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Supporting Innovative Child Protective Services

Recovering Together Program

Curriculum Guide: Substance Abuse Treatment for Women and Their Families

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August 2007

Acknowledgements

This curriculum was developed with the support of the Rocky Mountain Quality Improvement Center and the staff of the American Humane Children's Services Department. Their insight into the impact of substance abuse on protecting children has been tremendously valuable. Their encouragement has created an opportunity for this program to meet some of the needs of both the families who struggle with substance abuse and the professionals who serve them. Funding for the development of the Recovering Together Program was provided by the Children's Bureau, Administration on Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services, grant # 90-CA-1699.

Special thanks to Carol Harper, MPA, who served as the Director of the Rocky Mountain Quality Improvement Center during the development and pilot testing of the Recovering Together Program. Her skill and guidance in child welfare and community dynamics were essential in honoring our community's intention to make a difference for families.

Leslie Wilmot, MSSW, the Director of Child Welfare Training & Professional Development at the American Humane Association also provided useful editing and suggestions during the final curriculum development.

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I. Introduction

This document is for substance abuse treatment providers and their child welfare colleagues. It describes the Recovering Together Program (RTP), a program that treats families (mothers and their children) in which the mothers are receiving substance abuse services and the family is receiving child welfare services. The first section describes issues associated with collaboration between the two service systems and practical implications for replicating or developing a program like RTP as part of such a collaboration. The second section contains a detailed guide in the form of a curriculum for conducting the adult group in Phase 1 of the Recovering Together Program. A detailed curriculum for the children's group that is conducted concurrently in Phase 1 of RTP can be fund in a separate document.

Recovering Together Program Description

The Recovering Together Program (RTP) is a year-long therapeutic and educational program for mothers and their children, serving mothers who need help with both child maltreatment and substance abuse issues. Staffed by a multi-disciplinary team, RTP uses culturally appropriate and theory-driven treatment methods that are creatively designed for women and children's special needs. The RTP design includes advocacy and case management services for families. These approaches were selected based on a literature review completed before the initial design of the RTP program and continued throughout the three years of field-testing, formative evaluation, and modifications of the original model.

RTP consists of three phases. In Phase 1, the "initial treatment" phase, the mothers' and children's individual emotional and behavioral needs are the focus of treatment. Phase 1 includes enrollment in the program, intake interviews, 16 weeks of separate group therapy for women and their children, and recommendations and support for them to engage in community support group meetings or recovery activities. Common community support group and recovery activities include Alcoholics Anonymous (AA) or

Narcotics Anonymous (NA) meetings, support groups for victims of domestic violence or sexual abuse, classes related to concurrent legal requirements, and various religious activities. During field testing, families were also encouraged to use the local recreation center, and membership was paid through initial RTP grant funds. Each participant developed a primary treatment plan during this phase.

During Phase 1, the women learn about addiction and craving and are introduced to the basics of cognitive-behavioral techniques to make changes in their lives. Methods for transferring this information to the women are adjusted to the learning styles and culture of each group of participants. Meanwhile, the children participate in age-clustered educational therapy groups that involve play and art therapy techniques. These techniques allow the children to process their own experiences, learn about various emotions, and understand the effects of addiction on their family.

In this initial phase, the RTP family advocate begins to assist mothers in developing the skills necessary to access needed resources. Common needs include housing, transportation, and employment. In addition, based on knowledge that the mother will find it difficult to achieve abstinence if chronic medical problems have not been treated adequately, such treatment is accessed. Maximizing the physical health of both mother and children is addressed in this phase by referral to appropriate local resources.

RTP intervenes in the family's environmental system in all phases of treatment, but more directly in the second and third phases of treatment. During Phase 2**,** the program helps the participants re-create their family communication and behavior with family skill-building classes. Fathers/partners and/or other key adult extended family members may participate during this phase because of the important role they have in both the lives of the children as well as the potential supportive role they could have in the mothers' recovery. In this "skill-building" phase, the entire family's communication and problem-solving skills are the focus of the intervention. In addition to the 12 weeks of family skill-building classes provided by the RTP staff, mothers continue to attend community support group meetings. The curriculum used during this phase during the pilot testing was a modification of the DARE To Be You (DTBY) program (Miller-Heyl,

MacPhee, & Fritz, 2001). DTBY is a substance abuse prevention program that includes family training, education, and activities for teaching self-responsibility, personal and parenting efficacy, communication and social skills, and problem-solving and decision-making skills. The DTBY program was selected based on its strong research base and the local availability of DTBY facilities and trained staff. Other prevention programs have been suggested for this family skill-building phase, especially programs such as Incredible Years (Webster-Stratton & Hammond, 1997), Nurturing Parents (Substance Abuse and Mental Health Services Administration, n.d.) and Celebrating Families (Quittan, 2004). Therapy services continue on an individual or family basis during the second phase, and also include other family members, if appropriate.

Phase 3, the "lifestyle change" phase lasts approximately sixth months, or until program discharge. The mothers' vocational and social needs are the focus of advocacy efforts during this final phase, which includes ongoing adjunct treatment services as needed and mandatory support group meetings. During this time, unmet treatment goals are modified or fulfilled, and mothers engage in individual or family counseling to support their achievement of realistic treatment goals.

Barriers and Bridges to Collaboration

Child welfare workers and substance abuse counselors often work with the same families. The issues of child maltreatment and alcohol and drug misuse are closely related. However, there are barriers thwarting collaboration between workers in these two fields of human service. Lack of collaboration between case workers and counselors can create significant roadblocks to progress and reunification of families struggling with co-occurring substance abuse and child maltreatment issues. This introduction section describes the barriers to collaboration, and some suggestions to bridge these gaps to help families successfully reunite and create healthy, drug free lifestyles.

Historical gaps in understanding and communication between the substance abuse treatment and child welfare systems complicate the challenging task of reuniting families struggling with child maltreatment and addiction. Certainly, some families negotiate the maze of conflicting requirements and re-unify their families. However, in this author's experience, those families are rare, and a deeper understanding on how they beat the odds may be helpful. The maze of misunderstanding between workers in these two fields and gaps in needed services may form a barrier to success for most families, and the cost can be tremendous.

Co-occurrence but Limited Cross-System Collaboration

In the last few decades, research has confirmed a correlation between parental substance abuse and a higher likelihood of child maltreatment (National Clearinghouse on Child Abuse and Neglect Information, 2003). Many child maltreatment cases, especially neglect, are substance-related (American Humane, 2005). There is evidence to suggest that child welfare workers only vaguely understand substance-related disorders, and addiction counselors only get occasional, hazy glimpses of child welfare issues (Feig, 1998). Unfortunately, friendly collaboration is too often a rarity between child welfare

agencies and substance abuse treatment providers (U.S. Department of Health and Human Services (USDHHS), 1999).

Parents are often required to complete substance abuse treatment in order to regain or retain custody of their children following a documented incidence of neglect or abuse (USDHHS, 1999). When these parents fail, they may blame confusing and sometimes conflicting requirements of the courts, their child welfare case worker, and their substance abuse treatment counselor.

Documented Barriers to Cross-System Collaboration

There are several systemic, ideological, and logistical issues inherent in the current system of providing child welfare and substance abuse services that may impede collaboration between these service providers. In fact, "social disorganization within a community is one of the key characteristics correlated with child maltreatment." (Bright Futures, 2002, p. 220).

Due to the multiple foci of this document, this section will focus on collaboration barriers and collaboration bridges between only two groups within these systems, child welfare (case) workers and substance abuse treatment providers (counselors). Barriers and bridges may also exist between the many other service providers from whom these families seek services, but we will limit our discussion to case workers and counselors. The thesis is that several systemic ideological and logistical barriers thwart active collaboration between counselors and case workers. Identifying these barriers, as well as possible solutions for overcoming these difficulties, may result in better collaboration.

Perception of Divergent Underlying Values

Professionals working with families often bring strong beliefs and passionate hearts to tackle the challenging nature of this work. Since the ability to predict when substance abuse will create imminent danger is far from perfect, philosophical discussions of priorities and decision-making about strategy may

quickly become emotion-laden arguments. Discrepancies in apparent underlying values have created barriers to both understanding and mutual respect between counselors and case workers (USDHHS, 1999). These discrepancies include what to do in order to best address the situation, and even the order in which issues "must" be addressed.

Jumbled Screening, Assessment and Placement Procedures

Procedures for screening, assessment and appropriate substance abuse treatment placement may be poorly defined and haphazardly applied. Misunderstandings, delays or failure to provide relevant referral information, and client privacy rights may hinder accurate assessment and treatment planning. These factors may occur within or between agencies for a variety of reasons.

In "Children at the Crossroads", Gardner and Young (1998) comment that child welfare workers typically ask only one or two questions about alcohol and other drug use. Thus, they must subjectively assess substance abuse based on the client's own report, or in relatively rare instances, with the aid of obvious evidence observed during a home visit. Conversely, counselors using substance abuse screening and assessment instruments rarely include questions about current family management practices or the safety of the client's children, or even if child protective services are involved. Gardner and Young acknowledge that safety assessment may focus on completely different risk factors, depending on whether the assessor is a case worker or a counselor. The decisions and choices are different, despite working with the same family, since one professional may be concerned about a mother's suicidal ideation or unsafe sexual practices while the other is focused entirely on the safety of the children.

Financial Considerations

Financial resources available to the community and family also influence substance abuse treatment selections. There are inadequate treatment resources to meet existing needs, often preventing prompt, appropriate

substance abuse treatment placement (Gardner & Young, 1998). Managed care gatekeepers of treatment funds are very selective regarding who receives various treatment options in order to reduce spending with dwindling resources, whether the funds are private or public. Budgeting and program sustainability are constant concerns for treatment providers, and these issues may interfere with unbiased decisions about treatment program placement.

In addition, higher intensity treatment programs rarely include provisions for childcare, which then can potentially pass this expense to a family unable to afford this cost. If children are removed from the substance abusing parent's custody, and, if the family receives publicly funded housing and other benefits, these funds are often terminated. Homelessness creates a significant treatment barrier for any outpatient treatment modality. When a client is employed, scheduling and transportation may become significant barriers to treatment participation. Financial concerns may undermine many clients' ability to provide for their children's basic needs, a consideration in regaining custody. Clients may feel pressured to choose between a work opportunity and substance abuse treatment sessions, creating a dilemma for parents whose primary motivation for treatment is regaining custody of their children.

Difficulty in Treatment Engagement and Retention

The challenges of engaging and retaining parents in the recovery process are acknowledged by case workers and counselors alike. For example, the substance abuse field has historically emphasized that clients must "hit bottom" and sincerely desire abstinence before treatment can be effective. This practice, coupled with operating under "triage" conditions, makes counselors tend to pour their treatment efforts into clients with the best chance of recovery. Case workers have different timeframes, often prescribed by lawmakers unfamiliar with the complex challenges of substance abuse recovery. Case workers operate under federal mandates to reunify a family quickly and safely (Adoption and Safe Families Act, 1997). Case workers can be impatient with substance abuse

counselors' insistence that the client must shoulder responsibility for their own recovery while following an individualized timeframe. Counselors may feel pressured to emphasize a punitive or watchdog role when their first priority needs to be creating a therapeutic relationship.

For many parents referred to treatment by case workers, concerns and awareness about the effects of their substance abuse on their children are key reasons they elect to enter treatment (USDHHS, 1999). Unless family relationships are addressed in treatment, both the referring case worker and parents feel treatment is not relevant, contributing to high drop out rates.

Differing Expectations for a "Successful" Outcome

Expectations about what represents a successful outcome differ between substance abuse treatment and child welfare program evaluations (USDHHS, 1999). Most substance abuse treatment is considered successful when it results in decreased alcohol and drug use, decreased criminal behavior, and decreased need for and utilization of health care services. This definition of success could be achieved even if child safety issues remain. In contrast, in child welfare studies, the child's safety, well-being, and permanent placement are the primary goals (USDHHS, 1999). Success in a child welfare program could "technically" be achieved even without any changes in parental substance abuse, criminal behavior, or health care services as long as children have a safe home.

Differing Time Priorities

The child's rapidly ticking developmental clock, the caseworker's mandate to achieve timely safe placement permanency, and the gradual, complex cycles of recovery create differing time priorities. Sufficient progress in substance abuse recovery and parental skill building takes many months, and sometimes years. This process conflicts with legislative requirements regarding child permanency and children's developmental needs (Young, Gardner, Whitaker, Yeh, & Otero,

2005). The differing times lines have been referred to as "the four clocks" (Young et al, 1998) and include:

- Child welfare time limits regarding permanency for children in foster care as outlined in the Adoption and Safe Families Act which generally only allows a child to be in out-of-home placement no more than 19 out of the last 22 months
- The pace of recovery from addiction
- Time limits associated with public financial assistance, usually not more than two years in total of support
- Children's developmental time line

As these clocks tick, misunderstandings and frustration are common among case workers, counselors, and parents as they strive to find a reasonable schedule. The pressure on parents to attend child visitation, parenting classes, AA meetings, and therapy appointments while simultaneously finding a job and housing can create a stressful situation, ripe for relapse.

Another priority conflict is deciding which should be addressed first, child maltreatment or the alcohol or other drug problem. While most professionals would prioritize children's safety, a family might be considered "safe" and still use very poor parenting practices. Often, parenting classes may be required while substance abuse recovery is still very fragile. Abstinence from substance abuse does not automatically end all risk for child maltreatment. The withdrawal experience may last for years (USDHHS, 1999), and other risk factors may exist indefinitely without appropriate intervention. During withdrawal, a parent is likely to experience rapidly fluctuating, intense emotions formerly managed (or suppressed) with chemicals. This emotional rollercoaster may increase the likelihood of child maltreatment (Zuskin & Panfilis, 1987). Ideally, the parental substance abuse and emotional problems must be treated simultaneously and resources should be available to the family for respite care and child safety throughout this period (Childabuse.com, n.d.). Unfortunately, in real life, these

types of supportive resources are not always available. Therefore, the children ride the emotional roller coaster of early sobriety side by side with their recovering parent. Children in recovering families may develop unhealthy coping strategies in order to survive the emotional chaos that results. Their recovery may have more ups and downs than necessary, and that recovery may disintegrate due to a lack of appropriate services.

Lack of Training in Related Fields

Both child welfare and substance abuse agencies struggle with retention of staff (Institute for the Advancement of Social Work Research (IASW), 2005). Neither child welfare nor substance abuse pre-service training typically includes information on the other field (IASW). In addition, local staff need opportunities to learn together about each others' discipline and local practice. Lack of joint local in-service training may be a missed opportunity for counselors and case workers to interact constructively with respect to families' needs.

Physical isolation from each other's work sites also contributes to lack of knowledge regarding each other's fields. Both caseworkers and counselors' schedules are packed full, often overfull. Required paperwork all too often keeps them at their desks, unable to connect personally with each other. Caseworkers may get out of the office more, but they often travel on tight schedules to specific sites for meetings or for home visits. Rarely do counselors and caseworkers cross paths in a typical day. In addition, issues or concerns about client privacy may limit the exchange of information when they do meet.

Different Definitions of "the Client"

The U.S. Department of Health and Human Services (1999, online version) states that,

> "for many substance abuse treatment programs, the adult is the primary client and the one around whom services revolve. The adult's relationship with the drug is the focus of the clinical intervention, and everything else in

> the client's life is of secondary importance. For child welfare agencies, the child is the focus of activity, and the entire family is usually defined as the client. A variety of services may be offered to the family, with the intent of assuring the child's safety, within the family if possible. But when a choice must be made in balancing children's needs and parents' needs, the mandates of child welfare agencies demand that the children must come first."(Chapter 4, paragraph 4)

This divergent perspective has tremendous implications for inter-agency collaboration. If both agencies view themselves as the primary service provider, differences frequently arise around day-to-day decisions about working with families. The family may have two different treatment (or service) plans, with conflicting goals and desired outcomes.

Dissimilar Response to Setbacks and Information Sharing Issues

As mentioned above, case workers generally consider the child or family as the primary client(s), while a substance abuse counselor's client is generally the parent in recovery. This can create vastly different viewpoints about setbacks that arise in the recovery process. For instance, relapse is common for clients while in substance abuse treatment. From the counselor's perspective, a relapse is a regrettable learning opportunity for the client. A case worker, discovering evidence about the same relapse, may perceive it only as a serious threat to child safety. If client permission does not exist to share relapse information, attendance, and other relevant information with the case worker, the counselor may feel unwilling to share the information (excluding mandatory reporting duties). There is no difference between voluntary or court-ordered treatment – a referral to treatment is not signed consent. Only a written, signed consent releases the counselor from maintaining confidentiality except for mandatory reporting instances (U.S. Government, Code of Federal Regulations, 42 CFR Part 2). In substance abuse treatment, a safe atmosphere is critical so clients can be open about relapse and other struggles in sobriety. If legal charges threaten, or parental rights are likely to be terminated due to admitting to substance use, clients may fear participation in recovery activities. This situation

can create an ethical dilemma for counselors, frustration and distrust for the case worker of the substance abuse treatment system and counselors, and confusion for the client about what to do.

The National Center of Substance Abuse And Child Welfare (NCSACW) (2004a) explains that when counselors who treat substance abuse disorders are asked to report information about their clients' progress in treatment to case workers, or to testify in court, issues of confidentiality arise, both counselors and case workers potentially face serious consequences for breaching confidentiality, and they are understandably reluctant to risk unauthorized disclosure of protected information. Professionals in both fields struggle with clients' evasiveness, deception and long-held distrust of "the system," which counselors and case workers are seen to represent. Both professionals loathe endangering any trust established with these families.

Practical Aspects of Community Based Outpatient Treatment

While child well-being is probably the primary consideration for most human service professionals regardless of their specific fields of expertise, saving money on alternative placements may be a powerful factor favoring community-based outpatient treatment. Timely permanency, including return home if possible, is desirable because it is in the best interest of the child (Lutz, 2003; Monck, Reynolds, and Wigfall, 2003). Besides the prevailing motivation to keep children safe, governments are also aware of the financial burden of paying for out-of-home placement for children (Usher, C.L., 1998). Outpatient services that allow parents to start working immediately towards a safer, alcohol and drug-free environment for their children may stretch resources by saving money on both alternative placement costs and the relatively high cost of inpatient treatment.

Another observation is that the majority of this research may have been focused on severely damaged families. The nature of the child protection system at this point in history requires screening out low risk situations and complaints rooted in

civil custody battles involving a substance abusing parent. Yet these lower risk and recently disrupted families may present a very important opportunity for intervention. This author strongly advises including these lower risk families in the Recovering Together Program in order to prevent child maltreatment, and to provide an alternative suggestion when formal intervention is unfounded. Nevertheless, giving the highest priority to protecting children at imminent risk of neglect or abuse related to their parent's substance abuse is undeniably appropriate.

This literature review primarily targets publications written by federally funded researchers. A potential weakness of these studies is broad generalizations which may miss regional and philosophical differences found within each discipline. A related issue is that cultural differences in the importance of family and in family management practices should be considered in evaluating resources and preferences in each unique community.

Summary

To summarize, the following systemic and ideological barriers should be targets for collaboration between the substance abuse treatment and child welfare service communities.

- Perception of divergent underlying values
- Jumbled screening, assessment and placement procedures
- Financial considerations for services
- Difficulty in client treatment engagement and retention
- Varying expectations for client outcomes
- Differing time priorities
- Lack of training in related fields
- Isolation from each other's work sites
- Divergent definitions of "the client"
- Dissimilar response to recovery setbacks (relapse)

- Restricted and rare information sharing

Key Service Considerations for Implementing Collaborations

1. Create clear, community-specific guidelines and simple procedures for referral and placement

Each community could document their current procedures for referral and placement, providing a copy of the document to both counselors and caseworkers. Once the current procedures are documented, a brainstorming session with both frontline counselors and case workers along with decision makers may be arranged. It is possible that fairly simple shifts in procedures and the process of clarifying guidelines will eliminate much of the confusion. If a community desires more information about guidelines and procedures, an excellent initial protocol developed by Colorado stakeholders is available on the NCSACW website (National Center on Substance Abuse and Child Welfare, 2004b).

2. Provide services to children

Consider providing services to children whenever there are co-occurring substance abuse and child maltreatment issues. It may be helpful to provide child care during clients' counseling sessions and during community-based recovery activities. If possible, the child care setting should provide nutritious meals, predictable routines, and child-care professionals with some training in spotting signs of both parental substance use and child maltreatment. The hours that child care is available should include some evenings, since that is when many support groups and twelve-step meetings occur. Providing the simple intervention of convenient child care enables the parent to access community resources that will be available long after formal treatment ends. Receipt of reasonably simple documentation of parental attendance at the targeted recovery activities should be included in the child care arrangements.

If staff resources are available, children should also complete a developmentally appropriate curricula designed to gently address the issues of family addiction and emotional management. The Recovering Together Program children's curriculum (Finch, in press), developed as a companion to this curriculum, is an excellent example that specifically focuses on both of these issues. The classes may be offered to both children in out-of-home placement (formal or informal) and those who remain in the home during the parent's substance abuse treatment. If the child is in the custody of a kinship caregiver, it may be helpful to offer a caregiver support group at the same time and location of the children's group meetings.

3. Assess partnership strengths and weaknesses

Young, Gardner, Whitaker, Yeh, and Otero (2005) suggest using tools provided by the National Center on Substance Abuse and Child Welfare to assess the local (or statewide) capacity to work as partners in addressing the alcohol and other drug needs of parents in the child welfare system. The two assessment tools, for either the state or local level, are called Collaborative Capacity Instruments. These can be downloaded from the Child and Family Futures website at http://www.aodsystems.com/CCI/CCI_Start.htm. The ten major elements of the instrument are:

- Underlying Values and Principles of Collaborative Relationships
- Daily Practice - Client Intake, Screening, and Assessment
- Daily Practice - Client Engagement and Retention in Care
- Daily Practice - Services to Children
- Joint Accountability and Shared Outcomes
- Information Sharing and Data Systems
- Training and Staff Development
- Budgeting and Program Sustainability
- Working with the Courts
- Working with Related Agencies and the Community

The purpose of engaging in this assessment is to identify differences in values, perceptions, and practices. Knowledge in these areas will support the development of understanding, as well as suggest approaches and strategies to address barriers.

4. Include a practice of harm reduction within the substance abuse service array

Substance abuse treatment providers may wish to re-examine their treatment array in order to make harm reduction a viable service offered in the continuum of care. Harm reduction is "a public health concept of lowering the health consequences resulting from certain behaviors" (Hemphill, 2005). Historically, resistance in the United States treatment community relates to the perception that harm reduction is the direct opposite of an abstinence-based disease model. However, this approach has been widely implemented into the European theater and has it roots in the harm-reduction efforts in needle exchange programs of the 1980s (Hemphill). A parallel approach, such as reducing and preventing harm to children, is accepted in most other human service programs. Harm reduction may be a very good fit for some families with co-occurring substance abuse and child maltreatment issues.

The National Child Abuse and Neglect Data System (NCANDS) states that caretaker alcohol abuse was associated with increased likelihood of the child experiencing re-reporting and recurrence. (Fluke, Shusterman, Hollinshead, & Yuan, 2005). A child safety plan can require that a parent may contact a safe caregiver in the event of a relapse. If the parent is truly drug dependent, they may eventually choose abstinence as easier as and safer than attempting moderation. Meanwhile, realization and acceptance that their drug use poses a real risk to their children is definite progress.

5. Cross-discipline training

The National Center on Substance Abuse and Child Welfare (NCSACW) is a jointly funded initiative with the goal of providing tools, including training and

technical assistance, to professionals in both disciplines. The Center currently has two free self-tutorials available at http://www.ncsacw.samhsa.gov/ that will help each discipline establish baseline knowledge on the subjects of substance abuse and child welfare. The Center has arranged for these classes to provide continuing education credits for professionals in both substance abuse and social work fields.

6. Communicate and clarify values

Some excellent tools have recently become available to help communities facilitate healthy communication about shared and differing values on these issues. One of these tools, called the Collaborative Values Inventory (CVI), is available on the NCSACW website mentioned above at http://www.aodsystems.com/cvi/CVI.html. Using the CVI will help individuals seek out and understand the differences and similarities in values held by groups of counselors and case workers, and find common grounds to define who the client is and set in place mutual expectations for each other and for the client (USDHHS, 1999).

7. Visit each others' work sites

Isolation and differences can be overcome by personal visits to each other's work sites. It may be appropriate to attend each other's staff meetings, to create understanding, build awareness, and share information regarding joint client with several staff members at once. However, there is no substitute for a private visit to a colleague's office for case review or to discuss concerns. It may even be helpful for a substance abuse liaison to be co-located in child protection offices (Halligan, Gibson, Salmon, Taylor, & Davis, 2005).

8. Create joint accountability and shared outcomes

The idea of sharing responsibility for families' welfare may actually provide relief for many human services professionals. When providing services to this

population, the array of problems presented by a single family can be overwhelming to everyone concerned. If an atmosphere of cooperation and support begins to evolve, setting goals for success is fairly simple. At a minimum, the parent(s), case worker, and counselor can usually agree that reduction (or elimination) in substance use and procedures for protecting children in the event of a relapse are appropriate goals. Goals may be personalized to each family, and should include such issues as housing, mental and physical illness, communication conduits, transportation, and child care. Procedures for data sharing for analysis and evaluation may be integrated into the local record-keeping procedures.

The Colorado protocol states that "solutions focused on helping families are only implemented to the extent that there is accountability on the part of all team members involved. Therefore, every team member has the right to expect other members to follow through with agreed-upon goals. The team, not any one individual, is ultimately accountable for outcomes." (National Center on Substance Abuse and Child Welfare, 2004b, p. 32) If families are members of the team, and both substance abuse treatment providers and child welfare professionals participate, true partnership and shared responsibility provide fertile ground for success.

9. Establish conduits for sharing appropriate information

The Colorado protocol states that "information about outcomes should be specified carefully in the release of information between agencies, and clients should understand exactly which information will be shared". (National Center on Substance Abuse and Child Welfare, 2004). If client permission can be obtained, important information to target for sharing might include meeting attendance, participation level, and incidents of substance use. Clarify in what particular time frame sharing information across agencies and systems can be accomplished. Pay careful attention to legal requirements and client understanding of the benefits of cross-agency collaboration. The NCSACW site provides access to an

excellent presentation by Rene Popovits (2004), entitled "Navigating Muddy Waters: How to Increase Collaboration Across Systems in a Post-HIPAA Environment," which provides an overview of the various state and federal confidentiality laws that affect the ability of agency professionals to share information.

Summary: Bridges to Collaboration List

1. Clear, community-specific guidelines and simple procedures for referral and placement
2. Provision of services to children
3. Assessment of partnership strengths and weaknesses
4. Include Harm reduction in substance abuse service array
5. Cross-discipline training
6. Communicate and clarify values
7. Visit each other's work sites
8. Create joint accountability and shared outcomes
9. Establish conduits for sharing appropriate information

Challenging? Certainly. Modeling behaviors expected for clients and their children may be the most powerful intervention systems can offer. Learning how to overcome the very real barriers to productive collaborations between child welfare and substance abuse agencies is a powerful example of walking the very path we talk about. RTP presents a challenge and an opportunity for case workers, counselors and families. In order to increase families' likelihood of reunification, bridges must be built to overcome these barriers to success. A sustained effort is required to understand one another and establish a shared set of expectations. These mutual understanding and shared expectations are similar to those asked of parents in order for them to accomplish a healthy lifestyle for themselves and their children. If they can do that, against all the odds, then perhaps those who work in systems can put aside their fears and reach for the courage required.

Common Issues for Parents in the RTP

The following description of this population (Spear and Moorstein, pp. 28-36) is excerpted from Protecting Children, a publication of American Humane:

Many of the families in RTP have a single female head of household. In fact, only 31% of the families have a male cohabitant or spouse in the home. Observation of RTP participants indicates that, although it may be unlikely that these mothers are involved in a healthy domestic partnership, they do have some level of involvement with a sexual partner. In about half of the families, the children are living with a relative or foster parent, although all of the families hope to reunite eventually. Compared with the state population, DACODS evidence suggests that RTP participants may report slightly higher rates of family issues and problems. Forty-four percent of RTP mothers report that their cohabitating partners get drunk frequently and that nearly one-third of all participants in the program use drugs other than alcohol.

RTP mothers struggle to maintain steady employment and therefore struggle to achieve a steady and sufficient income. Seventy-four percent of RTP mothers did not graduate high school, and just over one-half do not hold valid driver licenses – two factors which potentially limit the mobility and income potential of these families. Although 40% of mothers report working full or part time in the past six months. However, at enrollment, 20% of these mothers stated that they worked less than five days during the previous 30 days. The remaining 60% of the mothers cite an inability to find a job, being in jail, and working irregular jobs. Even more daunting is that 26% of participants have not applied for a single job in the past six months. A substantial percent (29%) of RTP women report that they have been fired or told not to return to work in the past six months. Additionally, nearly 60% of all RTP participants report they have had problems with transportation in the past six months.

Sources of income for RTP participants include their jobs, a spouse or ex-spouse, child support from a spouse or ex-spouse, a sexual partner, family members, unemployment, welfare, and prostitution and other illegal activities. A spouse or ex-spouse is cited as the most common form of income, revealing these mothers' high level of dependence on current and past sexual partners to provide for their family. Studies have shown that these partners are also likely to have substance abuse problems (Ellis and Zucker, 1997; Kendler, Davis, and Kessler, 1997), which can be a tremendous barrier to treatment success.

Since all participants have been screened by county Department of Social Services for concerns about the children's safety, 34% have child neglect or abuse charges in the courts. Forty percent have some kind of active court involvement for drug- or alcohol-related legal problems, and almost one-half are currently on probation. Sixty-three percent of the families enter RTP because of legal pressure of some kind.

Substance abuse is a concern in these families; much of the treatment for both children and parents addresses the mother's relationship with various substances. Fifty-nine percent of RTP women report that, at some point in their lives, they have received treatment or counseling for alcohol, marijuana, or other drugs. DACOD data shows that RTP participants report a higher incidence of methamphetamine as either their primary or secondary drug of choice, compared with the statewide population of mothers in treatment. State DACODS data shows that participants report lower rates of using alcohol as a primary drug than those of the state population, yet they report alcohol as being more likely than the state to be a tertiary drug. Fifty-nine percent of RTP participants report that they are worried about their health or behaviors.

Although alcohol may not be reported as the primary drug for most RTP participants, they report having had more alcohol-related DUI arrests during the past 24 months than the state population. The local RTP group also reports having had more arrests other than DUIs than the state group. Table 1 illustrates characteristics of a representative RTP participant.

Table 1

Characteristics of RTP Participant

General Demographics	Children	Family Characteristics	Emotional & Behavioral Characteristics (past 12 months)	Physical Health, & Substance Abuse & Use (past 12 months)	Criminal Behavior (past 12 months)
Female	**2.5 children**	**In past 12 months, major change (marriage, divorce, etc.) in relationship**	**Prior mental health treatment**	**Prior substance abuse treatment**	**Arrested**
30 years old	**1.4 children living with her**	**Married once**	**Felt trapped, lonely, sad, depressed**	**Lost or gained 10 lbs**	**On probation or parole**
Caucasian	**Age range between 1 and 6 years**	**Supported by current or ex-spouse**	**Concentration and/or memory problems**	**Considers herself in good health**	**Child Protective Services taken action once**
No high school	**Child(ren) has been**	**Both parents alive**	**Felt anxious and/or fearful**	**Sleep trouble**	

diploma	**removed by Child Protective Services**				
Completed GED		**See mother almost daily**	**Had obsessive thoughts**	**Used alcohol or drugs**	
Not currently employed		**Never see father**	**Upset when reminded of the past**	**Drugs caused psychological problems**	
Problems with transportation in past 12 months		**Natural parents separated or divorced**	**Difficulty expressing feelings**	**Used drugs despite legal risks**	
		Felt loved by parents	**Guilt about events that could have been prevented**		
		In current contact with 2 family members	**Difficulty staying organized**		
			Insulted or swore at someone		

Co-occurring Disorders in RTP Women

Many mothers demonstrate a potential for "co-occurring disorders" along with any substance abuse disorders. The term, "with co-occurring disorders" is used to describe individuals who have both a mental disorder and a substance use disorder (GAIN Center, 2002). Frequently, women with substance abuse or dependence have comorbid mental health disorders (Dinitto and Crisp, 2002).

In the RTP mothers' self-report, depression was the most common complaint. During intake, 57% of women interviewed report that they had been previously diagnosed with depression, although only 34% had been treated for it. There were fewer reports of bipolar disorder, with only 6% being aware of a previous diagnosis of bipolar disorder and only half of those women ever being treated for it. Anxiety disorders were the second most common co-occurring complaint in the history of RTP mothers. Almost half of the women in RTP (49%) reported that they had been previously diagnosed with some type of anxiety disorder. That is substantially higher than women in the general population, of whom about 30% report problems with anxiety in their lifetime (Dinitto and Crisp, 2002). Twenty-six percent of the women had already been treated for anxiety problems. Despite the

likelihood that mothers (and children) in RTP are dealing with Post Traumatic Stress Disorder (PTSD), only about one-third (34%) of the women had been previously diagnosed upon RTP intake. Of those women previously diagnosed, 9% perceived they had actually received treatment for their trauma. Overall, 51% of RTP women reported having received treatment or counseling for a mental, emotional, behavioral, or psychological problem.

Childhood History - RTP Mothers' Experiences

In the RTP intake interview, mothers referred to the program provided information about their own childhoods. Regarding RTP mothers' childhood experiences, 74% report that their biological parents were divorced or separated, and 42% report that their fathers never or seldom spent enough time with them while they were growing up. Forty percent report that their mothers yelled at them often or always, and 34% report the same of their fathers. Mothers in this program experienced violence in their homes as a child, with 21% reporting that their mother or father hit them hard as a child. The participant's parent who "hit them" was the mother 29% of the time and the father 40% of the time. Participants who reported that their mothers were "very strict" comprise 49% of RTP participants, and those who reported a "very strict" father are 37% of participants.

Another important characteristic to consider about RTP participants is the mother's family history of alcohol and drug abuse, as well as current use within the family. In RTP mothers' families of origin, 31% of the women admitted that their own mothers or fathers (or both) either "often" or "always" got drunk. In addition, fourteen percent of participants reported that their fathers "always" used drugs, while 11% reported that their mothers used drugs "often" or "always."

At intake, RTP participants report experiencing some negative home environments. For instance, 14% of participants had experienced the death of their mother, and 31% reported that they seldom or never had current contact with their mothers. Forty percent had little or no current contact with their fathers, indicating that their own childhood family relationships may have been with neglecting or uninvolved parents.

Motivation for Treatment

Many of the women report that they are in treatment because they want to "get my kids back" or so they can "keep my family together." Although the referral to RTP usually comes from CPS, or via the Justice System then through the CPS system, the mother still must agree to attend and follow through with the referral. Families that complete the intake interview and attend sessions are motivated by their family connections. Mothers may have neglected or abused their children, but most women who participate in RTP are genuinely concerned about their children's well-being. Although conventional opinion may view female substance abusers as non-coping and lacking in effective parenting attributes, this is not always the case (Colten, 1982). Likewise, according to some RTP mothers, they do experience doubt about their parenting adequacy and they are uncomfortably aware of their children's unmet needs.

Many RTP families seem to have suffered from a lack of skills and resources rather than intent to harm their children. It is suspected that parents who have little or no attachment to their children are probably those who do not actively participate in the RTP; they are willing to lose parental custody or be incarcerated rather than follow through with treatment. A facet of attachment style to be queried further is how the attachment styles of the referred families relate to success in treatment.

In addition to CPS and the Justice System, other informal sources of encouragement for treatment often come from relatives. Eighty percent of mothers felt that their children would be supportive of them in seeking help for their substance abuse problems. The mother's parents were also a considerable influence on their decision to get help, with almost 70% expecting that their parents would be supportive of their attempt at substance abuse treatment. Even siblings and friends seem to have influence on the mothers' efforts to get help; 60-75% of women felt that these individuals would encourage their treatment efforts. This may indicate that the majority of mothers had such substantial substance-related problems as to be noticed, and to create some level of concern by those close to them.

Parenting Issues in RTP Families

Parenting issues in families that participate in RTP are very complex. The mothers of RTP children usually have a sincere desire to be good parents. However, their own families of origin modeled a variety of parenting styles, and they may lack some basic parenting skills necessary to produce healthy parenting behavior.

In community discussions, human service providers express the opinion that before these women undertake the task of examining and changing their parenting behavior, their substance abuse must be addressed. Substance misuse and abuse must be eliminated or greatly reduced. Co-occurring mental disorders must also be stabilized before effective behavior change can begin. During the development of RTP curriculum, staff observed that focusing on parenting behavior prematurely may be counterproductive, since activating mothers' guilt and low self-efficacy interfered with emotional stability. Therefore, parenting behavior is not emphasized until the second phase of the program, family skill-building classes using the DTBY curriculum (Miller-Heyl, MacPhee, and Fritz, 2001).

(Spear and Moorstein, pp. 28-36)

Gender Specific Treatment Issues

Most substance abuse treatment programming is based on a model of service for the single male, with little attention paid to parent-child relationships or indeed to

any other relationships. Few treatment programs exist for women, and most of those that do exist are also based on this "single individual" model.

A best practices review (Cates-Wessel, Spalding, & Lewis, 2001) by the Physician Leadership on National Drug Policy pointed out that providing treatment that is specific to the populations being served – particularly gender-specific treatment – has a major impact on the success of treatment. Moreover, this report also adds that providing "wrap-around" services necessary to recovery, such as childcare, transportation, and housing, is critical.

RTP is specifically designed for families with a female parent who is abusing alcohol or methamphetamines or is struggling with polysubstance abuse. Research finds that the children of addicted mothers are negatively impacted by this substance abuse (Child Welfare League of America, 1992; Gruber, Fleetwood, & Herring, 2001). Research also points out that single mothers with children are far less likely to successfully complete most substance abuse treatment programs than their male counterparts (Copeland & Hall, 1992; Marsh, D'Aunno, & Smith, 2000). In addition, research suggests that gender-specific treatment produces better results for women because of various factors related to parenting skills (Marsh et al.) and addresses current and historical trauma issues (Uhler & Parker, 2002).

Healthy relationships are important to success in recovery from substance abuse and for healthy development in children. Therefore, RTP includes family members in Phase 2 for family skill building classes. In addition, the author is also planning an adjunct treatment curriculum

for partners and kinship caregivers who are an important part of the recovering family.

Cultural Sensitivity in Addiction Treatment

Each counselor who trains this curriculum will bring his or her own cultural perspective to the process. Each family also brings its unique cultural perspective. This is both a blessing and a challenge, as each tries to reconcile new ideas about recovery with their own beliefs about the world. Within each community, individuals struggling with substance abuse are influenced by cultural norms regarding substance use, and their particular social group's expectations about their behavior. Sometimes these influences support recovery, and sometimes they may undermine the individual's effort to heal. Sensitivity to these cultural factors will help the counselor individualize the recovery process for each individual's and every family's needs.

Many of the concepts presented in RTP may vary from culture to culture. The emphasis on self-concept, for instance, may be valued more in some cultures than in others. Each counselor/facilitator should encourage open discussion of the ideas presented here, and respond fluidly to each group's needs. The curriculum presented in this guide reflects the community where it was developed, a rural area enriched by the Hispanic and Native American cultures.

Discussion of the cycles and circles in the wheel of life are found in many of the world's traditions. There is considerable variation among cultures in the specific description of those circles or wheels, yet the cycles of nature and life share similarities worldwide. For this reason, teachings of the Medicine Wheel are used to describe these cycles. These sacred teachings are presented here with the hope of bringing healing, specifically healing for addictions. An organization called originally recorded some of these teachings (2003), which were generously provided by a Gathering of Elders in 1995. These teachings include information on how the Medicine Wheel and the Twelve Steps actually work

together seamlessly. It is presented in the hopes that it provides a simple example to help people understand the Twelve Steps better and be able to adjust those steps to align with their own cultural beliefs. As an elder in Alcoholics Anonymous once said, "Take what you like, and leave the rest."

II. The Curriculum

How to Use This Curriculum

Purpose

This is a curriculum for facilitating the groups for mothers in Phase 1 of the Recovering Together Program. The goal of Phase One is to provide the opportunity for mothers to learn about themselves and about addiction before tackling their roles as a parent and a family member.

Curriculum Design

Each of the 16 weekly sessions of this curriculum follows the same format:

- Week number and name of session
- Main idea of the session
- Materials and equipment needed
- Session overview
- Parent activities including time, instructions, process notes for the trainer, handouts, and slides

This curriculum can be effectively presented by one skilled facilitator. If possible, the family advocate or the women's therapist may also attend and co-facilitate. At least four women are needed in the group for an appropriate group dynamic. Eight women is probably an ideal group size, but it is possible to start with ten families because of attrition issues in this population.

The facility needed for this group should provide a space that is private so the mothers can talk freely without fear of being overheard by their children or other family members. Due to the target population, some families may be living separately (children in alternative placement). This can create difficult transition following the multi-family group meal. Take this dynamic into consideration when choosing the location for the children's and women's groups. See the RTP community implementation guide for suggestions of possible community collaborators to help with providing child-friendly, roomy facilities and for ideas on serving and funding meals for families.

Meeting times generally work best immediately following school hours, and providing a meal for the families is an important part of the program design. Generally, meals should be served before group, as children are usually hungry and the interaction between and within families supports relationship building. Commonly, at the beginning of Phase 1 families keep to themselves, but by Phase 2 the children are playing together and the women are talking with each other easily.

After Group Follow-Up

It is important to take time after each session to debrief with the other counselors and facilitators from the children's group. This time is used to share significant events of the evening and what worked and what didn't work in the groups, ask for support or suggestions from other professionals in the room, and make note of what to check on or bring up the following week. For example, if the group moved to a discussion that needed to cut off due to time or for other purposes, share that with others and make a note to revisit the discussion the following week to make sure there was closure on the topic. In addition, it is an opportunity to discuss specific families and exchange important information that will enable better attendance to the needs of the entire family.

It is also important to document information that must be shared with other agencies, such as child protective services, if awareness regarding potential child abuse or neglect is disclosed or suspected. (If a child is in imminent danger an immediate call to CPS is required). It is recommended that facilitators also maintain a record of progress and to draw from lessons learned. Note that many of these families' attendance is court-ordered; thus, records kept may become part of the case or court record.

The Weekly Activities

Week 1 – Introduction to RTP and your group

Main Idea of Session

Orient participants to the Recovering Together Program. Ensure women are familiar with staff and introduced to other participants, and understand how to successfully complete Phase 1 of this three-phase program.

Optional (for replication research sites) – Meet legal and ethical requirements to inform participants about this research project, especially possible benefits and risks.

Materials/Equipment needed

- Materials
  - Name tags
  - Fine tip markers
  - Schedule of group meetings with dates
  - Local recovery activity schedules (attendance documentation attached)
  - Planners for participants
  - Presentation file or overhead transparencies
- Equipment
  - LCD or overhead projector; screen
  - Computer with PowerPoint or Adobe Reader (for LCD) or transparencies for overheads
  - Copy or fax machine for attendance sheets
  - Drug testing supplies, as needed
- Optional (for research participants)
  - Consent for current and future research form
  - Explanation of research form
  - Client Rights form

Weekly Slide Show Format - The list of materials is also on the first slide of each week's PowerPoint presentation to support the facilitator's preparation. Review Slide 1 after setting up projector and double check supplies. Begin presentation with Slide 2, which will be on the screen as participants enter the group room and

find their places. After everyone is settled in, review the agenda quickly and go to the Quiet Time slide. Leave that slide on the screen during the quiet time exercise, then flip to the Check-in slide. After that, follow the unique format of each week's session.

Session Overview

- Quiet Moment
- Introduce Ourselves
- Orientation to RTP
- Ground Rules of Group
- Nitty Gritty Research Stuff – Optional (for research sites or replication sites)
- Orientation to Recovery Activity Requirements
- Recovery Tool 1 - Planners

Week 1 Activities Overview

Introduce Ourselves

Time	***Activity and/or Slides***	***Facilitator Process Notes***
1-3 minutes	**1. Quiet Moment**	The first quiet moment should be a brief pause of a minute or so. During the pause, encourage participants to slow down. Congratulate them on having overcome all the challenges they faced to attend this first session. Affirm their willingness to be present.
	Slide 3	1. Ask participants to relax in their chairs, close their eyes or focus inwards, and turn their attention toward their body's position in the chair. 2. Ask them to congratulate themselves for all they did to get themselves to the group meeting tonight. 3. Ask them to say silently to themselves, "I am here, now, I am ready"

Time	*Activity and/or Slides*	*Facilitator Process Notes*
19 minutes	**2. Introduce Ourselves** Have clients share their first name only, and create a name tag for themselves. Other optional questions– 1. Their children's names and ages. 2. What they want to change. 3. Why they decided to try RTP. **Slide 4-5**	Clients are nervous and suspicious at first. This is normal for any social group, but especially true for women with substance abuse issues. Have them share only their first names. Sometimes participants know each other from mutual friends, parties or even family. Their previous interactions may not have been pleasant, and they may feel unsafe. Be prepared to acknowledge this and reassure them that there will be an opportunity to address safety and confidentiality during the group ground rule discussion after the break. Staff should all be introduced, even if they are not present (such as those working with their children). Also share the children's staff qualifications. Introduce all staff present, their name and qualifications. It may be helpful to mention your own experience briefly, either as a parent or in recovery. If you do not have much experience in either, it is best to acknowledge that directly. The counselor's supervisor, whether present or not, should also be introduced to the participants. Participants should understand that their facilitator is also accountable and has guidance, if needed.

Introduction to RTP

Time	*Activity and/or Slides*	*Facilitator Process Notes*
10 minutes	**3. Introduction to RTP** **Slides 6-17**	Provide an overview of the program and reveal the Recovering Together vision. Use the text notes below the slides to guide your discussion of each slide topic. Stop and ask about questions after each Phase slide. Review the year-long program plan during the last slide in this section. Women in early recovery may have difficulty with looking a year ahead but it is important for them to be informed.

Ground Rules for Group

Time	*Activity and/or Slides*	*Facilitator Process Notes*
20 minutes	**4. Ground Rules of Group** **Slides 18-26**	It is very important to create a safe environment. Certain rules will need to be reviewed in later weeks - use this time to reveal the underlying structure that supports safety within the group. The most important topic is confidentiality, so provide opportunity using the discussion questions. The discussion of relapse consequences is powerful, if clients feel safe enough to express their true opinion. Know your agency requirements BEFORE this discussion and let the participants know about limits to their freedom to choose the group members' consequences.
10 minutes	**Break** **Slide 27**	Inform clients before break if they need to provide a sample for drug testing. Let them know where smoking areas are located.

Orientation to Recovery Activity Requirements

Time	*Activity and/or Slides*	*Facilitator Process Notes*
30 minutes	**5. Orientation to Recovery Activity Requirements** **Slide 28**	The primary issue with explaining the RTP's twice weekly additional activity requirements is participant's memory and processing difficulty. It is important to use specific examples and double check on participants' understanding of how <u>each</u> example of a recovery activity meets these requirements. Help them personalize their plan to fit all this into the NEXT week. This segues seamlessly into passing out planners and meeting schedules.

Recovery Tool #1 – Planners

Time	*Activity and/or Slides*	*Facilitator Process Notes*
20 minutes	**6. Recovery Tool 1 – Planners** **Weekly assignment** **Slide 29-30**	Pass out the Recovery Tool 1 Planners, one to each participant. Have the participants write all the group meeting dates for Phase 1 in their planner. Know these ahead of time! Also, pass out AA/NA meeting schedules and help participants choose recovery activities for the next week. Inform them about alternative recovery activities to 12-step meetings. Instruct them to write their choice in planners now, if possible.

Optional Research Module

Time	*Activity and/or Slides*	*Facilitator Process Notes*
30 minutes	**7. Nitty Gritty Research Stuff** – *Optional* *(for those interested in gathering research data or replication sites)* **Slides 31-36**	It is recommended that the facilitator review all evaluation materials individually or in small groups prior to the first group session. It is included here for those clients who are unable to complete this module before the group begins. Ideally, if there are only a few who have not reviewed the research materials, they may need to stay late or schedule another session during the week. It is important for them to understand the research procedures, possible risks and benefits, and requirements for participation.

Week 1 Slides with Commentary

Slide 1

Week One - Materials/Equipment Needed

- Materials
  - **Name Tags**
  - **Fine tip markers**
  - **Local Recovery Activity Schedules (attendance documentation attached)**
  - **Planners for Participants**
  - **Presentation File or Overhead Transparencies**
- Equipment
  - **LCD projector & Screen**
  - **Computer with PowerPoint or Adobe Reader**
  - **Drug testing supplies, as needed**
- Optional (for research participants)
  - **Consent for current and future research form**
  - **Explanation of research form**
  - **Client Rights form**

1 Recovering Together Program

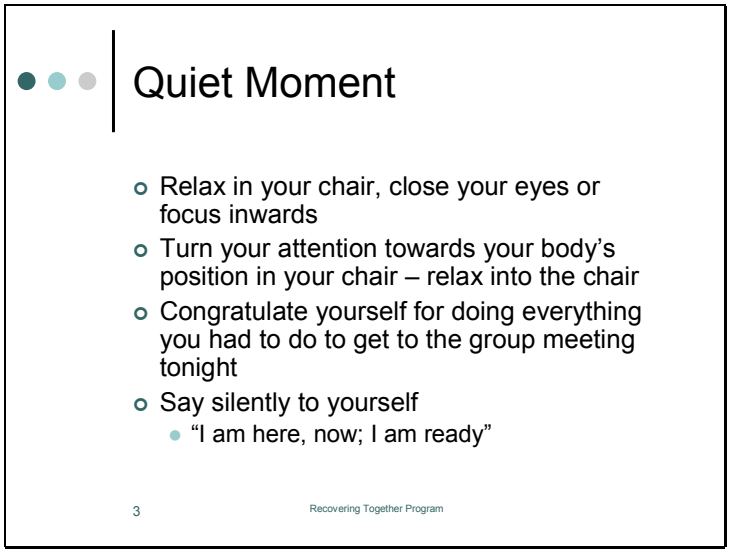
Slide 2

Recovering Together Program (RTP)

A treatment program designed for you

2 Recovering Together Program

Slide 3



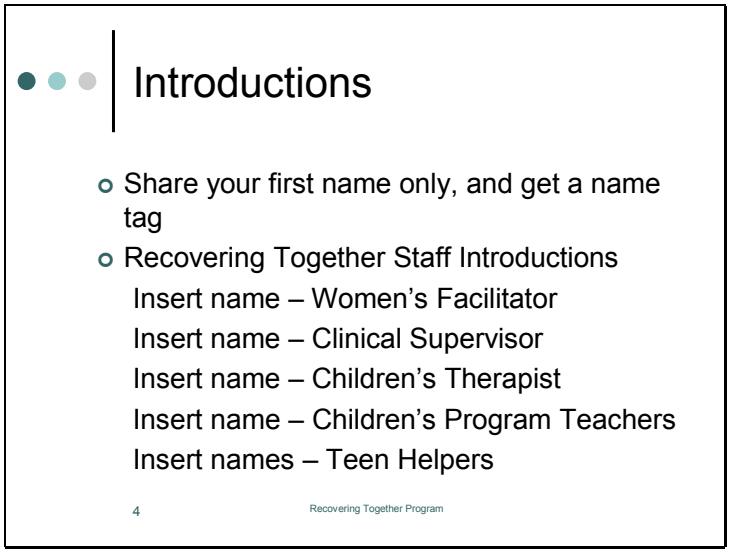
The first quiet moment should be a brief pause of a minute or so. During the pause, encourage participants to slow down. Congratulate them on having overcome all the challenges to attending this first session. Affirm their willingness to be present.

Ask participants to relax in their chairs, close their eyes or focus inwards, and turn their attention toward their body's position in the chair. Let their body sink into the chair, noticing that their muscles may relax a little more.

Ask them to congratulate themselves for all they did today, to get themselves to the group meeting tonight.

Say silently to themselves, "I am here, now, I am ready"

Slide 4



Have clients share their first name only, and create a name tag for themselves.

Some counselors may want to add one of the following questions to the introductions for participants –

Their children's names and ages-thus adjust the slide accordingly.

What they want to change.

Why they decided to try RTP.

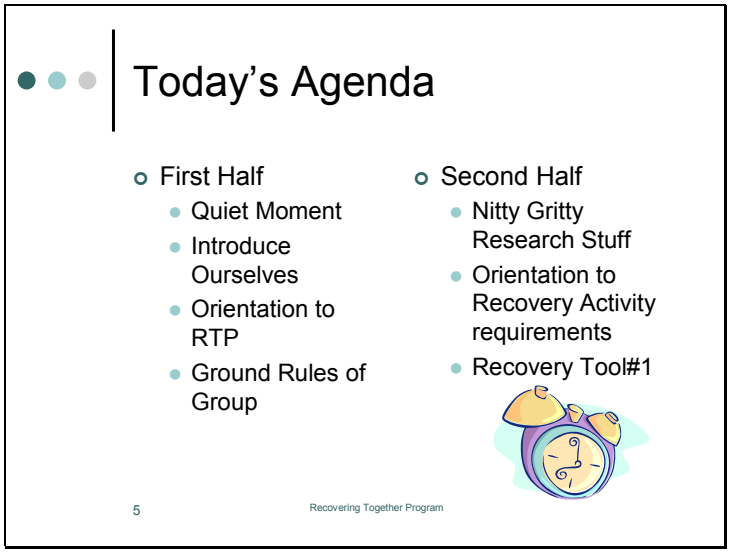
Staff Introductions

Clients are nervous and suspicious at first. This is normal for any social group, but especially true for women with substance abuse issues. Have them share only their first names. Sometimes participants know each other from mutual friends, parties or even family. Their previous interactions may not have been pleasant, and they may feel unsafe. Be prepared to acknowledge this and reassure them that there will be an opportunity to address safety and confidentiality during the group ground rule discussion after break.

Staff should all be introduced, even if they are not present. Mothers like to know who is working with their kids, and their qualifications to work with children.

It is important to introduce all staff present, their name and qualifications. It may be helpful to mention your own experience briefly, either as a parent or in recovery. If you do not have much experience in either, it is best to acknowledge that directly. The facilitator's supervisor, whether present or not, should also be introduced to the participants. Participants should understand that their facilitator is also accountable and has guidance, if needed.

Slide 5



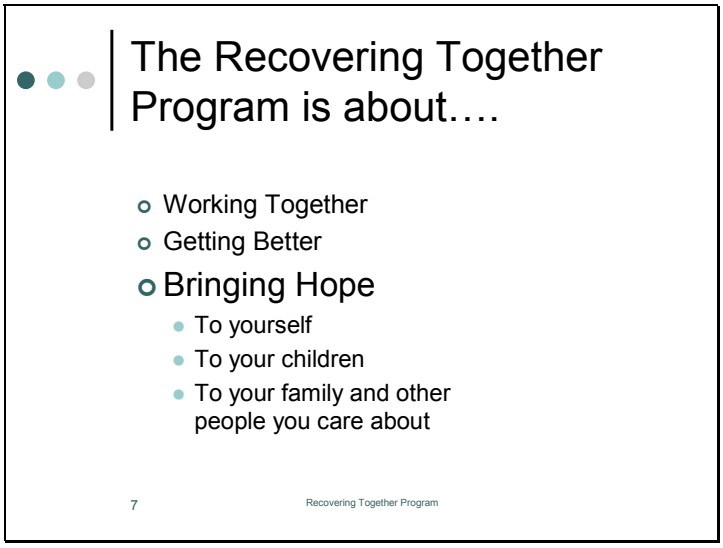
Orient participants to the Recovering Together Program. Ensure women are familiar with staff, introduced to other participants, and understand how to successfully complete Phase 1.

Slide 6

Slide #6 describes the overall theme of Recovering Together, which is empowerment, and specifically what the participants themselves will get out of Recovering Together, which is that they will learn to be free of substance abuse. They will learn to identify and manage destructive emotions and learn skills to support themselves and each other in a healthier lifestyle.

The slide provides an overview of the program and reveals the Recovering Together vision. Stop and ask about questions after each Phase slide. Review year-long program plan during last slide in this section. Women in early recovery may have difficulty with looking a year ahead.

Slide 7



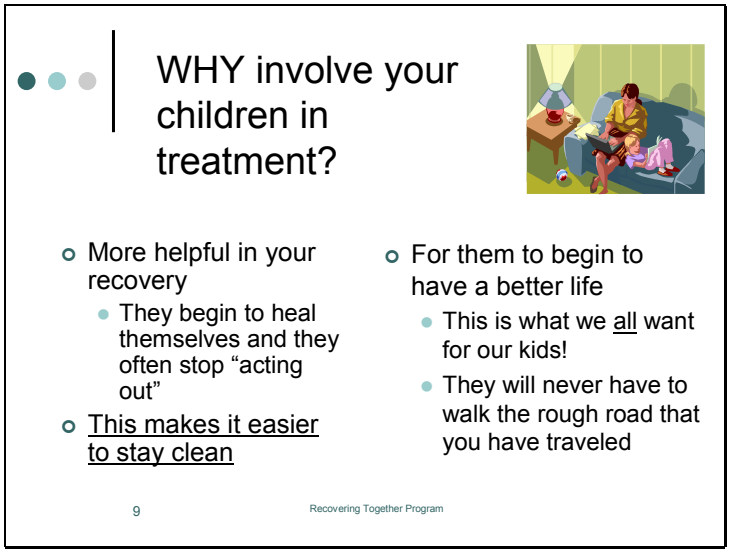
The slide describes some of the goals for the program and what it's about: working together, getting better, and bringing hope to themselves, to their children, and each other. Hope is something that is very precious and is also kind of hard to find when you are in the grips of an addiction.

Slide 8

This is a family program. Slide #8 describes the fact that this is a program custom-designed for moms. This begins to bring the clients into a relationship with the Recovering Together program and shows that it is specifically designed for people exactly like them. Phase 1 is just for the mother and kids.

One of the main selling points of the program is that it includes children in treatment wherever possible and that means that in Phase 2 anyone in the family that the mother invites can participate in the program. The final choice of who is included in the Family Skill Building Phase is always the mother's, as long as she is attending the program regularly.

Slide 9

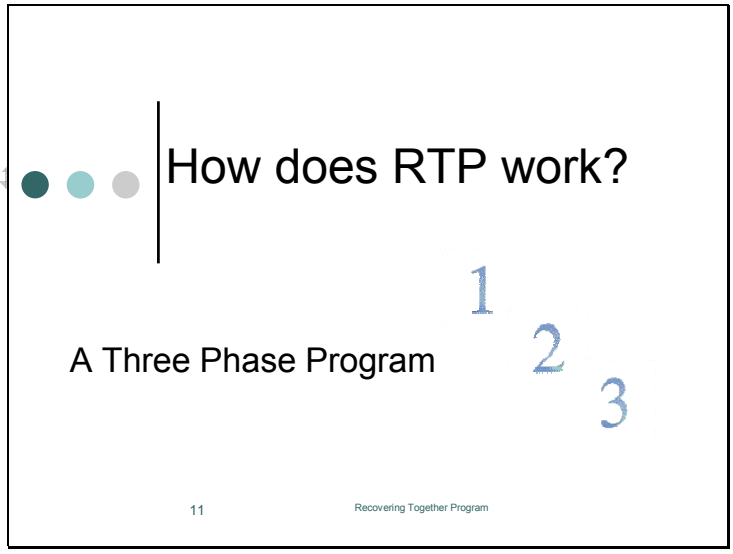


Almost always, mothers are enthusiastic about the idea of including their children in treatment, but they may not understand why we as treatment providers think that they need to attend the program. It is because children can actually be very helpful in recovery. As they begin to heal themselves they stop acting out and this makes it easier for mom to stay clean when they are not misbehaving because they don't know what to do with their feelings about her being drunk or stoned. It also addresses the mothers' fondest wish, which is almost always that their children have a better life than they do and that they won't have to walk that rough road that they have traveled.

Slide 10

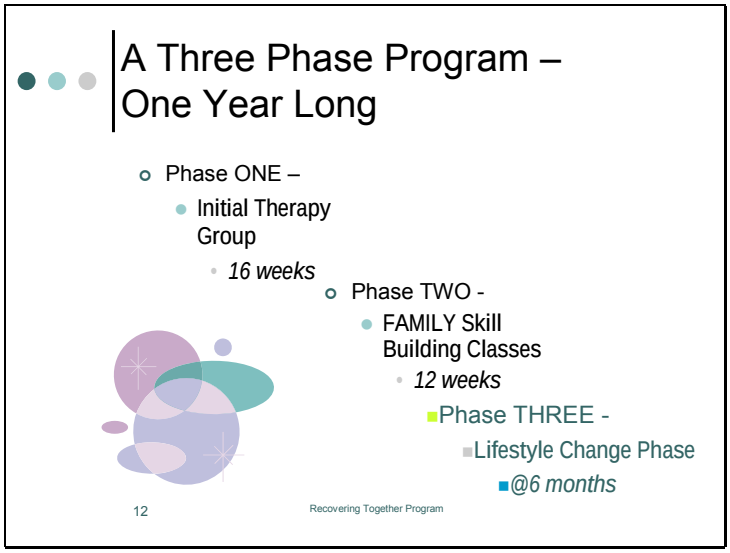
This doesn't mean that they will be instant little angels, but we are hoping to see improved behaviors and fewer health problems, better developmental levels and easier discipline with children. We are very interested in mothers' opinion about changes with these issues with the children.

Slide 11



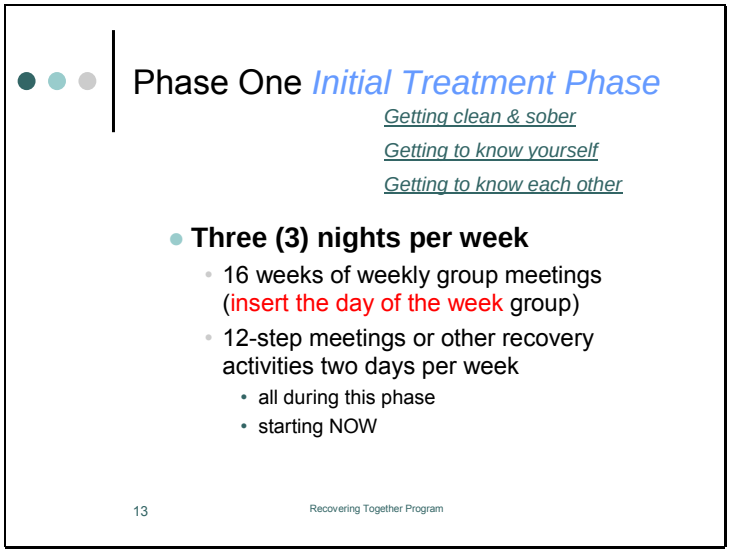
The next part of the slideshow is about the three phases of the Recovering Together program.

Slide 12

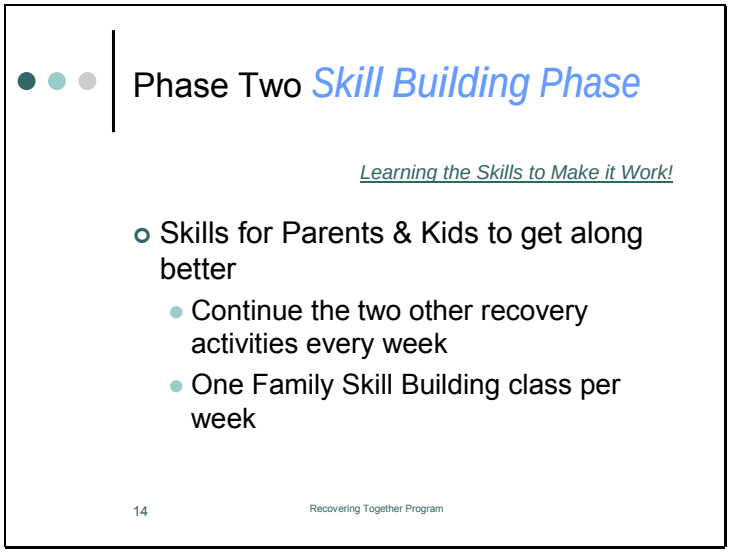


There is an overview; do not linger on the overview. Simply read the titles to the phases because an in-depth slide of each phase follows.

Slide 13


Phase One Initial Treatment Phase
Getting clean & sober
Getting to know yourself
Getting to know each other
Three (3) nights per week
16 weeks of weekly group meetings (insert the day of the week group)
12-step meetings or other recovery activities two days per week
all during this phase
starting NOW
13
Recovering Together Program

Slide 14


Phase Two Skill Building Phase
Learning the Skills to Make it Work!
Skills for Parents & Kids to get along better
Continue the two other recovery activities every week
One Family Skill Building class per week
14
Recovering Together Program

Slide 15

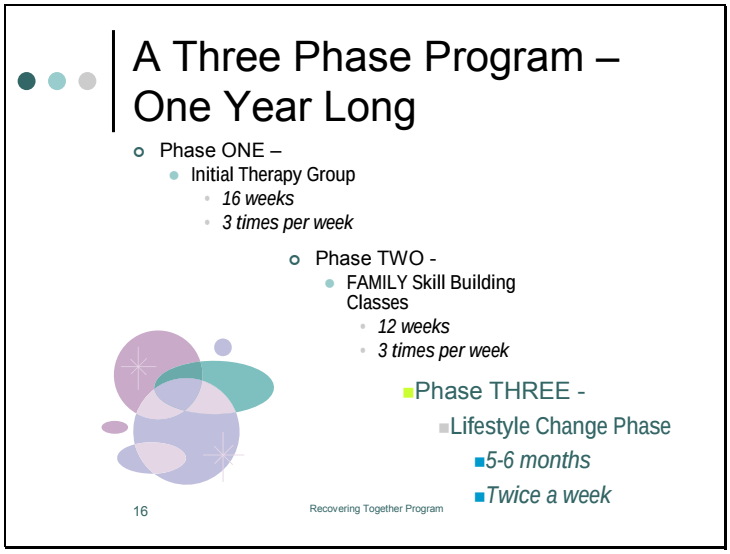
Phase Three *Lifestyle Change*

Making your new lifestyle work for YOU!

- **Customized for every family**
- **Learning about community support**
  - **Help to connect with the services YOU need**
- **Learning about job and education opportunities**

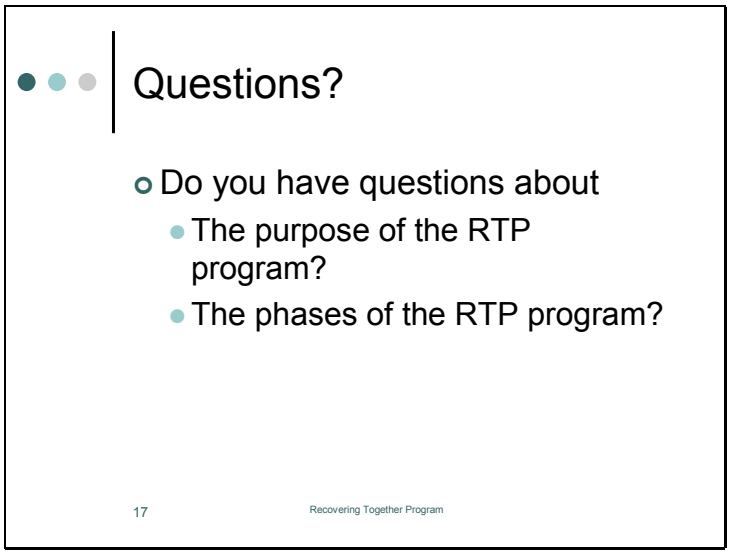
15 Recovering Together Program

Slide 16

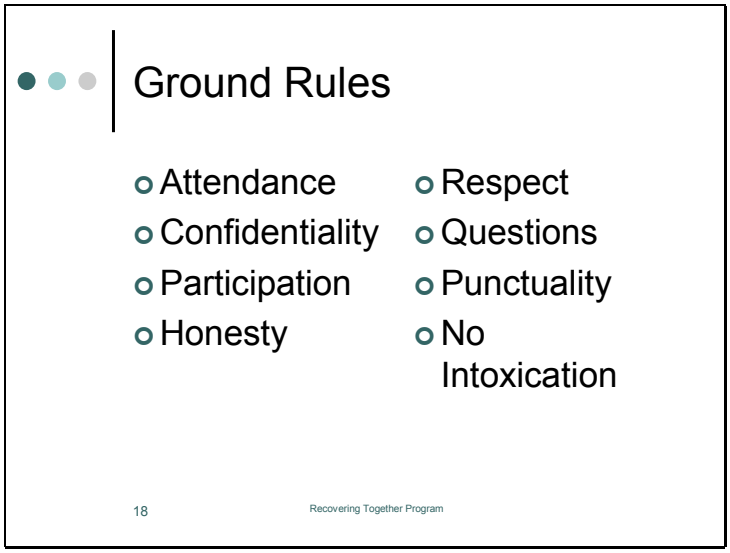


Review the phases and ask for questions.

Slide 17

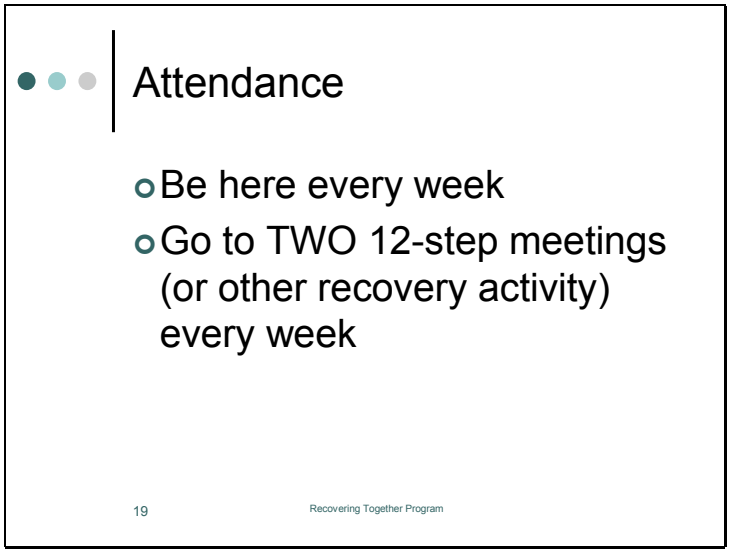


Slide 18

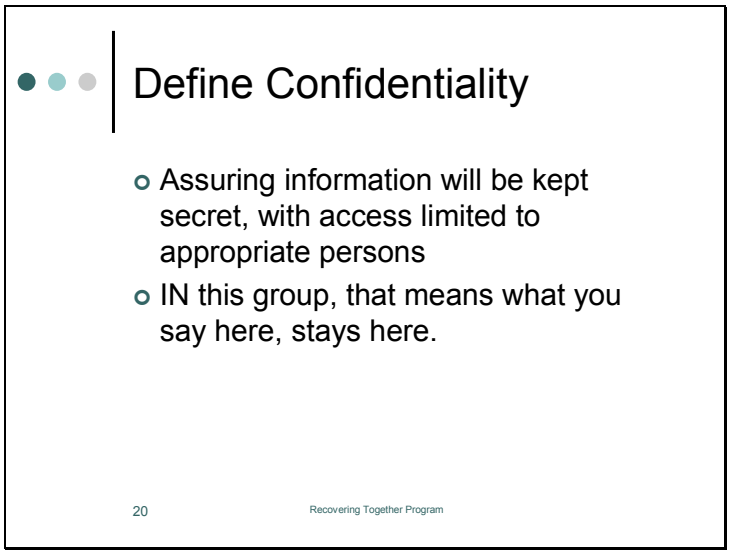


Very important for creating safety. Certain rules will need to be reviewed in later weeks - use this time to reveal the underlying structure that supports safety. The most important topic is confidentiality, so provide opportunity using the discussion questions. The discussion of relapse consequences is powerful, if clients feel safe enough to express their true opinion. Know your agency requirements BEFORE this discussion and let the participants know about limits to their freedom to choose the group members' consequences. Inform clients before break if they need to provide a sample for drug testing. Let them know where smoking areas are located.

Slide 19



Slide 20



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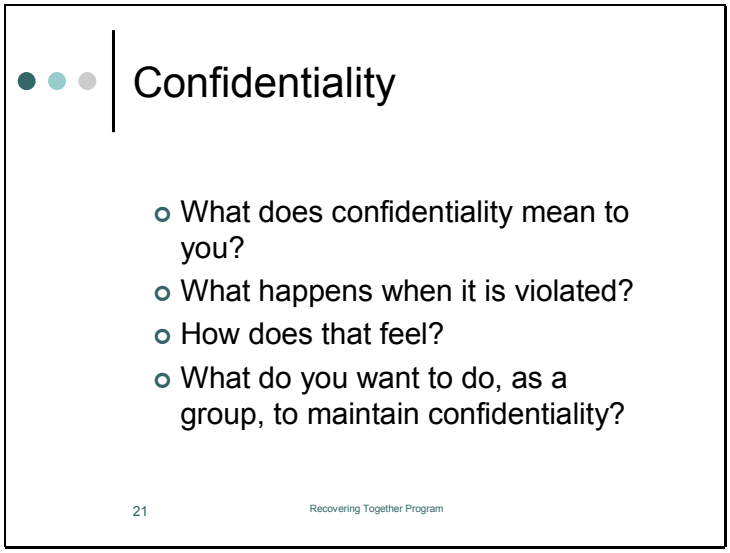

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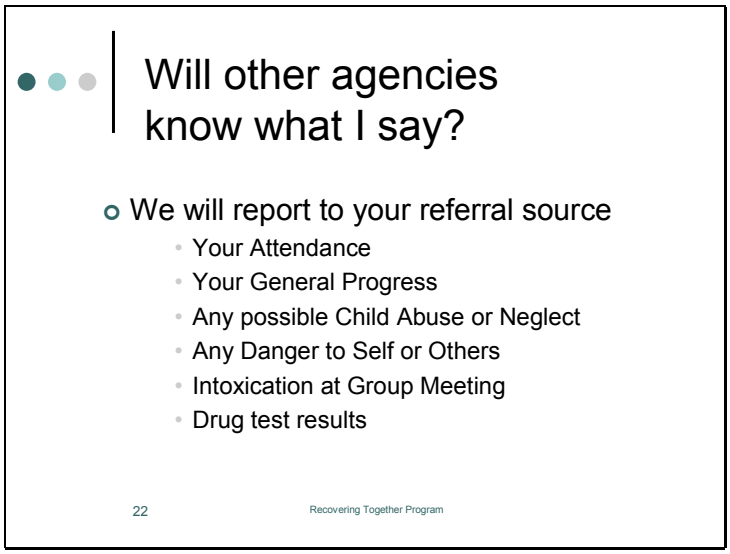
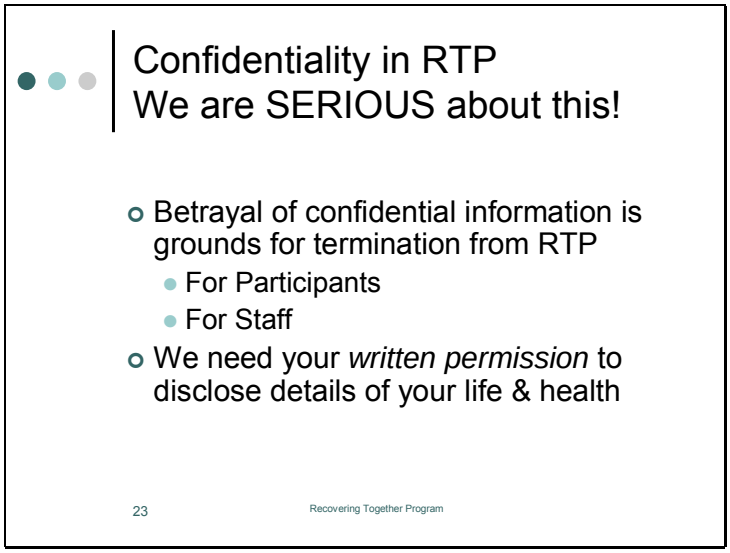
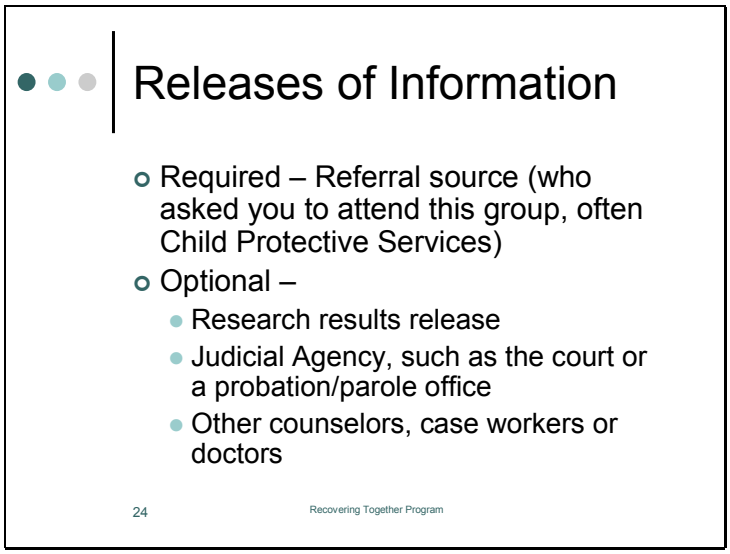


Slide 23



Slide 24



Slide 25

Build your own guidelines

- What about relapse – define consequences…. Any suggestions?

25 Recovering Together Program

Slide 26

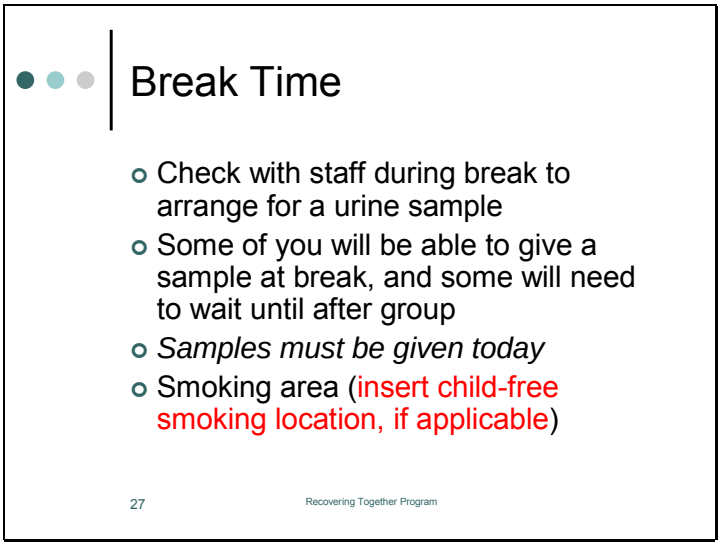
Are you ready to make a few new friends?

We hope so.

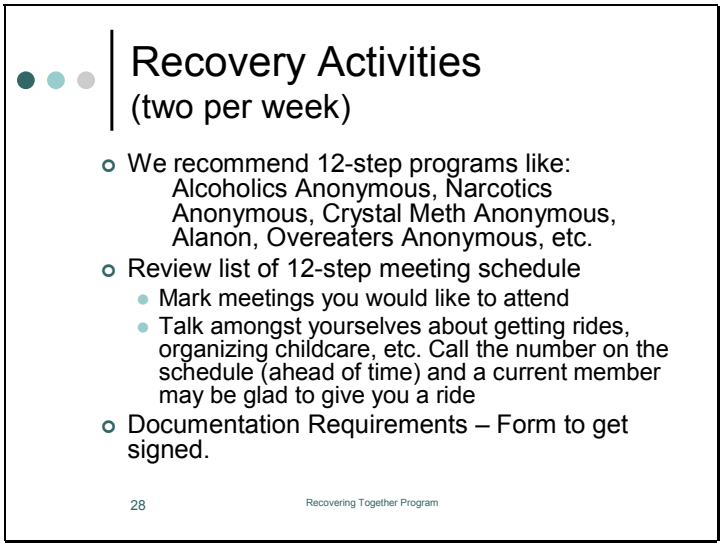
You may be pleasantly surprised.

26 Recovering Together Program

Slide 27

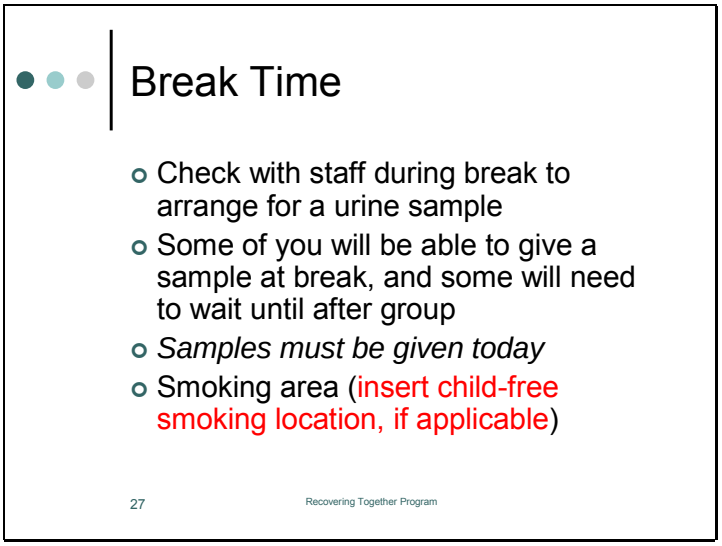

Break Time
Check with staff during break to arrange for a urine sample
Some of you will be able to give a sample at break, and some will need to wait until after group
Samples must be given today
Smoking area (insert child-free smoking location, if applicable)
27
Recovering Together Program

Slide 28



The primary issue with explaining the RTP twice weekly additional activity requirements is participants' memory and processing difficulty. It is important to use specific examples and double check on each participants' understanding of how to meet these requirements. Help them personalize their plan to fit all this into the NEXT week. This segues seamlessly into passing out planners and meeting schedules.

Slide 27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Some of you will be able to give a sample at break, and some will need to wait until after group
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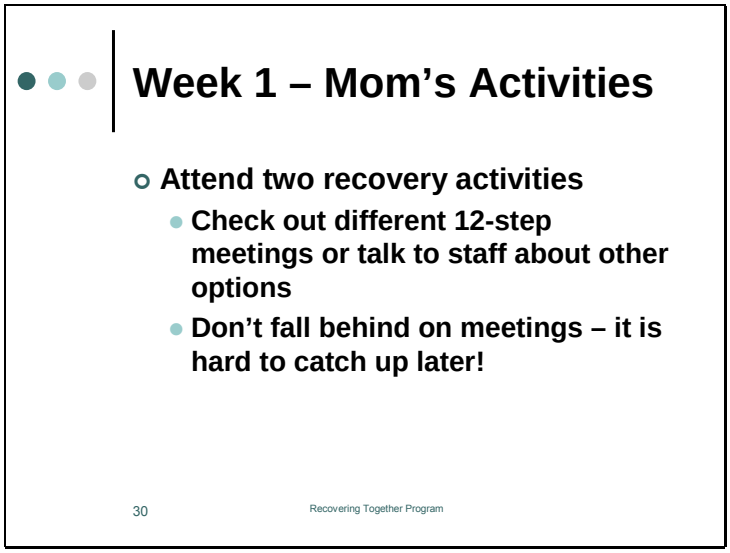
27
Recovering Together Program

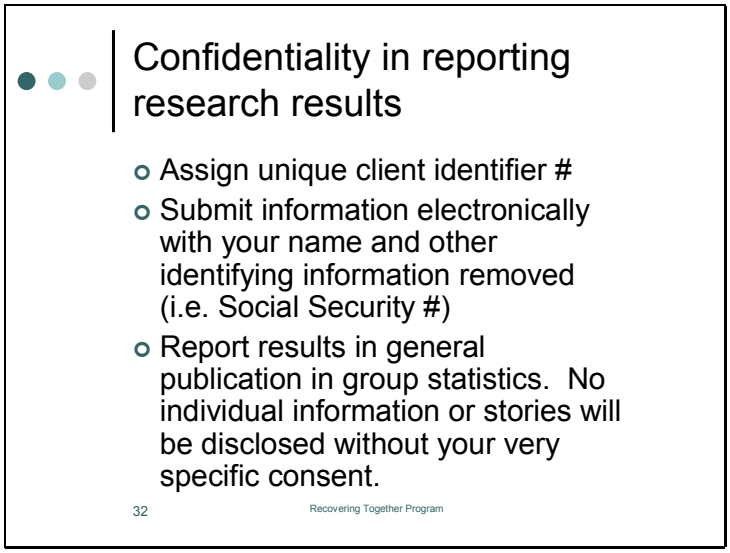
Slide 30


Week 1 – Mom's Activities
Attend two recovery activities
Check out different 12-step meetings or talk to staff about other options
Don't fall behind on meetings – it is hard to catch up later!
30
Recovering Together Program

Slide 31

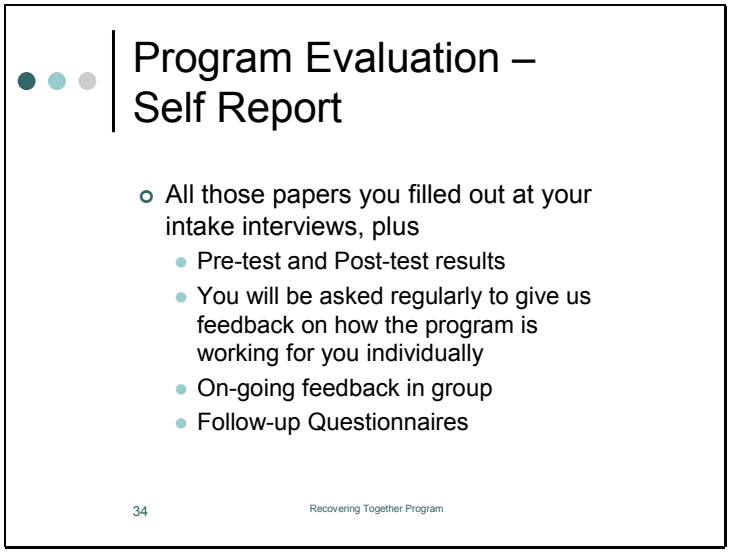
We recommend reviewing this material individually or in small groups while clients are waiting for the first group session. We are including it here for those clients who are unable to complete this module before the group begins. They may need to stay late or schedule a session during the week to ensure their understanding of the research procedures, possible risks and benefits and requirements for participation.

Slide 32

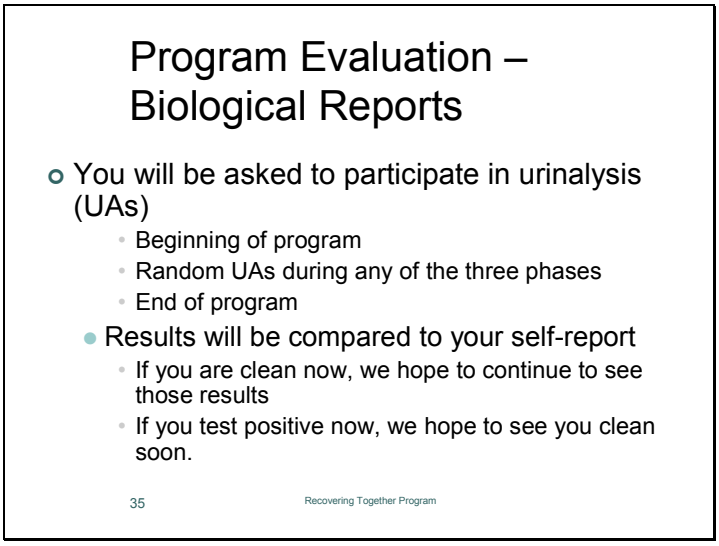


Slide 33

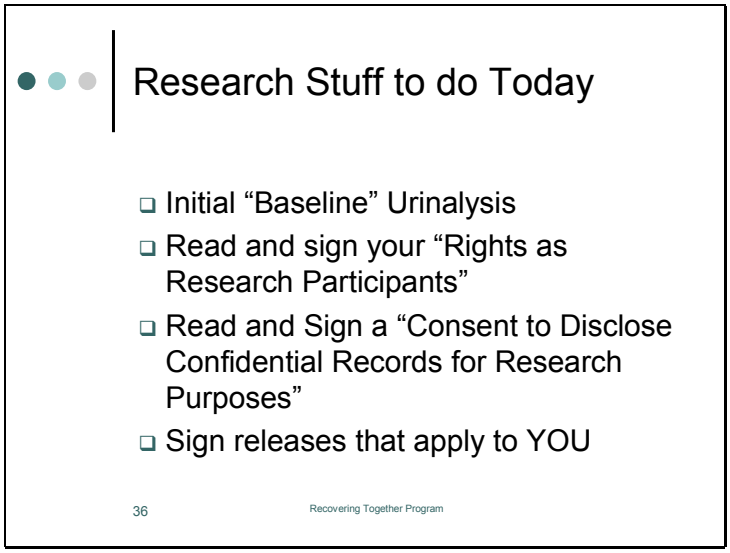
Slide 34



Slide 35



Slide 36


Research Stuff to do Today
Initial "Baseline" Urinalysis
Read and sign your "Rights as Research Participants"
Read and Sign a "Consent to Disclose Confidential Records for Research Purposes"
Sign releases that apply to YOU
36
Recovering Together Program

Week 2 – Priorities, Needs and Wants

Main Idea of Session

Introduce the hierarchy of needs. Understand how needs/wants relate to addiction, and practice noticing the difference between them.

Put recovery first or all your priorities will eventually suffer.

Materials/Equipment Needed

■ Materials
– Presentation file or overhead transparencies
– Sticky notes
– Pens
– Planners
– RTP video
■ Equipment
– LCD or overhead projector; screen
– Computer with PowerPoint or Adobe Reader (for LCD) or transparencies for overheads
– Copy or fax machine for attendance sheets
– Drug testing supplies, as needed

Session Overview

- Quiet Moment
- Check-in
- Needs and Wants
- Priority Activity
- Sponsorship
- Self-care Activities
- RTP Toolbox Tool 2
- Weekly Assignment

Week 2 Activities Overview

Time	*Activity and/or Slides*	*Facilitator Process Notes*
5 minutes	**1. Quiet Time** **Slide 3**	Walk the participants through a quiet time and ask them to notice tension in their bodies. Do progressive muscle relaxations (Instructions found on Women's RTP video)
30 minutes	**2. Check–in, longer to include 2nd check-in on recovery activities** **Slides 4- 5**	Go over the agenda for today. Introduce the basic check-in format which includes sharing their first names, how they are feeling today, and when their last use of alcohol or drug abuse happened. If they are taking prescription medication, their check-in use sharing should also include any narcotics or benzodiazepines taken. After participants have completed a basic check-in, introduce the check-in on recovery activities and how those went.

Needs and Wants

Time	*Activity and/or Slides*	*Facilitator Process Notes*
20 minutes	**3. Needs and Wants** **Slides 6-12**	Introduce Maslow's hierarchy of needs. Explain the pyramid shape of the hierarchy of needs. Discuss how that hierarchy of needs relates to staying clean and sober. Explain the difference between wants and needs. During discussion slide, use a white board or flip chart to record participant's brainstorming session. Continue until each participant has personalized the difference between a want and a need.

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- Check-in
- Needs and Wants
- Priority Activity
- Sponsorship
- Self-care Activities
- RTP Toolbox Tool 2
- Weekly Assignment

Time	*Activity and/or Slides*	*Facilitator Process Notes*
	vision. **Slides 15-16**	them. Following that discussion, say "Ok, now you are in recovery and are taking your power back from addiction. We can all work together to get these things back. What do you think you would be getting back first?" Then, go around and give one thing back to them, and then give back the next thing until you have given them all back.

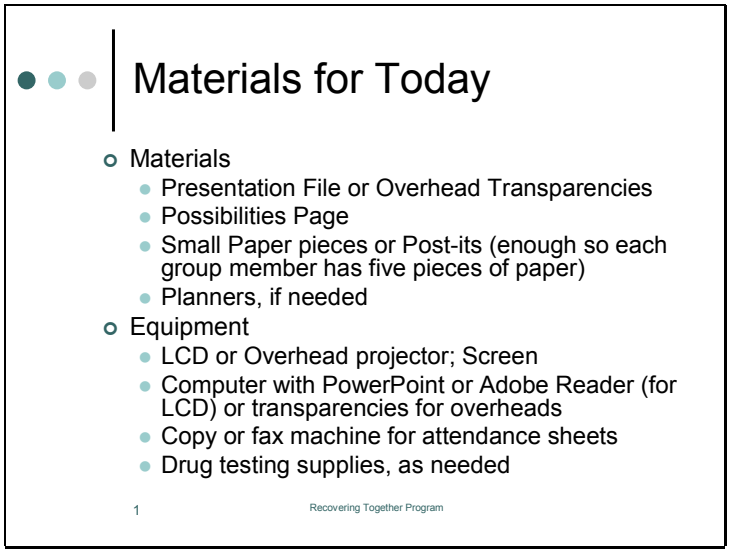
Self Care Activities

Time	*Activity and/or Slides*	*Facilitator Process Notes*
10 min	**6. What's a Sponsor?** **Slides 17-18**	Discuss "What is a Sponsor?" List the characteristics of good sponsors and discuss picking a sponsor. Make sure that you ask for questions and talk about the possibility of getting a temporary sponsor.
10 min	**7. Week 2 Recovery Tools** **Slide 19**	Have participants create a priority list in their planners, using the priorities identified in the priority activity above. Ask participants to begin a phone list in their planner of those to call if they feel like using drugs or drinking. If appropriate, have participants share their phone numbers with each other.
10 min	**8. Looking ahead – Preparation for next week's binder activity** **Slide 20**	Remind participants that during Week 4 they are going to be decorating their binders and telling their stories, so they may bring some stuff for decorating their binder. Suggest photos or drawings that they can glue onto it. Suggest they place those five pieces of paper in their planner and may refer to them for ideas about what to include on their binder decoration. Assure them that you will have decorating supplies and that they are just to bring ideas and any personal pictures or special things to decorate their own binder.

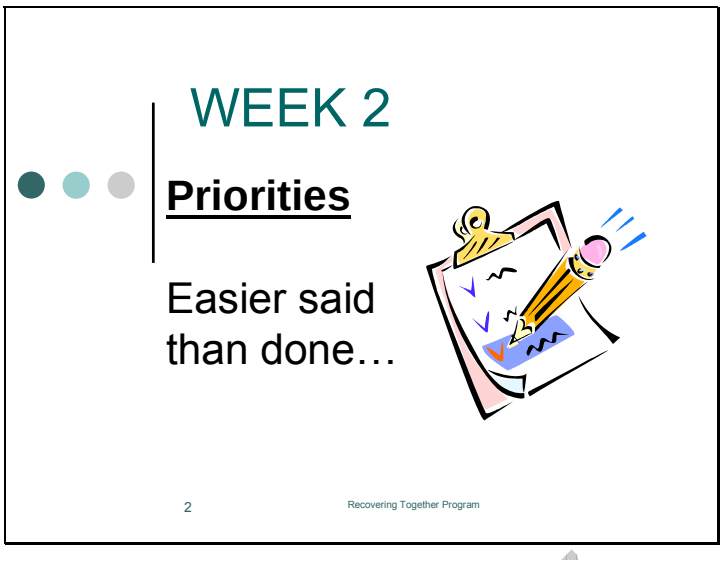
Time	*Activity and/or Slides*	*Facilitator Process Notes*
		Pictures of children are very common, but some women are incredibly creative!

Week 2 Slides with Commentary

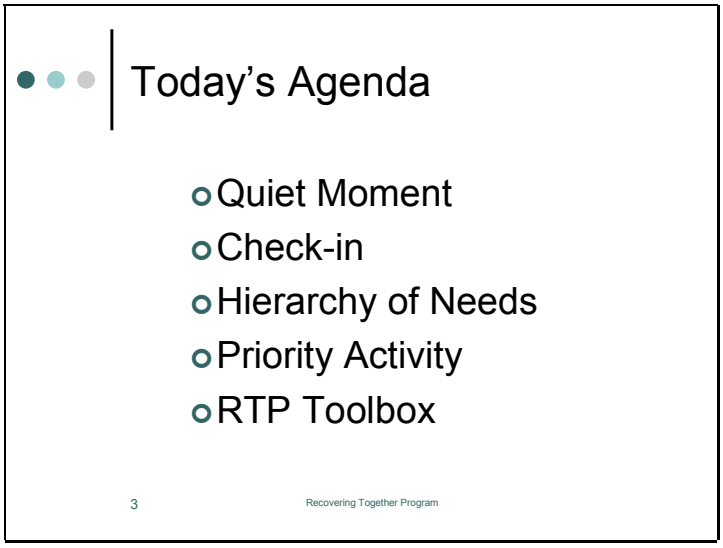
Slide 1



Slide 2

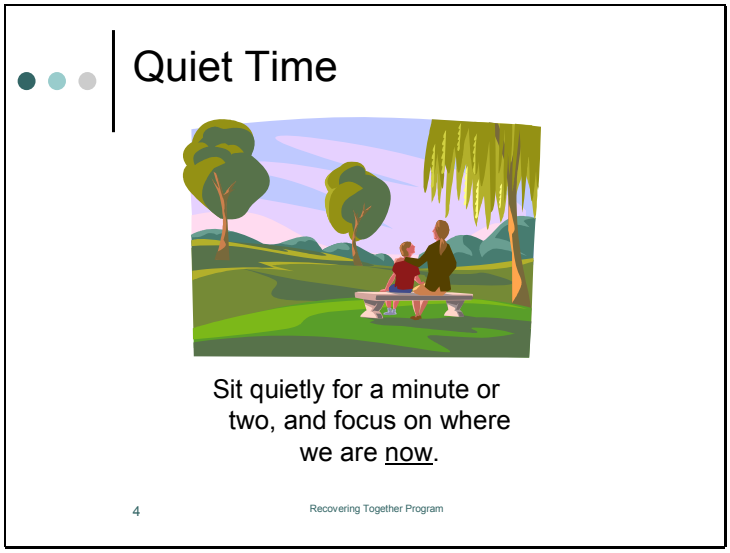


Slide 3



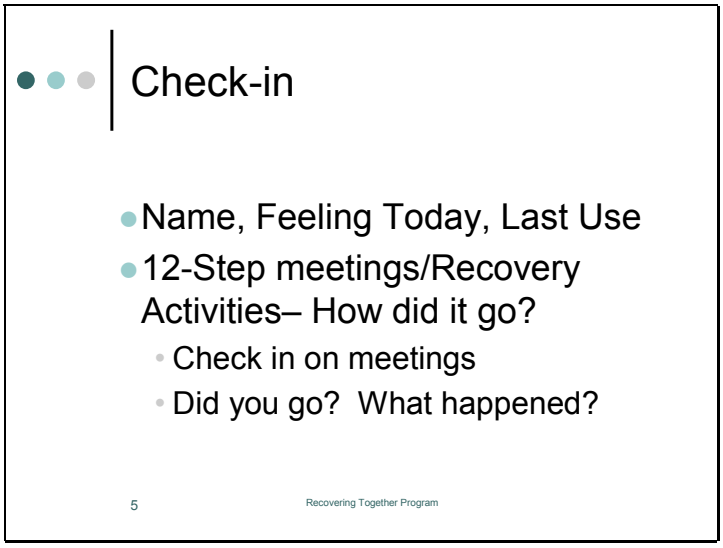
Review the agenda. Introduce the hierarchy of needs. Understand how needs/wants relate to addiction, and practice noticing the difference between them.

Slide 4



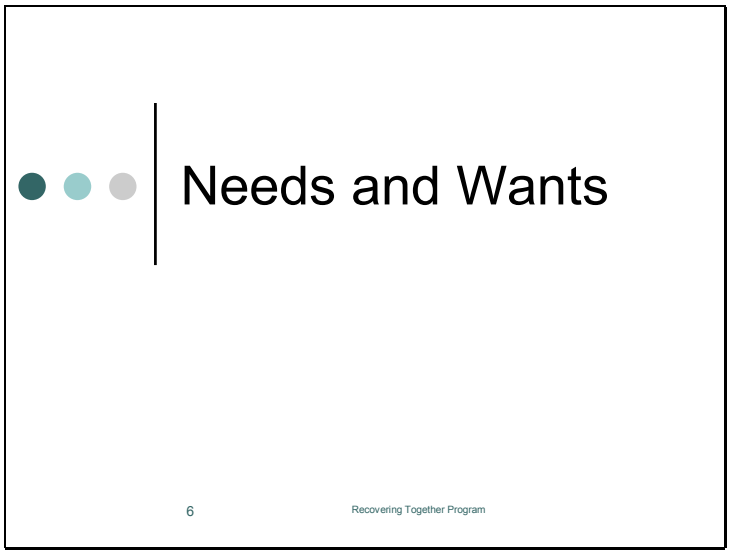
Walk the participants through a quiet time and ask them to notice tension in their bodies. Do progressive muscle relaxations (instructions found on Women's RTP video)

Slide 5

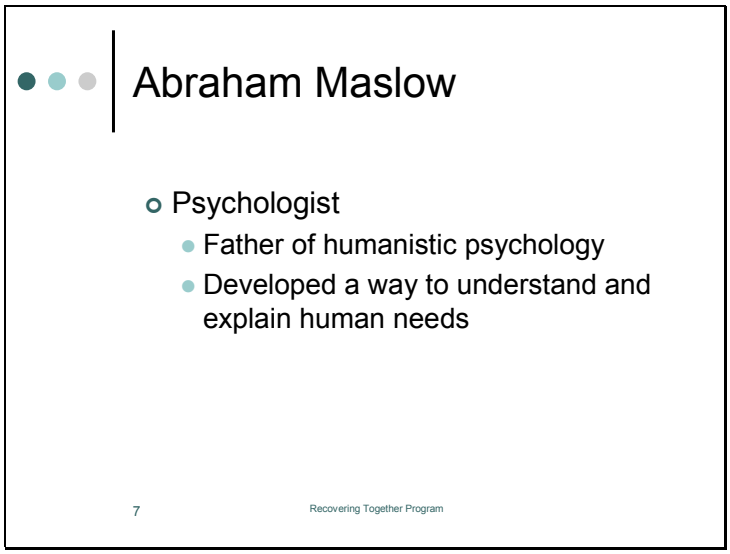


Introduce the basic check-in format which includes their names, how they are feeling today, and when their last use of alcohol or drug abuse happened. If they are taking prescription medication, this includes any narcotics or benzodaizepines. After participants have completed a basic check-in, introduce a check-in on recovery activities and how those went.

Slide 6



Slide 7



Introduce Maslow's hierarchy of needs. Explain the pyramid shape of the hierarchy of needs. Discuss how that hierarchy of needs relates to staying clean and sober. Explain the difference between wants and needs. During discussion slide, use a white board or flip chart to record participant's brainstorming session. Continue until each participant has personalized the difference between a want and a need.

Slide 8

Point out that the lowest or the absolute foundation of the pyramid is physiological needs and as you go up and get further and further away from the foundation, you get more and more away from basic survival and into more of a richer existence. MANY OF THESE FAMILIES ARE STRUGGLING WITH MEETING THEIR BASIC NEEDS IN THE FIRST AND SECOND LEVEL.

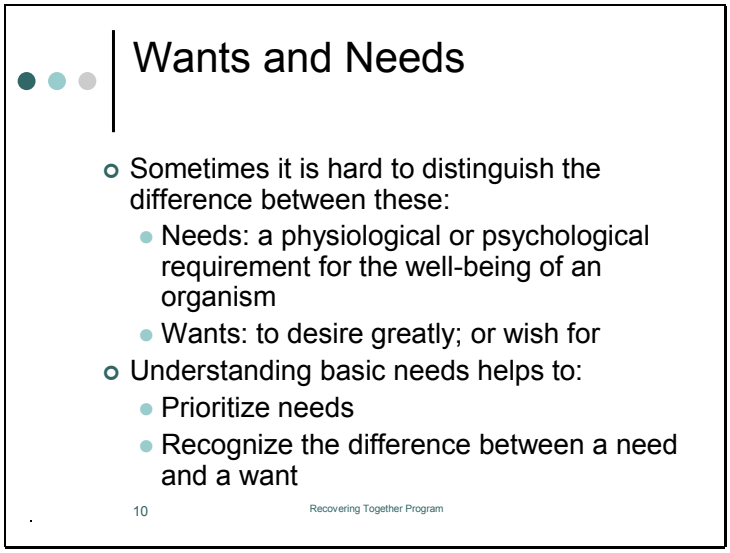
Retrieved May 11, 2005 from **www.akri.org/ cognition/motivate.htm ,** Applied Knowledge Research Institute.

Slide 9

Go through the details of each level of needs, such as physiological, safety, social, esteem, and finally actualization. Use examples to illustrate the needs, ask participants for examples to check their understanding of the concept.

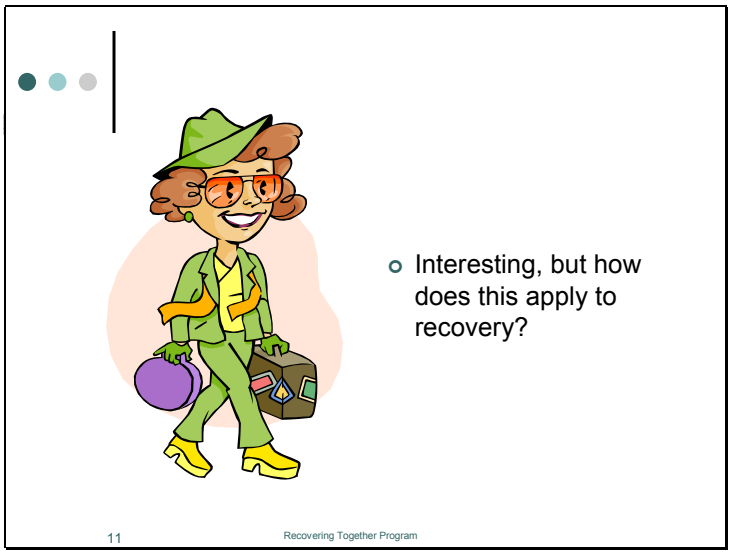
Retrieved May 11, 2005 from **www.akri.org/ cognition/motivate.htm ,** Applied Knowledge Research Institute.

Slide 10

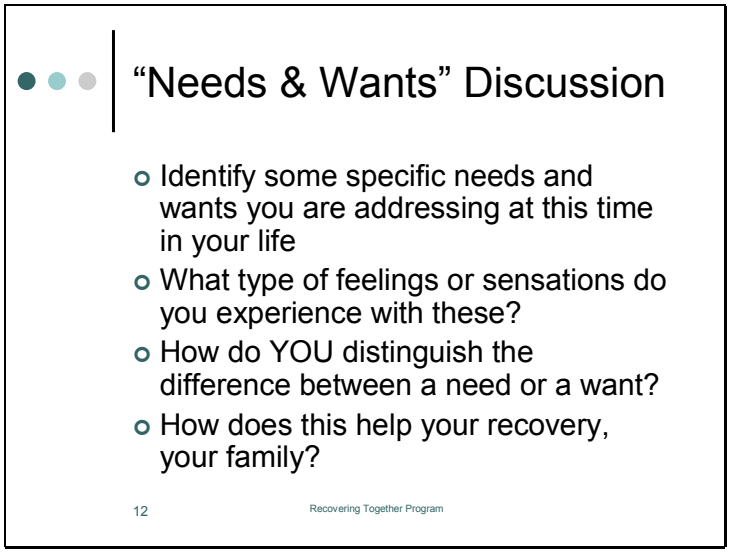


Do some brainstorming to identify specific needs and wants that the participants are working with right now.

Slide 11

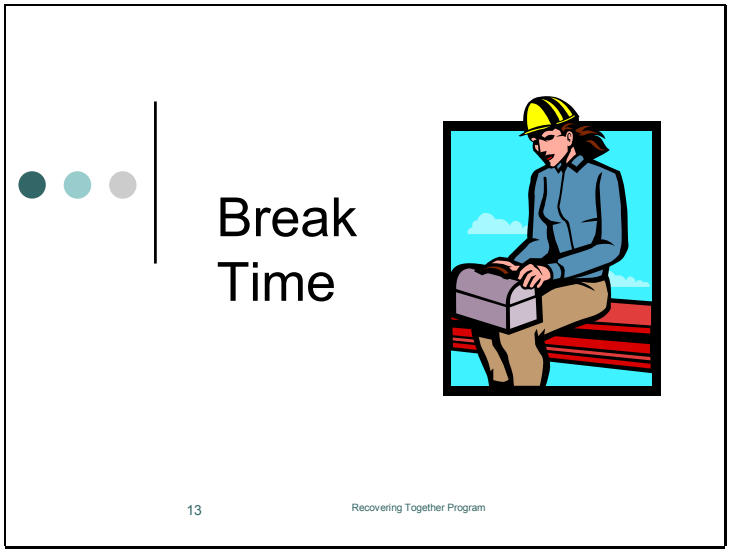


Slide 12

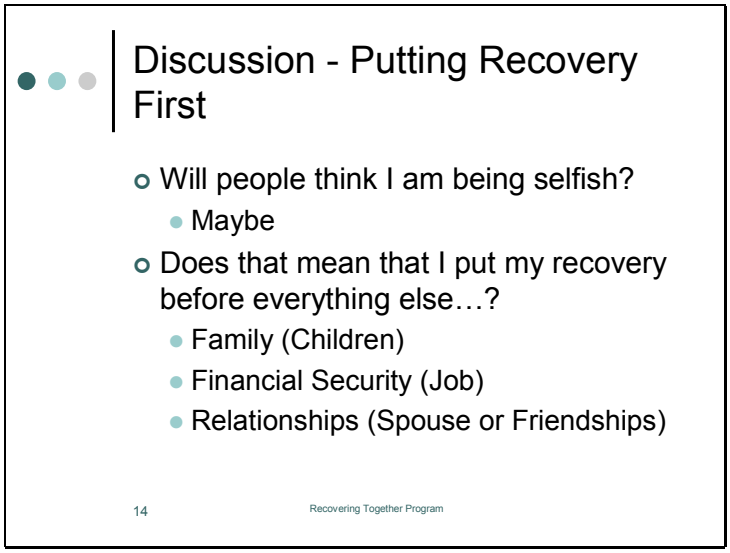


Use a white board or flip chart to record participants' brainstorming session of their needs and wants.

Slide 13

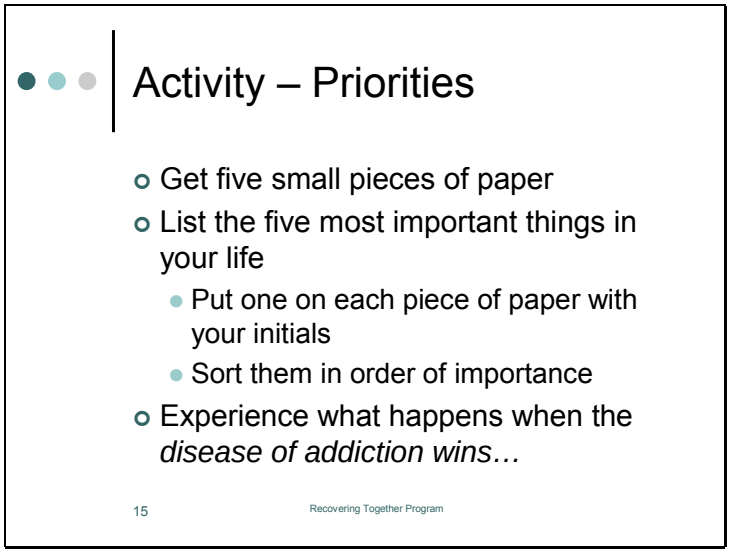


Slide 14



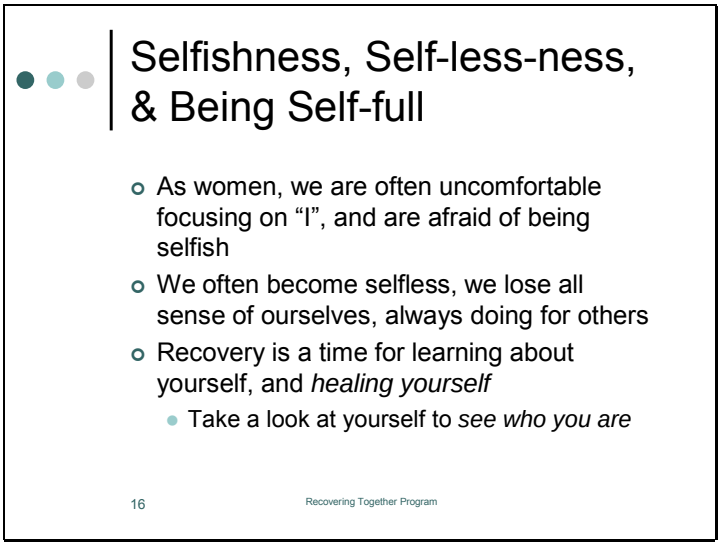
What does it mean to put recovery before everything else? Is being selfish "bad" if you are putting recovery first?

Slide 15



It is difficult for participants to name their priorities and put them in order of importance. It can be helpful for them to brainstorm together, and then individually decide on the five most important things. *Be sure to have them put one priority on each piece of paper, along with their initials.* Also put numerals 1-5 on each piece to indicate priority ratings. The experiential section of this activity involves experiencing what happens when they give control of their life to addiction. Put on a hat or mask to indicate that you (the facilitator) are now the addiction, to whom they have given all their power. Announce that because of addiction they have lost one of the most important things in their life. Collect one piece of paper from each person. Go around three more times until they are left with just one thing. Ask about the feelings experienced as addiction steals their power and what is most precious to them. Following that discussion, say "Ok, now you are in recovery and are taking your power back from addiction. We can all work together to get these things back. What do you think you would be getting back first?" Then, go around and give one thing back to them, and then give the next thing back until you have given them all back.

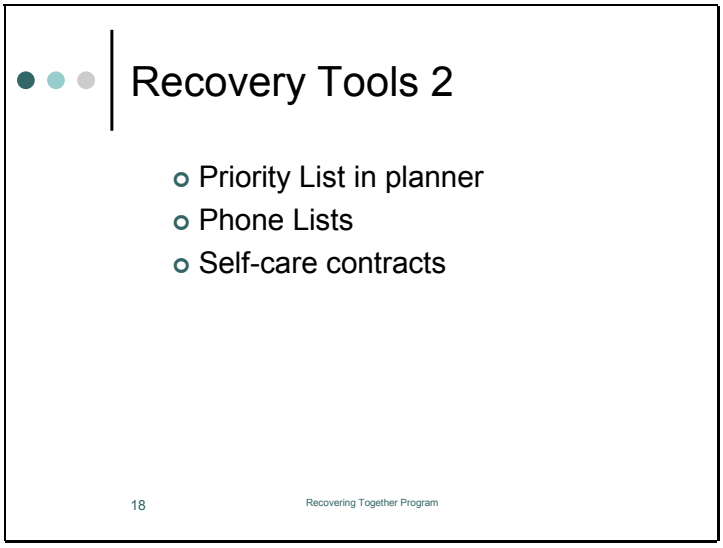
Slide 16



Slide 17

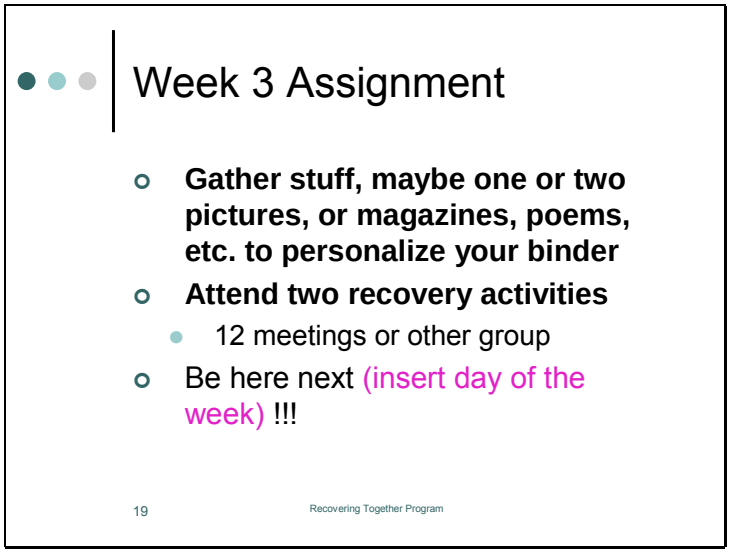
Discuss "What is a sponsor?" List the characteristics of good sponsors and discuss picking a sponsor. Make sure that you ask for questions and talk about the possibility of getting a temporary sponsor.

Slide 18



Have participants create a priority list in their planners, using the priorities identified in the priority activity above. Ask participants to begin a phone list in their planner of those to call if they feel like using drugs. If appropriate, have participants share their phone numbers with each other. Have participants create a simple weekly self-care contract.

Slide 19



Inform participants in Week 4 we are going to be decorating RTP binders and telling our stories, so they may bring some items for decorating their binder. Suggest photos or drawings that they can glue onto it. Suggest they hold onto to those five pieces of paper in their planner or use them for ideas about what to include on their binder decoration. Assure them that you will have decorating supplies, just bring ideas and special things. Pictures of children are very common, and some women are incredibly creative!

Week 3 – Self-Concept and Saving Yourself

Main Idea of Session

Help women answer the question "Who am I?" Understand the difference between performing roles (what they do) and genuinely understanding and expressing themselves as individuals. Understand and personalize the metaphor of the lifeboat.

Materials/Equipment Needed

- Materials
  - Participant binders
  - Handouts of all slide presentations for participants' binders
  - Lifeline page
  - Key Feeling chart
  - Pens
- Equipment
  - Folding chairs for life boat
  - LCD or overhead projector & screen
  - Computer with PowerPoint or Adobe Reader
  - Presentation file or overhead transparencies
  - Drug testing supplies, as needed

Note: The self concept activities are heavily influenced by the "Self" module from the book "Helping Women Recover" (Covington, 1999). The lifeboat activity is adapted from an experience at the Cuneo Women's Chemical Dependency unit in Chicago, Illinois (since closed).

Session Overview

Today's Agenda

Quiet Moment

Check-in

Who Am I? Activities

Lifeboat Activity

Recovery Topic and Tools

Week 3 Activities Overview

Time	***Activity and/or Slides***	***Facilitator Process Notes***
5 min	**1. Quiet Time** **Slide 4**	The quiet time activity this week is practicing the progressive relaxation that participants learned last week. Practice will develop a feeling of competence with the exercise. Learning a new skill can be stressful. Mention that <u>any</u> change creates natural levels of tension, which resolves by itself as we begin to feel comfortable with the new skill.
15 min	**2. Check-In** **Slide 5**	Introduce participants to the Key Feeling chart. Alert them to the expectation that they will use a "feeling word" or description of emotion during check-in. Differentiate between describing an emotion and a thought or opinion. Tell them to include a report about their alternative recovery activities during check-in.

Time	Activity and/or Slides	*Facilitator Process Notes*
25 min	**3. Self-Concept Activity** **Slides 6-9**	This activity consists of two sets of questions, designed to stimulate participants thought about their own identities. For many, their recent self-image is that of a "party girl," or much less flattering self-concepts. A positive, solid self-concept is rare among participants. Make mental notes to yourself about self-concepts that emerge for each participant. These can be valuable for later reference as you work with each participant. The questions begin on a more superficial, historical note, then gradually become more current and personal. Be prepared to answer the questions yourself, to provide a model of appropriate level of detail and disclosure. Suggest participants describe themselves as if someone else (i.e. a relative or a friend) who knew them well at each age being talked about. Usually this has the effect of revealing similarities and differences between participants. Since later questions delve gradually deeper in nature and become harder to answer give them explicit permission to take as much time as they need to answer the questions. Sometimes it is helpful to do some group brainstorming about usual roles that women play in our culture. Give examples of how answers should be a description of who they are as a person and not the role that they have. For instance, none of their answers can refer to the kind of work they do or relationships that they have, for instance, a wife, mother, or daughter. The facilitator should provide an example of the kinds of things that would describe themselves as a. Prior to the

discussion, give participants a few minutes first to write down ideas. Reassure them that they only need to come up with three things.

10 minutes	**Break** **Slide 9**	

Lifeboat activity

Time	*Activity and/or Slides*	*Facilitator Process Notes*
30 min	**4. Lifeboat Recovery** **Activity** **Slides 10-13**	Ownership of recovery – the art of saving yourself. The Lifeboat Recovery Activity needs to be set up beforehand, usually during break. Make a circle of chairs in a different area of the room. Use half the number of chairs as there are group members. Show the slide that says "Only one in four addicts will usually stay clean and sober." We provide chairs for half of the participants because we believe RTP can increase their odds of success. The participants need to ask themselves "Am I going to be a survivor or a casualty?" Point out that there is a small lifeboat on the slide and circling this lifeboat are some sharks. In order to stay clean and sober they are going to have to learn to put recovery first. Ask participants to imagine they are on the ocean liner "Treatment" and they discover there is a big leak somewhere. Point to the lifeboat, and explain that the Lifeboat Recovery is the only way to survive. What follows varies from group to group. Usually one or two people go directly to the lifeboat, and then others scramble to get a seat. Since there are not enough chairs, people may plop down on each other's laps or just lean over and put their leg in or something so that they are in the lifeboat. Other people will not get in at all. Regroup with all of the chairs and all of the participants present. Review the discussion questions. The lifeboat really is a very powerful metaphor for their recovery style up to this point. It is important to ask, if one of their old friends or even a new friend in this group jumps out of the

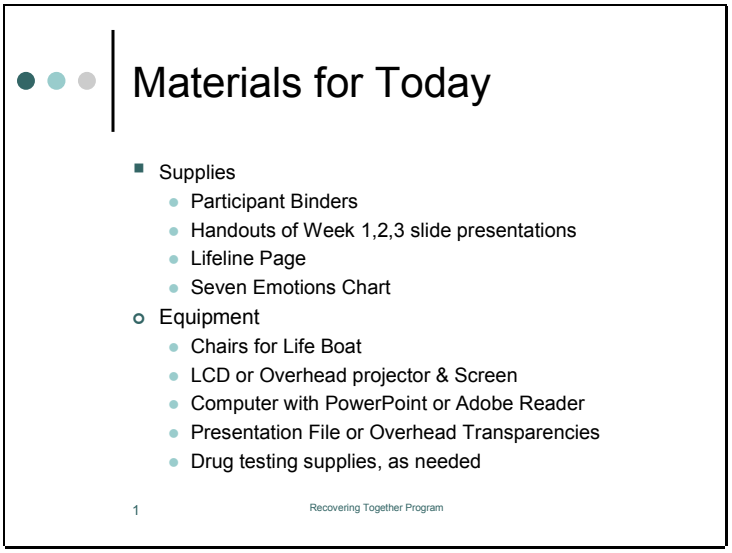
	lifeboat, are they going to jump back out to save them? The water is really too dangerous to risk it. Encourage them to stay in the boat, and just offer a hand up if the friend is willing to climb back in.

Recovery Tool 3 - Lifelines

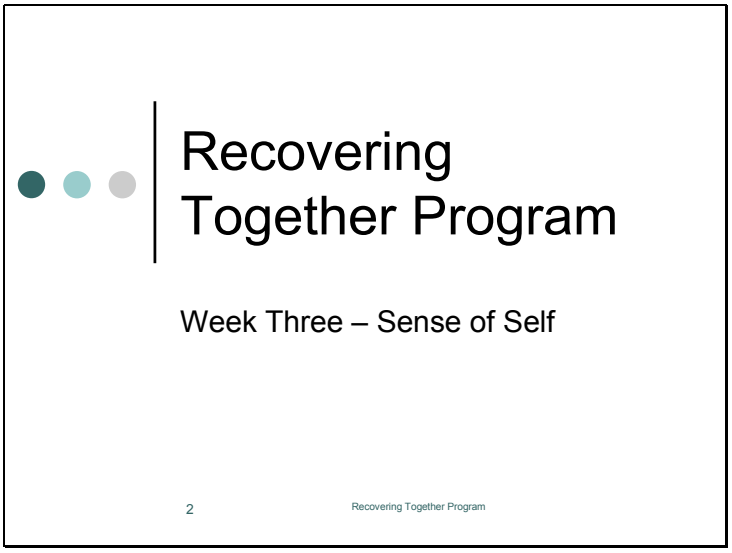
Time	***Activity and/or Slides***	***Facilitator Process Notes***
20 min	**5. My Lifelines – Recovery tool 3 and weekly assignment** **Slides 14-17**	Pass out My Lifeline, which is a one-page handout that should be kept in their binders. Explain to them how to do a lifeline. Have an example of a lifeline filled out. The facilitator does a lifeline for themselves to model the creation and sharing process. Be sure to include behaviors that model having appropriate boundaries about what feels safe to share. Tell them that this is their homework and that it's impossible to do it wrong. They need to bring it next week to help tell their story in Group. During story-telling next week, they are going to work on decorating binders. Have them continue collecting ideas or things for personalizing their binder.

Week 3 Slides with Commentary

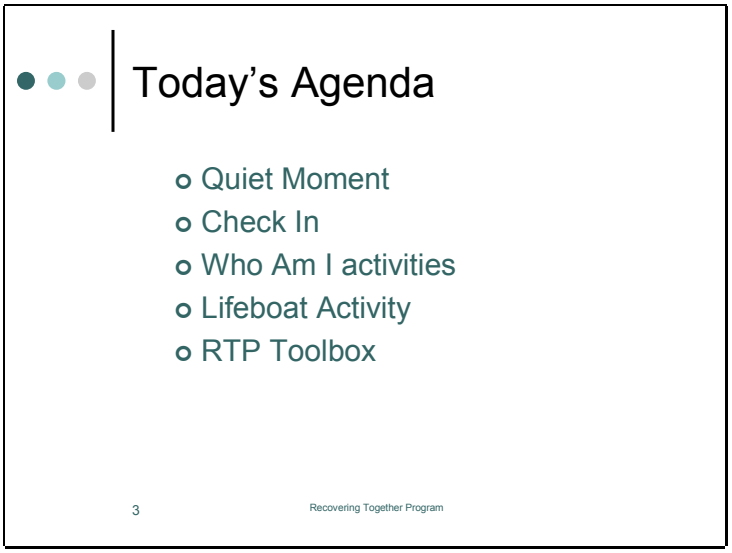
Slide 1



Slide 2



Slide 3

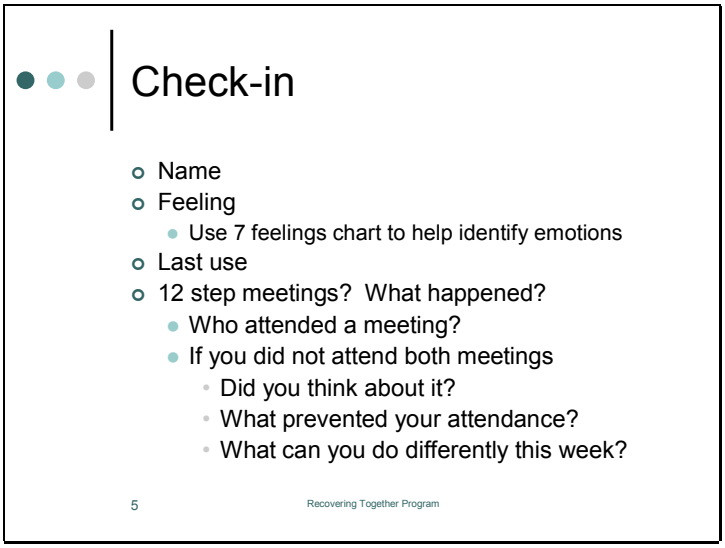


To help women to answer the question "Who am I?" Understand the difference between performing roles (what they do) and genuinely understanding and expressing themselves as individuals. Understand and personalize the metaphor of the lifeboat.

Slide 4

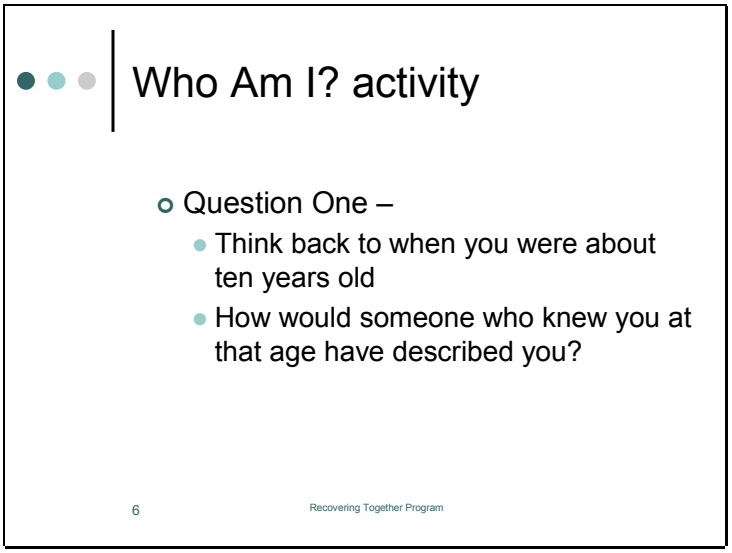
The quiet time activity this week is practicing the progressive relaxation that participants learned last week. Practice will develop a feeling of competence with the exercise. Learning a new skill can be stressful. Mention that any change creates natural levels of tension, which resolves itself as we begin to feel comfortable.

Slide 5



Introduce participants to the Seven Emotions or Key Feelings chart. Alert them to the expectation that they will use a "feeling word" or description of emotion during check-in. Differentiate between describing an emotion and a thought or opinion. Tell them to include a report about their alternative recovery activities (probably 12-step meetings) during check-in.

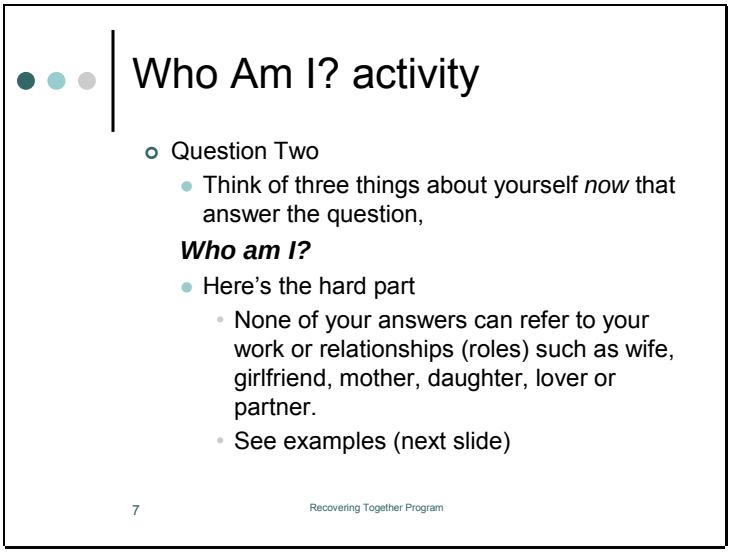
Slide 6



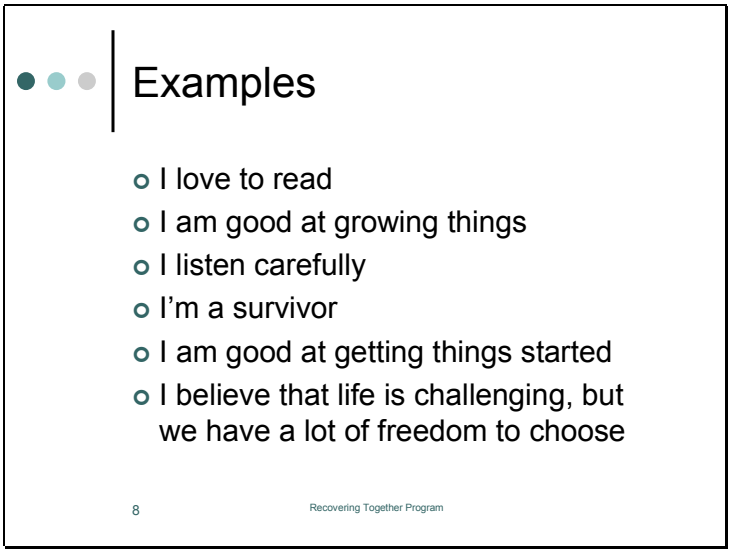
This activity consists of two sets of questions, designed to stimulate clients' thoughts about their own identities. Many times, a recent self-image is a "party girl", or other much less flattering self-concepts. A solid self-concept is rare. Make notes to yourself about concepts that emerge for each client. These can be valuable for later reference. The questions begin on a more superficial, historical note, then gradually become more current and personal. Be prepared to answer the questions yourself, to provide a model of appropriate level of detail and disclosure. Suggest participants describe themselves as if someone else (i.e., a relative or a friend) who knew them well at a certain age was the one doing the talking. Usually this has the effect of revealing similarities and differences between participants. The remainder of the questions delve gradually deeper and become harder to answer. Give them explicit permission to take as much time as they need to answer the questions.

Give examples of how answers should be a description of who they are as a person and not the role that they have. Sometimes it is helpful to do some group brainstorming about usual roles that women play in our culture. For instance, none of their answers can refer to the kind of work they do or relationships that they have, like a wife, mother or daughter. The counselor should make an example of the kinds of things that would describe themselves as a person. Give participants a few minutes first to write down ideas. Reassure them that they only need to come up with three things.

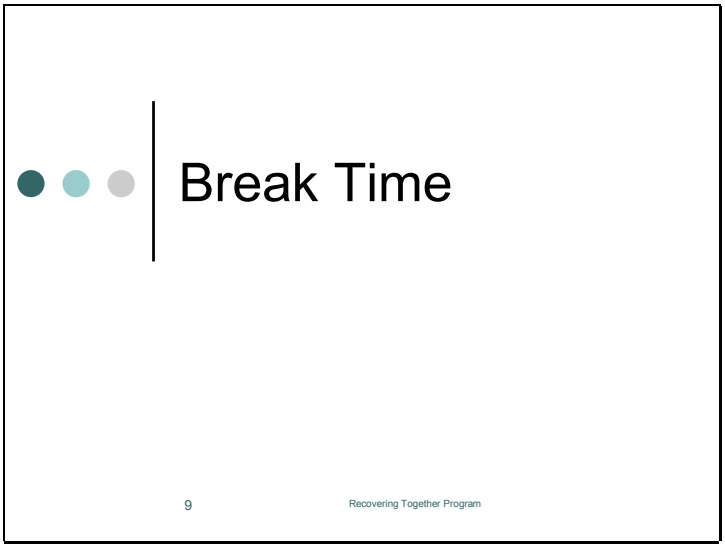
Slide 7



Slide 8

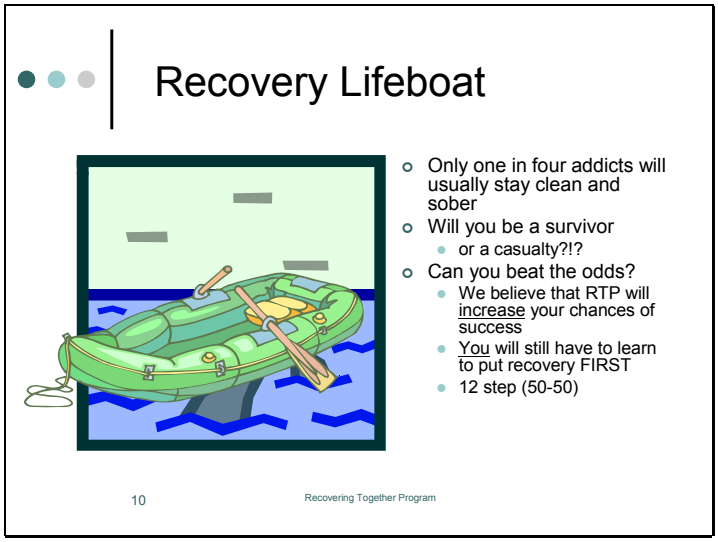


Slide 9



Begin process of random UAs, if this is part of your research or workplace policy.

Slide 10



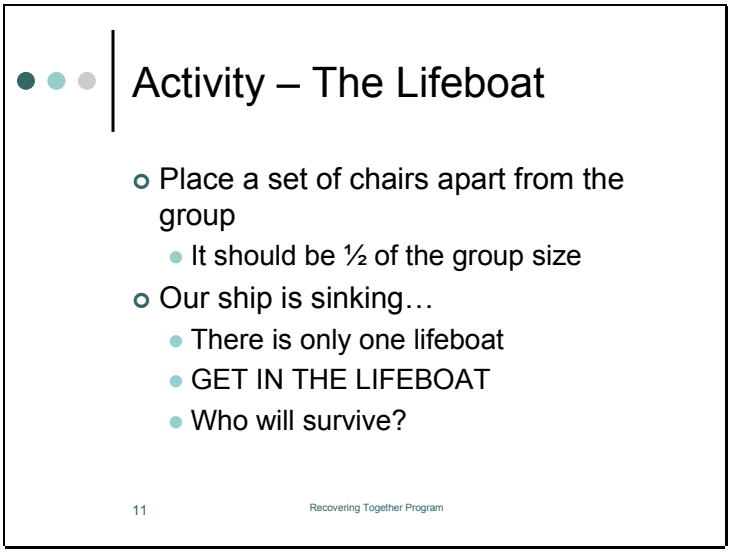
Ownership of recovery – the art of saving yourself. The Lifeboat needs to be set up before beginning the activity, usually during break. Make a circle of chairs in a different area of the room. Use half the number of chairs as there are group members. Show Slide 10. We provide chairs for half the participants because we believe RTP can increase their odds of success. The participants need to ask themselves "Am I going to be a survivor or a casualty?" Point out that there is a small lifeboat on the slide and circling this lifeboat are sharks.

In order to stay clean and sober they are going to have to learn to put recovery first. Ask participants to imagine they are on the ocean liner "Treatment" and they discover there is a big leak somewhere. Point to the "lifeboat" in the room, and explain that the Lifeboat Recovery is the only way to survive.

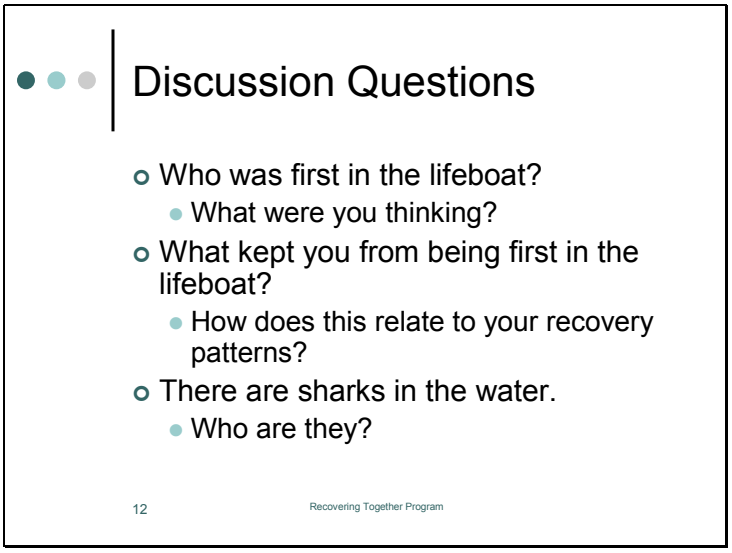
What follows varies from group to group. Usually one or two people go directly to the lifeboat, and then others scramble to get a seat. Since there are not enough chairs, people may plop down on each other's laps or just lean over and put their leg in or something so that they are in the lifeboat. Other people will not get in at all.

Regroup with all of the chairs and all of the members present. Review the discussion questions. The lifeboat really is a very powerful metaphor for their recovery style up to this point. It is important to ask, if one of their old friends or even a new friend in group jumps out of the lifeboat, are they going to jump back out to save them? The water is really too dangerous to risk it. Encourage them to stay in the boat, and just offer a hand up if the friend is willing to climb back in.

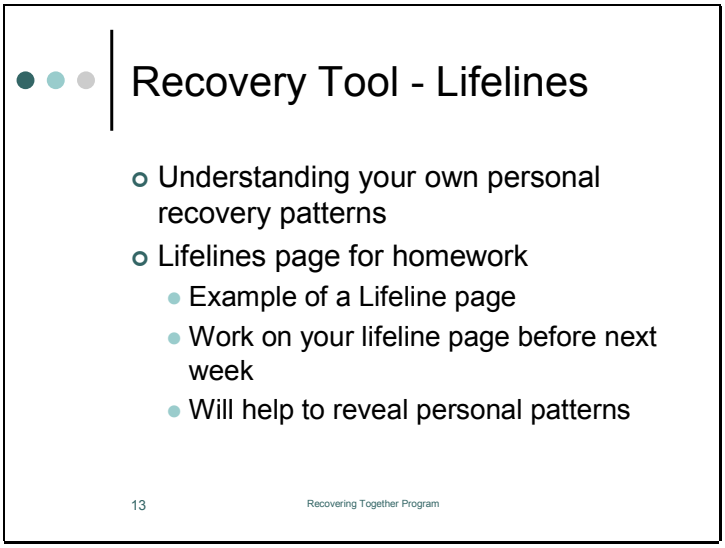
Slide 11



Slide 12

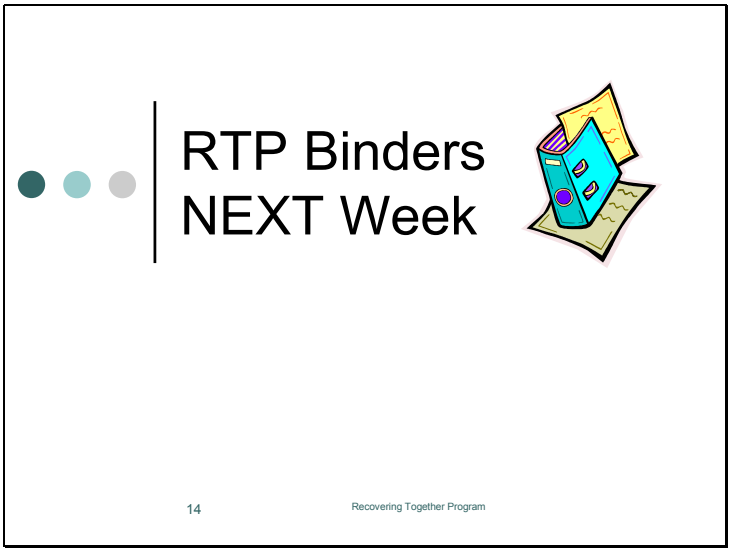


Slide 13

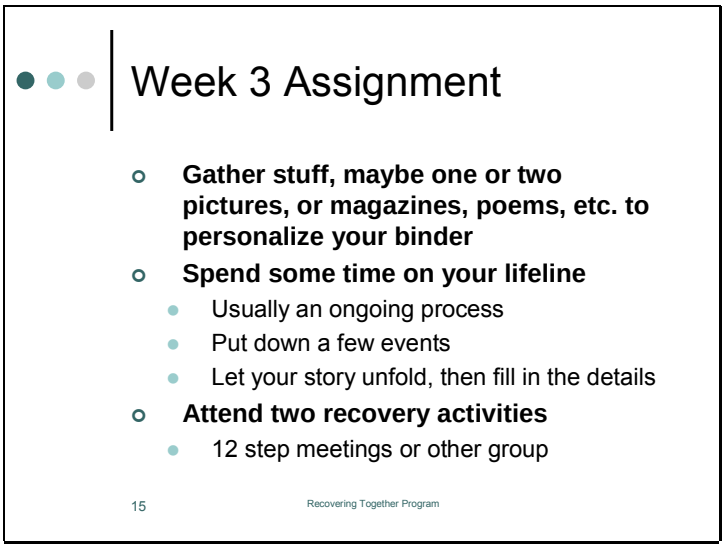


Pass out Lifelines, which is a one-page handout that should be kept in their binders. Explain to them how to do a lifeline. Have an example of a lifeline filled out. The instructor or group leader should do a lifeline for herself to model the creation and sharing process. Be sure to include behavior that models having appropriate boundaries about what feels safe to share.

Slide 14

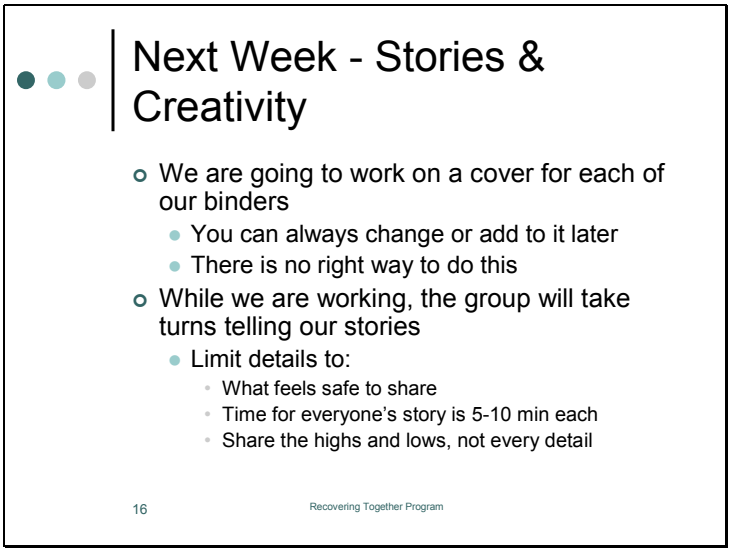


Slide 15



Tell them that this is their homework and that it's impossible to do it wrong. They need to bring it next week to help tell their story in Group. During story-telling next week, they are going to continue working on decorating binders. Have them continue collecting ideas or things for personalizing their binder.

Slide 16



Week 4 - Binders and Stories

Main Idea of Session

To gain a better sense of who we are by outlining and telling our stories. To gain more understanding and respect for each other by hearing the similarities and differences in our lives.

Materials/Equipment Needed

- Materials
  - Presentation file or overhead transparencies
  - Lots of decoration supplies (i.e., markers, glitter pens, stickers, use your imagination and ask participants for ideas)
  - Extra binders with handouts, as needed for participants
  - Extra My Lifeline Handouts
- Equipment
  - LCD or overhead projector; screen
  - Computer with PowerPoint or Adobe Reader (for LCD) or transparencies for overheads
  - Copy or fax machine for attendance sheets
  - Drug testing supplies, as needed

Session Overview

Check-in

Binders and Stories

Week 4 Activities

Time	*Activity and/or Slides*	*Facilitator Process Notes*
10 min	**1. Quiet Time** **Slide 3**	The relaxation activity during this quiet time is visualization of a peaceful place. This involves closing their eyes and imagining. Help them deepen the experience by asking about temperature, scents, texture, etc. in the room.
10 min	**2. Check-in** **Slide 4-5**	Remind participants that they need to say their first names, how they are feeling now, and when their last use was. Be sure to collect their alternative recovery activity attendance sheets and make copies. Focus check-in about AA/NA meetings. Who attended a meeting? If they did not attend both meetings, did they think about it? What prevented their attendance? What can they do differently this week? Discuss or have them share what other options besides 12-step meetings they attended.
3. Recovery Tool #4 Binders **Slide 6**		Recovery Tool 4 – Binder Prepare copies and binder prior to the group meeting. The binder should include copies of PowerPoint handouts, and other documents needed for each week's program. See Appendix for suggestions. Pass out the binders after check-in. Bring out the decorating supplies.

Review Lifelines

Time	*Activity and/or Slides*	*Facilitator Process Notes*
5 min	**4. Review Lifelines** **Slide 7**	Have everybody pull out their lifelines and ask if anybody was able to work on their lifeline. Review the suggestions on the lifeline and emphasize they know best what events may be significant. There are no "right" answers. Take time, if needed, for everybody to have something on their lifeline sheet.
	Break	*This week have participants take a break when there is an opportunity between women's stories.*

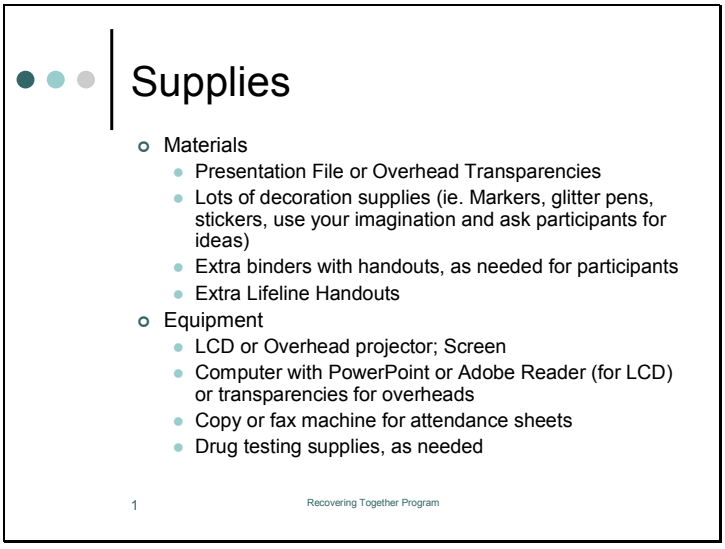
Life Stories

Time	*Activity and/or Slides*	*Facilitator Process Notes*
80 min	**5. Life Stories** **Slide 8**	Tell participants that we are going to go around and tell our life stories, but not in detail. This is very difficult for some participants. Reassure them that it is hard to be brief, and that is why we are going to use the lifelines to guide the story telling. ***Explain that if we don't finish the stories, then an additional group meeting may be scheduled this week.*** The easiest and most convenient thing would be for everybody to finish today. While someone is telling their story, the rest will be decorating their binder. This approach takes the pressure off the story-teller, and it really does help them to share openly about their lives. Instruct participants to listen carefully and do not interrupt with questions.

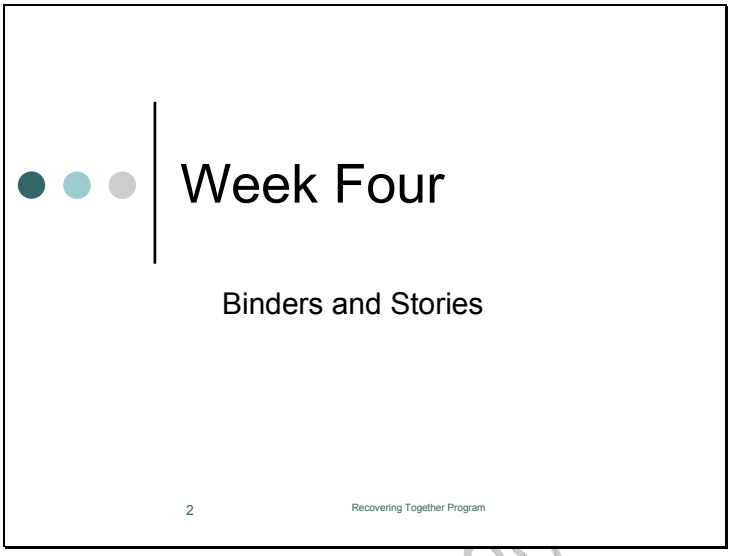
Time	*Activity and/or Slides*	*Facilitator Process Notes*
5 min	**6. Weekly Assignment** **Slide 9**	Pass out another clean copy of the lifelines and tell participants that after having listened to everybody's life story, they may want to add to their story. They may have noticed a different perspective on patterns in their life. Invite them to make a neater, (and revised, if needed) copy of their lifeline to keep in the front of their binder. We will use the lifelines again when we review relationships with drugs and with other people. Ask them to finish decorating their binder at home, if needed. They need to bring it back the following week and every week thereafter. Provide binder storage for them if their circumstances require. Binders cannot be taken into corrective facilities.

Week 4 Slides with Commentary

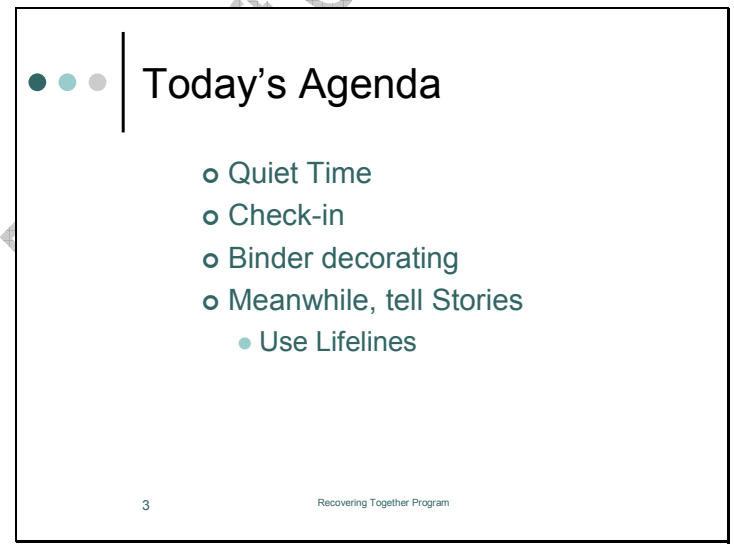
Slide 1



Slide 2

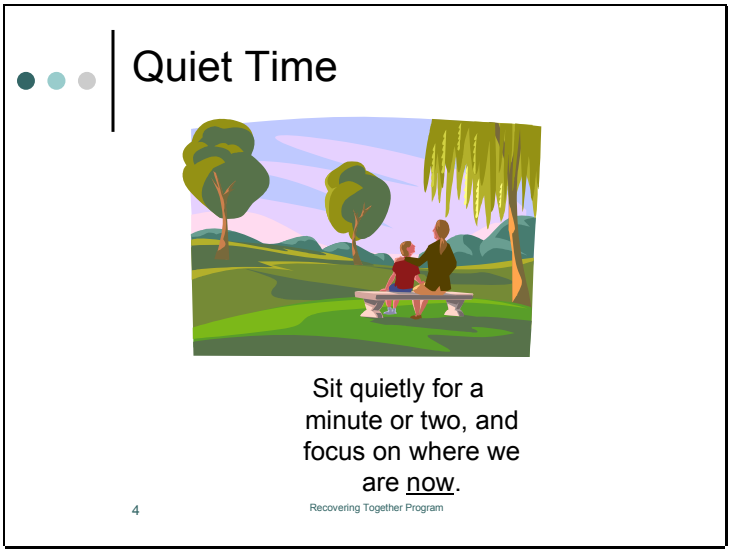


Slide 3



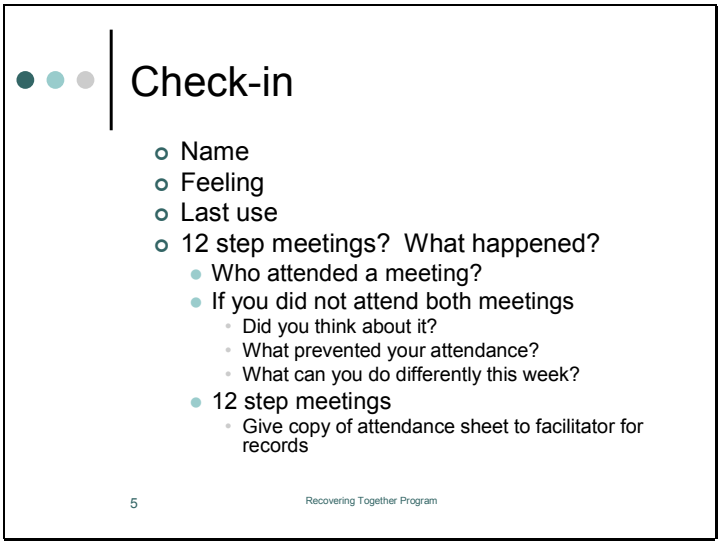
To gain a better sense of who we are by outlining and telling our stories. To gain more understanding and respect for each other by hearing the similarities and differences in our lives.

Slide 4



Relaxation activity during this quiet time is visualization of a peaceful place. This involves closing their eyes and imagining. Help them deepen the experience by asking about temperature, scents, texture, etc.

Slide 5



Remind participants that they need to say their names, how they are feeling now, and when their last use was. Be sure to collect their attendance sheets and make copies. Have the participants fill in the part of their incentive sheet that says how many incentives they receive to help understand the relationship between their behavior and the resulting reward.

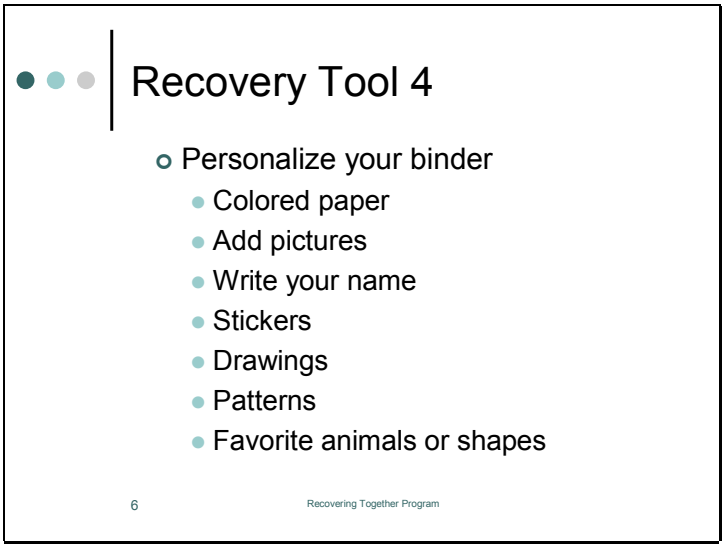
Focus check-in on AA/NA meetings.

Who attended a meeting? If you did not attend both meetings, did you think about it? What prevented your attendance?

What can you do differently this week?

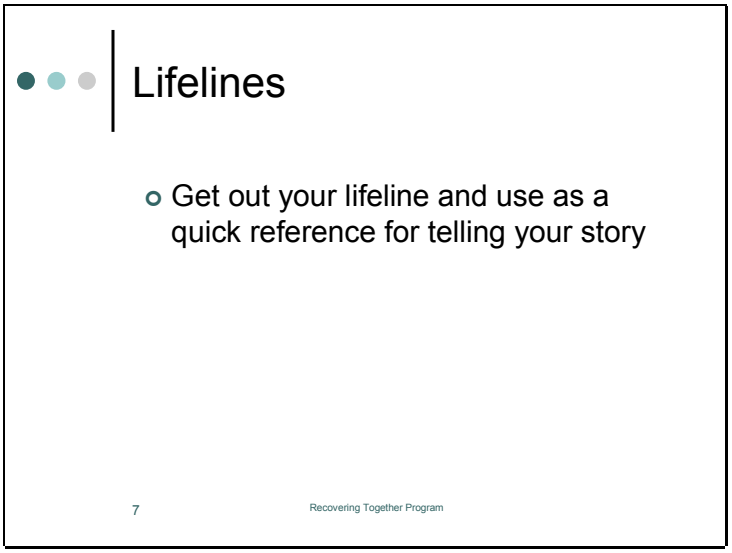
Discuss other options besides 12-step meetings.

Slide 6



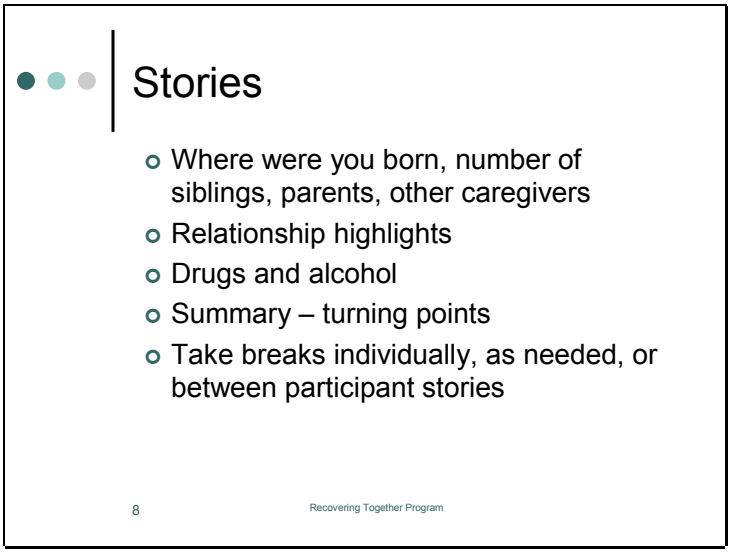
Prepare copies and binder at least one day prior to the group meeting. See Adult Phase 1 Binder to check for binder contents. Pass these out after check-in. Bring out the decorating supplies.

Slide 7



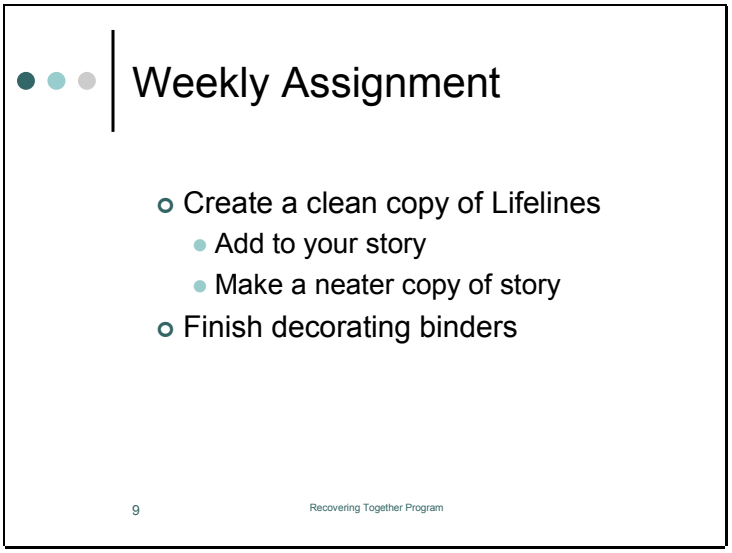
Have everybody pull out their lifelines and ask if anybody was able to work on their lifeline. Review the suggestions on the lifeline and emphasize they know best what events may be significant. There are no "right" answers. Take 10-15 minutes, if needed, for everybody to have something on their lifeline sheet.

Slide 8



Tell people that we are going to go around and tell our life stories, but not in great detail. This is very difficult for some participants. Reassure them that it is hard to be brief, and that is why we are going to use the lifelines. Explain that if we don't finish the stories, then an additional group meeting may be scheduled. The easiest and most convenient thing would be for everybody to finish today. During the stories, everybody should be decorating their binders. This activity takes the pressure off the story-teller, and it really does help them to share openly about their lives. Instruct participants to listen carefully and do not interrupt with questions.

Slide 9



Pass out another clean copy of the lifelines and tell people that after having listened to everybody's life story, they may want to add to their story. They may have noticed a different perspective on patterns in their life. Invite them to make a neater, nicer copy of their lifeline to keep in the front of their binder. We will use the lifelines again when we review relationships with drugs and with other people.

Ask them to finish decorating their binder at home, if needed. They need to bring it back the following week and every week thereafter. Provide binder storage for them if their circumstances require. Binders cannot be taken into corrective facilities.

Week 5 – Defining Your Relationship with Drugs

Main Idea of Session

Our relationships with alcohol and other drugs progress along a continuum. Participants personalize and classify their own relationships with various substances.

Materials/Equipment Needed

- Materials
  - Presentation file or overhead transparencies
  - Continuum handout (Relationship with Drugs) for binder – color copy recommended
  - Four Characteristics handout
  - Extra Continuum handouts (black & white OK)
  - Binders for any participants who missed last week
  - Copies of the "textbooks" of various 12-Step programs like Alcoholics Anonymous or Narcotics Anonymous, at least one for each participant
- Equipment
  - LCD or overhead projector; screen
  - Computer with PowerPoint or Adobe Reader (for LCD) or transparencies for overheads
  - Copy or fax machine for attendance sheets
  - Drug testing supplies, as needed

Session Overview

Check-in

Quiet Time

Personalizing Your Relationship with Drugs

The Continuum

Where is YOUR line? – Discussion

Recovery Topic and Tool 5 - Your Own Big Book

Week 5 Activities

Time	*Activity and/or Slides*	*Facilitator Process Notes*
10 min	**1. Quiet Time** **Slide 3**	"Rag doll" exercise or another energizing activity. This is an opportunity to make the point that stress management can involve both relaxation and energetic movement for stress release. View the RTP Women's video before group for a demonstration of the "Rag doll" activity.
15 min	**2. Agenda & Check-in** **Slide 4-6**	Emphasize that people need to pick one of the feelings off the Key Feelings chart or another word that actually describes a specific emotion. Emphasize that "I'm feeling okay" or "I'm feeling tired" are unacceptably vague descriptions. Learning to identify their own feelings is the first step in emotional management, which will be taught later. They do not need to *explain* their feelings at this time. All they need to do is identify them. Emphasize the difference between these two. Ask them to keep check-in brief. If they need to talk at length about an issue they can make an individual appointment with the facilitator or talk with a sober friend.

Personalizing Your Relationship with Drugs

Time	*Activity and/or Slides*	*Facilitator Process Notes*
15 min	**3. The Continuum**	During this discussion, the focus is about participants' relationship with a drug. Directly address objections some people have to being labeled an "addict" or "alcoholic". Emphasizing the relationship

	Slides 7-14	instead of the label is surprising for some participants. However, avoiding labels may work to reduce defensiveness. Ask participants to listen closely because they will be given a short, non-scored quiz on this later. Direct their attention to this information in their binder. For instance, they will need to know the four characteristics of a healthy relationship with a drug for next week's discussion.
15 min	**4. Personalizing Your Relationship with Drugs** **Slide 15**	Before the break, ask participants to begin thinking about where they think they might be in their own relationship with their drug of choice (a.k.a. primary drug). Instruct participants to come back from break ready to discuss their location on the drug relationship continuum.
10 min	**Break** **Slide 16**	

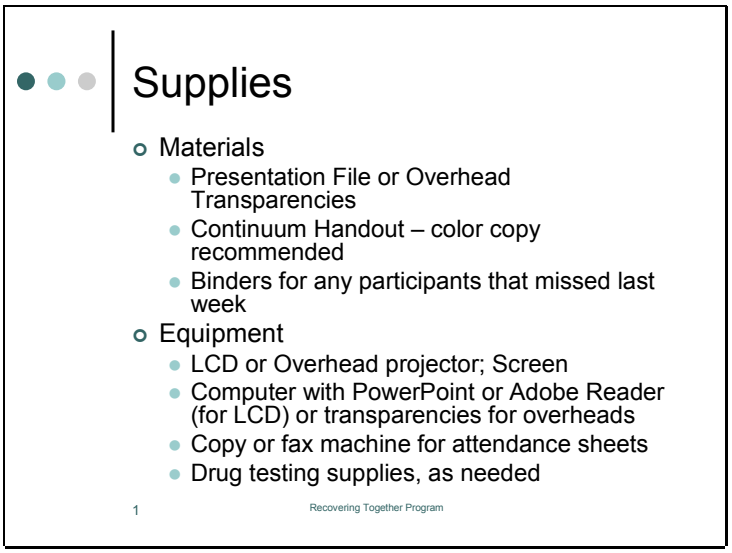
Discussion – Where is YOUR line?

30 min	**5. Where is YOUR line?** **Discussion** **Slide 17**	Have some black and white copies of the continuum (the Relationships with Drugs handout) to hand out for participants so they can to make notes on it. Keep one copy of the handout for you to indicate where each participant has identified themselves, and where staff may estimate the participant may be currently. Participants should have a color copy in their binder. If they think they are still on a two-way street, ask them, "does your relationship meet all the criteria of a healthy relationship with a drug?" This is on the handout Four Characteristics of a Healthy Relationship with a Drug. Have two or three participants compare their drug use with all four criteria, sharing their

		thoughts out loud to the group. This will help all participants learn how to determine where they are on the continuum. Often, responses range from abuse to toxic for their primary drug.
20 min	**6. Recovery Topic and Tool 5** **Slide 18**	Leave time to hand out "big books," including time to describe each of the books. These are the "textbooks" of various 12-Step programs like Alcoholics Anonymous or Narcotics Anonymous. Participants seem especially curious about the Red Book, the Native American big book. If you have enough of those, let people take more than one or tell them that once they have read the first one that you will give them another one. Let them know that these books are theirs to keep; they can write in them, put their name in them, etc.

Week 5 Slides with Commentary

Slide 1



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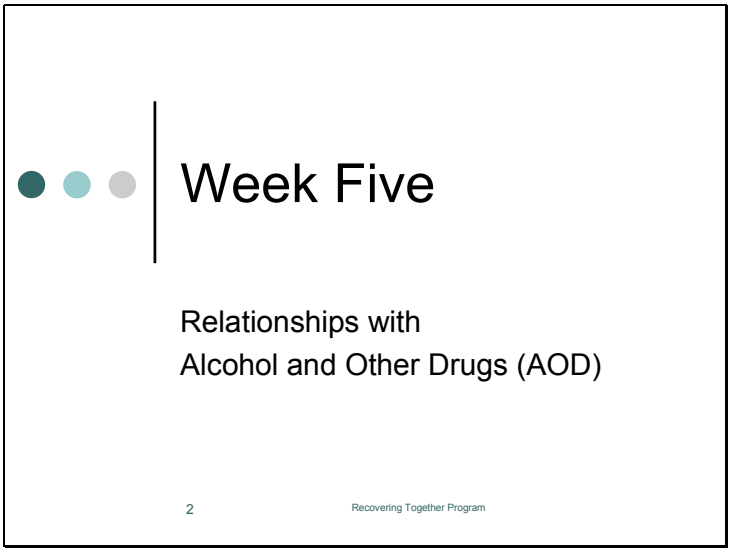
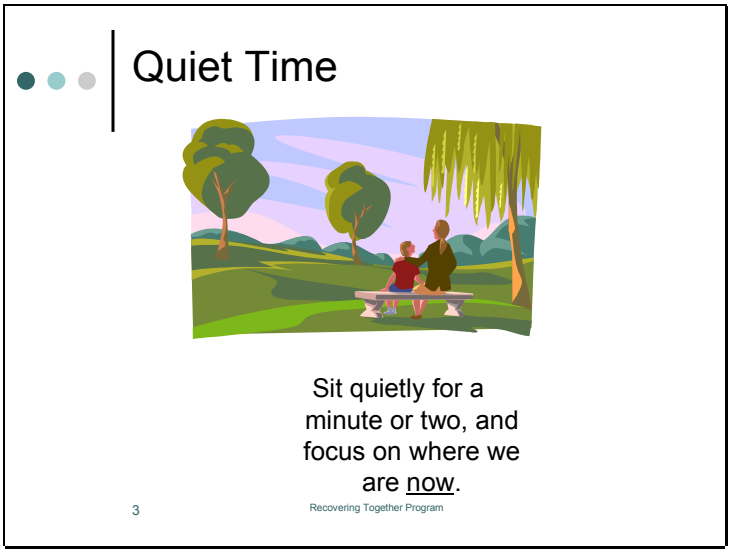
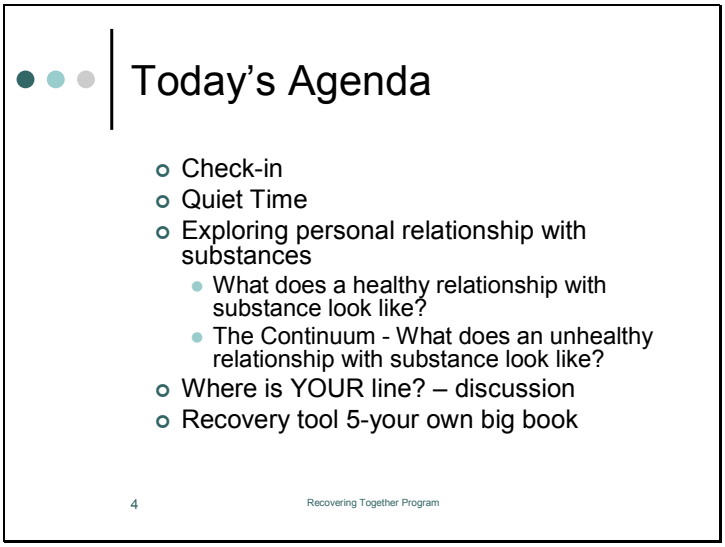


Slide 3

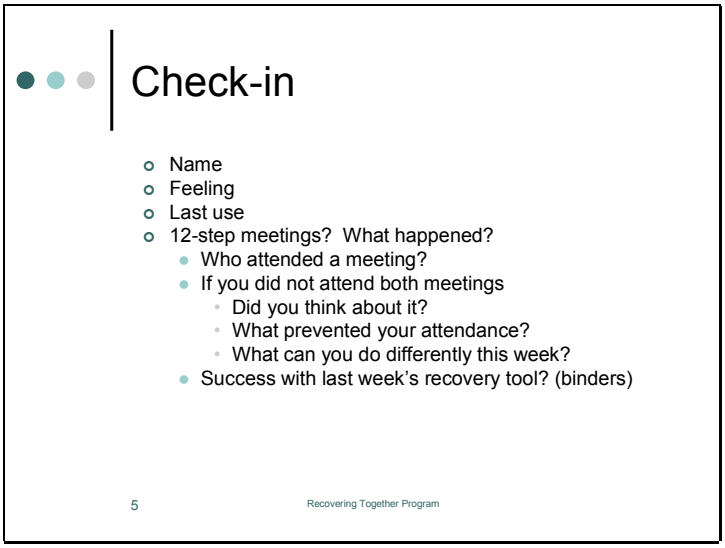


"Rag doll" exercise or another energizing activity. This is an opportunity to make the point that stress management can involve both relaxation and energetic movement for stress release. View the RTP Women's video before group for a demonstration of the "Rag doll" activity.

Slide 4



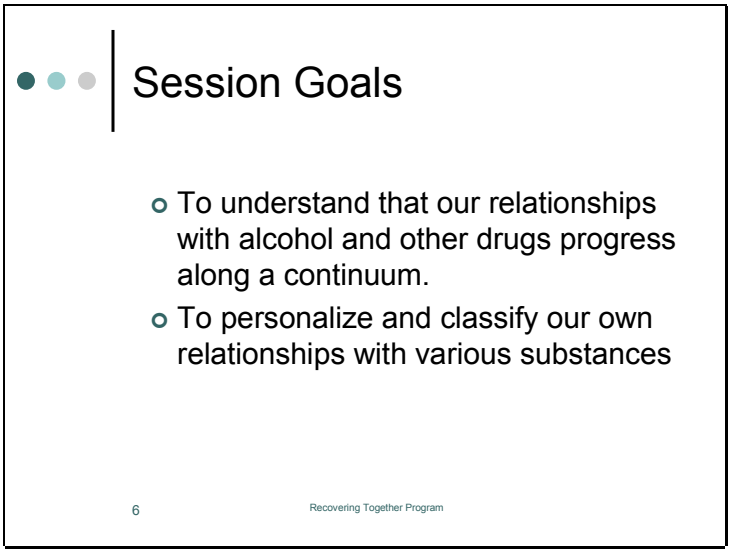
Slide 5



Emphasize that people need to pick one of the feelings off the feeling chart or another word that actually describes a specific emotion. Emphasize that "I'm feeling okay" or "I'm feeling tired" are vague descriptions and are inadequate. Learning to identify their feelings is the first step in emotional management, which will be taught later.

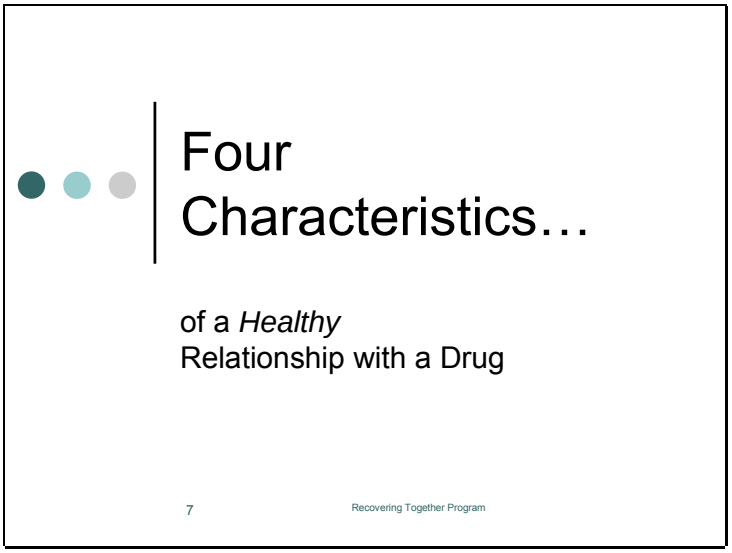
They do not need to *explain* their feelings at this time. All they need to do is identify them. Emphasize the difference between this. Ask them to keep check-in brief. If they need to talk at length about an issue they can make an individual appointment or talk with a sober friend.

Slide 6



Our relationships with alcohol and other drugs progress along a continuum. Participants personalize and classify their own relationships with various substances.

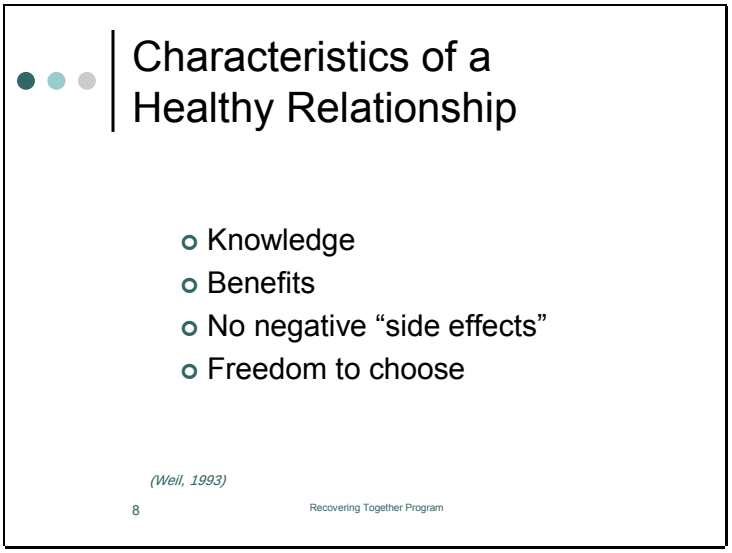
Slide 7



During this discussion program we talk about participants' relationship with a drug, not whether they are alcoholics or addicts. This is surprising for some participants, but may work to reduce defensiveness. Ask them to listen closely because they will be quizzed on it later. For instance, they will need to know the four characteristics of a healthy relationship with a drug for next week's discussion.

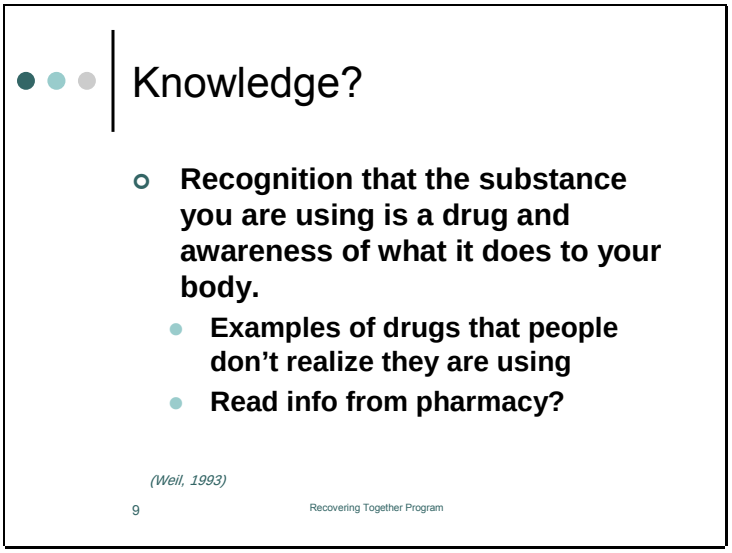
Before break, ask participants to begin thinking about where they might be in their own relationship with their drug of choice (a.k.a. primary drug). Instruct participants to come back from break ready to discuss their location on the drug relationship continuum.

Slide 8



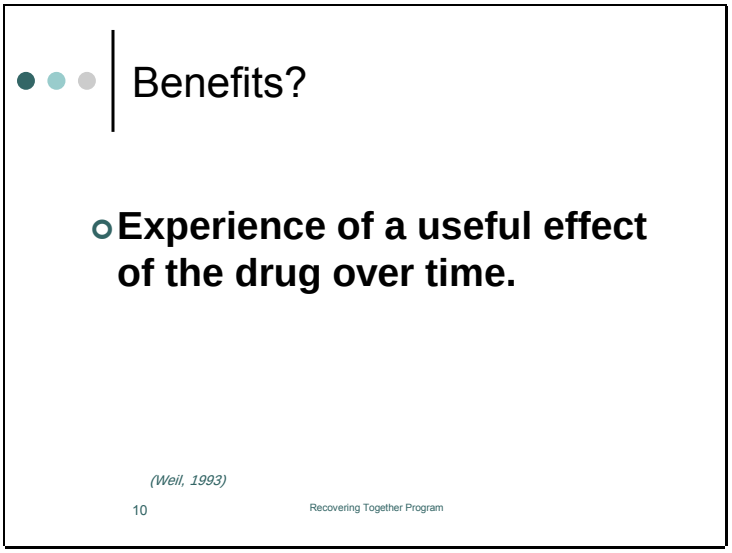
These four characteristics are modified from the book, "From Chocolate to Morphine: Everything You Need to Know about Mind-Altering Drugs" by Andrew Weil. (1993. New York: Houghton Mifflin)

Slide 9



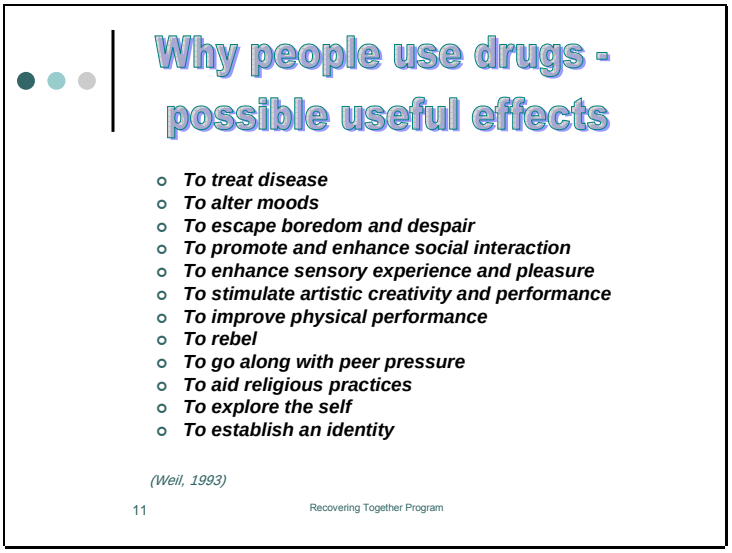
Weil. (1993). From Chocolate to Morphine: Everything You Need to Know about Mind-Altering Drugs. New York: Houghton Mifflin

Slide 10

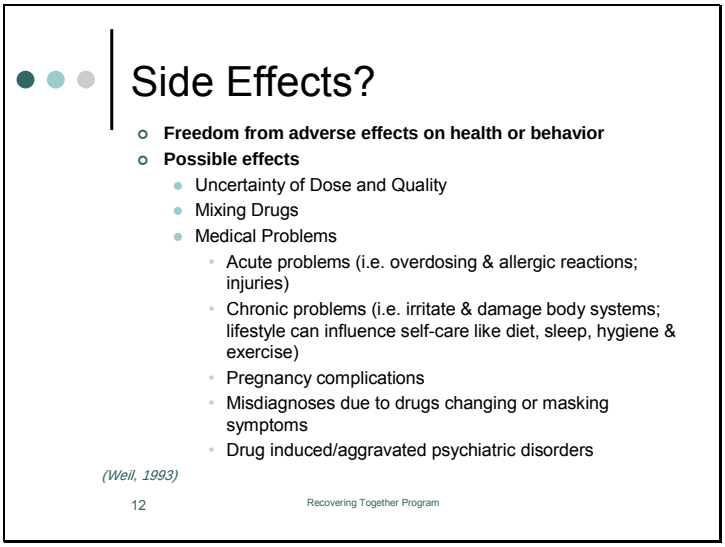


Weil, 1993.

Slide 11

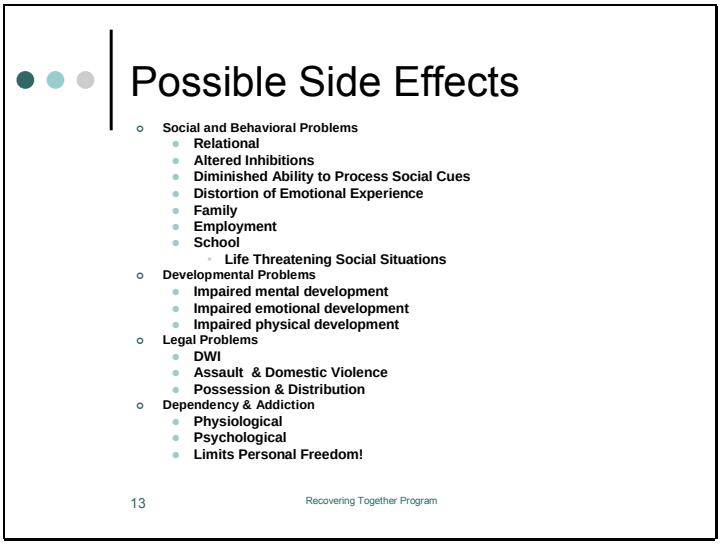


Slide 12

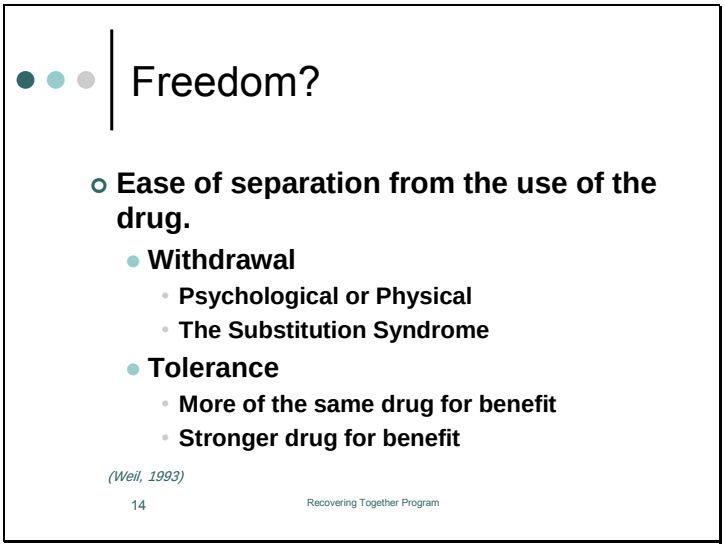


Weil, 1993.

Slide 13



Slide 14



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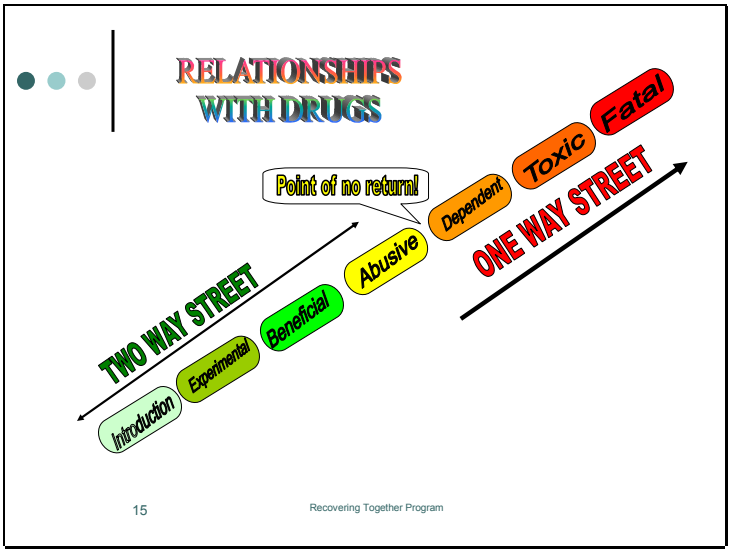
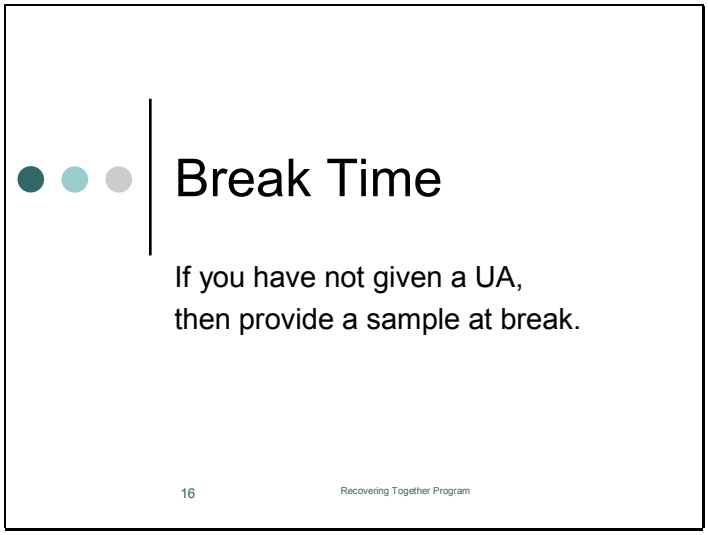
Slide 15

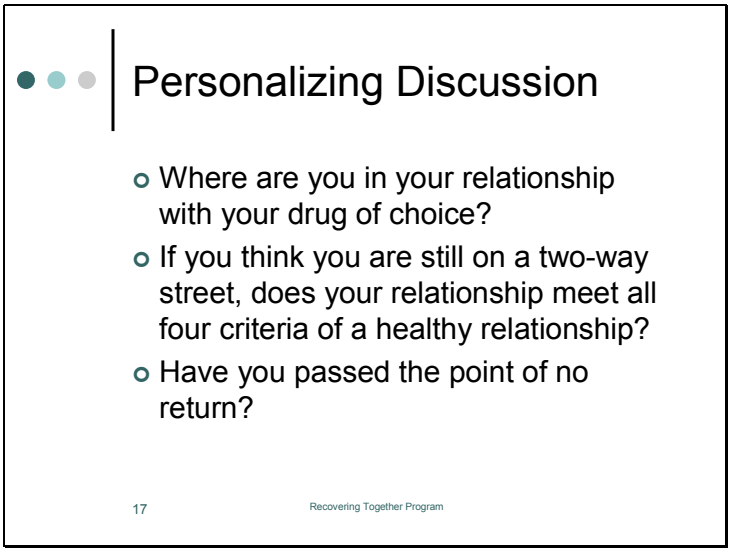


Have some black and white copies of the Continuum to hand out for participants to make notes. Keep one for yourself to indicate where each participant has identified themselves, and where staff may estimate the participant may be currently. Participants should have a color copy in their binder. If they think they are still on a two-way street, ask them "does your relationship meet all the criteria of a healthy relationship with a drug?" Have two or three participants compare their drug use with all four criteria. This will help all participants learn how to determine where they are on the continuum. Often, responses range from abuse to toxic for their primary drug. This discussion can be a "round robin," where each participant in turn identifies their own place in the continuum. It also works to use a "popcorn" style for this discussion, allowing participants to volunteer information on their personal continuum. If you have time, have them identify their relationship with a variety of drugs, legal and illegal, to develop competency in using the continuum model.

Slide 16



Slide 17



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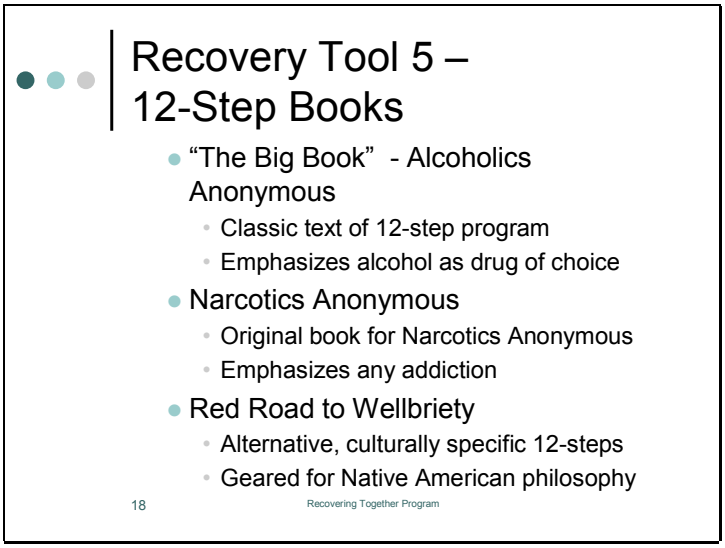
Slide 18



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Week 6 - Emotion and Addiction

Main Idea of Session

Learn about emotions as a neurological reality and how they are connected to the neurobiology of addiction. Learn the importance of identifying, managing and expressing feelings for recovery success.

Materials/Equipment Needed

- Materials
  - Presentation file or overhead transparencies
  - Relationships with Drugs Continuum handout – color copy recommended
  - Four Characteristics handout
- Equipment
  - LCD or overhead projector; screen
  - Computer with PowerPoint or Adobe Reader (for LCD) or transparencies for overheads
  - Copy or fax machine for attendance sheets
  - Drug testing supplies, as needed

Session Overview

Quiet time

Check-in

Four Characteristics

Continuum

Emotions and Addiction Presentation

Week 6 Activities

Time	*Activity and/or Slides*	*Facilitator Process Notes*
10 min	**1. Quiet Time** **Slide 3**	Emotional Exploration is a relaxation exercise that is progressive relaxation, but adds instruction about noticing their feelings. Once they are in a relaxed state, ask them to turn their attention toward any physical sensations linked to emotions. Sometimes it is helpful to use a metaphor such as "fishing"; visualize casting a lure and waiting to see what rises to the surface. Use any metaphor common in the local culture that would relate to quiet exploration.
20 min	**2. Check-in** **Slide 4-5**	Before check-in, remind the participants that they need to use a descriptive feeling word. Joke with them that if they have been consistently vague about their feelings, they are not going to have any more chances to do that after today. The check-in must include specific information about their current feelings – perhaps insights they discovered during Emotional Exploration. Always include check-in about most recent drug use and recovery activity attendance. Ask participants if they have looked at their big books, and what they found.

Review AOD relationships

15 min	**3. Review AOD Relationships** **Slide 6**	Participants should locate their Relationships with Drugs Continuum and Four Characteristics of a Healthy Relationship with Drugs handouts in their binders. With the handouts facedown, see if the group can collaborate and remember all four of the characteristics. Each person should come up with one until all four have been reached. Ask them if anybody has changed their mind her mind about where

she is on the drug relationship continuum. Have each participant locate her relationship with alcohol, if she has not done so already.

10 min

4. The Tangled Knot

Activity

Slide 7

This activity uses multi-colored yarn. Have participants hold the yarn and clip it off so their piece is about 2-3 feet long. Each participant should tie the two ends in a knot. Have them make a "Cat's Cradle" or another type of knot to represent their personal tangle of various emotions. Talk about how on a bad day, they get more and more twisted (twist your own yarn while describing this and engage in the other actions as you talk about them). The resulting knot may feel overwhelming. If we struggle and tug at the knot it gets worse. If we ignore it, there it will sit until we are ready to deal with it. It is necessary to untangle the knot and separate the strands in order to use the feelings.

In today's presentation, we will learn how feelings can be useful, but must be untangled before we can effectively harness their power. The power of emotion is huge – they will understand why after the presentation.

5 min

5. Recovery Tools 6

Slide 8-11

Tell them to keep that piece of string as a reminder to untangle their emotions. If they are having a hard day, then it's time to stop and separate the strands. Show them the Key Feeling chart and let them know you will explain it during the presentation after break.

Break

Slide 12

Emotional Education presentation

50 min **6. Emotional Education - The Brain, Emotions and Addiction**

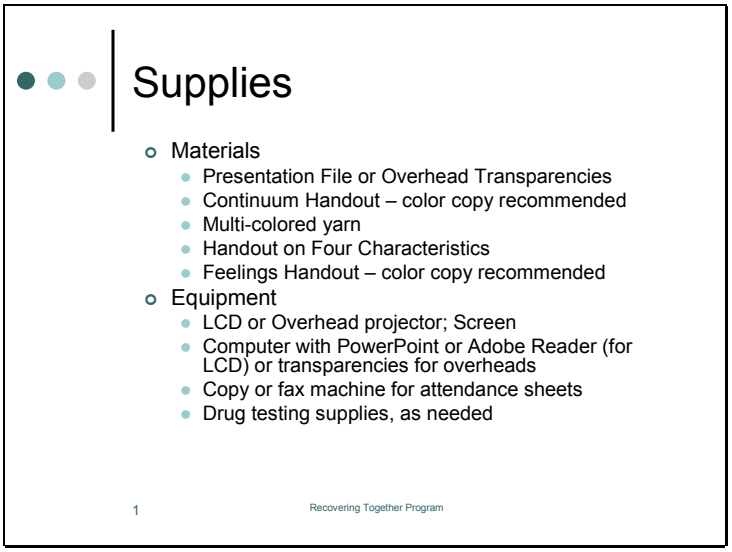
Slides 13-34

Important introduction to this presentation: Explain you are going to try to respect their intelligence, and at the same time appreciate that they are just starting to clear their heads from using drugs or alcohol for quite a while. This presentation is interesting but also contains a lot of information about the actual biology of the brain. Let them know that it's not important that they remember specific names of the brain parts, only the major concepts. If they don't understand something, make a big question mark on their notes page. Come back to those questions later or address them immediately during the presentation.

Emotional Education is a fairly unique approach in the Recovering Together program based on very recent research. They may never have been introduced to this information in any other treatment program or in the media. Make sure you leave plenty of time for the discussion questions.

Week 6 Slides with Commentary

Slide 1



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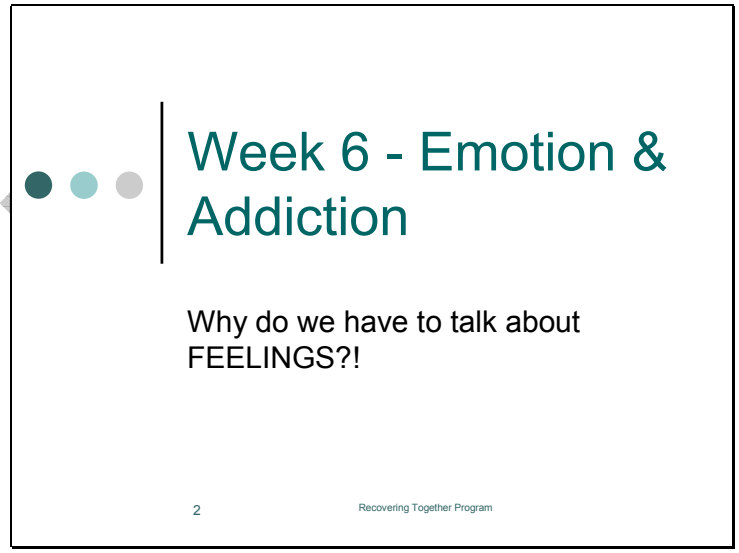
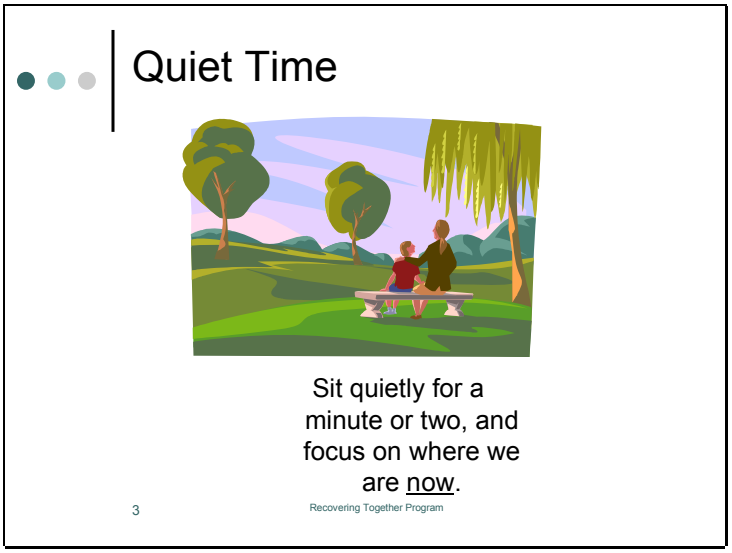
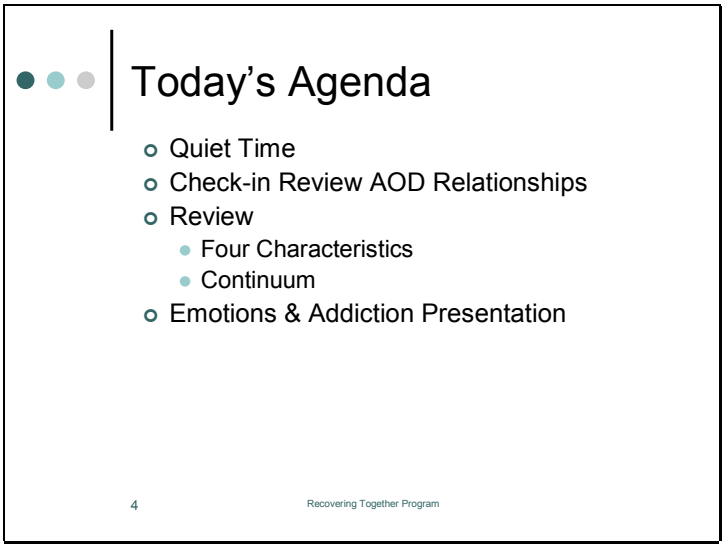


Slide 3



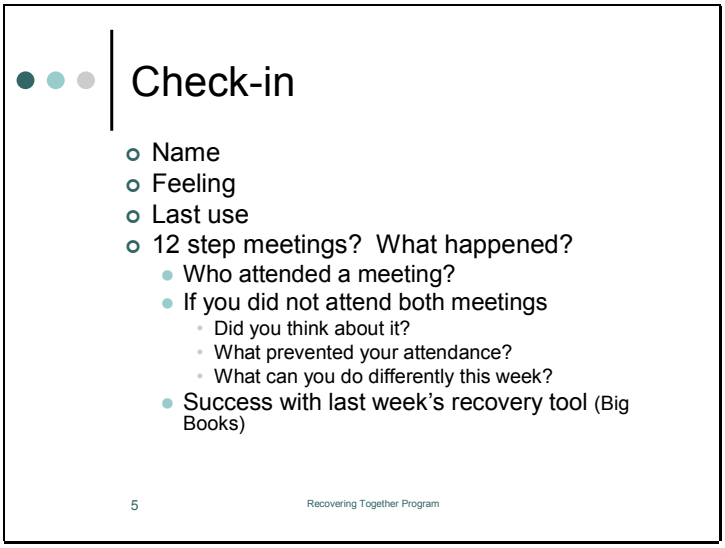
Emotional Exploration. A relaxation exercise that is basically progressive relaxation, but adds instruction about noticing their feelings. Once they are in a relaxed state, ask them to turn their attention toward any physical sensations linked to emotions. Sometimes it is helpful to use a metaphor such as "fishing"; visualize casting a lure and waiting to see what rises to the surface. Use any metaphor common in the local culture that would relate to quiet exploration.

Slide 4



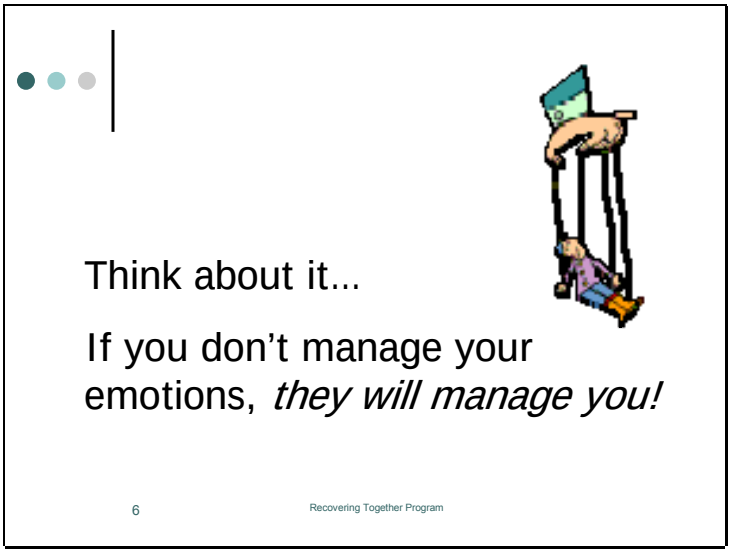
Learn about emotions as a neurological reality and how they are connected to the neurobiology of addiction. Learn the importance of identifying, managing and expressing feelings for recovery success.

Slide 5



Before check-in, remind the participants that they need to use a descriptive feeling word. Joke with them that if they have been consistently vague about their feelings, they are not going to have any more chances to do that. The check-in must include specific information about their current feelings – perhaps insights they discovered during Emotional Exploration. Always include check-in about most recent drug use and recovery activity attendance.

Slide 6

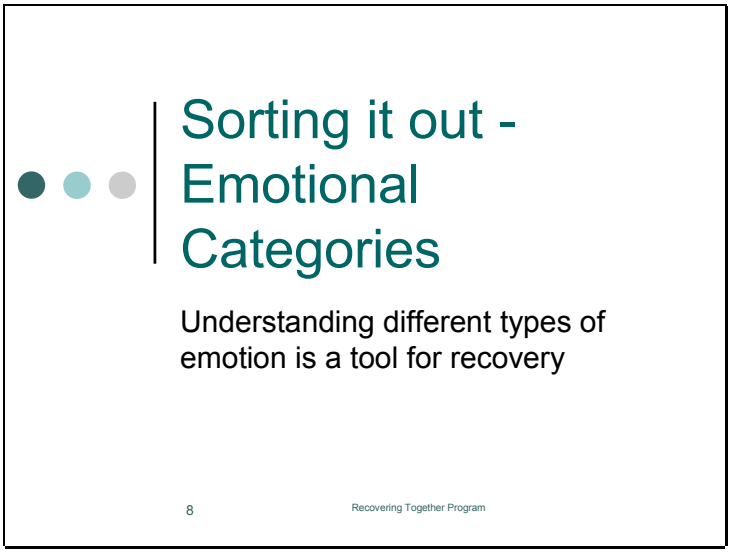


Participants should locate their Continuum and Four Characteristic handouts. With the handouts face down, see if the group can collaborate and remember all four of the characteristics. Each person should come up with one until all four have been reached. Ask them if anybody has changed her mind about where she is on the drug relationship continuum. Have each participant locate her relationship with alcohol, if they have not done so already.

Slide 7

This activity uses multi-colored yarn. Have participants hold the yarn and clip it off so their piece is about 2-3 feet long. Each participant should tie the two ends in a knot. Have them make a 'Cat's Cradle' or another type of knot to represent their personal tangle of various emotions. Talk about how on a bad day, they get more and more twisted (twist your own yarn while describing this). The resulting knot may feel overwhelming. If we struggle and tug at the knot it gets worse. If we ignore it, there it will sit until we are ready to deal with it. It is necessary to untangle the knot and separate the strands in order to use the feelings. In today's presentation, we will learn how feelings can be useful, but must be untangled before we can effectively harness their power. The power of emotion is huge – they will understand why after the presentation. Have them toss the instructor's knot around while discussing this metaphor as a group.

Slide 8



Tell them to keep that piece of string as a reminder to untangle their emotions. If they are having a hard day, then it's time to stop and separate the strands. Show them the Seven Emotions for Addiction Treatment chart and let them know you will explain it during the presentation after break.

Slide 9

Categories of Emotions

- **Are there basic emotions**
- Plutchik (1994) suggests there are eight basic emotions, grouped in pairs of opposites…

15.1 Basic Emotions In this proposed organizational scheme, the eight basic emotions appear across from their opposites at the middle level. Lower and higher intensity forms of each basic emotion appear at the bottom and top levels, respectively. (Modified from Plutchik, 1994.)

(Rosenzweig, Breedlove & Leiman, 2002).

9 Recovering Together Program

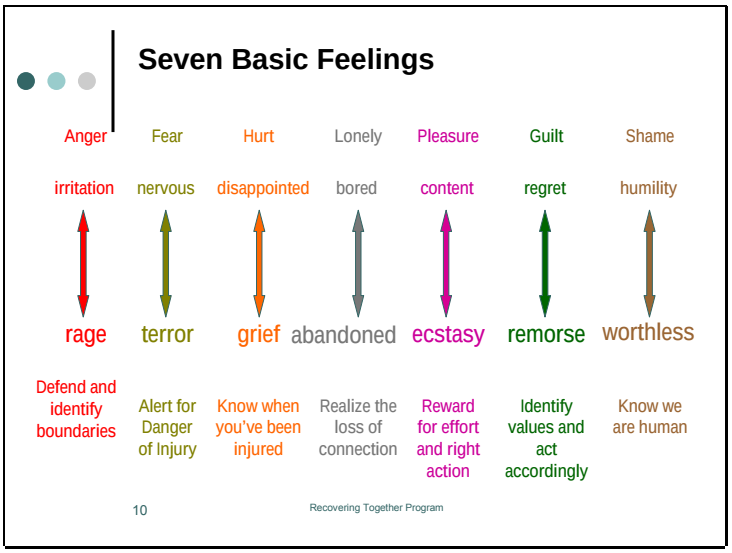
Important introduction to this presentation: Explain you are going to try to respect their intelligence, and at the same time appreciate that they are just starting to clear their heads from using drugs or alcohol for quite a while. This presentation is interesting but also contains a lot of information. If they start to feel overwhelmed, just review their Seven Emotions handout.

You are going to talk about the actual biology of the brain. Let them know that it's not important that they remember specific names of the brain parts, only the major concepts. If they don't understand something, make a big question mark on their notes page. Come back to those questions later or immediately during the presentation.

Emotional Education is a fairly unique approach in the Recovering Together program based on very recent research. They may never have been introduced to this information in any other treatment program or in the media. Make sure you leave plenty of time for the discussion questions.

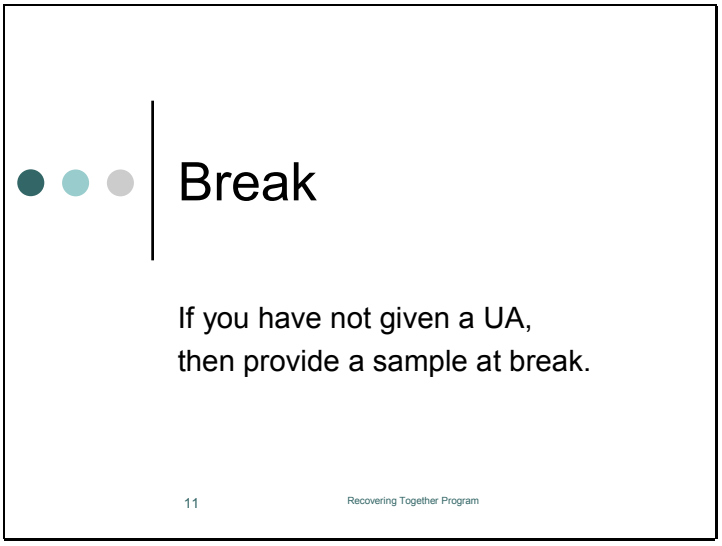
Rosenzweig, M.R., Breedlove, S.M., & Leiman, A.L. (2002). Biological psychology: An introduction to behavioral, cognitive, and clinical neuroscience (3rd ed). Sunderland, MA: Sinauer Associates. Fig. 15.1, p. 470

Slide 10

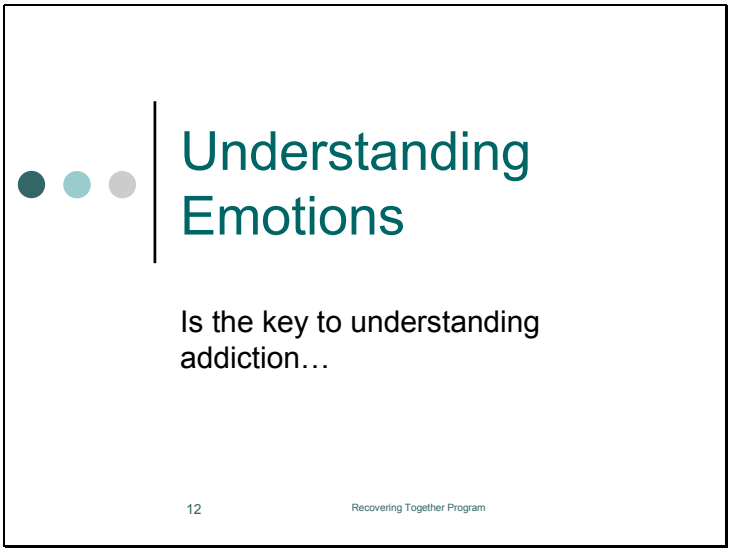


These seven basic feelings were first introduced to the author by staff at the Meadows treatment center in Wickenberg, Arizona.

Slide 11



Slide 12



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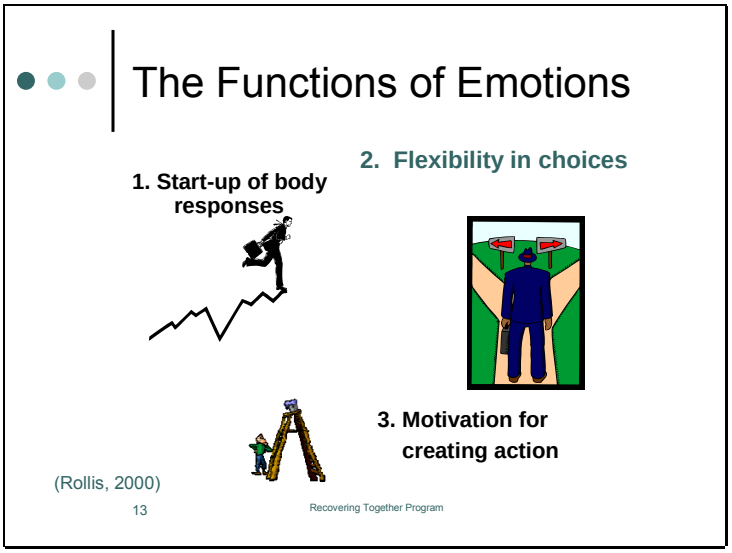

Rollis, E.T. (2000). Precis of The brain and emotion. Behavioral and Brain Sciences. 23:2, 177-234.

Microsoft Corporation. (n.d.) Microsoft Design Gallery. [Clipart]. Retrieved on June 6, 2002 from http://dgl.microsoft.com

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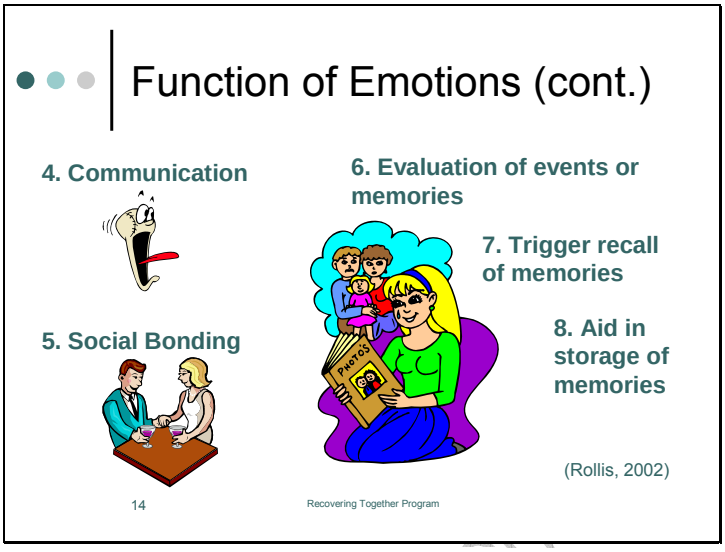


Rollis, 2000.

Slide 15

Functions of Emotions (cont.)

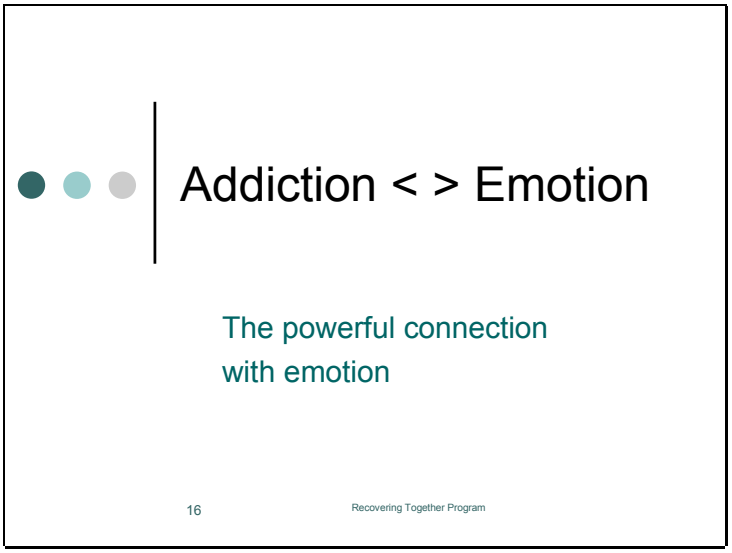
9. Help to achieve GOALS by producin *persistent and continuing* motivation and direction for behavior

(Rollis, 2002)

15 Recovering Together Program

Rollis, 2000.

Slide 16



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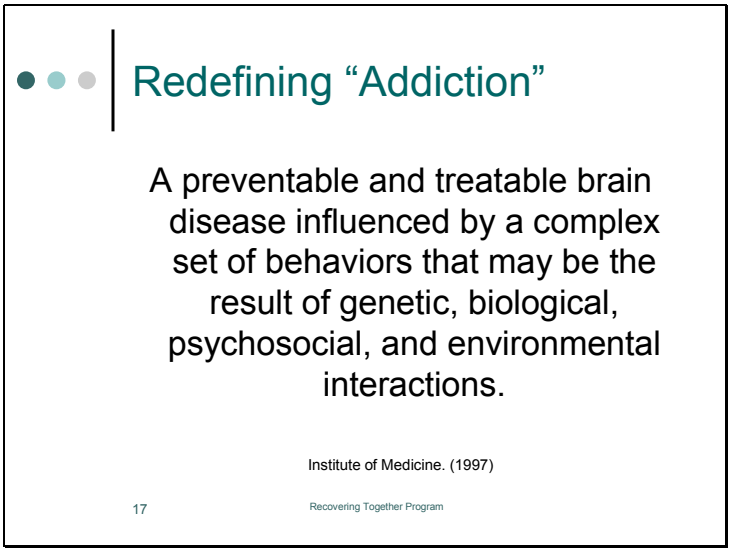

Institute of Medicine. (1997). *Dispelling the myths about addiction: Strategies to increase understanding and strengthen research.* Washington, D.C.: National Academy Press. Retrieved on April 13, 2002 from http://www.netlibrary.com/urlapi.asp?action=summary&v=1&bookid=964

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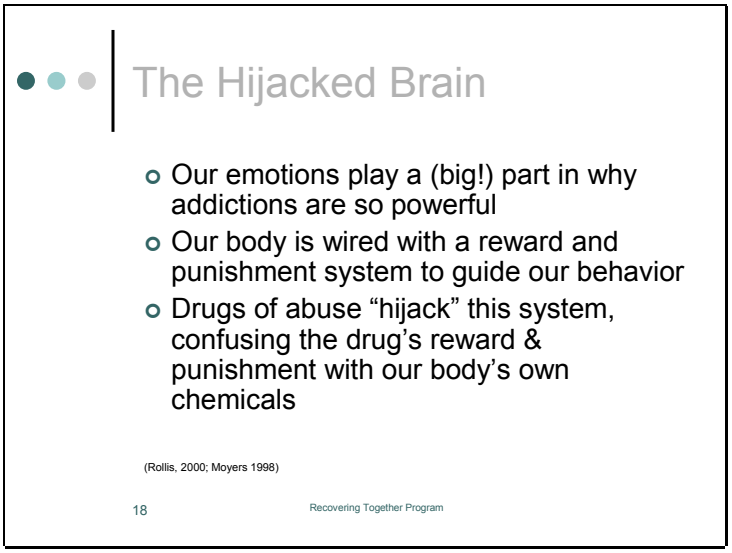

Rollis, 2000.

Moyers, B. (1998). Moyers on addiction: Close to home. *The Hijacked Brain.* [Motion Picture]. Public Affairs Television Inc.

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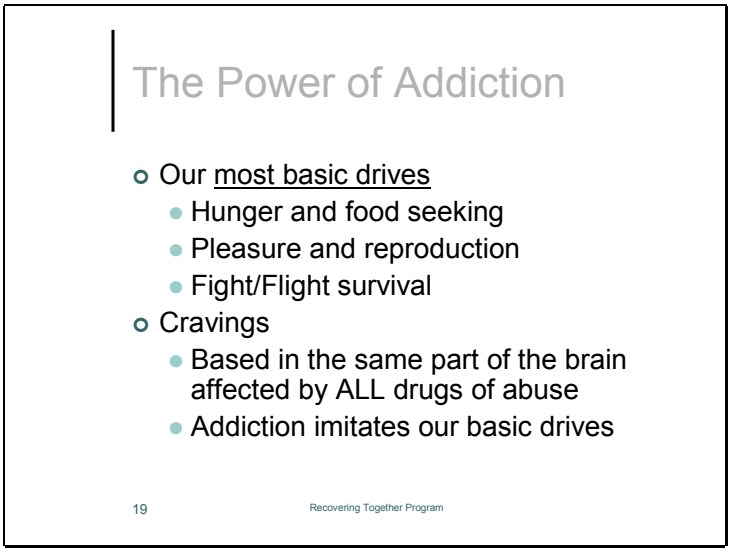
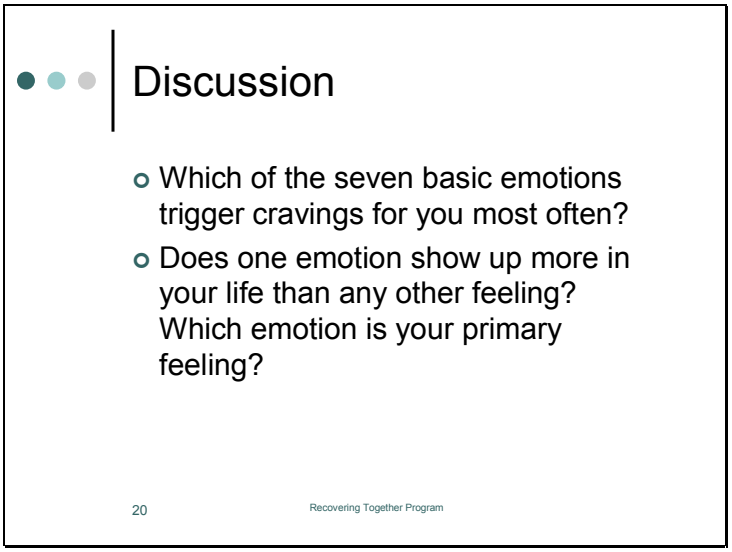


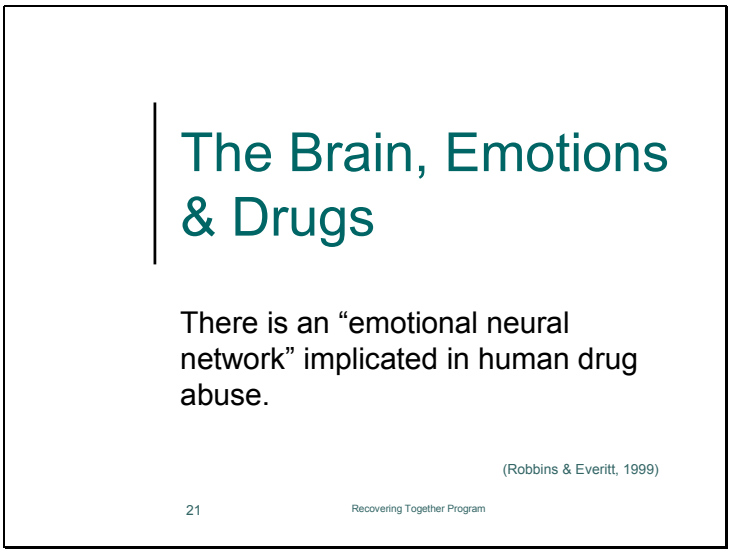
Perception of the author based on the evidence presented in this presentation, and cited research sources

Slide 20



We are providing more information on this topic in today's handout. Please read that and talk to your counselor about questions.

Slide 21



Robbins, T. W., & Everitt, B. J. (1999). Interaction of the dopaminergic system with mechanisms of associative learning and cognition. *Psychological Science, 10*(3), 199-202. Retrieved May 30, 2002, from http://www.ebsco.com/online/direct.asp?ArticleID=6LA41CW6800EXPKRTKAQ

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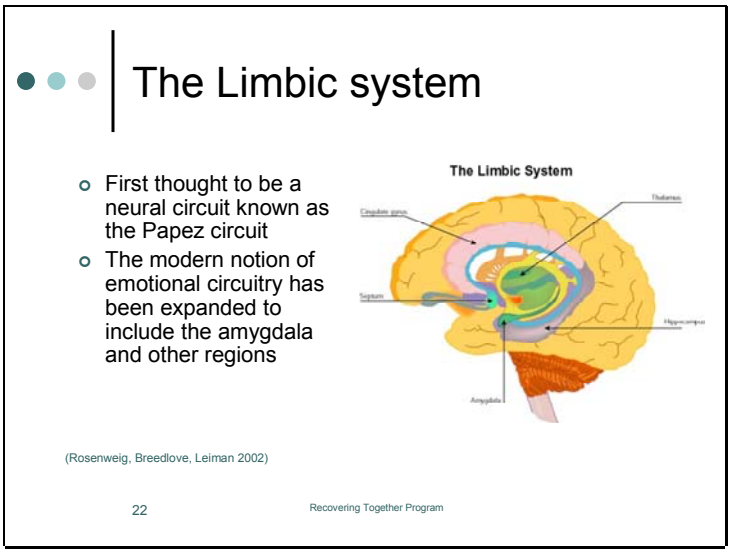

Rosenzweig, M.R., Breedlove, S.M., & Leiman, A.L. (2002). *Biological psychology: An introduction to behavioral, cognitive, and clinical neuroscience*, (3rd ed). Sunderland, MA: Sinauer Associates. p. 479

Drawing by Brent Humphries, retrieved on June 10, 2002 from http://ola.aacc.cc.md.us/psy214/dopamine.htm.

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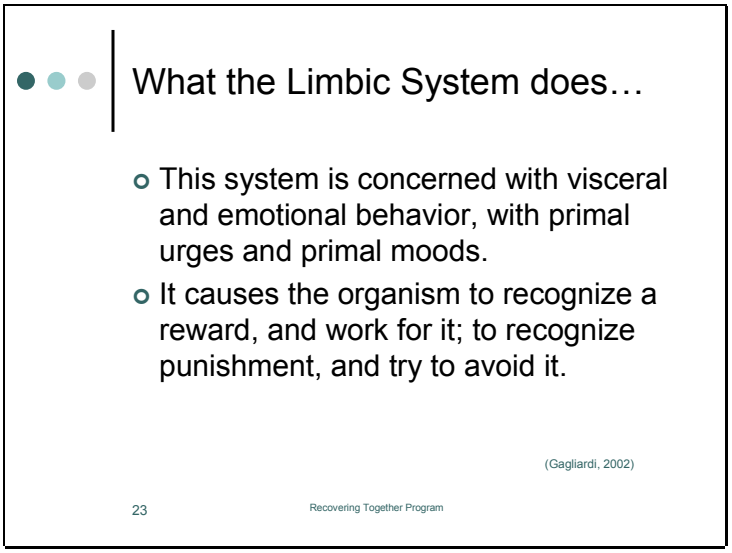

Gagliardi, S. (n.d.) Limbic system: *Visceral behaviors, emotion, and memorization*. Retrieved on May 9, 2002, from http://omeweb.umassmed.edu/curriculum/MBB1/MBBHTML/FB/LimbicOverviewFrames.html.

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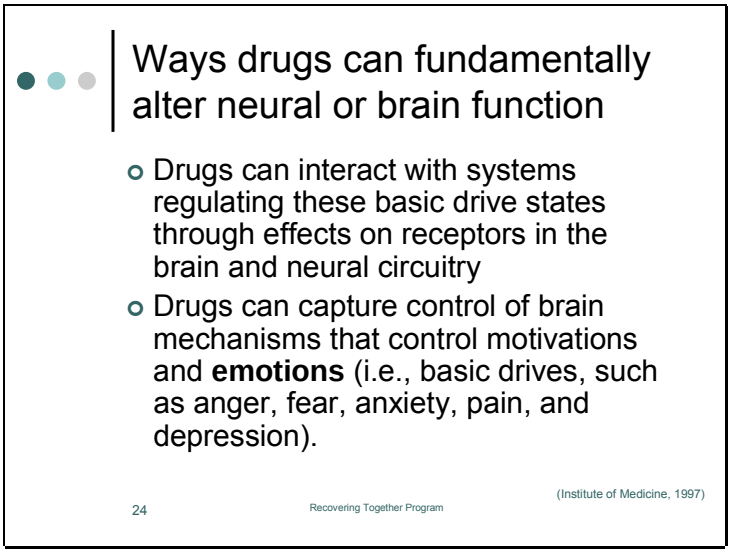

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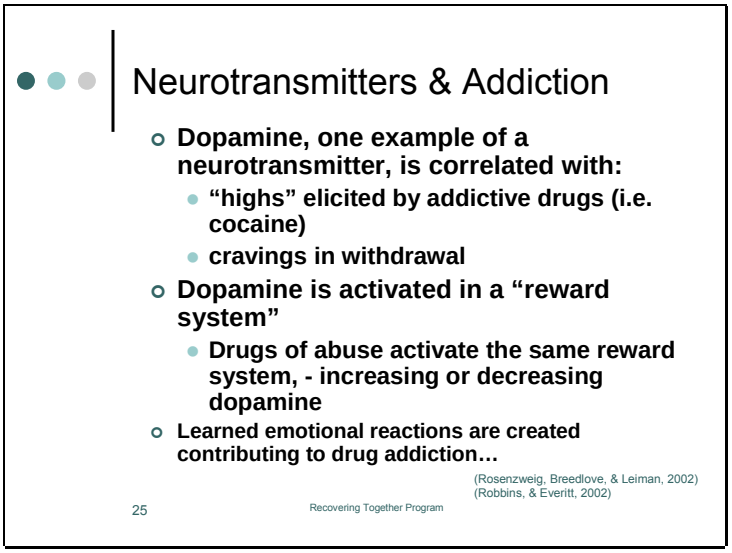

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Rosenzweig, M.R., Breedlove, S.M., & Leiman, A.L. (2002). *Biological psychology: An introduction to behavioral, cognitive, and clinical neuroscience*, (3rd ed). Sunderland, MA: Sinauer Associates.

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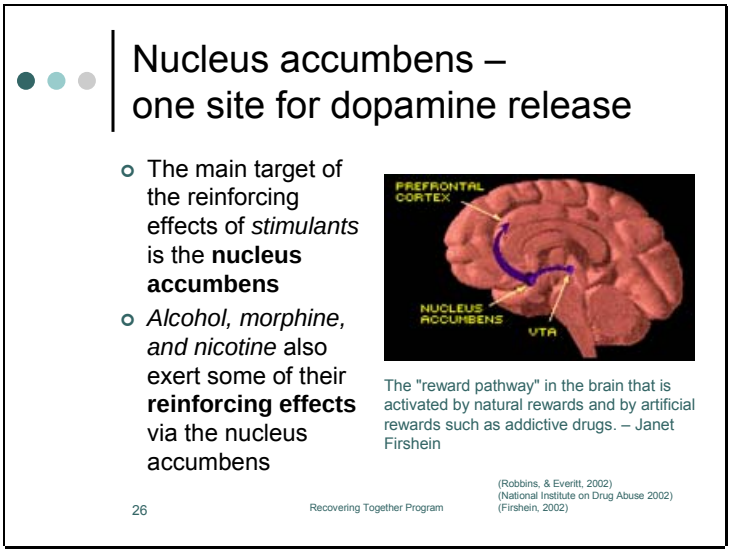

Robbins and Everitt, 1999.

Slide from National Institute on Drug Abuse; Slide Teaching Packet I, *For Health Practitioners, Teachers and Neuroscientists*. Retreived on June 9, 2002, from http://www.nida.nih.gov/Teaching/largegifs/slide-20.gif

Firshein, J. (n.d.) *Do All Drugs Affect the Brain Similarly?* PBS Online, Retrieved on June 10, 2002, from http://www.pbs.org/wnet/closetohome/science/html/similar.html

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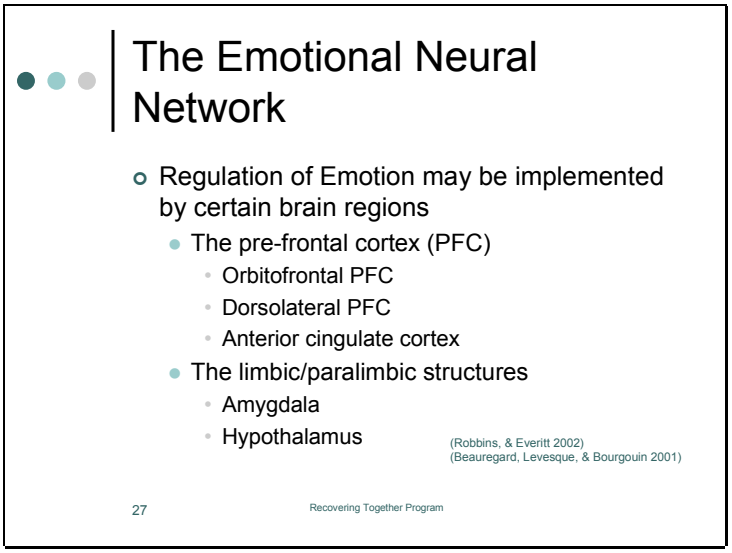

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Beauregard, M., Levesque, J. & Bourgouin, P. (2001). Neural correlates of conscious self-regulation of emotion. *The Journal of Neuroscience, (21),* RC165. Available at http://www.jneurosci.org/cgi/content/full/21/18/RC165

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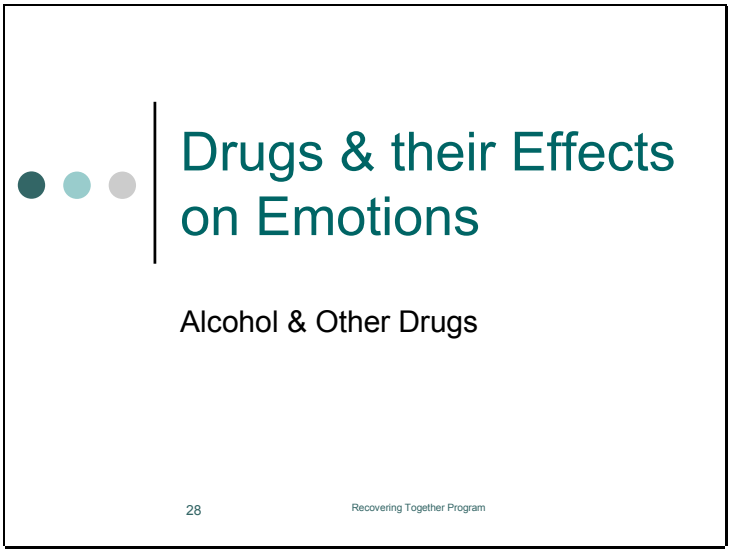

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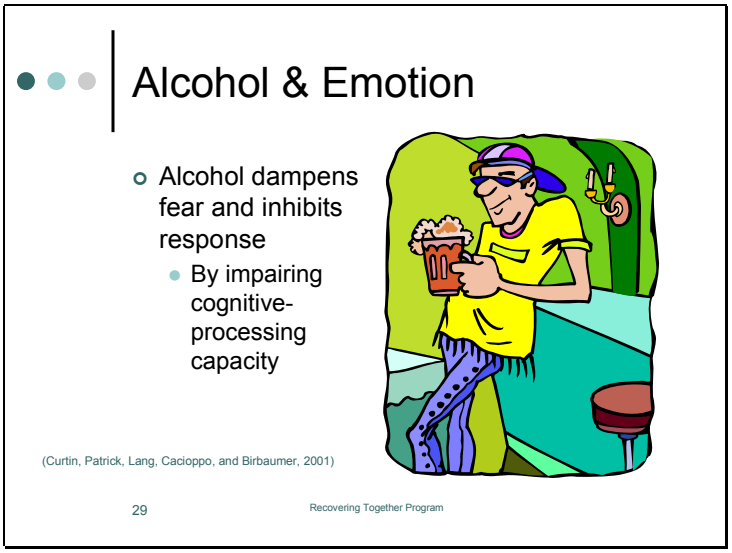

Curtin, J. J., Patrick, C. J., Lang, A. R., Cacioppo, J.T., and Birbaume, N. (2001, October). Alcohol affects emotion through cognition. *Psychological Science*, (12)6, p. 527-531, Retrieved May 30, 2002, at http://www.ebsco.com/online/direct.asp?ArticleID=A1AD7A7KWJL80AMQB78A

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Curtin, et al., 2001.

Microsoft Corporation. (n.d.) Microsoft Design Gallery. [Clipart]. Retrieved on June 6, 2002, from http://dgl.microsoft.com

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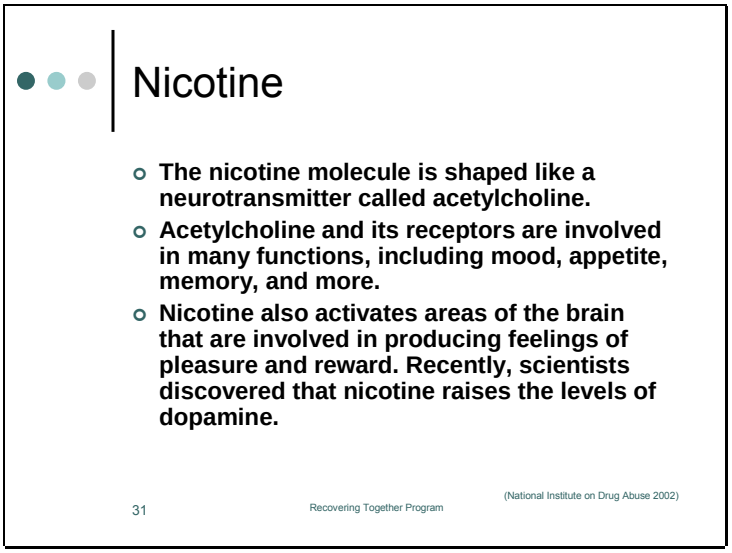

National Institute on Drug Abuse. (1998). *Mind over matter: Nicotine series*. NIH Publication No. 98-4248. National Institutes of Health. Retrieved on June 11, 2002, from http://www.nida.nih.gov/MOM/NIC/MOMNIC2.html

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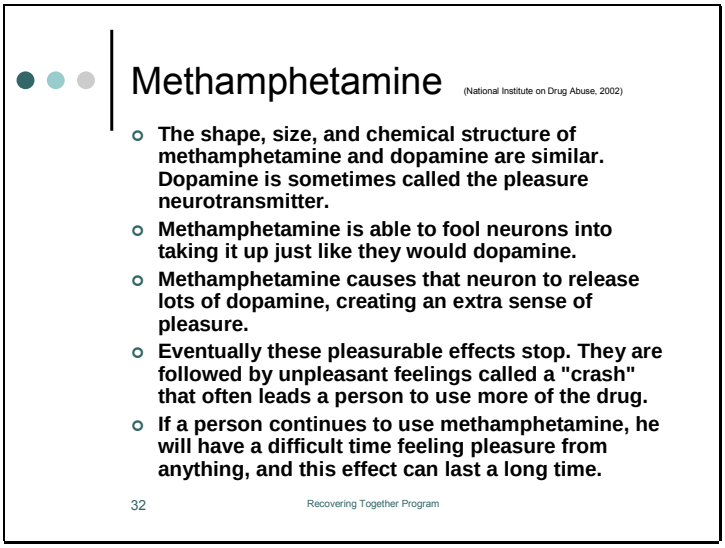

National Institute on Drug Abuse. (n.d.) *Mind over matter: Methamphetamine Series*. National Institutes of Health, Retrieved on June 11, 2002, from http://www.nida.nih.gov/MOM/METH/MOMMETH2.html

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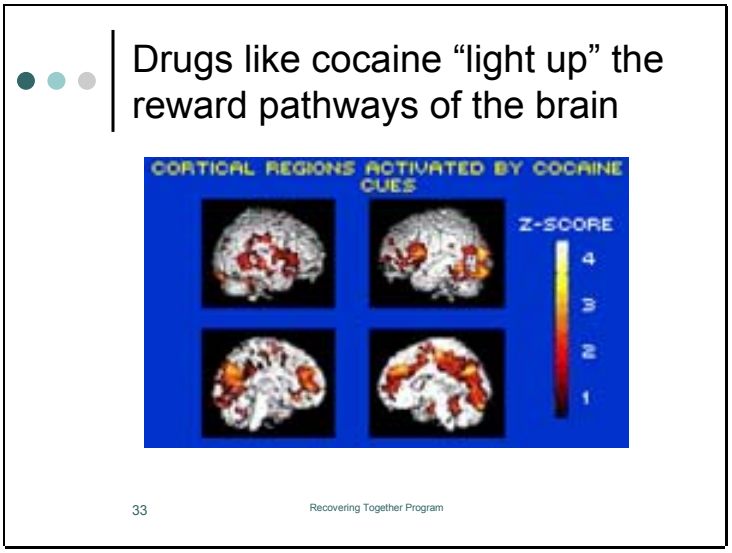

National Institute on Drug Abuse. (2001.) Slide Teaching Packet I, *For Health Practitioners, Teachers and Neuroscientists*, Retrieved on June 9, 2002, from http://www.nida.nih.gov/Teaching/largegifs/slide-20.gif

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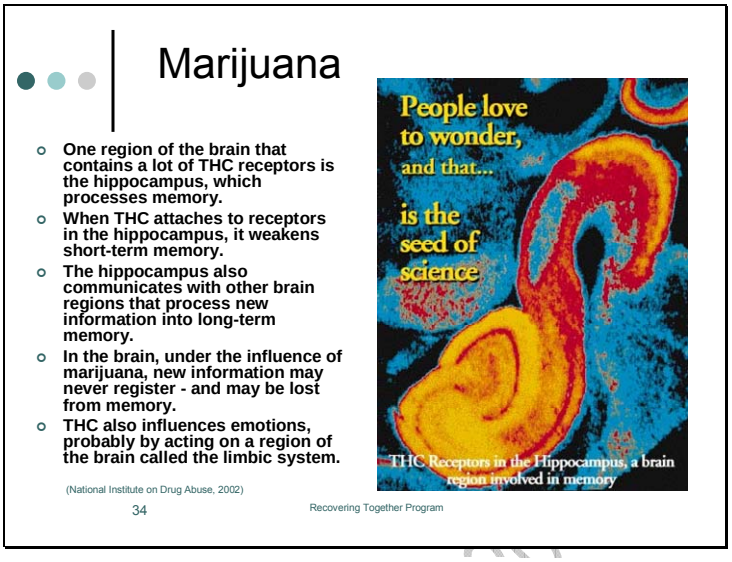


National Institute on Drug Abuse. (n.d.). Mind *over matter: Marijuana series*. National Institutes of Health, Retrieved on June 11, 2002, from http://www.nida.nih.gov/MOM/MJ/MOMMj4.html

Photo: Miles Herkenham, NIH, Retrieved from http://www.nida.nih.gov/MOM/MJ/MOMMJ5.html

Week 7 - Relapse and Craving

Main Idea of Session

Relapse is a process, not an event, and craving may be regarded as a warning sign from your brain of emotional deregulation.

- Understand the relapse cycle
- Perceive the connection between emotional experience and the relapse process
- Learn the skill of "urge surfing"
- Learn how relapse is related to motivation and stages of change
- Increase self efficacy as it is related to relapse triggers

The concept of "urge surfing" is adapted in general from Dialectical Behavior Therapy (Linehan, 1994) and specifically from a presentation by Deborah Safer, M.D. for the California Society of Medicine (Safer, 2003).

Materials/Equipment Needed

- Materials
  - Presentation file or overhead transparencies
  - Relationship with Drugs Continuum handout (for anyone who didn't get one last session)
  - Key Feeling chart (for anyone who didn't get one last session)
  - Relapse Warning Signs checklist
  - Relapse and Craving handout
  - Stages of Change handout
- Equipment
  - LCD or overhead projector; screen
  - Computer with PowerPoint or Adobe Reader (for LCD) or transparencies for overheads
  - Copy or fax machine for attendance sheets
  - Drug testing supplies, as needed

Session Overview

Quiet Time

Check-in

What is Craving?

Urge Surfing Activity

Break

Change and Relapse

Recovery Topic and Tool 7

Week 7 Activities

Time	*Activity and/or Slides*	*Facilitator Process Notes*
10 min	**1. Quiet Time** **Slide 3**	Quiet Beach Experience. After following a basic relaxation routine, lead participants in a visualization of watching waves roll in while standing on a peaceful beach. Use sensory cues like smell, sound and tactile sensations of sun and breeze. Emphasize the quiet observation of the rolling waves from the safety of the firm, warm sand.
20 min	**2. Check-in** **Slide 4-6**	Note in here what they are to check-in with. Have a Key Feeling Chart available for check-in and let the participants share it in order to become more proficient at identifying their feelings. Encourage participants to self-monitor or monitor each other on whether they really understand after somebody's check-in how that woman is feeling.

Craving and Urges

Time	*Activity and/or Slides*	*Facilitator Process Notes*
15 min	**3. What is Craving** **Slide 7-10**	This section introduces the terminology of craving and urges. These challenges are identified as reactions to emotional states and some factors which may trigger those feelings are identified. The continuum concept is applied to the levels of pleasure and discomfort which are closely related to relapse, craving and urges.

Urge Surfing Activity

Time	*Activity and/or Slides*	*Facilitator Process Notes*
10 min	**4. Urge Surfing Activity** **Slide 11**	Ask participants if they have ever been to the beach. If not, ask about any nearby body of water. Once the concept of waves is clear, discuss the concept of "Urge Surfing". Lead the group in using one of their own examples of a craving trigger. Help them make the connection between the "wave" concept and urges to act on their addiction. Urge surfing involves awareness without mindlessly giving in to the urge, like a surf board riding the waves. One simply notices and describes, moment to moment, the ebb and flow of the urge without reacting to it (Safer, 1999).
10 min	**Break** **Slide 12**	

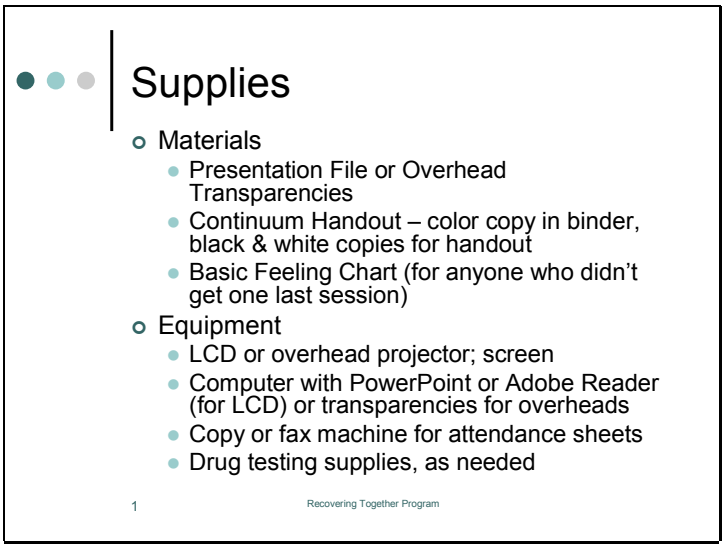
Change and Relapse

Time	*Activity and/or Slides*	*Facilitator Process Notes*

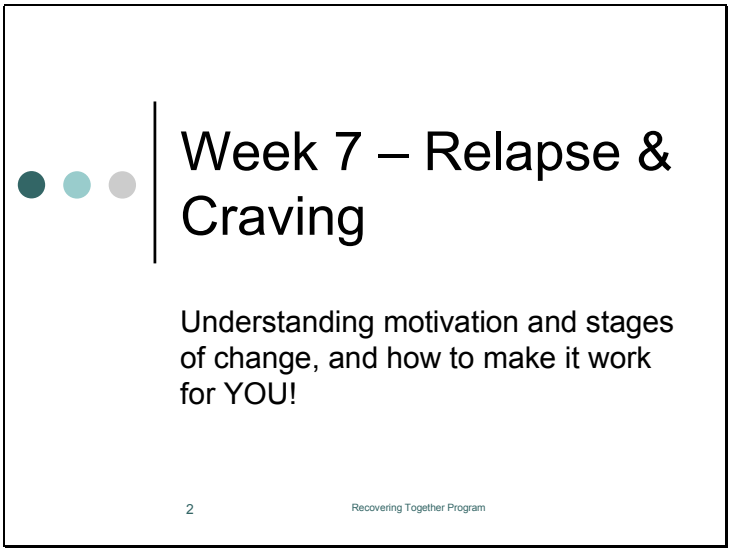
30 min	**5. Stages of Change** **Slide 13-19**	Introduce the concept of motivation for change and do a little brainstorming with the group about what motivates them. Show them the graphic of the Stages of Change. Provide an example of somebody changing something simple like their hair color. Relate how the process works for more difficult life changes such as substance abuse or eating/exercise habits. Refer back to last week's connection between addiction and emotion. How does emotion make those changes more challenging? Are the stages of change different or the same for simple vs. complex changes? Introduce the concept of how change gets easier over time with more practice and this will introduce the topic of self-efficacy. Show them the Steps to Relapse Prevention and give them a handout on that and walk them through their last relapse and prevention of additional relapse.
15 min	**6. Recovery Tool 7** **Slide 21**	The Recovery Topic is HALT (hungry, angry, lonely, and tired). The tool is a post-it pad that participants write HALT upon. Instruct participants to put HALT notes on the fridge, the bathroom mirror, their dashboard, etc. The best way to prevent relapse is to become more mindful about and take time to meet their personal needs. It's a good idea to HALT periodically and check to see if you are hungry, angry, lonely, or tired. If so, the best way to avoid relapse is to immediately make plans to attend to all of those things, if not in that moment, within the next 24 hours. For instance, get some sleep that night, make arrangements to have a good meal, talk through conflict if you are angry, and call a friend or spend some time with somebody who you trust.

Week 7 Slides with Commentary

Slide 1



Slide 2

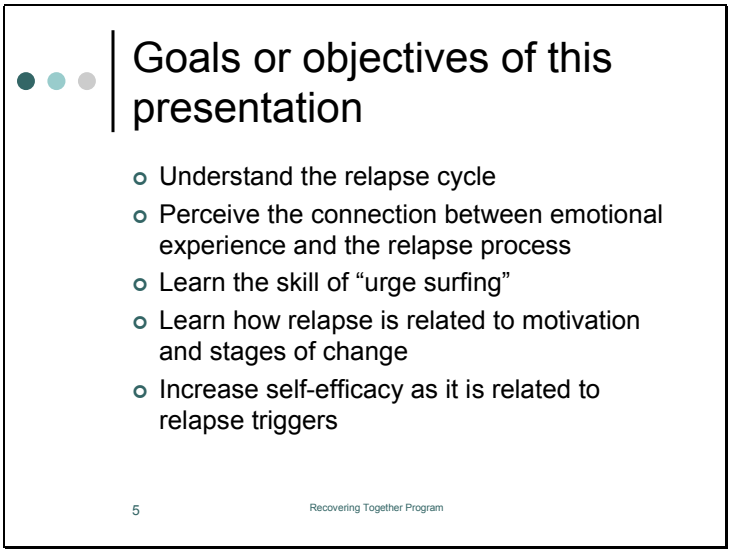


Slide 3

Quiet Beach Experience: After following a basic relaxation routine, lead participants in a visualization of watching waves roll in while standing on a peaceful beach. Use sensory cues like smell, sound and tactile sensations of sun and breeze. Emphasize the quiet observation of the rolling waves from the safety of the firm, warm sand.

Slide 4

Slide 5



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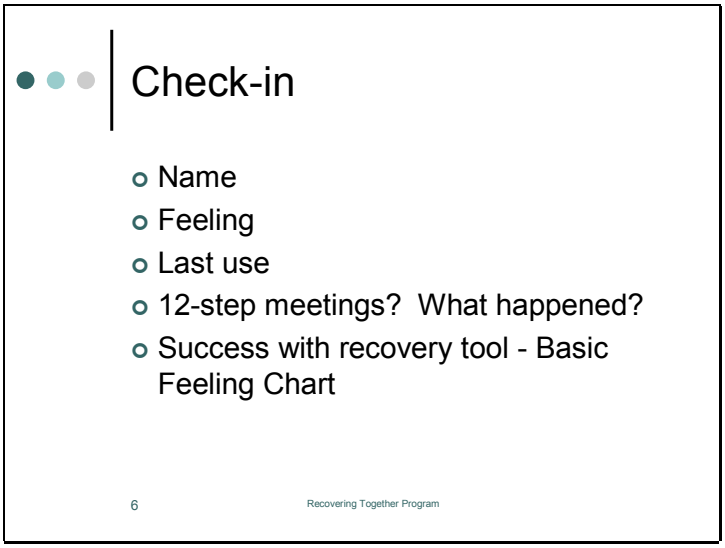
Slide 6



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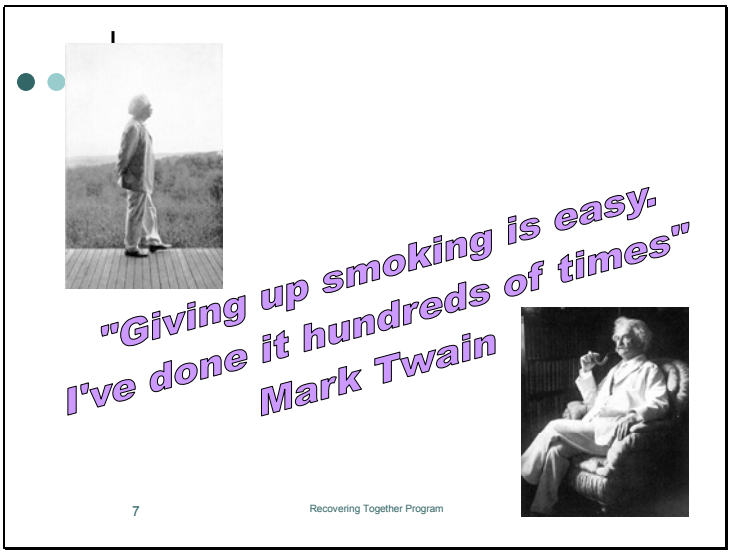
Slide 7



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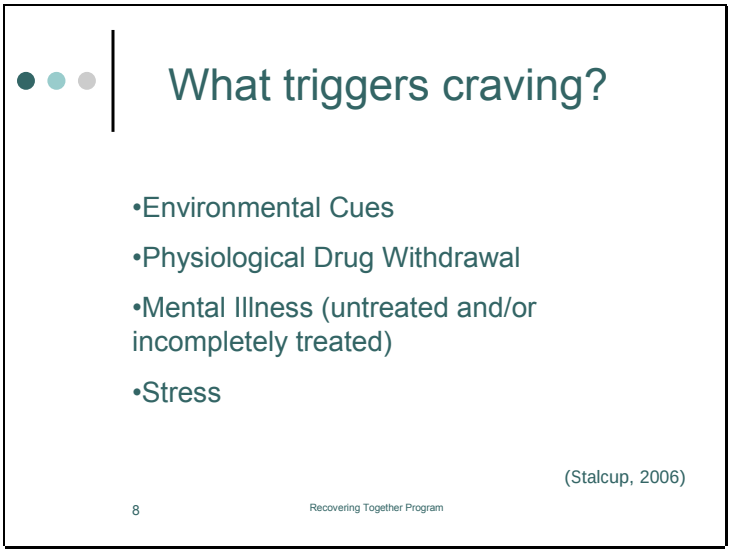

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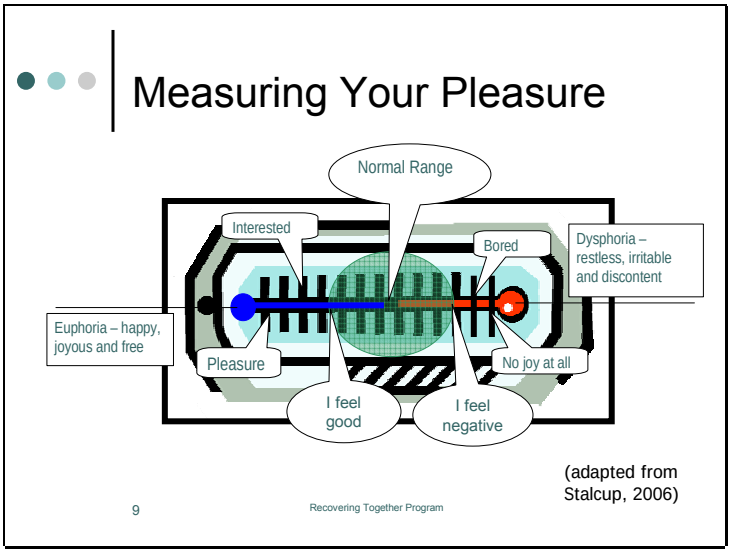
Slide 9



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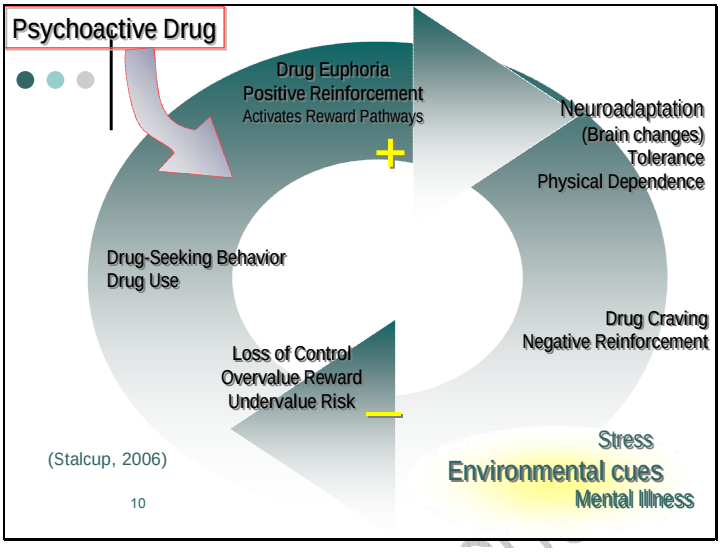

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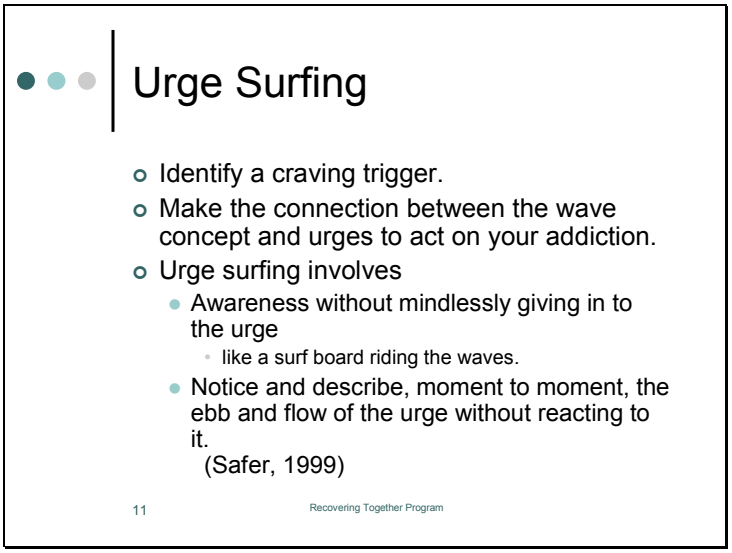

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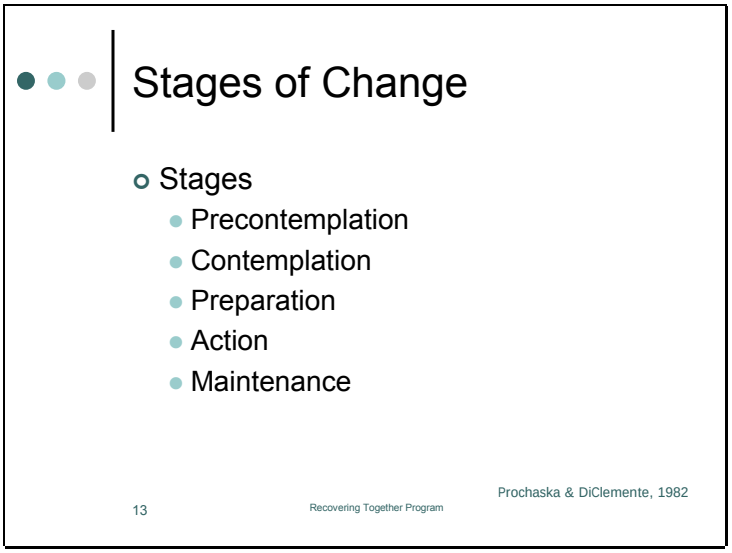
Slide 12

Check-in & Break

Slide 13

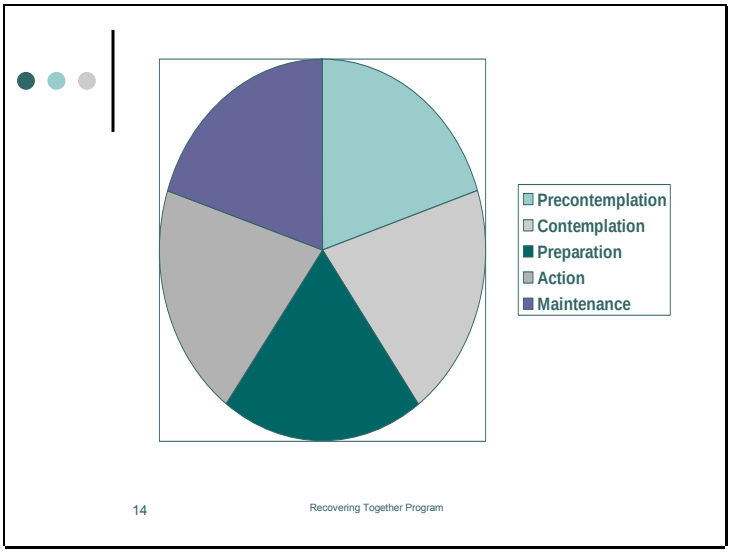


Introduce the concept of motivation for change and do a little brainstorming with the group about what motivates them. Show them the graphic of the Stages of Change. Provide an example of somebody changing something simple like their hair color. Relate how the process works to harder changes like substance abuse or eating/exercise habits. Refer back to last week's connection between addiction and emotion. How does emotion make those changes more challenging? Are the stages of change different or the same for simple vs. complex changes?

Introduce the concept of how change gets easier over time with more practice and this will introduce the topic of self-efficacy. Show them the Steps to Relapse Prevention and give them a handout on that and walk them through their last relapse and prevention of additional relapse.

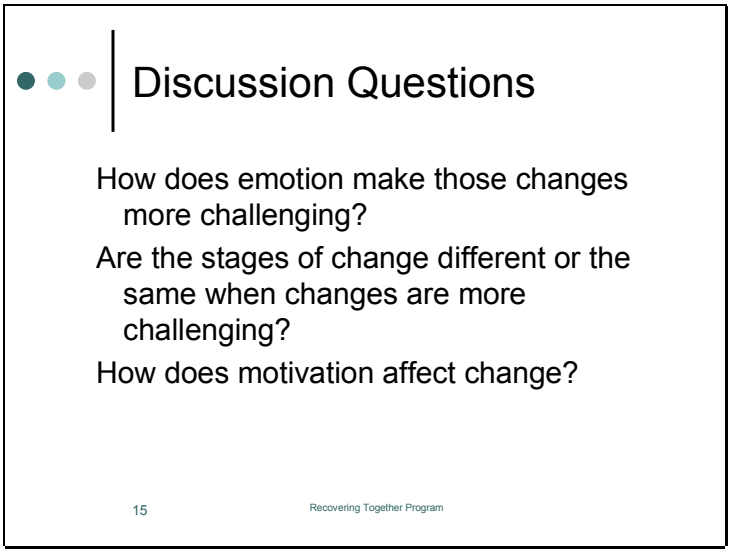
Prochaska, J.O., & DiClemente, C.C. (1982). Transtheoretical therapy toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*, 19(3), 276-287.

Slide 14

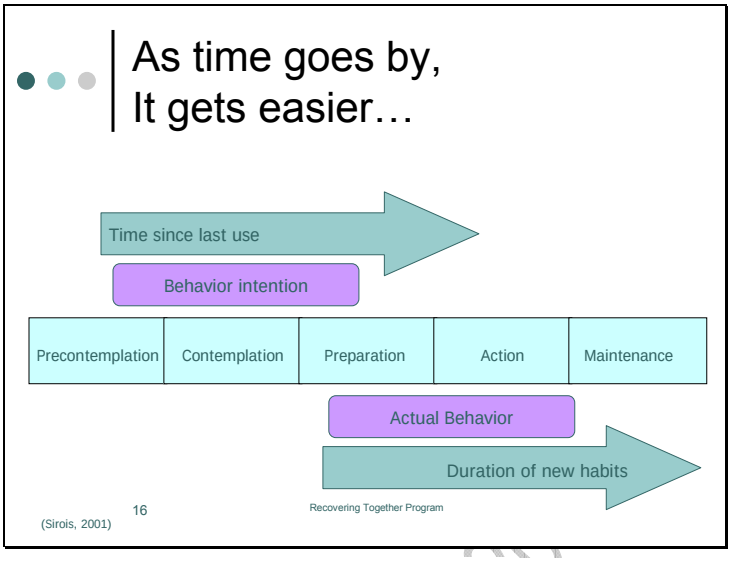


Prochaska, J.O., & DiClemente, C.C. (1982). Transtheoretical therapy toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*, 19(3), 276-287.

Slide 15

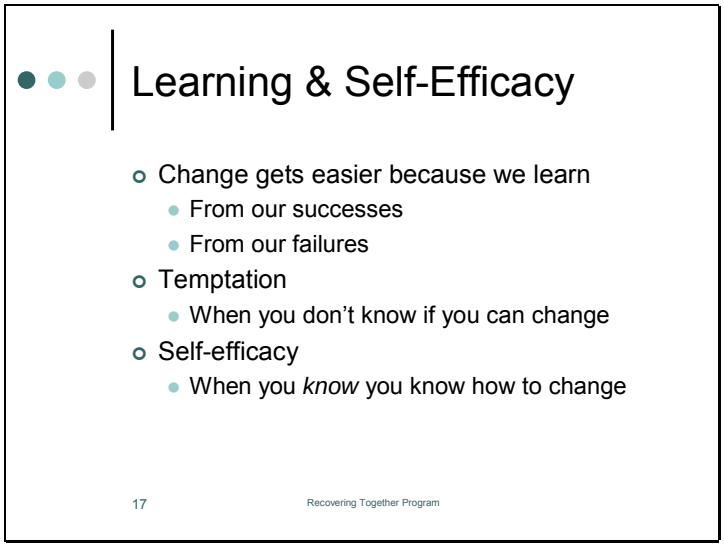

Discussion Questions
How does emotion make those changes more challenging?
Are the stages of change different or the same when changes are more challenging?
How does motivation affect change?
15
Recovering Together Program

Slide 16

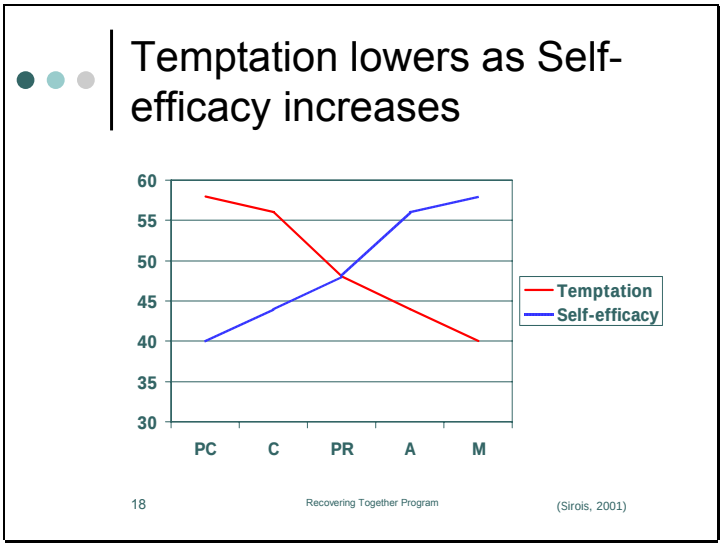


Sirois, F. (2001). Psychology of Motivation and Emotion. *Drug use, addiction, and treatment – Class 5.* Retrieved on February 9, 2004, from http://www.carleton.ca/~fsirois/49345A/49345class5.PDF

Slide 17


Learning & Self-Efficacy
Change gets easier because we learn
From our successes
From our failures
Temptation
When you don't know if you can change
Self-efficacy
When you know you know how to change
17
Recovering Together Program

Slide 18

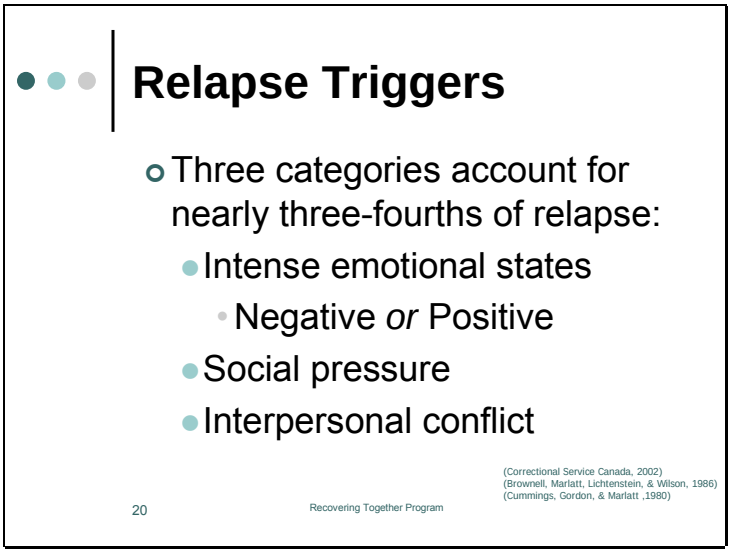


Sirois, 2001.

Slide 19

Correctional Service Canada. (n.d.). In *Relapse Technique*. Retrieved September 19, 2002, from http://www.csc-scc.gc.ca/text/pblct/litrev/treatmod/lit21e.shtml

Slide 20

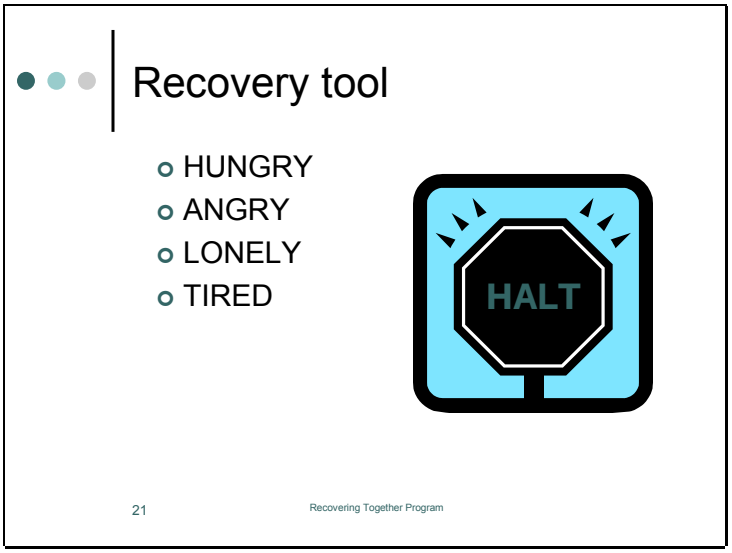


Correctional Service Canada. (n.d.). In *Relapse Technique*. Retrieved September 19, 2002, from http://www.csc-scc.gc.ca/text/pblct/litrev/treatmod/lit21e.shtml

Brownell, K. D., Marlatt, G. A., Lichtenstein, E., & Wilson, G. T. (1986), Understanding and preventing relapse, *American Psychologist*, 41, 765-782.

Cummings, C., Gordon, J. R., & Marlatt, G. A. (1980), Relapse: Prevention and prediction, In W. R. Miller (Ed.), *Addictive Behaviors* (pp. 291-321). New York: Pergamon Press.

Slide 21



The Recovery Topic is HALT (hungry, angry, lonely, and tired). The tool is a post-it pad that clients write HALT upon. Instruct participants to put HALT notes on the fridge, the bathroom mirror, their dashboard, etc. The best way to prevent relapse is to become more mindful about, and take time to meet their personal needs. It's a good idea to HALT periodically and check and see if you are hungry, angry, lonely, or tired. If so, the best way to avoid relapse is to immediately make plans to attend to all of those things, if not in that moment, within the next 24 hours. For instance, get some sleep that night, make arrangements to have a good meal, talk through conflict if you are angry, and call a friend or spend some time with somebody who you trust.

Week 8 – Self Esteem and Self Efficacy

Main Idea of Session

Understand that self-esteem grows from messages we tell ourselves and what others tell us, and how that relates to recovery. Distinguish between self-esteem and self-efficacy.

The picture frame activity in this session was contributed by Rhonda Eppard, CACIII from Cortez Addiction Recovery Services.

Materials/Equipment Needed

- Materials
  - Presentation file or overhead transparencies
  - Key Feeling chart – color copy in sheet protector (for check-in)
  - Pieces of paper
  - Washable markers
  - Tape
  - Sticky notes
  - Pens
- Equipment
  - LCD or overhead projector; screen
  - Computer with PowerPoint or Adobe Reader (for LCD) or transparencies for overheads
  - Copy or fax machine for attendance sheets
  - Drug testing supplies, as needed

Session Overview

Quiet time

Check-in

Self-Esteem and self-Efficacy

Recovery tool – Affirmations

Week 8 Activities

Time	*Activity and/or Slides*	*Facilitator Process Notes*
10 min	**1. Quiet Time** **Slides 2- 3**	Quiet time today will be a breathing exercise. Please see Women's Video for demonstration of the breathing exercise.
20 min	**2. Check-in** **Slide 4-5**	Go over the agenda for today. During check-in today ask participants to add a comment about how it went for them last week using the recovery tool of HALT.

Understanding Self-Esteem and Self-Efficacy

Time	*Activity and/or Slides*	*Process Notes*
10 min	**3. Understanding Self-Esteem & Self-Efficacy** **Slides 6-7**	It is important for the participants to understand what self-esteem and self-efficacy mean and the difference between those two terms. Sometimes even counselors are confused about this, so review this section before group and make sure that you understand it.

Messages and Addiction

20 min	**4. Messages and Addiction** **Slides 8-16**	This section explains how low self-esteem relates to addictive behavior. Creating self-efficacy and self-esteem is a strong weapon for fighting addiction. Addiction feeds on negative messages and we just can't afford to pollute our system with those messages. The first step in changing that is learning to recognize old tapes (messages we hear/repeat in our head). This leads to the next slide which talks about polluting messages and introduces the concept of the tape recorder. Ask

		whose voice it might be. Some participants will identify a parent's voice, but it could also be their peers, their teachers or their current sexual partners that criticize and tell them that they are not good enough.
	Break **Slide 17**	

Picture Frame Activity

Time	*Activity and/or Slides*	*Facilitator Process Notes*
25 min	**5. Picture Frame Activity** **Slide 18-20**	This is an activity that helps participants recognize that sometimes even positive messages or compliments can be challenging. One metaphor for this is "starving at the feast" because there are internal barriers to accepting the nurturing available all around us. Give each participant a piece of paper and ask them to draw a picture of a picture frame around the edge of the paper. Tape their picture frames on their back. Participants then write a positive sentence or compliment about each woman in the group in that woman's frame with washable markers. Suggest they write about something that they have noticed or thought about that person. Sometimes it helps to maybe give them a couple of examples, but once they start writing they see other people's examples on the frames.
25 min	**6. Recovery tool 8 –** **Healthy Messages**	This Recovery Tool is jokingly called Sticky Note Therapy, a simple way of getting affirmations posted around the environment of each participant's life. Give each participant a Sticky Note pad and a pen and then help them write at least three affirmations so that they understand the

Slide 21	guidelines of writing an affirmation. • present tense • positive vision • an absence of any kind of negative terms. I call this the "No-nos in affirmations" Everybody should write at least one affirmation on their sticky note pad. Suggest sticking one on the mirror and saying the affirmation out loud while looking themselves in the eye. Sometimes that is too challenging for people. Anywhere they choose to put the affirmation will be OK. Explain that this process requires repetition, and remind them how often they heard the negative messages. They need to hear the positive messages at least that many times. Note: Throughout this session ask participants to notice the physical sensation of pleasure felt when they open up to positive messages. Make sure every participant experiences this at least once. Relate that feeling back to the "short-cut" to good feelings that their addiction provided. Make sure they understand that letting themselves feel the pleasure of self-esteem and self-efficacy protects them and takes the power out of their addiction. Point out that they can move that power back inside them where it belongs with their new tool of positive messages.

Week 8 Slides with Commentary

Slide 1

Supplies

- Materials
  - Presentation File or Overhead Transparencies
  - Continuum Handout – color copy recommended
  - Pieces of paper or Sticky Notes
  - Washable markers
  - Tape
  - Sticky notes
  - Pens
- Equipment
  - LCD or Overhead projector; Screen
  - Computer with PowerPoint or Adobe Reader (for LCD) or transparencies for overheads
  - Copy or fax machine for attendance sheets
  - Drug testing supplies, as needed

1 Recovering Together Program

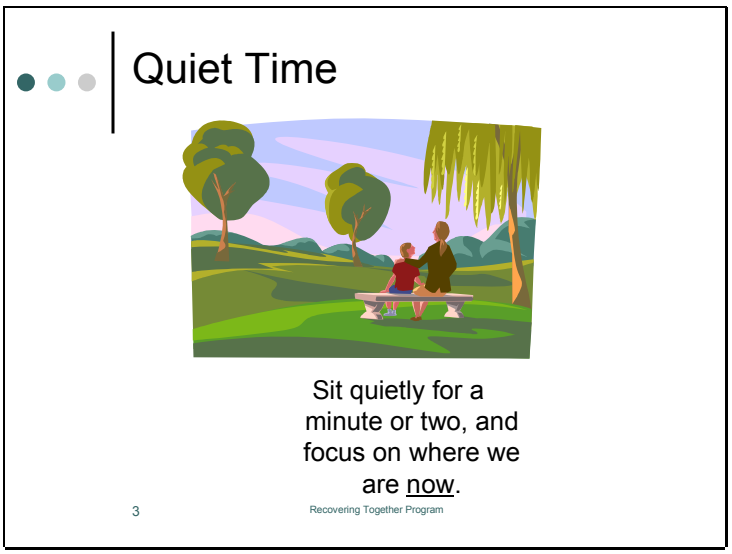
Slide 2

Self Esteem & Self Efficacy

Week Eight

2 Recovering Together Program

Slide 3

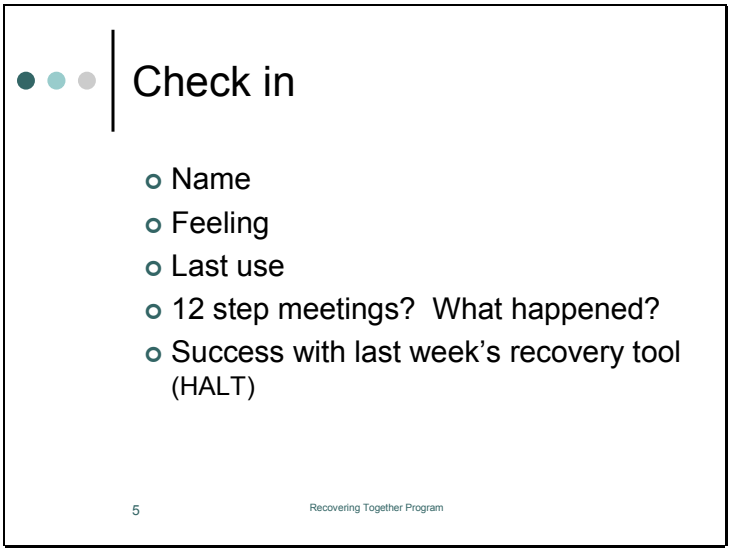


Quiet time today will be a breathing exercise. Please see Women's Video for demonstration of the breathing exercise.

Slide 4

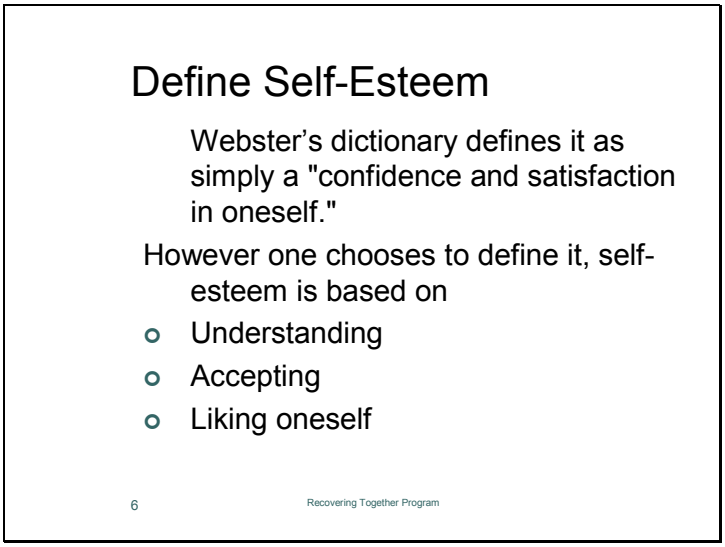
Understand that self-esteem grows from messages, and how that relates to recovery. Distinguish between self-esteem and self-efficacy.

Slide 5



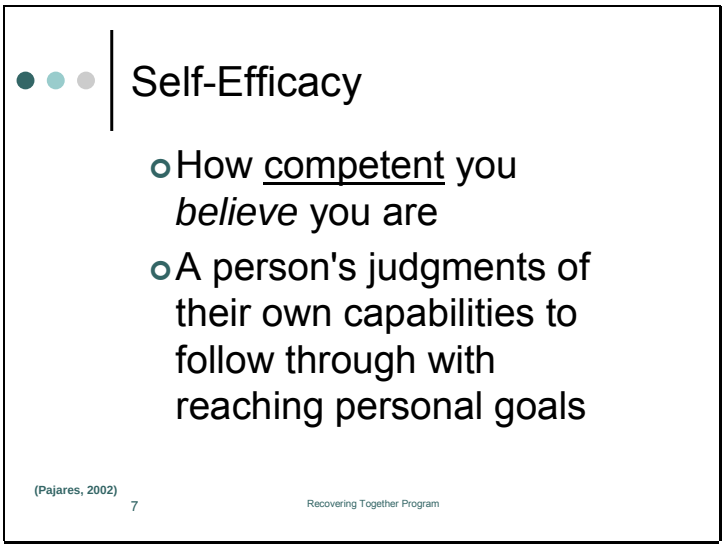
During check-in today we will ask people to add a comment about how it went last week using the recovery tool of HALT.

Slide 6



It is important for the participants to understand what self-esteem and self-efficacy mean and the difference between those two terms. Sometimes even the counselors are confused about this, so review this section before group and make sure that you understand it.

Slide 7



Pajares, F. (2002). *Overview of social cognitive theory and of self-efficacy*. Retrieved 6/1/2007 from http://www.emory.edu/EDUCATION/mfp/eff.html

Slide 8

This section explains how low self-esteem relates to addictive behavior. Creating self-efficacy and self-esteem is a strong weapon for fighting addiction. Addiction feeds on negative messages and we just can't afford to pollute our system with those messages. The first step in changing that is learning to recognize old tapes. This leads to the next slide which talks about polluting messages and introduces the concept of the tape recorder. Ask whose voice it might be. Be prepared that some participants may identify a parent's voice, but it could be their peers, their teachers or their current sexual partners that criticize and tell them that they are not good enough.

Slide 9

Polluting Messages

- Many of the messages we have heard were lies
  - People in our lives sometimes criticized and blamed us –
    so they wouldn't have to be responsible
  - We heard them so many times that we began to believe them…
  - At this point in our lives, these dishonest messages *may seem like* the truth!

An important part of RECOVERY is learning to recognize these "old tapes" and record NEW, HEALTHY messages

9 Recovering Together Program

Slide 10

Response Format

1 = Not at all true
2 = Hardly true
3 = Moderately true
4 = Exactly true

1		I can always manage to solve difficult problems if I try hard enough.
2		If someone opposes me, I can find the means and ways to get what I want.
3		It is easy for me to stick to my aims and accomplish my goals.
4		I am confident that I could deal efficiently with unexpected events.
5		Thanks to my resourcefulness, I know how to handle unforeseen situations.
6		I can solve most problems if I invest the necessary effort.
7		I can remain calm when facing difficulties because I can rely on my coping abilities.
8		When I am confronted with a problem, I can usually find several solutions.
9		If I am in trouble, I can usually think of a solution.
10		I can usually handle whatever comes my way.

10

Slide 11

Low Self-Esteem

- Low Self-Esteem is a self-fulfilling prophecy
  - If you think you can, you're right
  - If you think you can't, you're right
    - Individuals with low self-esteem may not expect to do well.
    - They sometimes avoid trying to accomplish things because they are sure they will fail
  - They may not give themselves a chance to experience success
    - As a result, their self-esteem remains low.

11 Recovering Together Program

Slide 12

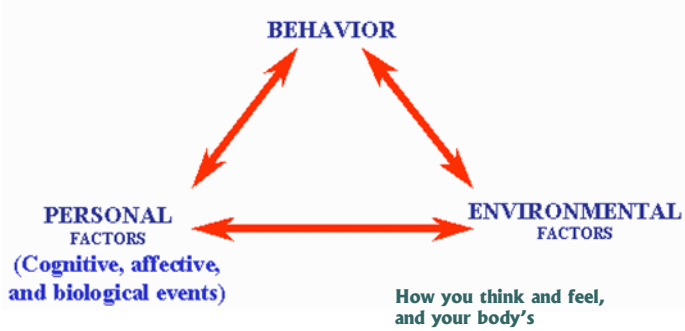
Characteristics of Low Self-esteem

- Individuals with low self-esteem
  - Do not expect to do well
  - Sometimes avoid doing new things because of fear of failure
  - Do not give themselves a chance to experience success
    - Keeping their self-esteem lower

12 Recovering Together Program

Slide 13

You have to start somewhere…



13 Recovering Together Program

Slide 14

Discussion Questions

- Have you ever heard of "fear of success"?
- Have you ever experienced it?

14 Recovering Together Program

Slide 15

The Best Way to increase self esteem

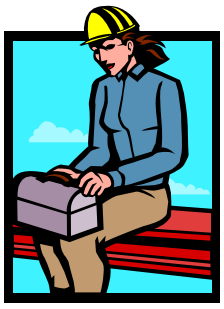
Realistic
Small
Steps

Then, stop and acknowledge your accomplishments

15 Recovering Together Program

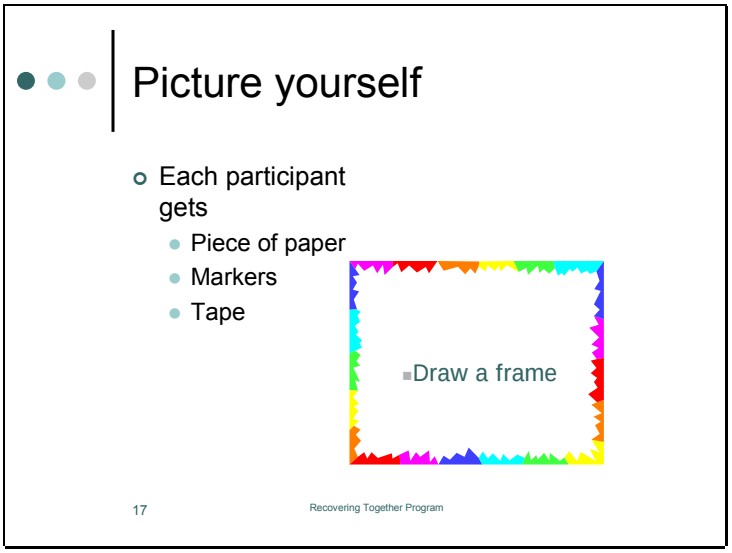
Slide 16

Check-in & Break



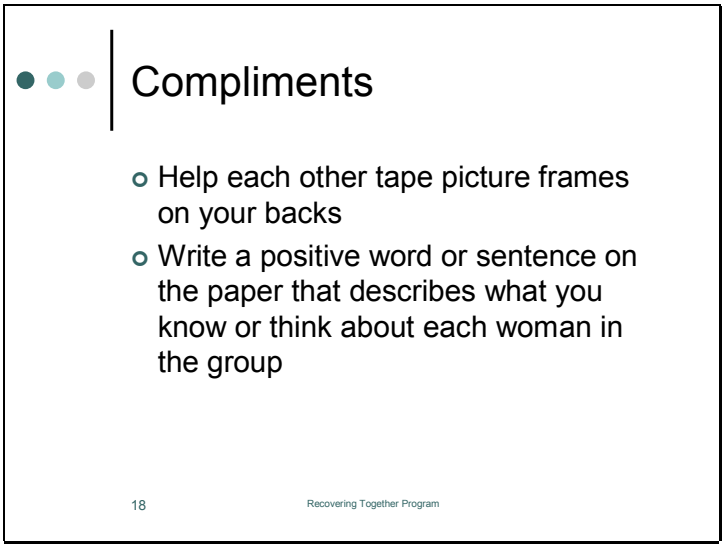
16 Recovering Together Program

Slide 17

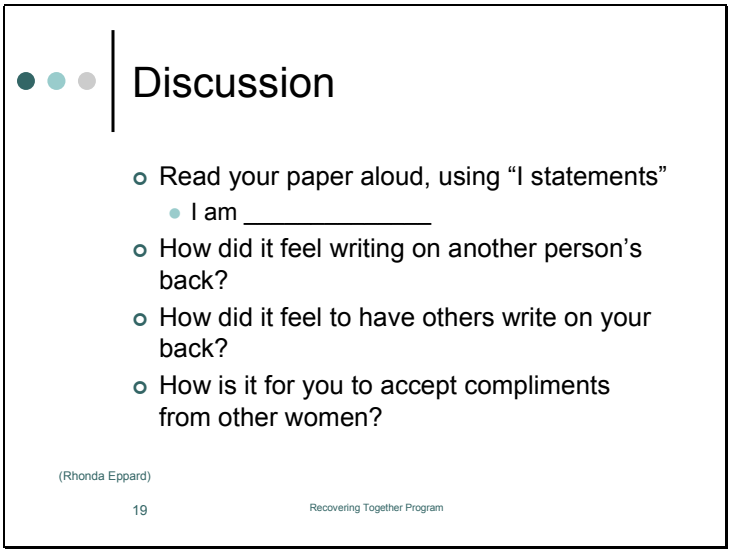


This is an activity that helps participants recognize that sometimes even positive messages or compliments can be challenging. One metaphor for this is "starving at the feast" and having a barrier to nurturing. Give each participant a piece of paper and have them draw a picture frame on it. Tape their picture frames on their backs. Participants then write a positive sentence or compliment about each woman in the group in that woman's frame with washable markers. Suggest they write about something that they have noticed or thought about that person. Sometimes it helps to maybe give them a couple of examples, but once they start writing they see other people's examples on the frames.

Slide 18

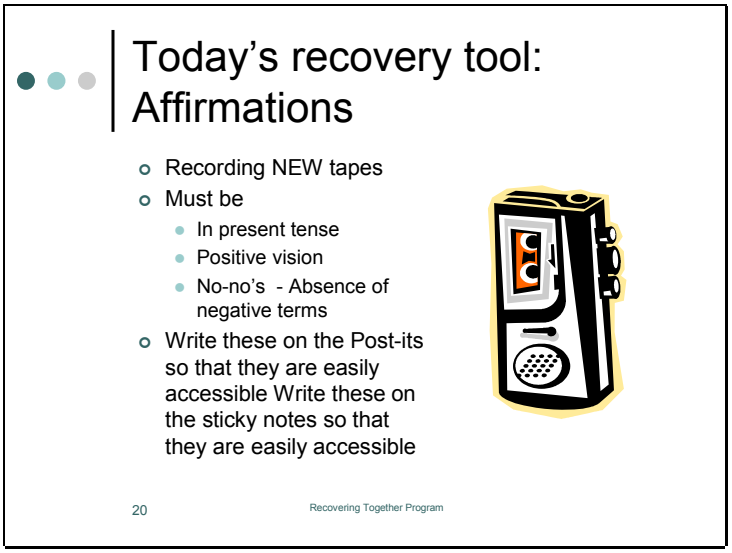


Slide 19



Rhonda Eppard, previous experience as addiction counselor

Slide 20



This Recovery Tool is jokingly called Sticky Note Therapy, a simple way of getting affirmations posted in each participant's life. Give each participant a Sticky Note pad and a pen and then lead them through creating three different affirmations so that they understand the guidelines of writing an affirmation.

- present tense
- positive vision
- an absence of any kind of negative terms. I call this the "No-nos in affirmations".

Everybody should write at least one affirmation on their sticky note pad. Suggest sticking one on the mirror and saying the affirmation out loud while looking themselves in the eye. Sometimes that is too challenging for people. Anywhere they choose to put the affirmation will be OK. Explain that this process requires repetition, and remind them how often they heard the negative messages. They need to hear the positive messages at least that many times.

Note: Throughout this session ask participants to notice the physical sensation of pleasure felt when they open up to positive messages. Make sure every participant experiences this at least once. Relate that feeling back to the "short-cut" to good feelings that their addiction provided. Make sure they

understand that letting themselves feel the pleasure of self-esteem and self-efficacy protects them and takes the power out of their addiction. Point out that they can move that power back inside them where it belongs with their new tool of positive messages.

Week 9 - Stress Management

Main Idea of Session

Learn about stress and the body. Understand the relationship between stress, emotions, and addiction. Learn basic stress management strategies.

Materials/Equipment Needed

- Materials
  - Presentation file or overhead transparencies
  - Key Feeling chart – color copy in sheet protector (for check-in)
  - Copies of the Holmes and Rahe Social Readjustment Scale - two copies for each participant
  - Stress Management handout
  - Pens
  - Relaxation CDs, extra copies for each participant to take home if possible
- Equipment
  - LCD or overhead projector; screen
  - Computer with PowerPoint or Adobe Reader (for LCD) or transparencies for overheads
  - Copy or fax machine for attendance sheets
  - Drug testing supplies, as needed
  - CD player or computer with speakers
  - Music for the relaxation activity

Session Overview

Quiet Time

Check-in

Presentation - Stress management

Understand the Stress Management Process

Learn Stress Management Skills

Week 9 Activities

Time	*Activity and/or Slides*	*Facilitator Process Notes*
20 min	**1. Quiet Time** **Slide 3**	The quiet time today is listening to some really nice, relaxing music. Have participants lay on the floor if possible. Use whichever relaxing music that staff selects. If possible, get copies of the CD to provide to participants. This is a very popular relaxation strategy, but some of the women may have never heard this type of music before. For this particular week the quiet time should be extended to try to get them all the way to a relaxed low-stress state. Lead them to identify where they notice stress in their bodies. Describe visualizing energy or warmth or even the music itself flowing to and through those body parts. That energy absorbs their tension and flows out of their body into the earth. Reassure participants that it is OK if they fall asleep. Ask if anyone had a hard time relaxing, and if so this could mean the process of learning to reduce stress levels is especially important for them to learn.
20 min	**2. Check-in** Name Feeling Last substance use Success with recovery tool-affirmations **Slide 4-5**	Go over the agenda. During check-in make sure to question participants about their affirmations in addition to the other normal check-in topics. Even if not all participants used the affirmation tools of last week, talk briefly about how important it is to actually try. It may be necessary to do a practice round of affirmations (each participant repeating their affirmation aloud) to get the discussion going. Encourage participants that it takes many repetitions of the positive messages to "record over" those old negative messages. The process of hearing positive messages may be stressful initially in itself – and that change of any kind can be initially stressful.

Stress and the Body

Time	*Activity and/or Slides*	*Facilitator Process Notes*
10 min	3. Overview of Stress Management **Slide 6 - 17**	We'll go through a series of slides that review some common stressors that are present in the lives of participants. Stress may be a familiar word, but their understanding of the actual physical process of stress can be very limited.

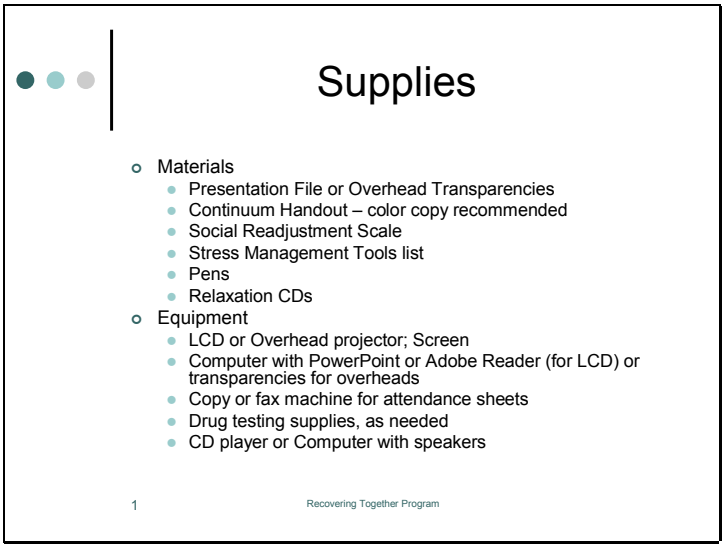
Identify Stressors Activities

Time	*Activity and/or Slides*	*Facilitator Process Notes*
20 min	4. Identify Stressors Activity (Part One) **Slides 18-20**	This is a two-part activity using the Social Readjustment Scale (Holmes & Rahe, 1967). Before the break you should introduce the scale and have participants fill it out and have them calculate their number of points. They may need assistance with point calculation. Have them start their break whenever they have completed the scale, and give a specific time for them to return.
10 min	**Break** **Slide 21**	
15 min	5. Substance-Induced Stressors (Part Two) **Slides 22-26**	After the break, have each participant fill out another Stress Scale, leaving out all the stressors caused by substance abuse or any substance use at all. After recalculating their score, ask the discussion question, "How much of your stress may be alleviated by abstinence?" It is usually very surprising for participants to realize that substance use is actually creating stress. They may have a strong belief that their drug of choice helps them

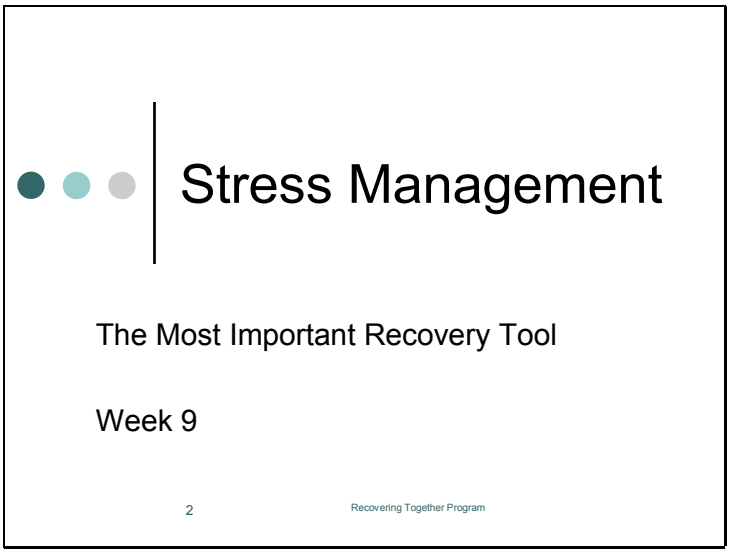
		manage their stress. The realization that they may reduce their stress by NOT using a substance is a big cognitive shift. Encourage the participants to discuss this paradox. One of the biggest triggers for craving and relapse is high stress. They still need new tools to deal with the stress of being a mom or just being. This leads to the Stress Hot Spots discussion.
20 min	6. Stress Hot Spots Activity **Slides 27-28**	This is a review of stress management tools mentioned in the presentation. Pass out the Stress Management Hot Spots & Cool Tools handout. Have participants identify their own "stress hot spots".
5 min	7. Recovery Topic and Recovery Tool 9 **Slide 29**	If possible, get copies of the relaxation music CD to provide to participants. If there is extra time then maybe have them listen to a track on the CD to see what kind of tool they are getting.

Week 9 Slides with Commentary

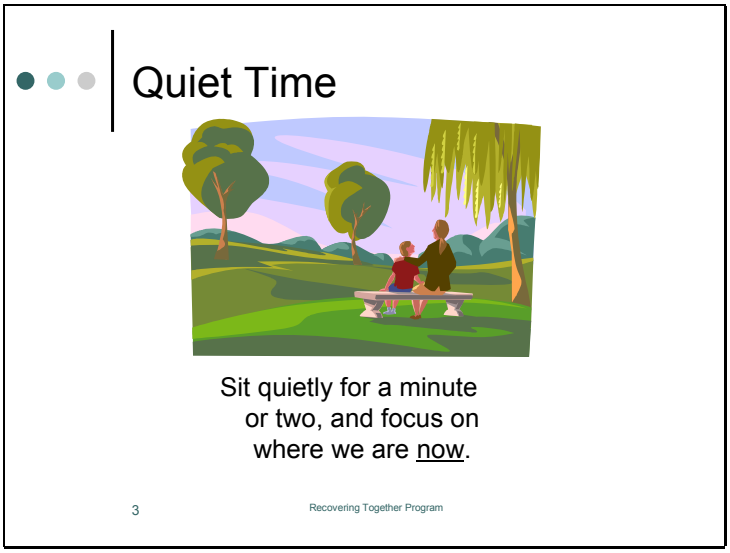
Slide 1



Slide 2

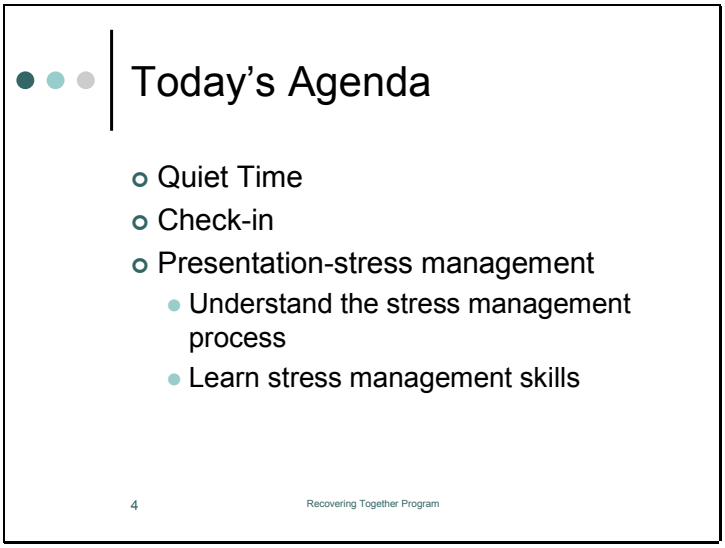


Slide 3



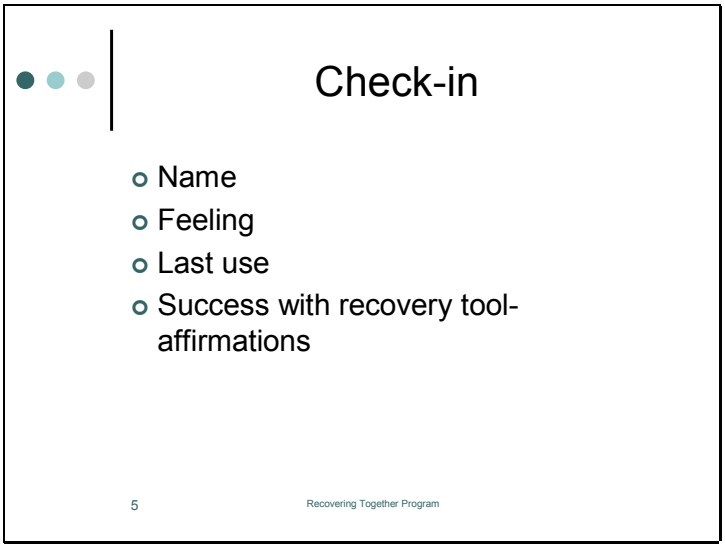
The quiet time today is listening to some really nice, relaxing music. Have participants lay on the floor if possible. Use whichever relaxing music that staff selects. If possible, get copies of the CD to provide to participants. This is a very popular relaxation strategy, but some of the women have never heard this type of music before. For this particular week the quiet time should be extended to try to get them all the way to a relaxed low-stress state. Lead them to identify where they notice stress in their body. Describe visualizing energy or warmth or even the music itself flowing to and through those body parts. That energy absorbs their tension and flows out of their body into the earth. Reassure participants that it is OK if they fall asleep. Ask if anyone had a hard time relaxing, and if so, this could mean it is especially important for them to learn this tool.

Slide 4



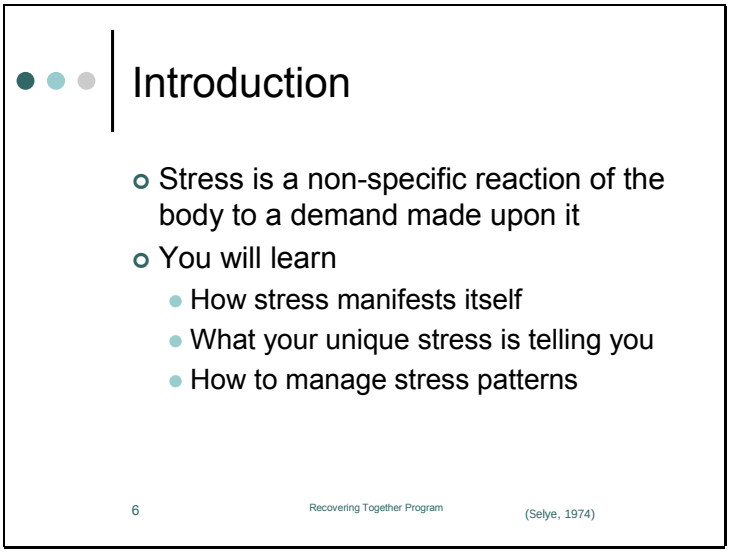
Learn about stress and the body. Understand the relationship between stress, emotions, and addiction. Learn basic stress management strategies.

Slide 5



During check-in, make sure to question participants about their affirmations. Not all participants may have used the affirmation tools last week, but talking about actually trying them is important. It may be necessary to do a practice round of affirmations (each participant repeating their affirmation aloud) to get the discussion going. Encourage participants that it takes many repetitions of the positive messages to "record over" those old negative messages. The process of hearing positive messages may be stressful in itself – use that to lead into the slide show since change of any kind can be stressful.

Slide 6



What we do here is go through a series of slides that review some stressors likely to be directly related to the participant's life. Stress may be a familiar word, but their understanding of the actual physical process of stress can be very limited.

Selye, H. (1974). *Stress without distress.* Philadelphia: J.P. Lippencott.

Slide 7

Emotional Stress

Arguing and conflicts cause **CHANGES** in your personal life and in your body
-- that is stress.

7 Recovering Together Program

Slide 8

Illness

- Catching a cold, breaking a bone, infections, a sore back, are all **CHANGES** in your body condition.

8 Recovering Together Program

Slide 9

Allergic Stress

- Allergic reactions are a part of your body's natural defense mechanism.
- The body responds as if under attack, creating stress.

9 Recovering Together Program

Slide 10

Environmental Factors

- Very hot or very cold climates can be stressful.
- Toxins or poisons cause **CHANGES** in your body's internal environment.

10 Recovering Together Program

Slide 11

Tobacco Use

- Tobacco is a powerful toxin!!
  - Did you really think it was helping you **handle** stress?
- Now you know it **IS** stress…

11 Recovering Together Program

Slide 12

Over Doing

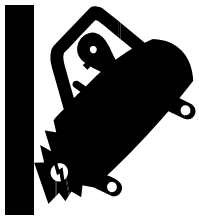
- **A major source of stress is Over Doing. If you are working (or partying) 16 hours a day, you won't rest.**
- **The energy drain on your system will cause the body to fall behind in regular repair work.**
- **There's not enough time or energy for the body to fix broken cells, or replace used up brain neurotransmitters.**

12 Recovering Together Program

Slide 13

Pushing Your Body Too Hard…

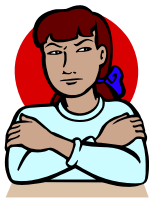
- **CHANGES will occur in your body's internal environment.**
- **You will "hit the wall."**
- **If you keep going, permanent damage may be done.**



13 Recovering Together Program

Slide 14

Hormonal Factors

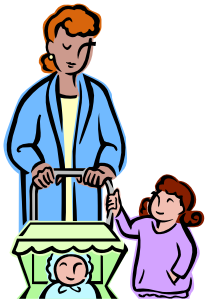


- **Pre-Menstrual Syndrome (PMS)**
  - We are designed to function best in the presence of female hormones, so lack of female hormones is a stress on the body
  - Prior to monthly menstruation, a woman's hormone levels drop sharply.
  - This temporary OVERSTRESS is popularly known as Pre Menstrual Syndrome (PMS).

14 Recovering Together Program

Slide 15

POST-PARTUM



- After a normal childbirth (or a miscarriage) some women may be thrown into OVERSTRESS by loss of the hormones of pregnancy.

15 Recovering Together Program

Slide 16

MENOPAUSE

- Hormone levels decline slowly during menopause, but this causes enough stress on the body to produce OVERSTRESS in many women.

16 Recovering Together Program

Slide 17

Taking Responsibility for Another **Person's Actions**

- When you take responsibility for *another person's actions*, **CHANGES** occur in your life over which you have little or no control.
- Taking responsibility for *another person's actions* is a major stressor.

17 Recovering Together Program

Slide 18

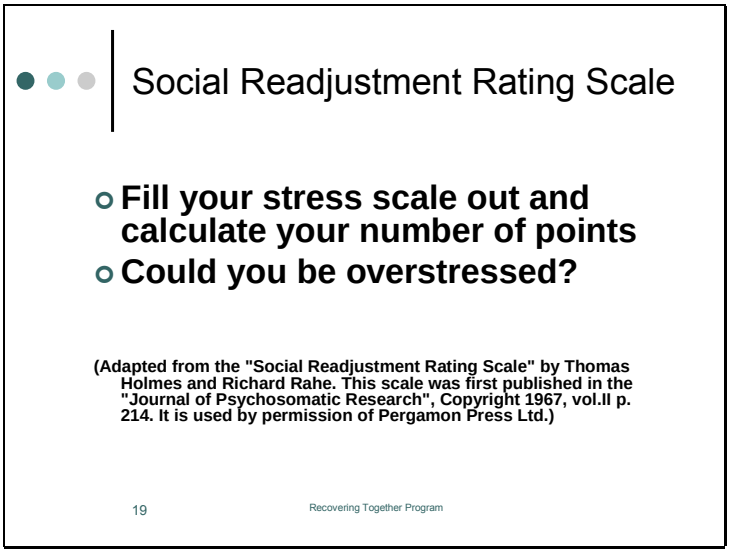
Stressors

- Dr. T.H. Holmes, of the University of Washington, created what he called his Social Readjustment Rating Scale
- He was able to correlate
  - the number of stress points a person accumulated in any two year period
  - with how serious an illness they were likely to experience.

18 Recovering Together Program

Holmes, T., & Rahe, R. (1967). Social Readjustment Rating Scale. *Journal of Psychosomatic Research, 2,* p. 214.

Slide 19



This is a two-part activity using the Social Readjustment Scale (Holmes & Rahe, 1967). Before break you should introduce the scale and have participants fill it out and have them calculate their number of points. They may need assistance with point calculation. Have them start their break whenever they have completed the scale, and give a specific time for them to return.

Holmes, T., & Rahe, R. (1967). Social Readjustment Rating Scale. *Journal of Psychosomatic Research, 2,* p. 214.

Slide 20

What is your stress score?

- More than 250 points within a two year period is likely to be followed by a life-threatening illness
- 150 points by an illness which may be serious, but not life-threatening
- with 20-50 points, recurrent bronchitis, cold sores or other illnesses may result

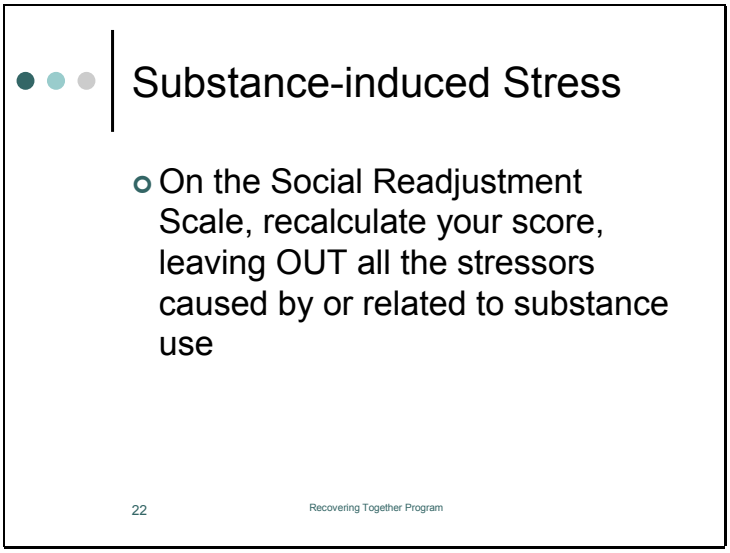
20 Recovering Together Program

Slide 21

Check-in & Break

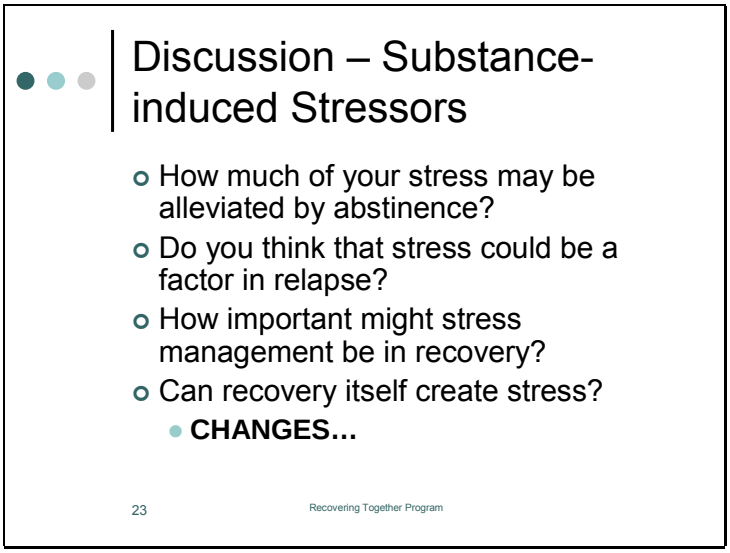
21 Recovering Together Program

Slide 22

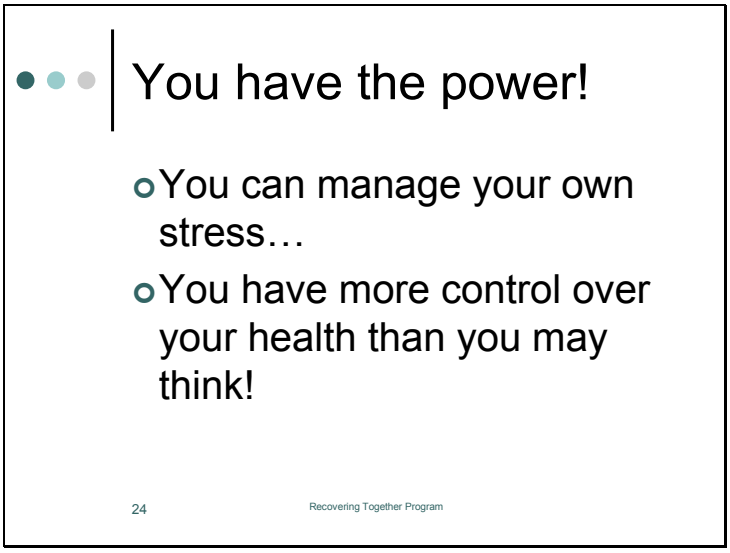


After break, have each participant fill out another Stress Scale, leaving out all the stressors caused by substance abuse or any substance use at all. After recalculating their score, ask the discussion question, "How much of your stress may be alleviated by abstinence?" It is usually very surprising for participants to realize that substance use is actually creating stress. They may have a strong belief that their drug of choice helps them manage their stress. The realization that they may reduce their stress by NOT using a substance is a big cognitive shift. Encourage the participants to discuss this paradox. One of the biggest triggers for craving and relapse is high stress. They still need new tools to deal with the stress of being a mom or just being. This leads to the Stress Hot Spots discussion.

Slide 23



Slide 24



Slide 25

Stress Management Tools

- Self Care
  - Home Defense
  - Nurturing Activities
  - Acceptance
- Relaxation Techniques
  - Breathing
  - Grounding
  - Rag doll
  - Progressive Muscle Relaxation

25 Recovering Together Program

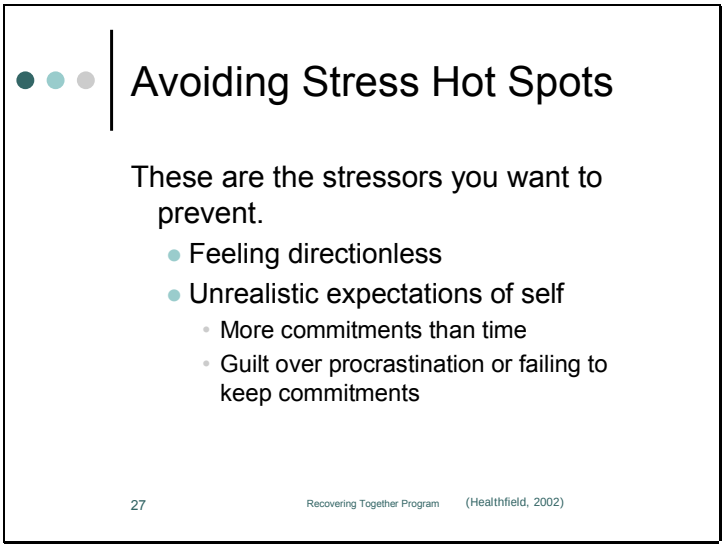
Slide 26

Overview of Stress Management

- Stress Management is an ongoing process
- ALL the skills you learn today help in managing your stress

26 Recovering Together Program

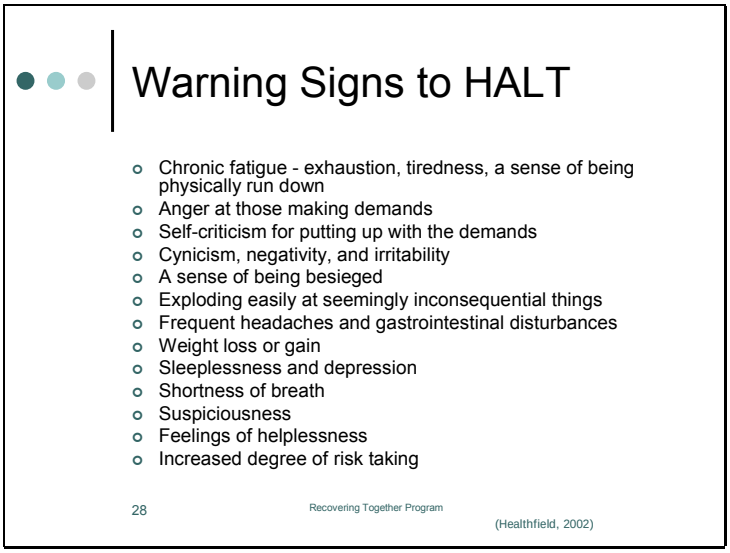
Slide 27



This is just a review of stress management tools mentioned in the presentation. Pass out the Stress Management Hot Spots and Cool Tools handout. Have participants identify their own "stress hot spots".

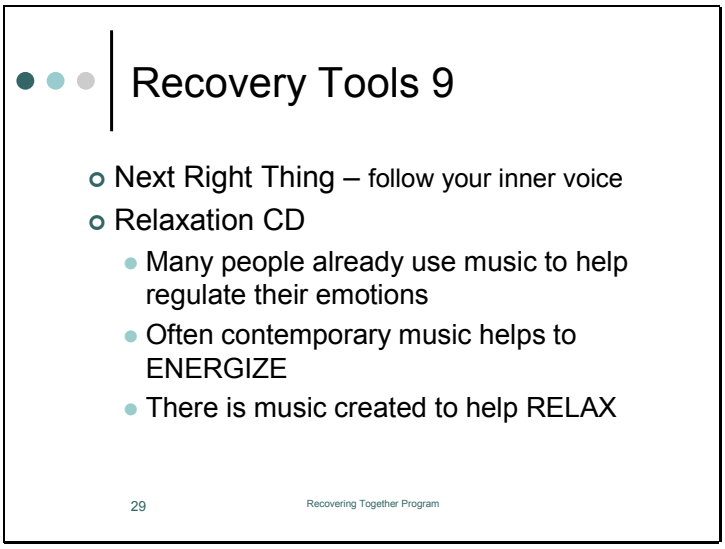
Healthfield, S. Tips for managing stress and change at work. Retrieved on February 2, 2004 from http://humanresources.about.com/library/weekly/aa032202a.htm

Slide 28



Healthfield, S. Tips for managing stress and change at work. Retrieved on February 2, 2004 from http://humanresources.about.com/library/weekly/aa032202a.htm

Slide 29



If possible, get copies of the relaxation music CD to provide to participants. If there is extra time, have them listen to a track on the CD to see what kind of tool they are getting.

Week 10 - Life Cycles and the 12-Steps

Main Idea of Session

Introduction to the 12-Steps and the Medicine Wheel. Discuss life cycles, stages of change, and that recovery is an ongoing process.

Materials/Equipment Needed

- Materials
  - Presentation file or overhead transparencies
  - Key Feeling chart – color copy in sheet protector (for check-in)
  - Life Cycles handout from White Bison
- Equipment
  - LCD or overhead projector; screen
  - Computer with PowerPoint or Adobe Reader (for LCD) or transparencies for overheads
  - Copy or fax machine for attendance sheets
  - Drug testing supplies, as needed
  - Blank copy of medicine wheel
  - Colored pencils or markers

Session Overview

Quiet time

Check-in

Success with Relaxation Techniques

Cycles of Life and 12-Steps

Presentation

Making your own Medicine Wheel

Week 10 Activities

Time	*Activity and/or Slides*	*Facilitator Process Notes*
10 min	**1. Quiet Time** **Slides 2-3**	Quiet time today should be a visualization of someone sitting in a quiet place out in nature looking over a meadow and leaning against a tree. All around the meadow are trees and flowers of many different shapes, sizes, and colors. Lead the participants to imagine the temperature of the breeze, the smells in the meadow of sunshine, flowers and nature, the sounds from the insects, animals and wind. Encourage them to imagine the tree supporting them being rooted in the earth, solid and sure. Help them include all their senses to fully experience the serenity of this safe place.
20 min	**2. Agenda and Check-in** **Slide 4 - 5**	Include name, feeling, last use of alcohol or drugs. Also include one example of how participants successfully managed their stress this week. The session today introduces several concepts previewing the recovery process participants have now begun. First, we review the Cycles of Life, concepts which are found in many different cultures throughout the world. Following that overview of the cycles, the Twelve Steps are introduced. After break, each of the steps is briefly explained. Then participants will learn about making their own cycle, a Medicine Wheel.

Introduction to Cycles of Life

Time	*Activity and/or Slides*	*Facilitator Process Notes*
15 min	3. Introduction to Cycles of	Show the presentation showing the cycle of life in the seasons, and then the cycle of

	Life and the Simple Cycle **Slides 6-8**	life in humans. These cycles are found across the world in various religions, in various traditions of native peoples and in complex civilizations. The Simple Cycle is introduced, and discussed.

Introduction to the 12 Steps

Time	***Activity and/or Slides***	***Facilitator Process Notes***
10 min	4. A Medicine Wheel and the 12 Steps **Slide 9-10**	Similar cycles are found in many of the Native American traditions. There is a Native American corporation in Colorado (called White Bison) which is sharing the teachings of the tribal elders. They are doing this in hopes of bringing healing to our world. They wrote down some elder's teachings on how the Medicine Wheel and the 12 Steps work together in a circle. This perspective helps many people to better understand both the 12 Steps and the Medicine Wheel. Several of the Medicine Wheel handouts this week are from The Red Road to Wellbriety, also known as The Red Book.
5 min	5. Why Understand and Unify Two Different Perspectives? **Slide 11**	A cross-cultural context to explain the 12-Steps of Alcoholics Anonymous (AA) can be helpful for participants. There are many misunderstandings about the 12-Steps. A key one is the stigma, bigotry and fear of religion, which can involve trauma associated with organized religion, and may play a role in those misunderstandings. A broader understanding of how the 12-Steps were developed may help participants overcome some of these concerns and experience

		the healing of the spiritual component of 12-Step programs. AA is an independent, secular organization whose sole purpose is to "help the addict who still suffers."

10 min Break

Slide 12

20 min	6. 12-Steps of Alcoholics Anonymous **Slides 13-24**	The slide presentation presents each step, which the facilitator may describe in her own words, including examples relevant to the participants. If the facilitator is unfamiliar with the steps, please see the 12-step addendum.

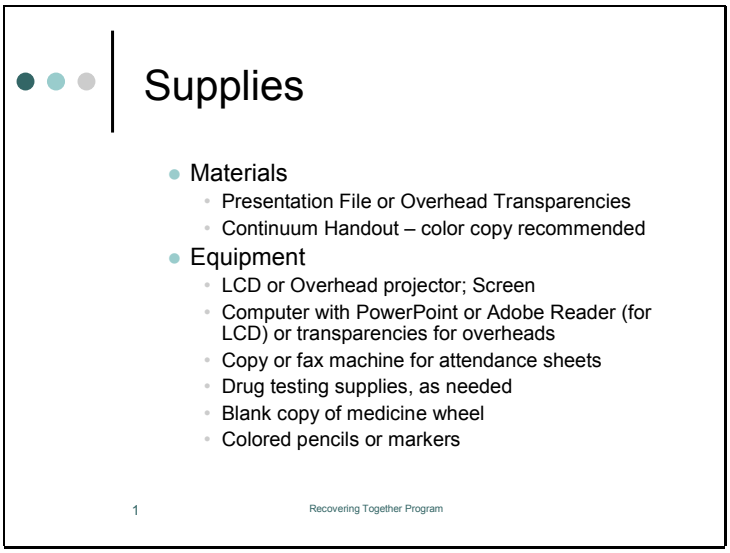
Medicine Wheel Activities

Time	***Activity and/or Slides***	***Facilitator Process Notes***
20 min	7. Medicine Wheel Activity **Slide 25**	Have participants draw their own medicine wheel to help personalize the concepts. Begin the drawing with a blank circle or a simple medicine wheel. Then, lead the participants through the process of layering meaning upon the wheel with words, colors, or pictures. On each of the four sides of the circle, write one of the four directions (East, South, West, and North). Next, write the name or draw a symbol for each of the four seasons with four different colors: Spring (East), Summer (South), Fall (West), and Winter (North). Pause to make sure everyone understands how the cycle moves through the seasons around the world. In the next layer of the drawing, indicate the four tasks with words or symbols: Recognize (East), Acknowledge (South), Forgive (West), Change (North). Four gifts can also be added to the hoop or wheel – hope (East),

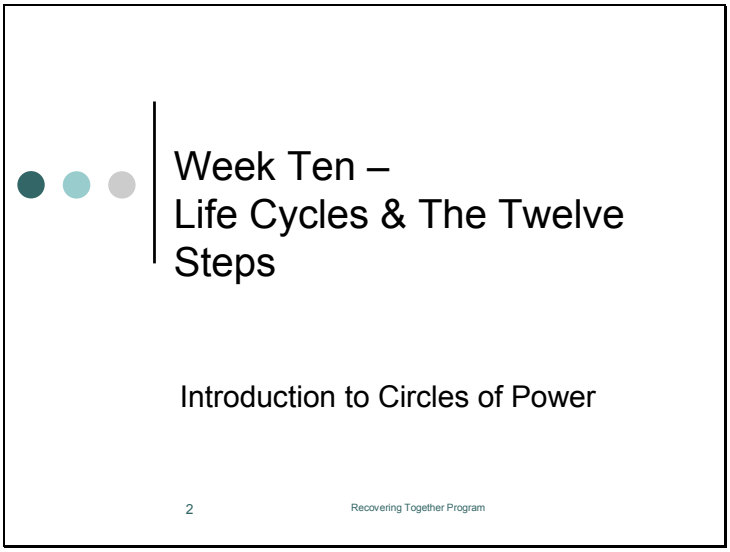
		healing (South), forgiveness (West), and unity (North).
10 min	8. Recovery Tool #10 **Slide 26**	Medicine Wheels Handout (White Bison, n.d.)

Week 10 Slides with Commentary

Slide 1



Slide 2



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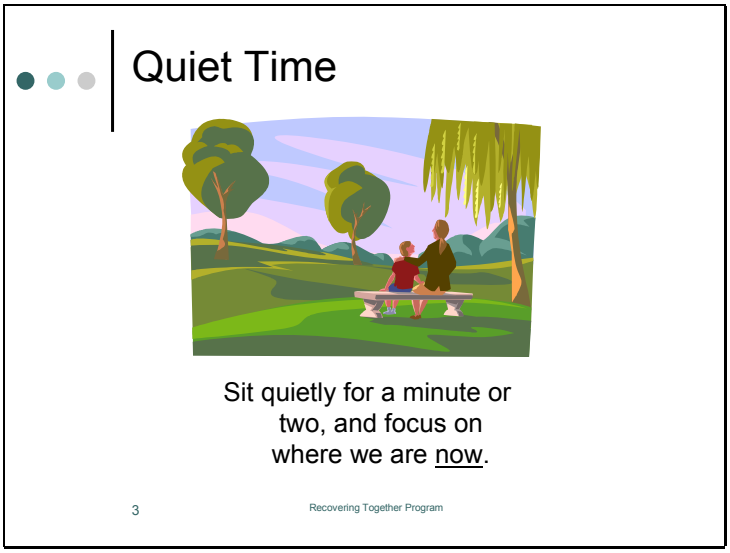
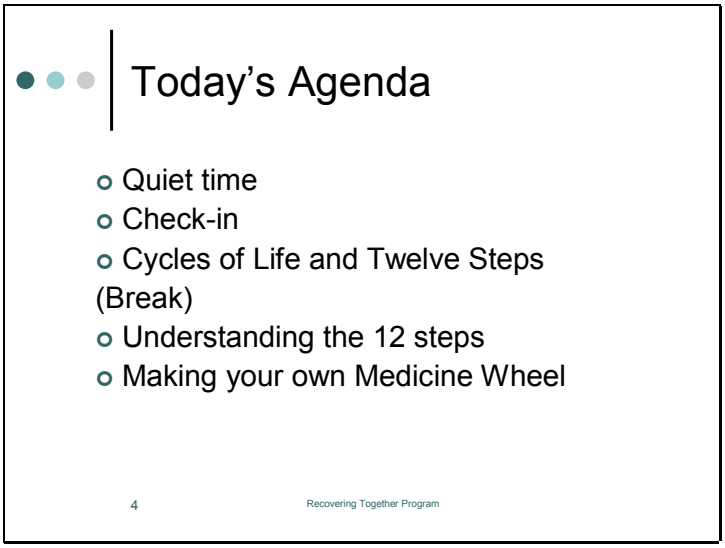


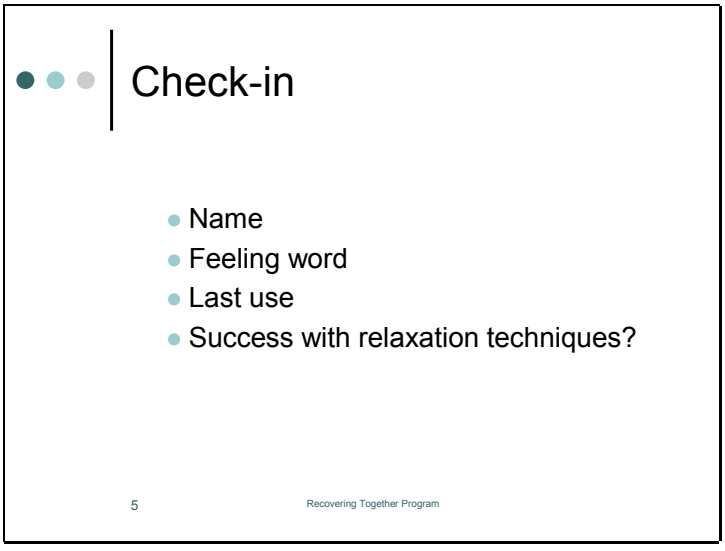
Quiet time today should be a visualization of someone sitting in a quiet place out in nature looking over a meadow and leaning against a tree. All around the meadow are trees and flowers of many different shapes, sizes, and colors. Lead the clients to imagine the temperature of the breeze, the smells in the meadow of sunshine, flowers and nature, the sounds from the insects, animals and wind. Help them include all their senses to fully experience the serenity of this safe place.

Slide 4

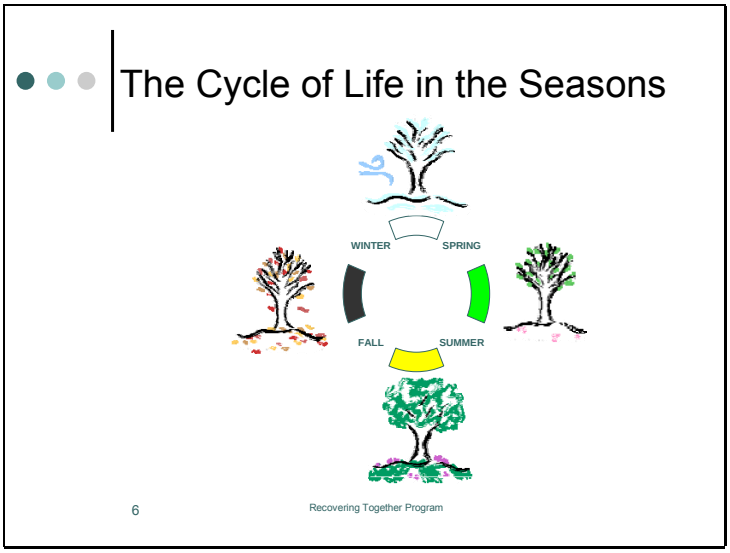


Introduction to the Twelve Steps and the Medicine Wheel. Discuss life cycles, stages of change, and that recovery is an ongoing process.

Slide 5

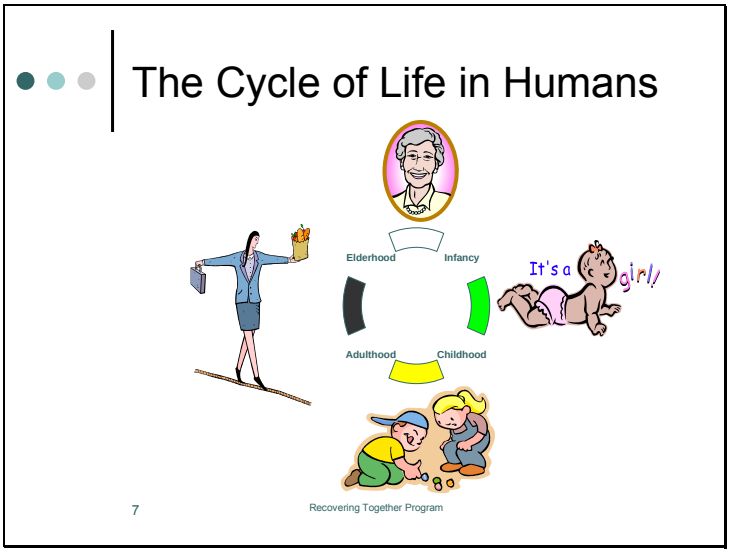


Slide 6



Presentation showing the cycle of life in the seasons, and then the cycle of life in humans. These cycles are found across the world in various religions - in various traditions of native peoples and in complex civilizations.

Slide 7



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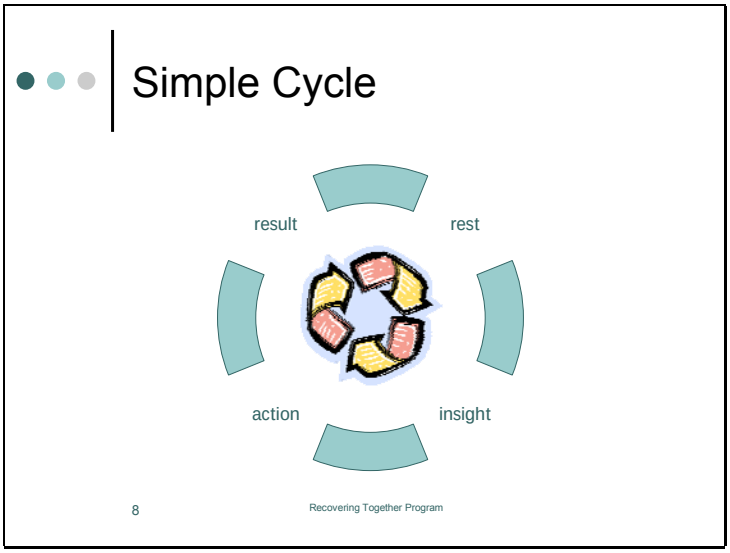


The Simple Cycle is introduced and discussed. Start with insight and use the example of making a sandwich. You will first get insight into the fact that you are hungry and you might even get insight to the fact that not only are you hungry, but you know what you want to eat and it's a sandwich. The kind of sandwich you want to eat in this case is a grilled cheese sandwich. The next step is to take action and so you go into the kitchen and get everything out for the sandwich. Whenever we take action that leads to the next part of the cycle, which is a result. Sometimes we get positive results and sometimes we get negative results, but whenever we take action we get results. If you got good results you would have this nice golden brown grilled cheese sandwich, which would be delicious. There would be a nurturing or a positive result. Let's say the phone rang while you were making the sandwich and you burned the sandwich. It's difficult, if not impossible to eat. This is a negative result, but you also get feedback that teaches you something. It teaches you that while making grilled cheese sandwiches, you need to stay pretty close to the stove and not get distracted. The cycle closes when you aren't hungry anymore and won't even think about food. The cycle begins again once you start to get hungry and you will probably want something different this time. That is the way the Simple Cycle works.

a.k.a. Sensitivity Cycle, Ron Kurtz, Hakomi

Slide 9

Similar cycles are found in many of the Native American traditions. There is a Native American corporation in Colorado (White Bison) sharing teachings of the tribal elders. They are doing this in hope of bringing healing to our world.

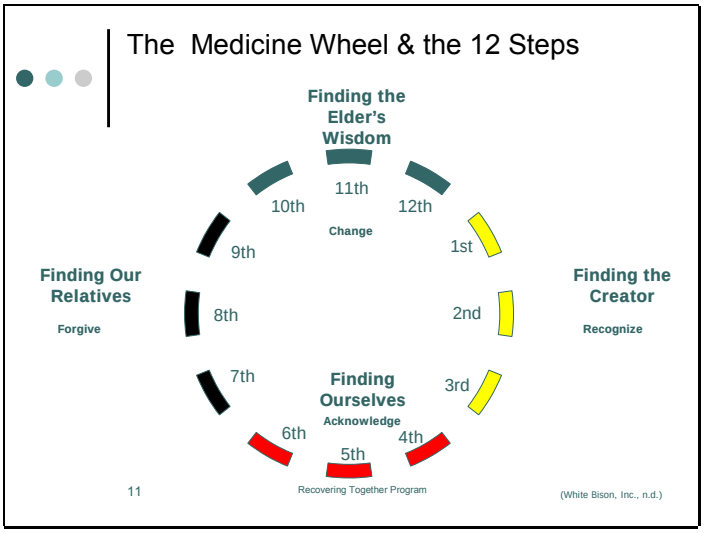
They wrote down some elder's teachings on how the Medicine Wheel and the 12 Steps work together in a circle. This perspective can help people understand both the 12 Steps and the Medicine Wheel better. Several of the Medicine Wheel handouts this week are from The Red Road to Wellbriety, also known as The Red Book.

The medicine wheel pictured here is from the White Bison website, www.whitebison.org.

Slide 10

Check-in & Break

Slide 11

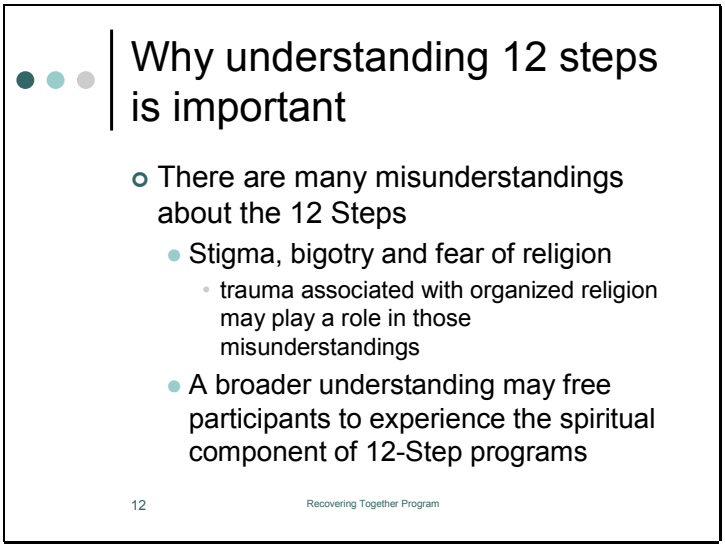


In this tribal perspective, the twelve steps are divided among the four directions of one traditional Medicine Wheel. (View an example of a Medicine Wheel and the steps) The 1st, 2nd, and 3rd steps relate to finding the Creator, and also recognizing our current inability to control our drug or alcohol use. In the 4th, 5th and 6th steps we find ourselves, acknowledging who we are and what we may need to do about it. The 7th, 8th, and 9th steps are about all our relationships and about forgiveness. These steps often involve asking for forgiveness from others. This direction also provides the gift of forgiveness within our own hearts. The 10th, 11th, and 12th steps are about finding the elder's wisdom. This direction brings change. During these steps we stabilize the lifelong process of recovery and share that recovery with others.

The book of Alcoholics Anonymous (the Big Book) was also provided to the world as a gift of healing. Since it was originally written by individuals influenced by Western European thinking, the steps were originally perceived as a straight line. They started with the 1st step and ended with the 12th step. In this Medicine Wheel tradition they are seen as a circle, but they are the same steps. It can be true that after a person has carried the message of recovery and personal experience to other people (12th step), they often find themselves circling around to recognize other problems/issues that still need to be addressed. For example, those same steps can be applied to other compulsive behaviors (i.e. drugs, eating, gambling, and sexual).

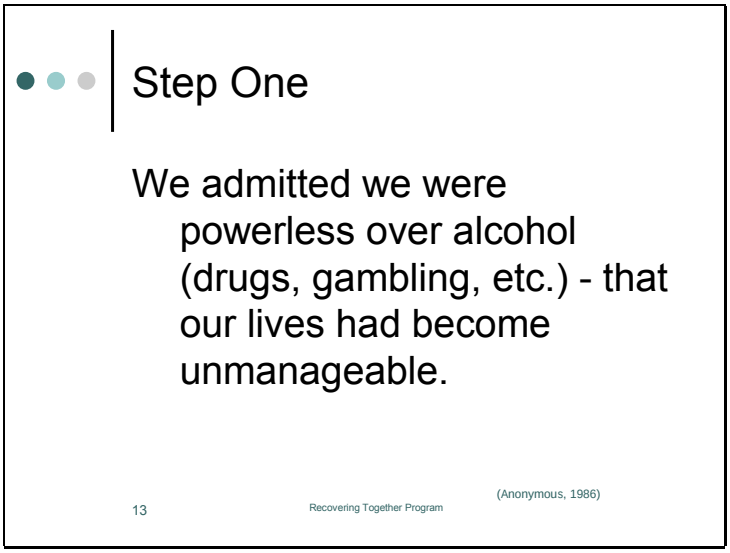
White Bison, Inc. (n.d.). *The Medicine Wheel and the Twelve Steps for Women.* Colorado Springs, CO: Author. Retrieved from http://www.whitebison.org

Slide 12



The slide presentation presents each step, which the counselor may describe in her own words, including examples relevant to the participants. If the counselor is unfamiliar with the steps, please see the 12 step addendum.

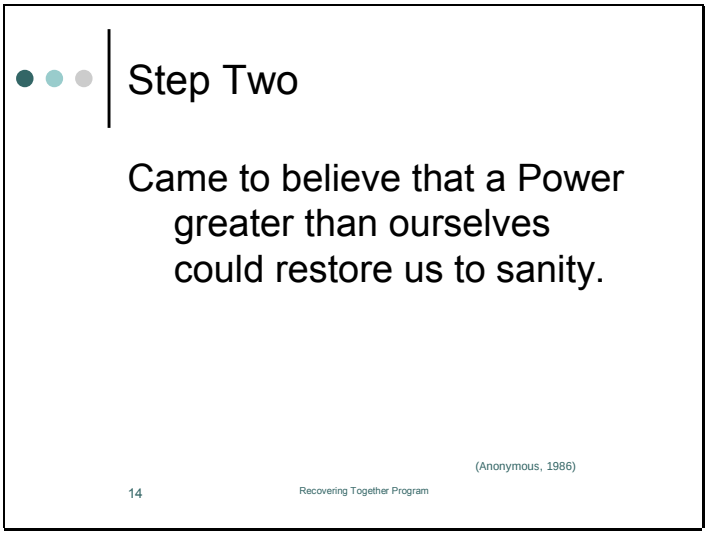
Slide 13



Anonymous (1986). *Alcoholics Anonymous* (3rd ed., rev.). New York, NY: Alcoholics Anonymous World Service, Inc.

The 1st Step: we admitted that we were powerless over alcohol (drugs, gambling, etc). People need to insert whatever their addiction is in front of alcohol or else they feel like these steps immediately don't apply to them and that it couldn't be useful. In the first part of the step we admitted that we are powerless over ___. Sometimes people that have really destructive relationship patterns even have to say that they are powerless over a certain person if that person is an addict or an alcoholic, or their mother or father, etc. The first part is admitting that we are powerless and we can't control that person, place, or thing. This includes admitting that our lives have become unmanageable, and many times, people are really resistant to the idea that their lives have become unmanageable. If they have a hard time accepting that their lives have become unmanageable, then sometimes it's helpful to think of a certain time when they first realized that they had a problem with that addiction as an unmanageable episode.

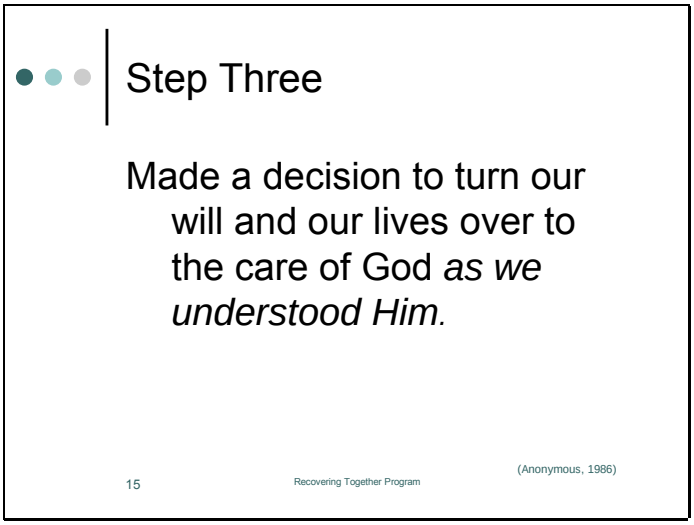
Slide 14



Anonymous (1986). *Alcoholics Anonymous* (3rd ed., rev.). New York, NY: Alcoholics Anonymous World Service, Inc.

Step 2 is "Came to believe in a power greater than ourselves could restore us to sanity." This is a challenging step for those people who have trouble with the concept of a Higher Power. They may think that a power greater than ourselves has to be God. That is not true. Sometimes if people are atheists or agnostics, then they substitute something else other than God as a power greater than themselves. Some examples include the group that they are attending. All of the people in the group together are staying sober and so the group is more powerful than they are. Sometimes it can be something like nature, or the power of kindness, or whatever they feel comfortable believing is more powerful than they are as an individual. The second part of the step is talking about restoring us to sanity. A lot of people resist this part of the step because they have a problem admitting to insanity. One folk definition of insanity is doing the same thing over and over again and expecting different results. Most people, if they are trying to recover from addiction, can readily admit that they have done the same thing over and over again and expected different results.

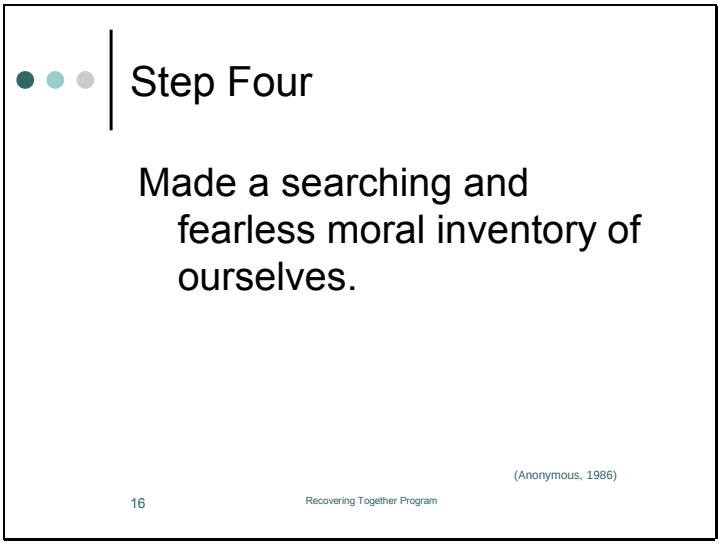
Slide 15



Anonymous (1986). *Alcoholics Anonymous* (3rd ed., rev.). New York, NY: Alcoholics Anonymous World Service, Inc.

At this point people are ready to make a decision to turn their will and their lives over to the care of God as they understand God. Many times people, if they don't believe in a Christian God or a male God, can substitute something else for the care of God as we understand God. It's important with Step 3 to realize that this particular step is the point when we make a decision. I was told a story, by Don Coyhis, who introduced me to how the Medicine Wheel may work together with the 12-steps. The story is that there were three frogs sitting on a log and one of the frogs made a decision to jump in the water. So, how many frogs are left on the log? The answer is three. There are three frogs left on the log because he didn't actually jump in the water, he made a decision to jump in the water. The way Don tells the story is that there are three green frogs sitting on the log and that when that one frog makes a decision, he turns into an orange frog. So, he's still a frog, but he's an orange frog now instead of a green frog. If he decides to jump in the water then he will be a wet, orange frog. If he decides to get angry then he will be an angry, orange frog, but he still won't be a green frog. Once you make that decision it changes things. That leads us to the next step.

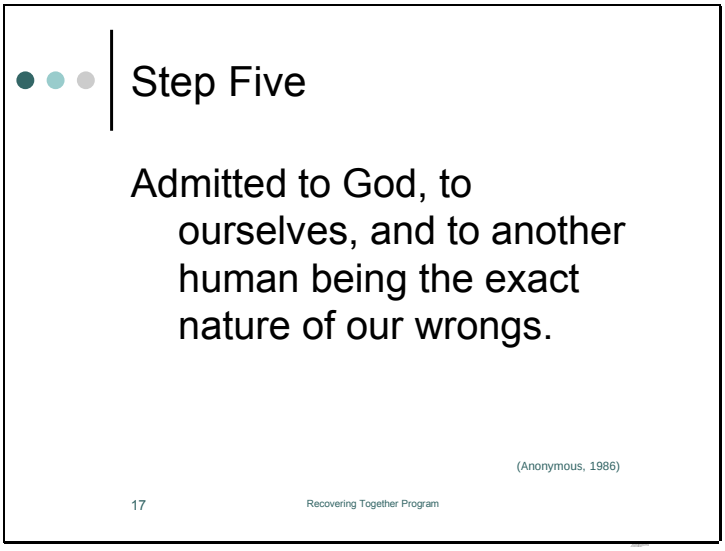
Slide 16



Anonymous (1986). *Alcoholics Anonymous* (3rd ed., rev.). New York, NY: Alcoholics Anonymous World Service, Inc.

At this point you might want to go back and show them the Medicine Wheel overview. The next step begins the part of the Medicine Wheel of finding ourselves. Appropriately, Step 4 is to make a searching and fearless moral inventory of ourselves. It's really important in Step 4 to make an inventory of both your assets and your defects, so that you know your faults, but you also know your strengths. This is a scary step for a lot of people which is why they mention "fearless" moral inventory of ourselves. The Medicine Wheel and 12-Step Workbook, if people have a hard time with this step, really gives a nice format and makes it pretty straightforward.

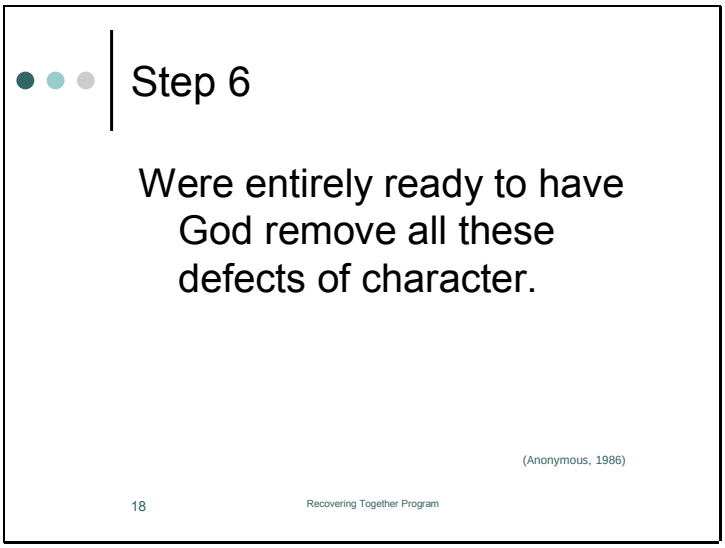
Slide 17



Anonymous (1986). *Alcoholics Anonymous* (3rd ed., Rev.). New York, NY: Alcoholics Anonymous World Service, Inc.

In Step 5, after making an inventory, we admit to God (or a higher power), to ourselves, and to one other human being the exact nature of our wrongs. The important thing about this step is that in the process of writing our 4th Step, you begin to admit the exact nature of our wrongs to ourselves and a power greater than ourselves. It's very important to read your 4th Step, your inventory, or discuss your inventory with another human being. In early recovery a common fear is that if someone knew everything about us, then they wouldn't love us or accept us anymore. It is recommended that you work this step with your sponsor. If for some reason your inventory includes things that you don't think you could tell a sponsor, you can share either all or just part of the list with someone else whom is more trustworthy. This can be a priest or a therapist or someone else that is ethically constrained from ever repeating what you have told them in your inventory. Once you have told that one person all of these things, while admitting them to yourself and to a power greater than yourself, then you are done with Step 5.

Slide 18



Anonymous (1986). *Alcoholics Anonymous* (3rd ed., rev.). New York, NY: Alcoholics Anonymous World Service, Inc.

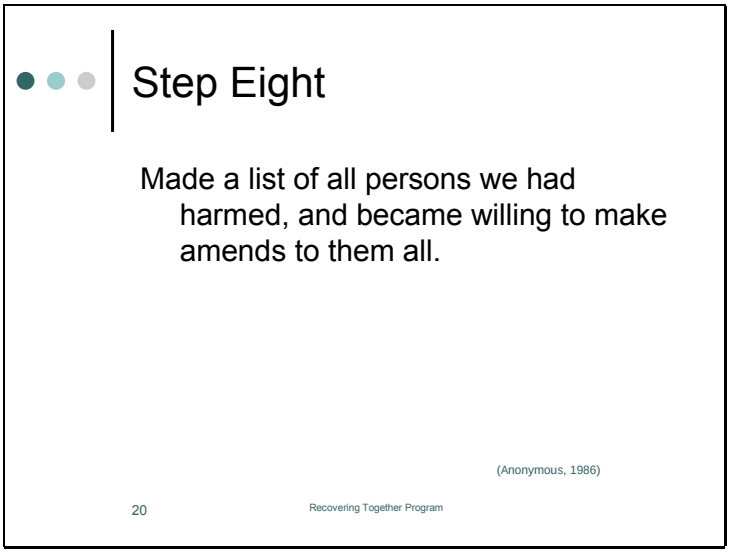
Step 6 is where we are entirely ready to have God remove all these defects of character. This seems like a pretty easy step on the surface because after the inventory process, we are SO ready to have these defects in character change. It seems like a no-brainer. However, it is important to realize that sometimes we hand them over, but then we take them back. Why? On some level, those defects of character may still be working for us. Another possibility is that we don't know another way to get our needs met.

Slide 19

Anonymous (1986). *Alcoholics Anonymous* (3rd ed., rev.). New York, NY: Alcoholics Anonymous World Service, Inc.

Step 7 is an opportunity to ask for some much needed help. A metaphor for this step is baking a cake. If we put a cake in the oven and let it bake as instructed, we will probably have success. However, if we keep opening the oven door to check on it, the cake may fall or be uneven. We need to trust the process. The trick here is to ask for help, then trust the process of life and healing to remove our defects of character. There will be many opportunities when they rear their ugly heads and we will have an opportunity to change. Meanwhile, we need to get on with working on the next step.

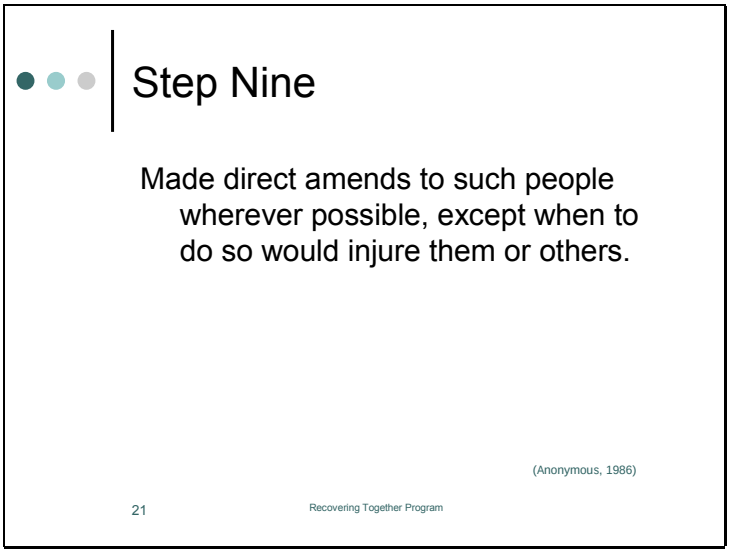
Slide 20



Anonymous (1986). *Alcoholics Anonymous* (3rd ed., Rev.). New York, NY: Alcoholics Anonymous World Service, Inc.

This is another step which many of us would love to avoid. It can be painful and downright embarrassing to write down all the selfish, inconsiderate and dishonest actions we committed while we were drinking and using drugs. However, these memories are already written in our minds and our hearts. Writing them down is a very important step to beginning the process of healing the damage and cleaning up the wreckage of our past. It is best not to dwell overlong on this process; simply write down the ones that you can remember and begin the next step.

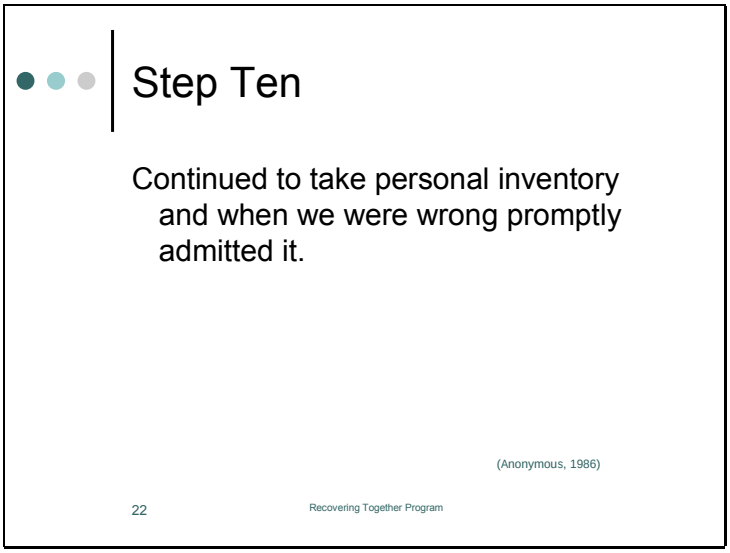
Slide 21



Anonymous (1986). *Alcoholics Anonymous* (3rd ed., rev.). New York, NY: Alcoholics Anonymous World Service, Inc.

This step is actually a journey that may vary greatly, depending on your circumstances. Some amends are rather straightforward, and easily accomplished. Others are complicated by distance, deaths of those affected, and by the complication of protecting those who may be harmed by your disclosures. It is recommended that you tackle the easy ones first, and get advice on the complicated issues. Remember, it is only your job to clean up your side of the street, you cannot control others' reactions or their even their attitudes. You can however, change your life completely by finishing this step.

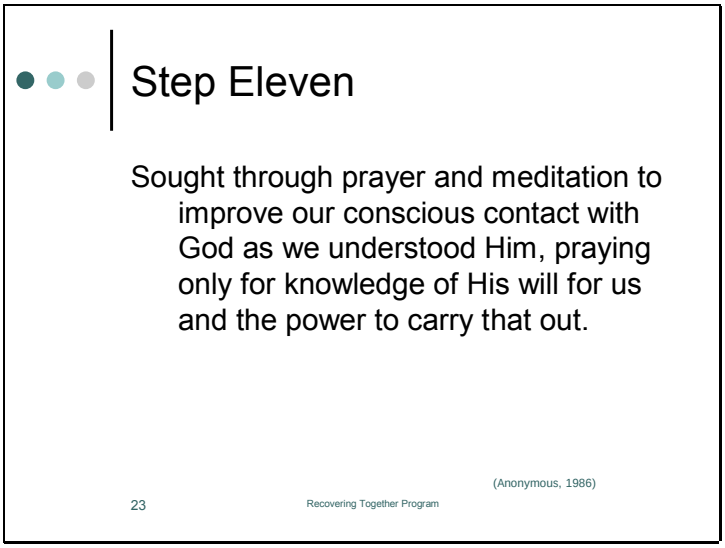
Slide 22



Anonymous (1986). *Alcoholics Anonymous* (3rd ed., Rev.). New York, NY: Alcoholics Anonymous World Service, Inc.

Once we have experienced the freedom and healing of admitting our mistakes and making amends, the process becomes easier. Freed of guilt and regret for the first time in years, we are usually anxious to free ourselves again. The inventory and amends process continues, and eventually becomes a lifestyle.

Slide 23

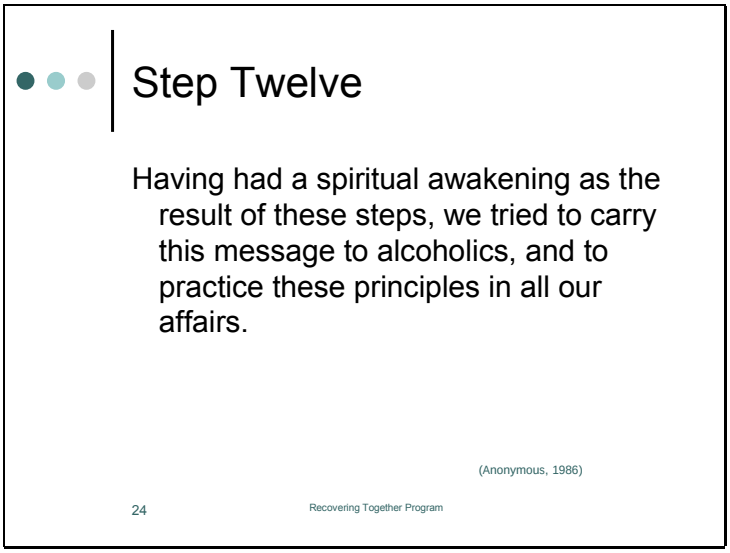


Anonymous (1986). *Alcoholics Anonymous* (3rd ed., rev.). New York, NY: Alcoholics Anonymous World Service, Inc.

Prayer and meditation are intimidating words to some of us. Note that in this step, we are only asked to connect with a power greater than ourselves. There is not a right or wrong way to do this. One elder, sober for over thirty years, shares that her entire retinue of prayer consists of two words, "Help" and "Thanks." Her meditation is walking in the woods or watching a sunset in silence.

The second part of this step, asking about God's will and the power to carry it out, can also be very simple. In the next unit we will learn about doing "the next right thing", listening to our inner voice, and drawing on that inner strength. If participants begin using that tool regularly, they will be prepared for this step.

Slide 24



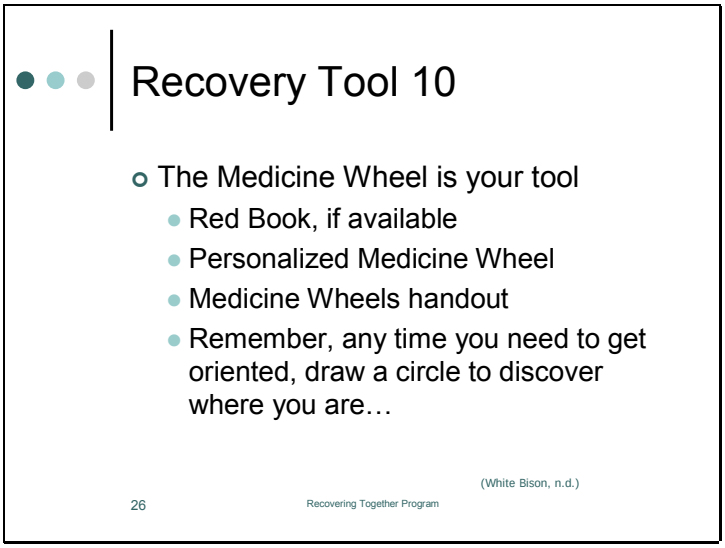
Anonymous (1986). *Alcoholics Anonymous* (3rd ed., rev.). New York, NY: Alcoholics Anonymous World Service, Inc.

This step is a celebration of gifts which we have received through the healing process of the preceding steps. There is usually no need to rush into this step, or to fear failure. The process of sharing our experience, strength, and hope with the many who cross our path will satisfy the requirements of this step. Opportunities arise, and we use the new tools and follow the path we already know. Everyone's work in this effort is completely unique, and it is only necessary to be genuine and realistic. You do your part, and then trust the process of recovery to unfold.

Slide 25

Have participants draw their own medicine wheel to help personalize the concepts. Begin the drawing with a blank circle or a simple medicine wheel. Then, lead the participants through the process of layering meaning upon the wheel with words, colors, or pictures. On each of the four sides of the circle, write one of the four directions (E,S,W,N). Next, write the name or draw a symbol for each of the four seasons with four different colors: Spring (E), Summer (S), Fall (W), and Winter (N). Pause to make sure everyone understands how the cycle moves through the seasons around the world, even though the direction of movement may change. In the next layer of the drawing, indicate the four tasks with words or symbols: Recognize (E), Acknowledge (S), Forgive (W), Change (N). Four gifts can also be added to the hoop or wheel – hope (E), healing (S), forgiveness (W), and unity (N).

Slide 26



Medicine Wheels Handout (White Bison, n.d.)

Week 11 - Interpersonal Violence

Main Idea of Session

- Learn about the cycle of interpersonal violence, and to recognize verbal, emotional, physical, social and sexual abuse. To understand what abuse is and how *common* it may be in this particular group of participants and among substance-abusing women.
- To understand the connection between childhood abuse and substance abuse
- Creating Healthy Relationships and Support Systems
- To understand the importance of supportive relationships

Materials/Equipment Needed

■ Materials
– Presentation file or overhead transparencies
– Key Feeling chart – color copy in sheet protector (for check-in)
– Abusive Relationships handouts
– Lifelines – Relationship Lifeline handout
■ Equipment
– LCD or overhead projector & screen
– Computer with PowerPoint or Adobe Reader (for LCD) or transparencies for overheads
– Copy or fax machine for attendance sheets
– Drug testing supplies, as needed

Session Overview

Quiet time

Check-in

Goals of Session

Presentation– What is Abuse? (Effects of Abuse and Impact on Recovery)

Discussion Exercise – Supportive Relationships

Relationship Lifelines – An Example

Week 11 Activities

Time	*Activity and/or Slides*	*Facilitator Process Notes*
10 min	**Quiet Time** **Slides 2-3**	This quiet time prepares participants for locating the "place of knowing" deep inside themselves. Although this is a fairly simple process, some participants doubt their own ability to listen for their inner wisdom. Upon reflection, the facilitator may be able to understand this doubt in the context of addiction. Imagine how many times they have used their drug of choice, even though they "knew better." Use this as an example of how they have already heard the inner voice many times, but perhaps didn't know how to listen. Ask participants to think of one thing that they definitely KNOW. Have them close their eyes and turn their attention inwards, toward their bodies. Next, they should locate the general area in their body where they feel this knowledge - this varies considerably in size and location. Some examples include in their head, their heart region, "in their gut," etc. It could be a definite, but tiny pinprick of light or a large, rather vague area. Have them get a tactile sensation of that knowing – explore temperature, color, texture, etc.
20 min	**2. Agenda & Check-in** **Slide 4-6**	Review the agenda & main ideas of this session. In addition to normal check-in (name, last use and current emotion), ask participants to reflect on last week's lesson about the 12 steps and the Medicine Wheel. Did they experience any reactions or thoughts this week about that topic?

Presentation – What is Abuse?

Time	*Activity and/or Slides*	*Facilitator Process Notes*

40 min	**3. Presentation – What is Abuse?** **Slides 7-23** **Take break based on group dynamics during this presentation**	This presentation reviews abuse on a spectrum of intensity, moving from intolerance to rejection, sabotage, and destruction. Prepare the participants, explaining that the topic of childhood and partner abuse can trigger memories and tangents of thoughts for participants. Give them instructions that if they find their mind wandering to gently acknowledge the memory or thought, and bring their attention back to the discussion topic. As the facilitator, attend to body language carefully to help participants stay fully present for the entire explanation. Look for opportunities for the group to acknowledge shared experiences and common reactions. After the slide show, pass around the handout and ask for questions. The discussion that follows can be time consuming – try to help participants manage emotional content. Offer individual counseling sessions to process any memories that emerge now or in the next few weeks. Refer to the presentation next week that will help explain how trauma, which can include experiencing abuse, can affect their recovery. Be aware that the women may be the perpetrator of abuse as well as the victim – help them acknowledge this and commit to developing awareness of patterns of abuse in their relationships.

Supportive Relationships Activity

Time	***Activity and/or Slides***	***Facilitator Process Notes***
25 min	**4. Supportive Relationships Activity**	This activity creates a circle of support. Show participants how to do a mind map of their personal circle of support. Give examples of how some of their closest family or friends may (or may not be)

	Slides 24-26	actively supportive of their recovery. Have participants create a circle in the middle of a paper, and draw their own support system. Help them brainstorm about strategies to "fill in the gaps."

Relationship Lifelines

Time	***Activity and/or Slides***	***Facilitator Process Notes***
15 min	**5. Relationship Lifelines** **Slide 27**	In unit three, participants created lifelines which included significant events in their lives, focusing on their relationship with alcohol and drugs. This week, have participants do a lifeline that illustrates their significant relationships with other people. For instance, they may put events from their childhood, like a parental divorce or their first boyfriend. They should indicate any marriages, divorces, or serious relationships. In addition, they may want to indicate if there were any abuse issues in the relationships, including verbal, physical, or sexual abuse. Help them identify and personalize the patterns which emerge. End this activity on a positive note, using the lifeline as a springboard for change.
10 min	**6. Recovery Tool 11** **Slide 28**	Today's tool is a concept to help participants with decision making. In early recovery, increased awareness of everyday choices can create a sense of being overwhelmed. Too many decisions all at once can lead to poor decisions. Therefore, participants should become aware of the concept of "the next right thing." Encourage participants to think about the quiet time which began the group session and use this approach in their daily lives as a tool when they feel overwhelmed. Using this process will help them locate the "place of knowing" deep inside. Lead them through the process of

	knowing again for the next fifteen minutes. Help them understand that that they already KNOW what to do next, if they just stop and listen for the "next right thing".

Prepare for Children's Role-Play

Mention to the mothers that next week the topic with be Family Roles and Addiction, and that the children will performing a short role-play. The children are usually quite excited about the play, they have been learning about this topic for several weeks. Nevertheless, it is sometimes scary for kids to talk about these topics in front of their mothers. Please be encouraging to the kids, and stay tuned for their performance.

Week 11 Slides with Commentary

Slide 1

Supplies

- Materials
  - Blank Lifelines
  - Abusive Relationship Handout
  - Presentation Week 11 or Overhead Transparencies
  - Sign-in Sheet
  - Weekly Staff Debriefing Form
- Equipment
  - LCD or Overhead projector & Screen
  - Computer with PowerPoint or Adobe Reader
  - Drug testing supplies, as needed
  - Copy or fax machine for attendance sheets

1 Recovering Together Program

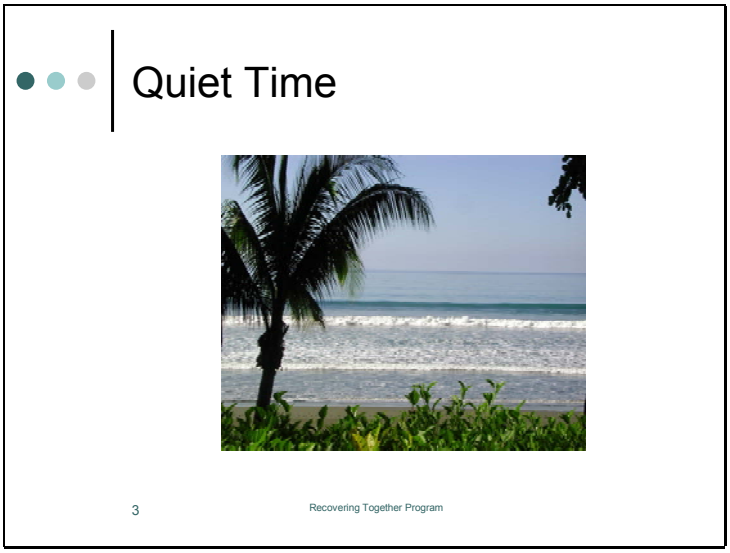
Slide 2

Interpersonal Violence and Healthy Relationships

Different sides of the relationship coin

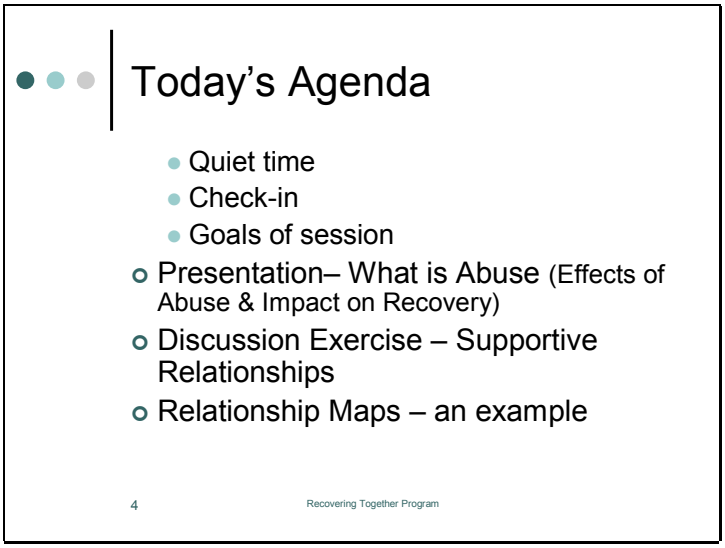
2 Recovering Together Program

Slide 3

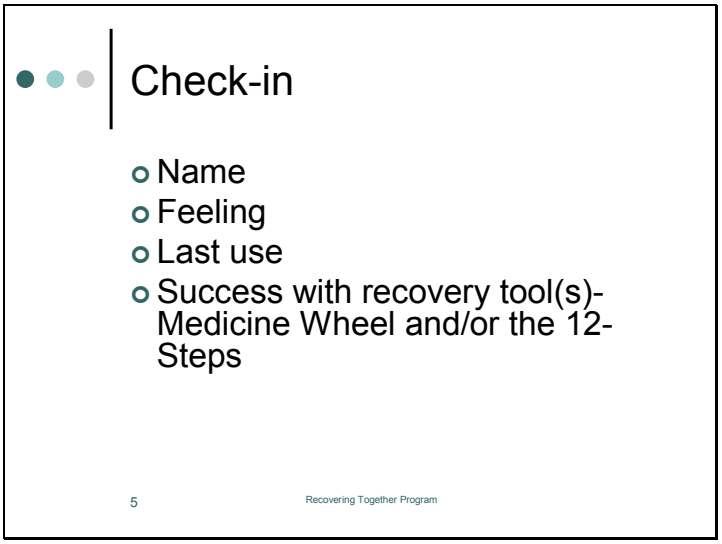


This quiet time prepares participants for locating the "place of knowing" deep inside themselves. Although this is a fairly simple process, some participants doubt their own ability to listen for their inner wisdom. Upon reflection, the counselor may be able to understand this doubt in the context of addiction. Imagine how many times they have used their drug of choice, even though they "knew better." Use this as an example of how they have already heard the inner voice many times, but perhaps didn't know how to listen. Ask participants to think of one (or more) things that they definitely KNOW. Have them close their eyes and turn their attention inwards, toward their bodies. Next, they should locate the general area in their body where they feel this knowledge - this varies considerably in size and location. Some examples include in their head, their heart region, "in their gut," etc. It could be a definite, but tiny pinprick of light or a large, rather vague area. Have them get a tactile sensation of that knowing – explore temperature, color, texture, etc.

Slide 4

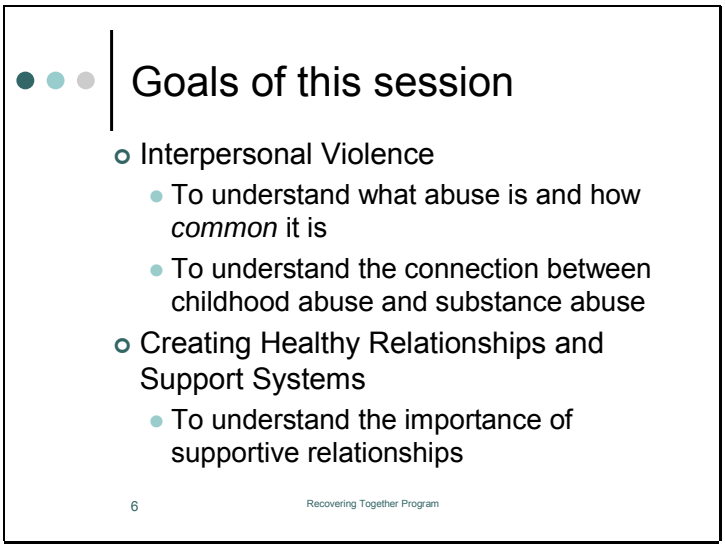


Slide 5



In addition to normal check-in (name, last use and current emotion) ask participants to reflect on last week's lesson about the Medicine Wheel and the 12 steps. Did they experience any reactions or thoughts this week about those topics? Did understanding the 12 steps help in their alternative recovery activities?

Slide 6



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- To understand the connection between childhood abuse and substance abuse
- Creating Healthy Relationships and Support Systems
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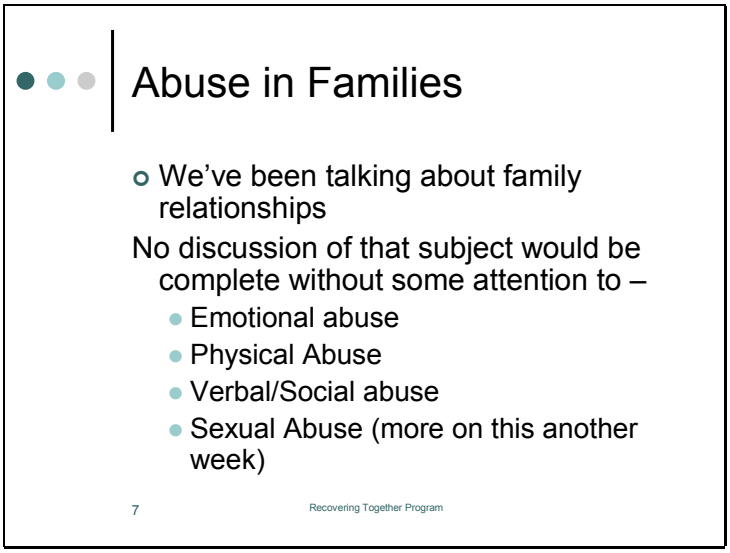
Slide 7



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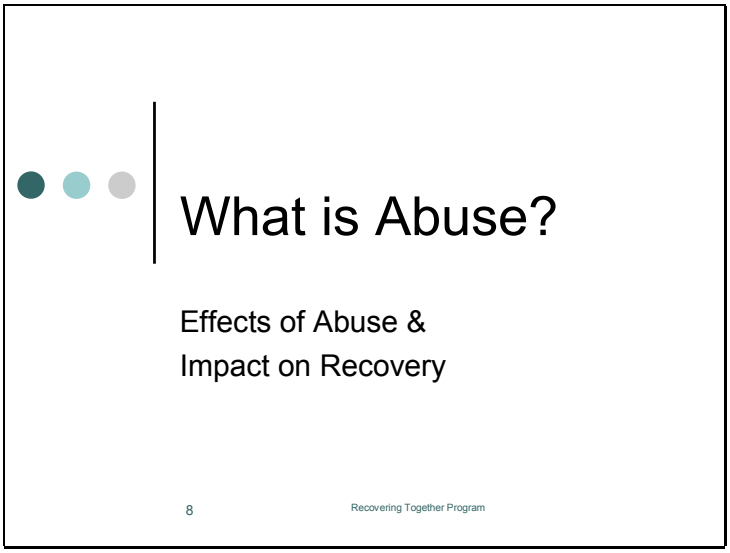
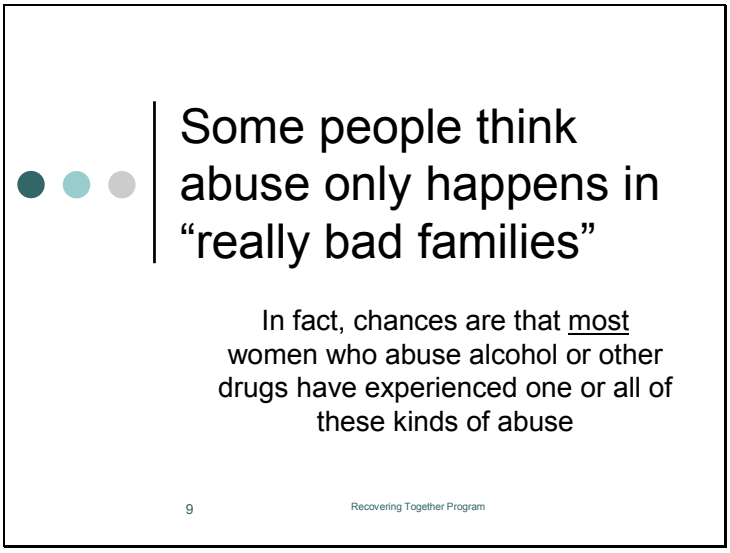
Slide 8



Slide 9



Slide 10

Just the facts…

- One study on alcoholic women found that
  - Three out of every four had been sexually abused
  - Three out of four had been emotionally abused
  - Half had been physically abused
- For many of the women, abuse had started before they were 10 years old.

(Covington, 1999)

10 Recovering Together Program

Covington, S. (1999). *Helping women recover: A program for treating addiction*. San Francisco, CA: Josey-Bass. p.144

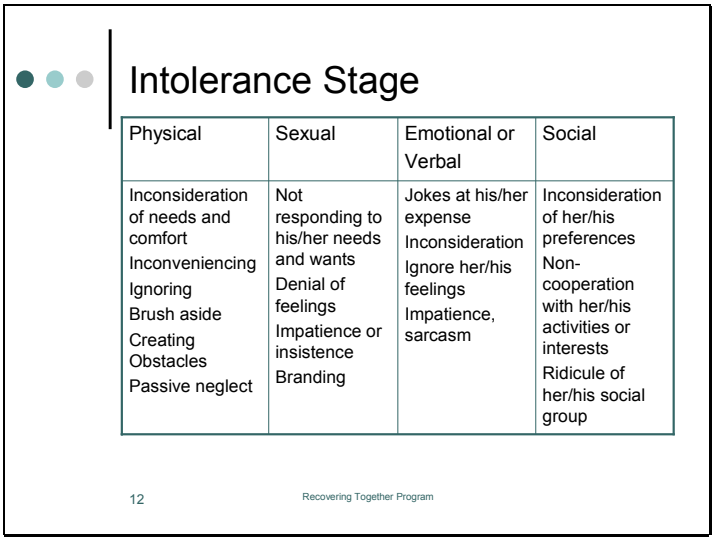
Slide 11

Family violence is a continuum

- It usually happens in stages
  - Gradually getting worse & more dangerous
  - Increasing in intensity & frequency over time
- There are four basic stages
  - Intolerance
  - Rejection
  - Sabotage
  - Destruction

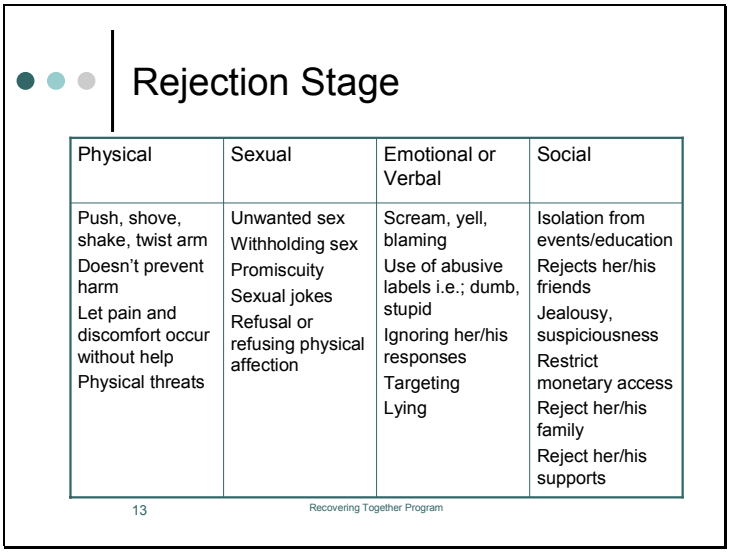
11 Recovering Together Program

Slide 12



Pettit, L. & Gibbons, G. (1999). Presentation at the workshop for Domestic Violence Risk Assessment in Durango, CO, on September 24, 1999 by AMEND (Abusive Men Exploring New Directions).

Slide 13



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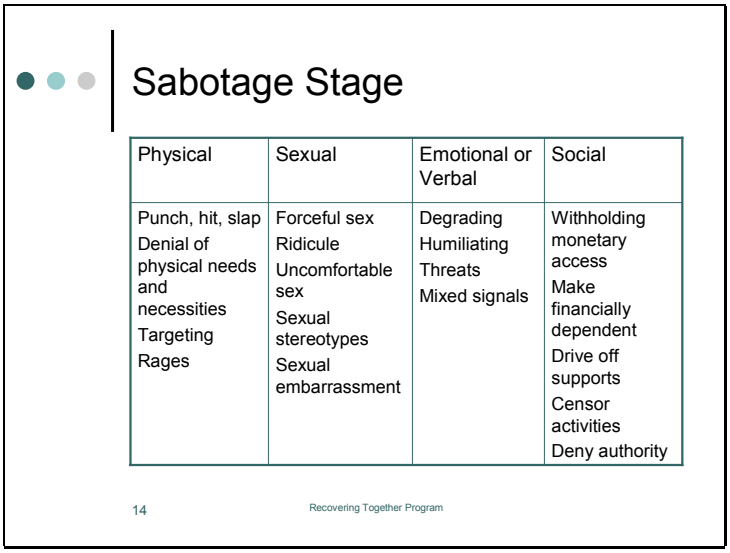

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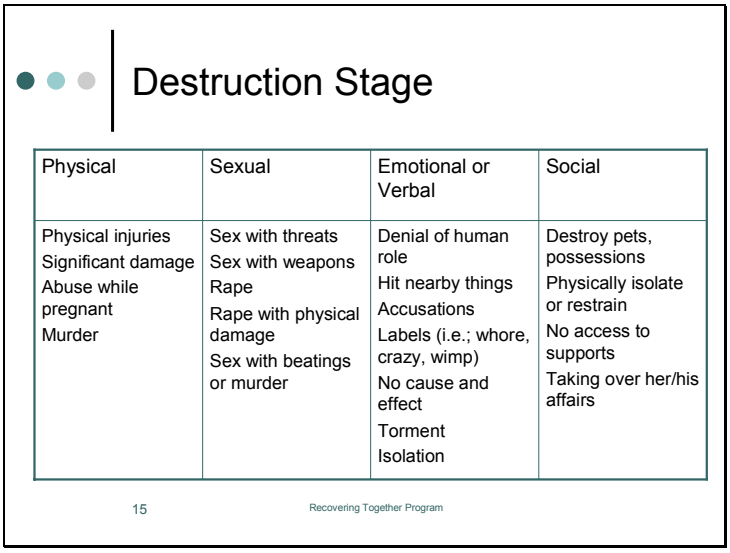

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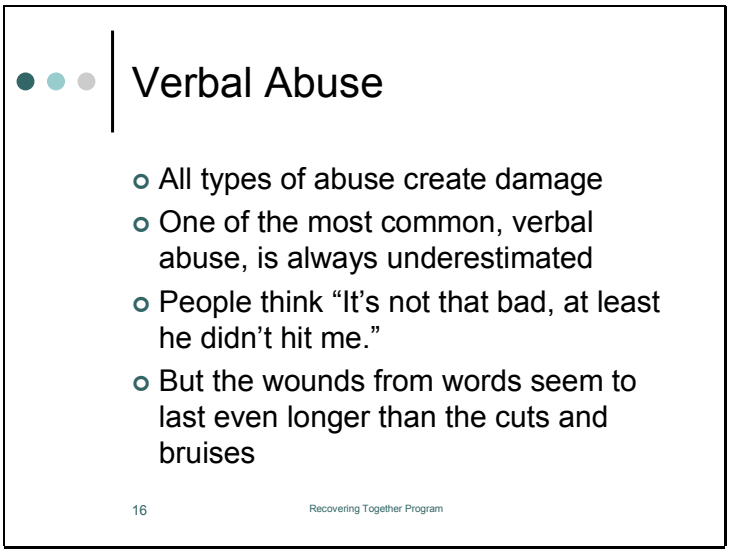

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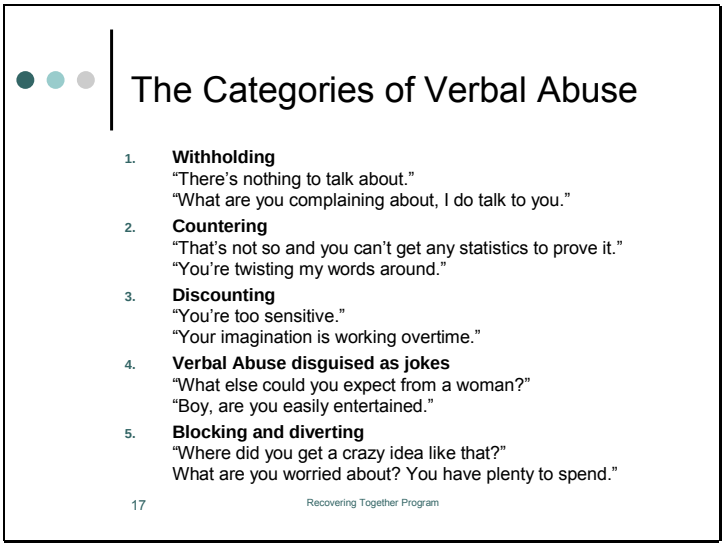

Evans, P. (1996). *Verbally Abusive Relationship: How to recognize it and how to respond*. Cincinnati, OH: Adams Media Corporation. P.77-78

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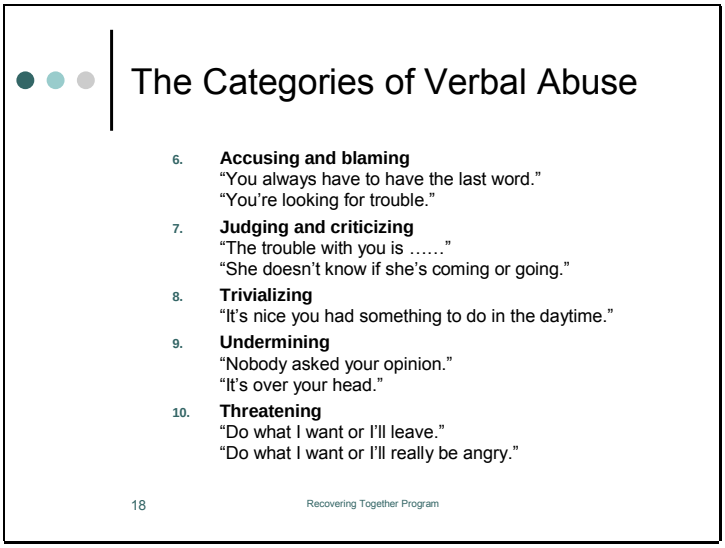

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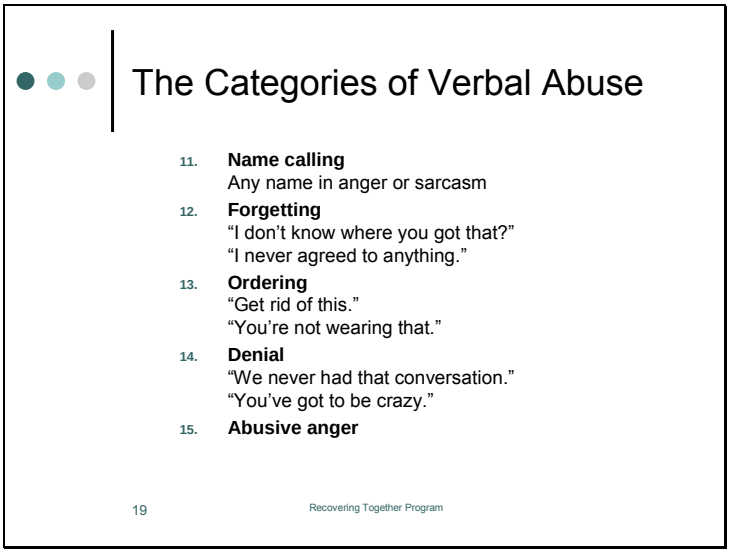

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Slide 20

Cycle of Domestic Violence

The Cycle of Domestic Violence shows how domestic violence often becomes a pattern made up of three stages.

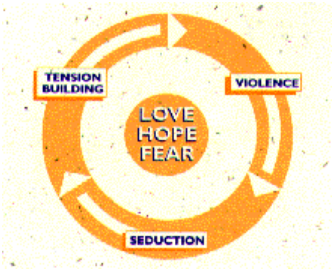
20 Recovering Together Program

Slide 21

Cycle of Violence

- **Tension Building**
  - criticism, yelling, swearing, using angry gestures, coercion, threats
- **Violence**
  - physical and sexual attacks and threats
- **Seduction**
  - apologies, blaming, promises to change, gifts

Three dynamics, love, hope and fear, keep the cycle in motion and make it hard to end a violent relationship.



(Walker, 1979)

21 Recovering Together Program

Walker, L. (1979). *The battered woman.* New York: Harper and Row.

Slide 22

What keeps us going…

- **Love/Hope/Fear are the dynamics that keep the cycle in motion**
  - **Love...**
    - for your partner, the relationship has its good points, it's not all bad
  - **Hope...**
    - that it will change, the relationship didn't begin like this
  - **Fear...**
    - that the threats to kill you or your family will become reality

22 Recovering Together Program

Slide 23

The cycle doesn't stop with just the parents

Victim

Perpetrator

Child will take on whatever role seems safest...

23 Recovering Together Program

Slide 24

What is a healthy relationship?

- Remember four characteristics of a healthy relationship with a drug?
  - Knowledge
  - Benefits
  - No negative "side effects"
  - Freedom to choose
  - These can be applied to human relations…

24 Recovering Together Program

"From Chocolate to Morphine: Everything You Need to Know about Mind-Altering Drugs" by Andrew Weil. (1993. New York: Houghton Mifflin)

Slide 25

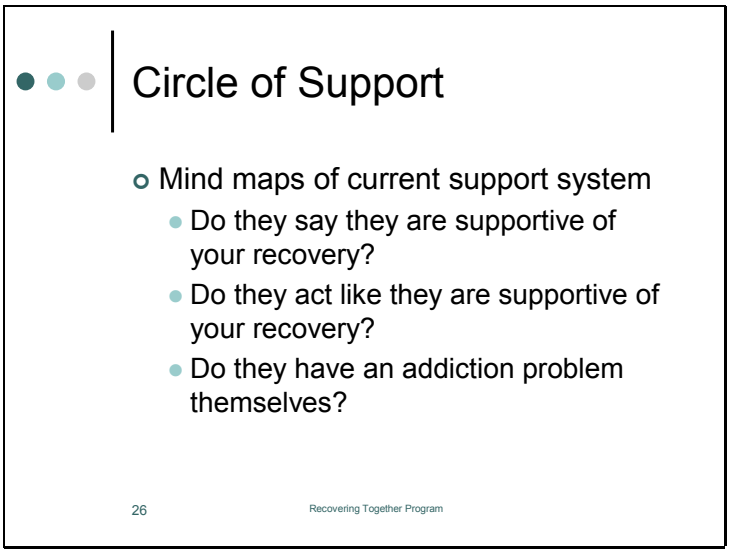
Characteristics of a Healthy Relationship

- Knowledge
  - What kind of relationship is it?
- Benefits
  - Are both people getting something out of it?
- No negative "side effects"
  - Is it violent or hurtful?
- Freedom to choose
  - Can I walk away from it at any time?

25 Recovering Together Program

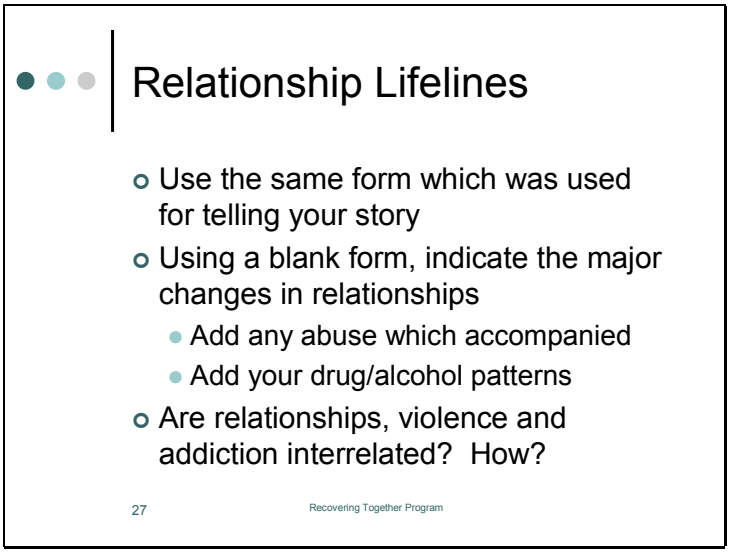
Adapted from *"From Chocolate to Morphine: Everything You Need to Know about Mind-Altering Drugs" by Andrew Weil. (1993. New York: Houghton Mifflin)*

Slide 26



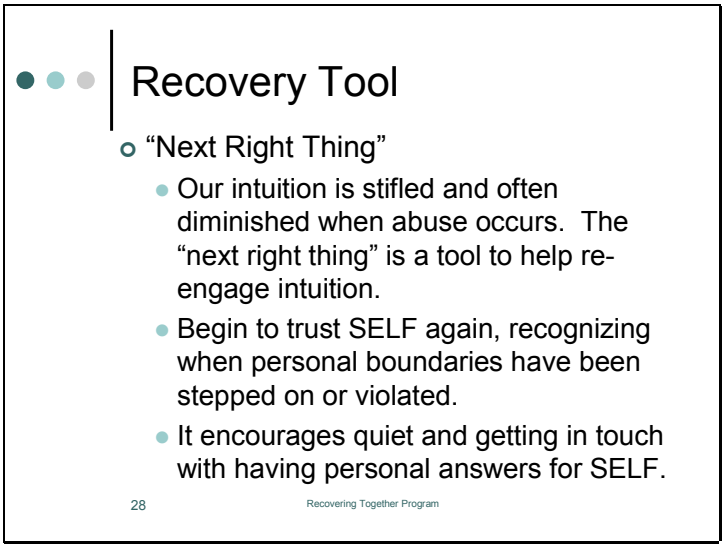
This is a simple process, using pen and paper to draw a map of an individual's support system. Draw a small circle in the center of the page (represents self). Then draw a small circle to represent anyone that can meet the criteria mentioned on this slide. It is difficult for some women to admit that some (or all) of their current support system may not meet the criteria. Help them brainstorm until a full circle is formed. Remember to include RTP staff, other women in the group, or family/friends who may have withdrawn during the participant's addiction. They may have become estranged from these people; acknowledge this and mention that may shift during the recovery process.

Slide 27



In unit three, participants created lifelines which included significant events in their lives focusing on their relationship with alcohol and drugs. This week, have participants do a lifeline that illustrates their significant relationships with other people. For instance, they may include events from their childhood, like a parental divorce or their first boyfriend. They should indicate any marriages, divorces, or serious relationships. In addition, they may want to indicate if their were any abuse issues in the relationships, including verbal, physical, sexual abuse. Help them identify and personalize the patterns which emerge. End this activity on a positive note, using the lifeline as a springboard for change.

Slide 28



Today's tool is a concept to help participants with decision making. In early recovery, increased awareness of choice points can create a sense of being overwhelmed. Too many decisions at once can lead to poor decisions. Therefore, participants should become aware of the concept of "the next right thing." Encourage participants to think about the quiet time which began the group session. This will help them locate the "place of knowing" deep inside. Lead them through the process of knowing what they will do in the next fifteen minutes following group. Help them understand that they already KNOW what to do next, if they just stop and listen for the "next right thing."

Week 12 - Addiction and Family Roles

Main Idea of Session

To understand how relationships with family of origin affect the ways in which current relationships are approached. Understand how families learn to maintain balance by taking on roles, and how addiction can create rigid roles that discourage genuine growth. To learn some common patterns or family roles in families where addiction or substance abuse are present.

Materials/Equipment Needed

- Materials
  - Presentation file or overhead transparencies
  - Key Feeling Chart – color copy in sheet protector (for check-in)
  - Family roles positive/negative handout
  - Meditation books, one copy for each participant
- Equipment
  - LCD or overhead projector and Screen
  - Computer with PowerPoint or Adobe Reader (for LCD) or transparencies for overheads
  - Drug testing supplies, as needed
  - Copy or fax machine for attendance sheets

Session Overview

Quiet time

Check-in

What is Family?

Topic - Family Roles and Addiction

Discussion – Prepare for Children's Play

Recovery tool 11

Children's Play

Multi-family discussion

Week 12 Activities

Time	*Activity and/or Slides*	*Facilitator Process Notes*
10 min	**1. Quiet Time** **Slide 3**	Quiet time today is a group reading from a meditation book. Have the participants practice taking 2-3 minutes to focus inward, center themselves, then listen to the reading from a daily meditation book. Help them imagine finding a quiet moment in the morning to reflect on a meaningful thought and plan their day.
20 min	**2. Check-in** **Slides 4-6**	During check-in, have participants briefly share their thoughts about the tool from last week in addition to the normal check-in topics. Did they notice their inner voice more? Did they stop and think about "the next right thing?" If not, can they think of a time during the last week when it might have helped if they had?

Discussion - What is family?

10 min	**3. Discussion - What is family?** **Slides 7-17**	Have each participant define who "family" is for them. There are several clinical issues within this topic. Common issues include: substance-abusing family members; poor boundaries with non-family members included in the inner circle and draining family resources; revolving door relationships that disrupt children's sense of family and/or excluding a long-time partner from the inner circle of family. As you go through the slides, ask mothers to give examples of each point, e.g., how

		subtle and nonverbal messages are given and understood by children (slide 11). Remember to validate each participant's own choice of who to include in their own family, but make a note of possible consequences for children to address later in family therapy sessions during Phase 3.

Family function and addiction

20 min	**4. Family Function and Addiction** **Slides 18-29**	In the family roles presentation, the primary issues which arise are participants' difficulty focusing on their family of origin and worry about the roles which their own children have assumed. Both of these are fruitful discussion topics, but it is important for the mother to at least identify roles she assumed in her childhood. Remember to emphasize two key points repeatedly: 1) These are not identities, they are simply roles assumed to compensate for enduring family problems. 2) Looking past the mask of a long-time role to the true identity within is challenging but worthwhile. Today's children's role- play is designed to help the whole family begin that process.
5 min	**5. Recovery Tool 12** **Slide 30**	Distribute daily meditation books to participants. Recommended books include *Each Day a New Beginning* (Hazelden, 1985) or *The Promise of a New Day* (Casey & Vanceburg, 1991).

	Break **Slide 32**	

Children's Role Play

5 min	**7. Discussion** **Slide 33**	Prepare the participants for the common feelings and thoughts which typically arise while watching the children's role-play. Help the participants to personalize and manage their feelings of fear and guilt which may arise, and introduce/focus on the feelings of hope and readiness to change that are also presented in the play. This play is a turning point for many parents and children in acknowledging the effect of addiction on their own family. This is truly an opportunity to recover together. Remind mothers to provide encouragement to their children, who may be nervous about openly acknowledging their own roles.

30 min	**8. Children's Role-Play**	Be prepared for children to "act out" or "shut down". Remember that they are in the process of violating the silent rules of don't talk, don't feel, don't trust. Staff can create safety for this to happen in a healing way.

Multi-family discussion – Rigid roles and genuine interaction

20 min	**9. Multi-family Discussion – Unlearning Rigid Roles & Practicing Genuine Interaction**	The children's therapist will lead this discussion, but may need support if the mothers have difficulty participating. Families need to be reminded often during this discussion that 1) the roles they may have played in the past DO NOT define their identity, and 2) individuals may switch roles many times during a lifetime or even within one day.

Week 12 – Slides with Commentary

Slide 1

Supply List

- Materials
  - Presentation File or Overhead Transparencies
  - Family roles positive/negative handout
  - Meditation books
- Equipment
  - LCD or Overhead projector & Screen
  - Computer with PowerPoint or Adobe Reader (for LCD) or transparencies for overheads
  - Drug testing supplies, as needed
  - Copy or fax machine for attendance sheets

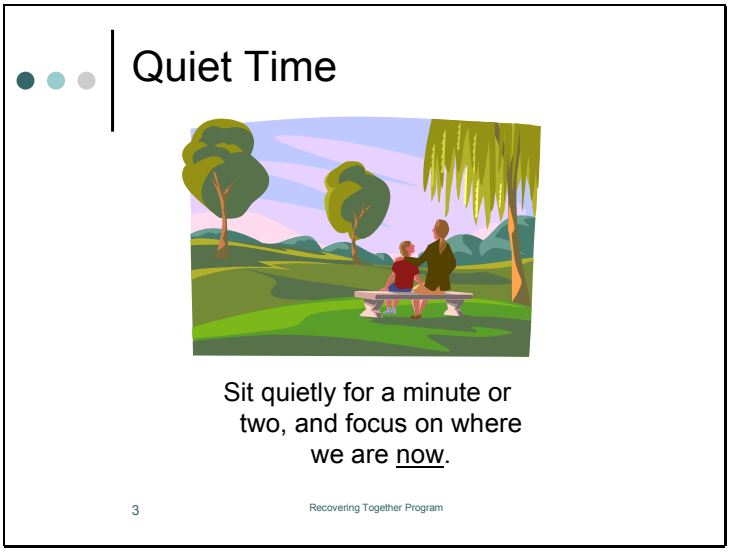
1 Recovering Together Program

Slide 2

Week 12 - Addiction & Family Roles

2 Recovering Together Program

Slide 3



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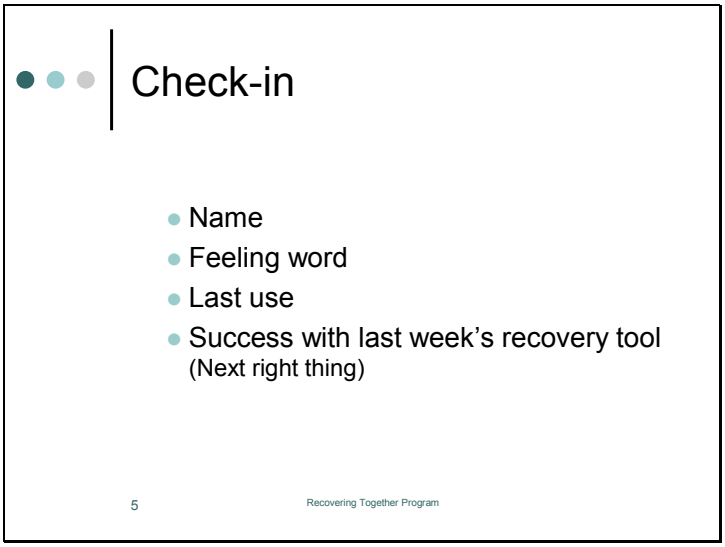
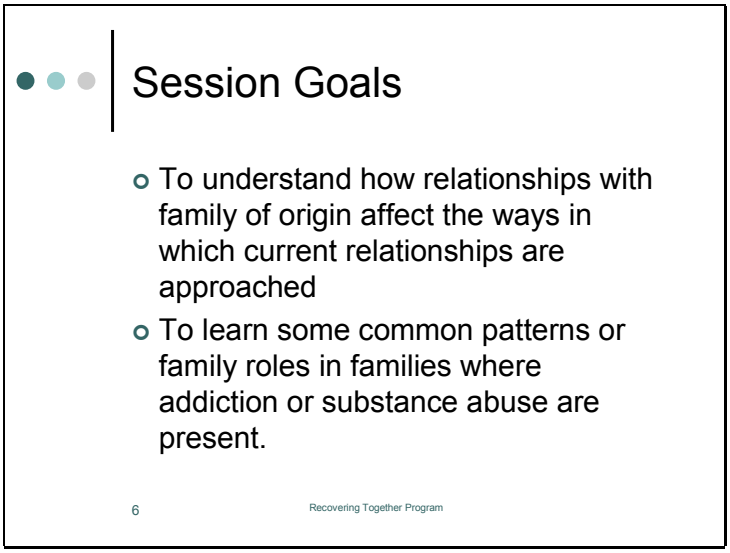
Slide 4

Slide 5



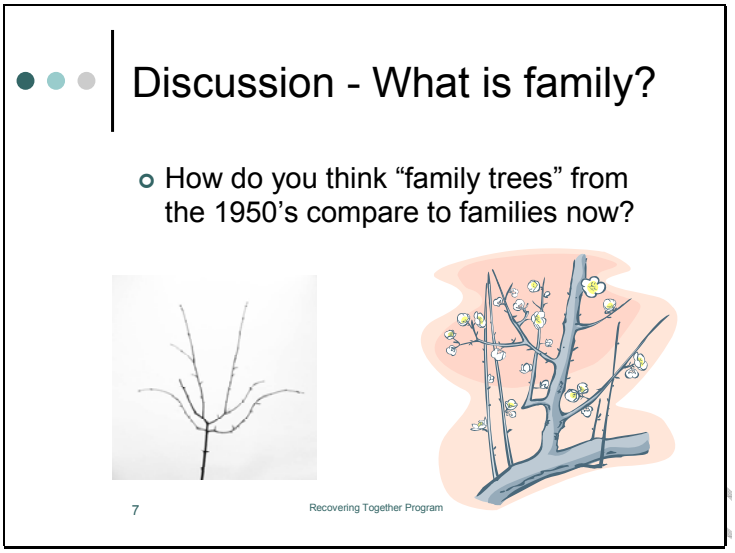
During check-in, have participants briefly share their thoughts about the tool from last week. Did they notice any Simple Cycles in their week? Did they think about the Medicine Wheel and/or 12 steps?

Slide 6



To understand how relationships with family of origin affect the ways in which current relationships are approached. Understand how families learn to maintain balance by taking on roles, and how addiction can create rigid roles that discourage genuine growth. To learn some common patterns or family roles in families where addiction or substance abuse are present.

Slide 7



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Slide 8

Structure of families has changed…

- Who is your family?
  - Growing up family (a.k.a. family of origin)
  - family now – children, spouse or partner, others?
- Drawing the line – who is not family?
  - Relatedness and interconnectedness

8 Recovering Together Program

Slide 9

During this presentation,
try to concentrate on your
family of origin,
and your own experience growing up.

Try not to get lost in thoughts of your own kids –
we will get to that later!

9 Recovering Together Program

Slide 10

"Dysfunctional" Families

- **Families are attempting to maintain balance**
  - **They are doing the best they can with what they have!**
    - example: Ben yells because he does not feel heard

10 Recovering Together Program

Slide 11

Difference between functional and dysfunctional families

- In functional families, the primary function of the family unit is to *meet growing children's needs*.
- One of the characteristics that sets distressed families apart is a *reversal* of this mission.

11 Recovering Together Program

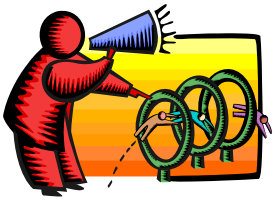
(Covington & Becket, 1988)

Covington, S., & Becket, L (1988). *Leaving the enchanted forest.* New York: Harper Collins. p. 70

Slide 12

Dysfunctional families

- Expect children to meet the needs of the family
  - This demand is communicated in many ways
    - Some direct
    - Many subtle and nonverbal



- Nevertheless, children get the message

12 Recovering Together Program

Slide 13

Stressors tip the balance

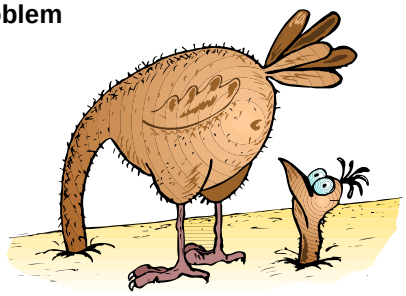
- Any major stressor can disturb the balance of a family
  - Addiction
  - Major illness or death
  - External threats like war or neighborhood violence
  - Internal threats such as a major betrayal or financial issues

13 Recovering Together Program

Slide 14

Common family reactions to alcohol & drug abuse

- **Deny the problem**



14 Recovering Together Program

Slide 15

The family tries to eliminate the problem through:

Threats

"don't tell or something bad will happen"

- bribes "if you don't bother mommy and her friends I'll buy you…"

- **hiding the alcohol or drugs**

"I get high in the bathroom, the kids don't know"

15 Recovering Together Program

Slide 16

The family tries to reorganize:

- **1st attempt at reorganization**
  - **sober spouse or another significant other taking action**
  - **Attempts to escape the problem by seeking a legal separation or divorce**

- **2nd attempt at reorganization**
  - **substance abusing member seeking help**

16 Recovering Together Program

Slide 17

If reorganization fails…

- The family will try to stabilize itself by creating rigid rules or roles in order to avoid destruction.
  - Rules can be written, but are often unwritten and unspoken

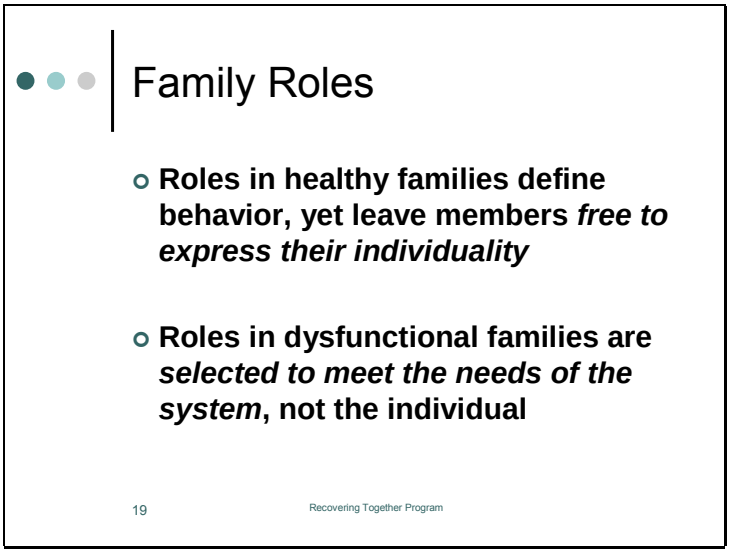
17 Recovering Together Program

Slide 18

Family Dynamics: The Rules

- **Don't talk**
- **Don't feel**
- **Don't trust**

Slide 19



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Slide 20

May be rigid or fluid

- May be assigned one person per role
- May switch rapidly among family members

Unhealthy families often use dysfunctional roles

- **They are simply mechanisms to maintain balance**

Slide 22

Dysfunctional Roles

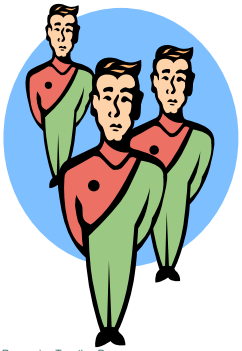
- These are not chosen
  - They are imposed on members through the <u>family system's needs</u>

22 Recovering Together Program

Slide 23

Dysfunctional Roles

- They deny feelings, uniqueness



23 Recovering Together Program

Slide 24

Dysfunctional Roles

- **Family members may not know themselves *except by their role***

24 Recovering Together Program

Different Family Roles: Victim or Star

- **Chemically Dependent**
  - **Outside:**
    - hostility, manipulation, aggression, blaming, charming, rigid values
  - **Inside:**
    - shame, guilt, fear, pain, hurt

25 Recovering Together Program

Wegscheider-Cruse, S. (1988). *The Family trap*. Minneapolis, Minn: Onsite.

Slide 26

Chief Enabler

- **Closest Emotionally to Victim, protector of family**
  - **Outside:**
    - self-righteous, super-responsible, sarcastic, passive, physically sick, martyr
  - **Inside:**
    - anger, hurt, guilt, low self-esteem

26 Recovering Together Program

Wegscheider-Cruse, S. (1988). *The Family trap*. Minneapolis, Minn: Onsite.

Slide 27

Family Hero

- **Caretaker of family**
  - **Outside:**
    - good kid, high achiever, follow rules, seeks approval, very responsible
  - **Inside:**
    - guilt, hurt, inadequacy

27 Recovering Together Program

Wegscheider-Cruse, S. (1988). *The Family trap*. Minneapolis, Minn: Onsite.

Slide 28

Scapegoat

- **Problem child**
  - **Outside:**
    - hostile, defiant, rule-breaker, in trouble
  - **Inside:**
    - rejection, hurt, jealousy, anger

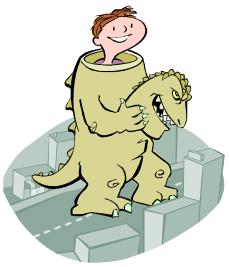
28 Recovering Together Program

Wegscheider-Cruse, S. (1988). *The Family trap*. Minneapolis, Minn: Onsite.

Slide 29

Mascot

- **Family Clown**
  - **Outside:**
    - immature, fragile, cute, hyperactive, distracting
  - **Inside:**
    - fear, anxiety, insecurity



29 Recovering Together Program

Wegscheider-Cruse, S. (1988). *The Family trap*. Minneapolis, Minn: Onsite.

Slide 30

Lost Child

- **Forgotten Child**
  - **Outside:**
    - shy, quiet, fantasy life, solitary, mediocre, attaches to things, not people
  - **Inside:**
    - rejection, hurt, anxiety

30 Recovering Together Program

Wegscheider-Cruse, S. (1988). *The Family trap*. Minneapolis, Minn: Onsite.

Slide 31

Recovery Tool

- "Meditation Books" are actually just daily readings
- Sit quietly in the morning, read the day's thoughts and ponder how that applies to your life.
- You can also look up a particular topic in the index, if you have something on your mind.

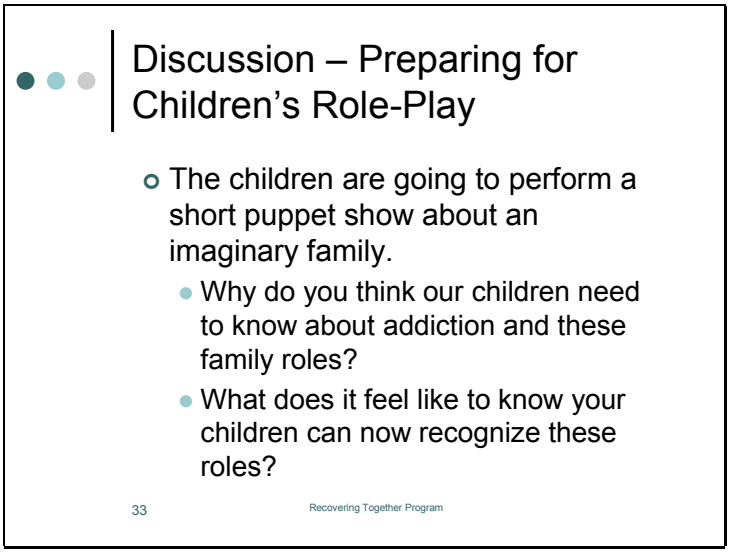
31 Recovering Together Program

Distribute daily meditation books to participants. Recommended books include *Each Day a New Beginning* (Hazelden, 1985) or *The Promise of a New Day* (Casey & Vanceburg, 1991).

Slide 32

Check-in & Break

Slide 33



Prepare the participants for the feelings and thoughts which typically arise while watching the children's role-play. Help the participants to personalize and manage their feelings of fear and guilt which may arise, and introduce feelings of hope and readiness to change. This play is a turning point for many parents and children in acknowledging the effect of addiction on their own family. This is truly an opportunity to recover together. Remind mothers to provide encouragement to their children, who may be nervous about openly acknowledging their own roles.

Be prepared for children to "act out" or "shut down." Remember that they are in the process of violating the silent rules of don't talk, don't feel, don't trust. Staff can create safety for this to happen in a healing way.

The children's therapist will lead this discussion, but may need support if the mothers have difficulty participating. Families need to be reminded often during this discussion that 1) the roles they may have played in the past DO NOT define their identity. 2) Individuals may switch roles many times during a lifetime or even within one day.

Week 13 - Trauma and Addiction

Main Idea of Session

Understanding the body's natural defenses related to trauma, and their relationship to addictive behaviors.

Materials/Equipment Needed

- Materials
  - Presentation file or overhead transparencies
  - Key Feeling chart – color copy in sheet protector (for check-in)
  - Self-awareness summary and Trauma questionnaire (Najavits, 2002)
  - Index cards
  - Pens
  - White board or flip board
  - Dry erase marker or markers
  - Glass marbles or large colored beads
- Equipment
  - LCD or overhead projector & screen
  - Computer with PowerPoint or Adobe Reader
  - Drug testing supplies, as needed
  - Copy or fax machine for attendance sheets

Session Overview

Quiet time

Check-in

Presentation – What is Trauma? (Impact of Trauma on Recovery)

Discussion – Addiction and Trauma

Week 13 Activities

Time	*Activity and/or Slides*	*Facilitator Process Notes*
10 min	**1. Quiet Time** **Slides 2- 3**	Walk the participants through a quiet time and ask them to notice tension in their bodies. Do progressive muscle relaxations – instructions in RTP Women's Video.
20 min	**2. Agenda & Check-in** **Slide 4-5**	Standard check-in, plus inquire about clients' experience with any reactions or thoughts this week about the children's role-play? Did their children refer to the role-play or process feelings about the discussion?

Discussion – Talking about Trauma

Time	*Activity and/or Slides*	*Facilitator Process Notes*
10 min	**3. Discussion – Talking about Trauma** **Slide 6-7**	The goal of this discussion is to create awareness in the participants that there are resources for them to talk about feelings which may arise during the discussion. Help them understand that although feelings and memories may arise during the discussion, it is OK just to notice them and let them go. "Just let the experiences that arise pass by like a cloud." It is certainly appropriate to acknowledge the feelings to the group today, but probing and discussing the memories in-depth can get in the way of learning about trauma. This is actually good practice for the participants to realize and manage the memories. Direct them to schedule individual sessions to discuss memories or flashbacks if they are intrusive or reoccur frequently. The message should be of empowerment to participants (knowledge is power), not to create apprehension about their reaction.

Presentation – What is trauma?

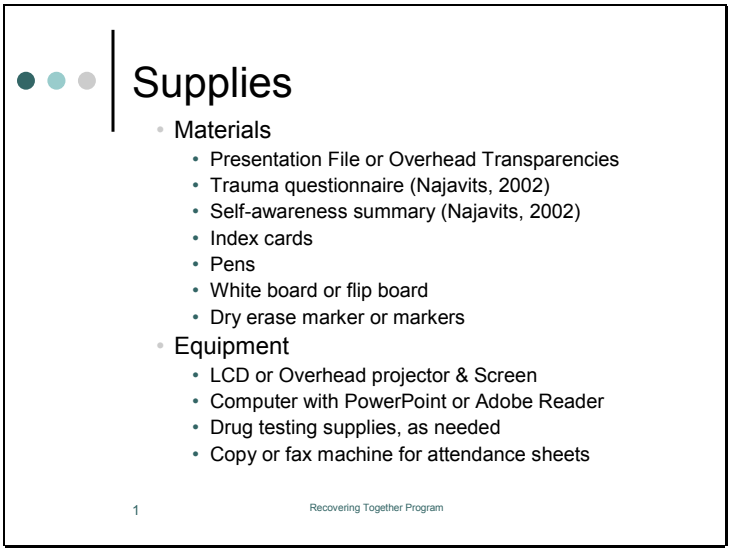
Time	*Activity and/or Slides*	*Facilitator Process Notes*
20 min	**4. Presentation – What is Trauma?** **Slide 8-15**	The purpose of the trauma questionnaires is to personalize the concept of trauma. However, asking each participant to share their personal experience can sidetrack the group. Just give them sufficient time to answer the questions on their own handout, and ask how many of them believe they have experienced a trauma. If there are some who have NOT, then ask if traumatic things have occurred to someone close to them. Then proceed with the presentation. Encourage questions!
10 min	**Break** **Slide 16**	

Effects of trauma on recovery

Time	*Activity and/or Slides*	*Facilitator Process Notes*
50 min	**5. Effects of Trauma on Recovery** **Slides 17-21**	The concept of this section is simple – participants need to understand that trauma can trigger relapse. The goal is to make this connection between trauma and relapse, and to empower participants to seek help BEFORE they relapse.

Week 13 Slides with Commentary

Slide 1



Slide 2

Trauma & Addiction week 13

Understanding the body's natural defenses, and their relationship to addictive behaviors

2 Recovering Together Program

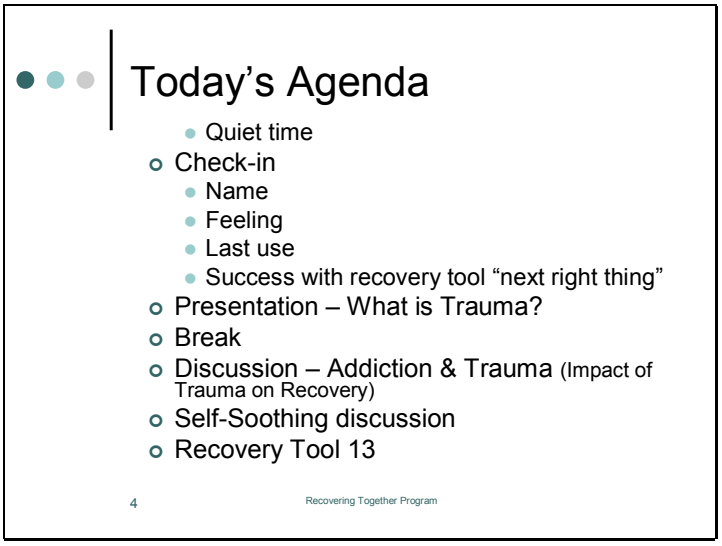
Quiet Time

Sit quietly for a minute or two, and focus on where we are now.

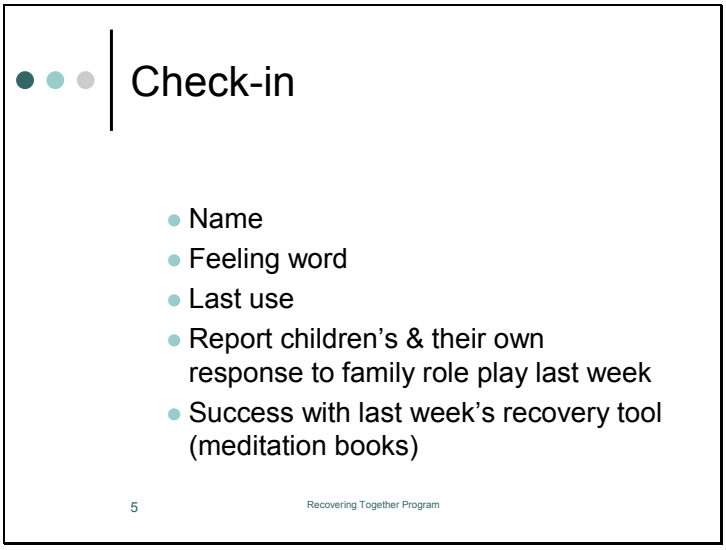
3 Recovering Together Program

Walk the participants through a quiet time and ask them to notice tension in their bodies. Do progressive muscle relaxations – instructions in RTP Women's Video.

Slide 4

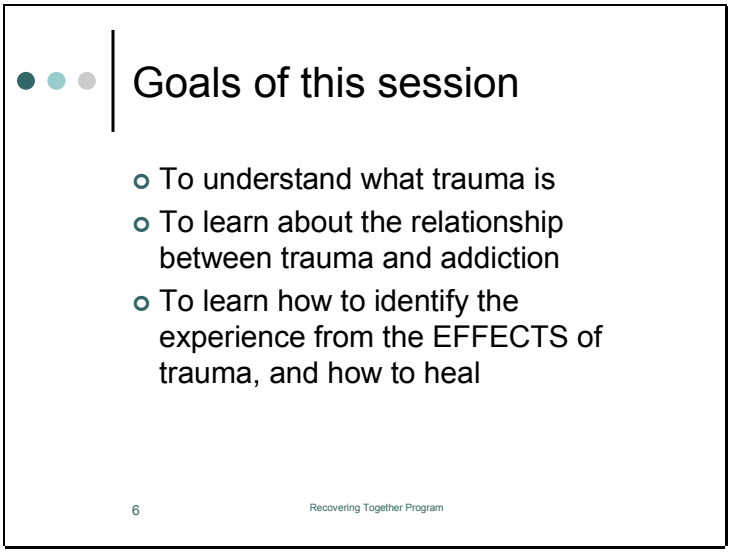


Slide 5



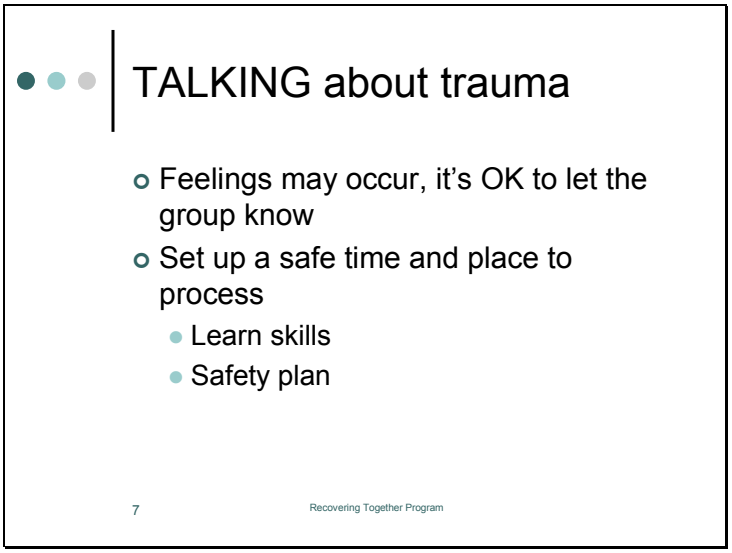
Standard check-in, plus inquire about client's experience with meditation books. Did they find a little time to read their daily meditation?

Slide 6



Understanding the body's natural defenses related to trauma, and their relationship to addictive behaviors.

Slide 7



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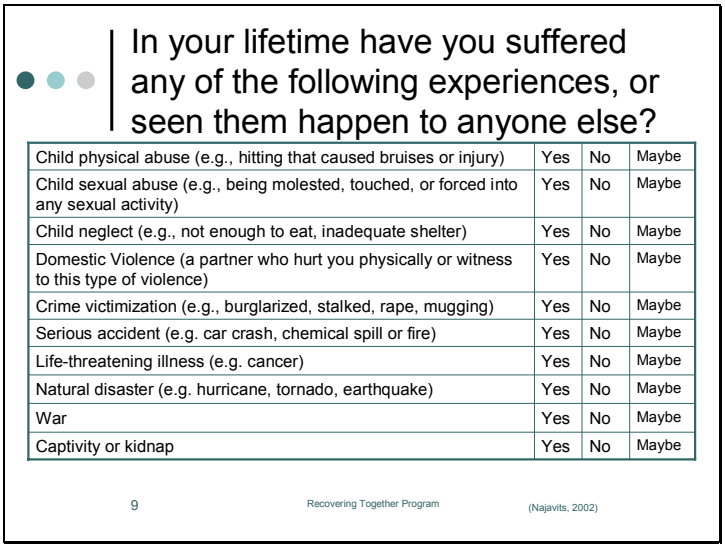
Slide 8

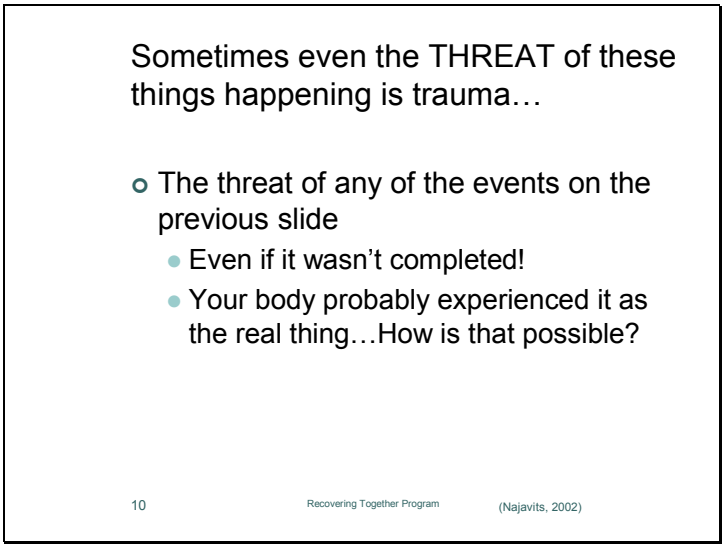
The trauma questionnaire's purpose is to personalize the concept of trauma. However, asking each participant to share their personal experience can sidetrack the group. Just give them sufficient time to answer the questions on their own handout, and ask how many people believe they have experienced a trauma. If there are some who have NOT, then ask if traumatic things have occurred to someone close to them. Then proceed with the presentation. Encourage questions!

Slide 9



Najavits, L. M. (2002). A w*oman's addiction workbook*. Oakland, CA: New Harbinger Publications, Inc, p.73.

Slide 10



Najavits, L.M. (2002) A woman's addiction workbook. P. 73.

Slide 11

Let's imagine

- A thousand years ago, you and your children are out in the forest, gathering food
- Suddenly, a tiger steps out in the path
- Your mind and body will IMMEDIATELY prepare to defend yourself and your children

11 Recovering Together Program

When faced with this situation

- What could happen?
  - One of you could die or get very hurt
  - The tiger could simply pass by…
- What will definitely happen?
  - Your body will prepare to -
    - Fight (defend yourself and family)
    - Flight (protect by running or climbing)
    - Freeze (tense up and don't move)

12 Recovering Together Program

Slide 13

A millennium hasn't changed this!

- Our bodies react the same exact way to the threats in our lives today
- If you have experienced any life-threatening event
  - or even believed you were truly threatened
- your body & mind PREPARED for fight, flight or freeze.

13 Recovering Together Program

Slide 14

Think back again to the tiger…

- When our bodies prepare for a threat
  - They prepare to DO SOMETHING
    - involving our personal participation
    - Including some kind of action or movement
- After taking this action, our bodies "turn off" the trauma & return to a regular state
- This is how our bodies are designed…they produce chemicals in the brain to complete the cycle.

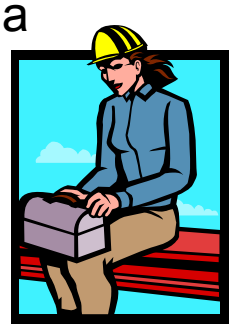
14 Recovering Together Program

Slide 15

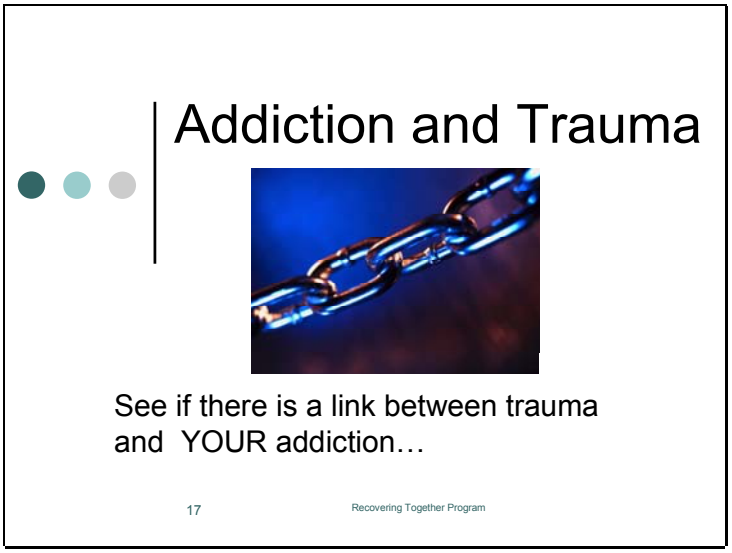
What happens if you can't DO anything?

- Your body and mind often don't "finish" processing the trauma
- This can lead to a reaction that resembles "getting stuck" in a kind of loop
- This is sometimes called PTSD

Time to take a Break

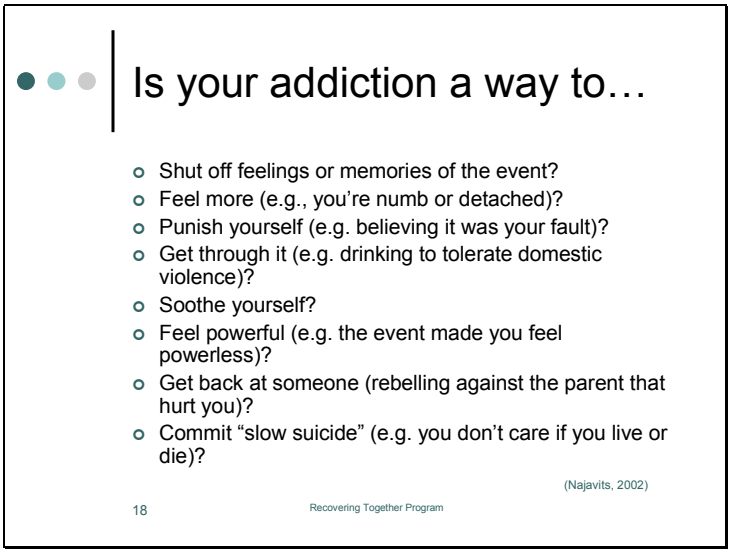


Slide 17



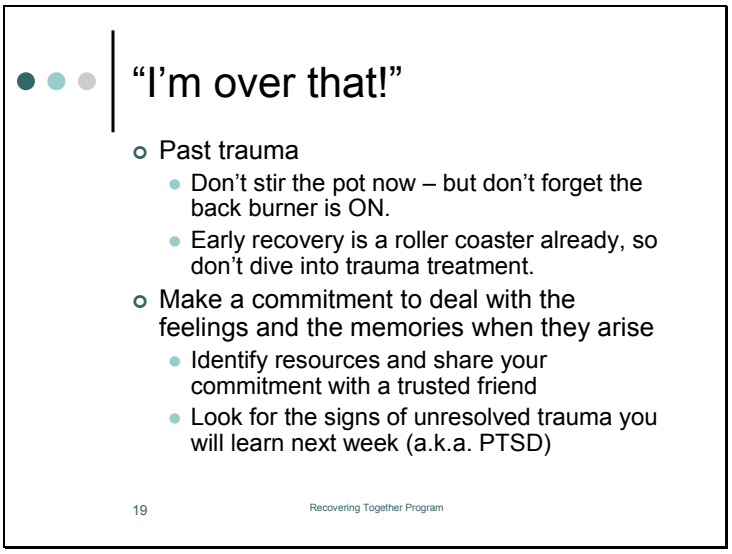
The concept of this section is simple – participants need to understand that trauma can trigger relapse. The goal is to make this connection between trauma and relapse, and to empower participants to seek help BEFORE they relapse.

Slide 18

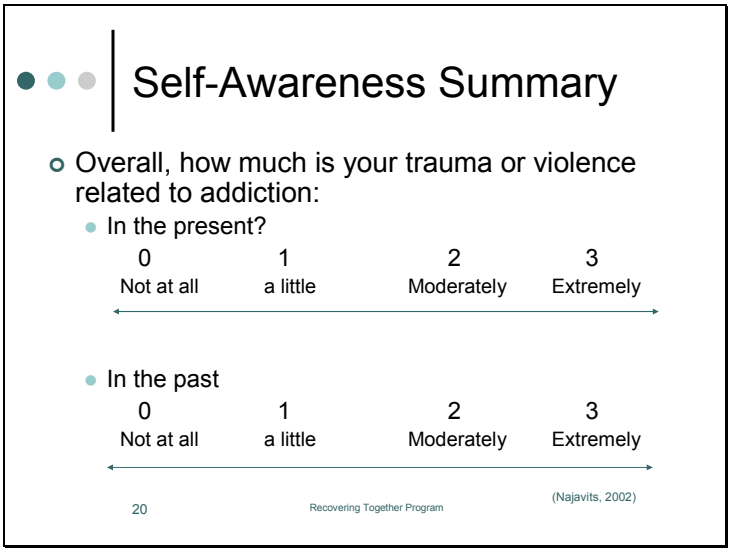


Najavits, 2002.

Slide 19



Slide 20



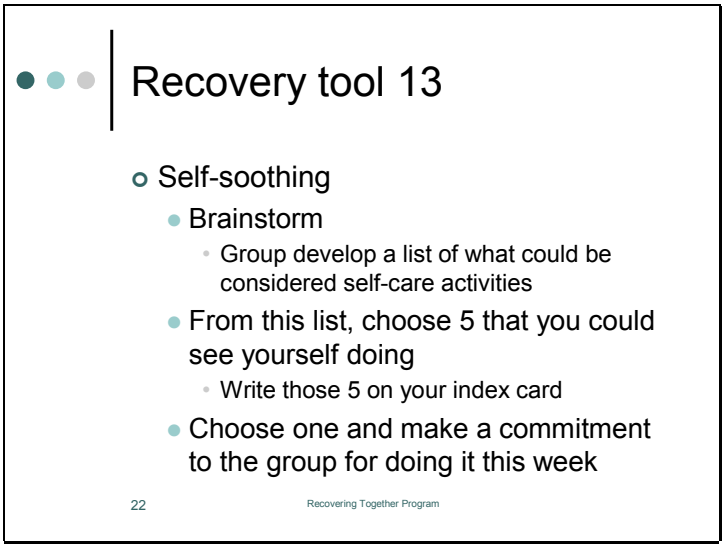
Najavits, 2002.

Slide 21

Trauma as a trigger

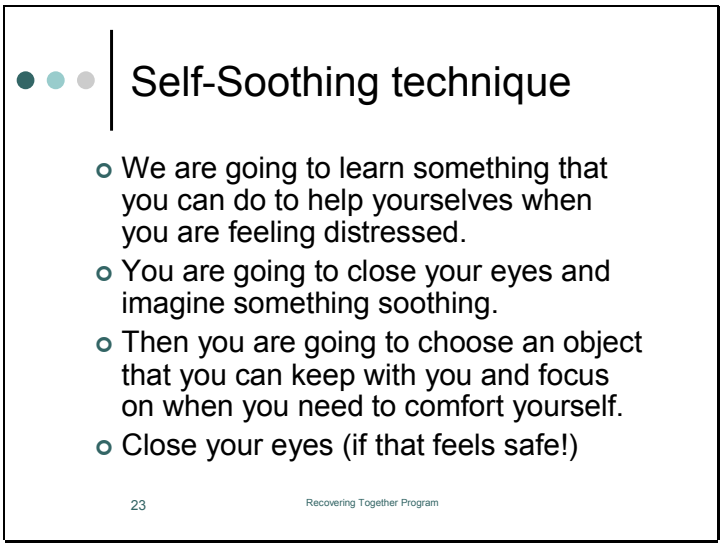
- Trauma can happen in recovery, too.
- Buried memories & feelings can gush out
  - Trigger for relapse
  - Seek help immediately
- Current stressors can affect you more strongly in early recovery
  - Be gentle & protective with yourself
  - "Overreaction" is simply a sign that you need attention – give it to yourself!

Slide 22



Self-soothing – Guide participants through the same process of creating safety from last week. This time, ask them if the spark of energy and the sphere has a color. Then encourage them to associate that color with serenity and safety. Have some glass marbles or large colored beads on hand. When each participant identifies their soothing color, hand them an object of that color and ask them to recreate that safe, serene feeling. Instruct them to practice this often with the object in their hand. Have them keep it handy for stressful times as a reminder, and as a tool to soothe themselves.

Slide 23


Self-Soothing technique
We are going to learn something that you can do to help yourselves when you are feeling distressed.
You are going to close your eyes and imagine something soothing.
Then you are going to choose an object that you can keep with you and focus on when you need to comfort yourself.
Close your eyes (if that feels safe!)
23
Recovering Together Program

Week 14 – PTSD and Sexual Abuse

Main Idea of Session

Understand Post Traumatic Stress Disorder (PTSD) and assess its impact on success in recovery. Learn how to identify PTSD, and how to heal. Discover the common problem of sexual abuse, and become aware of how it may affect current lifestyle choices.

Materials/Equipment Needed

- Materials
  - Presentation file or overhead transparencies
  - Key Feeling chart – color copy in sheet protector (for check-in)
  - Hand out: Recovery Evaluation Sheets (homework for next week)
- Equipment
  - LCD or overhead projector and screen
  - Computer with PowerPoint or Adobe Reader
  - Drug testing supplies, as needed
  - Copy or fax machine for attendance sheets

Session Overview

Quiet time

Check-in

PTSD Awareness

Coping with PTSD

Sexual Abuse – Impact on Recovery

Safety Exercise

Week 14 Activities

Time	*Activity and/or Slides*	*Facilitator Process Notes*
10 min	**1. Quiet Time** **Slide 3**	The relaxation activity during this quiet time is to practice using breath and simple movement to manage stress. This involves closing their eyes and imagining. Help them deepen the experience by asking about temperature, scents, texture, etc. Turn their attention inward towards their breathing. Don't ask them to change the pace of breathing, just to observe what it is like. Have them count five breaths, then squeeze their fist five times. Repeat this process five times, focusing their attention gently back inside if it begins to stray.
20 min	**2. Check in & Agenda** **Slide 4-5**	Review Standard check-in, plus each participant will provide the group with a short report about their experience with self-soothing this week. Do they still have their soothing object? Were they able to find time for themselves? If so, have them share about how it went. If they were not able to make time for self-soothing, were there days they needed it? What got in the way of making time for it?

PTSD Awareness

Time	*Activity and/or Slides*	*Facilitator Process Notes*
15 min	**3. PTSD Awareness** **Slides 6-17**	This presentation introduces Post Traumatic Stress Disorder (PTSD), and provides an overview of common signs and symptoms, then provides examples of both re-experiencing and avoidance symptoms. Take time for questions about specific symptoms, and ask participants to share briefly about their own experience with these symptoms in themselves or others (Carlson & Ruzek, n.d.).

Coping with PTSD

Time	*Activity and/or Slides*	*Process Notes*
15 min	**4. Coping with PTSD** **Slide 18**	This section shifts from describing the problem to providing a solution. Pass out handout of recommended lifestyle changes for PTSD patients. One common belief about PTSD is that "you just have to live with it." Make sure participants understand that their system (body, mind and spirit) is designed to finish processing the trauma, but has gotten stuck. Give them hope, and support self-efficacy that their inner wisdom will know when to work on their issues.
10 min	**Break** **Slide 19**	

Sexual Abuse – Impact on Recovery

Time	*Activity and/or Slides*	*Facilitator Process Notes*
30 min	**5. Sexual Abuse – Impact on recovery** **Slides 20-31**	Participants are very curious about this subject, as it is seldom discussed openly and factually. Overall this discussion is most successful if the emphasis is on the subject itself, rather than personal experiences of individuals. It is important to scan participants for signs of traumatic reaction, and to model attending to safety needs of individuals and the group.
20 min	6. Recovery Topic and Tool 14 **Slide 32**	Pass out Recovery Evaluation Worksheet, and review the form with participants. If possible, answer one section as a group to demonstrate filling out the form. Emphasize the need to remember to bring the completed worksheet next week. Brainstorm with participants how this might be accomplished. What lengths are they willing to go to in order to stay clean? Talk

	about the lengths they used to go for a drink or drug. Get a verbal commitment from each participant to bring the completed worksheet next week.

Week 14 Slides with Commentary

Slide 1

Supplies

- Materials
  - Presentation File or Overhead Transparencies
  - Hand out- Recovery Evaluation Sheets (for next week)
- Equipment
  - LCD or Overhead projector & Screen
  - Computer with PowerPoint or Adobe Reader
  - Drug testing supplies, as needed
  - Copy or fax machine for attendance sheets

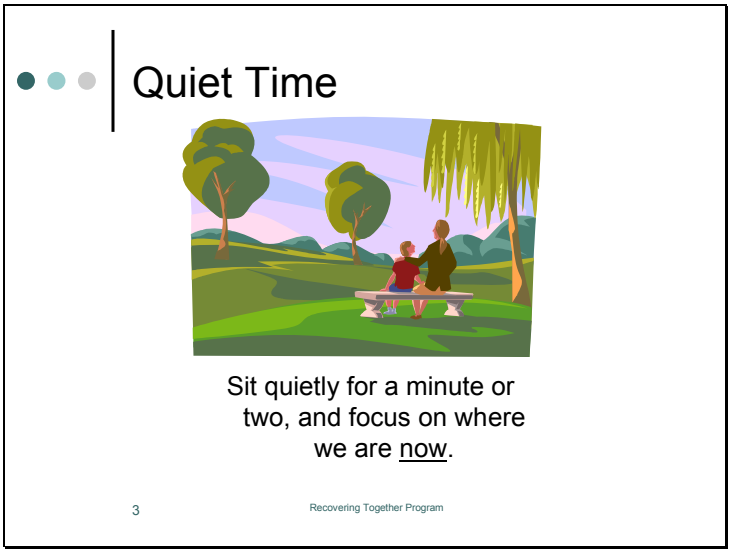
1 Recovering Together Program

Stress Disorders - week 14

Understanding the body's natural defenses, and their relationship to addictive behaviors

2 Recovering Together Program

Slide 3



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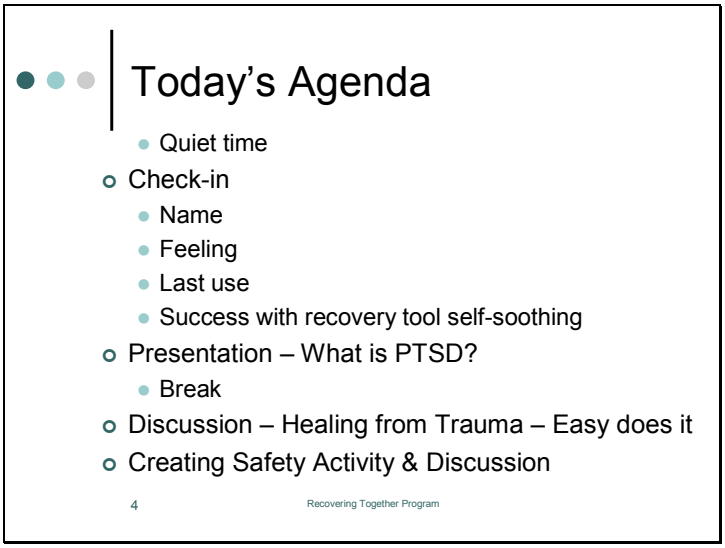
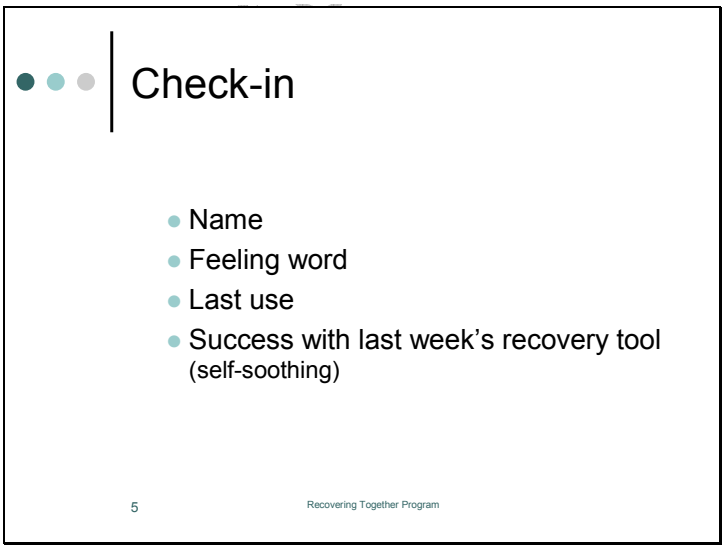
Slide 4



Slide 5



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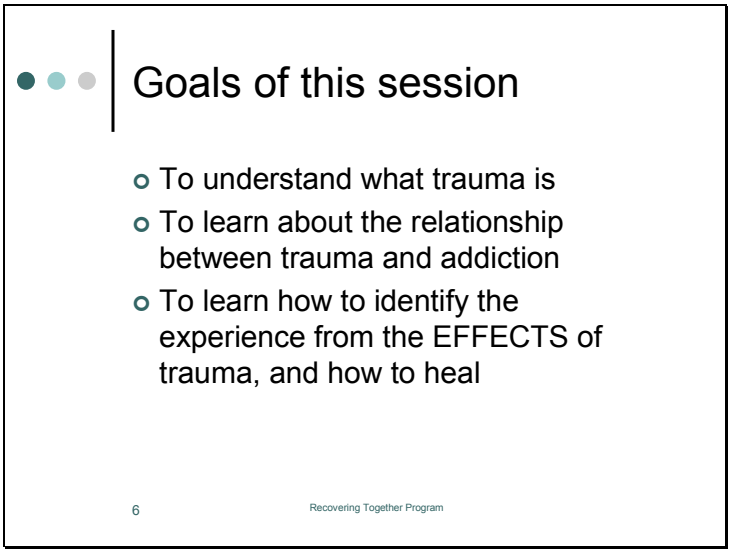
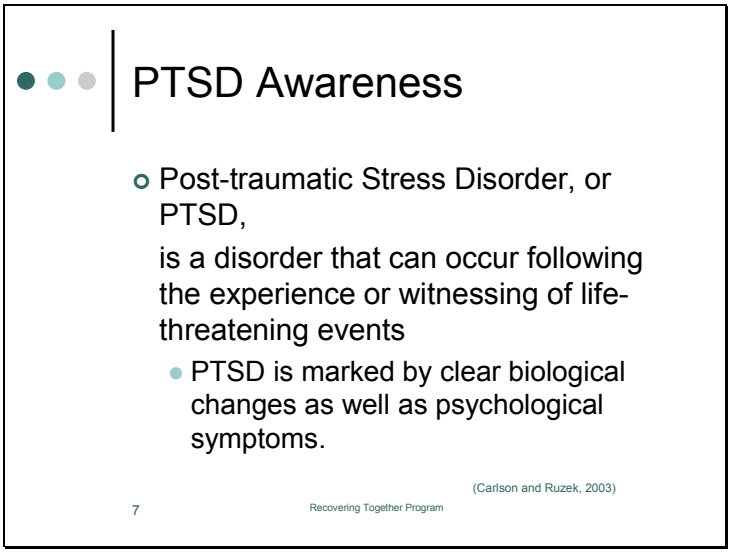
Slide 6



Understand PTSD and assess its impact on success in recovery. To learn how to identify Post Traumatic Stress Disorder, and how to heal. Discover the common problem of sexual abuse, and become aware of how it may affect current lifestyles.

Slide 7



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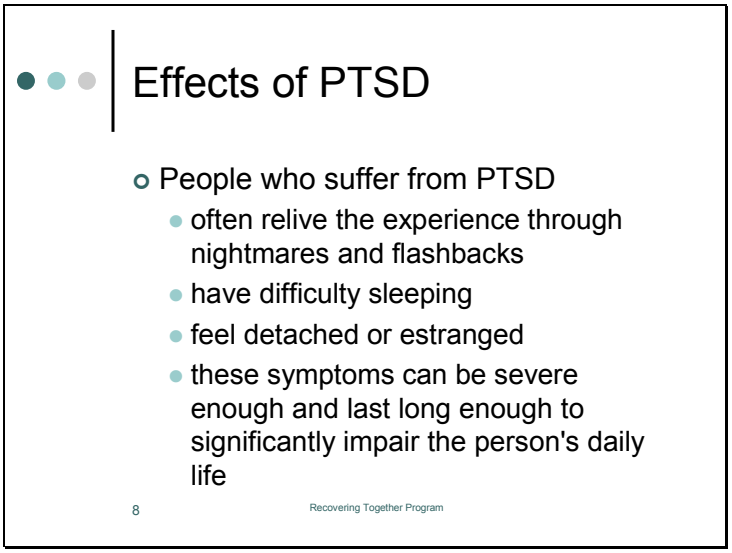
Slide 8



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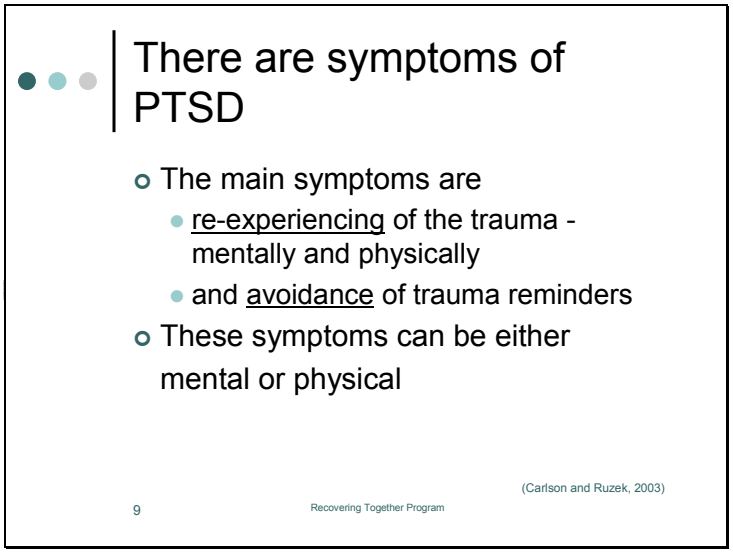

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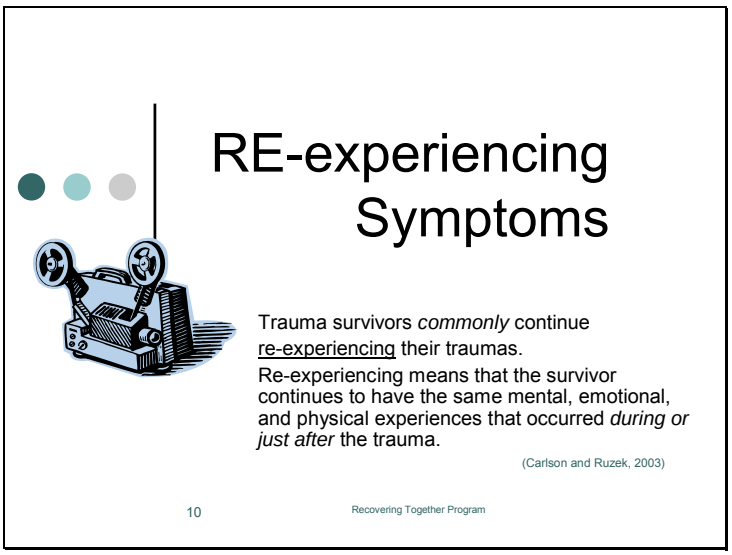
Slide 10



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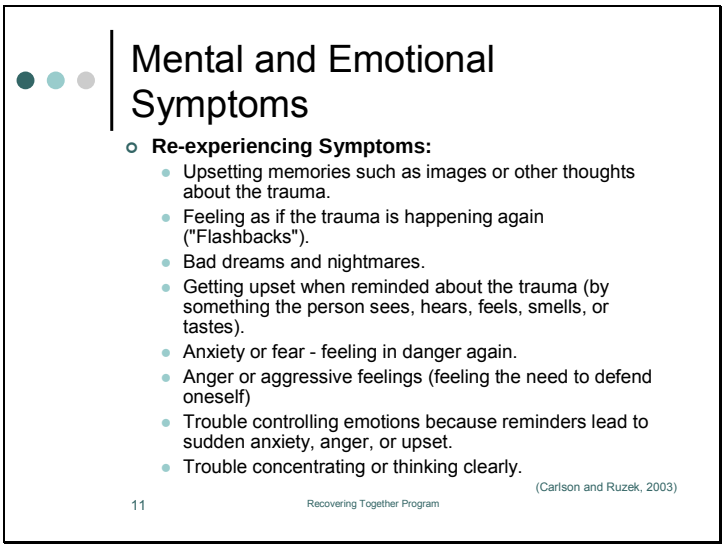

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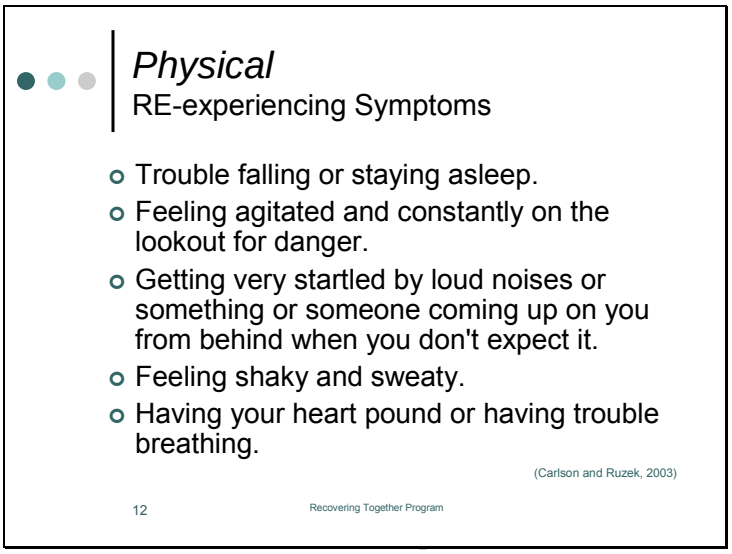
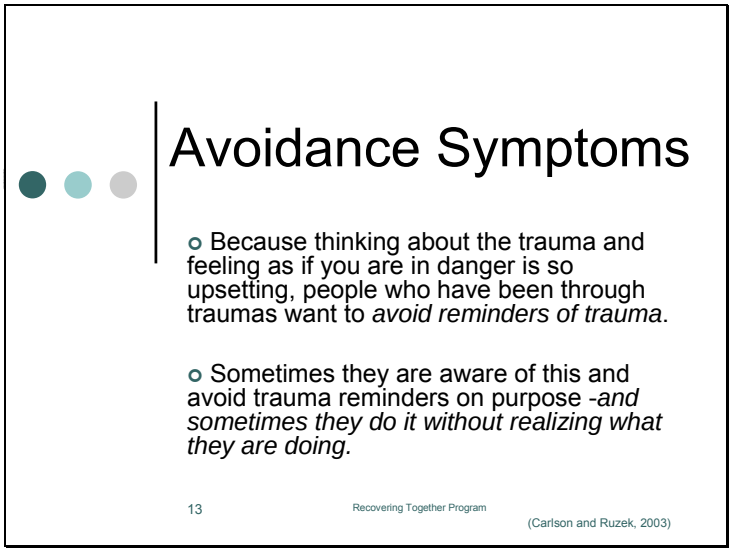
Slide 12

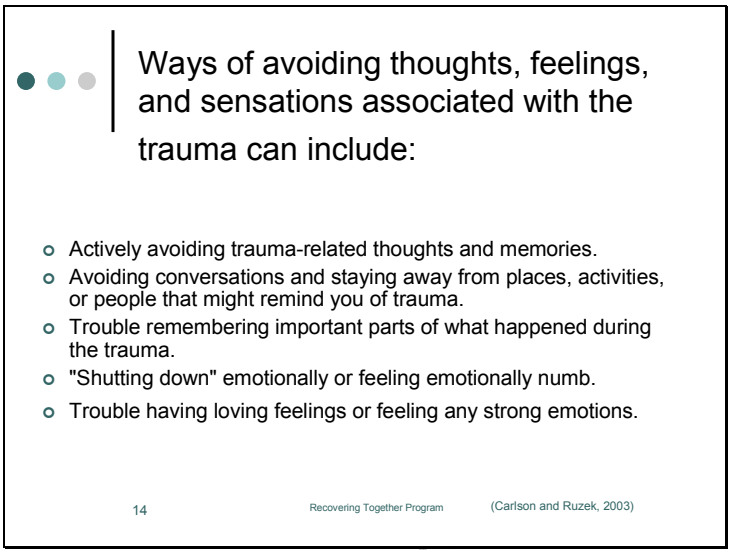


Slide 13



Carlson & Ruzek, Retrieved May 29, 2003 from http://www.ncptsd.org/facts/general/fs_what_is_ptsd.html. National Center for PTSD.

Slide 14



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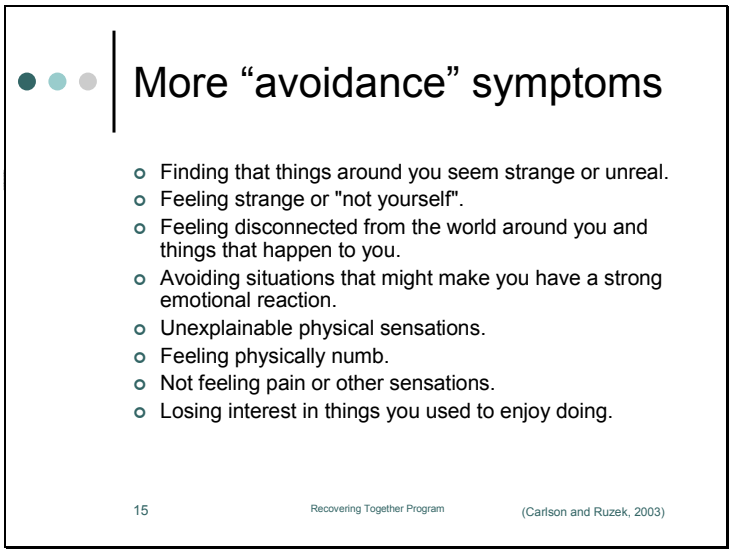


Carlson & Ruzek, Retrieved May 29, 2003 from http://www.ncptsd.org/facts/general/fs_what_is_ptsd.html. National Center for PTSD.

Slide 16

Avoidance is a natural defense – It helps us cope with emergencies!

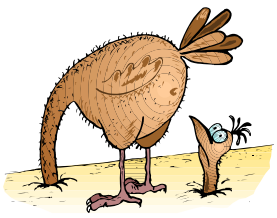
- Avoiding thinking about trauma or avoiding treatment for your trauma-related problems may keep a person from feeling upset in the short run.

(Carlson and Ruzek, 2003)

Slide 17

But it only works for awhile!

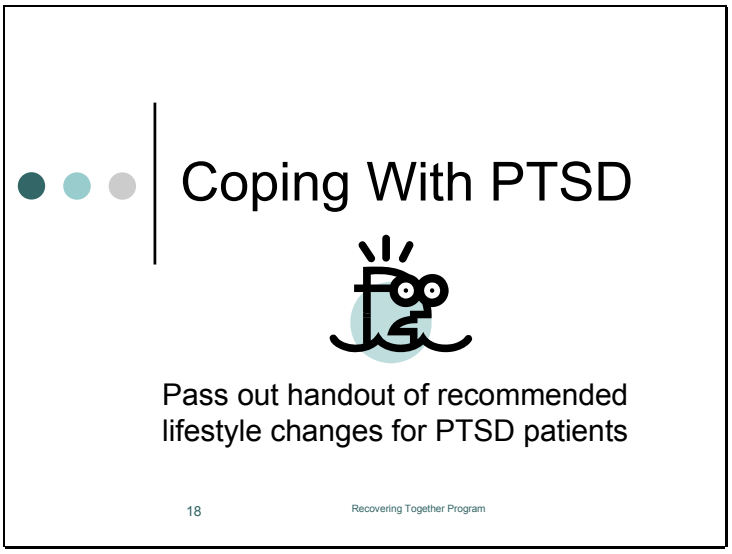
- Avoiding trauma <u>treatment</u> *prevents progress* on <u>coping</u> with trauma so that symptoms *don't go away*.



(Carlson and Ruzek, 2003)

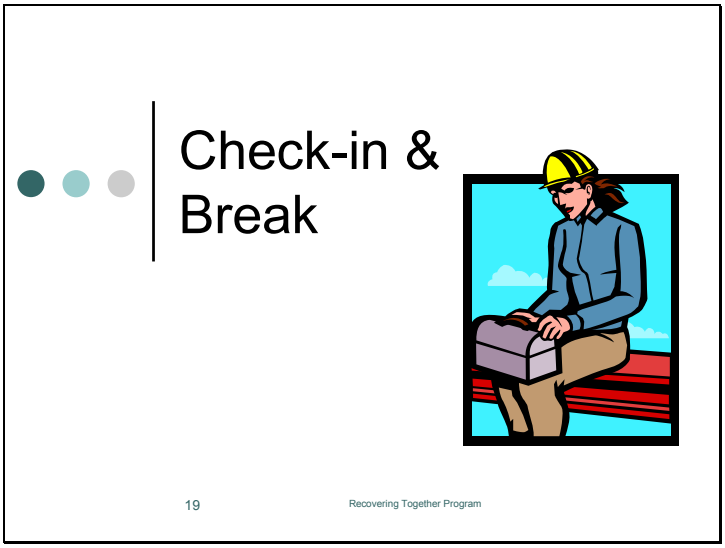
Carlson & Ruzek, Retrieved May 29, 2003 from http://www.ncptsd.org/facts/general/fs_what_is_ptsd.html. National Center for PTSD.

Slide 18



This section shifts from describing the problem to providing a solution. Pass out the handout of recommended lifestyle changes for PTSD patients. One common belief about PTSD is that “you just have to live with it.” Make sure participants understand that their system is designed to finish processing the trauma, but has gotten stuck. Give them hope, and support self-efficacy that their inner wisdom will know when to work on their issues.

Slide 19



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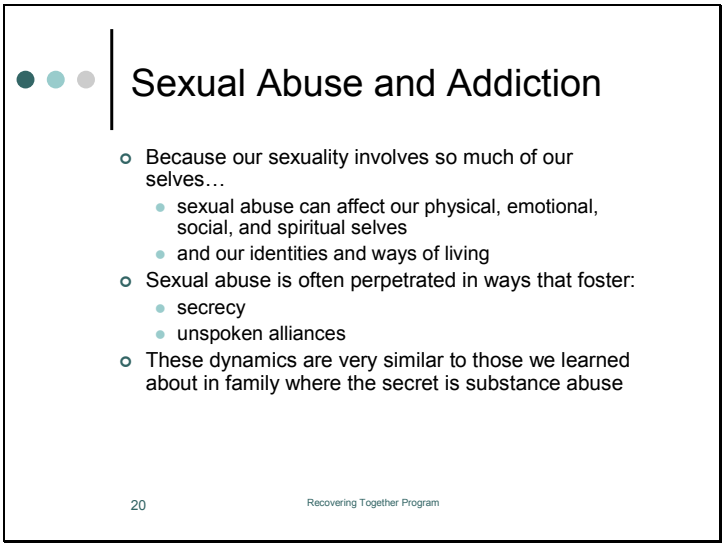
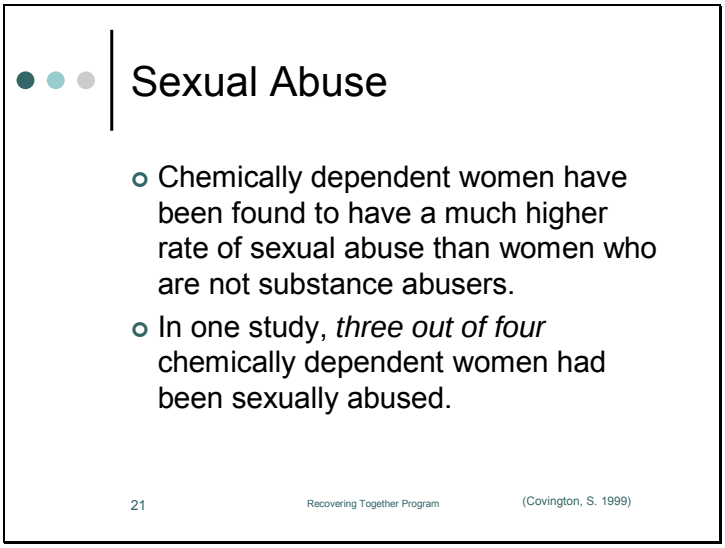


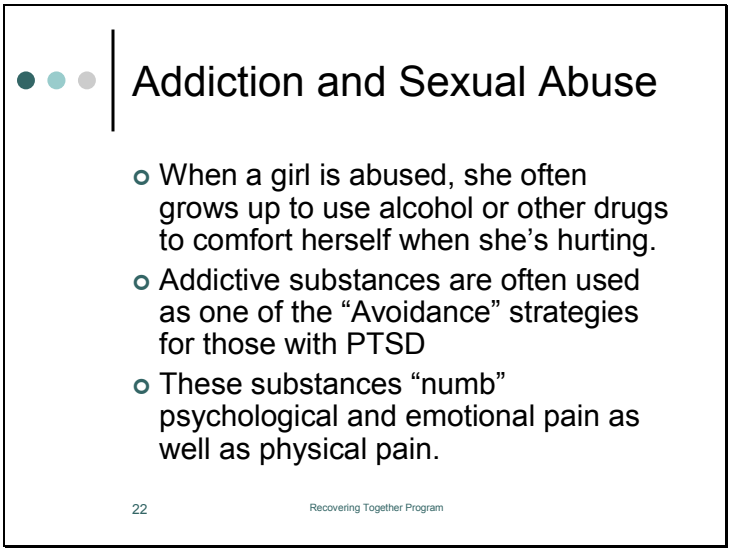
Participants are very curious about this subject, as it is seldom discussed openly and factually. Overall this discussion is most successful if the emphasis is on the subject itself, rather than personal experiences of individuals. It is important to scan participants for signs of traumatic reaction, and to model attending to safety needs of individuals and the group.

Slide 21



Helping Women Recover Facilitator's Guide. Stephanie S. Covington

Slide 22



Slide 23

Memories of Abuse

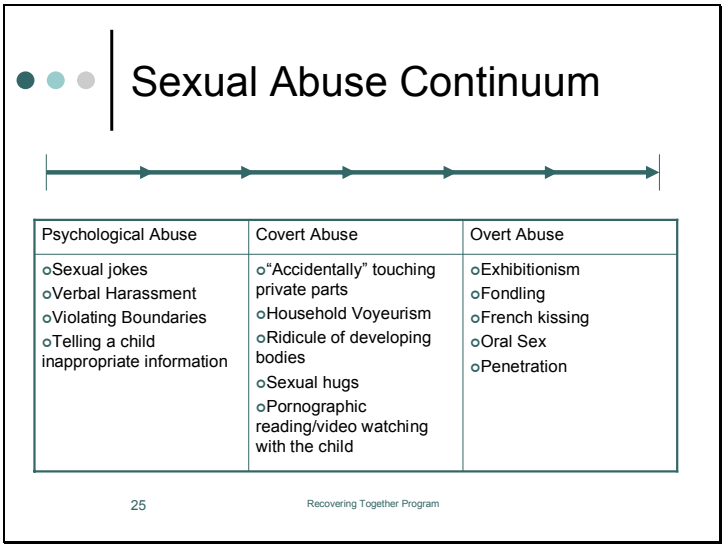
- Alcohol and other drugs are also effective for covering over memories (functions to cope with RE-experiencing abuse)
- Memories of abuse are
  - Sometimes remembered clearly
  - Sometimes only certain events are remembered
  - Sometimes the memory is completely repressed
    - especially if the abuse happened very young
    - Or if clouded by drinking or drug use

Slide 24

Discussion Question

- Have you ever used alcohol or other drugs to deal with an unpleasant memory?

Slide 25



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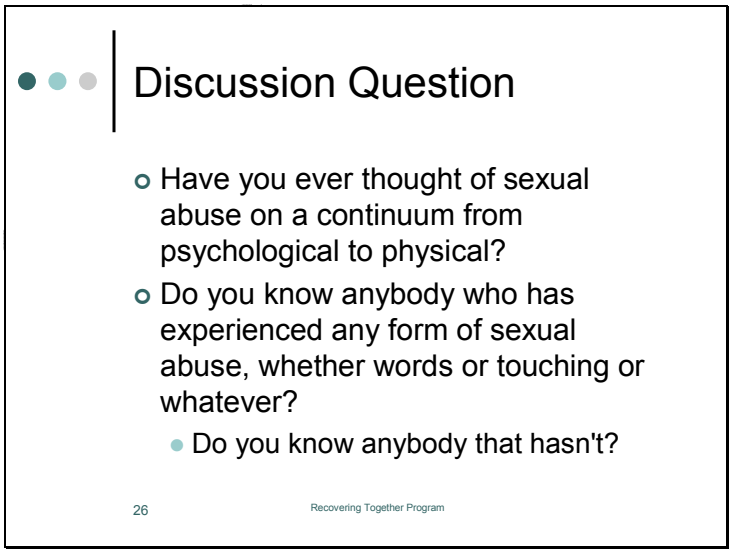

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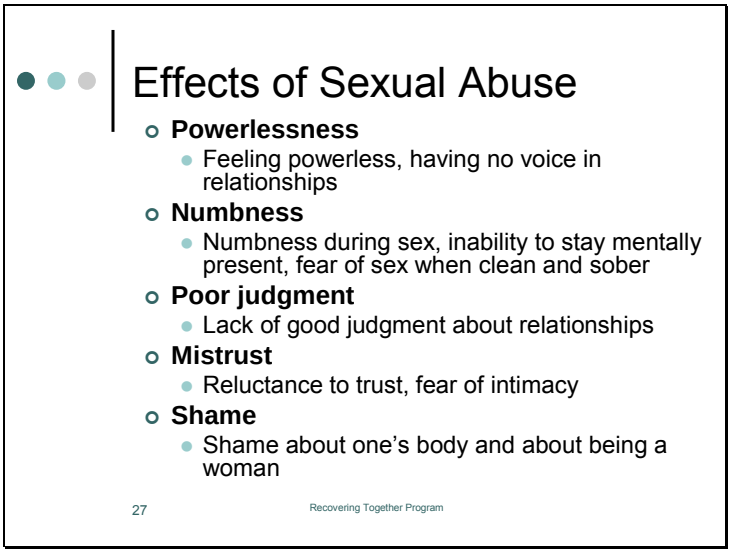

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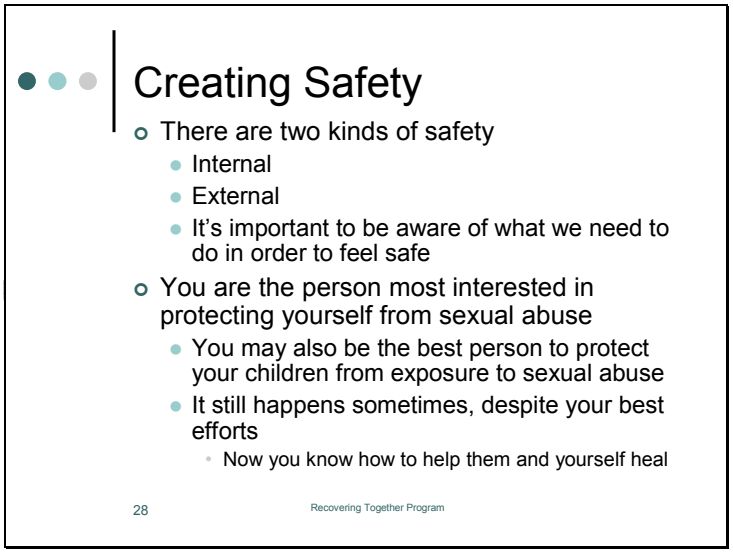

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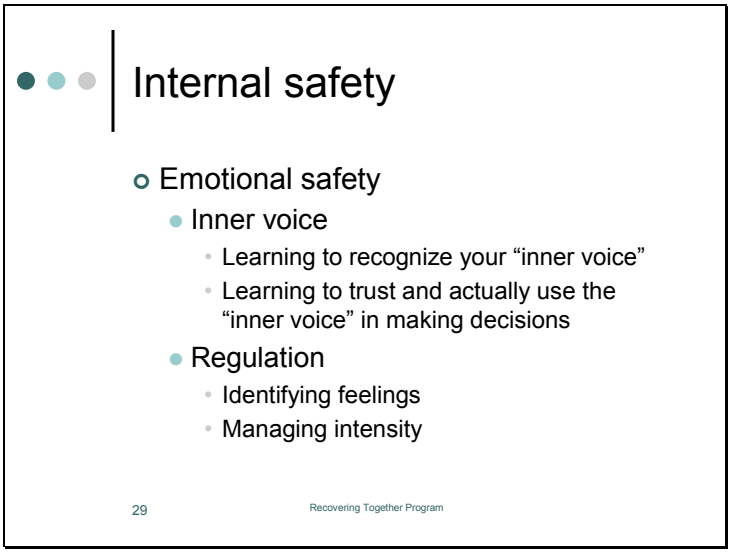
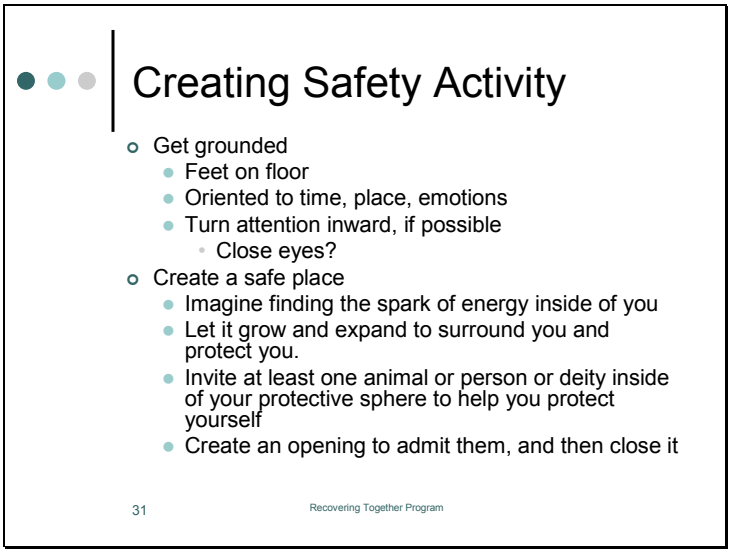
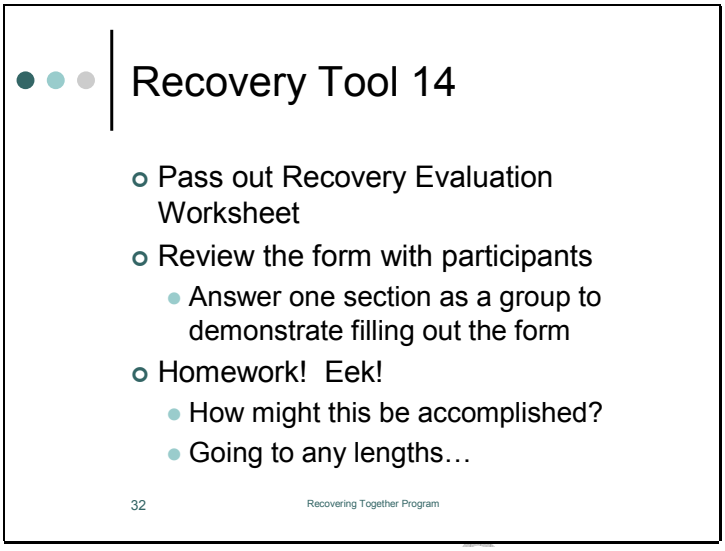


Slide 30

Slide 31


Creating Safety Activity
Get grounded
Feet on floor
Oriented to time, place, emotions
Turn attention inward, if possible
Close eyes?
Create a safe place
Imagine finding the spark of energy inside of you
Let it grow and expand to surround you and protect you.
Invite at least one animal or person or deity inside of your protective sphere to help you protect yourself
Create an opening to admit them, and then close it
31
Recovering Together Program

Slide 32



Pass out the Recovery Evaluation Worksheet, and review the form with participants. If possible, answer one section as a group to demonstrate filling out the form. Emphasize the need to remember and bring the completed worksheet next week. Brainstorm with participants how this might be accomplished. What lengths are they willing to go to in order to stay clean? Talk about the lengths they used to go for a drink or drug. Get a verbal commitment from each participant to bring the completed worksheet next week.

Week 15 - Relapse Prevention

Main Idea of Session

Understand the process of relapse, and the importance of prevention. Carefully review current and past recovery efforts to identify strengths and weaknesses in participants' personal recovery efforts.

Materials/Equipment Needed

- Materials
  - Presentation file or overhead transparencies
  - Key Feeling chart – color copy in sheet protector (for check-in)
  - Extra Recovery Evaluation worksheets
  - Copies of Recovery Planning Grids
  - Copies of Personal Recovery Pattern summaries
  - Relapse warning signs checklists
- Equipment
  - LCD or Overhead projector and screen
  - Computer with PowerPoint or Adobe Reader
  - Drug testing supplies, as needed
  - Copy or fax machine for attendance sheets

Session Overview

Quiet time

Check-in

Presentation – The Relapse Process

Recovery Evaluation Worksheet Review

Recovery Planning

Relapse Prevention Strategies

Week Fifteen Activities

Time	*Activity and/or Slides*	*Facilitator Process Notes*
10 min	**Quiet Time** **Slide 3**	"Rag doll" exercise or another energizing activity. This is an opportunity to make the point that stress management can involve both relaxation and energetic movement for stress release. View the RTP Women's video before group for a demonstration of the "Rag doll" activity.
20 min	**Agenda & Check-in** **Slide 4-5**	In addition to standard check-in today, add a question about how participants did on completion of the Recovery Evaluation Worksheet. After everyone has shared about that, ask participants to provide a brief check-in about how they feel about completing RTP Phase 1. This will begin the transition process, to be continued next week.

Presentation - The Relapse Process

10 min	Presentation - The Relapse Process **Slides 6-13**	The core principle of relapse prevention is that relapse is not a sudden event. This presentation looks at the difference between abstinence and recovery, and provides concrete steps that participants can take to prevent relapse (Grace, 2005). Use examples and discuss this concept until participants seem to understand and begin to accept it. There may be resistance to admitting to themselves that relapse only snuck up on them because they weren't listening for its footsteps (the signs).
10 minutes	Relapse Warning Signs **Slide 14**	Pass out Relapse Warning Sign checklists and give participants time to read and complete the checklist. Next, have participants get out their Recovery Evaluation Worksheets, and finish completing if needed.

Review Recovery Evaluation worksheets and complete Personal Recovery

Summary

10 min	Review Personal Recovery Evaluation Worksheets **Slide 16**	The Personal Recovery Evaluation Worksheet (Gorski & Miller, 1986) is actually very simple to complete. Some may or may not have completed it, but go through the worksheet section by section. Have participants write quick notes on their summaries as you go through each section. Let them know they will use the summaries after break to analyze their individual relapse patterns. If participants have completed both the Recovery Evaluation and their Warning Sign checklist, have them lay out their tools as shown in the slide and start their break. Participants will use their recovery evaluation worksheets and their relapse warning sign checklists as resources to help them complete their personal recovery pattern summary. Be sure to emphasize that this process can help them identify both the strengths which already exist for their recovery, and to pinpoint the risks that may threaten recovery.
10 min	**Break** **Slide 17**	

Recovery Planning

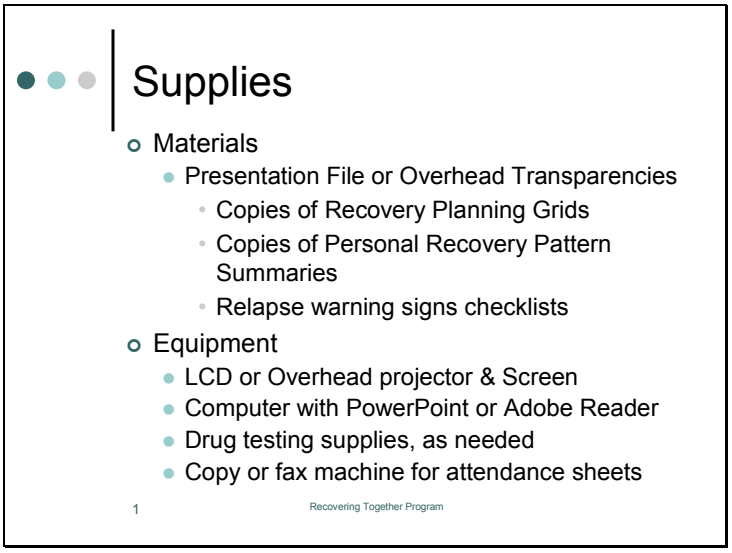
Time	***Activity and/or Slides***	***Process Notes***
20 min	**Recovery Planning**	The recovery plan is fairly simple to complete, but certain participants can be

	Slide 18	resistant to mapping out their time. It is important to raise awareness of this resistance without pushing too much. Simply acknowledge that planning can seem like a big deal, and sometimes we don't even know why. Resistance can be acknowledged and studied whenever they are ready. This is a good time to use the "one day at a time" slogan, having participants fill out each day before looking at the week as a whole. Each participant should have recovery activities, personal time, and time to connect with others. Mothers have a very hard time finding "alone time" – use this as an opportunity to brainstorm and share solutions among group members.
Relapse Prevention Strategies		
20 min	**Relapse Prevention Strategies**	Have participants share their plans with the group and get feedback. For each day of the week, fill in the recovery activities which they ARE ALREADY DOING. Look to see if there are any holes in the recovery plan. Brainstorm with the group how to repair that hole in their recovery fabric. Instruct them to continue reviewing the plan, and to ask other friends in recovery, their family, etc. for feedback on the plan's feasibility. *Schedule family conferences for plan review over the next two weeks (before Phase 2 begins).* Emphasize that very few people are successful at preventing relapse all alone, but many are successful when they get help.
10 min	8. Recovery Topic and Tool 15	Participants will keep a copy of their evaluations, checklists, and plans in their RTP notebooks. Make sure they have a blank copy of each tool for future use, and

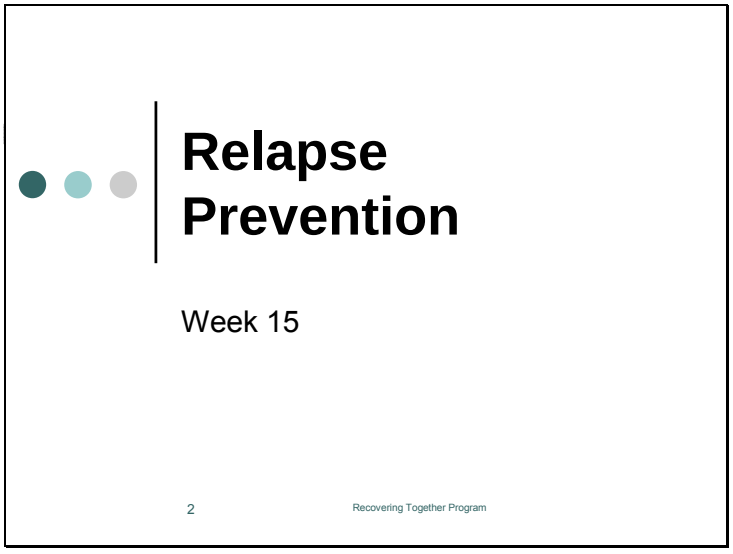
Slide 19	that the documents are in their clinical file. They may need more time for completion, but a copy of each document needs to be in their file before Phase 2.

Week 15 Slides with Commentary

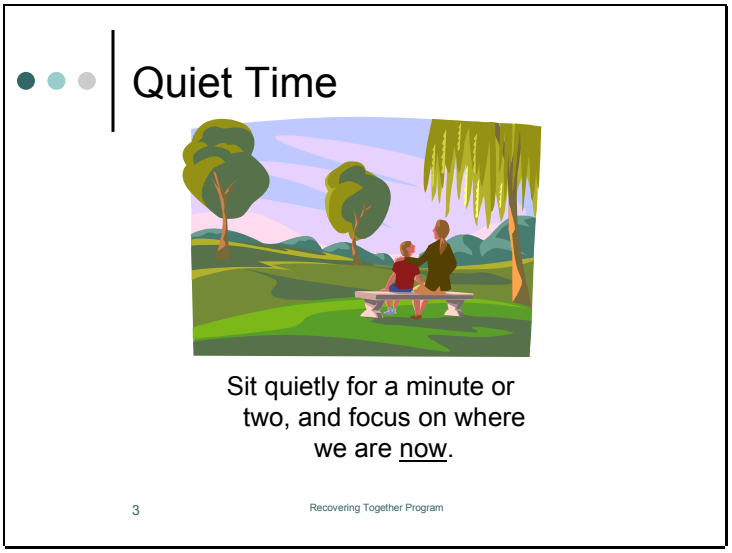
Slide 1



Slide 2



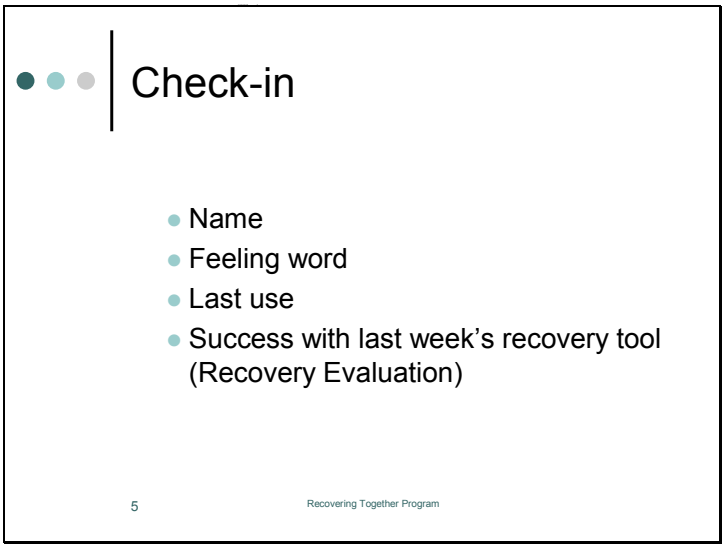
Slide 3



Relaxation activity during this quiet time is to practice using breath and simple movement to manage stress. This involves closing their eyes and imagining. Help them deepen the experience by asking about temperature, scents, texture, etc. Turn their attention inward toward their breathing. Don't change the pace of breathing, just observe. Have them count five breaths, then squeeze their fist five times. Repeat this process five times, focusing their attention gently back inside if it begins to stray.

Slide 4

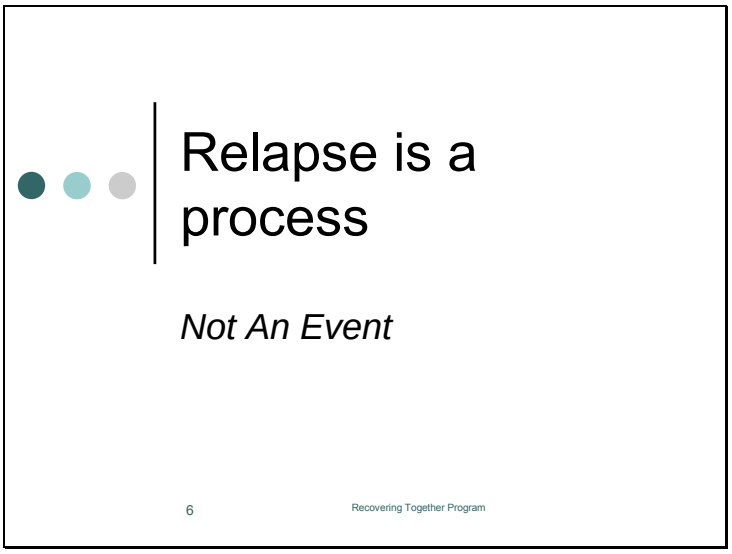
Slide 5



In addition to standard check-in today, add a question about how participants did on completion of the Recovery Evaluation Worksheet. After everyone has shared about that, ask participants to provide a brief check-in

about how they feel about completing Phase 1. This will begin the transition process, to be continued next week.

Slide 6



The core principle of relapse prevention is that relapse is not a sudden event. This presentation looks at the difference between abstinence and recovery, and provides concrete steps that clients can take to prevent relapse (Grace, 2005).

Use examples and discuss this concept until the clients seem to understand and begin to accept this concept. There may be resistance to admitting to themselves that relapse only snuck up on them because they weren't listening for its footsteps.

Slide 7

The Relapse Process

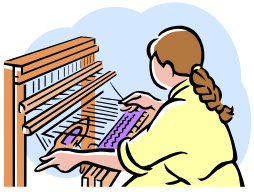
- Just like recovery, relapse is a process
- Recovery is like knitting a sweater: stitch by stitch
- Relapse is like the sweater unraveling.
  - It may feel sudden
  - It may feel unstoppable
  - It actually unravels stitch by stitch
  - You can stop the relapse process, unravel the weak stitches, and start knitting again

7 Recovering Together Program

Slide 8

Awareness helps!

- The key to tighten the stitch is Awareness
- Becoming aware of relapse prevention information provides resources to help you
  - Strengthen
  - Repair
  - Continue weaving in the fabric of your recovery
- Watch for Relapse Warning Signs (see Handout)



8 Recovering Together Program

Pass out the Relapse Warning Sign checklist and give participants time to read and complete the checklist. After that, have participants get out their Recovery Evaluation Worksheets, and finish completing if needed.

Slide 9

Abstinence Versus Recovery

- **Abstinence** is just saying no, and it counts on willpower alone.

- **Recovery** is the process of gaining skills to cope with life's issues constructively.

9 Recovering Together Program

Grace, K.F. (2005). *Ways to decrease relapse events*. Retrieved August 19, 2006, from Clinical Tools Web Site: http://images.clinicaltools.com/images/cmealcohol/education/relapseprevention.pdf

Slide 10

Recovering is Coping

- Active coping vs. Emergency coping
  - Active coping is keeping your mind, body and spirit in recovery
    - Strategies vary greatly from individual to individual
    - Requires time and energy
  - Emergency coping happens when you are in danger of relapse
    - DO something besides taking a step toward relapse

(Grace, 2005)

10 Recovering Together Program

Grace, 2005.

Slide 11

"Call on God, but row away from the rocks"

-Hunter S. Thompson

11 Recovering Together Program

Slide 12

"on course" for Recovery

- Asking for help and getting support
- Learning and putting into practice coping skills
- Increasing self-awareness by paying attention to:
  - Thoughts
  - Feelings
  - Behaviors

(Grace, 2005)

12 Recovering Together Program

Grace, 2005.

Slide 13

"on course" for Recovery

- Examining values and spirituality
- Cultivating enjoyment of being clean and sober
- Taking good care of yourself
- We are either steering towards recovery or relapse

(Grace, 2005)

13 Recovering Together Program

Grace, 2005.

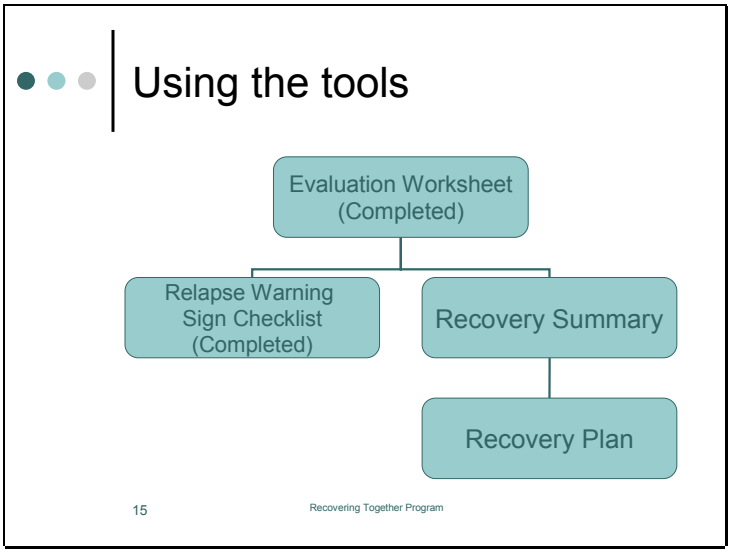
Slide 14

Relapse Warning List

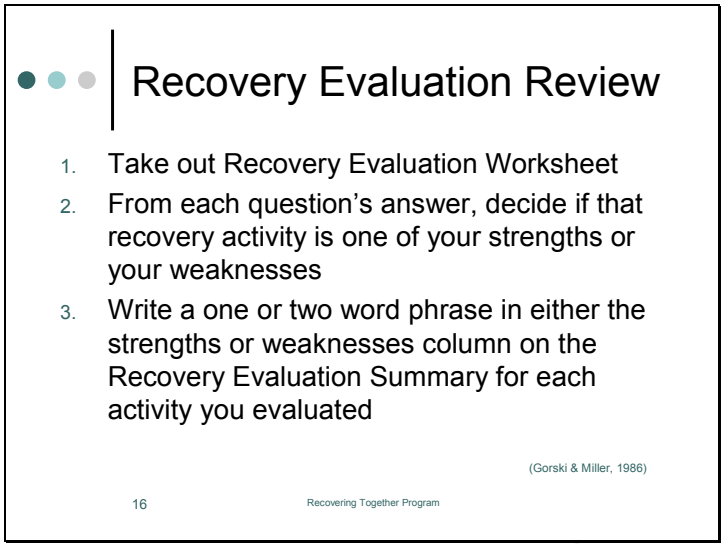
- Read through Relapse symptoms check list
- Check off those symptoms that you have experienced
- Make a list of the five most "telling signs" that apply to you

14 Recovering Together Program

Slide 15


Using the tools
Evaluation Worksheet (Completed)
Relapse Warning Sign Checklist (Completed)
Recovery Summary
Recovery Plan
15
Recovering Together Program

Slide 16



The Personal Recovery Evaluation Worksheet is actually very simple to complete, but may be intimidating to some clients. Some may or may not have completed it, but go through the worksheet section by section. Have clients write quick notes on their summaries as you go through each section, identifying their personal strengths and weaknesses. Let them know they will use the summaries after break to analyze their individual recovery and relapse patterns.

If participants have completed both the Recovery Evaluation and their checklists, have them lay out their tools as shown in the slide and start their break.

The Recovery Evaluation worksheet is based on relapse prevention work done about 20 years ago by Gorski, T.T., & Miller, M. (1986). *Staying sober-A guide for relapse prevention.* Independence, MO: Independence Press.

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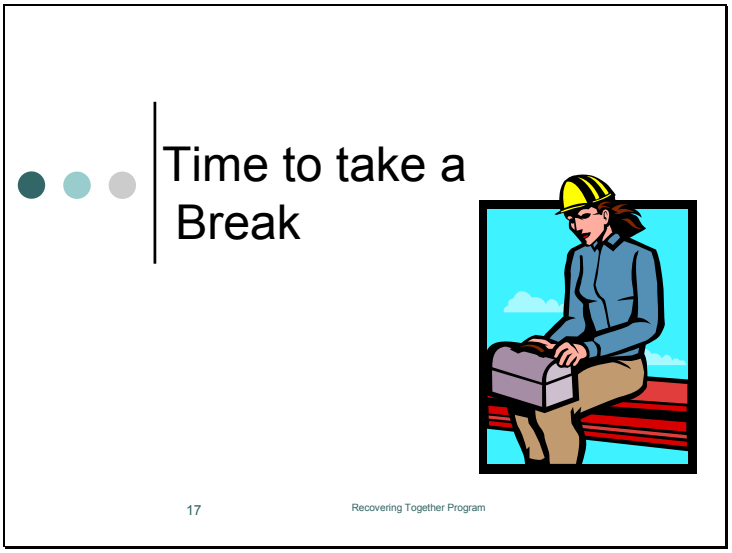

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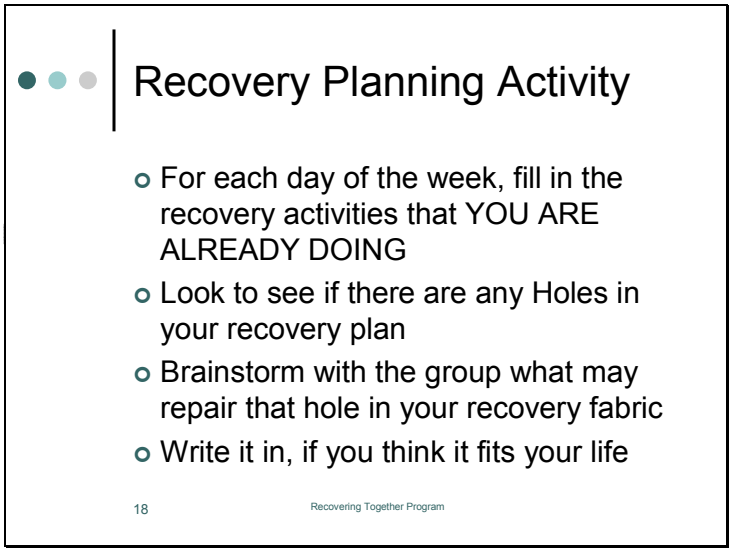
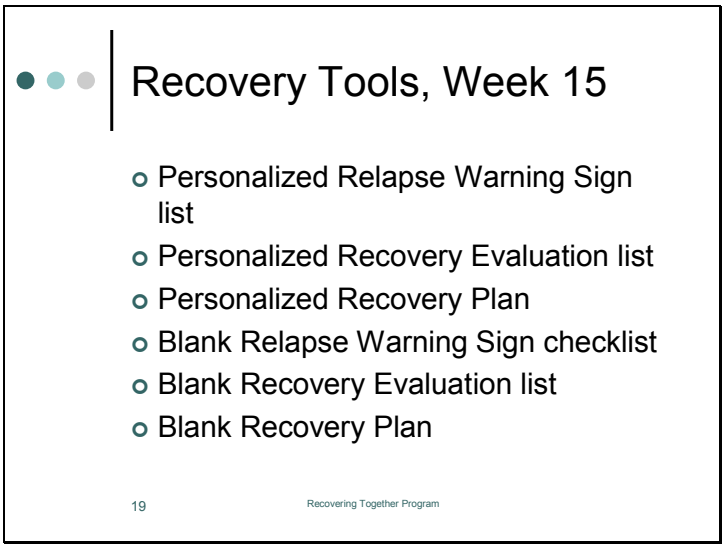


Have participants share their plans with the group and get feedback. Instruct them to continue reviewing the plan, and to ask other friends in recovery, their family, etc. for feedback on the plan's feasibility. Schedule family conferences for plan review over the next two weeks (before Phase 2 begins).

Slide 19



Participants will keep a copy of their evaluations, checklists, and plans in the RTP notebook. Make sure they have a blank copy of each tool for future use, and that the documents are in their clinical file. They may need more time for completion, but a copy needs to be in their file before Phase 2.

Week 16 - Transition

Main Idea of Session

Design individual self-care contracts and have the group witness the signing of their contracts. Review of overall program structure and requirements. Introduction to Dare to be YOU staff and family certificates. Re-vision recovery.

Materials/Equipment Needed

- Materials
  - Presentation file or overhead transparencies
  - Key Feeling chart – color copy in sheet protector (for check-in)
  - Self-care contracts
  - Certificate of completion for each group member and her family
  - Frame for certificate (optional)
  - Sheet protectors (optional)
- Equipment
  - LCD or overhead projector and screen
  - Computer with PowerPoint or Adobe Reader
  - Drug testing supplies, as needed
  - Copy or fax machine for attendance sheets

Session Overview

Quiet Time

Check-in

Review Recovery Plans

Self-Care Contracts

Success with recovery tool – Recovery Evaluation

Family Certificate Ceremony

Week 16 Activities

Time	*Activity and/or Slides*	*Facilitator Process Notes*
10 min	**1. Quiet Time** **Slide 3**	Re-vision recovery – Tell participants that sometimes it is difficult to imagine themselves clean and sober, and that today's visualization is a vision of healing for themselves. Participants will get quiet, go inside themselves, and imagine themselves standing in a relaxed pose. Then they will notice that their skin, hair and body are all healthy looking. They are wearing a beautiful outfit in a beautiful color, a healthy color. They begin to spin slowly, dancing in the joy of the satisfaction of beginning their lives anew. Let them complete the vision their own way, giving them time to imagine more or simply to enjoy the vision they now have of themselves in recovery.
30 min	**2. Check-in & Agenda** **Slide 4-5**	In addition to standard check-in, have participants report their progress this week with finalizing their recovery plan. Are they ready to turn in their plan for their clinical file – have they completed/scheduled their family conference?

Self-Care Contracts

Time	*Activity and/or Slides*	*Facilitator Process Notes*
20 min	**3. Review of Program Structure and** **Slide 6-10**	Each client will be given a self-care contract to fill out, and they may take out their recovery plan to help them fill out their contract. Take plenty of time for each participant to customize her relapse intervention and to list her resources. Have them read their plans aloud to the group, and have the group members watch the signing. The group leader should sign the contract as witness.

20 min	**4. Recovery Topic and Tool 16 Self-Care Contracts** **Slide 11-12** **NO BREAK – Proceed to Certificate Ceremony**	The recovery tool this week is the self-care contract, the completed recovery plan, and the written instructions for the remaining phases. Have the participants put them in their binders – sheet protectors are nice.

Family Certificate Ceremony

Time	***Activity and/or Slides***	***Facilitator Process Notes***
?	**5. Family Completion Certificates**	The completion certificates provide positive reinforcement for the work already completed, and provide a tangible reminder of recovery. Families really do hang these up if you provide a frame! Because of issues with attachment and object constancy, these families definitely need a tangible reminder of their RTP experience and their recovery tools. Kids may have their own certificates from the children's program, and the Mom is presented with one for herself. A celebration snack is nice. Don't call it a party or graduation! That can be a trigger for some people – "transition ceremony" is OK.

Week 16 Slides with Commentary

Slide 1

Materials List

- Materials
  - Presentation File or Overhead Transparencies
  - Self-care contracts
  - Certificate of completion for each group member & her family
  - Frame for certificate (optional)
  - Sheet protectors (optional)
- Equipment
  - LCD or Overhead projector & Screen
  - Computer with PowerPoint or Adobe Reader
  - Drug testing supplies, as needed
  - Copy or fax machine for attendance sheets

1 Recovering Together Program

Slide 2

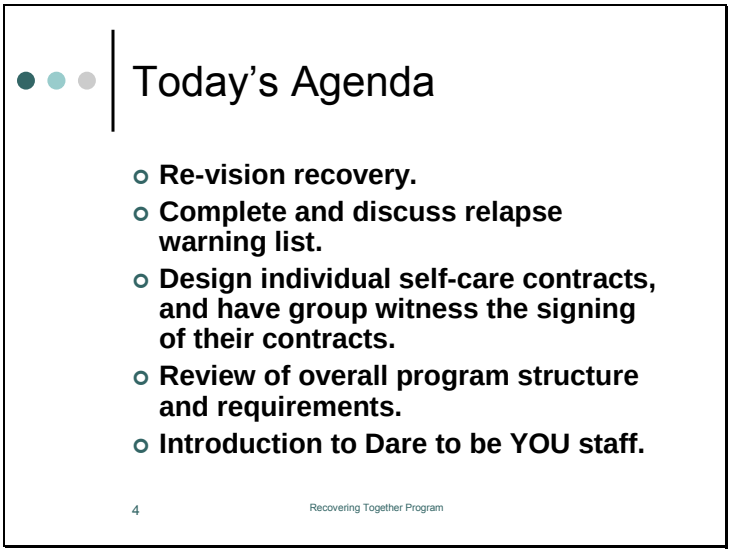
Week 16 -Transition

2 Recovering Together Program

Slide 3

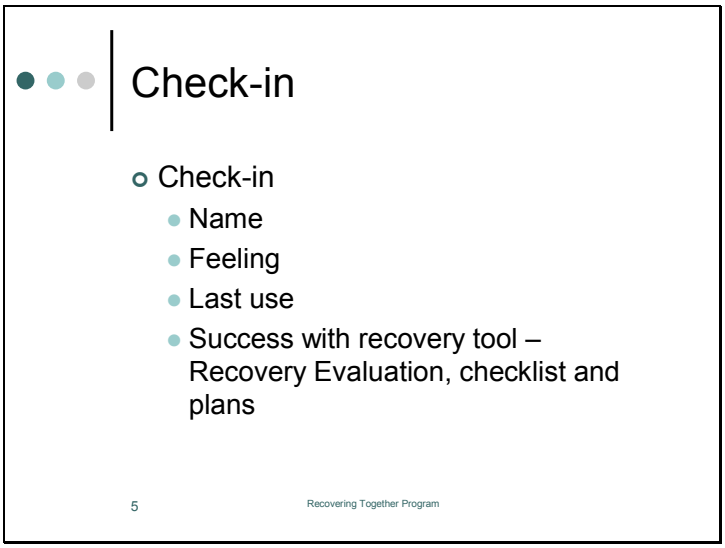
Re-vision recovery – Tell participants that sometimes it is difficult to imagine themselves clean and sober, and that today's visualization is a vision of healing for themselves. Participants will get quiet, go inside themselves, and imagine themselves standing in a relaxed pose. Then they will notice that their skin, hair and body are all healthy looking. They are wearing a beautiful outfit in a color that is joyous and healthy. They begin to spin slowly, dancing in the joy of the satisfaction of beginning their lives anew. Let them complete the vision their own way, giving them time to imagine more or simply to enjoy the vision they now have of themselves in recovery.

Slide 4



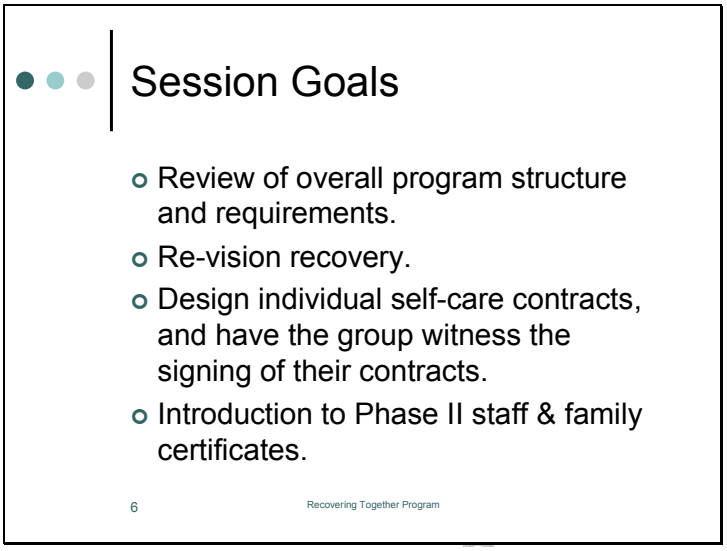
Design individual self-care contracts, and have the group witness the signing of their contracts. Review of overall program structure and requirements. Introduction to Dare to be YOU staff and family certificates. Re-vision recovery.

Slide 5

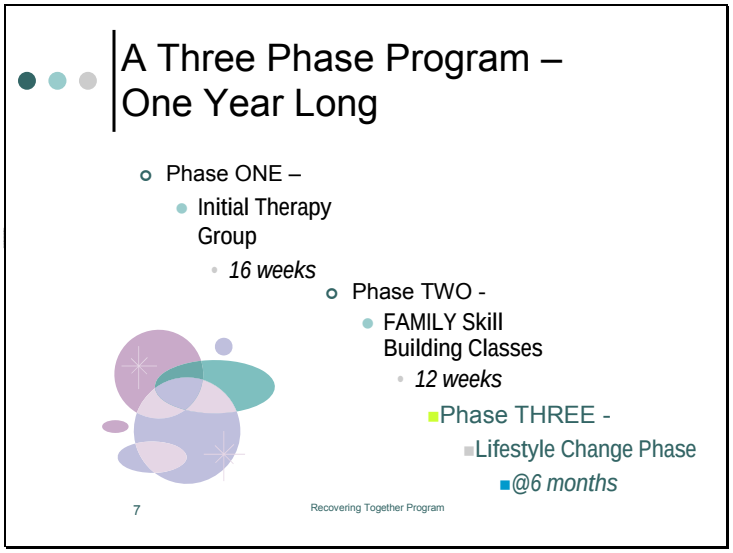


In addition to standard check-in, have participants report their progress this week with finalizing their recovery plan. Are they ready to turn in their plan for their clinical file? Have they completed/scheduled their family conference?

Slide 6

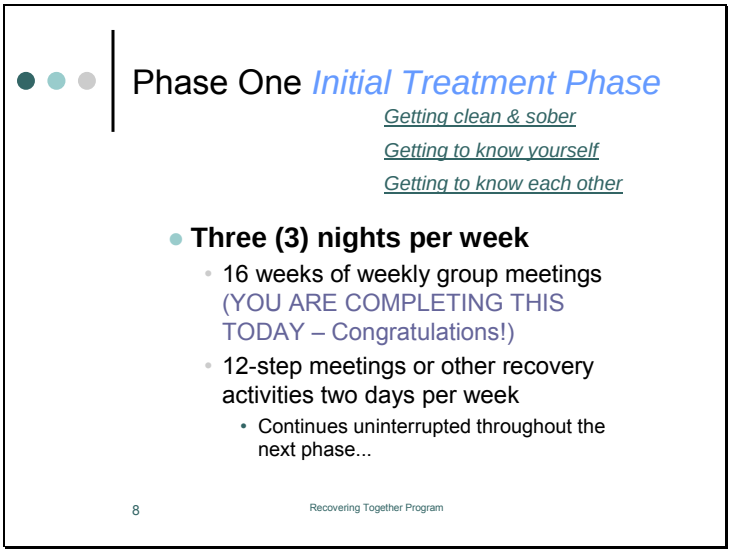


Slide 7

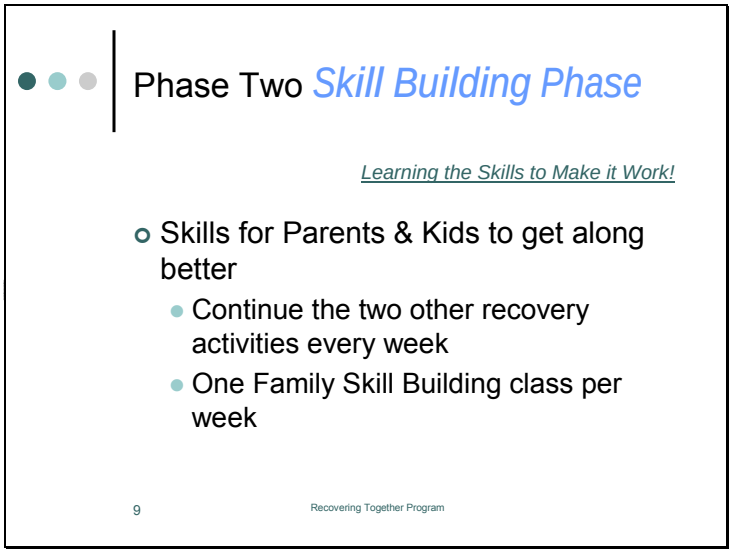


This is an overview; do not linger on the overview. Simply read the titles to the phases because an in-depth slide of each phase follows.

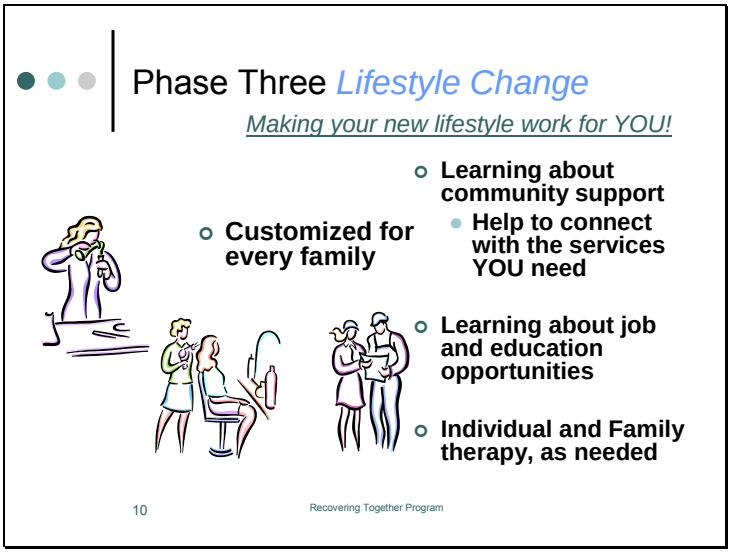
Slide 8



Slide 9



Slide 10



Slide 11

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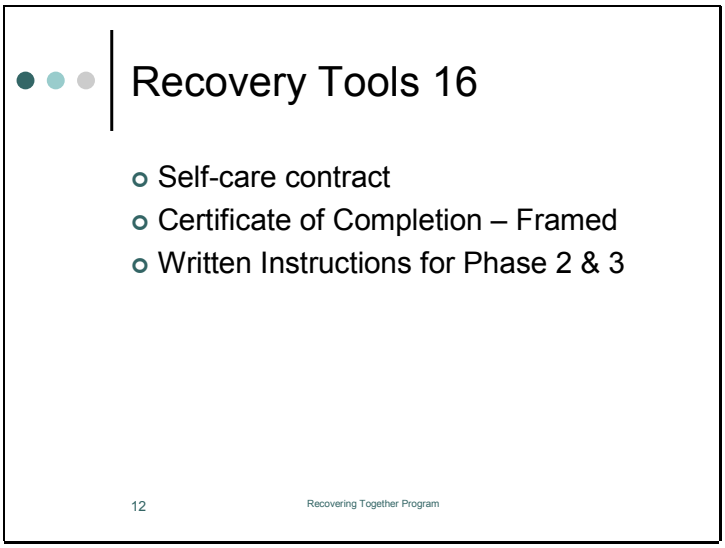
Slide 12



The recovery tool this week is the self-care contract, the completed recovery plan, and the written instructions for the remaining phases. Have the participants put them in their binders – sheet protectors are nice.

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Appendix A - Handout List & Documents

Week Needed	Name of Handout
W1	Local Recovery Activity Schedules (attendance documentation attached)
W1	Schedule of Multi-Family Group Meetings with Dates
W1	Consent for current and future research form
W1	Explanation of research form
W1	Research Participant Rights form
W3	Lifeline Handouts
W3	Handouts of All Presentations for Binder
W3-W16	Key Feeling Chart, color copy recommended, 1 for each participant binder, 1 in sheet protector for facilitator
W5, W6	Continuum Handout – color copy recommended, 1 for each participant binder
W5, W6	Xtra Continuum Handouts (black & white OK)
W5, W6	Four Characteristics handout
W7	Relapse warning signs checklists
W7	Relapse and Craving handout
W7	Stages of Change handout
W9	Social Readjustment Scale
W9	Stress Management Handout
W10	Cycle of Life Handout (White Bison, n.d.)
W11	Abusive Relationships handouts
W12	Family roles positive/negative handout
W13	Self-awareness summary (Najavits, 2002)
W13	Trauma questionnaire (Najavits, 2002)
W15	Personal Recovery Pattern Summaries
W15	Recovery Evaluation worksheets
W15	Recovery Planning Grids
W16	Self-Care contracts
W16	Family Certificates

Handout 1 – Local Recovery Activity Schedule

Look in your local newspaper, personals section, for days and times of various support groups. Also, look in the yellow pages for Alcoholics Anonymous and call their answering service. They will give you a time/place to pick up a complete schedule of AA meetings, and will probably know the contact number for other 12 step meetings. It is a good idea to also contact local churches, continuing education organizations, domestic violence, sexual assault, advocacy centers and community mental health clinics to find out about upcoming support groups.

Handout 2 – Schedule of Moms' Therapy

PHASE / WEEK	Topic	Date
ONE / 1	Introduction to RTP	
ONE / 2	Priorities, Needs & Wants	
ONE / 3	Self-concept & Saving Yourself	
ONE / 4	Binders and Stories	
ONE / 5	Defining Your Relationship with Substances	
ONE / 6	Emotion & Addiction	
ONE / 7	Relapse & Craving	
ONE / 8	Self-Esteem & Self-Efficacy	
ONE / 9	Stress Management	
ONE / 10	Life Cycles & the 12 Steps	
ONE / 11	Interpersonal Violence	
ONE / 12	Addiction & Family Roles	
ONE / 13	Trauma & Addiction	
ONE / 14	PTSD & Sexual Abuse	
ONE / 15	Relapse Prevention	
ONE / 16	Transition to Phase Two	
TWO / 1	Family Skill Building topic	
TWO / 2	Family Skill Building topic	
TWO / 3	Family Skill Building topic	
TWO / 4	Family Skill Building topic	
TWO / 5	Family Skill Building topic	
TWO / 6	Family Skill Building topic	
TWO / 7	Family Skill Building topic	
TWO / 8	Family Skill Building topic	
TWO / 9	Family Skill Building topic	
TWO / 10	Family Skill Building topic	
TWO / 11	Family Skill Building topic	
TWO / 12	Family Skill Building topic	
TWO / 13	Family Skill Building topic	
TWO / 14	Family Skill Building topic	
TWO / 15	Family Skill Building topic	
TWO / 16	Family Skill Building topic	
THREE/ 1	Transition Interview, Treatment Plan Review	
THREE/ 5	Support System Review	
THREE/ 9	Individualized Topic	
THREE/ 14	Individualized Topic	
THREE/ 19	Aftercare Planning, Final Data Collection	
THREE/ 20	Closure	

Total of 52 weeks = one year long program

Clarity Counseling P.C.

Simple, Clear Solutions
For Difficult Times

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Name: _____
Last Name First Name Middle Initial

2. Date of Birth: _____/_____/_____ 3. Date of Admission/Discharge: _____/____/____
Month/ Day / Year Month Day Year

4. Date authorization initiated: _____/_____/_____
Month Day Year

5. Authorization initiated by: _____
Name of Individual & Relationship to client or provider

6. Description of the information to be used or disclosed, and purpose for each. Be specific.

Description of information	Purpose of use or disclosure
__Information from Assessment Instruments__	__Program Evaluation___
__Biological Drug/Alcohol Test Results__	__Program Evaluation___
__Attendance Results_____	___Program Evaluation___

_____ _____
(use another sheet if more lines are required)

(Client may state, "at my request" for "purpose" when the client initiates the authorization but elects not to provide a statement of purpose.)

7. Name of the person or classes of persons authorized to make such a use or disclosure:
___Recovering Together Program Staff _____

8. Name of the person or classes of persons to whom you may make the requested use or disclosure: Clarity Counseling P.C. _

9. Expiration date or event upon which this authorization is no longer valid and this information can no longer be used or disclosed as specified in this authorization:
____End of the research study_____

(For the authorization is to be used specifically for research, "end of the research study" or "none" is sufficient for expiration date.)

10. Signature of the client or personal representative: _____

11. Date of signature: _____/_____/_____
Month Day Year

12. (If a personal representative was used, describe the client's personal representative's authority to act: _____).

Handout 4 – Explanation of Research Plan

Handout 5 – Research Participant Rights

My Lifeline

Name _____

birth

now

Could Include:
Childhood Events
Major Changes
School/Jobs
Marriage, Divorce
Births, Deaths
First use all drugs
Heavy use drugs
Violence
Legal Issues

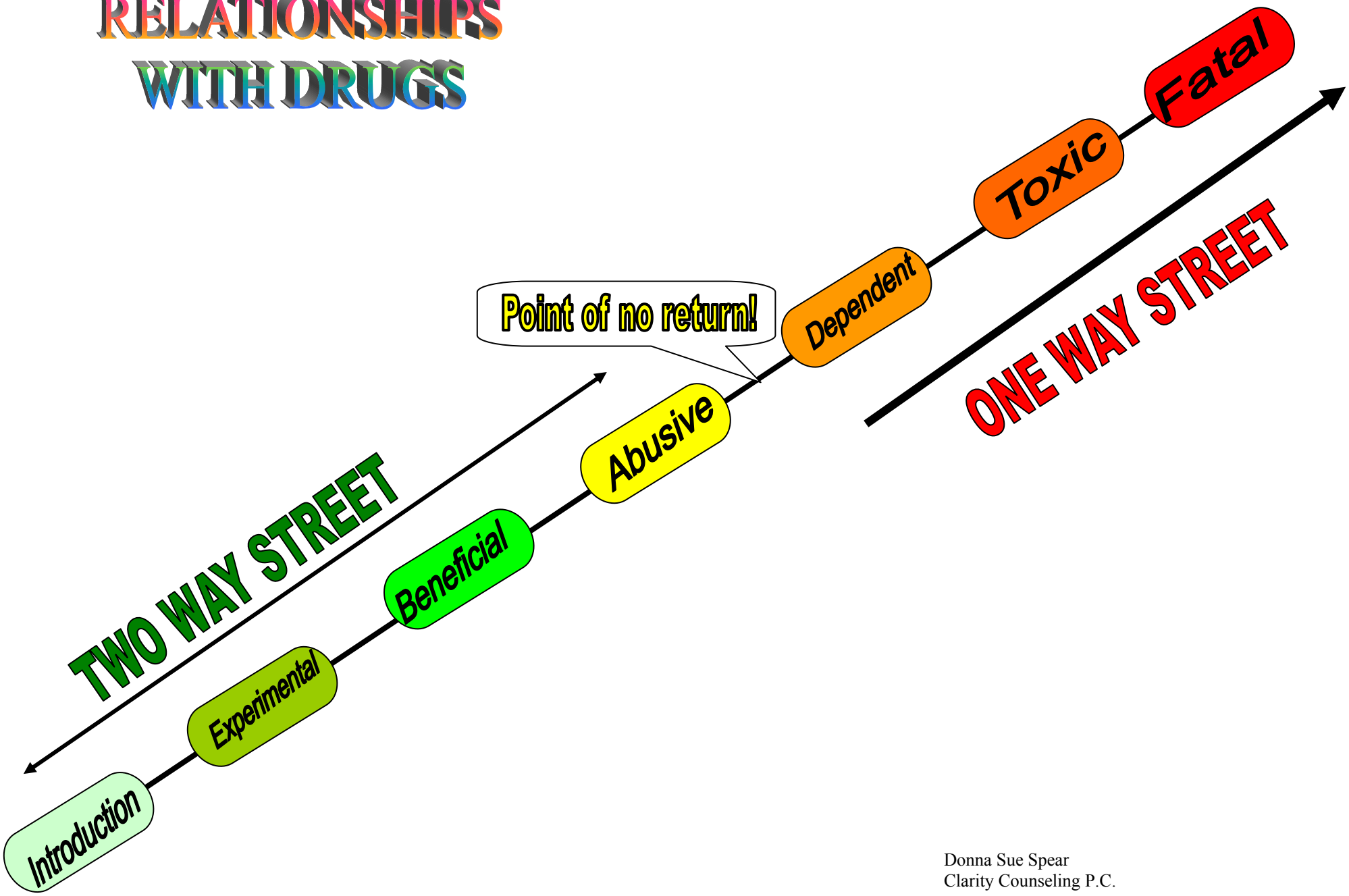
Handout 7 – Handouts of All Presentations for Binder

Print the desired handout format from the PowerPoint file, providing a copy of each week's slides in either two to six slides per page.

Key Feeling Handout

Anger	Fear	Hurt	Lonely	Pleasure	Guilt	Shame
irritation	nervous	disappointed	bored	content	regret	humility
rage	terror	grief	abandoned	ecstasy	remorse	worthless
Defend and identify boundaries	Alert for Danger of Injury	Know when you've been injured	Realize the loss of connection	Reward for effort and right action	Identify values and align with behavior	Know we are human

RELATIONSHIPS WITH DRUGS



Donna Sue Spear
Clarity Counseling P.C.

Handout 10 – Four Characteristics

Four Characteristics of a Healthy Relationship with a Drug

1. **Recognition that the substance you are using is a drug and awareness of what it does to your body.**

2. **Experience of a useful effect of the drug over time.**

3. **Ease of separation from the use of the drug.**

4. **Freedom from adverse effects on health or behavior.**

FROM - Weil, Andrew. From Chocolate to Morphine: everything you need to know about mind-altering drugs. Houghton Mifflin, New York, N.Y. 1993,1983 pp.15-21; 25-2

Handout 11 – Relapse Warning Signs Checklist

RELAPSE WARNING SIGNS

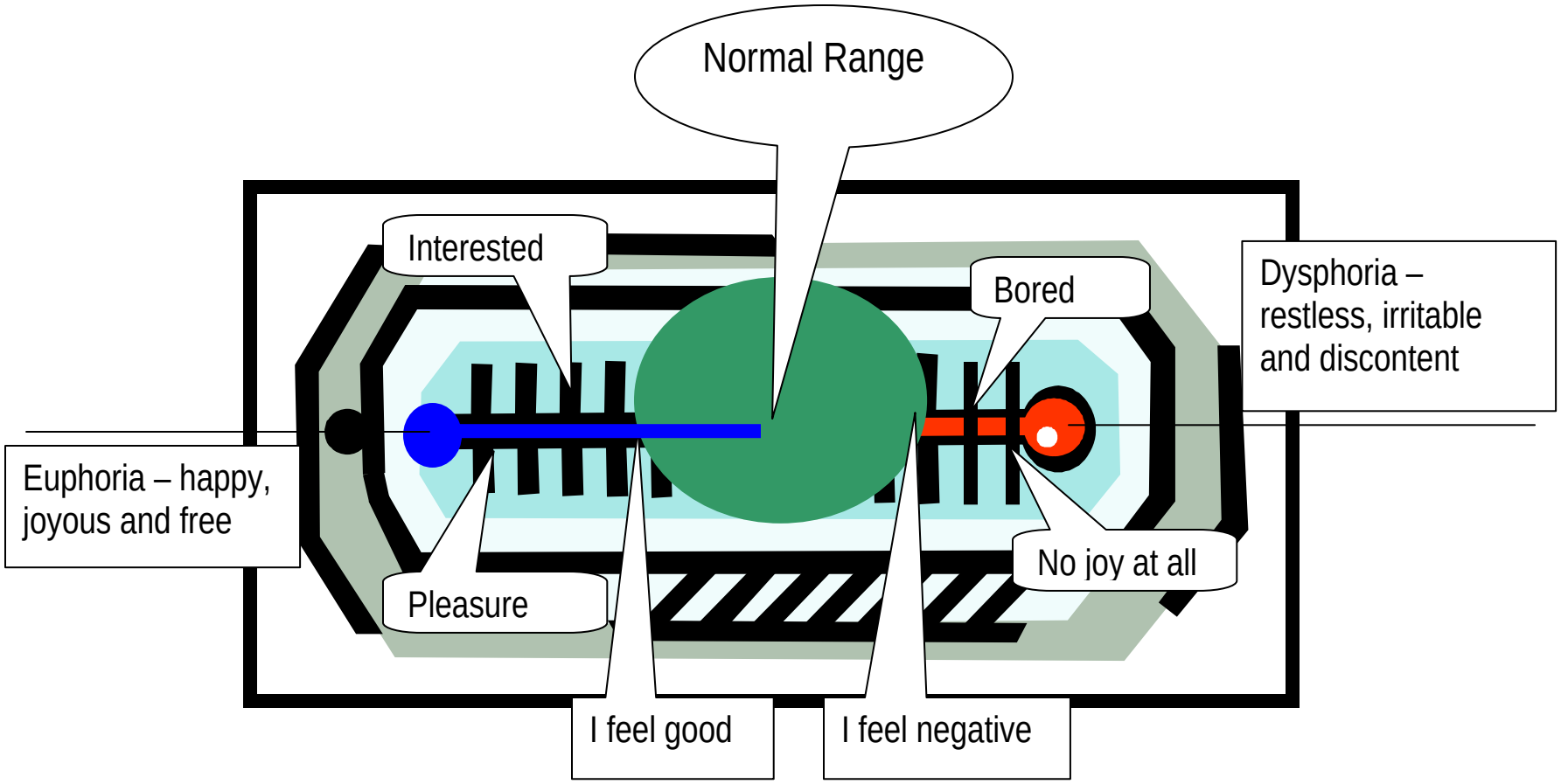
Use this checklist to identify signs that alert you to prevent relapse

- ☐ I start doubting my ability to stay sober.
- ☐ I deny my fears.
- ☐ I develop an “I don’t care attitude”.
- ☐ I openly reject help.
- ☐ I decide being abstinent is all I need.
- ☐ I complain often about aches and pains.
- ☐ I try to force sobriety upon others.
- ☐ I avoid talking about my problems.
- ☐ I feel sorry for myself.
- ☐ I overreact to situations.
- ☐ I start isolating myself.
- ☐ I do very few new things.
- ☐ I start getting depressed.
- ☐ I start unrealistic or haphazard planning.
- ☐ I live in the past.
- ☐ I find my life plans beginning to fail.
- ☐ I view my problems as unsolvable.
- ☐ I long for happiness.
- ☐ I begin to lie.
- ☐ I avoid having fun.
- ☐ I overanalyze myself.
- ☐ I become irritated with friends/family.
- ☐ I experienced periods of confusion.
- ☐ I am easily angered.
- ☐ I convince myself I’m cured.

- I begin doubting my drug problem.
- I progressively lose my daily routine.

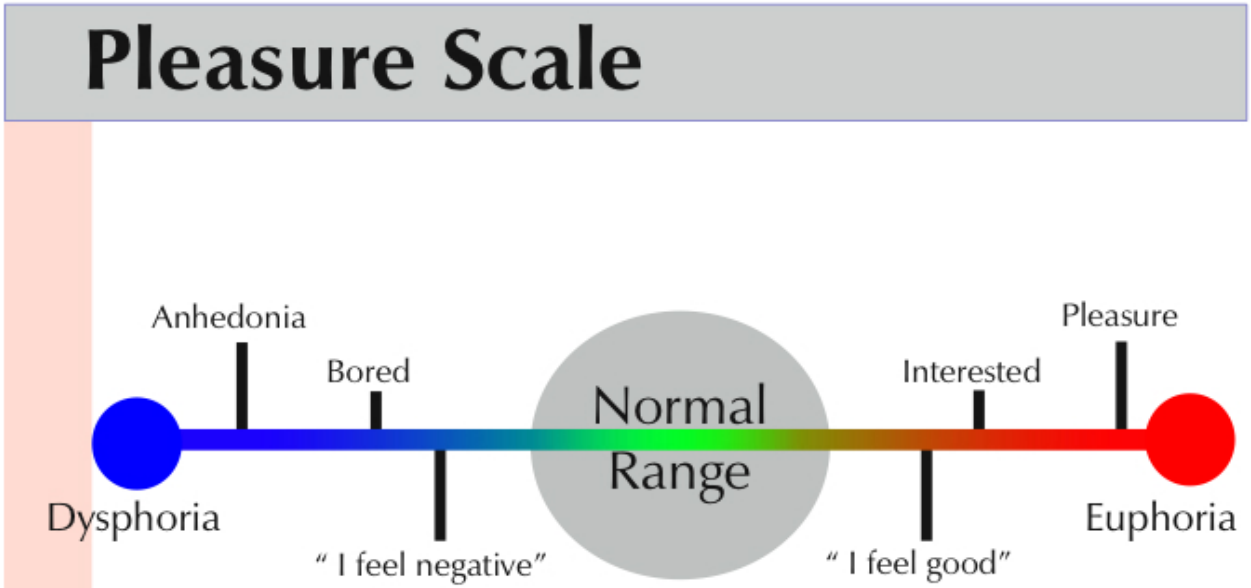
- I sporadically attend support or aftercare meetings.
- I tell myself that ‘I’ll never drink/use again.”
- I rationalize that drinking or using drugs can’t make my life worse than it is now.
- I doubt my ability to help myself.
- I become overconfident about my recovery.
- I have fantasies about social drinking or drug using.
- I increase my use of aspirin/nonprescription medications.
- I develop overwhelming feelings of dislike for someone.
- I stop attending support meetings or classes.
- I start idle daydreaming and wishful thinking.
- I am overwhelmed with loneliness, frustration, anger and tension.
- I begin visiting drinking or drug using “friends” and places.
- I practice controlled drinking or controlled drug use.
- I eat irregularly (over/under eating)
- I begin blaming people, places, things and conditions for my problems.

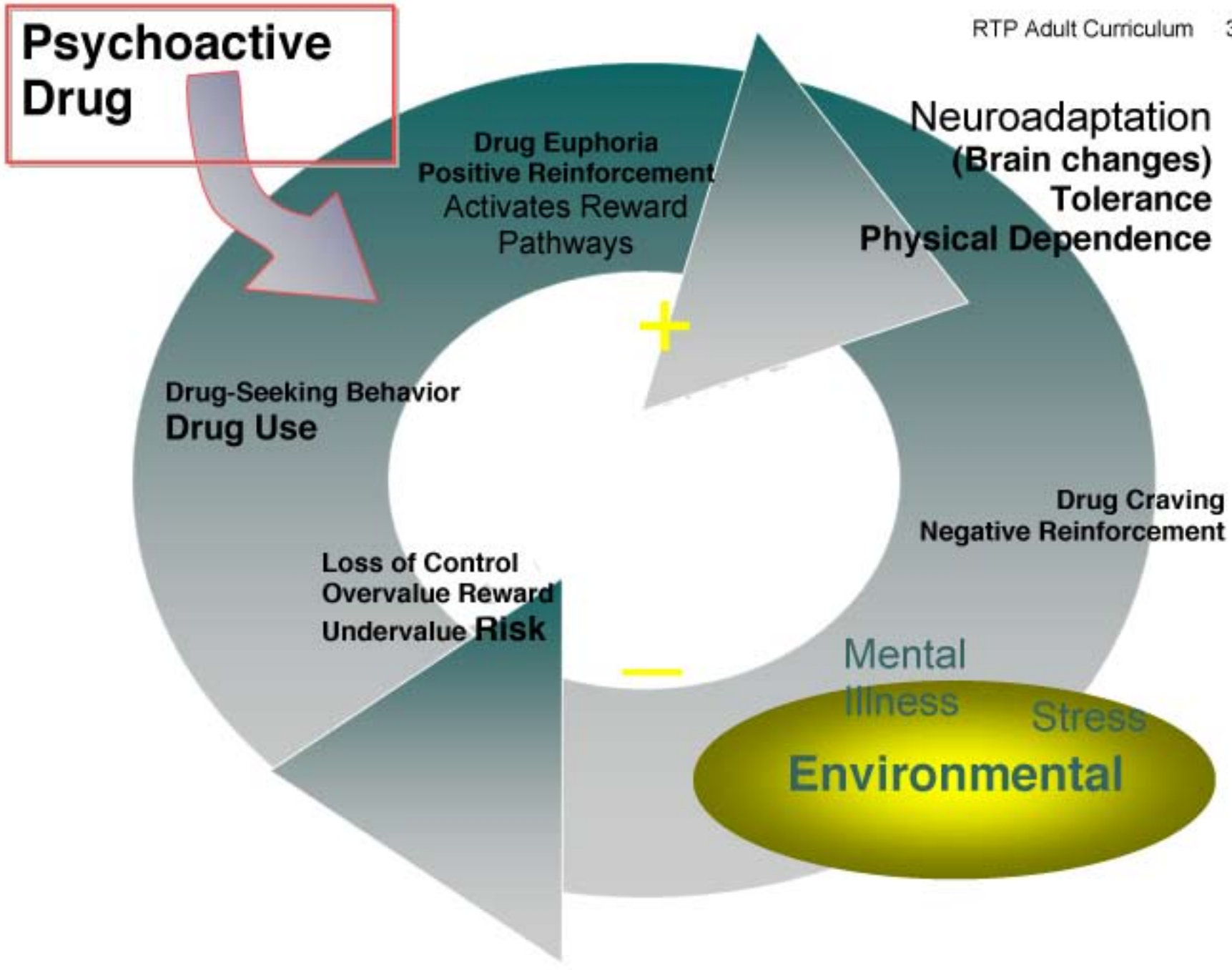
Pleasure & Craving Scale Handout



Adapted from Stalcup, S. A. (2006, May 1). *Methamphetamine Treatment.* Paper presented at the meeting of the 14th Annual Children's Justice Conference. Retrieved August 31, 2006 from http://www.dshscjc.com/public/SessionNotes/C-09.ppt

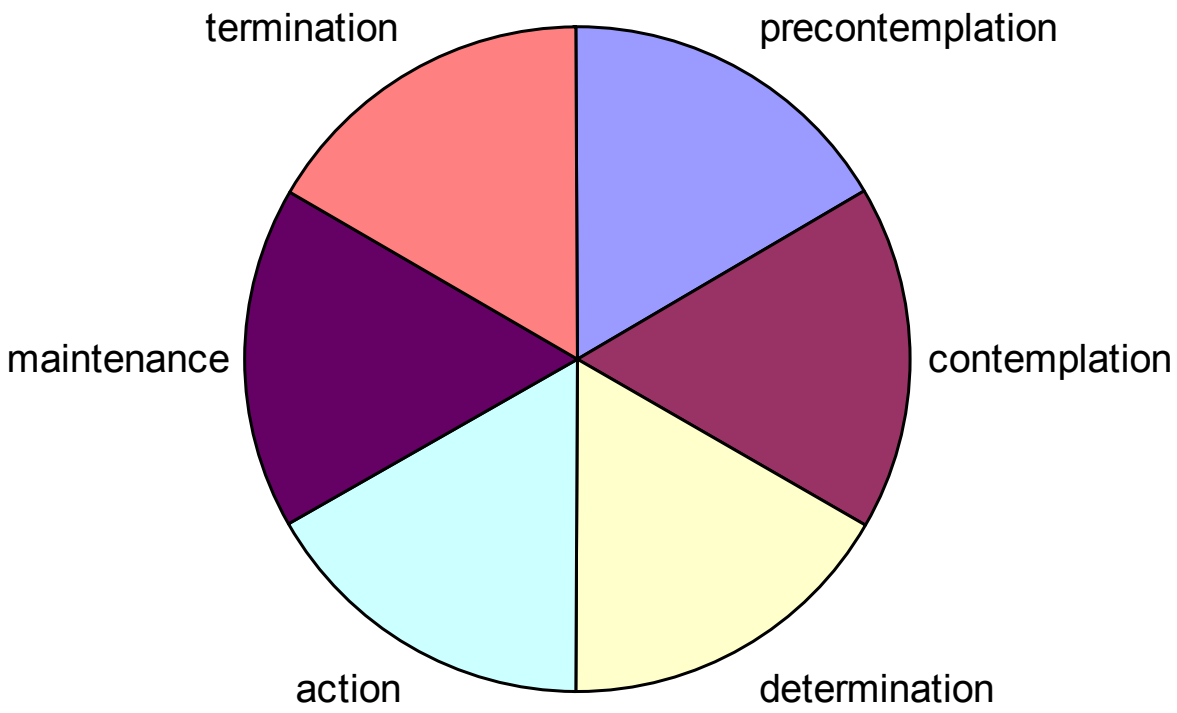
Pleasure & Craving Scale Handout





Adapted from Stalcup, S. A. (2006, May 1). *Methamphetamine Treatment*. Paper presented at the meeting of the 14th Annual Children's Justice Conference. Retrieved August 31, 2006 from

Stages of Change



Look Out for Healthy Students

Student Health Services

Social Readjustment Scale (Holmes-Rahe Scale)

The goal is to identify possible factors that may make you experience stressful events and increase your susceptibility to illness. Read the event list below. For each event, mark down how many times you have experienced the event in the past year (past 12 months). Once you are done with the list, add up your total score and look in the back to interpret your score!

LIFE EVENT	TIMES EVENT HAPPENNED	X	EVENT VALUE	=	YOUR SCORE
Death of spouse		X	100	=	
Divorce		X	73	=	
Marital separation		X	65	=	
Jail term		X	63	=	
Death of close family member		X	63	=	
Personal injury or illness		X	53	=	
Marriage		X	50	=	
Fired from job		X	47	=	
Marital reconciliation		X	45	=	
Retirement		X	45	=	
Change in health of a family member		X	44	=	
Pregnancy		X	40	=	
Sex difficulties		X	39	=	
Gain of new family member		X	39	=	
Business readjustment		X	39	=	
Change in financial state		X	38	=	
Death of a close friend		X	37	=	
Change to different line of work		X	36	=	
Change in number of arguments with spouse		X	35	=	
Mortgage (large one)		X	31	=	
Foreclosure of mortgage or loan		X	30	=	
Change in responsibility at work		X	29	=	
Son or daughter leaving home		X	29	=	
Trouble with In-Laws		X	29	=	
Outstanding personal achievement		X	28	=	
Wife began or stopped work		X	26	=	
Began or finished school		X	26	=	
Change in living conditions		X	25	=	
Revision of personal habits		X	24	=	

SUBTOTAL = _____

(Cont. on Back)

Stress Management

Stress Management Do's and Don'ts

Do: Relax…

- Self Care
  - Home Defense
  - Nurturing Activities
  - Acceptance
- Relaxation Techniques
  - Breathing
  - Grounding
  - Rag doll
  - Progressive Muscle Relaxation

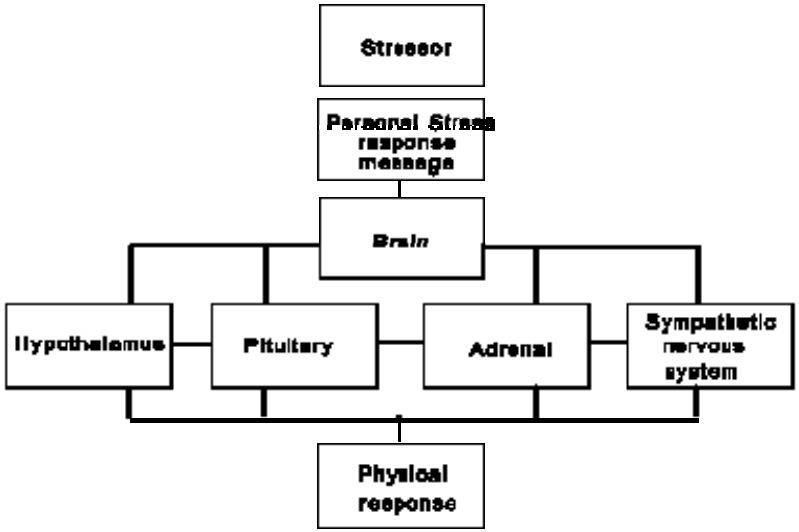
Don't:

These are the stressors you want to prevent.

- Feeling direction-less
- "Should" on yourself - Unrealistic expectations of self
  - More commitments than time
  - Guilt over procrastination or failing to keep commitments

What is the stress/relaxation physical response cycle?

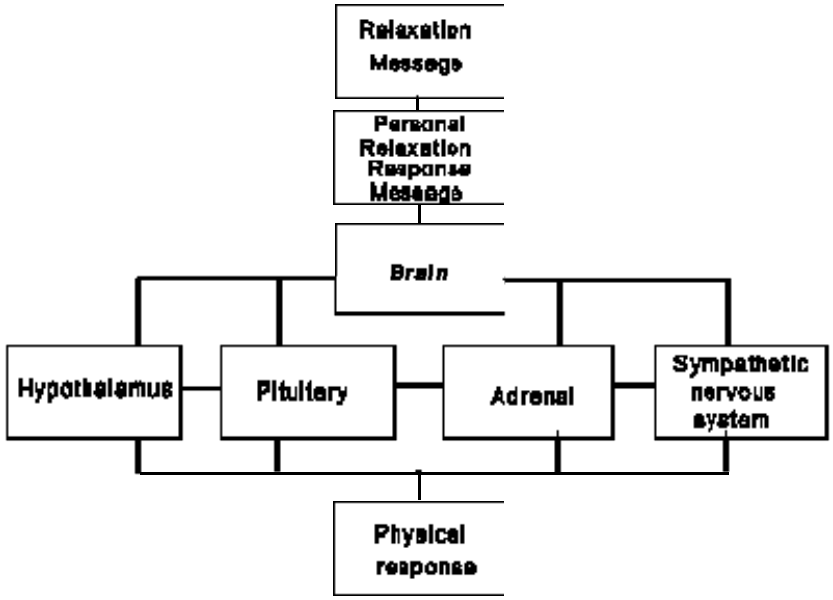
The physical response to stress is as follows:



The signs of this physical response include:

Increased: heart rate, blood pressure, respiration, perspiration, pupil dilation, muscle tension. In the state of chronic stress, heart rate, blood pressure, and respiration are chronically elevated.

The physical response to relaxation is as follows:



The signs of this physical response include:

Decreased: heart rate, blood pressure, respiration, pupil dilation, muscle tension

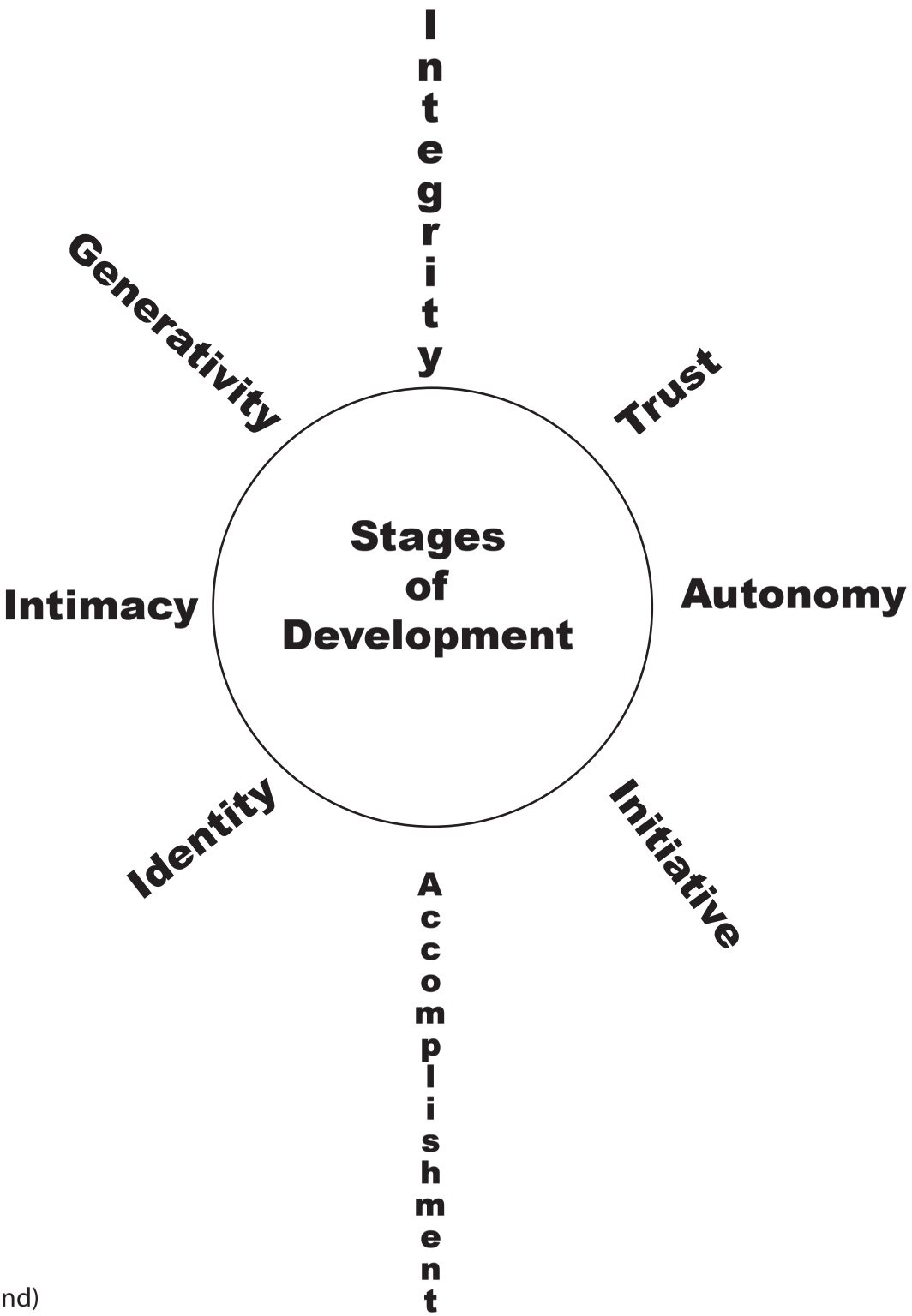
Stress management strategy is to evoke the relaxation physical response on a regular, daily basis.

Adapted from Messina, J. J., & Messina, C. M. (1999). *Tools for Coping Series*. Retrieved March 10, 2007, from Coping.org Web Site: http://www.coping.org/growth/stress.htm

The Medicine Wheel and the Twelve Steps

The Medicine Wheel Teaching

Stages of Development



(White Bison, Inc., nd)

THE MEDICINE WHEEL AND THE TWELVE STEPS

THE CYCLE OF LIFE

Stages of Development

AGE	HEALTHY DEVELOPMENT	UNHEALTHY DEVELOPMENT
	"TRUST"	**"MISTRUST"**
1st Year	• Need TLC and body contact • People are good and trustworthy • World is a good place	• Family breakup or parental rejection • World is not safe • Withdrawal in later life • Unable to trust and develop close relationships
	"AUTONOMY"	**"SHAME/DOUBT"**
1-2years	• I love this world and all it offers • Exploration/Independence • Become your own being; separate from parent	• Over controlled by parents • Shame on you or bad boy/girl frequently • Fearful or ashamed of self in later life
	"INITIATIVE"	**"GUILT"**
3-7 years	• Active imagination • Role play and pretend • Test boundaries between imagination and reality	• Told don't be silly and grow up • Made to feel foolish for using imagination • Develop unreasonable fears and guilt in later life • May live in fantasy and daydream in later life
	"ACCOMPLISHMENT"	**"LOW SELF ESTEEM"**
8-11 years	• Feel good for something and good at something • Need to receive praise and recognition for accomplishments	• Overly critical parents • Feel no good and lack self-confidence • Low self-esteem in later life

(White Bison, Inc. n.d.)

AGE	HEALTHY DEVELOPMENT	UNHEALTHY DEVELOPMENT
12-18 years	**"IDENTITY"** • Need to belong, to be somebody • Need to get attention and praise for things done well • Develop answers to questions like: "Who am I?", "Why am I?" "Where am I going?"	**"INFERIORITY"** • Lack self-worth • Low self-esteem • Become good at being bad • Attracts attention inappropriately • Late life problems may be depression, suicide attempts, addictions
19-30 years	**"INTIMACY"** • Share ideas with friends • Openly shares innermost thoughts and feelings • Not worried about what others think of you	**"ISOLATION"** • Coldness, inability to share thoughts and feelings • Unable to form and maintain close relationships • Unreasonable fears of openness and disclosure
30-40 years	**"GENERATIVELY"** • Unselfish giving/sharing • Give to and guide others • Not looking for what's in it for me • Service to others	**"STAGNATION"** • Self-centered/seeking • Take from others • What's in it for me • Overly Materialistic
Rest of life	**"INTEGRITY"** • Mentally healthy adult • Break away from parents and relate to them on an adult level • Sees order and worth in the world • Have sense of own values, rules and code of life	**"DESPAIR"** • Fear and hopelessness • Judgmental, prejudiced • Can't trust others • Feels world is a bad place • May lack good values and conscience

(White Bison Inc., n.d.)

Basic Rights in a Relationship

Besides understanding the various categories of verbal abuse and recognizing the abuser's reality, it is useful to understand the basic rights of relationship which are violated by verbal abuse (verbally abusive relationships are often physically abusive as well). Following is a list of some of these rights:

- The right to good will from the other.
- The right to be heard by the other and to be responded to with courtesy.
- The right to have your own view, even if your mate has a different view.
- The right to have your feelings and experienced acknowledged as real.
- The right to receive a sincere apology for any jokes you find offensive.
- The right to clear and informative answers to questions that concern what is legitimately your business.
- The right to live free from accusation and blame.
- The right to have your work and your interests spoken of with respect.
- The right to encouragement.
- The right to live free from emotional and physical threat.
- The right to live free from angry outbursts and rage.
- The right to be called by no name that devalues you.
- The right to be respectfully asked rather than ordered.

(Evans, 1996)

Continuums of Violence

Type

Stage	Physical	Sexual	Emotional	Social/ Environmental
Intolerance	• Inconsideration of needs and comfort • Inconveniencing • Ignoring • Brush aside • Obsticalizing • Passive neglect	• Not responding to his/her needs and wants • Denial of feelings • Impatience or insistence	• Jokes at his/her expense • Inconsideration • Ignore her/his feelings • Impatience, sarcasm	• Inconsideration of her/his preferences • Non cooperation with her/his activities or interests • Ridicule of her/his place class or supports
Rejection	• Push, shove, shake twist arm • Doesn't prevent harm • Let pain and discomfort occur without help • Physical threats	• Unwanted sex or • Withholding sex • Promiscuity • Sexual jokes • Refusal or refusing physical affection	• Scream, yell, blaming • Use of abusive labels i.e.; dumb, stupid • Ignoring her/his responses • Targeting • Lying	• Isolation from events/ education • Rejects her/his friends • Jealousy, suspiciousness • Restrict monetary access • Reject her/his family • Reject her/his supports
Sabotage	• Punch, hit, slap • Denial of physical needs and necessities • Targeting • Rages	• Forceful sex • Ridicule • Uncomfortable sex • Sexual stereotypes • Sexual embarrassment	• Degrading • Humiliating • Threats • Mixed signals	• Withholding monetary access • Make financially dependent • Drive off supports • Censor activities • Deny authority
Destruction	• Physical injuries • Significant damage • Abuse while pregnant • Murder	• Sex with threats • Sex with weapons • Rape • Rape with physical damage • Sex with beatings or murder	• Denial of human role • Hit nearby things • Accusations • Labels (i.e.; whore, crazy, wimp) • No cause and effect • Torment • Isolation	• Destroy pets, possessions • Physically isolate or restrain • No access to supports • Taking over her/his affairs

(Pettit and Gibbons, 1999)

Some Characteristics that Might Identify A Potential Batterer

1. Does a man report having been physically or psychologically abused as a child?
2. Was the man's mother battered by his father?
3. Has the man been known to display violence against other people?
4. Does he play with guns and use them to protect himself from other people?
5. Does he lose his temper frequently and more easily than seems necessary?
6. Does he commit acts of violence against objects and things rather than people?
7. Does he drink alcohol excessively?
8. Does he display an unsual amount of jealousy when you are not with him? Is he jealous of significant other people in your life?
9. Does he expect you to spend all your free time with him or to keep him informed of your whereabouts?
10. Does he become enraged when you do not listen to his advice?
11. Does he have a dual personality?
13. Do you get a sense of fear when he becomes angry with you? Does *not* making him angry become and important part of your behavior?
14. Does he have rigid ideas of what people should do that are determined by male and female sex-role stereotypes?
15. Do you think you are being battered? If so, the probability is high that you are a battered woman and should seek help immediately.

(Walker, 1979)

Potential Partners:

What to Look For and What to Look Out For

Step 1: If we have been in an abusive relationship, we should seek treatment, counseling, group support and involvement in recovery for some time before seriously considering a new partner. Until we change, we are likely to continue - on an unconscious level - to attract the same kinds of people.

Step 2: After non-sexual dating of several people, spend several non-sexual months getting to know a new potential partner.

Step 3: Check our new prospect against these lists, after we know them well. Then check ourselves. Only after we have acquired healthy traits through recovery will we attract healthy people.

Step 4: If people with many of the traits in the left hand column seem "boring", repeat first three steps until healthy prospects become interesting and attractive.

Look For:	Look Out For:
Traits of Potential Healthy Partners	**Traits of Potential Abusive/Battering Partners**
Spiritual	
A spiritual higher power, comfortable with personal spirituality.	Focuses on earthly higher powers; money control, work, sex, prestige, own body, addictions.
History	
Accepts responsibility for past relationship dynamics. Has resolved past relationships.	Any history of being a batterer. Blames former partners for "causing it".
Some family history of constructive conflict resolution. Recognizes and deals with effects of family of origin history.	Was a victim or, especially, an observer of violence in family of origin. Unaware of impact of family of origin.
Peer Relations	
Average or better position among peers.	Is in the lower portion of peer group.
Healthy relationships with same sex peers.	Difficulty with peers, critical, isolated.
Friendships	
Several supportive non-sexual friendships with both sexes.	Few or no supportive relationships.
Partner is "best friend" but has several "good friends".	Partner is only significant support person, friends are sometimes other addicts.

(Pettit and Gibbons, 1999)

Public Presence	
Presents consistent personality in both public and private.	Presents dual personality, public and private very different.
Jealousy	
Appropriate boundaries with partner's opposite sex relationships.	Pathologically jealous of partner's relationships with either sex, including with children. Craves attention.
Control	
Accepting and supportive of partner's activities and interests	Attempts to control money, time, access to support, friendships, even food of partner. Critical and unsupportive of partner's interests.
When in control, accepts resulting responsibility.	When in control, does not accept responsibility but blames others for choices.
Tolerance	
Accepts opposing realities of others while maintaining own reality.	Intolerant of differing opinions, thoughts and feelings.
Allows others to have feelings and is supportive.	Can't stand another's bad moods.
Is proactive regarding stress - acknowledges stress when present and takes self-care measures.	Very low stress tolerance, unable to see constructive alternatives, perceives self as victim to outside forces.
Capability	
Appear competent and capable on their own whether or not you are their partner.	Have some problems but you think they would be more likely to fulfill potential with your support.
Financial	
Lives mostly within means, financial problems temporary, manageable.	May have chronic financial history, difficulty with spending impulse control, especially when "making up" to victim.
Responsibility	
Acknowledges own role in conflicts and holds others accountable for theirs.	Blames others in conflicts, focuses on others entirely as the cause of problems.
Self Care	
Willingly cares for self whether partner is present or absent. Readily does basic food, clothing, shelter and health functions.	Unwilling to be responsible for basic self-care. Angry if partner doesn't do for them.
Relationship style	
Has preferred style, and is willing to negotiate, but does not deny own preference.	Rigidly committed to traditional male-dominated sex roles, threatened by other styles.

(Pettit and Gibbons, 1999)

View of Relationships Comfortable with self and with being alone. Considers relationship a desirable choice, but not an absolute necessity.	Uncomfortable, highly dependent on partner. Consciously fears enmeshment and control by partner so controls in reaction to unrealistic fears. Unconsciously fears abandonment, so attempts to restrict partner's life.
Assertiveness Able to ask partner directly to meet wants and needs, then accepts either yes or no.	Unable to be assertive about wants and needs. Won't ask, yet holds resentments about unmet needs. Can't accept no.
World View Sees world in balanced, realistic perspective and not as threatening.	Views world negatively with strong critical opinions, awfulizes.
Addictions Slight or no alcohol use. No other chemical addictions.	Often chemically dependent but not always. Alcohol is not cause of violence but does contribute to loss of control.
Recovery Active recovery, if involved. Attends meetings, calls sponsor, works steps, active social life with recovery friends.	Often unable to stay in recovery. Honesty difficult, resists responsibility for past behavior.
Sex Considerate sex partner also willing to state own needs.	Often demands degrading and unusual sex practices. Uses sex to control. Uses force or manipulation to get sex.
Communication Communicates thoughts and feelings frequently in an appropriate, non-judgmental way.	Often withholds communication until angry. Then verbally abuses, using abusive techniques such as countering, undermining, criticizing, blaming, threatening and verbal raging.
Accountability Makes amends for hurtful behavior fairly quickly, being specific about where they were wrong and acknowledging impact on the partner. Changes behavior in future.	Unable to be accountable but instead engages in seductive, flattering, excessive make-up behavior to deflect and minimize the abuse. Repeats abusive behavior.
Entitlement Moderate in demands on others, feeling of entitlement in proportion to earned position in relationships with others.	Huge sense of entitlement. Not necessary to earn deferential treatment, think they just deserve it.

Source: Developed by Eric McDowell from various publications, conference notes, clinical observations and therapist interviews (particularly with Elizabeth Ewins, *Meadows Therapist) for presentation at the Alaska Women's Conference, March, 1996 in Juneau, Alaska.*

(Pettit and Gibbons, 1990)

RTP Family Roles Pros & Cons Worksheet

	Victim	Enabler	Hero	Scapegoat	Mascot	Lost Child
+ payoffs						
- costs						

Self-Awareness Summary

- Overall, how much is your trauma or violence related to addiction:
  - In the present?

  - In the past

Najavits, L. M. (2002). A w*oman's addiction workbook*. Oakland, CA: New Harbinger Publications, Inc. p. 74-75

In your lifetime have you suffered any of the following experiences, or seen them happen to anyone else?

Child physical abuse (e.g., hitting that caused bruises or injury)	Yes	No	Maybe
Child sexual abuse (e.g., being molested, touched, or forced into any sexual activity	Yes	No	Maybe
Child neglect (e.g., not enough to eat, inadequate shelter)	Yes	No	Maybe
Domestic Violence (a partner who hurt you physically or witness to this type of violence)	Yes	No	Maybe
Crime victimization (e.g., burglarized, stalked, rape, mugging)	Yes	No	Maybe
Serious accident (e.g. car crash, chemical spill or fire)	Yes	No	Maybe
Life-threatening illness (e.g. cancer)	Yes	No	Maybe
Natural disaster (e.g. hurricane, tornado, earthquake)	Yes	No	Maybe
War	Yes	No	Maybe
Captivity or kidnap	Yes	No	Maybe

(Najavits, 2002)

Dealing With the Effects of Trauma
A Self-Help Guide

Things You Can Do Every Day to Help Yourself Feel Better

There are many things that happen every day that can cause you to feel ill, uncomfortable, upset, anxious, or irritated. You will want to do things to help yourself feel better as quickly as possible, without doing anything that has negative consequences, for example, drinking, committing crimes, hurting yourself, risking your life, or eating lots of junk food.

- **Read through the following list.** Check off the ideas that appeal to you and give each of them a try when you need to help yourself feel better. Make a list of the ones you find to be most useful, along with those you have successfully used in the past, and hang the list in a prominent place—like on your refrigerator door-as a reminder at times when you need to comfort yourself. Use these techniques whenever you are having a hard time or as a special treat to yourself.
- **Do something fun or creative,** something you really enjoy, like crafts, needlework, painting, drawing, woodworking, making a sculpture, reading fiction, comics, mystery novels, or inspirational writings, doing crossword or jigsaw puzzles, playing a game, taking some photographs, going fishing, going to a movie or other community event, or gardening.
- **Get some exercise.** Exercise is a great way to help yourself feel better while improving your overall stamina and health. The right exercise can even be fun.
- **Write something.** Writing can help you feel better. You can keep lists, record dreams, respond to questions, and explore your feelings. All ways are correct. Don't worry about how well you write. It's not important. It is only for you. Writing about the trauma or traumatic events also helps a lot. It allows you to safely process the emotions you are experiencing. It tells your mind that you are taking care of the situation and helps to relieve the difficult symptoms you may be experiencing. Keep your writings in a safe place where others cannot read them. Share them only with people you feel comfortable with. You may even want to write a letter to the person or people who have treated you badly, telling them how it affected you, and not send the letter.
- **Use your spiritual resources.** Spiritual resources and making use of these resources varies from person to person. For some people it means praying, going to church, or reaching out to a member of the clergy. For others it is meditating or reading affirmations and other kinds of inspirational materials. It may include rituals and ceremonies—whatever feels right to you. Spiritual work does not necessarily occur within the bounds of an organized religion. Remember, you can be spiritual without being religious.
- **Do something routine.** When you don't feel well, it helps to do something "normal"—the kind of thing you do every day or often, things that are part of your routine like taking a shower, washing your hair, making yourself a sandwich, calling a friend or family member, making your bed, walking the dog, or getting gas in the car.
- **Wear something that makes you feel good.** Everybody has certain clothes or jewelry that they enjoy wearing. These are the things to wear when you need to comfort yourself.
- **Get some little things done.** It always helps you feel better if you accomplish something, even if it is a very small thing. Think of some easy things to do that don't take much time. Then do them. Here are some ideas: clean out one drawer, put five pictures in a photo album, dust a book case, read a page in a favorite book, do a load of laundry, cook yourself something healthful, send someone a card.
- **Learn something new.** Think about a topic that you are interested in but have never explored. Find some information on it in the library. Check it out on the Internet. Go to a class. Look at something in a new way. Read a favorite saying, poem, or piece of scripture, and see if you can find new meaning in it.

Tips for Talking to Children in Trauma

Interventions at Home for Preschoolers to Adolescents

Children are just as affected as adults are by a disaster or traumatic event. Some may be affected even more, but no one realizes it. Without intending to, we, as parents, may send our children a message that it is not all right to talk about the experience. This may cause confusion, self-doubt, and feelings of helplessness for a child. Children need to hear that it is normal to feel frightened during and after a disaster or traumatic event. When you acknowledge and normalize these feelings for your children, it will help them cope with their experience and move on.

Following exposure to a disaster or traumatic event, children are likely to show signs of stress. Signs include sadness and anxiety, outbursts and tantrums, aggressive behavior, a return to earlier behavior that was outgrown, stomachaches and headaches, and an ongoing desire to stay home from school or away from friends. These reactions are normal and usually do not last long. Whether your child is a preschooler, adolescent, or somewhere in between, you can help your child by following the suggestions below.

Preschooler

- Stick to regular family routines.
- Make an extra effort to provide comfort and reassurance.
- Avoid unnecessary separations.
- Permit a child to sleep in the parents' room temporarily.
- Encourage expression of feelings and emotions through play, drawing, puppet shows, and storytelling.
- Limit media exposure.
- Develop a safety plan for future incidents.

Elementary Age Children

- Provide extra attention and consideration.
- Set gentle but firm limits for acting out behavior.
- Listen to a child's repeated telling of his/her trauma experience.
- Encourage expression of thoughts and feelings through conversation and play.
- Provide home chores and rehabilitation activities that are structured, but not too demanding.
- Rehearse safety measures for future incidents.
- Point out kind deeds and the ways in which people helped each other during the disaster or traumatic event.

Preadolescents and Adolescents

- Provide extra attention and consideration.
- Be there to listen to your children, but don't force them to talk about feelings and emotions.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

Additional Resources

American Academy of Child and Adolescent Psychiatry (AACAP)
3615 Wisconsin Avenue, N.W.
Washington, DC 20016-3007
Local phone: 202-966-7300
Toll-free: 800-333-7636
Fax: 202-966-2891
Web site: www.aacap.org

National Association of School Psychologists
National Emergency Assistance Team
4340 East West Highway, Suite 402
Bethesda, MD 20814
Phone: 301-657-0270
Web site: www.nasponline.org/NEAT

National Center for Children Exposed to Violence
Yale Child Study Center
230 South Frontage Road, P.O. Box 207900
New Haven, CT 06520-7900
Local phone: 203-785-7047
Toll-free: 877-49 NCCEV (496-2238)
Fax: 203-785-4608
Web site: www.nccev.org/violence/children_terrorism.htm

National Mental Health Association
2001 N. Beauregard Street, 12th Floor
Alexandria, VA 22311
Local phone: 703-684-7742
Toll-free: 800-969-NMHA (6642)
Fax: 703-684-5968
Web site: www.nmha.org/reassurance/anniversary/index.cfm

Federal Emergency Management Agency (FEMA)
(Information for Children & Adolescents)
P.O. Box 2012
Jessup, MD 20794-2012
Toll-free: 800-480-2520
Web site: www.fema.gov/kids/

National Institute of Mental Health
Office of Communications
6001 Executive Boulevard
Room 8184, MSC 9663
Bethesda, MD 20892-9663
Local phone: 301-443-4513
Toll-free: 866-615-NIMH (6464)
TTY: 301-443-8431
Fax: 301-443-4279
Web site: www.nimh.nih.gov

- Encourage discussion of trauma experiences among peers.
- Promote involvement with community recovery work.
- Urge participation in physical activities.
- Encourage resumption of regular social and recreational activities.
- Rehearse family safety measures for future incidents.

It is important to remember that you do not have to "fix" how your child feels. Instead, focus on helping your child understand and deal with his or her experiences. Healing is an evolving state for most children, but some may need professional help.

If signs of stress do not subside after a few weeks, or if they get worse, consider consulting a mental health professional who has special training in working with children. In time, and with help, your children will a return to health.

Note: Inclusion of a resource in this fact sheet does not imply endorsement by the Center for Mental Health Services, the Substance Abuse and Mental Health Services Administration, or the U.S. Department of Health and Human Services.

NMH02-0138

9/2005

A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

Name _____ Date _____

Strengths	Weaknesses

Recovery Action	Never	Sometimes	Often
	0	1	2
1. How often did you attend group or individual counseling sessions?			
2. How often did you regularly attend AA or self-help group meetings?			
3. How often did you talk with your sponsor in your Twelve Step self-help group (AA, NA, etc.)? If you did not have a sponsor, check never.			
4. Are you working actively on the twelve steps?			
5. How frequently did you eat three well-balanced meals per day?			
6. How often did you eat foods high in sugars (candy, chocolate, cakes, etc.)?			
7. How often did you drink beverages containing caffeine?			
8. How often did you use nicotine (including cigarettes, cigars, and smokeless tobacco)?			
9. How often did you exercise at least three times per week for a minimum period of 20 to 30 minutes in a manner that was strenuous enough to make you breathe hard and begin to sweat?			
10. How often have you used relaxation techniques?			
11. How often did you use prayer and meditation on a regular basis to help you recover?			
12. How frequently did you talk with people about your life and ask for feedback on a regular basis?			
13. How often did you attempt to solve problems promptly as they came up?			
14 How often did you schedule time for recreational activities (recreational activities are activities you consider to be fun)?			
15. How often did you schedule time for activities with your family?			
16. How often did you schedule time to spend with friends?			
17. How often did you work on a regular schedule that didn't interfere with recreational or treatment activities?			
18. How often did you schedule some quiet time to think and plan your recovery program on a regular basis?			
Total			

(Gorski, T.T. and Miller, 1986)

Name _____ Date _____

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
							Morning
							Afternoon
							Evening

Recovery Planning Grid.doc **Name** _____

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
Morning							
Afternoon							
Evening							

Completion Certificate

This is awarded to

_____

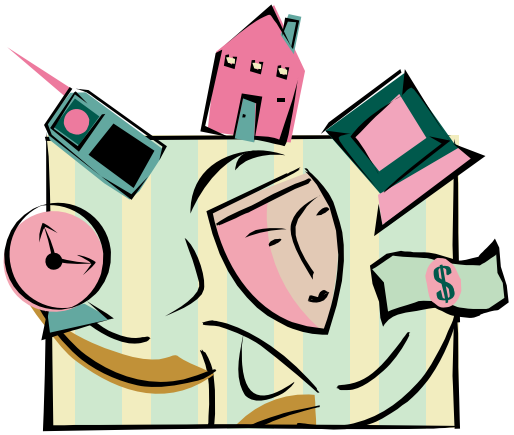
for successfully completing

Phase One

of the *Recovering Together Program*

_____ _____

Completion Certificate



This is awarded to

_____

For successfully completing

Phase One

of the *Recovering Together Program*

_____

RTP Master Lists

- EQUIPMENT
  - LCD or Overhead projector
  - Screen for Images **or** a blank wall/whiteboard
  - Laptop with Presentation files **or** Overhead Transparencies
  - Microsoft Word & PowerPoint **or** Adobe Reader
  - Drug testing supplies, as needed
  - Copy or fax machine for attendance sheets
- RTP Binder

- Local Recovery Activity Schedules (attendance documentation attached)
- Schedule of Multi-Family Group Meetings with Dates
- Consent for current and future research form
- Explanation of research form
- Research Participant Rights form
- Lifeline Handouts
- Handouts of All Presentations for Binder
- Key Feeling Chart, color copy recommended, 1 for each participant binder, 1 in sheet protector for facilitator
- Continuum Handout – color copy recommended, 1 for each participant binder
- Xtra Continuum Handouts (black & white OK)
- Four Characteristics handout
- Relapse warning signs checklists
- Relapse and Craving handout
- Stages of Change handout
- Social Readjustment Scale
- Stress Management Handout
- Cycle of Life Handout (White Bison, n.d.)
- Abusive Relationships handouts
- Family roles positive/negative handout
- Self-awareness summary (Najavits, 2002)
- Trauma questionnaire (Najavits, 2002)
- Personal Recovery Pattern Summaries
- Recovery Evaluation worksheets
- Recovery Planning Grids
- Self-Care contracts
- Family Certificates

SUPPLIES – Binders with handouts, as needed for participants

– Decoration supplies (ie. Markers, glitter pens, stickers, use your imagination and ask participants for ideas)
– Envelopes (to hold pieces of paper later)
– Index cards
– Marker or markers, Dry erase
– Markers, Fine tip
– Markers, Washable
– Meditation books
– Multi-colored yarn
– Name Tags
– Paper pieces (enough so each group member has one for each woman in our group) or Sticky Notes
– Pens
– Planners for Participants
– Presentation File or Overhead Transparencies
– Relaxation CD's
– Big Books (ie. Alcoholics Anonymous, Narcotics Anonymous, Red Road To Wellbriety)
– Sticky notes
– Tape

References

American Humane. (2005). *Specific Needs of the Rocky Mountain Region*. Retrieved December 9, 2005, from American Humane Association Web Site: http://www.americanhumane.org/site/PageServer?pagename=pc_best_practice_rmqic_needs

Anonymous (1986). *Alcoholics Anonymous* (3rd ed., Rev.). New York, NY: Alcoholics Anonymous World Service, Inc.

Applied Knowledge Research Institute . (2005). *Maslow's Hierarchy of Need*. Retrieved May 11, 2005, from www.akri.org/cognition/motivate.htm

Beauregard, M., Levesque, J., & Bourgouin, P. (2001). Neural correlates of conscious self-regulation of emotion. *The Journal of Neuroscience, (21),* RC165. Available at http://www.jneurosci.org/cgi/content/full/21/18/RC165

Bright Futures. (2002). Child Maltreatment. In *Bright Futures in Practice: Mental Health (2002) is* (Initial Interventions: Community). Retrieved March 11, 2006, from Bright Futures at Georgetown University Web Site: http://www.brightfutures.org/mentalhealth/pdf/bridges/maltreatment.pdf

Brownell, K. D., Marlatt, G. A., Lichtenstein, E., & Wilson, G. T. (1986). Understanding and preventing relapse. *American Psychologist, 41,* 765-782.

Carlson, E. B., & Ruzek, J. (, n.d.). *What is Posttraumatic Stress Disorder?* Retrieved May 29, 2003, from National Center for PTSD Web Site: http://www.ncptsd.org/facts/general/fs_what_is_ptsd.html

Casey, K., & Vanceburg, M. (1991). *promise of a new day: A book of daily meditations* (2nd ed.). Cener City, Minnesota: Hazelden Meditation Series.

Cates-Wessel, K., Spalding, K., & Lewis, D. (2001). *Best Practices Initiative: State-Level Issues for Medicaid/Welfare and Substance Abuse Treatment* (). Retrieved November 3, 2002 from http://caas.caas.biomed.brown.edu/plndp/Resources/Best_Practices.pdf

Child Welfare League of America (1992). *Children at the front: A different view of the war on alcohol and drugs.* Washington, DC: Author.

Childabuse.com. (n.d.). The Relationship between Parental Alcohol, Drug Abuse and Child Maltreatment. In *Facts and Stats* (Study 14). Retrieved March 5, 2006, from Childabuse.com Web Site: http://www.childabuse.com/fs14.htm

Copeland, J., & Hall, W. (1992). A comparison of predictors of treatment drop-out of women seeking drug and alcohol treatment in a specialist and two traditional mixed-sex treatment services. *British Journal of Addiction, 87,* 883-889.

Correctional Service Canada. *In Relapse Technique*. Retrieved September 19, 2002, from Correctional Service Canada Web Site: http://www.csc-scc.gc.ca/text/pblct/litrev/treatmod/lit21e.shtml

Covington, S. (1999). Helping women recover: A program for treating addiction. San Francisco, CA: Josey-Bass. Covington, S., & Becket, L (1988). *Leaving the enchanted forest.* New York: Harper Collins.

Cummings, C., Gordon, J. R., & Marlatt, G. A. (1980). *Addictive Behaviors.* New York: Pergamon Press.

Curtin, J. J., Patrick, C. J., Lang, A. R., Cacioppo, J. T., & Birbaume, N. (2001). *Alcohol affects emotion through cognition*. Retrieved May 30, 2002, from Psychological Science Web Site: http://www.ebsco.com/online/direct.asp?ArticleID=A1AD7A7KWJL80AMQB78A

Dinitto, D. M., & Crisp, C. (2002). Addictions and Women with Major psychiatric disorders. In S.L.A. Straussner & S. Brown (Eds.), *The handbook of addiction treatment for women* (pp. 423-450). New York NY: Jossey-Bass.

Ellis, D. A., & Zucker, R. A. (1997). The Role of Family Influences in Development and Risk. *Alcohol and Research World, 21,* 218-227.

Evans, P. (1996). *Verbally Abusive Relationship: How to recognize it and how to respond*. Cincinnati, OH: Adams Media Corporation. P.77-78

Feig, L. (1998). Understanding the problem: the gap between substance abuse programs and child welfare services. In R. Hampton, V. Senatore & T. Gullotta (Eds.), *Substance abuse ,family violence, and child welfare: Bridging perspectives*. Thousand Oaks, CA: Sage Publications.

Finch, K. (in press). *Recovering Together Program: Children's Curricula.* Englewood, CO: American Humane.

Firshein, J. *Do All Drugs Affect the Brain Similarly?* Retrieved June 10, 2002, from PBS Online Web Site: http://www.pbs.org/wnet/closetohome/science/html/similar.html

Fluke, J. D., Shusterman, G. R., Hollinshead, D., & Yuan, Y T. (2005, July). *Rereporting and recurrence of child maltreatment: Findings from NCANDS* (). Retrieved March 11, 2006 from http://aspe.hhs.gov/hsp/05/child-maltreat-rereporting/

Gagliardi, S. *Limbic system: Visceral behaviors, emotion, and memorization*. Retrieved May 9, 2002, from http://omeweb.umassmed.edu/curriculum/MBB1/MBBHTML/FB/LimbicOverviewFrames.html

Gardner, S. L., & Young, N. K. (1998). Children at the Crossroads. *Public Welfare; 56,* 3-12.

Gorski, T. T., & Miller, M. (1986). *Staying sober-A guide for relapse prevention.* Independence, MO: Independence Press.

Grace, K.F. (2005). *Ways to decrease relapse events*. Retrieved August 19, 2006, from Clinical Tools Web Site: http://images.clinicaltools.com/images/cmealcohol/education/relapseprevention.pdf

Gruber, K. J., Fleetwood, T. W., & Herring, M. W. (2001). In-home continuing care services for substance-affectedfamilies: The Bridges program. *Social Work, 46*(3), 267-278.

Halligan, C., Gibson, J., Salmon, S. R., Taylor, D., & Davis, D. (2005, July 19). *Pretreatment Education and Support Program*. Paper presented at the meeting of the Third Annual Rocky Mountain Quality Improvement Center Conference. Retrieved March 11, 2006 from http://www.americanhumane.org/site/PageServer?pagename=pc_best_practice_rmqic_homepage

Hazelden Meditation Series (1985). *Each day a new beginning: Daily meditations for women*. New York: Harper & Row.

Healthfield, S. *Tips for managing stress and change at work*. Retrieved February 2, 2004, from http://humanresources.about.com/library/weekly/aa032202a.htm

Hemphill, M. L. (2005). *Harm Reduction All Around*. Retrieved March 11, 2006, from Body Health Resources Corporation Web Site: http://www.thebody.com/asp/novdec05/harm_reduction.html

Herkenham, M. Retrieved from NIH Web Site: http://www.nida.nih.gov/MOM/MJ/MOMMJ5.html

Holmes, T., & Rahe, R. (1967). Social Readjustment Rating Scale. *Journal of Psychosomatic Research, 2,* p. 214.

Humphries, B. *The Limbic System (drawing)*. Retrieved June 10, 2002, from http://ola.aacc.cc.md.us/psy214/dopamine.htm

Institute for the Advancement of Social Work Research (2005). *Factors influencing retention of child welfare staff: A systematic review of the research*. Retrieved March 11, 2006 from http://www.charityadvantage.com/iaswr/images/ExecSummaryCWWI.pdf

Institute Of Medicine. (1997). *Dispelling the myths about addiction: Strategies to increase understanding and strengthen research*. Retrieved April 13, 2002, from Washington, D.C. National Academy Press Web Site: http://www.netlibrary.com/urlapi.asp?action=summary&v=1&bookid=964

Kendler, K. S., Davis, C. G., & Kessler, R. C. (1997). The familial aggregation of common psychiatric and substance use disorders in the National Comorbidity Survey: a family history. *British Journal of Psychiatry,* 170, 541-548. Retrieved July 28, 2005, from http://bjp.rcpsych.org/

Linehan, M. M. (1994). Acceptance and change: The central dialectic in psychotherapy. In S. C. Hayes, N. S. Jacobson, V. M. Follette, & M. J. Dougher (Eds.), *Acceptance and change: Content and context in psychotherapy* (pp. 73–86). Reno, NV:Context Press.

Lutz L. (2003). *Achieving Timely Permanency for Children in the Welfare System: pioneering possibilities amidst daunting challenges*, NY Hunter College School of Social Work, National Resource Centre for Foster Care & Permanency Planning, NY USA.

Marsh, J. C., D'Aunno, T. A., & Smith, B. D. (2000). Increasing access and providing social services to improve drug abuse treatment for women with children. *Addiction, 95,* 1237-1247.

Microsoft Corporation. (2002, June 6) (n.d.) *Microsoft Design Gallery*. Retrieved from http://dgl.microsoft.com.

Miller-Heyl, J., MacPhee, D., & Fritz, J. J. (2001). *DARE to be you: A systems approach to the early prevention of problem behaviors.* New York: Klewer Academic/Plenum.

Monck. E., Reynolds, J., & Wigfall, V. (2003). *The role of concurrent planning: Making permanent placements for young children.* London, England: British Association for Adoption and Fostering.

Moyers, B. (1998). Moyers on addiction: Close to home. *The Hijacked Brain.* [Motion Picture]. Public Affairs Television Inc.

Najavits, L. M. (2002). A w*oman's addiction workbook*. Oakland, CA: New Harbinger Publications, Inc.

National Center on Substance Abuse and Child Welfare (NCSACW). (2004a). In *Understanding Child Welfare and the Dependency Court: A Guide for Substance Abuse Treatment Professionals* (Collaboration: Benefits for Parents in Treatment). Retrieved March 11, 2006, from http://www.ncsacw.samhsa.gov/tutorials/tutorial.asp?cid=1&sid=0&page_id=9

National Center on Substance Abuse and Child Welfare. (2004b). NCSACW Products. In *Improving services to families: Strategies for substance abuse treatment, child welfare, and dependency court* (Screening and Assessment). Retrieved March 19, 2006, from Substance Abuse and Mental Health Services Administration Web Site: http://www.ncsacw.samhsa.gov/files/Colorado_DraftProtocol.pdf

National Center on Substance Abuse and Child Welfare. (n.d.). *Resources*. Retrieved January 221, 2006, from Substance Abuse and Mental Health Services Administration Web Site: http://www.ncsacw.samhsa.gov/

National Clearinghouse On Child Abuse And Neglect Information. (2003, December). Substance Abuse and Child Maltreatment. In *Gateways to Information: Protecting Children and Strengthening Families*. Retrieved March 5, 2006, from http://nccanch.acf.hhs.gov/pubs/factsheets/subabuse_childmal.cfm

National Institute On Drug Abuse . *Mind over matter: Methamphetamine Series*. Retrieved June 11, 2002, from National Institutes of Health Web Site: http://www.nida.nih.gov/MOM/METH/MOMMETH2.html

National Institute On Drug Abuse. (1998). *Mind over matter: Nicotine series*. Retrieved June 11, 2002, from National Institutes of Health Web Site: http://www.nida.nih.gov/MOM/NIC/MOMNIC2.html

National Institute On Drug Abuse. *For Health Practitioners, Teachers and Neuroscientists*. Retrieved June 9, 2002, from http://www.nida.nih.gov/Teaching/largegifs/slide-20.gif

National Institute On Drug Abuse. *Mind over matter: Marijuana series*. Retrieved June 11, 2002, from National Institutes of Health Web Site: http://www.nida.nih.gov/MOM/MJ/MOMMj4.html

Pajares, F. (2002). *Overview of social cognitive theory and of self-efficacy*. Retrieved from Emory University Web Site: http://www.emory.edu/EDUCATION/mfp/eff.html

Pettit, L. & Gibbons, G. (1999). Presentation at the workshop for Domestic Violence Risk Assessment in Durango, CO, on September 24, 1999 by AMEND (Abusive Men Exploring New Directions).

Pettit, L. & Gibbons, G. (1999). Presentation at the workshop for Domestic Violence Risk Assessment in Durango, CO, on September 24, 1999 by AMEND (Abusive Men Exploring New Directions).

Popovits, R. (2004, July 14). *Navigating Muddy Waters: How to Increase Collaboration Across Systems*. Paper presented at the meeting of the 1st National Conference on Substance Abuse, Child Welfare and the Dependency Courts. Retrieved March 11, 2006 from http://www.cffutures.org/Conferences/Baltimore_Conference/At-a-Glance.pdf

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice, 19*(3), 276-287.

Public Affairs Television Inc. (1998). *Moyers on addiction: Close to home. the Hijacked Brain* [Motion picture]. United States

Quittan, G. A. (2004). *An evaluation of the impact of the Celebrating Families! program and family drug treatment court (FTDC) on parents receiving family reunification services.* Unpublished doctoral dissertation, College of Social Work, San Jose State University. Available at http://www.preventionpartnership.us/

Robbins, T. W., & Everitt, B. J. (1999). Interaction of the dopaminergic system with mechanisms of associative learning and cognition. *Psychological Science, 10*(3), 199-202. Retrieved May 30, 2002, from http://www.ebsco.com/online/direct.asp?ArticleID=6LA41CW6800EXPKRTKAQ

Rollis, E. T. (2000). Precis of the brain and emotion. *Behavioral & Brain Sciences, 23*(2), 177-234.

Rosenzweig, M. R., Breedlove, S. M., & Leiman, A. L. (2002). *Biological psychology: An introduction to behavioral, cognitive, and clinical neuroscience* (3rd ed.). Sunderland, MA: Sinauer Associates.

Safer, D. (2003, October). *Dialectical Behavioral Therapy in the Treatment of Bulimia and Binge Eating Disorder: Research and Practical Applications.* Paper presented at the meeting of the Addiction Medicine State of the Art 2003. Retrieved July 9, 2006 from http://csam.autoupdate.com/pdf/misc/Safer.ppt

Selye, H. (1974). *Stress without distress.* Philidelphia: J.P. Lippencott.

Sirois, F. (2001). *Psychology of Motivation and Emotion. Drug use, addiction, and treatment – Class 5*. Retrieved February 9, 2004, from http://www.carleton.ca/~fsirois/49345A/49345class5.PDF

Spear, D.S. & Moorstein, K. (2006). Recovering Together Program: Tailoring treatment for mothers with substance abuse problems and their children. Protecting Children, 4, 20. pp. 24-38. American Humane, Denver, CO.

Stalcup, S. A. (2006, May 1). *Methamphetamine Treatment* . Paper presented at the meeting of the 14th Annual Children's Justice Conference. Retrieved August 31, 2006 from http://www.dshscjc.com/public/SessionNotes/C-09.ppt

Substance Abuse and Mental Health Services Administration. (n.d.). *Nurturing parenting programs.* Retrieved September 21, 2005, from http://modelprograms.samhsa.gov/ print.cfm?pkProgramid=368

U.S. Department Of Health And Human Services (1999). *Blending Perspectives and Building Common Ground. A Report to Congress on Substance Abuse and Child Protection*. Washington, DC: U.S. Government Printing Office. Retrieved March 11, 2006, from Department of Health and Human Services, Administration for Children and Families Web Site: http://aspe.hhs.gov/HSP/subabuse99/subabuse.htm

U.S. Government, Code of Federal Regulations, 42 CFR Part 2. Retrieved 02/07/2006 from http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr2_04.html

Uhler, A. S., & Parker, O. V. (2002). Treating women drug abusers: Action therapy and trauma assessment. *Science and Practice Perspectives, 1,* 30-35.

Usher, C. L. (1998). *Managing care across systems to improve outcomes for families and communities.* Journal of Behavioral Health Services & Research, 25, Issue 2

Walker, L. (1979). *The battered woman.* New York: Harper and Row.

Webster-Stratton, C. H. & Hammond, M. (1997). Treating children with early onset conduct problems: A comparison of child and parent training programs. *Journal of Consulting and Clinical Psychology*, 65, 93-109.

Wegscheider-Cruse, S. (1988). *The Family trap*. Minneapolis, Minn: Onsite.

Weil, Andrew. *From Chocolate to Morphine: everything you need to know about mind-altering drugs.* (2nd ed.). Houghton Mifflin, New York, N.Y. 1993,1983 pp.15-21; 25-26

White Bison (2003, Summer/Fall). The Wellbriety Movement. *Wellbriety, 4,* 1-8.

White Bison, Inc. (2002) The red road to wellbriety: In the Native American way. Author, Colorado Springs, CO.

White Bison, Inc. (n.d.). *The medicine wheel and the twelve steps for women.* Colorado Springs CO: Author. Retrieved from http://www.whitebison.org

Young, N. K., Gardner, S. L., Whitaker, B., Yeh, S., & Otero, C. (2005, April). *A Review of Alcohol and Other Drug Issues in the States' Child and Family Services Reviews and Program Improvement Plans* (Version 18). Retrieved March 5, 2006 from http://www.ncsacw.samhsa.gov/files/SummaryofCFSRs.pdf

Zuskin, R., & Panfilis, D. (1987). Working with CPS families with alcohol or other drug (AOD) problems. *The APSAC Advisor, 8,* 7-11.