughts, feelings, and actions that lead him or her back to active chemical dependency.

Relapse warning signs: A series of thoughts, feelings, and actions triggered by a situation or condition that lead from stable recovery back to alcohol or drug use.

Self-defeating behavior: A behavior that a person uses that causes him or her to be worse off than before. Even though the person doesn't like the result, he or she continues the behavior.

Thought: 1. A talk that a person has with himself or herself. 2. A picture or visualization that forms in a person's mind.

Unmanageable feeling: A feeling that a person does not want to have or pretends not to have until the feeling causes a negative reaction.

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Appendix of TAP 19: Counselor's Manual for Relapse Prevention With Chemically Dependent Criminal Offenders

Relapse Prevention Workbook for Chemically Dependent Criminal Offenders

Introduction

If you are reading this workbook, you probably have had trouble with alcohol or drugs and have gotten into trouble with the law. Many people who have trouble with alcohol and drugs don't believe it is a problem for them. You may not believe it is a problem for you.

The purpose of this workbook is to find out if you have a problem with alcohol or drugs and how this connects with your problems with the law. If you can understand how the two are connected, you may be able to prevent problems from happening again.

Problems with the law usually occur for one or both of the following reasons.

- The way you think gets you into trouble
- You have an alcohol or drug problem that gets you in trouble.

Some people know they have an alcohol or drug problem. They want to stop using, but they haven't been able to. These people are called chemically dependent. This workbook is designed to help you if you have a problem with alcohol or drugs and the law, whether or not you believe you are chemically dependent.

One thing you probably want to do is to resolve your problems with the law. In order for that to happen, you must be willing to do several things.

- *Consider that you might have a problem with alcohol and/or drugs.* If alcohol and drugs get you into trouble with the law, your family, or your job, it is likely that you are chemically dependent. If this is true, the only way you can resolve these problems is to stop using alcohol and drugs. This may not be easy, but you can do it if you will accept help.
- *Consider that your thinking might be wrong on some issues.* If your thinking is wrong, it can cause you to act in ways that get you into trouble. It can cause you to feel like you don't fit in, prevent you from getting what you want out of life, and cause you to not get along with other people. When this happens, the only way you know how to feel good is to try to fool or "con" other people.
- *Decide that you can change your life.* No matter how much people try to help you, you must be willing to believe that you can make your life better if you do certain things. You must be willing to look honestly at your life and want to change. If you are willing to do this, you can make your life different. This workbook can help you.

Section I: What Are My Problems?

The first section of this workbook has two self-tests. If you are honest when you answer the questions, you will find out

- *If you are chemically dependent (can't stop using alcohol and drugs without help)*. By finding out whether you are chemically dependent, you can make decisions that will change your future.
- *If your personality is like that of other offenders*. You will see evidence of these similarities in your life. Your personality is made up of the way you think, feel, and act. These questions will help you to decide if you want to change your personality.

Understanding your problems is important in getting where you want to go. It is all right if you don't like what you find, but if you want to change, you must accept that you have problems.

To get where you want to go, you have to be honest about where you are. It is like the man who called somebody to ask directions to get to his house. He didn't want to tell the person where he was at the time because he didn't want him to know, so he told him he was somewhere else. Of course, the directions he received were useless to him.

Section II: How Did I Get Here?

The second section of this workbook will help you understand how you have gotten into trouble in the past. By understanding your past thoughts, feelings, and actions, you can understand what will happen in the future unless you change. This section will show you what you have to change.

This section will also help you to understand your thinking, feeling, and ways of acting that caused you to use alcohol or drugs or break the law. It will help you understand how one thing leads to the other.

Sections III, IV, and V: How To Change

The final three sections of this workbook teach you how to change your thoughts, feelings, and ways of acting that have gotten you into trouble in the past. They will show you how to make a plan that you can use on a daily basis to change your life for the better.

This workbook alone will not change your life. You must also use other forms of help. You can change your life for the better if you are willing to do several things.

- *Not Use Alcohol or Drugs*. The first thing you must do is be willing to stop using alcohol and drugs. Recovery from chemical dependency must begin with abstinence. There is help available to do this.
- *Attend Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) Meetings*. The best place to find out how to recover is somewhere you can be with people who have been in

the same situation as you. You should attend as many meetings as possible. The more you talk with recovering people, the more you can learn from them.

When you go to meetings, listen to what people say. Ask yourself, "How am I like these people?" "How did they change?" "What things did they do that I can try?" Ask someone to be your sponsor. A sponsor is a person whom you respect who has been sober for quite a while. This is someone you can talk to on a one-on-one basis. He or she can help you by listening and sharing his or her own experiences.

When you speak at these meetings, be as honest as you can. You will get more help if you tell people how you really think and feel than if you try to impress them. Read as many of the AA or NA books as possible. The more you read about recovery, the more your thinking will change. When your thinking changes, you will start to feel and act differently.

- *Get Counseling*. Go to one-on-one counseling sessions at least once a week, and more often if you can. Counseling will help you work on issues that may cause problems in recovery.
- *Read This Workbook*. By reading and doing the exercises in this workbook, you will have a better chance of recovery and less chance of relapse. Follow the instructions very carefully. Sometimes it will seem as if you are doing the same thing over and over again. This repetition forces you to see certain things again and again so you will remember them. Many times the instructions will have you copy answers from previous exercises. This is to help you understand how all of the exercises and all the things in the exercises and in your life work together.

Sometimes you won't understand why you are doing a certain thing. The reason will become clearer as you move on. Sometimes you may get angry and frustrated. Sometimes you will want to quit. This is normal. Quit for a while, but then try again later. People who do not quit are more likely to recover.

Try to work in the workbook for 1 or 2 hours, once or twice a day. There is plenty of space available for each answer. You do not have to fill in every line for every question.

If you have trouble reading this workbook or understanding it, ask for help. It may not be easy, but learning how to ask for help is one of the things you must do to recover.

Most of all, you must put your work into action. It is only by working on changing that we will change and our lives will get better. It can happen to you if you try.

We know of a man who spent over half of his life in reform schools and prisons. He finished high school in prison but had no further education. He began attending AA in prison, and got out of prison at age 35. He worked very hard at his recovery. Today, he has two college degrees, is married and has a family, and works as a counselor with inmates. He has been sober for over 10 years.

You can change your life too. But, you must understand that it will take time and hard work.

The "Big Book" is the "school book" of AA that shows you how to recover. It uses the letters H-O-W to explain how to recover. This workbook will work for you in the same way.

Honesty—This means being totally honest about how you think, feel, and act. Unless you are willing to be honest, you cannot make progress.

Open-mindedness—You must be willing to think that you may be wrong about some things. Unless you can do this, you cannot change. If you do not change, the same things will keep happening to you.

Willingness—You must be willing to try difficult things that you do not like and that sometimes hurt at first. The easiest thing for you to do is what you have always done. The hardest thing to do is change. But you can do it if you work on changing day by day. If you change a little each day, in the end you will be a different person.

Section I: What Are My Problems?

This first section contains two tests. (1) the Alcohol and Drug Addiction Test and (2) the Offender Personality Self-Test. Completing each test will help you to understand yourself better and begin to change.

Alcohol and Drug Addiction Test

Purpose. This test describes things that happen to people who are addicted to alcohol or drugs. By taking this test, you will be able to determine if you are addicted and, if so, how serious your addiction is. To be addicted means that you cannot stop using alcohol or drugs without help. This test was adopted from the Jellinek Chart for Addiction. The following problems do not happen to people who are not addicted.

Instructions. Read each question and think back over your life. If this has ever happened to you, make a check mark in the left column (*yes*). If this has never happened to you, make a check mark in the right column (*no*). When you are finished, see the scoring sheet at the end of the test.

Yes	No	
____	____	1. *Use to feel better:* I use alcohol or drugs to get away from things that bother me or are hard to face.
____	____	2. *Use to solve most problems*: I use alcohol or drugs to try to solve most of my problems and things that bother me.
____	____	3. *It takes more*: It takes more or stronger kinds of alcohol or drugs to get the same feelings than it used to.
____	____	4. *Memory loss*: Sometimes after I have been using, I do not

remember what happened.

5. *Sneaking*: Sometimes I hide from other people how much I'm using or drinking. This might be because I do not want people to know or because I do not want to share.

6. *Dependence*: I rarely do anything for fun unless I use alcohol or drugs.

7. *Fast start*: I use stronger alcohol or drugs or use a lot quickly at first to get a "good start."

8. *Feel guilty*: I feel guilty about using alcohol or drugs or about the things that I do when I use.

9. *Do not listen*: Other people complain or try to talk to me about my using but I do not listen.

10. *Regular blackouts*: I do not remember what happened and I get into trouble when I use alcohol or drugs.

11. *Excuses*: I use problems in my life as an excuse for using alcohol or drugs. I feel that I have to use to deal with these problems.

12. *Using more than others*: I use more than most people, so I hang around people who use as much or more so that I feel that I fit in.

13. *Feel bad*: I feel bad about how my using hurts other people, but I don't know what to do about it.

14. *Show off*: I show off or get pushy with other people to feel better and prove that I am okay.

15. *Promises*: I promise to get my life in order and do better. I mean it, but it doesn't work out that way.

16. *Control*: I try to control my use, but it doesn't work.

17. *Give up other things*: I've stopped doing things that I used to do that didn't involve using alcohol or drugs.

____ ____ 18. *Make changes*: I change jobs, move, or leave a relationship to try to make my life better, but it doesn't make any difference.

____ ____ 19. *Work and money troubles*: I have problems on the job, owe money or can't work at all because of my using.

____ ____ 20. *Avoid friends and family*: I avoid old friends and family that do not use—unless I need something from them.

____ ____ 21. *Neglect food*: I do not eat healthy foods or eat at regular times, especially when I'm using.

____ ____ 22. *Resentment*: I feel like other people are out to get me, and I feel angry a lot.

____ ____ 23. *Withdrawal*: I need a drink or a drug in the morning or else I get the shakes or sweats because I feel terrible.

____ ____ 24. *Can't make decisions*: I can't make decisions about even small things. I just wait until things happen.

____ ____ 25. *Health problems*: I am sick, have lost a lot of weight, or feel physically bad most of the time.

____ ____ 26. *Decrease in amount to get high*: It takes less for me to get high or doesn't matter how much I use because I can't get the effect I want.

____ ____ 27. *Over the line*: I do things I said I would never do or things that do not reflect the way I was raised.

____ ____ 28. *Use all the time*: I use whenever I can, and I don't try to have a normal life.

____ ____ 29. *Find someone worse*: I try to use with people who are worse off than I am so that I feel better.

____ ____ 30. *Major damage*: Even when I'm not using, I have a hard time thinking, remembering,and doing things that used to be easy.

____ ____ 31. *Afraid*: I feel like something terrible might happen to me, people are out to get me, and I have to be on guard at all times.

____ ____ 32. *Give up*: I don't try to change anything. I just wait to see what happens.

____ ____ 33. *Using is everything*: Getting something to use, using, and getting over using are my whole life.

____ ____ 34. *Turn to God*: I want God or religion to save me from my life.

____ ____ 35. *I'm lost*: I don't try to pretend my life is normal. I know I am an addict or an alcoholic. I believe that things will never change.

____ ____ 36. *Desperation*: I am willing to do anything to get better.

____ ____ 37. *Confinement*: I have been in jails and mental wards because of my using.

Part of the Relapse Prevention Workbook for Chemically Dependent Criminal Offenders

Scoring Sheet for Alcohol and Drug Addiction Test

Early Stage Addiction

Count up the number of *yes* answers you checked in questions 1–12 and write the number below.

Number of checks for questions 1–12 _____

If you have one or more checks in this section, there is a possibility that you are addicted to alcohol or drugs. This means that you use alcohol or drugs to try to solve problems and to make yourself feel better. While using alcohol or drugs will not really make things better, it will feel like it does. If you have any checks in this section, you have a possibility of becoming addicted if you keep using. The closer your score is to 12, the higher your chance of addiction.

Middle Stage Addiction

Count up the number of *yes* answers you checked in questions 13–24 and write the number below.

Number of checks for questions 13–24 ____

Any number of checks in this section means that you are addicted and have started to have bad things happen to you because of your addiction. During this stage, you may try to do things to

control your addiction. Some of these may work for a while, but not for long. For questions 13–24, the closer your score is to 12, the more addicted you are, and the worse things will get if you do not get help.

Late Stage Addiction

Count up the number of *yes* answers you checked in questions 25–37 and write the number below.

Number of checks for questions 25–37 ____

Any number of checks in this section means that you are in the late stage of addiction. During this stage, you may have given up and thought that you could not do anything to change. Serious life problems, such as being sick, or going to jail or a mental ward, have happened or will happen to you if you do not try to get help. For questions 25–37, the closer your score is to 13, the more addicted you are. Your chances of dying are high if you continue to use.

Reactions: Complete the sentences below and think about what they mean for your recovery.

1. How do you feel about the results of the test you just took?

   _____

   _____

2. What do you think about the results of the test you just took?

   _____

   _____

3. What do you want to do about the results of the test you just took?

   _____

   _____

It is normal to feel angry or upset about the results of this test. Some people think, "This doesn't mean anything," and try to ignore the results. This is called *denial*. Alcoholics and addicts usually deny that they are dependent on alcohol or drugs because they can't think about how to live without drinking or using. You can give up here and repeat the past, or you can decide to change.

Complete the following sentences.

If I do not stop using, I will probably

If I do stop using, I might be able to

Offender Personality Self-Test

Purpose. This test is to determine whether you are similar to other people who commit crimes. People who commit crimes behave in certain ways. These behaviors show how these people have learned to think. Although you may not like to think of yourself as having an offender personality, it is important for you to find out if you do. The problems that your thinking and behaviors cause with the law can help you see that you need to change. (Adapted from DSMIIIR criteria.)

Instructions. Read the following descriptions and check the left column (*yes*) if this has happened to you or if you have done this and the right column (*no*) if this has not happened to you or you have not done this. Read the scoring instructions at the end of this test to find your results.

Part 1: Before Age 15

Yes	No	
____	____	1. *Skipped school*: I often skipped school because I didn't want to be there or because I wanted to do other things.
____	____	2. *Ran away*: I ran away from home or from where I lived at least two times, overnight.
____	____	3. *Fights*: I started physical fights with others more than once.
____	____	4. *Weapons*: I used a gun, knife, club, chain, or other weapon in more than one fight.
____	____	5. *Sex*: I forced someone into sex or sexual activity.
____	____	6. *Cruelty to animals*: Sometimes I was cruel to or hurt animals.
____	____	7. *Cruelty to people*: I physically hurt other people sometimes.

____	____	8. *Property damage*: I destroyed or damaged other people's property on purpose.
____	____	9. *Fires*: I set fires on purpose.
____	____	10. *Lying*: I often lied to other people.
____	____	11. *Theft*: I took things that didn't belong to me, forged checks, or broke into places to steal more than once.
____	____	12. *Robbery*: I forced people to give me things that belonged to them.
____	____	Total in each column for questions 1–12.

Scoring: Add up the check marks in the *yes* column for questions 1–12 and put the number in the space above. Do the same for the *no* column. If you have three or more *yes* answers, you act and think similarly to people who commit crimes. This behavior usually starts very early in life. This means you will have to work hard to change the way you think and act.

Part 2: Since Age 15

Yes	No	
____	____	13. *Work problems*: I haven't worked when work was available, have skipped work or classes because I wanted to, or have quit several jobs or schools without any plans for the future.
____	____	14. *Illegal activities*: I have committed crimes or done illegal things that I could have been arrested for.
____	____	15. *Using violence*: I have had many physical fights or have beaten up my spouse, lover, or children.
____	____	16. *Avoid money responsibilities*: I have failed to pay bills or child support, or I have failed to take care of my family.
____	____	17. *Moving around*: I have moved without having a job, drifted from place to place, or have lived without a home for more than a month at a time.
____	____	18. *Conning*: I have lied, used false names, or conned people to get what I want.
____	____	19. *Reckless*: I have driven a car recklessly while using or drinking or

have acted in ways that caused danger to others.

____ ____ 20. *Parenting*: I have failed to take care of my children by leaving them alone, not feeding them, or depending on others to take care of them for me.

____ ____ 21. *Relationships*: I have never been able to stay faithful to a sexual partner for more than 1 year.

____ ____ 22. *Remorse*: I do not feel bad most of the time when I steal from, hurt, or treat someone else badly.

____ ____ Total in column for questions 13–22.

Scoring: Add up the check marks in the *yes* column for questions 13–22 and put the number in the space above. Do the same for the *no* column. If you have four or more *yes* answers, it means you act and think similarly to other people who commit crimes. If you did not have three or more *yes* answers on the section before age 15, it may mean that your offender behavior is completely connected to your alcohol and drug use. One way to make sure is to review your *yes* answers on questions 13–22 and ask yourself if these things always happened when you were trying to get alcohol or drugs, using alcohol or drugs, or because you had been using alcohol or drugs recently. If alcohol and drugs were not part of why you did these things, ask yourself what happened or changed in your life that made you start doing them.

Reactions: Complete the sentences below and think about what they mean in your recovery.

1. How do you feel about the results of the test you just took?

2. What do you think about the results of the test you just took?

3. What do you want to do about the results of the test you just took?

It is normal to feel angry or upset about the results of this test. Some people think, "This doesn't mean anything," and try to ignore the results. Part of what causes people to continue to get into trouble with the law is that they ignore things that they do not want to hear. This is called *denial*. You can quit here and repeat the past, or you can decide to change by continuing to work in this workbook. In order to change, you must accept who you are now.

Complete the following sentences.

If I do not change the way I think, I will probably

_____

_____

_____

If I do change the way I think, I might be able to

_____

_____

_____

The Offender Personality Self-Test and the Alcohol and Drug Addiction Test will help you understand what you must change as you complete this workbook. You will need to change in order to avoid having problems with the law. The remainder of this workbook will show you how to do this.

Section II: How Did I Get Here?

In this second section, you will find out how your problems have changed your life. You will find that you have had the same things happen over and over again. You will find out why and begin to understand how you can change this. It is important to be as honest as you can on these exercises. This is the only way you can find out what you need to change.

Exercise No. 1: Why Do I Want To Change?

Purpose. In this exercise, you will look at why you want to change. It is important to ask yourself this question. If you only want to escape the problems that you are facing right now, this workbook will not help you. If you want to change your life, it will.

Instructions. Complete the following sentences.

1. The reason I decided to try to get sober and clean this time is . . . (Tell what happened that made you seek help, such as job, health, or legal problems.)

   _____

2. Unless I really want to give up alcohol and drugs, I will not get better. Things might get better for a short time, but this will not last. I want to change because . . .

Exercise No. 2: Reasons for Relapse

Purpose. This exercise will show you why you have trouble with recovery. By knowing this, you will know more about what you need to change.

When someone is having trouble staying sober and clean, it is because that person is having trouble with one of four major areas of recovery:

1. *Acceptance of their disease*: People who are having trouble accepting their disease believe they can still use alcohol or drugs and learn to control their use.
2. *Unable to stabilize*: Every time they try to stop using, they become sick, feel crazy, or cannot think about anything except drugs or alcohol. Therefore, they use alcohol or drugs to feel better.
3. *Cannot get comfortable being sober*: When they stop using, they do not know how to change the way they live so they can enjoy sobriety.
4. *Relapse*: They get sober and clean, they attend AA or NA meetings and enjoy sobriety, but then something happens, and they become unhappy and start to use again.

Instructions. Answer the following questions.

True	False	
____	____	1. I believe that I can learn to drink or use drugs and control my use so that it will not hurt me.
____	____	2. I know that I should not use alcohol or drugs at all, but every time I try to quit, I get sick and feel crazy, so I use alcohol or drugs to feel better.
____	____	3. I know I cannot use alcohol or drugs, but when I quit for a while, I always end up using again.
____	____	4. I know I cannot use alcohol or drugs, and I attend AA or NA and do everything I can to stay sober and clean. Sometimes I get very happy in recovery, but I still end up using again.

Notice if your above answers change as you complete the next exercise.

Exercise No. 3: Alcohol/Drug/Legal Calendar

Purpose. This exercise will help you to examine your past and how things have gone for you. By doing this exercise, you will begin to understand how your alcohol or drug use and legal problems are related.

Instructions. Write a history of your problems with the law, alcohol, and drugs. Include all the times you went to jail, were arrested, and went into treatment, the times when you were clean and sober, and the times you relapsed. Complete a month-by-month calendar of your alcohol/drug/legal activities. (A sample calendar appears in the hard copy of this TAP.)

Do this by writing in the year you first got into trouble with the law or began to use alcohol and drugs on a regular basis. Make a wavy line through the middle of each month that you used alcohol and/or drugs. Write the name of the drug you usually used during that time under the line. Draw a straight line where you weren't using any alcohol or drugs. Write in the name of any treatment centers or jails you were in under either line and put a line up and down to show the beginning and the end of that time. Above the line for each period you weren't using, write a word that reminds you of that time. Do the same for any period you were using. Write in parentheses the things you used to help you abstain from alcohol/drugs. Write this information in each line for every year up to and including the present. Make additional copies of the calendar if necessary.

Exercise No. 4: Relapse Episode List

Purpose. This exercise will help you notice what happened when you tried not to use alcohol and drugs. By understanding what happened during these times, you can see what to change.

Instructions. Make three copies of this exercise. Go back to Exercise No. 3 and fill out one of the worksheets for each of the last three times you tried to stay clean and sober.

Attempt no. _____

1. I stopped using on _____(month and year).
2. I stayed completely clean and sober for _____ (days, weeks, months, and/or years).
3. When I stopped using alcohol/drugs, I used the following help:

A. AA/NA. Meetings per week ._____
B. Sponsor. I talked to my sponsor _____ times (fill in number of times per week).
C. Worked on steps: 1 2 3 4 5 6 7 8 9 10 11 12 none
D. Detox. Number of days _____.
E. Outpatient counseling. Number of times per month _____.
F. Inpatient program. Length of inpatient time _____.
G. Prescribed medications _____

4. How did you feel during this time? (check one)

. I never felt good or calm.

A. I felt good once in a while, but it didn't last.
B. I felt good most of the time, but sometimes I felt awful.
C. I always felt good and thought I could do well.

5. I had problems during this period of not using.

I had the following problems with people. Example: *I fought with my wife.*

. _____
A. _____
B. _____
C. _____

I had the following problems with situations. Example: *I lived in a place where there were drug dealers.*

D. _____
E. _____
F. _____
G. _____

I had the following problems with thoughts and feelings. Example: *I was angry and couldn't seem to think about anything but using alcohol or drugs.*

H. _____
I. _____
J. _____
K. _____

I had the following problems with pain and sickness. Example: *My back hurt and I was tired all the time.*

L. _____
M. _____
N. _____
O. _____

6. I started to use again when:

. I started to think

_____

A. I started to feel

_____

B. I wanted to

_____

7. The first drug I used was (include alcohol):

   Then I used

   _____

   Then I used

   _____

8. I used for _____ (days, weeks, months, and/or years) before stopping again.

Exercise No. 5: Summary of Relapse History

Purpose. In this exercise, you will see if the same reasons caused you to return to using alcohol or drugs.

Instructions. Reread the Alcohol/Drug/Legal Calendar (Exercise No. 3) and the worksheets from Exercise No. 4 and answer the questions below. Remember that you do not have to fill in every line.

1. I first attempted recovery in _____ (fill in month and year).
2. Since that time, I have tried to quit using _____ times.

3. The longest I have been able to be completely free of alcohol and drugs (including methadone) was _____ (days, months, or years).
4. The problems that appeared more than once before I started using alcohol or drugs again are:
    A. Problems with people:
        1. _____
        2. _____
        3. _____
        4. _____
    B. Problems with situations:
        1. _____
        2. _____
        3. _____
        4. _____
    C. Problems with thoughts and feelings:
        1. _____
        2. _____
        3. _____
        4. _____

    D. Problems with pain and sickness:

        5. _____
        6. _____
        7. _____
        8. _____
5. These problems usually happen in the following order:
    A. _____
    B. _____
    C. _____
    D. _____
    E. _____
    F. _____
    G. _____
    H. _____
    I. _____
    J. _____
6. I started to use alcohol or drugs again when:
    A. I started to think

    _____

    B. I started to feel

    _____

C. I wanted to

7. The first drug I used was (include alcohol): _____

   Then I used

   Then I used

Exercise No. 6: Life and Addiction History

Purpose. It is important to understand your life, how it has caused your addiction to progress, and how it has helped or hindered your recovery. This exercise will help you do this.

Instructions. For each period in your life, answer the list of questions. Take your time and try to remember as much as possible. You may skip periods that do not apply to your life (for example, if you did not go to high school or college).

1. *Childhood before you started school*: Describe what happened to you in your childhood and how it causes problems now when you try to recover.

   Use during this time: Do you remember using alcohol or drugs during this time? Tell what you recall about your use of alcohol or drugs and the use of other people around you.

   A. What and how much were you using? What and how much were your family members using?

   B. How often were you using? How often were other family members using?

C. What did alcohol or drugs help you or other family members do that could not be done without using?

D. What thoughts, feelings, or situations/problems did using help you or other family members to avoid?

E. What happened to you or other family members as a result of using?

F. How did people around you act when they used? Was there violence? Was there divorce, money worries, or other problems?

G. What crimes did you or other family members commit, or what trouble did you or they get into?

2. *Grades K–6*: Describe what happened to you in grade school and how you find that causes problems when you try to recover.

   Use during grade school: Describe your alcohol and drug use or that of a family member during grade school. Do you remember using alcohol or drugs during this period?

   A. What and how much were you or your family members using?

B. How often were you using? How often were other family members using?

C. What did alcohol or drugs help you or your family members do that could not be done without using?

D. What thoughts, feelings, problems or situations did the alcohol or drugs help you or other family members avoid?

E. What happened to you or your family because of your use or their use?

F. How did people around you act when they used? Was there violence? Was there divorce, money worries, or other problems?

G. What crimes did you or other family members commit, or what trouble did you or they get into?

3. *Junior high and high school*: Describe what happened to you in junior high school and high school and how that causes problems when you try to recover.

   Use during junior high and high school: Describe your alcohol and drug use and that of family members during junior high and high school. Do you remember using alcohol or drugs during this period?

A. What and how much were you and other family members using?

B. How often were you using it? How often were other family members using?

C. What did alcohol or drugs help you or other family members do that could not be done without using?

D. What thoughts, feelings, problems, or situations did alcohol or drugs help you or your family members to avoid?

E. What happened to you or other family members because of using?

F. How did people around you act when they used? Was there violence? Was there divorce, money worries, or other problems?

G. What crimes did you or other family members commit, or what trouble did you or they get into?

4. *College*: Describe what happened to you in college and how that causes problems when you try to recover.

   Use During College: Describe your alcohol and drug use in college.

   A. What and how much were you using?

   B. How often were you using?

   C. What did alcohol or drugs help you do that you couldn't do without using?

   D. What thoughts, feelings, problems, or situations did alcohol or drugs help you to avoid?

   E. What happened to you because of using?

   F. What crimes did you commit, or what trouble did you get into?

5. *Military*: Describe what happened to you in the military and how that causes problems when you try to recover.

   Use During Military: Describe your alcohol and drug use in the military.

A. What and how much were you using?

B. How often were you using?

C. What did alcohol or drugs help you do that you couldn't do without using?

D. What thoughts, feelings, problems, or situations did alcohol or drugs help you to avoid?

E. What happened to you because of using?

F. What crimes did you commit, or what trouble did you get into?

6. *Adult work*: Describe what happened to you in your adult work history and how that causes problems when you try to recover.

   Impact of using upon work: Describe your alcohol and drug use in the jobs you've had.

   A. What and how much were you using?

B. How often were you using?

C. What did alcohol or drugs help you do that you couldn't do without using?

D. What thoughts, feelings, problems, or situations did alcohol or drugs help you to avoid?

E. What happened to you because of using?

F. What crimes did you commit, or what trouble did you get into?

7. *Adult family/intimate relationships*: Describe your adult family/intimate relationship history and how this causes problems when you try to recover.

   Impact of using upon family/intimate life: Describe the impact your alcohol and drug use had on your family life and intimate relationships.

   A. What and how much were you using?

   B. How often were you using?

C. What did alcohol or drugs help you do that you couldn't do without using?

D. What thoughts, feelings, problems, or situations did alcohol or drugs help you to avoid?

E. What happened to you because of using?

F. What crimes did you commit, or what trouble did you get into?

8. *Adult social/friendship*: Describe your adult social/friendship history and how that causes problems when you try to recover.

   Impact of addiction on social life and friendships: Describe the impact your alcohol and drug use has had on your social life and friendships.

   A. What and how much were you using?

   B. How often were you using?

C. What did alcohol or drugs help you do that you couldn't do without using?

D. What thoughts, feelings, problems, or situations did alcohol or drugs help you to avoid?

E. What happened to you because of using?

F. What crimes did you commit, or what trouble did you get into?

Instructions: Read the history you just completed. Think about what you wrote, and complete the following statements.

9. The things that I used to believe alcohol or drugs would help me do or become in my life are . . .

10. The thoughts, feelings, problems, and situations I used to believe that alcohol or drugs could help me cope with are . . .

Exercise No. 7: Life History Summary

Purpose. To understand your drug or alcohol use, it is helpful to review the main points in your life. Main points are things that have happened to you, decisions you have made, or things you did that have a strong impact on where you are today.

Instructions. Review the previous exercise and use the form below to list the main points in your history.

Life Event History	Alcohol/Drug Use and Crime History
1. Childhood Before School	
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2. Grade School	
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3. Junior High and High School	

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4. College	
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5. Military	
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6. Adult Work	
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7. Adult Family/Intimate Relationships	

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8. Adult Social and Friendship	
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.	.

9. The three main things I used to believe alcohol or drugs would help me do or become in my life are . . .
    A. _____
    B. _____
    C. _____
10. The three main thoughts about myself and others that I have used alcohol or drugs to cope with are . . .
    A. _____
    B. _____
    C. _____
11. The three main feelings I used alcohol or drugs to help me cope with are . . .
    A. _____
    B. _____
    C. _____
12. The three main problems or situations I used alcohol or drugs to help me cope with are . . .
    A. _____
    B. _____
    C. _____

Section III: How Do These Warning Signs Happen to Me?

In this section you will learn how the warning signs combine to cause you to relapse into criminal behavior and alcohol and drug use.

Exercise No. 8: Alcohol and Drug Relapse Warning Signs

Purpose. There are many ways you can tell that you may relapse—that is, start using drugs or alcohol again. This section will help you examine thoughts, feelings, and behaviors you have before you relapse.

Instructions. Read the following lists of relapse warning signs. Place a check mark next to any that have happened to you. Place a question mark next to any that you do not understand. Underline any words that cause you to have strong thoughts or feelings, or make you want to do something.

Phase I: Internal Warning Signs

___ 1. *Trouble thinking clearly*: Sometimes I cannot understand what is going on. At times, it is hard to think, or I can only think about the same thing over and over. At times I cannot think at all, or when I do, I make mistakes that I usually would not make

.___ 2. *Trouble managing feelings and emotions*: Sometimes I have mood swings. I go from feeling excited to feeling depressed within a matter of minutes. Sometimes I do not feel anything when I know I should. At times the way I feel does not match up with anything that is happening. At times I feel or act crazy and feel bad later. When these things happen, I try to forget about them.

___ 3. *Trouble remembering things*: At times, I forget things I have just learned. Sometimes I can remember things from the past and other times I can't, no matter how hard I try. Sometimes when I can't remember, I make mistakes that I feel bad about later.

___ 4. *Trouble managing stress*: Sometimes I do not know when I am tense until I become really uptight. When I try to relax, it gets worse. Sometimes it gets so bad that I am afraid I might collapse or go crazy.

___ 5. *Trouble sleeping*: At times, I cannot sleep at night. When I do, I still feel tired the next day. Sometimes I have strange dreams and nightmares, including dreams about using that seem real. Sometimes I get very tired and sleep much longer than usual.

___ 6. *Trouble with physical coordination*: Sometimes I stagger, have dizzy spells, stumble, or have accidents. At times reading and writing become more difficult.

___ 7. *Feelings of shame, guilt, and hopelessness*: At times I feel guilty and ashamed. I think something is wrong with me and I am afraid I won't get better. When these things happen, I try to take care of them on my own. I do not tell anyone. No matter how hard I try, things seem to get worse and I begin to think it is hopeless to try.

Phase II: Return of Denial

___ 8. *Concern about well-being*: Sometimes I worry about my recovery. This worry comes and goes and doesn't seem to last very long.

___ 9. *Denial of the concern*: In order to deal with these worries, I try not to think about them. Soon I forget what I was worried about. Sometimes even when I try to remember, I can't.

Phase III: Avoidance and Defensive Behavior

___ 10. *Believing "I'll never use again"*: Sometimes I believe I will never use alcohol or drugs again. Sometimes I tell others, but most of the time I keep this to myself. When I start believing this, I do not feel I have to work as hard to stay clean and sober.

___ 11. *Thinking about others instead of myself*: When I stop working as hard to stay sober and clean, I find myself blaming other people for my problems. Sometimes I think others should be acting differently, and I criticize them to others or to myself.

___ 12. *Defensiveness*: When I start thinking this way, I feel as if others do not like what I am doing. I get angry when people try to talk to me and I avoid them. I do not let other people talk, or I do not talk so they won't find out how I feel.

___ 13. *Compulsive behaviors*: I overdo things and get wrapped up in things so I do not have time to think. I may get overinvolved with work, sex, food, exercise, or AA, just so I do not have to think about or feel my problems. This doesn't make my problems go away.

___ 14. *Impulsive behavior*: I become so stressed out that I do things on the spur of the moment that I feel bad about later.

___ 15. *Tendencies toward loneliness*: Even though I want to be around people, I make excuses so that I do not have to. I spend more time alone, and do things to avoid thinking and feeling.

Phase IV: Crisis Building

___ 16. *Tunnel vision*: I look only at a small part of my life, and ignore everything else. When little things go wrong, I blow up and feel like life is unfair.

___ 17. *Minor depression*: I start to feel down and depressed. I have less and less energy, and I oversleep. I try not to feel these things by getting busy and not talking about it, but the feelings do not go away.

___ 18. *Loss of constructive planning*: I stop making plans for my day and react to whatever comes up.

___ 19. *Plans begin to fail*: My plans are not well thought out or realistic. I begin to have more and more problems. I feel bad about them, but do not know how to solve them.

Phase V: Immobilization

___ 20. *Daydreaming and wishful thinking*: I daydream about something that might solve all my problems like winning the lottery or running away to another place.

___ 21. *Feeling that nothing can be solved*: I begin to feel as if I have failed at recovery. Nothing I do appears to make things better.

___ 22. *Unfulfilled wish to be happy*: I want things to work out and I want to be happy, but I don't know how to make them better or I'm afraid to try.

Phase VI: Confusion and Overreaction

___ 23. *Periods of confusion*: I can't figure anything out. This makes me angry with myself and I become more confused.

___ 24. *Easily angered*: I become angry with people over little things. I feel angry most of the time and am afraid I might hurt someone. Sometimes I want to hurt others.

___ 25. *Irritation with friends*: When other people try to talk to me about what is going on, I think they are criticizing me and we have arguments.

Phase VII: Depression

____ 26. *Irregular eating habits*: I stop eating regular meals, and eat junk food instead. I either overeat or eat little or nothing.

___ 27. *Lack of desire to take action*: I feel scared and trapped. It seems impossible to start, let alone finish anything.

___ 28. *Irregular sleeping habits*: I find it impossible to sleep until I am completely exhausted. When I finally get to sleep, I have bad dreams and may sleep for 12 to 20 hours at a time.

___ 29. *Loss of daily structure*: I get so stressed and miserable that I cannot make decisions. I miss appointments and meetings. Sometimes I plan on going, but I am running so late that I decide not to go at all.

___ 30. *Periods of deep depression*: I feel hungry, angry, lonely, and tired. I feel angry with others. They try to help, but I think that nobody really cares.

Phase VIII: Behavioral Loss of Control

___ 31. *Irregular attendance at AA/NA and treatment meetings*: I stop going to my regular AA or NA meetings. I miss counseling appointments. I begin to feel that there are more important things to do and that the sessions aren't helping anyway.

___ 32. *Development of an "I don't care" attitude*: I feel like everything is hopeless. I don't want other people to know this, so I act as if I don't care.

___ 33. *Open rejection of help*: When people try to help me, I blow up and drive them away. I tell others that I do not need their help and avoid anyone who might see how I really feel.

___ 34. *Feelings of powerlessness and helplessness*: Things appear to be so bad that it seems useless to try to do anything to make them better.

Phase IX: Recognition of Loss of Control

___ 35. *Self-pity*: I feel sorry for myself and try to get sympathy and attention from friends or AA/NA and family members.

___ 36. *Thoughts of social drinking*: I start thinking that maybe I could drink or use drugs and stay in control. I think about how good it would feel to drink or use drugs for just a little while.

___ 37. *Conscious lying*: I start to lie to others even when I do not need to.

___ 38. *Complete loss of selfconfidence*: I think I am a total failure at recovery and in life. I do not believe that I can change things for the better, no matter what I do.

Phase X: Option Reduction

___ 39. *Deep resentments*: I feel angry with the world and feel as if everyone is against me.

___ 40. *Discontinue all treatment and AA/NA*: I do not attend AA/NA meetings, avoid my sponsor, and have stopped going to counseling or aftercare.

___ 41. *Overwhelming loneliness, frustration, anger, and tension*: I begin to feel like I am insane and think my only choices are drinking or using drugs, suicide, or insanity.

___ 42. *Loss of behavioral control*: I have problems in all areas of my life. I cannot control how I act, think, or feel.

Phase XI: Return to Use, or Physical/Emotional Collapse

___ 43. *Return to "controlled" use*: I try to use with control and sometimes I am able to do this for a short period.

___ 44. *Shame and guilt*: I feel ashamed and guilty for using and believe that if I had done things the right way, this wouldn't have happened to me. I believe I am a bad person because I've started to use again.

___ 45. *Loss of control*: I begin to use just as much or more than I did before.

___ 46. *Life problems*: I begin to have severe problems with my spouse/partner, job, friends, health, or the law. I need professional help in order to get better.

Exercise No. 9: Offender Relapse Warning Signs

Purpose. This offender relapse warning sign list will help you to understand how you return to breaking the law, even when you do not want to.

Instructions. Below is a list of thoughts, feelings, and actions that offenders may experience before committing a crime. Read the list and place a check mark next to any signs that you have experienced. Place a question mark next to any that you do not understand. Underline any words that cause you to have strong thoughts or feelings or make you want to do something. (This list was adapted from the work of Stanton E. Samenow, Ph.D.)

Phase I: Internal Dysfunction: During this period, changes occur in thoughts and feelings. These changes are unnoticed by other people.

___ 1. *Worry*: I worry about being able to survive in the real world. I wonder how I am going to be able to find and keep a job, pay bills and fines, get along with my family, or stay away from my old friends.

___ 2. *Denial*: I tell myself it will all work out. I pretend everything is all right. When people ask me about my problems, I tell them I will be okay, even though I am not sure.

___ 3. *Belief that troubles are over*: I convince myself that I've learned my lesson and will never do anything illegal again. I tell my friends, family, counselor and probation officer, "I've really learned this time," even though I do not have a plan for how to change.

___ 4. *Uncomfortable feelings*: I feel uncomfortable around people who are not involved in illegal activities. They seem boring, and I get nervous and jumpy. I want more excitement in my life.

___ 5. *"All or nothing" thinking*: I feel like I must be the best or I will be nothing. I must be very successful at everything I do. I get excited and build up in my mind how successful I must be. I feel that if I do not do everything right, I will fail.

___ 6. *Unrealistic feelings*: I think things should go my way just because I want them to. Because other people want me to succeed and I want to do well, things will happen the way I want them to.

___ 7. *Not planning ahead*: I do not plan for the future. When people ask me what my plans are, I tell them what I think they want to hear.

___ 8. *Lack of effort*: I do not do things that I do not like or that are boring or hard for me. I do not look into jobs or other things that might help me, and I find excuses for not doing these things.

___ 9. *Building self up*: I make myself feel better by putting other people down. I tell myself how stupid other people are. Most of the time I just think it, but sometimes I tell people that they are dumb or do not know anything.

___ 10. *Poor decision making*: I make decisions on the spur of the moment without thinking about what might happen. Afterwards, I think, "I really screwed up."

___ 11. *Sensing a lack of trust*: I feel like others do not agree with me or do not trust me. I think people should trust me no matter what I may have done in the past. I tell them I have changed, and I expect them to believe me. Their lack of trust makes me angry.

Phase II: External Dysfunction: In this phase, other people start to notice that you are acting differently. Your behavior starts to cause problems with others.

___ 12. *Feeling put down*: I think other people are putting me down when they point bad things out to me or when things do not happen the way I want. I think people do not understand me, and I begin to argue with them.

___ 13. *Wanting to be alone*: I start to avoid my family and other people. I wander around alone or go places by myself.

___ 14. *Feeling depressed*: I feel depressed, lonely, and angry. I don't think other people understand me. I start having problems sleeping, or I don't eat regularly and eat junk food. I feel hopeless.

___ 15. *Denying fears*: I do not want others to know I am afraid because I think being afraid is being weak. I tell people I am fine when I am really not. I'd rather tell people what they want to hear so that they won't know how I really feel.

___ 16. *Having envious thoughts*: I start to think about people I know who break the law and get away with it. I start to wish that I could do that, too. I wonder if there is an easier way to do things.

Phase III: Loss of Control: Your feelings at this time seem to control you. You can't seem to get yourself back on track. You feel like you can never change and wonder why you should try.

___ 17. *Avoiding responsibility*: I do what I want instead of what I told people I would do. When things go wrong, I tell people "I forgot." I either change the subject, or do not give them an answer. Sometimes I say "yes" when I do not really mean it.

___ 18. *Using alcohol or drugs*: Sometimes I feel good but I want to feel better. Sometimes I feel bad and I want to escape from my feelings. I begin to use alcohol or drugs to make good feelings better or to get rid of bad feelings. At first, I keep this a secret. If my probation officer, counselor, or family asks me about it, I lie.

___ 19. *Seeing old friends*: I start to hang around people who commit crimes. I want to be comfortable and they are the only people who seem to understand me. I go back to my old hangouts. I call people I know from jail or prison. I tell myself I am only doing this to find out how they are doing.

___ 20. *Missing appointments*: I miss appointments with my probation officer, counselor, job interview, or school. I make up excuses as to why I wasn't there. I begin to believe these people are out to get me and I can't trust them.

___ 21. *Thinking "I can't"*: I tell people I can't do something, or I don't know how

when I really just do not want to. I feel afraid or angry when I think about doing things that others want me to do.

___ 22. *Playing the victim*: I blame others when things go wrong. I tell people I couldn't help it. I feel like others are picking on me or are not giving me a chance. I feel like people will never be satisfied with me.

___ 23. *Not understanding how I hurt others*: I feel like other people are always telling me that I hurt them. I do not see how the things I do may hurt other people, and sometimes I get frustrated and I do not care.

___ 24. *Committing petty crimes*: I start stealing small things. I begin using illegal drugs, destroying other people's property, or getting into fights.

___ 25. *Rejecting others*: When people ask me what is wrong, I tell them that there is nothing wrong. If they persist, I tell them to leave me alone, yell at them, or do something to make them leave me alone.

___ 26. *Thinking that I'm always right*: I don't back down when other people do not agree with me. I feel that I am never wrong no matter what. I feel if I admit to others that I am wrong, they will think I am weak and will take advantage of me. Even if it turns out I am wrong, I leave or start a fight rather than admit it.

___ 27. *Feeling entitled to what I want*: I think other people should give me what I want, when I want it. If they do not, I have a right to take it. I feel angry that they won't do what I want or give me what I want. I feel like I have to teach them a lesson. I start thinking about illegal things I can do to get what I want.

___ 28. *Feeling that my anger is justified*: I feel that if I do not get what I want, I have the right to get angry, threaten, hurt, or get even with people. I feel I have the right to do whatever I have to because other people do not understand.

___ 29. *Wanting to win*: I feel I must win at all costs. I get "high" when I come out on top, even if the fight wasn't important. I will do whatever it takes to get back at someone who makes me angry. I am willing to commit crimes just to make me feel on top of things.

Phase IV: Return to Regular Law Breaking: You now get back into breaking the law on a regular basis.

___ 30. *Believing "just this time"*: I decide to get even with someone just this one time. I sell drugs, steal something, or do something that I probably won't get caught at.

___ 31. *Worsening of a pattern*: Soon I start breaking the law on a regular basis. I am always thinking about how I can get away with something.

___ 32. *Having serious problems*: I get caught, picked up on a probation violation, have run-ins with the police, and get rejected by my family.

Exercise No. 10A: Initial Alcohol and Drug Warning Sign List

Purpose. This exercise will help you notice which of the warning signs are important to you, and help you understand them better.

Instructions. Make three copies of this exercise. Pick the three warning signs that you had the strongest feelings and thoughts about in the Alcohol and Drug Relapse Warning Signs exercise and list them on the worksheets in this exercise. For each one, follow the directions below.

1. Alcohol and Drug Warning Sign: No. _____
    A. Title

    _____

    B. Write the words you underlined.

    _____

    _____

    C. Why did you pick this sign?

    _____

    _____

    D. Write the warning sign in your own words, beginning with:

    I know my recovery is in trouble when . . .

    _____

    _____

    _____

    Repeat this sentence several times out loud. Then complete the sentences that follow.

    E. When I say this sentence . . .
        1. My thoughts are

        _____

2. My feelings are

3. I want to

Exercise No. 10B: Initial Offender Warning Sign List

Purpose. In this exercise you will find out which of the warning signs are important to you and understand them better.

Instructions. Make three copies of this exercise. Choose the three warning signs that you had the strongest feelings and thoughts about in the Offender Relapse Warning Sign List Exercise and list them on the worksheets in this exercise. For each one, follow the directions below.

1. Offender Relapse Warning Sign: No. _____
   A. Title

   B. Write the words you underlined.

   C. Why did you pick this sign?

D. Write the warning sign in your own words, beginning with:

I know my recovery is in trouble when . . .

Repeat this sentence several times out loud. Then complete the sentences that follow.

E. When I say this sentence . . .
   1. My thoughts are
   2. My feelings are
   3. I want to

Exercise No. 11: Warning Sign Analysis

Purpose This exercise will help you to understand how each warning sign you checked in the previous section can happen to you.

Instructions. Write down each title of the six relapse warning signs you identified in Exercise No. 10 (A and B). Then complete the following exercises about each one. If you are having trouble, quit for a short period, but come back to the exercise.

1. *Initial Relapse Warning Signs:*

Alcohol and Drug Warning Signs	*Offender Warning Signs*
No. 1 _____	No. 1 _____
No. 2 _____	No. 2 _____
No. 3 _____	No. 3 _____

2. *Description*: Describe how these relapse warning signs work together to set you up to return to using and criminal behavior. Refer to the thoughts, feelings, and things you wanted to do in Exercise No. 10 to help you complete this description.

_____

_____

_____

_____

_____

_____

_____

3. Write down any new thoughts, feelings or urges that you had when describing the warning signs (above).

A. _____	D. _____
B. _____	E. _____
C. _____	F. _____

4. *Past experience*: Describe a time in the past when one of these warning signs happened to you when you were sober and clean. Describe it as a story with a beginning, middle, and

end. Include who was there, what happened, and where and when it happened. Also state what you were feeling, thinking, and wanted to do.

5. *Key ideas*: List the key ideas from the story of your past experience.
   A. It happened at (where and when)

   B. I was with

   C. What was going on was

   D. I thought

E. I felt

F. I wanted to

G. The next thing I thought was

H. The next thing I felt was

I. The next thing I did was

6. *Future Experience*: Think about a time in the future when this warning sign might happen to you while you are sober and clean. Describe it as a story with a beginning, middle, and end. Include who might be there, what might happen, and where and when it might happen. Also state what feelings and thoughts you might have and what you would want to do.
7. *Key Ideas*: List the key ideas from the story of your future experience.
   A. It happened at (where and when)

   B. I was with

C. What was going on was

D. I thought

E. I felt

F. I wanted to

G. The next thing I thought was

H. The next thing I felt was

I. The next thing I did was

8. *Reactions to this exercise*: During this exercise . . .
    A. I thought

    B. I felt

    C. I wanted to

9. Finish the following sentence five times, each time giving it a new ending.

    I am now beginning to realize . . .

    A.
    B.
    C.
    D.
    E.

Exercise No. 12: Combined Warning Sign List

Purpose. This exercise will help you to see things that happen to you over and over again and that lead you to relapse into alcohol or drug use or breaking the law.

Instructions. Go back to Exercise No. 11 and take all of the key ideas, warning signs, and reactions listed in sections 2a, 4, 6, and 7. Combine them into one list below. If any of the items on the list are similar, write only one of them. Check them off on Exercise No. 11 as you write them here.

A.
B.
C.
D.
E.

F.
G.
H.
I.
J.
K.
L.
M.
N.
O.
P.
Q.
R.
S.

Exercise No. 13: First Ordered Warning Sign List

Purpose. This exercise will help you to put the warning signs in the order that they happen to you. This will help you to learn how to stop them from causing a relapse.

Instructions. Go back to the combined warning sign list (Exercise No. 12) and put the signs in the order that they happen to you. Write down a few key words that will help you to remember each warning sign on the line labeled Summary Title.

1. Warning Sign:

   Summary Title:

2. Warning Sign:

   Summary Title:

3. Warning Sign:

Summary Title:

4. Warning Sign:

Summary Title:

5. Warning Sign:

Summary Title:

6. Warning Sign:

Summary Title:

7. Warning Sign:

Summary Title:

8. Warning Sign:

Summary Title:

9. Warning Sign:

Summary Title:

10. Warning Sign:

Summary Title:

11. Warning Sign:

Summary Title:

12. Warning Sign:

Summary Title:

13. Warning Sign:

Summary Title:

14. Warning Sign:

Summary Title:

Review the First Ordered Warning Sign List on the previous pages of this exercise. Read the list out loud to another person such as a counselor or your AA/NA sponsor. Ask him or her if it makes sense. Does each warning sign lead to the next? Does the list begin with the real first warning sign, or is there something that happens before this that starts the process? Does the list end in alcohol or drug use or breaking the law?

If your answer to any of these questions is no, make a note about missing items in the margin of the First Ordered Warning Sign List. Write the missing warning signs on the lines below. Then go back to the First Ordered Warning Sign List and draw in an arrow that shows where the missing item should go. Write the letter that stands for the missing warning sign next to the arrow.

A.
B.
C.
D.
E.
F.

G. _____
H. _____

_____

Exercise No. 14: Final Warning Sign List

Purpose. This exercise will help you to make a complete Final Warning Sign List. It may appear that these exercises are repetitious. However, this repetition is needed to make a complete list.

Instructions. Rewrite the First Ordered Warning Sign List you completed in Exercise No. 13, again adding in any new warning signs that you think of in the order that they belong. Rewrite the summary title and write a complete sentence that describes each warning sign. This sentence should tell you what happens and to whom.

Example: I feel angry at other people. The first thing that happens is a high-risk situation. This starts the warning signs.

High-Risk Situation:

_____

_____

Warning Signs:

1. Summary Title:

   _____

   Warning Sign Sentence:

   _____

   _____

2. Summary Title:

   _____

   Warning Sign Sentence:

   _____

   _____

3. Summary Title:

Warning Sign Sentence:

4. Summary Title:

Warning Sign Sentence:

5. Summary Title:

Warning Sign Sentence:

6. Summary Title:

Warning Sign Sentence:

7. Summary Title:

Warning Sign Sentence:

8. Summary Title:

   Warning Sign Sentence:

9. Summary Title:

   Warning Sign Sentence:

10. Summary Title:

    Warning Sign Sentence:

11. Summary Title:

    Warning Sign Sentence:

12. Summary Title:

Warning Sign Sentence:

13. Summary Title:

Warning Sign Sentence:

14. Summary Title:

Warning Sign Sentence:

15. Summary Title:

Warning Sign Sentence:

16. Summary Title:

Warning Sign Sentence:

17. Summary Title:

Warning Sign Sentence:

18. Summary Title:

Warning Sign Sentence:

19. Summary Title:

Warning Sign Sentence:

20. Summary Title:

Warning Sign Sentence:

Exercise No. 15: Critical Warning Sign

Purpose. This exercise will help you see which warning signs you can begin to change when they happen to you.

Instructions. Make three copies of this work sheet. Reread your final warning sign list in Exercise No. 14. Choose three warning signs between no. 3 and no. 8 that you would recognize when they happen to you. Fill out the worksheet below for each one.

*Critical Warning Sign No.*_____

1. Summary title of the warning sign: _____
2. Describe how this warning sign happened to you in the past.

3. When this warning sign happened . . .
    A. My thought was

    B. My feeling was

    C. I wanted to

4. What I did that was not helpful

5. What do you think would help you when this warning sign happens?

6. How could you handle your feelings differently to help you when this warning sign happens?

7. How could you act in a way that would help you when this warning sign happens?

8. How could you handle this warning sign if it happened again so that it would not cause more warning signs?

9. New Skills: What skills do you need to learn so that you can be successful with your plan in no. 8 above?
   A.
   B.
   C.
   D.
   E.

Section IV: How Can I Get Better?

In this section of the workbook, you can learn how your thoughts, feelings, and actions can be changed. By changing how you think, feel, and act in different situations, you can change your life. This will require you to be as honest as you can and not give up when you get discouraged.

Exercise No. 16: Warning Sign Management Strategy

Purpose. This exercise will help you to learn how to stop your past warning signs from happening again. This will help you to see problems you may have and how you can change them.

Instructions. Make three copies of this worksheet. Write the title of each of the three critical warning signs from Exercise No. 15 on each of the worksheets. Imagine a time in the future when this critical warning sign might happen again. Imagine handling this warning sign the way you used to. Then imagine handling it in a new way. Follow the directions and answer the questions below about your new way of handling the critical warning sign. Do not hesitate to ask other people for their ideas. Do the exercise for each of the three critical warning signs.

Critical Warning Sign No. _____

Summary Title of the Warning Sign _____

1. *Strategy List*: What are three ways of handling the critical warning sign that might work better in the future?
   A. _____
   _____
   B. _____
   _____
   C. _____
   _____
2. *Which Strategy*: Which strategy is most likely to work? [ ] A [ ] B [ ] C

   Why did you choose this one?

   _____
   _____
3. What are the steps that you can take to make this strategy work? What do you have to do first, second, and so on?
   A. _____
   _____
   B. _____
   _____

C. _____

_____

D. _____

_____

E. _____

_____

4. *Mental Rehearsal*: Try to act this strategy out in your head.
   A. What problems did you have when you tried to imagine doing this?

   _____

   _____

   B. What went right?

   _____

   _____

   C. What changes do you have to make in order to make this strategy work?

   _____

   _____

Exercise No. 17: Identifying High-Risk Situations

Purpose. This exercise will help you see the kinds of things that trigger your warning signs. These are called high-risk situations. By knowing what these high-risk situations are, you can learn to avoid them or handle them better.

Instructions. Reread Exercise No. 14—Final Warning Sign List. Write down the *high-risk* situation that triggers your warning signs. This should be your first warning sign.

1. High-Risk Situation:

   _____

2. Think about times in the past when your final list of warning signs was triggered. Describe different high-risk situations that caused this. Describe what was going on and how you thought, felt, and acted.
    A. High-Risk Situation:

    B. High-Risk Situation:

    C. High-Risk Situation:

D. High-Risk Situation:

3. Combined High-Risk Situations. List below anything that happens in more than one of your high-risk situations.

A.
B.
C.
D.
E.
F.
G.

4. Go back to Exercise No. 7—Life History Summary. Copy sections 9, 10, 11, and 12 below.

(9) The three main things I used to believe alcohol or drugs would help me do or become in my life are . . .

.
A.
B.

(10) The three main thoughts about myself and others that I have used alcohol or drugs to cope with are . . .

C.
D.
E.

(11) The three main feelings that I have used alcohol or drugs to cope with are . . .

F. _____
G. _____
H. _____

(12) The three main problems or situations that I used alcohol or drugs to cope with are . . .

I. _____
J. _____
K. _____

5. Critical High-Risk Situations: Are any of the above problems or situations (9, 10, 11, or 12) similar to the combined high-risk situations you listed in no. 3? If they are, write them below and give each one a short title (summary title) that will help you to remember it.

0. A. Critical High-Risk Situation

_____

_____

Summary Title

_____

1. Critical High-Risk Situation

_____

_____

Summary Title

_____

2. Critical High-Risk Situation

_____

_____

Summary Title

_____

3. D. Critical High-Risk Situation

Summary Title

Exercise No. 18: Identification of Core Beliefs

Purpose. This exercise will help you to understand why you react to the high-risk situation the way you do. Usually this is because you believe things are a certain way when they really are not. You must be willing to consider that the way you believe things are might be wrong.

Instructions. Make four copies of this exercise. Take each of the critical high-risk situations from Exercise No. 17, part 5, and list it on one of these worksheets. Answer the following questions and follow the directions about each one.

1. Summary Title of Critical High-Risk Situation

2. Critical High-Risk Situation _____. Describe how this situation happened in the past. Include your thoughts, feelings, and actions.

3. Read the description you wrote above. Close your eyes, breathe deeply, and try to picture yourself there. Say the following sentence over and over, and write a new ending each time: "When I am in this situation I believe . . ."
   A.

B.

C.

D.

E.

F.

G.

H.

I.

J.

Exercise No. 19: Combined Mistaken Belief List

Purpose. We operate on a number of Core Beliefs. Sometimes these beliefs are true, but we do not know how to deal with what they tell us. Sometimes we learn things that are not true. These are called Mistaken Beliefs. We act as if they are true even though they cause us pain and stop us from changing our lives. These mistaken beliefs can cause us to do things and feel things that will cause us to drink, use drugs, or break the law again.

All core beliefs appear in the form of thoughts that are either mandates or injunctions. Mandates are thoughts that usually begin with "I must." Injunctions are thoughts that usually begin with "I can't." We believe something bad will happen unless we follow our mandates and injunctions.

Examples of Mandates and Injunctions

Mandate: I must always be in control and not show others when I am afraid.

Injunction: I can't cry or people will think I am weak.

Instructions. Read the list of endings to the sentence, "When I am in this situation I believe . . ." in Exercise No. 18, part 3, for each of the four worksheets. Circle any endings that begin, "I must" or "I have to." List them below on the Mandate List. Write any that are similar only once. Put a square around any endings that begin, "I can't" or "I won't." List them below on the Injunction List. Write only once any that are similar.

1. Mandate List
    - A. _____
    - B. _____
    - C. _____
    - D. _____
    - E. _____
2. Injunction List
    - A. _____
    - B. _____
    - C. _____
    - D. _____
    - E. _____

Many times you will have feelings that will cause you to think of the mandate or injunction. What you have learned about these thoughts and feelings usually determines how you will act.

Instructions. Take the list of mandates and injunctions from this exercise to someone whom you respect and believe to be honest. Look for someone who has been sober, clean, and out of trouble for a long period. This could be a counselor, someone in AA or NA, or an acquaintance. Ask the person if he or she thinks these mandates and injunctions are true. If the person does not think the mandates and injunctions are true, circle them.

If you have a belief that is true and is causing pain for you, write down how you are dealing with it. Ask people whom you trust how they deal with this situation to make it work for them.

Exercise No. 20: Challenging Mandates and Injunctions

Purpose. This exercise will help you to understand your mandates and injunctions and make choices about how you want them to affect you in the future.

Instructions. Fill out this page and the following worksheets about your mandates and injunctions by using the information from Exercise No. 19.

1. List the mandates you think might be false after talking with other people about them.
   - A. _____
   - B. _____
   - C. _____
   - D. _____
   - E. _____
2. List the injunctions you think might be false after talking with other people about them.
   - A. _____
   - B. _____
   - C. _____
   - D. _____
   - E. _____
3. List the mandates and injunctions you believe might be true after talking with other people about them, even though the way you handle them doesn't work.
   - A. _____
   - B. _____
   - C. _____
   - D. _____
   - E. _____

Exercise No. 21: Challenging Mandates

Purpose. This exercise will help you to understand why you continue to think and feel the way you do. It will also help you change these thoughts and feelings. Complete as much of the worksheet as you can.

Instructions. Make five copies of this exercise. Go back to each of the mandates from Exercise No. 20, part 1. Complete the following statement and answer the questions about the statement:

1. Mandate _____:

   I Must

   _____

   _____

   Or else (What do you believe will happen?)

2. Challenging the Mandate:
    A. Who taught you that you must do this?

    B. Is it possible you were taught wrong?

    C. Do you believe the mandate is [ ] True or [ ] False?
    D. If it is false, what might be the truth?

    Based on this truth, another way I can think is

    E. The feelings that I have when I think this way are

    If I change the way I think, I will feel

    F. When I think this way, I want to

What I could do instead is

3. If I continue to think, feel, and act the way I did in the past, what is . . .

1. The best that can happen?

2. The worst that can happen?

3. Most likely to happen?

4. If I change the way I think, feel, and act, what is . . .

. The best that can happen?

A. The worst that can happen?

B. Most likely to happen?

Exercise No. 22: Challenging Injunctions

Purpose. This exercise will help you to understand why you think and feel the way you do and how you can change these thoughts and feelings. Complete as much of the worksheet as you can.

Instructions. Make five copies of this exercise. For each of the injunctions listed in Exercise No. 20, part 2, complete the statements below:

1. Injunction _____:

   I Must

   _____

   _____

   Or else (What do you believe will happen?)

   _____

   _____

2. Challenging the Injunction:
   A. Who taught you that you must do this?

      _____

      _____

   B. Is it possible you were taught wrong?

      _____

      _____

   C. Do you believe the Injunction is [ ] True or [ ] False?
   D. If it is false, what might be the truth?

      _____

      _____

      Based on this truth, another way I can think is

E. The feelings that I have when I think this way are

If I change the way I think, I will feel

F. When I think this way, I want to

What I could do instead is

3. If I continue to think, feel, and act the way I did in the past, what is . . .
   A. The best that can happen?

   B. The worst that can happen?

   C. Most likely to happen?

4. If I change the way I think, feel, and act, what is . . .
    A. The best that can happen?

    B. The worst that can happen?

    C. Most likely to happen?

Exercise No. 23: Improved Reactions to Mandates and Injunctions

Purpose. This exercise will help you find new ways to react to the mandates and injunctions that are true.

Instructions. Make five copies of this exercise. For each of the mandates and injunctions listed in Exercise No. 20, part 3, complete the statements and answer the questions below.

1. Mandate or Injunction _____
    A. A. I Must or Can't

    Or else (What do you believe will happen?)

    Another way I can think is

B. The feelings that I have when I think this way are

If I change the way I think, I will feel

C. When I think this way, I want to

What I could do instead is

2. If you continue to think, feel, and act the way you have in the past, what is . . .
   A. The best that can happen?

   B. The worst that can happen?

   C. The most likely to happen?

3. If you change the way you think, feel, and act, what is . . .
    A. The best that can happen?

    B. The worst that can happen?

    C. The most likely to happen?

Exercise No. 24: Management of High-Risk Situation

Purpose. Make four copies of this exercise. The exercise will help you pull together all of the things you have learned. You will have a better chance at recovery if you use everything you learn.

Instructions. Use one worksheet in this exercise for each of the four Critical High-Risk Situations in Exercise No. 17, part 5. Answer the following questions.

1. Summary title of critical high-risk situation _____

2. Describe the critical high-risk situation.

3. Describe three ways you can avoid this critical high-risk situation without avoiding responsibility.
   A. _____
   B. _____
   C. _____

4. List three ways that you could handle the situation differently if you cannot avoid it.
   A. _____
   B. _____
   C. _____

5. Read the mandates from the worksheets in Exercise No. 21. List the one that happens most often when you are in this critical high-risk situation. Then write down a different way that you could think instead.
   A. Mandate

      _____

      A different way to think is

      _____

6. Read the injunctions from the worksheets in Exercise No. 22. List the one that happens most often when you are in this critical high-risk situation. Then write down a different way that you could think instead.
    A. Injunction

    A different way to think is

7. Read the mandates and injunctions from the worksheets in exercises no. 21 and 22. List the one that happens most often when you are in this critical high-risk situation. Then write down a different way that you could act instead.
    A. Mandate/Injunction

    A different way to think is

8. Read the worksheets for Exercise No. 16 again. List the summary titles of the critical warning signs that happen because of this critical high-risk situation. Describe how the critical warning signs happen to you. Then describe what you will do differently in the future to prevent the warning signs from getting worse.
    A. Summary Title No. 1

    B. Summary Title No. 2

    C. Summary Title No. 3

    D. The way these critical warning signs happen to me is

E. What I will do in the future to prevent the warning signs from getting worse is

Section V: What Is My Personal Plan To Recover?

In this section, you will pull together all that you have learned to form relapse prevention strategies. You will also map out a daily plan and inventory for recovery day by day. You have almost completed the workbook. When you do you will be ready to move forward in your ongoing recovery.

Exercise No. 25: Relapse Prevention Strategy No.

Purpose. This exercise will help you to put to use all that you have learned.

Instructions. Make four copies of this exercise. Fill out one for each of the worksheets that you completed in Exercise No. 24. Read the exercises and answer the questions on this page and on the top of the next page (up through "When I have these mistaken beliefs, I need to . . ."). Then write the information on a card. Also finish the rest of the questions in this exercise.

Read the card every morning before you start your day. Carry the card with you every day so that you can use it to remember how to deal with high-risk situations. Review the information on the card every night. Talk to someone in AA or NA about anything on the card that happened to you that day and how it worked out for you. Make any changes you have to in order to make things work out better.

Critical High-Risk Situation _____

Summary Title

How it happens

When this happens, I need to

1.
2.
3.

Mistaken beliefs (mandates and injunctions) it results in

1.
2.
3.

When I have these mistaken beliefs, I need to

Think:

Feel:

Act:

Three critical warning signs mistaken beliefs cause

1.
2.
3.

When these warning signs occur, I need to

1.

2. _____
3. _____

Summary of Action Plan: Describe how you are going to avoid or handle the critical high-risk situation, correct the mistaken beliefs, and stop the relapse warning signs from getting worse.

_____
_____
_____
_____

People who will help me with this plan if I have trouble:

Name Telephone Number

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Exercise No. 26: Daily Recovery Plan

Purpose. Having a plan for each day will help you to recover and stay in recovery. There are some basic things you can do to recover. Not everyone who recovers does all these things. However, people who have trouble recovering must do them if they want to be successful. Many of these things are simple. While they are important for almost everyone, they are very important for people in recovery. They help to heal the brain damage and other problems that result from drinking and drug use that make it hard to handle your thoughts, feelings, and actions.

Instructions. Read the information below. Review it when you make out your daily plan for recovery.

1. *Diet*: The things you eat and drink can affect the way you think, feel, and act. Sugar, white flour, and caffeine can cause depression, mood swings, and angry feelings. They can cause you to be confused and make you tired. Chemically dependent people should use them only in very small amounts.

You should try to eat three small meals and three snacks per day. You should eat fruit, vegetables, whole grain bread and cereal, meat, and dairy products.

2. *Vitamins*: When you are recovering from chemical dependency, the right kinds of vitamins can improve the way you think, feel, and act. It is a good idea to take vitamin B complex or a stress formula tablet daily.
3. *Meetings*: Going to AA or NA meetings can help you in recovery more than anything else. It is important that you go to as many meetings as possible. The more you are around other recovering people, the more your thinking will change.
4. *Exercise*: Aerobic exercise for a half hour each day will help your body to recover from the damage done by alcohol and drugs. Examples of aerobic exercise are fast walking, running, swimming, cycling, and rowing. These activities make your heart beat faster and your lungs work better. You do not need to work out until you're exhausted. Aerobic exercise is different from lifting weights or other body building exercises.
5. *Relaxation*: By learning how to relax, you can get back in control when you begin feeling "crazy." The easiest way to relax is to follow this three-step process:
    A. Breathe in and out through your nose.
    B. Feel your lungs fill up with air when you breathe in and feel them empty when you breathe out.
    C. Gradually slow down your breathing to a slow, regular rhythm. Practice this deep, relaxed breathing several times a day. The more you practice, the better it will work when you need it.
6. *Rest*: You will feel better if you have a set time to go to bed at night and a set time to get up in the morning. Regular rest helps you recover from the damage that alcohol or drugs have done to your body and mind. It also helps you think more clearly.
7. *Work on Other Problems*: Make it a goal each day to work on other things besides recovery. These things may be getting a job, finding a place to live, or paying off debts. If you are working at making progress, even in small ways, you will feel better about yourself.
8. *Sponsor*: Get a sponsor through AA or NA and talk to that person face to face, or on the phone, at least once each day. It helps to have someone to talk to who knows what you are going through. Your sponsor can give you advice and hope.
9. *Daily Plan and Inventory*: You can increase your chances of recovery if you fill out and use your daily recovery plan and inventory sheets.
10. *Review Relapse Prevention Strategies*: By reading your relapse prevention strategies from Exercise No. 25 every day, you will be more aware of your high-risk situations and relapse warning signs. This awareness will help you avoid trouble before it gets out of hand.

Daily Recovery Plan Sheet

Purpose: Make as many copies of this sheet as you need. Having a plan for each day will help you recover. It is important that you fill out one of these sheets every day and review it every night to see how much of it you completed. Check off each item that you complete. Talk to your AA/NA sponsor about how well you stuck with your plan.

Day _____ Date _____ Name _____

Planned Meal and Snack Times

_____ _____ _____

_____ _____ _____

Take Vitamins _____

Planned Recovery Activities

See Counselor _____ Time _____

Talk to Sponsor _____ Time _____

Go to AA/NA _____ Times _____

Things I have to do today:

.

Activity	Time
1. Make out my daily schedule	
2.	.
3.	.
4.	.
5.	.
6.	.
7.	.
8.	.
9.	.
10.	.
11.	.
12.	.
13.	.
14.	.
15.	.

Sponsor's phone no.

Second contact and phone no.

Exercise No. 27: Evening Inventory Sheet

Purpose. Make as many copies of this sheet as you need. This exercise will help you learn day by day. You will change a little bit each day.

Instructions. At the end of each day, review your Relapse Prevention Plans from Exercise No. 25. Then answer the questions in this exercise. Talk to someone whom you trust, such as an AA/NA sponsor or a sober friend. Review this sheet with this person. Ask him or her for ideas on whether you could handle things better and how.

1. What high-risk situations did you have today?

2. How did you handle them? How did you think, feel, and act?

3. What mandates and injunctions did you have today?

4. How did you handle them?

5. What warning signs did you have today?

6. How did you handle them?

7. I need to call

   _____

   to talk about the answers to these questions.

8. What was the most important thing you learned?

9. What can you do differently tomorrow to make things better?

Concluding Remarks

We hope you have worked through all the exercises in this workbook. If you have, then you are ready for the next step, which is the most important of all: putting your relapse prevention plan into action. If you have not completed the entire workbook, we hope you will go back and complete it.

You must stop using alcohol and drugs. However, this action alone will not change your life. Recovery means giving up your old ways of thinking, feeling, and acting, so that you can have a better life. You *can* live without worrying about legal problems, getting alcohol or drugs, and all of the issues associated with chemical dependency.

In order for this to happen, you must put the things you have learned here into action. You also must be willing to learn more. Many people who used to abuse alcohol or drugs and commit crimes are living healthy, happy lives today because they worked on the suggestions in this workbook. You can, too.