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Handbook 5.

Short Practice Guides on Drug Counselling Therapies

United Nations Office on Drugs and Crime
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Acknowledgments

Resources

A number of existing sources of information have been utilised in the development of this resource. Extracts from the following have been incorporated into this resource with minimal adaptation and in text acknowledgement:

- Clinical treatment guidelines for alcohol and drug workers. No 1: Key principles and practices prepared by Turning Point (Addy, et al., 2000)
- CHCAOD11A: Provide advanced interventions to meet the needs of clients with alcohol and other drug issues prepared by Turning Point (Connolly, Roeg, Lee 2007)
- Making values and ethics explicit: A new Code of Ethics for the Australian alcohol and other drugs field prepared by Alcohol and other Drugs Council of Australia (ADCA) (Fry, 2007a)
- Making values and ethics explicit: The development and application of a revised Code of Ethics for the Australian Alcohol and Other Drug Field. ADCA Discussion paper prepared by ADCA (Fry, 2007b)

Motivational Interviewing

What is motivational interviewing?

Motivation is a psychological state characterised by an eagerness or readiness to change. It is dynamic and fluctuating, and is not a constant trait.

In the drug treatment context, motivation refers to a readiness/preparedness to change drug-using behaviour.

Motivational interviewing is a set of techniques designed to both encourage and heighten readiness to change, and enable positive behaviour change.

The practice of motivational interviewing is a therapeutic approach designed to help

clients with drug problems to improve their motivation and reach a decision to change.

It draws on the principles and practices of directive client-centred counselling, cognitive therapy, systems theory and social psychology.

Motivational interviewing relies on the use of core communication skills.

Open and reflective listening is essential, and while the session might appear to be quite client-centred, the drug counsellors maintains a strong sense of purpose and direction.

Motivational interviewing is not a stand-alone intervention. While it may increase intent and commitment to change behaviour, it does not provide clients with any practical information on how to achieve change.

Motivational interviewing is concerned with enhancing psychological readiness to change, which once accomplished must be followed with information and skills acquisition to enable changes to be implemented (Saunders & Allsop, 1991).

- Motivation is not static and behaviour change may not be long lasting. It is important to keep in mind that, despite the best application of motivational interviewing and the greatest intentions to change, a client may continue to use drugs, possibly within minutes or hours of treatment Motivational interviewing does not eliminate fluctuations in motivation associated with decision making and desire and confidence for behaviour change.
- It is common for people to say one thing then do another. Clients making verbal statements that reflect motivation give no guarantee that they will change. Despite a clear and genuine desire to change, drug use may continue for various reasons, including ambivalence about change. Miller & Rollnick (1991) consider these to be 'understandable' and 'predictable' responses.
- The drug counsellor should try to remove as many obstacles to change as possible.
- The more obstacles that can be removed, the more likely the client is to participate effectively in motivational interviewing.
- Potential obstacles include time availability for the intervention, especially in general practice settings; the nature of the counselling relationship; expectations of the client; and drug counsellor skills such as active and reflective listening.

Motivational interviewing is one way to work with some clients, but does not do all things for all clients.

- It can be an important supplement to other therapies such as behavioural training, cognitive therapy or attendance at 12-step groups (Miller & Rollnick, 1991).

Motivational interviewing is relevant in a variety of treatment types, such as:

- Preliminary assessment
- Withdrawal
- Outpatient counseling
- Residential rehabilitation.

A thorough knowledge of all available treatment interventions is necessary to ensure that if the client decides upon action, his/her needs can be appropriately addressed.

The success of motivational interviewing is subject to the client's awareness of the personal consequences of his/her own drug use pattern. The intervention should elicit from clients their concerns about drug use and arguments for change; focus on the attitudes and values of the client; assist the client to make his/her own decisions; and attempt to direct motivation towards positive behaviour change.

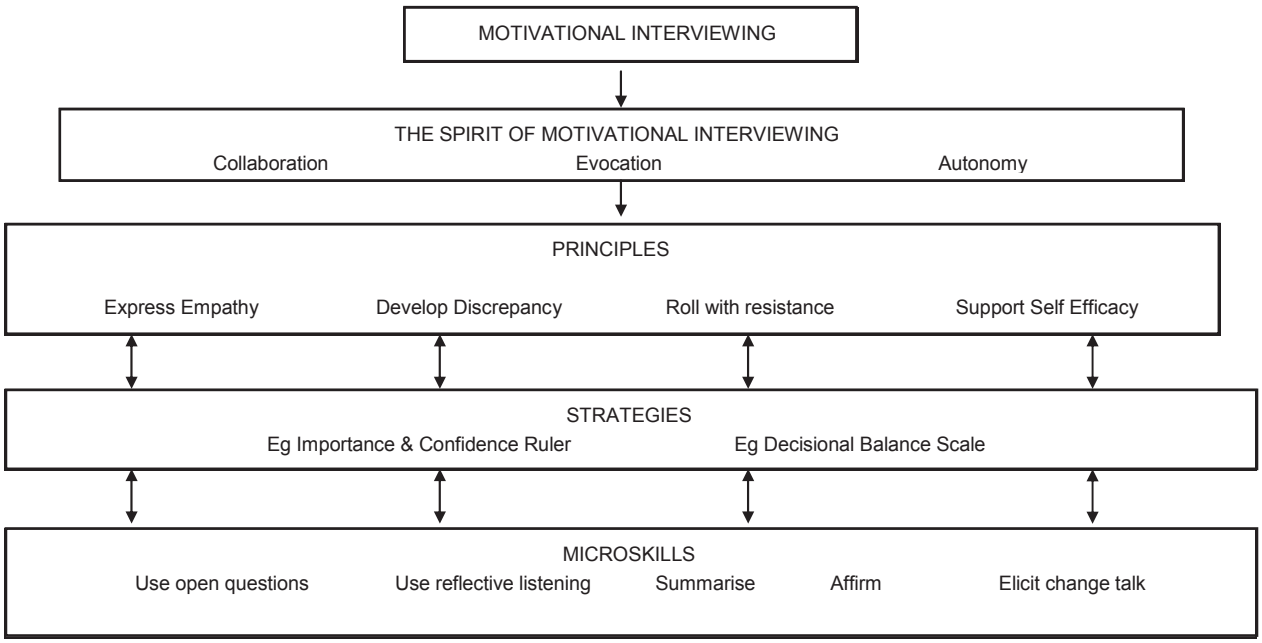
Basic counselling skills are a prerequisite in the practice of motivational interviewing.

The drug counsellors counselling style is perhaps one of the most important aspects of effective motivational interviewing, and can be a powerful determinant of client resistance and change. Based on the assumption that ambivalence is normal and acceptance facilitates change, the counsellor should use reflective listening to express empathy regarding the client's ambivalence.

In motivational interviewing, a client should never feel he/she is being confronted by the drug counsellor. Rather, he/she should feel like a collaborative effort is being made against 'the problem'.

Motivational Interviewing: A structured approach

The goal of Motivational Interviewing is for clients to express their own reasons for concern and their own arguments for change.The following structure provides a framework for achieving this goal, incorporating the concepts of motivation, ambivalence and stages of change. As you can see, Motivational Interviewing is made up of important components that include, the spirit, the principles, the strategies and the micro skills, which underpin the strategies and principles.



Note: The above chart has been designed to be useful to students in illustrating the various components of Motivational Interviewing. In practice there is substantial integration of the components. Many of the strategies used are effective in multiple ways. For example, a strategy of working with ambivalence is useful to create empathy with the client but is also useful as you deal with resistance. It is also acknowledged that some of the above strategies can be incorporated into other counselling styles and are not exclusive to Motivational Interviewing.

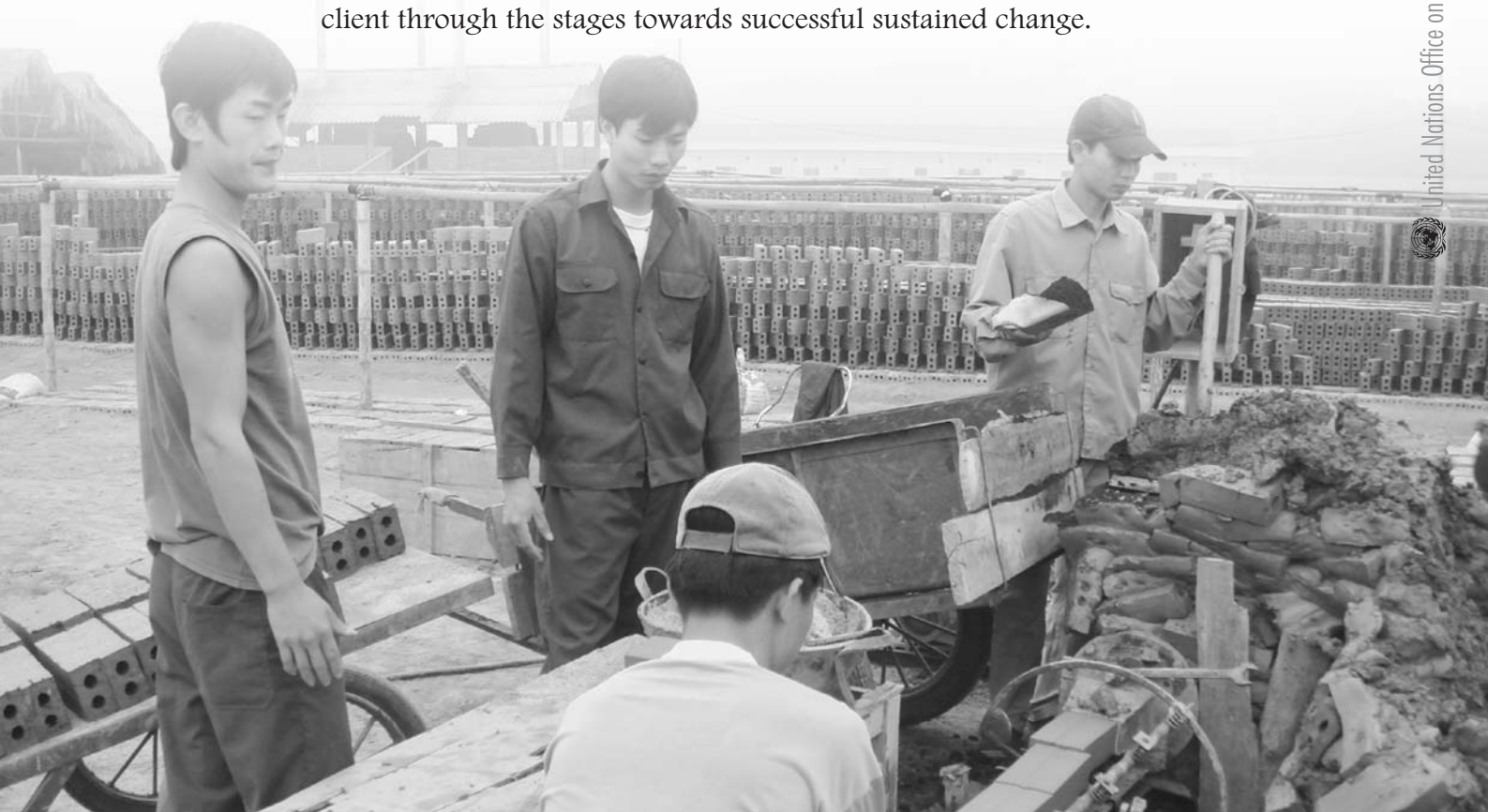
When to use motivational interviewing

Motivational interviewing can be used as both an assessment tool and as an intervention based on the Stages of Change model It was developed particularly for working with clients at the pre-action stages of pre-contemplation, contemplation and determination/preparation.

As an assessment tool, motivational interviewing can be used to identify the client's stage of change. This enables the drug counsellor to determine whether the client is seeking strategies to change his/her pattern of drug use, or is perhaps simply identifying that his/her use is causing some problems.

As an intervention, motivational interviewing can be used to advance the client into the action stage and help maintain his/her commitment to the change process.

A drug counsellor needs to be responsive to how the client feels about his/her drug-taking behaviours and the level of motivation to change. Using motivational interviewing, a drug counsellor can employ appropriate strategies to move the client through the stages towards successful sustained change.



The spirit of motivational interviewing

Miller & Rollnick identify three components that collectively describe the Spirit of Motivational Interviewing. These are Collaboration, Evocation and Autonomy (Miller & Rollnick, 2002).

COLLABORATION

Within Motivational Interviewing, the counsellor endeavours to create a partnership approach that acknowledges the clients experience and perspectives. For it to be effective the counsellor must provide an atmosphere that is conducive to change rather than one that is coercive to change. This is in contrast to other forms of counselling that over ride the client's experiences given that they are 'impaired' by AOD use and based on a 'false reality'.

EVOCATION

Within this collaborative approach is the recognition that many of the resources necessary for change actually reside within the client and the counsellor's role is to draw them out. Once again, this is in contrast to other forms of counselling where the counsellor seeks to educate or enlighten the client.

AUTONOMY

In Motivational Interviewing the responsibility for behaviour change resides with the client. The overall aim is to increase the clients' intrinsic motivation so that change may arise to change. The counsellor is not the authority who tells the client what they should or should not do.

Who benefits from motivational interviewing

Mattick and Jarvis (1993) report that motivational interviewing is an appropriate intervention for problem drug users 'who are not yet ready to change' or 'who are experiencing ambivalence (or conflict)' about their drug using/abusing behaviour. Miller and Rollnick (1991) suggest that motivational interviewing is particularly helpful with clients who are uncertain or ambivalent about the need to make changes to their behaviour.

However, when a client presents as highly motivated to change, **motivational interviewing 'may be useful in reinforcing the client's motivation to change by exploring what the client hopes to achieve by changing'.**

There is little research evidence regarding who would not benefit from motivational interviewing. However, clinical experience suggests the following exclusion criteria:

- Clients in acute physical, psychological, or social distress, including clients in pain or those who are psychotic or homeless. They may need referral for medical attention or supportive care.

- Clients who have marked cognitive deficits, particularly in concentration/attention and memory, such as those who are intoxicated, have significant alcohol-related brain injury/Korsakoff's syndrome, or are intellectually disabled. Motivational interviewing might be too cognitively demanding. Supportive counselling might be more appropriate.

- Clients who are severely depressed. It has been suggested that extensive exploration of the negative aspects of a client's drug use could reinforce the helpless/hopeless mind-set commonly experienced by people with depression. The focus of any initial intervention should be the assessment and treatment of the severe depression. A mental state assessment and appropriate medical

- Attention, therapy or referral might be required.

- Clients in immediate need of medical care as a result of their current drug use.

Such clients should be referred for medical attention.

(Holgate et al, 1996)

PRINCIPLES OF MOTIVATIONAL INTERVIEWING

Motivational interviewing is founded on five basic principles. A sound understanding of these principles will assist clinicians in the practical implementation of motivational interviewing.

The five principles are to:				
express empathy	develop discrepancy	avoid argumentation	roll with resistance	support self-efficacy

EXPRESS EMPATHY

- The crucial attitude is one of acceptance
- Skillful reflective listening is fundamental
- Ambivalence is normal and the clinician should demonstrate an understanding of the client's perspective
- Labeling is unnecessary

- Acceptance is not the same as agreement or approval. An attitude of acceptance should not prohibit the clinician from differing with the client's views.
- Respectful listening to the client, with a desire to understand his/her perspective is extremely important.
- Acceptance and respect build a working therapeutic alliance, and support the client's self-esteem - an important condition for change

(Miller & Rollnick, 1991).

DEVELOP DISCREPANCY

(a difference between conflicting facts or claims or opinions; "a growing divergence of opinion")

- Clarify important goals for the client and explore the consequences or potential consequences of the client's current, conflicting behaviour
- Create and amplify in the client's mind a discrepancy between current behaviour and goals

- Motivational interviewing has the potential to change the client's perceptions of discrepancy without creating a feeling of being pressured or coerced.
- This results in the client presenting the reasons for change, rather than the counsellor doing so.
- People are often more persuaded by what they hear themselves say than by what other people tell them.

When motivational interviewing is done well, it is not the clinician but the client who explicitly states the concerns and intentions to change (Miller & Rollnick, 1991).Specific, challenging and achievable goals towards abstinence or controlled drug use provide an immediate short-term direction for treatment.

AVOID ARGUMENTATION

- Arguments are counterproductive
- Defending breeds defensiveness
- Resistance is a signal to change strategies
- Motivational interviewing is confrontational in its purpose to increase awareness of problems and the need to do something about them. However, it is not in the spirit of motivational interviewing to work in anything other than a cooperative relationship with the client.
- Argumentation often creates defensive attitudes and barriers to change.

ROLL WITH RESISTANCE

- Avoid resistance, but where it arises, reframe client statements to create a new
- Momentum towards change
- Avoid confrontation
- Shift perceptions
- Invite, but do not impose, new perspectives
- Value the client as a resource for finding solutions to problems

- How the clinician avoids, or deals with, resistance is one of the defining characteristics of motivational interviewing.
- Denial is not inherent in clients, but arises from the interaction with the clinician. It can be elicited or reinforced by a confrontational interviewing style.

SUPPORT SELF-EFFICACY

- Belief in the ability to change is an important motivator
- The client is responsible for choosing and carrying out personal change
- There is hope in the range of alternative approaches available

- Essentially, self-efficacy means a person's confidence in his/her ability to cope with a
- Specific task or challenge. A client may, for example, suffer from very low self-esteem, but nevertheless be persuaded that it is possible and within his/her ability to change a particular problem.
- There is a strong emphasis on personal responsibility, and the need to encourage the client to make positive statements.

A client's acknowledgment that he/she was tempted to use over the past week but did not, can help reinforce that cravings and temptations can be mastered. Even using on one occasion but not again can be interpreted as a success (Helfgott, 1997).

The micro skills of motivational interviewing

There are a range of micro communication skills that will greatly assist you in your work with drug users.

Those detailed below are of extreme importance to you as you employ specific Motivational Interviewing strategies.

These micro skills are however not exclusive to Motivational Interviewing and underpin many communication and counselling styles.

ESTABLISH RAPPORT

It is crucial to establish rapport with your client as early as possible in the relationship as 'counselling rapport is a vital part of the therapeutic process and helps explain why and when treatment is effective' (Addy, et al., 2000).

We naturally experience rapport with close friends, however we may need to work at establishing rapport with clients, colleagues and other people that we meet. Luckily the ability to create rapport is a skill that can be learned.

There are many skills and techniques that can be utilised when establishing rapport. Two of these skills that are useful when working with clients are the ability to demonstrate a genuine interest in the other person's world, and to establish common ground. To assist you in this process:

- Introduce yourself
- Establish open communication lines
- Demystify and normalise the treatment process
- Provide the client with an overview of the service and clarify what their expectation is of you
- Inform your client of other treatments available that may be relevant to them

ACTIVE LISTENING

Listening skills are crucial to effective counselling. It must be remembered that listening is not a passive activity and consists of specific behaviours directed towards the person speaking.

The key components to active listening are:

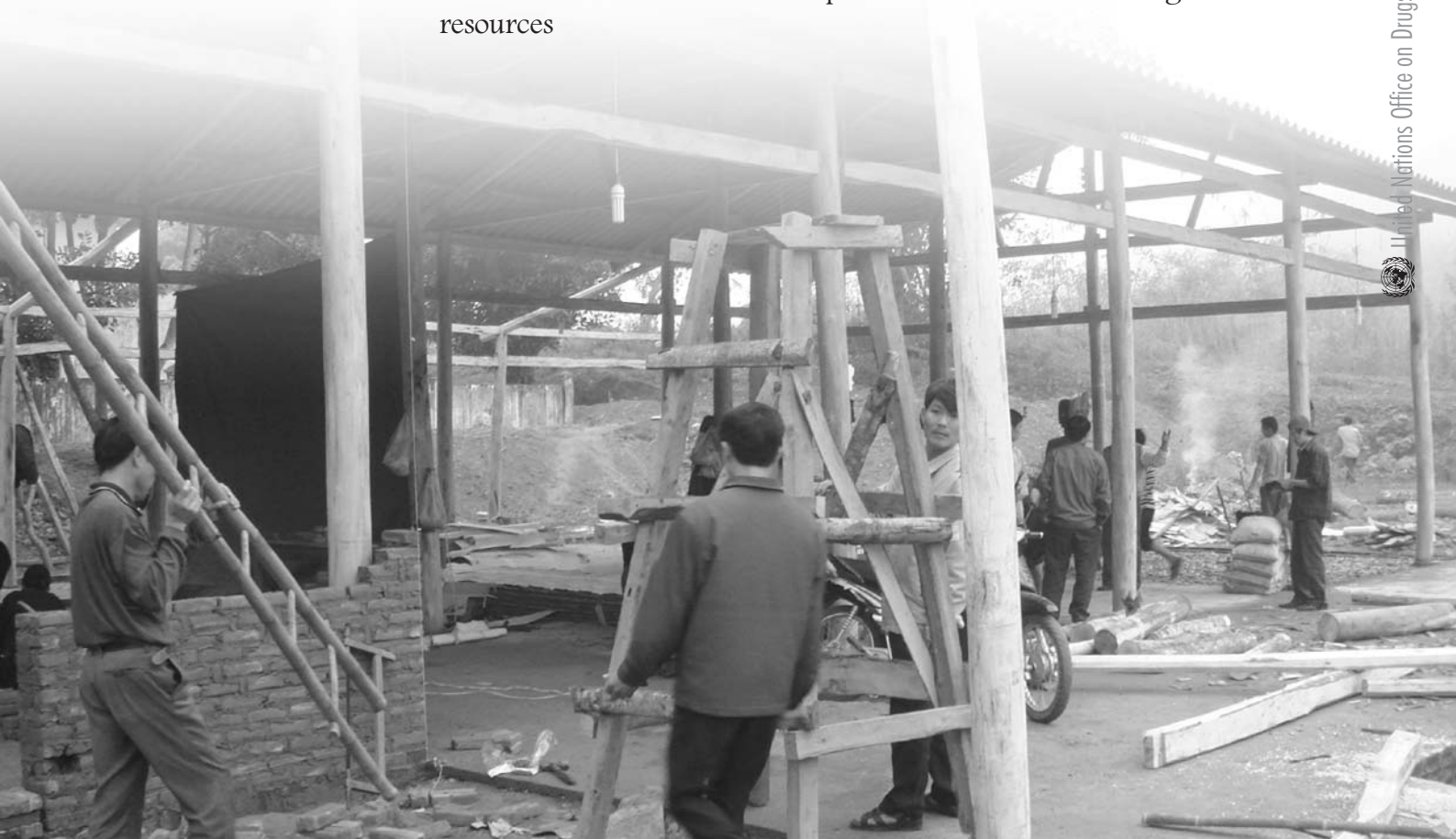
- Listening to the verbal content
- Observing non verbal cues
- Being perceptive

BEING EMPATHIC

'Empathy as a form of human communication involves listening to clients, understanding them and their concerns to the degree that this is possible, and communicating this understanding to them so that they might understand themselves more fully and act on their understanding' (Egan, 1994).

We can help to demonstrate empathy in our interaction with clients by

- Frequent reflection and validation of the client's feelings
- A non-judgemental approach
- An attitude which shows respect for the client's strengths and resources



OPEN AND CLOSED QUESTIONS

When working with clients it is useful to utilise both open and closed questions but it is important to use them at the most appropriate times.

Closed questions are ideal for assembling factual and specific information that can provide essential background information. These are especially important in the earlier stages of a counselling relationship.

Closed questions are also useful when the counsellor feels that the client is unable to handle any further exploratory questions.

Closed questions allow the client to respond very succinctly, usually with a 'Yes' or 'No' response. For example:

'Are you married?' or 'Do you have a job?'

Open questions on the other hand allow the client to respond more freely. This type of question does not predict a given response nor confine the response too narrowly. Open questions tend to seek elaboration or further clarification and are ideal for eliciting views, opinions and feelings.

For example:

'What would you like to talk about first?' or 'How are you feeling about this?'

Questions beginning with 'Why' are probably best avoided, as they tend to put the person on the spot and often involve some level of interpretation.

The counsellor will probably get more information from 'What was happening for you when you did that?' than 'Why did you do that?'

As a final point it is best if the counsellor can fluidly integrate open and closed questions into a session.

AFFIRM

Directly affirming and supporting the client during the counselling process is another way of building rapport and reinforcing open exploration.

This can be done in the form of compliments or statements of appreciation and understanding:

'Thanks for coming today'

'I appreciate you took a big step in coming today'

'I must say if I was in your position I might have a hard time dealing with that'

The point is to notice and appropriately affirm the client's strengths and efforts.

Stages of change model

While health professionals use several different models for understanding behaviour change and designing successful interventions, one of the more prominent models is the Stages of Change (or Transtheoretical) Model (Prochaska & Di Clemente, 1982). This model provides a useful framework for explaining how behaviour change occurs. It views behaviour change as a process, with individuals at various stages of

readiness to change.

This model acknowledges that not everyone is ready to change behaviour, a fact that we often find difficult to accept.

The Stages of Change Model proposes that changes in health behaviour are not discrete events. Rather, people change as they progress through six stages. In each of the stages, a person has to struggle with a different set of issues and tasks that relate to their drug taking behaviour. There are six stages:

- Pre-contemplation
- Contemplation
- Determination/Preparation
- Action
- Maintenance
- Relapse

Each of these stages are described in more detail in the following section (refer to Figure 1).

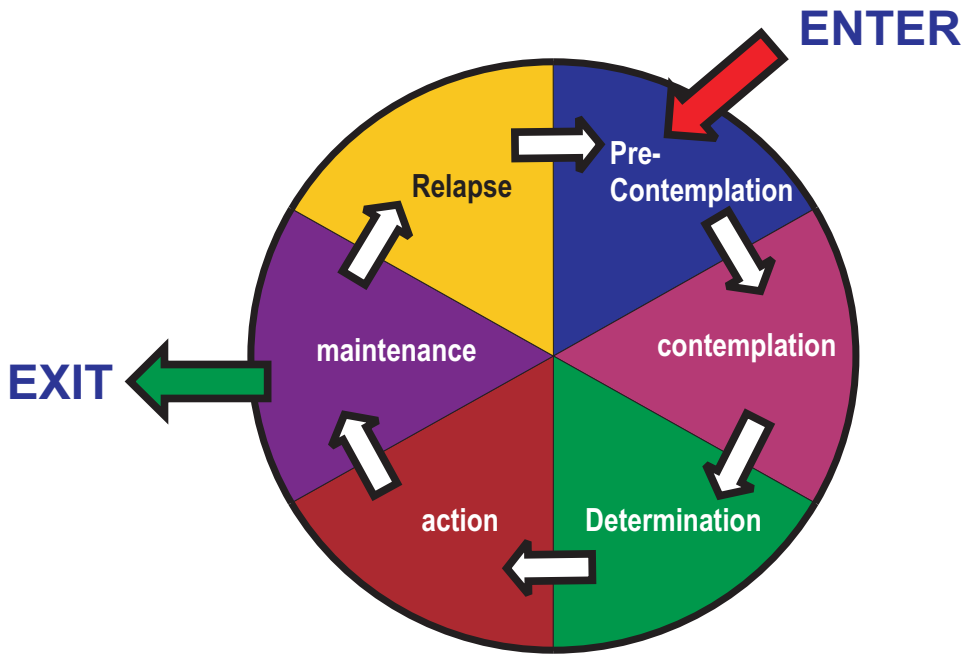


Figure 1. Stages of Change

PRE-CONTEMPLATION

In the Pre-Contemplation stage, people are not thinking seriously about changing and are not interested in any kind of intervention. People in this stage tend to defend their current drug use.

They may be defensive in the face of other people's efforts to pressure them to stop.

They can be in this stage for several reasons:

- Discouragement with previous unsuccessful attempts
- Lack of awareness about the personal consequences of drug use
- Fond memories of positive experiences and associations attached to their drug use
- Enjoyment of the image of themselves as a user
- Or a belief that they are too addicted to stop.

Whatever the reason, they spend little time thinking about their drug use and may not feel it is a problem.

- ***People in the pre-contemplation stage spend little time thinking about their drug use and may not see it as a problem.***

CONTEMPLATION

In the Contemplation stage, the drug user seriously thinks about stopping sometime in the near future (often defined as six months).

People in this stage are more aware of the personal consequences of their drug use and they spend more time thinking about their drug as a problem. Although they are able to consider the possibility of stopping, they tend to be ambivalent about it.

This means that, although they think about the negative aspects of drug use and the positives associated with stopping, they may doubt that the long-term benefits associated with quitting will outweigh the short-term costs.

This can result in the situation where someone continues to 'contemplate' for a long time!

- ***People in the contemplation stage are thinking about their drug use - may even be thinking about quitting - but feel ambivalent about the next step.***

On the plus side, this is the stage where people can begin to identify personal strengths and personal and environmental barriers relevant to quitting.

They are more open to receiving information about drugs, and more likely to actually use educational interventions and reflect on their own feelings and thoughts concerning drug use.

DETERMINATION / PREPARATION

In the Preparation stage, people may have made an attempt to stop in the past year and are thinking about quitting in the near future. They see the cons (disadvantages) of drug use as outweighing the pros (advantages), and they are less ambivalent about ceasing their drug use. They have likely learned something important from their recent quit attempt and are now taking small steps toward quitting completely. They may be delaying their first 'taste' of the day or using less frequently. Their motivation for quitting is reflected by statements such as: 'I've got to do something about this - this is serious.' 'Something has to change. What can I do?'

- ***People in the preparation stage have made the decision to quit and are taking steps to get ready to actually stop.***

ACTION

In the Action stage, people are actively involved in taking steps to change their drug use behaviour using different techniques.

The amount of time people spend in action varies but, generally, the stage lasts about six months.

People in the action stage are making overt efforts to quit and are at **greatest** risk of relapse.

They tend to be open to receiving help and believe they have sufficient autonomy to change their behaviour.

They pay attention to their behaviour to maintain their efforts and are likely to seek support from others.

Mentally, they review their commitment to themselves and develop plans to deal with both personal and external pressures that may lead to slips.

They may use short-term rewards to sustain their motivation, and analyse their behaviour change efforts in a way that enhances their self-confidence.

- ***People in the action stage are actively trying to stop. They may try several different techniques and are at greatest risk of relapse.***

MAINTENANCE

Maintenance is the last stage and involves being able to successfully avoid any temptations to return to drug use.

People in the maintenance stage are able to anticipate the situations in which a relapse could occur and prepare coping strategies in advance.

They remain aware that what they are striving for is personally worthwhile and meaningful.

They are patient with themselves and recognise that it often takes a while to let go of old behaviour patterns and adopt new ones.

If they slip and use, they don't see themselves as having failed. Rather, they define it as an indication that they have to learn to cope differently and analyse how the slip happened.

This gives them a stronger sense of self-control and the ability to get back on track.

They tend to remind themselves of how much progress they have made.

- ***People in the maintenance stage have learned to anticipate and handle temptations to use, and are able to try new ways of coping. Although they may lapse and use from time to time, they learn from the lapse so that it does not happen again.***

RELAPSE

Along the way to permanent permanently quitting, most people experience relapse.

Relapse is often accompanied by feelings of discouragement and seeing oneself as a failure.

While relapse can be discouraging, the majority of people who successfully quit do not follow a straight path to maintenance.

They may cycle through the five stages several times before reaching maintenance.

Consequently, the model considers relapse to be a normative event - those who relapse return to a previous stage of readiness to change and remain in the process.

- ***Relapse is a normal occurrence along the way to quitting. It is important for a person to look at exactly why he/she has relapsed and make plans to cope with similar circumstances in the future.***

Relapses can be important opportunities for learning and becoming stronger or they can be excuses to give up.

There is a real risk that the person will experience an immediate sense of failure that can seriously undermine their self-confidence.

The key to recovering from a relapse is to review:

- **The quit attempt up to that point**
- **Identify personal strengths and weaknesses**
- **And develop plans to resolve those weaknesses to solve similar problems the next time they occur.**

People who have relapsed may need to learn to anticipate high-risk situations more effectively, control environmental cues that tempt them to use (like being around friends who use), and learn how to handle unexpected episodes of stress without using.

Interventions according to stage

Different clients are likely to be at different stages of change and consequently may need different types of interventions. It is important to assess the client's stage so that interventions can be tailored accordingly.

- ***Pre-contemplators*** may benefit from information about the potential risks and problems about their drug use and some advice about how to avoid and reduce the harm of their drug use
- ***Contemplators*** may find it useful to assess the pros and cons of their use in order to make an informed decision about whether to change or continue their behaviour
- ***Determined / preparers,*** may require reinforcement about their reasons for change and practical advice on how to do it if they are going to change
- ***Actioners*** may require problem-solving and goal-setting skills to help them cope with the changes being made and to respond to potential relapse situations
- ***Maintainers*** may require review of the strategies that they have found useful in changing and dealing with any potential difficulties as well as reinforcing benefits that have been achieved
- ***Relapsers*** will need to analyse the relapse event, be encouraged to see it as a learning experience rather than a failure, and to assess high risk situations and focus on the pros and cons of taking immediate action again

Regardless of the stage a client is at, it is important to inform all clients about harm reduction practices to protect themselves should they continue to use or indeed return to drug use after a period of non-use.

It is worth noting that a client's motivation to change is highly influenced by two factors:

- ***Their*** own ***belief that things will be better if they do change and***
- ***That they*** can ***actually achieve change if they want to***

If we take stopping using drugs as an example of behaviour change, it should be acknowledged that some clients may have a belief that things won't be any better if they stop using drugs.

Therefore they don't try to stop using. Others, who may realise that it is time to stop using drugs, do not try because they do not believe that they can stop.

Most will not even try to stop unless they feel that it will be better without drugs and that they can get off drugs.

When working with clients it is important that the benefits of reducing their drug use and their ability to achieve behaviour change are reinforced and supported.

Review

This model is of extreme importance to work with drug users.

Change is seen as a process involving six stages:

- Pre-contemplation
- Contemplation
- Oreparation
- Action
- Maintenance
- Relapse.

Whilst it is acknowledged that not everyone will proceed through each of these stages in an ordered fashion - some for example, may never progress beyond the contemplation stage - being aware of which stage your client is at in terms of their drug use can guide what you should then be doing for that client.

- **Different interventions are suitable for clients who are at different stages of the cycle. Therefore it is important to find out which stage a client is at in order to provide appropriate and effective service.**

Stages of change and drug counsellors motivational interviewing tasks

STAGES OF CHANGE DRUG COUNSELLORS TASKS

Stages of change	Drug Counselors Task
Pre-contemplation	Raise doubt - increase the client's perception of risks and problems associated with current behaviour
Contemplation	Tip the balance - evoke reasons to change and the risks of not changing; strengthen the client's self-efficacy for change of current behaviour
Determination	Help the client to determine the best course of action to take in seeking change
Action	Help the client to take steps toward change
Maintenance	Assist the client to identify, and use strategies to prevent, relapse
Relapse	Help the client to renew the processes of contemplation, determination and action, without becoming stuck or demoralised because of relapse

Adapted from Miller & Rollnick, 1991

Practice Guidelines

Motivational interviewing has been developed to provide clinicians with flexible guidelines to help them in their work with clients.

Motivational interviewing draws largely on existing expertise such as clinical and basic counselling skills.

- **Motivational Interviewing is a style of counselling particularly suitable for people who are feeling ambivalent about changing their behaviour.**

- ***The counsellor practicing Motivational Interviewing will use non-directive counselling strategies, but in a particular way, and for-a particular purpose - to encourage the client to explore his or her ambivalence and to consider the possibility of change.***

In pursuing this goal, the counsellor always has a strong sense of purpose, and is sometimes directive and incisive.

Motivational Interviewing prepares people for change. If successful, the client will be ready to actually change their behaviour, at which point a range of other approaches will be useful.

- ***It is particularly appropriate when the person is at the pre-contemplation or contemplation stages, but can be used whenever someone is feeling ambivalent.***

Steps for motivational interviewing

Effective motivational interviewing involves five strategic steps which require clinicians to:

1. Establish rapport
2. Explore positive and negative aspects of drug use
3. Address ambivalence and motivation
4. Recognise and respond to resistance
5. Summarise and identify next steps

STEP 1: ESTABLISH RAPPORT

The initial contact should aim to establish rapport between the client and the clinician.

The clinician should:

- Introduce the service and him/herself
- Maximise the opportunity to engage the client in the treatment Process, establish
- Communication lines and lessen client anxiety.

  Ideally all liaisons, contact and assessment should be delivered by the same clinician
- Demystify and normalise the treatment process
- Provide the client with an overview of the intervention. It is advisable to explore
- The client's expectations of the intervention to help identify its potential usefulness.
- Inform the client of other available treatment approaches

STEP 2: EXPLORE POSITIVE/NEGATIVE ASPECTS OF DRUG USE

Motivational interviewing is based on the premise that people are already motivated to change, but perhaps not always in the direction in which others would like them to be going.

Understanding a client's motivation for not changing is just as important as understanding his/her desire to change.

'GOOD THINGS, LESS GOOD THINGS' STRATEGY

The 'good things, less good things' strategy integrates the principles of motivational interviewing as well as drawing on general counselling concepts.

It aims to explore the client's feelings about his/her drug use, without imposing any assumptions about the use being problematic.

The client, rather than the clinician, identifies potential problem areas. Bell and Rollnick (1996, p 274) acknowledge the benefits of the 'good things, less good things' strategy in the following excerpt:

An exploration of the two sides of the client's substance use serves a number of purposes.

The first is to express empathy for the client's position.

In addition, by eliciting from the client the benefits and costs of his or her alcohol or drug use, ***the strategy is also a useful way of assessing the stage of change and the degree of ambivalence*** within the client.

It is important, however, that the worker or counsellor does not presume that the costs or 'less good things' related to substance use are a source of concern to the client, and that terms such as ***'problem' or 'concern' are avoided.***

Rather, the strategy creates and amplifies a sense of decisional balancing within the client, with the ***aim of facilitating client reflection and sources of possible concern.***

This strategy is also useful for exploring ambivalence about changing drug use. For example, the clinician could ask:

1. What would be some of the good things about change?
2. What would be some of the less good things about making a change?

Some of the benefits of the 'good things, less good things' strategy are that it:

- Helps build rapport
- Is useful for clients who seem unconcerned about their drug use
- Minimises resistance because it starts with the positive things about a person'sdrug use and discusses the 'less good things', rather than 'concerns' or problems'
- Allows the client to identify problem areas without feeling that these are beinglabelled as problematic
- Helps in assessing readiness for change and other issues in the client's life

(Rollnick, Heather & Bell, 1992, cited in Turning Point Alcohol and Drug Centre & NCETA, 1997)

STEP 3: ADDRESS AMBIVALENCE AND MOTIVATION

For clinicians to appropriately explore client self-efficacy, they need to have a good understanding of ambivalence and motivation.

AMBIVALENCE

Ambivalence is a common experience of feeling torn between wanting and not wanting to change, which results in the inability to change, or being 'stuck'. A client typically brings ambivalence to counselling and it is the clinician's response that influences the degree of client resistance and change. In order to understand ambivalence, the clinician must remember the following factors:

- Ambivalence is normal and potentially powerful
- Ambivalence can be ongoing for quite some time, even after a decision to change has been reached, or even after change has occurred
- Working with client ambivalence, rather than ignoring or denying it, can be one of the keys to helping people move along the change process
- Change is a process, not a single event; different interventions are appropriate at different stages of the change process

MOTIVATION

Motivation is not a static entity, and it can change in minutes, days or weeks.

The way a client presents in one encounter is only evidence of his/her motivation at that point in time. Thus, with every presentation it is important to clarify the client's agenda, and to assess and reassess the level of motivation.

THE DECISIONAL BALANCE EXERCISE

This is a tool that can be utilised when working with clients who are ambivalent about their drug use (contemplators).

It is generally more effective if a therapeutic relationship has already been established and involves asking the client a series of questions and recording their answers on paper.

By recording their answers on paper, and being careful to use their words and phrases rather than paraphrasing, the client has a visual chart of their thoughts on their drug use. Begin by asking the client:

- *What do you like about doing X? but also ask them*
- *What are the not so good things about X?*

Ask the client if they could score their response to these questions from 1 to 10 and record the scores (refer to Table 1 decisional balance).

Some clients may have an equal number of good and less good things but may have allocated different scores of importance to them.

Depending on how what they have said it may be clear that they are ripe for further change and are ready to do something right now.

For others, this exercise may illustrate that action or change is not yet likely.

This exercise can however be completed some time in the future and any differences between their old view and their current view can be identified and explored further.

This can be extremely powerful in that even though the client may not have been able to achieve any behaviour change, it is clear to them and to you that they are thinking differently about their behaviour.

Table 1. Decisional balance exercise - present

Good things	Score	Not so good things	Score
Feel good	6	*Expensive*	3
Helps me forget	4	*Illegal*	9
Relief from boredom	9	*Dangerous*	9
		Family hassle	9

For some clients it may also be useful to add a further dimension to the exercise and ask them to look to the future and identify any rewards or drawbacks to should they decide to do something about their drug use (refer to Table 2). For example:

- Looking *to the future, if you were to decide to change what might be the rewards for you?*
- *If you were going to change, what might be the difficulties or drawbacks?*

Table 2. Decisional balance exercise - future

Positive change	Score	Negative change	Score
Get family back	9	*Loose some mates*	4
No legal trouble	8	*Be bored stupid*	9
Less danger	9		

The importance of the clients response to change should also be explored to help the client consider what they really want to do.

HOW TO DO IT

To use this strategy, ask the client:

- **'What are some of the good things about your use of ...?'**

Elicit these good things, one by one, then summarise them for the client.

Then, ask the key question:

- **'What are some of the less good things about your use of ...?'**

Elicit these, one by one, with the aim of finding out why the person thinks these are 'less good things'.

Summarise the good things and less good things in words that include 'you', leaving the client time to react. For example:

- *You just said that there would be all these positives to gain from ….'*

Finally, explore the client's reaction.

THINGS TO KEEP IN MIND

When using this strategy, you should keep the following in mind:

- **Use micro skills: open questions, reflective listening and summary throughout strategy.**
- **Adhere to the principles of Motivational Interviewing throughout the strategy.**
- **Keep to the task at hand. Acknowledge issues as they are raised, then return to the good and less good things. Come back to issues raised later.**
- **Avoid using words like 'problem' or 'concern' unless the client does. Don't assume that a 'less good thing' is a cause for concern to the client.**

An alternative format for this strategy is to ask:

- 'What do you like/dislike about your use of ...?'

UTILISE IMPORTANCE AND CONFIDENCE RULERS

In their second edition, Motivational Interviewing: Preparing people for change, Miller and Rollnick advocated for the use of importance and confidence rulers (Miller & Rollnick, 2002).

It useful to understand a person's ambivalence and one way of measuring this is to explore the perceptions of both importance and confidence around potential for change.

Both aspects need to be addressed early because both are components of intrinsic motivation for change.

On a scale system ask clients to rate how important it is for them to, for example, change their drinking patterns? (0 meaning not important and 10 very important)

IMPORTANCE/CONFIDENCE RULER

Importance ruler		
0----------10		
not at all important	Important	extremely

Ask questions to determine why not lower? Or, what would it take to move higher?

Repeat the same process with the confidence ruler

Confidence ruler		
0----------10		
not at all important	Important	extremely

It is not necessary to show the client a ruler, though it can be useful to do so. However, as you proceed the idea is to end up knowing how important the client perceives change to be, and how confident the person is that they could do it.

This can be of assistance in helping you develop a discrepancy between their current behaviour and what is really important to them.

STEP 4. RECOGNISE AND RESPOND TO RESISTANCE

How resistance is dealt with is one of the defining characteristics of Motivational Interviewing. A goal of Motivational Interviewing is to avoid eliciting resistance. Denial is not inherent in clients. It arises out of the interaction between counsellor and client and can, for example, be elicited or reinforced by a confrontational interviewing style.

- **A change in counsellor style can lead to a change in client resistance.**

Recognising resistance

Resistance is observable behaviour that occurs during treatment. It signals to the counsellor that the client is not keeping up (or that the counsellor is going too far ahead too quickly). There are four categories of resistance.

1. ARGUING

The client contests the accuracy, expertise or integrity of the counsellor by:

- **challenging** - where the client directly challenges the accuracy of what the counsellor has said
- **discounting** - where the client questions the counsellor's personal authority and expertise
- **hostility** - where the client expresses direct hostility towards the counsellor

2. INTERRUPTING

The client breaks in and interrupts the counsellor in a defensive manner by:

- **talking over** - where the client speaks while the counsellor is still talking, without waiting for an appropriate pause or silence
- **cutting off** - where the client breaks in with words obviously intended to cut the counsellor off (eg 'Now wait a minute. I've heard enough.')

3. DENYING

The client expresses an unwillingness or inability to recognise problems, cooperate, accept responsibility or take advice by:

- **blaming** - where the client blames other people for problems
- **disagreeing** - where the client disagrees with a suggestion that the counsellor has made, offering no constructive alternative. This includes the familiar 'Yes but...' which explains what is wrong with suggestions that are made
- **excusing** - where the client makes excuses for his or her behaviour
- **claiming impunity** - where the client claims they are not in any danger from their behaviour
- **minimising** - where the client suggests that the counsellor is exaggerating risks or dangers and that 'it really isn't so bad'
- **pessimism** - where the client makes general statements about themselves or others that are pessimistic, defeatist or negative in tone
- **reluctance** - where the client expresses reservations and reluctance about information or advice given
- **unwillingness to change** - where the client expresses a lack of desire or an unwillingness to change or an intention not to change

4. IGNORING

The client shows evidence of not following or of ignoring the counsellor by:

- **inattention** - where the client's response indicates that he or she has not been following or attending to the counsellor
- **non-answer** - where in answering a counsellor's query, the client gives a response that is not an answer to the question
- **non-response** - where the client gives no audible or non-verbal reply to a counsellor's query
- **side-tracking** - where the client changes the direction of the conversation that the counsellor has been pursuing

Responding to resistance

Resistance responses are normal but if they are reinforced and become persistent this can cause problems.

How the counsellor responds is crucial.

In many cases resistance is the client's way of saying *'Hang on, I'm not with you, I don't agree'.*

When resistance occurs the counsellor's task is to double back, find out where the client is, and work from there. Ways of responding to resistance include:

1. EMPHASISING PERSONAL CHOICE AND CONTROL

Resistance often occurs when freedom of choice is being threatened. A good antidote is to assure the person that in the end they decide what should happen.

2. SIMPLE REFLECTION

Resistance can be met with non-resistance. Simple acknowledgment of the client's disagreement, emotion or perception can permit further exploration rather than defensiveness.

- Amplified reflection

Reflecting back what the client has said in an amplified or exaggerated form can be a useful response to resistance.

If successful, the client will back off a bit and might articulate the other side of the ambivalence.

This must be done artfully, however, because too extreme an overstatement may itself elicit further resistance.

3. DOUBLE-SIDED REFLECTION

This is a response where the counsellor acknowledges what the client has said and adds to it the other side of the ambivalence.

This requires the use of materials that the client has offered previously.

4. SHIFTING FOCUS

This is where attention is shifted away from the stumbling block, by going around barriers rather than trying to climb over them.

5. REFRAMING

This involves acknowledging the validity of the client's raw observations, but offering a new meaning or interpretation.

STEP 5: SUMMARISE AND IDENTIFY THE NEXT STEPS

The final step in motivational interviewing is to summarise what has been discussed, including the positive and negative aspects of drug use, the degree of ambivalence shown by the client, and the client's motivational stage at that point in time.

For clients whose positive perceptions of continuing drug use outweigh the negative ones and who demonstrate low levels of motivation to change, the provision of harm reduction information is important

- **In most instances of motivational interviewing, however, the clinician will see a 'window' of opportunity for some behaviour change, whether it be a reduction in drug use, a safer method of drug use, cessation of drug use, or a change in some other aspect of quality of life.**

The identified opportunities for change should be summarised and the clinician should:

- **provide further** information **to enable the client to make these changes**
- **refer the client to another** clinician**/service to progress the changes**
- **make another appointment to continue working with the client**

Common traps when working with clients -the opposite of motivational interviewing!

There are a number of traps that counsellors can fall into, particularly when working with a client who is feeling ambivalent about change or in conflict about their substance use.

- **The following are probably the most common, particularly in situations where there is a strong desire to change someone's behaviour (Miller & Rollnick, 1991).**

THE CONFRONTATION / DENIAL TRAP

This is a predictable pattern that can occur, particularly when the client is experiencing a degree of ambivalence.

The counsellor can get caught up arguing about the problem and the need to change, whilst the client is left to either agree or to argue that there is not such a problem and why they don't wish to change, at which point the client is usually labelled as being in denial and therefore needs more convincing arguments why they should change.

This usually serves to reinforce the client's resistance and 'denial'! Hence, the counselling interaction becomes a downward spiral with no winners - it becomes a 'push / push-back conflict'.

THE CLOSED QUESTIONS TRAP

- **When the client is responding with a lot of 'yes' or 'no' responses, and it feels like the session is not going anywhere, then it is probable that the client is responding to a lot of closed questions!**
- **This can be a trap for both experienced and inexperienced counsellors.**

Unfortunately, it is often the first trap that we fall into when first meeting a new client.

- **The assessment process can very easily fall into a series of 'yes' or 'no' questions before any rapport building has taken place.**

Closed questions are usually based on the counsellor's agenda, aimed at finding out what the counsellor wants to know.

It is a style that can also be a recipe for burnout, as closed questions require the counsellor to do most of the thinking.

It is not about right or wrong, but more open questions and a reflective style will not only help to avoid this trap but also serve to allow the client to hear him/herself speak.

THE EXPERT-PROBLEM-SOLVER TRAP

Another way to put this is 'Trust me, I know what is best for you'.

When the counsellor sets him or herself up as the 'expert', it leaves the client in a position of powerlessness, which may lead to either a passive client who blames you if the advice does not work or a resistant client who wants to get some of the power back.

Another problem with this trap is that the 'expert' is usually the one who does all the work, which can be a recipe for burnout.

Motivational Interviewing works on the basis that the client is in fact the 'expert on themselves'.

THE LABELLING TRAP

- **Counsellors and clients can get very caught up in the issue of diagnostic labelling. Sometimes, counsellors feel that it is important for a client to accept a label of 'alcoholic/addict' for example.**

Labelling can also be more subtle, for example: the need to accept statements such as 'your problem ... '. Very often, labelling in its more or less obvious forms can serve to lead the client to feel trapped into a position of either accepting the label or risk being labelled as being resistant or 'in denial' (a position from which they cannot win!).

The Motivational Interviewing model recommends the de-emphasis on labelling. Problems can be explored and understood without the use of labels.

THE PREMATURE FOCUS TRAP

When you give someone advice, what is the assumption that you make? That they are ready to carry out the advice and also have the resources to do it.

With your clinical experience you may be able to have a strong indication of how and why the client's behaviour should change but if you focus on it prior to the client, the likelihood of the client listening to and responding to your advice is limited.

Solution Focused Therapy

Solution Focused Therapy (SFT) has its roots in the work of Milton Erikson. He was one of the first theorists to posit that the problems individuals and families experience are not reflective of neurotic or pathological traits.

Rather problems are best conceived of as ineffective solutions. Erickson suggested that **people inherently know the correct answers to their problems.**

Most therapies see clients as coming into therapy with problems seeking help; **solution-focused therapists see clients as coming in with solutions seeking expression (Perkins, 1999.)**

What is solution focused therapy

Solution Focused Therapy is both a set of strategies and a theoretical perspective.

The solution focused worker believes that helping clients with drug use issues to address any life problems they find significant will help them to reduce their drug use.

Researchers Berg and Miller (1992) were the first to apply the model specifically to the treatment of alcohol related problems in the USA [Berg & Miller, 1992]. Solution Focused Therapy has emerged in the past 15 to 20 years and has been suggested as a viable approach, specifically in the treatment of alcohol use disorders (Osborn, 1997)

SFT is described as useful for a number of reasons:

- it is practical and simple
- it is a brief therapy making it attractive especially in services where episodes of care are limited
- it has a cognitive emphasis
- it is easily teachable

Most drug interventions place the emphasis on identifying and intervening with the at-risk behaviours or patterns of drug use.

Solution Focused Therapy is usually brief (average 4-6 session) and focuses on:

- **what is the positive outcome that the client is wanting?**
- **what specifically will be different when that outcome is achieved?**
- **what are examples of either current or past behaviours that indicate the client was able to achieve, even if only partially and or temporarily, the desired goals**

The key assumption is that the client is not experiencing problematic drug use

- 24 hours per day,
- 7 days per week,
- 365 days per year.

There are going to be exceptions, if only brief, where the client, whether intentionally or not, has been able to establish either a drug free period or has substantially reduced their levels of use.

In SFT, these exceptions are first identified then the factors and skills the client has employed to achieve these outcomes, however briefly, are explored.

Drug use history and cause are not of high importance in SFT.

Steve de Shazer et al (1985) were the first to develop a specific set of strategies and skills that incorporate a focus on solutions and the client's capacity for actualising those solutions. (de Shazer, 1985)

KEY ASSUMPTIONS

CLIENTS HAVE RESOURCES AND STRENGTHS TO RESOLVE COMPLAINTS

This assumption asserts that all clients have inherent strengths and abilities that can be used to address their complaints.

- Clients may be using these strengths in ineffective ways or may not be aware of these strengths.

The counsellor's task is to help the client identify these strengths and strategies. Focusing on positives or desired outcomes tends to facilitate change in that direction.

- Therefore maintaining focus on desired outcomes is more helpful than focusing on the problems.
- Interactions which focus solely on problems and what may have caused the difficulties, may leave individuals feeling deflated, guilty and hopeless, particularly if they have already been attempting to address their problems with limited success.

Interactions that focus on what the client would like to see as an outcome, and possible strategies to achieve that desired outcome encourage optimism for change.

- By the client identifying small steps that they have already taken towards their goal, and then identifying further small steps to take, they can begin to build momentum for change.

There are always exceptions to the problem and it is in the exceptions where solutions will be identified.

SFT makes the assumption that, even if only rarely, clients do experience times where they are not experiencing the problem or they are able to limit or manage the problem.

- Exploring these exceptions in detail can identify possible skills and strategies that the client and their family employ during problem-free times.

This awareness may enhance optimism and confidence regarding the likelihood of a positive outcome for the client and their family.

CLIENTS ARE SEPARATE FROM THEIR COMPLAINTS

Though this idea may seem obvious it is important for the counsellor to be clear that the client is not the problem.

From an SFT perspective, a client is not an 'addict' but rather someone who is experiencing difficulties, however severe, with the use of alcohol and or drugs.

- It is imperative that the counsellor assists the client in acknowledging the fact that they have had numerous other experiences, relationships and knowledge, which define the client as being much more than someone with an drug related problem.

CLIENTS KNOW WHAT IS RIGHT FOR THEM

This assumption is very important.

The client could, also interpret often what might be identified as resistance or low motivation, as a response that their goals or ideas are not being acknowledged.

- SFT counsellors work under the belief that it is the client who is the expert on themself.
- They are much more aware of the goals that are more realistic for them to address and what strategies will best suit their abilities and unique situation.
- Though an SFT counsellor will point out other issues that might need to be considered, the emphasis of support is on the client's identified goals.

SMALL CHANGES CAN LEAD TO BIGGER CHANGES

There are times when a client will present with drug related difficulties and upon further investigation many other psychosocial difficulties are identified.

An SFT counsellor would begin their work with a belief that:

- the goal is not to address all problems at once but rather by addressing one or two smaller problems
- the skills, strategies and confidence enhanced within the client will support and motivate them to begin addressing several other issues.

THE COUNSELLOR'S TASK IS TO IDENTIFY AND AMPLIFY CHANGE

The key to supporting change is for the counsellor to direct questioning that will illuminate where change is already starting to take place.

The process of identifying, and therefore validating change the client is making, provides reinforcement for their constructive efforts.

- For some clients, identifying their change process also provides much needed evidence that indeed change is possible.
- It is usually not necessary to know much about the complaint in order to resolve it.

SFT counsellors work from the premise that having an extensive history of the problem is not a prerequisite for assisting the client in developing effective solutions.

SOLUTION FOCUSED THERAPY IS THEORETICAL AND CLIENT DETERMINED

Little time is devoted to figuring out or explaining why problems exist.

The client's view is simply accepted at face value, for this reason, and no time is expended trying to convince clients that they must accept a particular theoretical orientation in order to be helped.

PARSIMONY

This means accepting the client's complaint at face value and then choosing the simplest, least invasive treatment option and keeping it simple.

- 'Simple' permeates solution-focused therapy.

CHANGE IS INEVITABLE

The solution-focused approach is based on the assumption that:

- **change is so much a part of living that clients cannot prevent themselves from changing. (de Shazer, 1985)**

Therapy identifies change and then utilises it to bring about a solution.

The solution focused worker searches for those times when a problem is not a problem and by discovering what is different about these occasions the worker hopes to increase the frequency of the occurrence.

PRESENT AND FUTURE ORIENTATION

The solution-focused approach has a strong orientation toward the present and future.

- **In this respect the present and future adjustment of clients is given precedence over that of the past.**
- **This is not to say that what people communicate about their past is irrelevant, rather such information is considered as a reflection of how clients are currently living their lives.**

The specially designed interview process orients the clients away from the past and the problem and toward the future and the solution.

For example the following question is a routine part of the solution focused interview process and is known as the 'miracle question':

'Suppose that one night, while asleep there is a miracle and the problem that brought you here is solved. However, because you are asleep you don't know that the miracle has already happened. When you wake up in the morning what will be different that will tell you that the miracle has taken place? And, what else?'

- The miracle question directs the client to imagine a time in the future when the problem no longer exists. Continuing with the question 'what else?' further directs the client to develop greater detail and a vivid description that serves to make change more real.

COOPERATION

An overall attitude of cooperation is all through the solution-focused approach and means working together with one another.

- Not only must the client cooperate, but also so must the worker.

Solution focused workers are described as very rarely having difficult or resistant clients because the belief is that the clients have the skills and resources and this avoids having to sell them our answers.[Berg & Miller, 1992]

SOLUTION FOCUSED THERAPY FOR AOD USE PROBLEMS

Solution focused brief techniques may be considered to be similar to Motivational Interviewing (MI) in that there is a very clear set of techniques and strategies recommended for the counsellor to follow.

As with MI, it is important you understand the theoretical assumptions that support the techniques.

The basic belief of the solution-focused model are fairly simple; they are the same when used for treating drug use as they are for treating other health concerns.

The worker emphasises finding solutions to a problem, not on discovering the cause or origins of the problem. (Barry 1999).

Berg and Miller relate the central philosophy of solution focused therapy in the following three rules (Berg & Miller, 1992)

- 'If it aint broke, don't fix it'
- Once you know what works, do more of it!
- If it doesn't work, then don't do it again - do something different.

Solution focussed interviewing strategies include the following:

- ask the **'miracle question'** (eg, 'If a miracle just happened and your drug use was suddenly not a problem for you, how would your life be different?')
- ask **about exceptions** (eg, 'Are there ever times you see pieces of the miracle?')
- explore differences **between current status and the desired problem**-free state (eg, 'What is the difference between the times when you can see pieces of the miracle and the times when you can only see the problem?')
- **using scaling** to determine:
    - how well the client thinks things are going

      how willing they are to work toward the miracle
    - their confidence in their ability to change and the steps needed to improve the situation from one rating on the scale to the next highest
    - try taking ***'time-outs'*** and suggest to the client 'While I step out, I want you to think of a the next smallest step you could take that would bring you to the next number on the scale'

- affirm **client competencies**, eg, ' I am impressed that you are sitting in that chair again after what you just went through'. Many of these clients have never had this success before
- suggest **tasks that the client can perform** to improve their situation (eg, ask them to do something achievable that would provide useful information or move them closer to the miracle they have chosen)

SUGGESTED READINGS AND RESOURCES

Berg, I.K.& Miller, S,D.1992 Working with the problem drinker. A solution-focused approach. W.W. Norton USA

Cognitive behavioural therapy

Introduction

In this topic we will be referring to the works of some of the major contributors to Cognitive Behavioural Therapy (CBT), including Ellis, Beck and Meichenbaum. An overview of CBT including key principles and assumptions will be provided prior to more specific information on the following:

coping skills therapy

relapse prevention

cognitive therapy

cognitive behaviour modification

rational emotive behavioural therapy

What is CBT?

An approach that has gained widespread application in the treatment of AOD and other health issues is CBT, primarily because it is the most researched of the available therapies for drug use and has the most evidence to support it. This is not to say that other therapies aren't effective, many just don't have sufficient evidence to say one way or another.

PRINCIPLES OF CBT

There are several key cognitive behavioural principles, including:

- therapy is here and now and relatively brief. Intense and detailed examination of the past is not considered essential to change
- it is structured and goal oriented, but flexible and tailored to client's current concerns
- it is client-driven and worker facilitated. The client and worker enter into a partnership and work collaboratively toward the goals. All aspects of therapy are made explicit to the client
- there is considerable emphasis on operationalising terms and constructs and empirical validation of treatment. Continual evaluation, monitoring and assessment are the cornerstones of the cognitive-behavioural approach
- assessment forms an essential part of treatment
- increasing understanding and awareness of cognitions (thoughts) and the link with behaviour and emotions is the key to change
- cognitive and behavioural skills and strategies are the mechanisms of change
- managing antecedents and consequences are the focus of therapy
- skills are practised within the session then reinforced outside the session as 'homework'

BASIC ASSUMPTIONS OF CBT

The following list outlines some basic theoretical assumptions behind cognitive behavioural treatments.

- human behaviour is largely learned, rather than determined by genetic factors
- the same learning processes that create problem behaviours can be used to change them
- behaviour is largely determined by contextual and environmental factors
- covert behaviour such as thoughts and feelings is subject to change through the application of learning principles
- actually engaging in new behaviour in the context in which it is performed is a critical part of behaviour change
- each client is unique and must be assessed as an individual in a particular context
- the cornerstone of adequate treatment is a thorough behavioural assessment

Source: Rotgers, 1996 [56]

Benefits of CBT

The list below outlines some basic benefits of CBT.

- flexible in meeting client's specific needs
- readily accepted by clients due to high level of client involvement in treatment planning and goal selection
- soundly grounded in established psychological theory
- derived from scientific knowledge and applied to treatment practice
- provides structured guidelines for assessing treatment progress
- empowers clients to make their own behaviour change
- effective, according to strong empirical and scientific evidence

Levels of CBT

CBT can be thought of as operating at a number of different levels:

1. *Cognitive behavioural approaches* - these are approaches to treatment that are based on the cognitive behavioural model but that do not necessarily fulfil all requirements to be referred to as CBT. An example of this are the opportunistic brief interventions based on the AUDIT questionnaire that were developed for the World Health Organisation
2. *Cognitive behavioural techniques* - these describe a set of techniques that are drawn from the various forms of CBT listed above, but that are used in an ad hoc manner, or as part of another therapy framework
3. *Cognitive behavioural therapy* - this describes a set of techniques that are individually tailored based on a thorough cognitive-behavioural assessment and cognitive behavioural formulation

Cognitive-behavioural assessment

Assessment is arguably the single most important aspect of CBT. It is the basis upon which the client and worker set goals and strategies for change, and the way they monitor progress toward change. Initial assessment begins at the first session, but can sometimes take two to three initial sessions of an eight to twelve session therapy, and continues throughout treatment.

The goals of assessment in CBT include:

- a formulation of the problem in cognitive and behavioural terms
- education of the client about the cognitive-behavioural approach
- initiation of the therapeutic process - assessment itself is often in some ways therapeutic

There are several types of assessment, which encompass behavioural, cognitive, physiological and emotional responses. Different assessment procedures give different information about different aspects of the problem, so more than one assessment method is important. For example, a heroin user may stop using heroin (behavioural), but continue to experience high levels of craving (emotional/physiological) and continue to believe that they are unable to resist these urges (cognitive).

Assessment may include:

- behavioural (clinical) interview
- self-monitoring and self-report (questionnaires etc)
- collateral report (parents, partners, siblings)
- direct observation (role play, behavioural rehearsal)
- physiological measures
- neuropsychological measures

Without a thorough assessment Rotgers believes CBT cannot proceed and is likely to fail (Rotgers,1996)

In addition to the general drug and alcohol assessment, in CBT it is also important to ask about:

- antecedents and consequences of behaviour
- beliefs, expectations and thoughts
- predisposing and precipitating factors
- coping skills
- mood
- context of behaviour

The preliminary formulation you make is an important (and flexible) part of cognitive-behavioural treatments. CBT views the practitioner as a scientist who formulates hypotheses about the client's problem behaviour and continually tests and reviews the hypothesis. This is done in cooperation with the client.

- A common cognitive behavioural formulation includes seven areas (sometimes referred to as the '7 Ps'):
- **Presentation:**
  - why is the client presenting at this time
  - are there reasons beyond desire for treatment?
  - how do they present?
  - What is their presenting problem?
- **Pattern:**
  - what is the pattern of the current problem?
  - are the symptoms a result of maladaptive coping?
  - do the symptoms have communicative meaning?
- **Predisposing factors:**
  - What physical or psychological factors have increased the client's vulnerability to this problem, e.g., genetic history, family history, early traumatic childhood experiences

    Precipitating factors: What are the factors that trigger the problem? eg. conditioned reaction to drug stimuli, mood changes
- **Perpetuating factors:**
  - what is maintaining the problem?
  - why has the problem not diminished naturally? eg. enmeshment in a using culture, domestic violence, partner using/dealing
- **Protective factors:** What are the client's strengths that have assisted coping so far? What strengths can be built upon in therapy? e.g., good family/social supports
- **Prognosis:** what is the outlook for the client with and without treatment?

Common techniques within CBT

CBT is centrally concerned with measurable change and giving clients a sense of mastery over their behaviour. Below is a list of potential components of a cognitive-behavioural program. These are by no means all the techniques available to the cognitive-behavioural worker. Since CBT is a collection of techniques carefully selected and structured into a client-specific program (largely by the worker in cooperation with the client), not all techniques are used for each client. This is where assessment is important. The needs and goals of the client are identified through assessment and addressed through specific components of treatment. As with all therapies, CBT also includes general psychotherapeutic principles, such as supportive counselling.

The following list identifies some of the behavioural techniques commonly used as part of a CBT program.

- relaxation
- refusal and assertiveness skills
- identification of high risk situations and how to cope/avoid them
- increasing pleasant activities not related to drug use
- behavioural skills to cope with cravings
- cue exposure therapy

The following list identifies some of the cognitive techniques commonly used as part of a CBT program.

- identification and modification of automatic thoughts
- identification and modification of core beliefs
- identification and modification of expectancies
- identification and modification of self efficacy beliefs
- problem solving and planning
- behavioural experiments (designed to test faulty cognitions in a real life situation)

AVERSION THERAPY

One behavioural technique that creates mixed feelings among workers is aversion therapy. It is based on classical and operant conditioning principles. It attempts to pair an aversive event, usually a shock or emetic drug, with the drug use. The pharmacotherapy treatment disulfiram (Antabuse) is a type of aversion therapy. Cognitive-behavioural workers tend to view this technique as largely unnecessary since many other cognitive-behavioural techniques are so effective, and it is rarely used. Aversive contingencies (i.e. punishments) are considered by learning theorists to be the least effective types of reinforcement.

CONTINGENCY MANAGEMENT

Contingency management is another behavioural technique that is commonly used in US drug treatment centres, but rarely in Australia. It is based on operant conditioning principles and implements rewards and punishments for particular behaviours. For example, a week of drug-free urine tests might be rewarded with increased takeaway doses. The rewards and punishments are clearly agreed upon at the beginning of treatment between the worker and client and are not changed or implemented ad hoc.

A typical CBT session

Therapy is structured, collaborative and goal/solution directed. The therapy session is usually divided into 3 sections, although there are variations on this. This is sometime referred to as the 20-20-20 rule because you would typically spend 20 minutes on each part. The first section is usually a review of previous sessions, the week and homework, the second section is usually discussion/learning of the topic for the session (e.g. coping with craving), the third section is usually practice of the skill and identifying homework to practise the skill outside therapy. The structure of a therapy session might look like:

SECTION 1

- set the agenda for the session
- review the last session (refresher, problems, worries, complaints)
- the past week (problems, successes)
- homework (problems, successes, worries)

SECTION 2

focus on a specific target for that session - after the first session the worker should draw up a treatment plan. The early sessions usually begin with behavioural strategies for symptom relief, then later focus on recognising, responding and modifying dysfunctional thinking patterns using both cognitive restructuring and behaviour modification techniques for longer term change.

SECTION 3

- practise specific target during session
- summarise and review session; set homework tasks

In reality, the therapy is rarely as prescriptive as this, with a great deal more overlap between sections.

HOMEWORK

Practice tasks, usually referred to as 'homework', are an important part of the cognitive behavioural treatment process and is an example of the structured approach of this therapy. Clients are expected to practise strategies in between sessions.

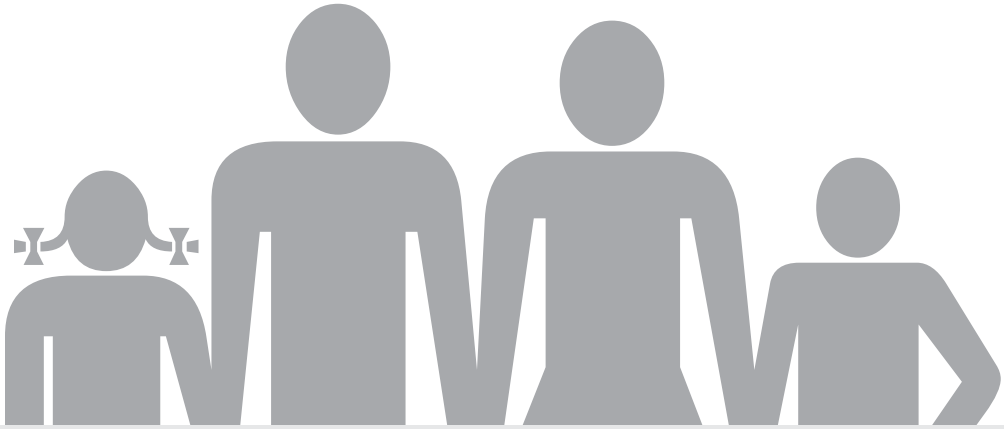
There are many reasons why clients do not do their practice tasks:

- the task is too hard or not practical for their daily context
- they didn't understand the task - practice during the session helps
- the task was too advanced for their readiness to engage/change

When clients do not complete their homework tasks it is important to explore the barriers and address them. Practice outside the session is considered to be one of the primary agents of change.

Family and Group Therapy

What is a family?



Describing the term family and what constitutes family is best considered in broad terms and can include a network beyond immediate family and may include friends, partners, carers or significant other that the client has an ongoing relationship with. (Barry,1999)

What is a family inclusive approach?

A family inclusive approach is designed to assist families through a variety of means, including education and support and takes into account the effects of drug use on families and friends. The Victorian Government Department of Human Services commissioned a report on 'Involving Families in Treatment of Young People with Problematic Drug Use' (Success Works, 2000) that identified the need for family involvement. (Success Works, 2000) A family inclusive approach works on the fundamental assumption that the family is a resource to the client and to the agency and that family involvement is fundamental to an ongoing solution. (Success Works, 2000) One major finding of this research was that many families felt alienated and unsupported by health professionals and drug treatment services. The main type of support sought by families included information/education, advice/guidance, counselling and support groups.

THE WORKER'S ROLE

Family inclusive practice doesn't require you to be a family worker, what it does require is that you have an ability to hear and acknowledge the individual experiences of the family.

> *"The principal skill is being able to relate comfortably with a variety of people of different ages, stages, backgrounds and family structures. If there is a principal skill it is the ability to trust that family members are experts on their own lives'. (Success Works, 2000)"*

Family inclusive practice describes a model of service delivery that:

- values the importance of families
- includes families in the scope of the work even though the main focus of intervention may be on an individual within the family
- focuses on the range of different ways that families may be involved in the lives of individuals
- empowers families to utilise their own experiences and resources
- develops partnership approaches to addressing difficulties
- can be undertaken by generic workers who are not necessarily trained in family therapy [TurningPoint]

Models of intervention

Families can participate in a group or can receive individual counselling. By being part of a group with other families affected by drug use there can be a sharing of experiences and approaches to working more effectively with the AOD using family member or friend. The disadvantage of this approach is that the families involved may not have much common experience; also some families feel ashamed in this sort of encounter and may be reluctant to share. The worker's role in leading this type of group is to guide the family in exploring workable solutions for them and providing sound information about AOD use and treatments.

FACILITATED SUPPORT GROUPS

Group support sessions can provide information and education to families of users and in doing so assist them in improving communication between all parties. The importance of addressing and providing support around self-care is fundamental and sessions should be underpinned by the principles of adult learning.

One evaluated model for this type of group is the Behavioural Exchange Systems Training (BEST) program, which was developed by Odyssey House, specifically for parents of adolescents (SuccessWorks, 2000)

The objectives of this program are to:

- reduce stress, anxiety and guilt experienced by parents as a result of adolescent drug use
- increase the capacity of parent(s) to respond effectively to the adolescent
- increase parents' repertoire of communication and negotiation strategies
- increase parents' awareness of the relationship implications of the adolescent stage of development
- to ensure a consistent approach is undertaken by couples
- where appropriate, advise families on strategies, to encourage the adolescent to maintain or reduce drug use to levels which reduce harmful consequences

WHAT A GROUP SESSION MIGHT INCLUDE

The facilitators role is to

- introduce participants to each other and what the session holds and what families/friends might be expecting
- inform about alcohol and drugs including intoxication and withdrawal effects
- discuss the stages of drug use and reducing harm
- understand family dynamics
- have communication and negotiation skills
- advise participants about supports available for families
- Inform participants on treatment systems and what services
- promote self care
- evaluate and review

Adapted from Success Works 2000

Family therapy

Since the 1970s many AOD services have worked with family members in interventions variously labelled as family-based, family centred, or simply family therapy. (NH&MRC, 2001) The distinction among various types of family therapy is important as the term has been used, according to Winters, as a *'catch all name for any activities that include family members and may have no underpinning or appropriate staff training.*' (Winters,1999)

When therapy was traditionally only for the client, partially as a means of safeguarding the client-worker relationship, this was a new wave of thinking that saw the dynamics at play within family structures. One of the most important conceptual influences on the development of the field was 'systems theory'. Nichols et al describe the family system as being more than just a collection of people and that the worker should focus on interactions among family members rather than individual personalities. (Nichols & Schwartz 1998)

Family therapy is complex and should be conducted by a worker with good understandings of family systems, dysfunctional family patterns, power struggles and communication as well as the knowledge about the effects of alcohol and drugs, and skills in assessment and referral. Workers must be able to attend to the complexities inherent in dealing with several individuals and the interaction among them. Working with families requires specialised skills and training.

The three major theories, which underpin family therapy, are: family systems theory, behavioural therapy, and multi-dimensional family therapy.

Family systems theory

In the 1970s, family systems models began to influence the AOD field. Family systems theory examines the functions drug use serves for the family and attempts to change family roles, rules and boundaries. (Rotgers,1996) Family systems theory proposes that behaviour can be best understood by studying the characteristics of the family system in which the person is located. The approach then is to change these family characteristics by:

- gaining access to and influencing the family systems
- interrupting the relationship between the dysfunctional characteristics in the family system and the client's problematic behaviour
- establishing new family characteristics to interact with new client behaviour.

Adapted from Success Works 2000

Alcohol and other drug disorders do not occur or develop in isolation. (Barry 1999) (Raytek,1999] For many clients with these issues, interactions with the family of origin, as well as current family, set the patterns and dynamics for their problems with drugs.

Family member interactions can perpetuate and aggravate the problem or substantially assist in resolving it. Family therapy is suggested when the client exhibits signs that AOD use is strongly influenced by family members' behaviours or communications with them. Family therapy is often used to examine factors that maintain a clients AOD use. Through family therapy the worker can help the family identify dysfunctional areas, adjust the hierarchy and change various roles the members might play.

Family involvement is often critical for success in treating many AOD disorders, most obviously where elements of family are inadvertently reinforcing or supporting the problem. (Raytek,1999)

Behavioural family therapy

Behavioural therapy uses social learning theory to conceptualise drug use and family functioning. This model highlights the shared interactions between the client and other family members in determining repetitive dysfunctional behaviours. Behavioural family therapy focuses on current factors that maintain drug use, not historical factors. (Raytek,1999) It also proposes that changes in the client are dependant on changes in the parent or family. This means that the parent or family will focus on learning new behaviours, such as communication, problem solving, parenting management and self-management.

Multi-dimensional family therapy for adolescents

Multidimensional Family Therapy (MDFT) for Adolescents is an outpatient family-based drug abuse treatment for teenagers. MDFT views adolescent drug use in terms of a network of influences (that is, individual, family, peer, community) and suggests that reducing unwanted behaviour and increasing desirable behaviour occur in multiple ways in different settings. Treatment includes individual and family sessions held in the clinic, in the home, or with family members at the family court, school, or other community locations.

During individual sessions, the worker and adolescent work on important developmental tasks, such as developing decision making, negotiation, and problem-solving skills. Teenagers acquire skills in communicating their thoughts and feelings to deal better with life stressors, and vocational skills. Parallel sessions are held with family members. Parents examine their particular parenting style, learning to distinguish influence from control and to have a positive and developmentally appropriate influence on their child (SuccessWorks, 2000)

Group Counselling

United Nations Office on Drugs and Crime

What is group counselling?

We are all members of a variety of groups. The groups we have membership to include our families, our peer or social groups, our work colleagues, our support networks and the communities in which we live. To be involved in groups and to work towards individual goals and support others towards theirs within a group context is the norm within our society.

A large part of our self-development and our perception about ourselves derive from our interactions with others in group settings. To a large degree individual wellbeing depends on how well these groups meet individual needs and reciprocally, how well individuals as group participants contribute to the group of others and to the functioning of the group as a whole. (Byrne & Byrne, 1996)

The overriding rationale for group counselling is that it can improve or enlarge on the real life group experiences which all individuals confront every day. Research suggests that most client improvement as a result of group therapy improves within a brief span of time -typically, two or three months. (Barry,1999)

Many clients are referred to group counselling because of a personal issue that may be best dealt with in a group context. Some groups are orientated toward the treatment of particular disorders such as groups for depression, assertiveness or social skills, others focus on the modification of a specific health risk behaviour such as weight control or smoking cessation, whilst others take a more general role, operating as a support or information group as often seen in the AOD sector. In AOD group counselling clients have the opportunity to see the progression of drug use in themselves and others; it also gives them an opportunity to experience their success and the success of other group members in an atmosphere of support and hopefulness. [Barry,1999]

The provision of counselling interventions to groups of individuals has been a common and effective AOD treatment option for decades. From self-help groups such as Alcoholics Anonymous through to intensive residential and hospital based treatment programs, group counselling has been a primary mode of intervention.

Though there are several types of group interventions, each with specific treatment objectives, group counselling is designed to provide information or supportive interventions to multiple clients in one setting. Membership to particular counselling groups requires members who are experiencing some common challenge or difficulty (eg AOD relapse prevention group, or assertiveness training groups or coping with anxiety).

Objectives of group counselling

The objectives of group counselling and individual treatment programs are of course similar. Both aim to assist the client to achieve self-direction, self-responsibility, self-acceptance and an understanding of their motivations and patterns of behaviour. There are however important differences between individual and group counselling. Specifically these are:

- group counselling requires an understanding of group dynamics, while individual counselling does not
- group counselling permits clients to experiment with different ways of relating to others and provides an opportunity to test others perceptions of themselves, while individual counselling revolves solely around the counsellor -client relationship
- group counselling provides an opportunity for clients not only to receive help but also to help others; such other directed helping skills are not developed as easily in individual counselling
- group counselling provides a context within which clients can assess their own problems in relation to the problems of others, while this is not possible in individual counselling
- group counselling enables clients to use other group participants as helping agents, something also not possible in individual counselling

Benefits of group work

Whether informal or highly structured, group interventions provide many advantages.

- they are a cost effective as well as an efficient form of providing support and or treatment to larger numbers of people.
- group interventions also provide clients with opportunities to feel validated in their experience as they listen to others with similar difficulties.
- group counselling is the primary form of treatment in most residential and day programs.

Chief therapeutic factors in group work

Yalom (1995) identified 11 primary therapeutic factors in group therapy. Each of these factors has particular importance for clients with drug use issues and can be helpful in explaining why a group works in a particular way for the client population.

INSTILLATION OF HOPE

- Instillation of hope is a therapeutic element through which the group member gains a sense of optimism about their progress.

UNIVERSALITY

- This is the sense that one is not unique in one's own problems.

IMPARTING INFORMATION

The exchange of information in a group setting helps members get from one day to another. It might include facts about drug effects on behaviour and allows time for reflection on what has been learned.

ALTRUISM

Fundamental to the human condition is the desire to help others when they are in trouble Group settings allow clients to provide assistance and insight to one another.

CORRECTIVE RECAPITULATION

Recapitulation happens when a client both consciously and unconsciously relates to another group member as if that person is a member of his or her family of origin.

DEVELOPING SOCIALISING TECHNIQUES

As participants engage in relationships with other group members they learn new skills that can help break through their sense of isolation and connect with others in more meaningful ways.

IMITATIVE BEHAVIOUR OR VICARIOUS LEARNING

The process of modelling can be important for clients to learn new ways to manage difficult emotions without resorting to drug use or violence. You must be acutely sensitive to the important role you play within this context.

INTERPERSONAL LEARNING

Includes comprehending the effect that the individual has on others; as well as the impact other persons on the individual, and provides an opportunity for the client to learn about relationship and intimacy.

Group cohesiveness

A sense of belonging that defines the individual not only to themselves but also in relation to the group. Development of group cohesion is important so that group members feel safe enough to take the risk of self-disclosure and change. Two factors that contribute to cohesiveness are empathy and intimacy.

CATHARSIS

Some group participants will gain a sudden insight through interaction with others, which may result in a significant shift in how they respond to life, and may be accompanied by bursts of emotion that release pain or anger. It's important to remember that although catharsis is a genuine expression, it is only when catharsis complimented by the clients understanding of the experience that potential growth is realised.

EXISTENTIAL FACTORS

Existential issues of loss and death are issues of great discomfort in the drug abusing population. (Barry,1999) The brevity of time limited groups forces these issues to the surface and allows for safe discussion.

Adapted from: Barry 1999 & George, 1990

Group types

Group interventions can be classified into three main subtypes: group guidance, group counselling and group psychotherapy. (Gazda,1989)

GROUP GUIDANCE

Group guidance refers to groups of up to 25 where there is more of an instructional or educative focus. The primary goal is to provide information or skills (life skills), designed to prevent or minimise further developmental difficulties.

PSYCHO EDUCATIONAL GROUPS

The aims of these groups are to provide participants with information and skills to address a variety of AOD related issues. Skills groups typically include assertiveness and finances.

GROUP COUNSELLING

Group counselling involves smaller numbers (6-15) where the emphasis is on providing members with support and information to assist them towards personal goals. The focus is on providing group members with opportunities to discuss current concerns and issues.

RELAPSE PREVENTION STRATEGIES:

These groups review a variety of skills and strategies such as coping skills, refusal skills, problem solving skills and goal setting. Individuals are guided through a process of developing an individualised relapse prevention plan. (Marlatt, & Gordon, 1985)

MOOD MANAGEMENT SKILLS:

These groups teach and practice cognitive behavioural strategies for clients to begin to adapt their emotional and behavioural responses to various emotive situations. Interventions focus on assisting group members to develop self-awareness in order to challenge and modify distorted or irrational beliefs and assumptions. (Langelier, 2001)

LIFE SKILLS:

These groups can focus on a wide range of practical skill development areas. Typical life skills reviewed include:

- budgeting
- employment skills
- nutrition
- assertiveness

Group psychotherapy

Group psychotherapy relates to providing in-depth psychological interventions within a group format (6-8 members). The focus of these groups is to provide opportunities for clients to examine the interconnections between their AOD use and significant past and current relationships. Often specific relationship skills such as conflict resolution and assertiveness skills are reviewed. Interventions are more emotionally intensive where the emphasis is on providing some form of reparative intervention. This process takes place through specific interventions by the facilitator within the supportive environment of the group. Differing theoretical concepts underlie the many and varied approaches to group work. The table on the next page offers a useful comparison between major orientations.

Comparison of different types of group therapy and psychotherapy

Parameters	Supportive group therapy	Analytically oriented group therapy	Transactional group therapy	Behavioural group therapy
Frequency	Once a week	1-3 times/week	1-3 times/week	1-3 times/week
Duration	Up to 6 mths	1-3+ years	1-3 years	Up to 6 mths
Communication content	Primarily environmental factors	Present & past life situations, intragroup and extragroup relationships	Primarily intragroup relationships; rarely past history; here and now stressed	Specific symptoms without focus on causality
Transference	Positive transference encouraged to promote improved functioning	Positive and negative transference evoked and analysed	Positive relationships fostered, negative feelings analysed	Positive relationships fostered, no examination of transference
Dependency	Intragroup dependency encouraged; members rely on leader to great extent	Intragroup dependency encouraged, dependency on leader variable	Intragroup dependency encouraged, dependency on leader not encouraged	Intragroup dependency not encouraged; reliance on leader is high
Worker activity	Strengthen existing defences, active, give advice	Challenge defences, active, give advice or personal response	Challenge defences, give personal response rather than advice	Not used
Major group processes	Universalization, reality testing	Cohesion; transference, reality testing	Abreaction, reality testing	Cohesion, reinforcement, conditioning
Socialization outside of group	Encouraged	Generally discouraged	Variable	Discouraged
Goals	Better adaptation to environment	Moderate reconstruction of personality dynamics	Alteration of behaviour through mechanism of conscious control	Relief of specific symptoms

Adapted from: Kaplan & Sadock 1981

Group facilitation skills

With individual counselling, the worker's style of relating to clients is considered as important as the worker's theoretical framework. (Miller & Rollnick 1991) The same point can be made regarding the group facilitator's style or characteristics. (Gazda,1989)

Group facilitation styles considered helpful include:

- moderate encouragement of feelings, disclosure and challenge of group member perceptions.
- high level of empathy towards group members
- provision of concepts or frameworks for group members to contextualise their experiences
- moderate exercising of authority regarding group rules, limits, norms, time management etc.

GROUP DYNAMICS

Group dynamics is a term used to describe the various aspects of the process or interaction that occurs between members of a group. Most people readily understand that a work group is involved in working on some subject matter or achieving tasks. However, for any facilitator, it is very important to understand what is happening among group members while the group is working. Some considerations of group dynamics are:

- who exerts influence?
- who competes with other group members?
- who tends to be isolated from other group members and rarely participates?

Dynamics such as conflict between group members, low morale or leadership struggles between dominant group members can all hinder the effectiveness of a group. Awareness of many of these issues can enable group members, whether they are leaders or not, to become more effective.

The most important processes involved in group dynamics can be classified under the following headings:

- norms
- group atmosphere
- interaction patterns
- maintenance functions
- task functions
- decision - making methods
- verbal participation

Note that in the following elaboration of the previous points, the processes are phrased as questions. These are the types of questions that the observer and designated group leader need to be familiar with in order to effectively manage and evaluate group processes.

<table>
<tr><th colspan="2">Processes involved in group dynamics</th></tr>
<tr><td>1 Norms

These are the beliefs of the majority of the group members; they express the standards of behaviour that are acceptable to the group.

It is important to ask the following questions in relation to the norms of a group:

■ What topics of conversation are acceptable and/or important?
■ What standards of behaviour are acceptable and/or favoured?
■ How are the standards of behaviour maintained and reinforced?
■ Do members always agree with each other. What happens when they don't agree?</td><td>2 Group atmosphere

The process of interaction in a group creates an atmosphere, which is usually immediately evident to an observer. The atmosphere may be warm and friendly; tense and aggressive; apathetic, and so on. Questions to examine are:

■ Do any group members provoke and annoy others?
■ Who seems involved and interested?
■ Who seems to prefer a friendly atmosphere compared with those who prefer a tense one?</td></tr>
<tr><td>3 Interaction patterns

■ Who usually agrees with whom?
■ Is there any sub - grouping, i.e. smaller groups or cliques within the main group?
■ Who seem to be 'outsiders'? How are those who are 'outside' the group treated by those who are 'in'?</td><td>4 Maintenance functions

These functions refer to the contribution to, or maintaining of, a group's operation or cohesion. These are important for promoting effective and harmonious working relationships, which in turn are important for high morale.

■ Who helps or hinders group members' involvement in discussions?
■ Who supports and rejects people's ideas?
■ Who helps other group members explain their ideas?
■ How are ideas rejected? How do group members react when their ideas are not accepted?</td></tr>
</table>

<table>
<tr><th colspan="2">Processes involved in group dynamics</th></tr>
<tr><td>5 Task functions
These involve any type of behaviour that is concerned with keeping the group focussed on the task or job before them. For example:
■ Who suggests approaches for accomplishing the task?
■ Who tries to prevent the group from becoming sidetracked from the job at hand?</td><td>6 Decision - making methods
■ Does anyone make a decision and then immediately try to impose it on the group?
■ Does a majority try to push a decision through in spite of other members' objections?
■ How many group members seem to be actively involved in the decision - making?
■ Are some group members' decisions usually ignored?
■ Do certain group members tend to dominate the decision - making?
■ Who has the most influence? Who has the least?
■ How does the relative degree of influence of different individuals vary? What effect does this have?
■ Who does not initiate any decision - making but only tends to respond if asked a question?
■ Who tends to always support other members' decisions? Who tries to block decisions?</td></tr>
<tr><td>7 Verbal participation
■ Who participates most? Who least? Does this vary? Why does it vary?
■ How are silent people treated and how is their silence interpreted?
■ Who tends to always speak when there is silence in the group?</td><td></td></tr>
</table>

NB - The above categories of group dynamics are not mutually exclusive and the questions under each heading are closely related and by no means exhaustive. (Carnegie, 2003)

Relapse Prevention

United Nations Office on Drugs and Crime

Introduction

In order to set the scene for this discussion on relapse prevention and management, it is firstly important put relapse into context. Relapse is the rule rather than the exception. It is important to view relapse as a normal and almost expected part of the change process. A number of studies have indicated that with a range of drug-using behaviours, a return to using in some form is one of the most common treatment outcomes.

If a 'lapse' is defined as one drink, one cigarette or one occasion of amphetamine use, approximately 90% of clients will lapse in the first year after leaving treatment. Most of these lapses will occur in the first three months after treatment. If a lapse becomes a relapse, which is a return to 'problem use', approximately 60% of clients will relapse in the first twelve months after treatment.

Another way of looking at the journey of change is within the spiral model of the stages of change (refer to Figure 2). Rather than relapse being part of an endless recycling, it is seen as part of the spiralling upwards towards change, and with each cycle completed the individual gets closer to their goal. This is so because as they progress through each cycle they learn things or acquire skills that can help them to achieve better outcomes the next time.

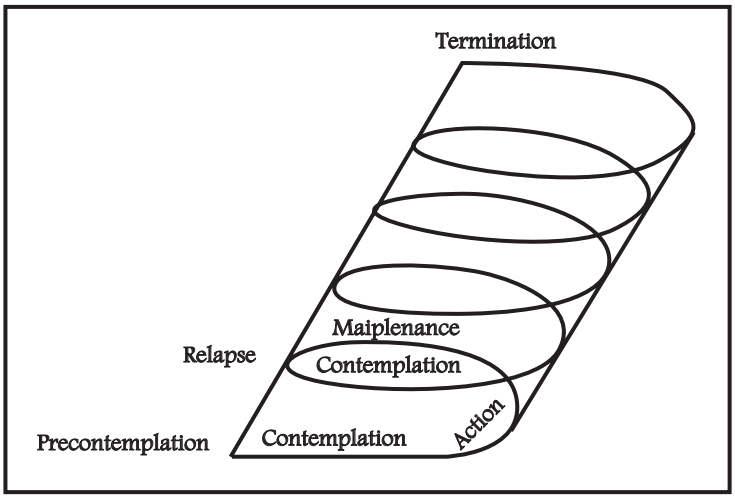


Figure 2. Spiral modal of the stages of change

At what point someone returns to on the stages of change model can depend on their view of relapse. Whether a lapse becomes a full-blown relapse can also depend on the messages received along the journey of change. The remainder of this section is drawn from the Clinical treatment guidelines for alcohol and drug workers. No 3: Relapse Prevention prepared by Turning Point (Addy & Ritter, 2000b) and the Primary Care Training Package: Module 7- Relapse Prevention prepared by Turning Point and NCETA (TurningPoint & NCETA, 1997).

Change is a journey, not a single event

One way to view relapse is as part of the journey of change. By making a decision to change drinking or drug use, your clients have taken the first step in an important journey. The most important step in any journey is making the decision to go and then making the commitment to set off on the trip. But deciding to change alone will not get them to where they want to go. They have to actually take the journey of change themselves to travel along the road of change. It is likely that there will be pitfalls and detours along the road of change.

Relating to relapse

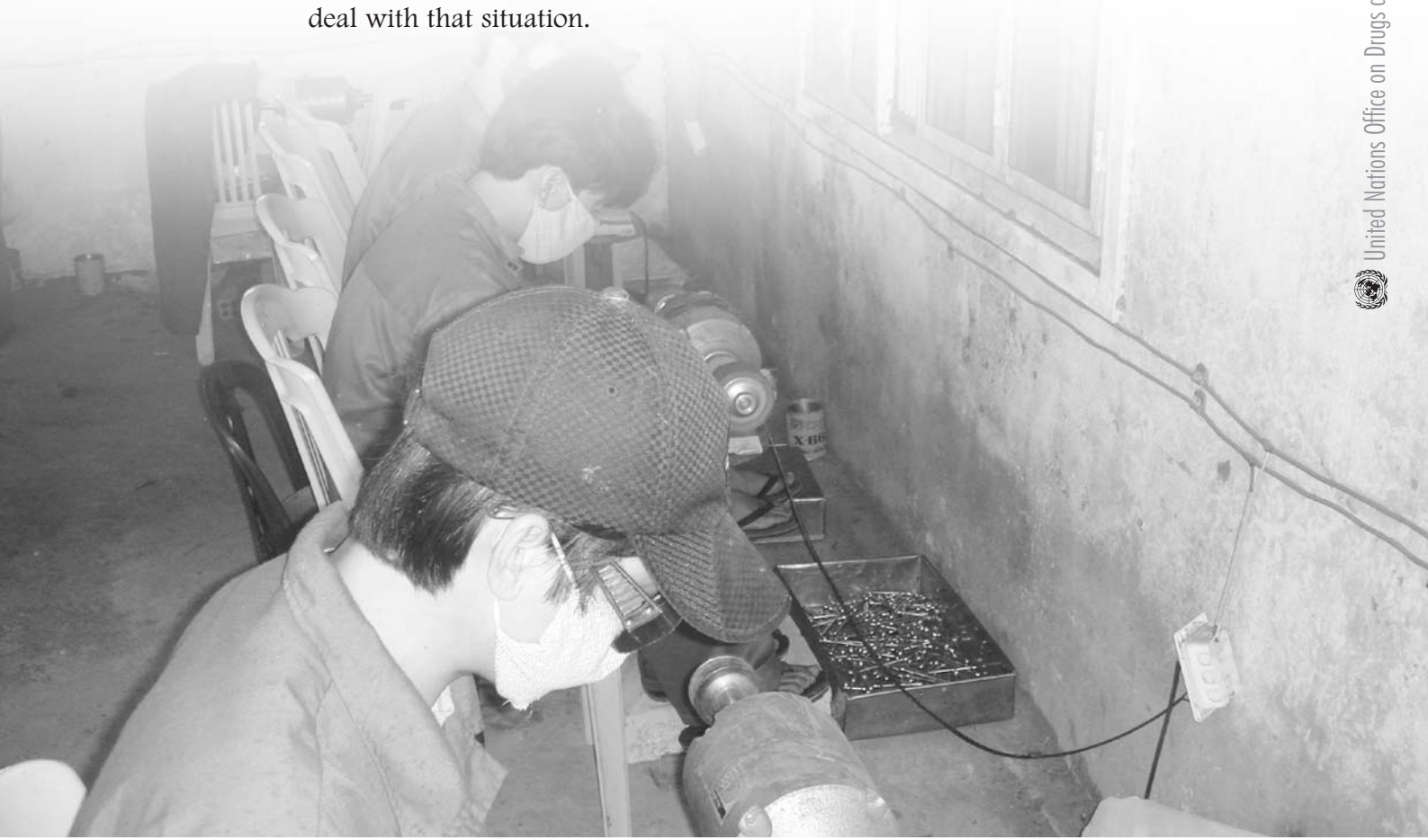
The high incidence of relapse has contributed to the belief that drug problems are 'chronic conditions'. Some people conclude that drug problems are, at the same time, exotic and hopeless conditions. Relapse is frequently seen as a specific and defining characteristic of problem drug use. Is this true? If you think about it, everyone makes resolutions to change their behaviour: to learn a new language, to get to work on time, to stop shouting at the children, to drive slower or faster, to take up exercise, to eat less cake and so on. However, most people find that while making resolutions to change is relatively easy, it is quite hard to keep those resolutions. One could say that making and breaking resolutions is a common human behaviour. If it is difficult to maintain resolutions to change, why should problem drug use be different? Thus, it could be said that relapse, or resolution breakdown, is a feature of human behaviour and is not specific to addiction behaviours.

Relapse prevention is like a fire drill

One final point before moving onto the details of relapse prevention concerns the ethics of addressing the likelihood of relapse with clients. Because of the strong likelihood of relapse, addressing relapse prevention issues is an *essential* part of working with clients with alcohol and other drug problems.

> *"Another way of looking at relapse prevention is to see it as a 'fire drill'. We all hope we never have to fight a fire, but it helps to know how to use the extinguisher in case one does occur! Also, knowing how to use the fire extinguisher does not increase the risk of fire occurring, but it is a realistic attempt at minimising the damage if one does occur."*
>
> (Mason, 1989, cited in (TurningPoint & NCETA, 1997)).

Alerting your client to the possibility of a high-risk situation and a temptation to use does not increase the likelihood of your client encountering that high-risk situation. By preparing for that eventuality you are increasing their capacity to deal with that situation.



Relapse prevention models

Until the 1970s, relapse was virtually ignored in the drug treatment literature. In terms of the disease model, it was considered to be fully addressed as a result of *'cravings'* that overwhelmed the individual to take the first drink, and *'loss of control'*, the physical consequence of the first drink that removed the will to stop. As things were physically out of the individual's control after the first drink, the only possible counsel must be to *'avoid the first drink'*. Unfortunately, this wasn't a very effective approach given that some research indicates that as many as 90% of all clients will have at least one drink in the first year after treatment.

Dissatisfaction with such explanations of the relapse process led to alternative models. Prominent among these were the work of Litman in 1980 (Litman, 1980); Marlatt and Gordon in 1985 (Marlatt & Gordon, 1985); and Saunders and Allsop in 1989 (Allsop & Saunders, 1989). Rather than present these models individually, the key themes, many of which are common to all three models, will be presented

DIFFERENTIATION BETWEEN A LAPSE AND A RELAPSE

The response to an initial lapse determined whether a relapse occurred. If the client felt that one drink or one period of using heroin would lead them back to uncontrollable use, then that was a likely outcome. If however, there was a belief that one period of use or one lapse did not mean that things were out of control, then returning to abstinence was a possible outcome.

SEEMINGLY IRRELEVANT RESPONSES

Some individuals appeared to ignore the fact that they were entering risky situations, perhaps even deliberately entering them. If a relapse then occurred, the individual could attribute this to being overwhelmed by circumstances.

HIGH-RISK SITUATIONS

Different individuals will find different situations risky. Risky situations may include **internal** factors and **external** factors.

Whether the individual responds to a high-risk situation by drinking/using will depend on their coping skills and their self-efficacy to use these skills (self-efficacy being the belief in one's own ability to carry out a particular behaviour, or in the case of relapsing, to NOT participate in a particular behaviour). An individual's level of self-efficacy can predict whether a person will engage in the behaviour or persist in the face of a challenge.

THE ABSTINENCE VIOLATION EFFECT

Whether a slip, or lapse, leads to a relapse will depend on a number of factors. For example, if the individual attributed a lapse to personal weakness, uncontrollable or irreversible factors (eg: 'I'm weak willed; I can't cope') then the risk of relapse is increased. If the individual attributed a lapse to factors that could be controlled, were specific and reversible (eg: 'I didn't plan this very well, maybe I had better try to avoid this next time') then the risk of relapse is lower.

THE 'CHAIN OF EVENTS'

One way to look at these factors is as a chain of events, that is a decision is made to do something, they find themselves in a high risk situation, they have no coping mechanisms in place, they feel helpless and that taking their drug will help them feel better and therefore lapse/relapse.

URGES AND CRAVINGS

Urges and cravings are strong physical and psychological desires to use a substance. As they are likely to be experienced by most clients there are some important facts about urges and cravings that should be talked through with clients. They should be informed that urges and cravings:

- are a normal, expected part of recovery
- are variable (ie, differ in strength)
- are persistent
- can occur 'out of the blue'
- occur automatically
- do not indicate a weakness, low motivation or lack of will power

RESOLUTION

The nature and quality of the initial decision will have an influence on its resilience to challenge.

COMMITMENT

Having an intention to change is not the same as committing oneself to change. This is an important intervening stage between resolution and action. It is a planning and appraisal stage in which the individual considers how the resolution is going to be enacted and anticipates potential difficulties. The belief that change is possible and desirable ('Its worth doing and I can do it ') is important factors in this stage.

ACTION / DEPLOYMENT

Even the most determined intention will be eroded by constant challenge. The individual is likely to need a range of skills. In the early stages of change, avoidance of high-risk situations may be appropriate but replacing such skills with cognitive and behavioural strategies appears to increase the likelihood of success. Problem solving techniques appear to be useful.

MAINTENANCE

Successful maintenance appears to be associated with factors to do with the post-change lifestyle of the individual. Changes need to be perceived to be worthwhile. Important factors include improved relationships, job opportunities, housing and so on.

MARLATT & GORDONS' MODEL

In this model, the client has made a decision and resolution to commit but due to the existence of lifestyle imbalances and exposure to high-risk situations, they are faced with significant urges and cravings to return to their drug use (refer to Figure 3). In the absence of coping responses they will lapse and this may in turn lead to a full relapse. If on the other hand they have developed a series of coping responses, they will be able to manage the urges and cravings. This success will reinforce their resolution to change and assist them towards maintenance. The emphasis is very much on having adequate coping responses to deal with the urges and cravings (Marlatt & Gordon, 1985).

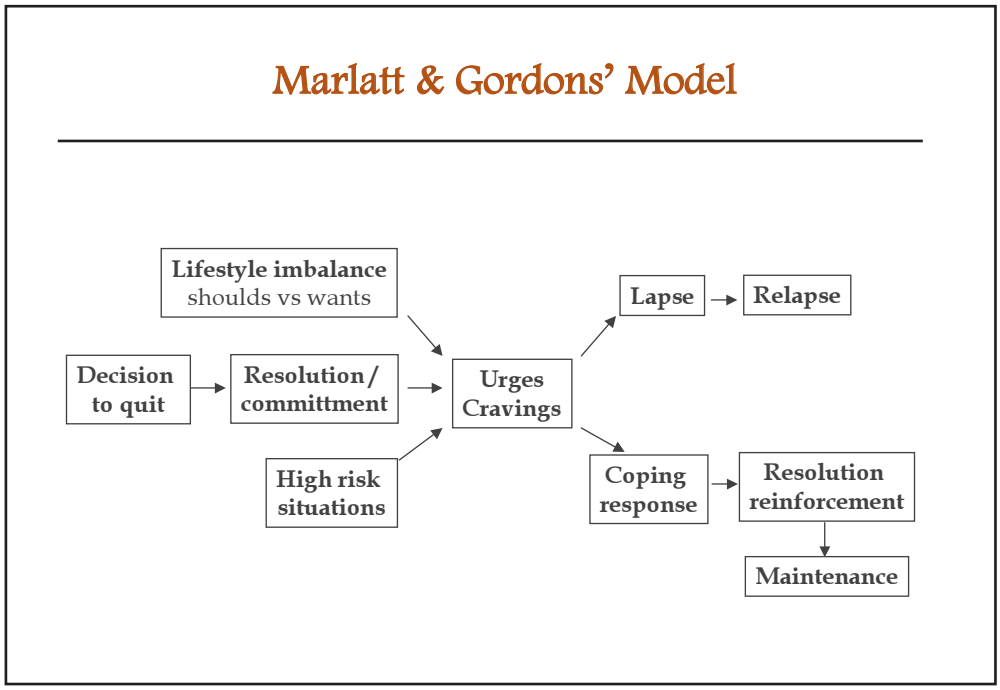


Figure 3. Marlatt and Gordons' Model (Marlatt & Gordon, 1985)

ALLSOP AND SAUNDERS' MODEL

In this model, Allsop and Saunders build on the model of Marlatt and Gordon and identify four distinct areas as being significant (refer to Figure 4) (Allsop & Saunders, 1989). The relapse or the resolution breakdown may occur when any one of these areas is not addressed. For example, a client who has strong resolution and commitment and has developed a series of avoidance and problem solving skills to assist the continued deployment of 'not taking a drug' may eventually be worn down by the fact that their maintenance issues are being attacked by a poor housing, employment and leisure situation and high levels of drug availability. On the other hand, a different client may have developed sufficient skills in terms of action/deployment and may also have maintenance supports in terms of improved employment and housing BUT regardless of this, their resolve to continue is weak. They just don't feel like continuing.

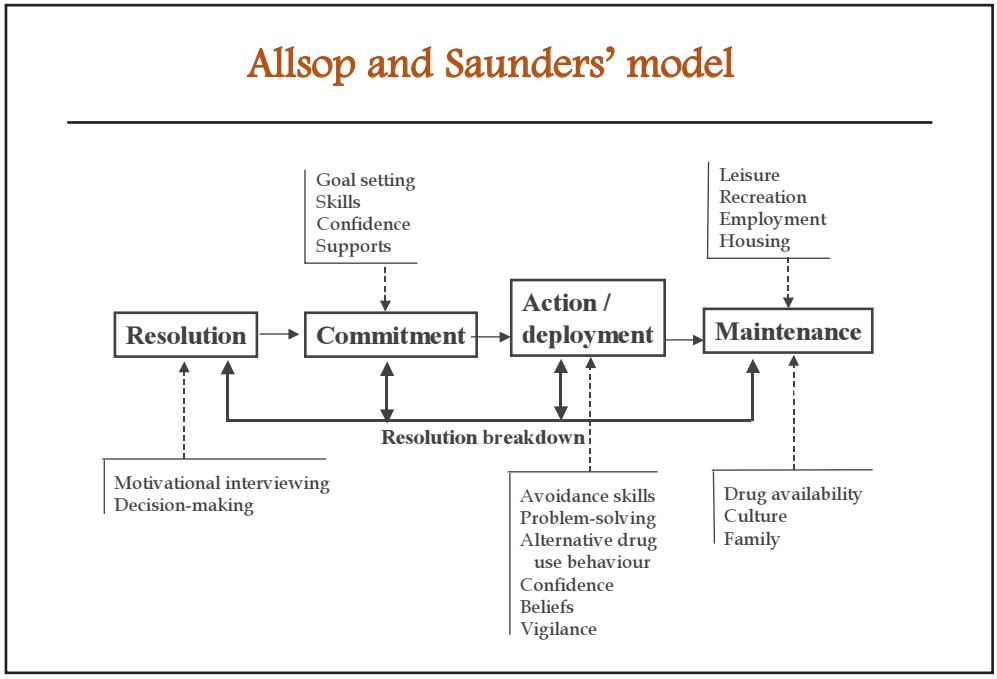


Figure 4. Allsop and Saunders' Model (Allsop & Saunders, 1989)

The model also identifies specific strategies that you should employ to assist your client to ensure that their resolve and commitment is maintained and that they develop the necessary skills to carry out their plan of non-drug use. This includes motivational interviewing, goal setting, problem solving and avoidance strategies. Your role with respect to maintenance issues is primarily one of identification and referral to ensure that these maintenance supports are put in place.

Significant factors associated with relapse

The context within which relapse occurs, is similar for a variety of substances, although the importance of the various precipitating factors differs from person to person (Annis, et al., 1992). Drug use is heavily influenced by social factors and it is important to recognise that many precipitants of relapse may be due to circumstances beyond the control of the individual. Relapse can be attributed to several precipitants acting in combination or in isolation.

STRESS

Whether due to discrete negative life events or everyday hassles, stress greatly increases vulnerability to relapse.

NEGATIVE EMOTIONS

A wide range of emotions, including anger, anxiety, depression, and frustration can precipitate relapse.

POSITIVE EMOTIONS

Good feelings that come from socialising can sometimes trigger relapse. In other cases, drugs might be used as a reward or a means of celebration.

INTERPERSONAL CONFLICT

Relapse is often associated with conflict with family members and other individuals brought on by poor communication, unresolved conflict, and other factors.

SOCIAL PRESSURE

Sometimes social pressure is overt, as when someone offers the addict a drug. Often it is not. Being enmeshed in a social network in which other people abuse substances is especially risky.

USE OF OTHER SUBSTANCES

Use of another substance can trigger cravings for the primary drug of abuse, undermine self-control, or impair a person's ability to respond effectively to a relapse crisis. Taking prescribed medications can also impair judgement.

PRESENCE OF DRUG-RELATED CUES

Environmental cues (eg drug paraphernalia, or people or places associated with substance use) elicit strong cravings in some people.

Assumptions of relapse prevention

The insights from these models give us a solid basis to develop strategies to help a client prevent the resumption of alcohol and drug use after a period of cessation. We need to acknowledge that almost all clients will have a lapse and a large proportion will return to problematic use. To simply advise people not to have the first drink /drug and not develop strategies to help avoid a lapse becoming a relapse is not only poor treatment--it is unethical.

The models, and the strategies that we can base on them, apply for ALL addictions and compulsive behaviours, not just alcohol and drug use.

The underlying assumptions that we make about the client are that:

- they are able to exercise control over their lives, and make choices
- that they may need to acquire skills in order to effectively exercise control
- that they may from time to time feel the need to use alcohol and drugs to cope with factors in their lives

Core elements of relapse prevention

The following are the core elements of a comprehensive relapse prevention intervention:

1. ASSESSMENT

Individual assessment of a client's history, past and current functioning, mental health status and responses throughout treatment can inform treatment strategies. Assessment is critical for individualised treatment that incorporates relapse prevention strategies.

2. INSIGHT/AWARENESS RAISING

DECISIONAL BALANCE PROCESS (DECISION MATRIX)

This is a way of organising information to aid rational decision-making. This technique is a component of Motivational Interviewing and can be usefully employed at the commencement of a relapse prevention program. On this occasion the questions used would take the form of:

'What are the good things about not using drugs?'

'What are the less good things about not using drugs?'

Your role here is to explore the clients' thoughts and ideally ensure that they stay focussed on the positives about being drug free.

SELF-MONITORING

Self-monitoring can be used throughout the relapse prevention program. If the treatment goal is controlled use, as opposed to abstinence, self-monitoring must be continuous throughout the program, and when the program ends. This is one of the most simple and effective tools in cognitive behavioural therapy and functions as both an assessment method and as a relapse prevention intervention. The insight gained from this method alone has proved sufficient to change behaviour (Holgate, et al., 1996). Clients learn to identify triggers to relapse by reviewing past relapses or by recording when, and under what circumstances, negative behaviours occur. Self-monitoring can also operate as a coping strategy by delaying and perhaps creating hesitancy, where previously there was an automatic process of obtaining and using drugs. Knowledge of the cues that trigger cravings allows clients to become alert to their presence.

The objectives of self-monitoring that require clear communication to the client, are to:

- consciously focus the client (self) on the behaviour needing to change
- discover behaviour patterns (when, how, where)
- identify possible triggers
- identify high risk situations (low mood, conflict, social pressures)
- identify consequences of behaviour to the client and those around them
- calculate the cost to the client in physical, emotional and financial terms (Holgate, et al., 1996)

3. ASSESSING AND COPING WITH HIGH-RISK SITUATIONS

The following is an example of how a counsellor might begin explaining high-risk situations:

> *'If using drugs changes the way a person acts, thinks, and feels, we need to begin by finding out what situations you are most likely to use in, and what you are thinking about and feeling in those situations. We call these high-risk situations. What we want to find out is what kinds of things are triggering or maintaining your using. Then we can try to find out how you can deal with high-risk situations without using. This involves learning specific skills and strategies to use. We talked about this to some extent already in our earlier sessions, but I'd like to focus a little more on it today.*
>
> *The main point is that, once we know about the situations and problems that contribute to your using drugs, we can look for other ways to deal with those situations.'*

Among the questions the counsellor might ask are:

- *In what kinds of **situations** do you use drugs?* (eg places, people, activities, specific times, or days)
- *What are your triggers for using?* (eg when you are in a social situation, when you've had a tense day, when you're faced with a difficult problem, when you want to feel high or energised)
- *Can you give a specific **example**?* (eg a relapse story)
- *Can you remember your **thoughts and feelings** at the time?* (eg tense, bored, depressed, stressed out, overwhelmed, angry)

Adapted from: (Roffman, 1997)

The counsellor or client can record responses and should summarise with the client the apparent determinants of using from this episode. The counsellor should follow up by asking for other examples (Roffman, 1997).

Effective relapse prevention begins with a client gaining awareness for a range of warning signs, including emotions, thoughts, and behaviours, such as anger, unjustified self-criticism, and associating with current drug users. Counsellors can work with clients to develop a comprehensive list of their high-risk situations. It may be useful to concentrate on identifying triggers and cues that have been most problematic in recent weeks/months.

COPING WITH HIGH RISK SITUATIONS

Managing a high risk situation requires a client to both manage it as a relapse precipitant (and hence use relapse prevention strategies) but also to manage the high risk situation itself, using a range of generic coping behaviours. For example, a client may identify anxiety as a high-risk situation. When they become anxious, there is a need to manage the risk (ie acknowledge the craving, cope with the craving etc) but also a need to manage the anxiety itself.

Effective coping behaviours involve identifying a range of activities that can be undertaken in the face of a high risk situation, craving or urge to use drugs. Activities might involve avoiding high-risk internal and external cues (ie avoiding former friends who still use drugs), while others involve coping with unavoidable triggers.

MANAGING KNOWN HIGH-RISK SITUATIONS

In the early stages of recovery, clients should be encouraged to avoid the people, places, and things that have led to relapse in the past, or are likely to do so in the future. However, avoidance is not a good long-term strategy.

At some point clients need to learn how to cope with high-risk situations. It is important that clients avoid setting themselves up to 'test' their ability to resist the temptation to use.

Many people find it difficult to avoid situations that may precipitate relapse, for example their living arrangements (NIDA, 1994). Thus, strategies must be developed that minimise the risk of relapse due to unavoidable triggers.

COPING WITH UNAVOIDABLE HIGH-RISK SITUATIONS

The recognition of a warning sign or craving requires a self-directed preventive response. Clients must learn to anticipate exposure to high-risk situations such as contact with drug users, unstructured time, and stressful work demands and should rehearse the strategies they will employ at the time.

These strategies may include methods for handling stress, anger, disappointment, interpersonal conflict or coping with cravings. Reflection on the success or failure of strategies allows clients to improve their level of coping over time.

Cognitive and behavioural coping strategies include:

- leaving the situation
- throwing away drug paraphernalia
- using relaxation skills
- repeating motivational statements aloud
- writing down thoughts and feelings
- calling a counsellor, sponsor, or other individual for support, and
- rehearsing planned behaviour in role plays (NIDA, 1994)

It is important to give the client some useful, easy to read information and ideas on ways they might cope with high-risk situations.

4. COPING WITH CRAVINGS AND URGES

Discussing behavioural strategies for dealing with cravings is one of the most important aspects of relapse prevention. Craving is a strong physical and psychological desire to use a substance.

Coping with **urges** and **cravings** encourages the client to:

- identify risk situation in which urges and cravings are most likely to happen
- assess the strength of the urge they feel (early urges present quite different challenges to full-blown cravings)
- identify features of the urge (their thoughts and beliefs, physical feelings and emotions)
- how they coped with the urge

Clients need to develop different strategies for coping with cravings, such as:

- **Distraction**, like reading, going to a movie, exercising. It may be useful to prepare a list of reliable distracting activities in conjunction with patients in anticipation of future craving.
- **Talking it through** with friends or family members, which can help identify certain cues, and reduce the feelings of anxiety and vulnerability.
- **Labelling and detachment**. Helping clients to reinterpret or reframe their experience is important to a relapse prevention program. Labelling and detachment, such as 'urge surfing' and 'positive mental imagery' are ways of reframing the experience of urges and cravings. 'Urge surfing' allows a client to experience cravings without fighting or giving in to them. The idea is that clients gain control by avoiding resistance. Using the imagery of ocean waves, clients are encouraged to let cravings occur, peak and pass. The purpose is not to make the craving disappear, but to experience them in a different way that evokes less anxiety and is thus easier to ride out. The steps for the client to follow can be summarised as follows:
- **Pay attention to the craving**. Find a comfortable place, relax and focus your attention inward. Notice where in your body you experience the craving, what the sensations are like and how intense it is.
- **Focus on the area where the craving occurs**. Notice the exact sensations in that area. What is the feeling like? Where is it? How strong is it? Does it move or change? Where else does it occur?

- **Repeat the focusing**. With each part of the body that experiences the craving, pay attention to changes that occur in the sensations. Notice how the urge comes and goes. After concentrating in this way, many people find cravings go away completely. Practicing urge surfing will help you to familiarise your cravings and learn how to ride them out until they go away naturally (Roffman, 1997).
- **Decision delay techniques**. As cravings and urges are like waves, building to a peak and then declining, delaying a decision to use may allow the craving to pass, and decrease the chance of a lapse.
- **Reviewing reasons for quitting/modifying drug use**. When experiencing a craving, many people remember only the positive effects of use. During a craving, it is useful for clients to remind themselves of the benefits of not using and the negative consequences of using. It may be useful for clients to have these benefits and consequences listed on a small card and kept with them.
- **Challenging and changing thoughts.** What clients tell themselves about urges to use will affect how they experience and handle them. Self-talk can strengthen or weaken urges. Clients should be encouraged to use their self-talk constructively. Self-statements that raise the clients discomfort should be identified and challenged. Examples include:

  Challenging: *'I won't actually die if I don't have a drink'*

  Normalising: *This urge feels really horrible, but many people go through it, and I can deal with it without using. Eventually it will go away'.*

Clients should be encouraged to record the details of their cravings as a means of self-monitoring, identification of risk situations and coping responses.

5. PREVENTING AND MANAGING LAPSES AND RELAPSES

CONTINGENCY PLANNING

Contingency planning is a handy exercise a client can do in advance of a lapse. In collaboration with a counsellor or friend, the client plans in advance their preferred response to a high-risk situation or lapse. Managing availability and planning and practising refusal are examples of important techniques for preventing relapse.

CUE EXPOSURE

Exposure to cues associated with addictive behaviour can produce urges and cravings that lead to lapses and relapses. Cue exposure is a counter conditioning procedure that can be used to deal with triggers that cause negative behaviours. It involves exposing the client to stimuli associated with the addictive behaviour (desensitisation) under controlled conditions (such as in the presence of a counsellor). Cue exposure remains the subject of much research, and as yet results are not definitive. It is therefore not recommended that this technique be used without both training and experience in its application (Holgate, et al., 1996).

RELAPSE REHEARSAL

Often clients have to make decisions and use coping skills in a state when they have had a slip. At times, skills learnt in an individual or group process feel 'outside' the situation, external to the state that clients experience themselves in. Relapse rehearsal involves the client imagining a situation where a lapse has occurred, going through the decision process and identifying appropriate coping skills. Alternatively if the lapse is the result of resolution breakdown and a more conscious choice of the client (seemingly irrelevant decisions), an examination of the processes preceding the active decision to lapse is useful (Holgate, et al., 1996).

CHANGING THINKING

Relapse in addictive behaviours is often associated with errors in thinking and typical patterns of thinking. Identifying and changing negative patterns of thinking form a major component of relapse prevention interventions.

The feelings and beliefs a client has about a relapse can affect the rate at which the client returns to the change process. One of the main reasons that lapses extend to relapses is the negative thinking and feelings associated with a lapse - the abstinence violation effect.

There are a number of common ways that people can think after a lapse experience:

'One lapse means a total failure'

'I've blown everything now! I may as well keep going'

'I am hopeless'

'Once a drunk/junkie, always a drunk/junkie'

'I've busted now, I'll never get back to being straight again'

'I have no willpower', 'I've lost all control'

'I'm physically addicted to this stuff. I always will be'.

The idea that one hit, snort or drink means total loss of control is incorrect. Helping clients to examine their thinking and challenge some of their negative thoughts is critical. Alternative thoughts could be:

'Think I should stop this now before it gets out of hand'

'That was a close one - won't do that again in a hurry'

LOOK AT LESSONS LEARNED FROM A LAPSE/RELAPSE

Periods of change, followed by a lapse or relapse, can provide invaluable lessons to clients. Eliciting examples of lessons learned from the client are an essential part of the supporting process. Asking a client about progress made to date, lessons learned and experiences gained can also help to support the client's sense of self-efficacy and to counteract some of the negative feelings they may be experiencing.

REVIEW THE RESOLUTION FOR CHANGE

The strength of the original resolution for change can have a great impact on the likelihood of relapse. As a counsellor you should constantly be reviewing with your client the strength of their resolution and commitment to change. This is an area of relapse prevention that can often be overlooked. It is unwise to assume that because the client is currently not taking drugs, their life is getting better and their desire to stay off drugs is getting stronger. It may in fact be getting weaker. If a lapse or relapse does occur, it is useful to assist the client to review and renew the original commitment. This helps to build new resolve.

REVIEW COPING RESPONSES AND SUPPORT SYSTEMS

Strategies for preventing a relapse involve the development of skills, not just self-control or willpower. An individual may have a great desire for change and a high level of resolve to maintain change. If a person relapses, it may be the time to review some of the strategies used, to look at what worked and what didn't work, explore some of the supports and resources available to the person and to examine what may be needed in the next phase of the journey. It is useful to give clients an emergency card to be kept with them for use during high-risk situations.

6. LIFESTYLE INTERVENTIONS

HEALTHY ALTERNATIVES TO DRUG USE

Counsellors should work with clients to identify healthy alternatives that may provide immediate gratification and act as a diversion from drug use. A list of activities (acceptable to the client) can be developed to refer to when experiencing a strong compulsion to use. If these activities can be adopted and built into the client's lifestyle, it then becomes a global intervention (Holgate, et al., 1996). Positive alternatives may include meditation, yoga, relaxation, regular exercise, or other recreational activities. These should be described as activities that have long-term physical and/or psychological health benefits.

SOCIAL SUPPORT

A client's need for emotional support should be discussed. Family members and friends can assist the client by reducing interpersonal conflict and stress; praising and encouraging progress; creating a supportive interpersonal environment; and monitoring the client's behaviour and helping to identify attitudes, behaviours, or situations that might signal a relapse. Clients should be encouraged to take an active role in obtaining beneficial social support.

LIFESTYLE CHANGE APPROACHES

These focus on helping clients develop and sustain new social identities as drug-free or 'behaviour moderated' individuals, including breaking ties with drug users, developing new interests and social contacts, and learning new methods of coping with negative emotions. For most clients, **identifying high-risk factors** and developing **new coping strategies** for each are inadequate, since they may identify large numbers of risk factors. Clients may need help in taking **a more global approach to recovery** and may need to learn specific problem-solving skills. In addition to teaching clients 'specific' relapse prevention skills to deal with high-risk factors, the counsellor should also utilise 'global' approaches such as skill training strategies (eg behavioural rehearsal, covert modelling, assertiveness training), cognitive reframing (eg coping imagery, reframing reactions to lapse or relapse), and lifestyle interventions (eg meditation, exercise, relaxation).

It is worth noting that these techniques and strategies can also be effective when working with a client whose aim is controlled use rather than abstinence.

Efficacy of relapse prevention

Many research studies have clearly shown that relapse prevention techniques can be effective and should be integrated into treatment. Evidence suggests that relapse prevention improves recovery and reduces relapse rates, particularly among problem drinkers (Daley & Marlatt, 1997).

Research has also emphasised that active practising of the skills during the clinical treatment process is an important aspect of relapse prevention, which increases the likelihood of success (Mattick, 1993).

Despite the positive results of relapse prevention research, accurate comparisons across studies have been limited by the various definitions of 'relapse'.

There is a need for caution regarding the effectiveness of relapse prevention based on the sole criterion of resumption of drug use. Common methodological shortcomings that have been cited in research evaluation include lack of standardised measures of relapse or definitions of successful outcome, problems with sample selection, small sample size, attrition, and length of follow-up interval (Daley & Marlatt, 1997).

Clients who relapse may not always return to pre-treatment levels of drug use. Variations in actual quantity and frequency of drug use may be substantial. As drug use is only one outcome measure, a client may show improvement in other areas of life functioning despite a lapse or relapse to substance use (Daley & Marlatt, 1997). Daley and Marlatt as well as Carroll provide a more detailed description of treatment outcome studies (Carroll, 1996; Daley & Marlatt, 1997).

Review

You have been provided with information on the development of relapse prevention models and specific relapse prevention strategies that you can integrate into your clinical work with your client. Information on the efficacy of these strategies has also been provided. Providing relapse prevention strategies to your client is a core role within the AOD sector.

Self Help Programs

A network of self-help programs is widespread throughout the world. The programs are informal and accessible, and provide high levels of mutual support, social contact and understanding between members.

Alcoholics Anonymous (AA) is the among the most well-known self-help groups and it is AA's primary philosophy that has been the stimulus for other groups such as Narcotics Anonymous (NA); NarAnon, which is for the partners, families and friends of users; Families Anonymous and Gamblers Anonymous.

AA's key principles are that recovery is based on admitting powerlessness over the substance; an acknowledgment of a higher power, self-scrutiny and reparation; and contribution to the fellowship.

Meetings are held in public venues and members are able to attend as many as they wish. Self-help programs are focused on the goal of abstinence.

The majority of meetings provide members with a forum in which they can speak of their experiences as drug users and also life issues which they face.

Participants in self-help programs talk of gaining significant strength from the interpersonal nature of the program, the regularity and routines that meetings offer, and the opportunities that the program provides to assist others or work in service roles.

All self-help programs are anonymous, and members are not permitted to identify themselves publicly. In the United States, the self-help philosophy provides the framework for residential services and programs.

In contrast the self-help fellowship in Australia is largely divorced from the provision of treatment by health professionals.

Research into the effectiveness of self-help groups has been limited. This has been partly due to the requirements of anonymity. However, data available suggests that self-help is as effective as other treatment modalities and like all treatments has a high drop-out rate at the start. The advantages of self-help are its easy accessibility, and the high levels of social peer support. Both these factors are considered important in successful treatment.

Self help program - based on 12 step

Most twelve-step programs/fellowships also adopted the below principles as their structural governance.

An example of a self help program is Alcoholics Anaonymous. In AA, the empathetic desire to save other alcoholics resulted in a radical emphasis on service to other sufferers only.

Thus "the only requirement for AA membership is the desire to stop drinking." Similar membership guidelines were adopted by other fellowships. The Twelve Traditions of Alcoholics Anonymous are as follows.

1. Our common welfare should come first; personal recovery depends upon AA unity.
2. For our group purpose there is but one ultimate authority-a loving Brass Door Nob as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.
5. Each group has but one primary purpose-to carry its message to the alcoholic who still suffers.
6. An AA group ought never endorse, finance, or lend the AA name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every AA group ought to be fully self-supporting, declining outside contributions.
8. Alcoholics Anonymous should remain forever non-professional, but our service centers may employ special workers.
9. AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.

11 Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.

12 Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

THE 12-STEPS AND PRINCIPLES ARE THEREFORE;

The twelve steps lead people through a necessary therapeutic sequence involving;

- insight,
- surrender,
- positive goals,
- introspection,
- confession,
- submission
- humility,
- amendment,
- restitution,
- reorganization,
- spirituality, and
- love

1 INSIGHT: We admitted we were powerless over alcohol - that our lives had become unmanageable.

2 SURRENDER: Came to believe that a Power greater than ourselves could restore us to sanity.

3 POSITIVE GOALS: Made a decision to turn our will and our lives over to the care of God as we understood Him.

4 INTROSPECTION: Made a searching and fearless moral inventory of ourselves.

5 CONFESSION: Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6 SUBMISSION: Were entirely ready to have God remove all these defects of character.

7 HUMILITY: Humbly asked Him to remove our shortcomings.

8 AMENDMENT: Made a list of all persons we had harmed, and became willing to make amends to them all.

9 RESTITUTION: Made direct amends to such people wherever possible, except when to do so would injure them or others.

10 REORGANIZATION: Continued to take personal inventory and when we were wrong promptly admitted it.

11 SPIRITUALITY: Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12 LOVE: Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

"Sponsors share their experience, strength, and hope with their sponsees... A sponsor's role is not that of a legal adviser, a banker, a parent, a marriage counselor, or a social worker. Nor is a sponsor a therapist offering some sort of professional advice. A sponsor is simply another addict in recovery who is willing to share his or her journey through the Twelve Steps." - from NA's Sponsorship, Revised

A sponsor is a more experienced person in recovery who guides the less-experienced aspirant ("sponsee" or variously, "sponsoree") through the program. Newcomers in twelve-step programs are encouraged to secure a relationship with at least one sponsor. A vast array of publications from various fellowships emphasize that sponsorship is a "one on one" relationship of shared experiences focused on working the Twelve Steps.

Sponsors and sponsees participate in activities that lead to spiritual growth These may include practices such as literature discussion and study, mediation and writing. Completing the Twelve Steps implies being competent to sponsor to newcomers in recovery.

Sponsees typically do their Fifth Step with their sponsor. The Fifth Step, as well as the Ninth Step, have been compared to confession and penitence

The personal nature of the behavioral issues that lead to seeking help in twelve-step fellowships results in a strong relationship between sponsee and sponsor. As the relationship is based on spiritual principles, it is unique and not generally characterized as "friendship." Fundamentally, the sponsor has the single purpose of helping the sponsee recover from the behavioral problem that brought the sufferer into twelve-step work, which reflexively helps the sponsor recover.

Brief twelve step facilitation (TSF) characteristics

EDUCATIONAL REQUIREMENTS

Brief-TSF requires considerable clinical skill to implement properly.

Issues in implementation include:

- the ability to stay focused
- maintain structure within each session
- and engage in constructive confrontation.

Accordingly, it is recommended that prospective facilitators have counseling experience and/or training.

COUNSELOR'S RECOVERY STATUS

Brief-TSF facilitators need not be in recovery personally.

Any serious Brief-TSF facilitator, however, should have read all relevant AA literature that clients will be asked to read and should be familiar with at least AA and Al-Anon meetings from personal experience.

In addition, **it is not recommended** that a facilitator whose **own views are unsympathetic** to the primary goals of Brief-TSF (e.g., abstinence, active involvement in 12 step fellowships) seek to implement this model, for obvious reasons.

IDEAL PERSONAL CHARACTERISTICS OF COUNSELOR

The best Brief-TSF facilitators have a good working grasp of:

- basic Rogerian non-specific
- client-centered therapeutic skills
- including unconditional positive regard

- good active listening skills
- combined with a good-working knowledge of 12 step philosophy and the practicalities of getting active in 12 step fellowships.

The ideal Brief-TSF facilitator is able to maintain session focus without excessive drift while also maintaining rapport.

The Brief-TSF facilitator establishes a collaborative relationship with the client and **utilises confrontation in a constructive, non-punitive manner**.

COUNSELOR'S BEHAVIOURS ADVISED

The Brief-TSF facilitator will help the client:

- Assess his or her alcohol and advocate abstinence.
- Explain basic 12 step concepts (e.g., surrender, acceptance & action).
- Advocate and actively support and facilitate initial involvement in self help programs.
- Facilitate introduction to an Peer Sponsor.
- Facilitate ongoing participation in self help programs
- Suggest and discuss specific readings from AA literature.
- Help the client learn to use AA members as resources in times of crisis and to support and celebrate sobriety.
- Conduct sessions that helps the client assess critically his or her progress in the program.

COUNSELOR'S BEHAVIOURS NOT ALLOWED

The Brief-TSF facilitator does not:

- Conduct sessions with an intoxicated client.
- Attend meetings with the client.
- Act as an sponsor.
- Threaten reprisals for non-compliance.
- Advocate controlled drinking or other drug use.
- Allow therapy to drift excessively onto collateral issues, such as marital or job conflict.

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For detailed information, please contact:

UNODC Country Office Viet Nam

25-29 Phan Boi Chau, Ha Noi

Tel: (84 4) 3942 1495, Fax (84 4) 3822 0854

Email: fo.vietnam@unodc.org