REHABILITATION PROGRAM FOR INMATES

(convicts and pre-trial detainees)
with mental and behavioral disorders due to use of psychoactive substances for the State Criminal Executive Service of Ukraine

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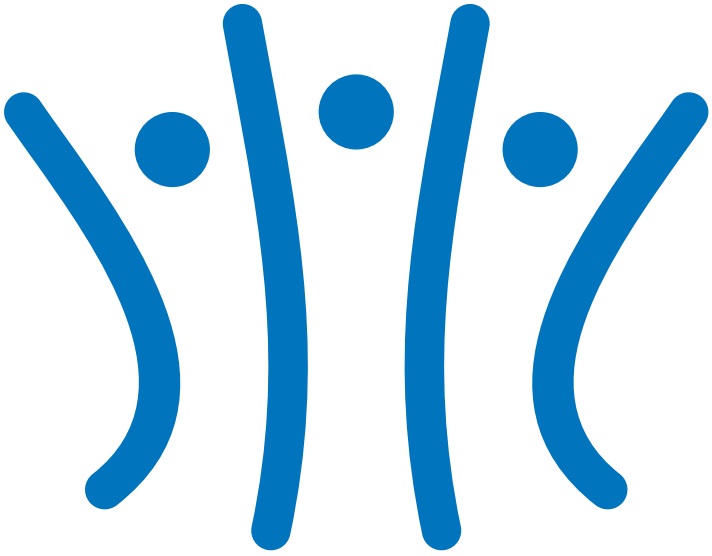

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It is an honour for me to write a brief preface to the Manual you are holding (or have on the screen in front of you). The publication you are about to read, study or use as a reference manual is not a popular science book (although, due to the quality of both its content and authors, it can undoubtedly be considered as such). It is, without belittling it in any way, a work tool, an instrument designed for a greater purpose than the mere popularisation of knowledge. Its aim is the putting into practice of the Ukrainian National Programme for Combating Drug Addiction among the Prison Population. This project has seen the FIIAPP (International and Ibero-American Foundation for Administration and Public Policies, working within the framework of the EU Action against Drugs and Organized Crime Project) facilitating contact and serving as a link to implement the cooperation between the General Secretariat of Penitentiary Institutions attached to Spain's Interior Ministry and the Prison Service of the Ministry of Justice of Ukraine.

The first thing I would like to highlight is the hard work, professionalism and commitment not only of the government officials of the Spanish Interior Ministry, but also of the experts of the Ministry of Justice of Ukraine who have worked regularly on this project over the past year.

It should be noted that this Manual is merely an intermediate step towards achieving the aforementioned objective (the National Rehabilitation Programme). The publication of this Manual has been preceded by other activities: visits to prisons and detention centres in Ukraine, seminars, contacts with academic authorities, work groups and, above all and of especial importance, the long, inconspicuous and never sufficiently valued task of jointly drafting it. To the difficulty of adapting EU best practices to the legal and cultural reality of the Ukraine (including language in a text of wide scientific scope), it is necessary to add an equally significant one, namely the fact that this Manual has been drafted by two teams working 4,000 kilometres apart: in English by the Spanish experts and in Ukrainian and/or English by their Ukrainian counterparts.

It seems relevant to point out that, given its eminently practical nature and foreseeing a rapid, but at the same time, effective implementation of the National Rehabilitation Programme by the Ukrainian Ministry of Justice, the project has involved the participation not only of scientists and technicians (psychologists, psychiatrists, narcologists, etc.), but also of legal experts, who reviewed the adaptation of the Manual to Ukrainian legislation. Please bear in mind that the socio-healthcare rehabilitation of individuals in state custody directly affects their fundamental rights, and therefore must be subject to a detailed review and adaptation to the legal and institutional framework of any democratic state.

The psychologists of Spain's Senior Technical Body of Penitentiary Institutions, Mr Oscar Herrero and Mr Francisco Requena deserve special recognition for their experience, knowledge and the "psychology" employed in the development and implementation of this programme. The testimony of the staff with whom they have worked leaves not the slightest doubt as to their exceptionally high professional and personal worth. It is of equal importance to remember that this Manual could not have been written if it had not been adopted and so decisively moved forward by the Ministry of Justice of Ukraine, which threw open the doors of its institutions (thus removing those prejudices that are so often mentioned by other European and Western countries) and put its finest experts at the disposal of this project. Neither must we forget the work done by the experts of the Regional Office of the EU- ACT Project in Ukraine and by the project staff at the FIIAPP headquarters in Madrid, who have acted as a liaison between the experts of both administrations and have helped (and will continue to do so with the same enthusiasm) to remove the many obstacles that such an ambitious project as this always encounters. Article 25.2 of the Spanish Constitution clearly and concisely states the overriding objective of the punishments within the Spanish legal-social system:

> *"Punishments entailing imprisonment and security measures shall be aimed at re-education and social rehabilitation (...)."*

In order to implement article 25.2 of the Constitution effectively, Spain's public institutions, led in this area by the General Secretariat of Penitentiary Institutions, have, in recent decades, worked tirelessly, with the result being that our country now boasts one of the most advanced prison systems in the world, especially where the treatment and rehabilitation of drug addicts is concerned.

This work has earned it numerous and significant international plaudits. Perhaps the most important upshot of these are experiences like this, when the sincere interest expressed by other countries, such as the case that concerns us here, namely Ukraine, encourages the thirst for more knowledge and the urge to adapt these improvements to other realities such as those of the Ukraine.

I would like to take this opportunity to mention "The United Nations Standard Minimum Rules for the Treatment of Prisoners" (also known as the Nelson Mandela Rules as they are inspired by this great man). These Rules establish one of the guiding principles of prison activity:

> *"The need to evaluate, promote, protect and improve the physical and mental health of persons deprived of their liberty, including those who require special attention"*

Drug addicts are, by definition, vulnerable individuals and, as such, entitled to this special attention. Therefore, this mandate is not a condensation of, but rather the fundamental background to the principles that inspire this project which following the publication of this Manual, will begin to be implemented.

I hope that, once you have read this book, we will have fulfilled our objective and produced a truly useful and practical tool to help you with your work.

Finally, I would like to point out that the FIIAPP will remain committed to participating in international cooperation programmes and projects, in the building of opportunities for exchange that foster and consolidate trusting relationships between public administrations and international organisations, as well as the sharing of experiences with European institutions to continue working to improve public systems for the benefit of the public at large. Keep counting on us.

ANNA TERRÓN CUSÍ
Director of the FIIAPP

Implementation of the strategic course aimed at integration into the European Union, which Ukraine has adopted, needs to adapt and update the reform process as well as align multiple aspects of the public life with the European standards.

Gradual reform of the Ukrainian penitentiary system is a component of the general policy of Ukrainian reforms towards forming a civil society and the legal state where democracy, human rights and freedoms are the highest social values.

The main goal of the penitentiary reform, which is secured by the Ministry of Justice of Ukraine in the strategic document "Passport: reforming the penitentiary system and probation", is determined as ensuring by the penitentiary system of the social security by correcting and re-socializing individuals in conflict with the law.

In addition to the implementation of a number of individual strategic targets, the achievement of this goal anticipates the coordination of penitentiary reform objectives with the measures of other reforms underway in the state, which is conditioned by their shared social and political orientation. In particular, this refers to the state policy of Ukraine in relation to drugs.

A strategic paradigm of the Ukrainian state policy on drugs determines the need for a comprehensive transition from punitive, criminal and legal-oriented anti-drug measures to the treatment and preventive measures as the most fruitful ones in the context of overcoming drug addiction.

It is aimed at ensuring the resolution of the societal drug problem in the interests of a human being, reliable public health protection, and securing the state from the threat of spreading drug addiction and drug-related crimes.

The state policy in the field of execution of criminal punishments and probation has common objectives with the policy on drugs, as a certain share of convicts and

detained individuals have a history of using drugs or other intoxicating substances, as well as health problems caused by the consequences of this issue.

"Rehabilitation Program for convicts and pre-trial detainees with mental and behavioral disorders due to use of psychoactive substances (for the State Criminal Executive Service of Ukraine)" elaborated in the framework of EU-ACT Project (EU Action against Drugs and Organised Crime) is a tool able of ensuring rehabilitation of drug-addicted individuals serving sentences in the penal facilities, forming motivation to phase out drug addiction, restoring social adaptation skills, anti-drug persistence, teaching self-preservation skills, and first of all, the ability to a full-fledged life.

Introduction of the program is an integral part of changing strategic priorities in the treatment of drug addicted people in penitentiary institutions that are included in the State Policy Strategy on Drugs for the period up to 2020, which is approved by the Resolution No. 735-r of the Cabinet of Ministers of Ukraine dated August 28, 2013. In particular, such changes presuppose the development and implementation of programs to prevent relapsing of drug abuse and possible repeated criminal behavior in individuals released from detention facilities.

A Manual "Rehabilitation Program for convicts and pre-trial detainees with mental and behavioral disorders due to use of psychoactive substances (for the State Criminal Executive Service of Ukraine)" is an important and powerful tool aimed at addressing issues that the State Criminal Executive Service of Ukraine is facing now.

This Manual provides a meaningful and professional rehabilitation program for inmates, which is applicable to individuals with problems caused by the abuse of psychoactive substances. Rehabilitation measures are focused on forming in these individuals motivation for phasing out addictions, restoring social adaptation skills, teaching self-preservation skills, and first of all, the ability to full-fledged life.

DENYS CHERNYSHOV
Deputy Minister of Justice of Ukraine

Dear Reader,

This is “Rehabilitation program for convicts and pre-trial detainees with mental and behavioral disorders due to use of psychoactive substances for the Criminal Executive Service of Ukraine”, which describes peculiarities of arrangement and conduct of correctional and rehabilitation activities with addicted individuals.

Currently, the State Criminal Executive Service of Ukraine faces many challenges and issues in this area of its official activities.

In this regard, the development and implementation of correctional and rehabilitation programs for addicted convicts and pre-trial detainees are becoming particularly important and topical.

The rehabilitation program for convicts and pre-trial detainees developed in cooperation with Spanish experts is applicable to individuals suffering from problems caused by the use of psychoactive substances. After all, the relation of repeated offenses and addiction is commonly recognized.

This program is based on international experience and organically combines psychological influence with medical, educational, and social components. Considerable attention is dedicated to the matter of program participants motivation, as willingness to changes helps to achieve positive dynamics and enhance the efficiency of the rehabilitation process for convicts and pre-trial detainees, and minimizes risks of repeated offenses.

In addition, this program contains a course of training sessions aimed at developing skills needed for self-regulation of negative mental states and emotions, decision-making and planning of the future life, ability to self-assessment correction, forming healthy lifestyle habits, and constructive organization of leisure.

Only comprehensive, systematic, and purposeful influence on the convicts personality, correction of negative traits and qualities, implementation of rehabilitation programs will make it possible to resolve addiction problems, avoid risky situations in the future, and select effective strategy of behavior in case of a breakdown. The above will prevent reoffending, ensure more successful reintegration of such individual into the society, and increase the safety of the society.

OLEH TORKUNOV
Deputy Head of SCES Administration
on observing rights of convicts and pre-trial detainees

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INTRODUCTION

The scope of the problem

Modern penitentiary systems manage populations of a significant size. Prison inmates, both males and females, are special individuals with severe vulnerabilities in different areas of their personalities. Among other problems, the population of incarcerated offenders tend to present frequently a history of substance use and mental disorder. Both problems are more prevalent among offender samples in comparison with general population. Therefore, penitentiary systems must deal with the enforcement of prison sentences of individuals with specific treatment needs. To cope in adequate ways with these needs is a matter of public health, and promotes a humane enforcement of the prison sentences.

Drug rehabilitation programs are a basic component of most correctional strategies, due to the high prevalence of addictive behaviours among prison inmates and the strong criminogenic power of drug use. Like any other program implemented with offender population, drug treatment must adhere to basic principles that guarantee its effectiveness. Moreover, ongoing evaluation of these programs is necessary. The comorbidity between drug use and mental disorder is also a well-established fact. The so called dual pathology further complicates the intervention with offenders, and is a significant obstacle for treatment effectiveness. Therefore, rather than as an exception, it must be considered as a major challenge for correctional interventions.

International expert bodies concerned with drug treatment in penitentiary settings have made several evidence based recommendations that should guide the design and implementation of effective interventions.

Drugs and crime

The relationship between offending and substance use has been ascertained by a variety of studies conducted in medical and forensic settings. For instance, Fazel, Bains & Doll (2006) reviewed thirteen studies with a total sample of 7563 prisoners. The authors found significant variation in the estimates of prevalence of substance abuse and dependence, attributable to methodological issues. The estimates

of prevalence for alcohol abuse and dependence in male prisoners ranged from 18 to 30%, and 10 to 24% in female prisoners. These prevalence estimates are significantly higher than those found in general population surveys. This difference is particularly intense for female population. Furthermore, drug use has been found to be a risk factor for suicidal behavior among offenders. Heroin or crack cocaine users are considered responsible for a significant amount of crime (MacDonald, Tinsley, Collingwood, Jamieson & Pudney, 2005) and frequently reoffend and relapse in substance misuse (Pierce et al, 2017). There are several theories for this association between opiates and crime (Hayhurst et al 2017). One theory suggests that it is grounded on the need of high economical incomes to fund drug use. Other theories imply that the illegality of drug use is associated with an antisocial lifestyle that promotes opportunities for crime. A third theory proposes that the link between drug abuse and crime stems from the psychopharmacological effects of drug use on behaviour, such as disinhibition. These effects could promote violent offending. Hayhurst et al (2017) conducted a meta-analysis (including 20 studies) to assess the link between opiate use and criminal behaviour. Their results indicate that criminal behaviour (mean age of onset = 16.7) precedes drug use (mean age of onset = 19.6). The onset of drug abuse was associated with increases in acquisitive offences like theft.

Therefore, interventions aimed to reduce substance misuse among offender population should be a priority of prison systems.

Drugs and mental disorder in prison populations

Psychiatric disorders are highly prevalent among incarcerated offenders. Analytical data show high rates of comorbid substance use and anxiety disorders, depression, bipolar affective disorder, attention-deficit hyperactivity disorder, psychotic illness, borderline and antisocial personality disorder (NIDA, 2018a). Fazel & Danesh (2002) reviewed 62 surveys of psychiatric disorders among prison inmates, conducted in 12 different countries. The total sample included 22790 prisoners. The results indicated that 3-7% of men had some form of psychotic disorder, 10% major depression, and 65% a personality disorder (41% of these men met criteria for Antisocial Personality Disorder). For females, 4% had a psychotic disorder, 12% major depression and 42% a personality disorder (21% of whom met criteria for Antisocial Personality Disorder). Prisoners were several times more likely to present psychosis and major depression, and about ten times more likely to have antisocial personality disorder, than the general population. In a more recent study, focused on the prevalence of psychotic disorders, Fazel & Seewald (2012) found a prevalence of 3.6% for males, and 3.9% for female offenders. Total sample comprised 33,588 individuals. Fazel, Doll & Langström (2008) reviewed 25 surveys concerned with mental disorder in juvenile offenders. These studies included a total sample of 13,778 boys and 2,972 girls. Among boys,

3.3% were diagnosed with psychotic illness, 10.6% with major depression, 11.7% with ADHD and 52.8% with conduct disorder. Among girls, 2.7% were diagnosed with some kind of psychotic disorder, 29.2% with major depression, 18.5% with ADHD, and 52.8% with conduct disorder. The averaged odds ratio indicated that juveniles were 10 times more likely to suffer from psychosis than the general adolescent population.

The high comorbidity between substance use and other mental illnesses does not necessarily mean a causal relationship. Three main pathways can contribute to comorbidity (NIDA, 2018a): (a) common risk factors, (b) mental illness may contribute to substance use, and (c) substance use can contribute to the development of mental illness.

Nevertheless, there are empirical data that indicate that comorbidity is a risk factor for reoffending. Schizophrenia and other psychoses are associated with violence and violent offending, particularly homicide. However, most of the excess risk appears to be mediated by substance abuse comorbidity. The risk in these patients with dual diagnoses is similar to the risk level of individuals who experience substance abuse without psychosis. Fazel, Gulati, Linsell, Geddes & Grann (2009) reviewed the literature that reported on violent offending in individuals with schizophrenia and other psychotic disorders. The review considered a total number of 20 studies, including a sample of 18,423 individuals. Those individuals who presented both a psychiatric diagnose and a substance misuse problem presented an increased likelihood of violent offending. This probability was nine times larger in comorbid individuals in comparison with general population. Those diagnosed with psychotic disorders who were not comorbid drug users, presented a probability of violent offending two times higher than general population samples. Fazel et al (2009) found in a longitudinal study of a sample of 8003 schizophrenic patients a 13.2% rate of violent offending. Risk was mostly confined to those with a comorbid substance use disorder. Their likelihood of committing a violent offence was 4 times larger than the probability of community controls. In congruence with these results, Chang, Lichtestein, Langström, Larsson & Fazel (2016) found that among released prisoners in Sweden, rates of violent reoffending were lower during periods when individuals were dispensed antipsychotics, antidepressants, OST and drugs for addictive disorders, compared with periods in which they were not dispensed these medications. Lichtenstein et. al. (2012) found that among patients with ADHD and comorbid substance use, rates of criminality were lower during periods when they were receiving ADHD medication.

Characteristics of effective correctional treatment

Several well-conducted meta-analyses have identified cognitive-behavioral therapy (CBT) as a particularly effective intervention for reducing the recidivism of juvenile and adult offenders. Landenberger & Lipsey (2005) conducted a meta-analysis of

58 experimental and quasi-experimental studies of the effects of CBT on recidivism. The mean odds ratio representing the average effect of intervention was 1.53, indicating that the odds of success (no recidivism in the post-intervention interval of approximately 12 months) for individuals in the treatment group were higher than for individuals in the control group. In relation to the mean recidivism rate for the control groups of about 0.40, this odds ratio indicates a recidivism reduction of 25%. Lipsey & Cullen (2007) reviewed the meta-analytic literature concerning effectiveness of offender treatment. They found a significant heterogeneity among studies, but results showed a clear tendency to reoffending rates reduction in CBT programs. The rate of reduction ranged from –8% to –60%.

Drug treatment is intended to help addicted individuals stop compulsive drug seeking and use. Drug addiction treatment can include medications, behavioral therapies or their combination. Behavioral therapies can help motivate people to participate in Drug therapy, offer strategies for coping with drug cravings, teach ways to avoid drugs and prevent relapse (NIDA, 2018b). The US National Institute of Drug Abuse (NIDA, 2012) indicates that the following criteria should guide effective drug treatment with offender population:

1. Drug addiction is a chronic brain disease that affects behavior. This means that drug addiction leads to enduring brain alterations that influence behavior.
2. Recovery from drug addiction requires effective treatment, followed by management of the problem over time. Effective drug abuse treatment engages participants in a therapeutic process, retains them in treatment for an appropriate length of time, and helps them learn to maintain abstinence.
3. Treatment must last long enough to produce stable behavioral changes. In treatment, the drug abuser is taught to break old patterns of thinking and behaving and to learn new skills for avoiding drug use and criminal behavior.
4. Assessment is the first step in treatment. This means that a comprehensive evaluation, including mental health issues, should be conducted prior to treatment.
5. Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations. Individuals differ in terms of age, gender, ethnicity and culture, problem severity, recovery stage, and level of supervision needed. Individuals also respond differently to different treatment approaches and treatment providers. In general, drug treatment should address issues of motivation, problem solving, and skill-building for resisting drug use and criminal behavior.
6. Drug use during treatment should be carefully monitored. Individuals trying to recover from drug addiction may experience a relapse, or return to drug use. An undetected relapse can progress to serious drug abuse, but detected use can present opportunities for therapeutic intervention.

7. Treatment should target factors that are associated with criminal behavior, like antisocial cognition. Treatment that provides specific cognitive skills training to help individuals recognize errors in judgment that lead to drug abuse and criminal behavior may improve outcomes.
8. Penitentiary institutions should incorporate rehabilitation planning for drug abusing inmates. The coordination of rehabilitation program with correctional planning can encourage participation in rehabilitation program and can help treatment providers incorporate correctional requirements as treatment goals.
9. Continuity of care is essential for drug abusers re-entering the community. Offenders who complete prison based treatment and continue with treatment in the community have the best outcomes.
10. A balance of rewards and sanctions encourages pro-social behavior and treatment participation. When providing correctional supervision of individuals participating in rehabilitation program, it is important to reinforce positive behavior.
11. Inmates with co-occurring drug abuse and mental health problems often require an integrated treatment approach. High rates of mental health problems are found both in offender populations and in those with substance abuse problems. Drug abuse treatment can sometimes address depression, anxiety, and other mental health problems.
12. Medications are an important and even integral in some cases part of treatment for many drug abusing offenders.
13. Treatment planning for drug abusing offenders who are living in or re-entering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis.

Addiction can be managed successfully. Treatment enables participants to cope with the disruptive effects of addiction on the brain. Nevertheless, addiction is a chronic disorder, and relapse is not only possible but likely.

The present program

The present program is a psychological and educative therapy for drug abuse. It is oriented to modify personal factors related with drug abuse, and to train participants in adequate ways to cope with addiction symptoms. Therefore it is not a medical intervention, but both kind of treatment are not incompatible. Furthermore, they could have positive synergic effects and promote recovery with further effectiveness than their isolated use.

The general guidelines of the program are:

1. Psychological and educational intervention. The sessions are aimed to provide the participants with relevant knowledge regarding healthy habits, risky behaviors, or

practical life skills. Furthermore, the intervention are oriented to provide the participants with positive psychological coping skills oriented to promote a drug free life.

2. Structured. It includes several sessions with clear goals and methodologies. All sessions are grouped in modules that will address different relevant topics.
3. Evidence based. Theoretical background and intervention techniques are grounded on empirical research and associated international recommendations.
4. Oriented to different goals according to the motivational stage of the participants. Recovery from a substance misuse disorder is complex, rather than a linear process. The concept of motivation and readiness to change are of paramount relevance. The program incorporates different pathways for participants according to their stage of change.
5. Group intervention. Human resources are limited in all public systems, and the efficiency of their work must be maximized. Therefore, the program is designed to be implemented in a group format. Furthermore, the group has also a therapeutic role, and enables the therapist to promote positive group processes.
6. Explicitly contemplates adaptations to specific populations, like female offenders and mentally disorder offenders.

The program covers the following areas:

1. **Initial evaluation.** The assessment process should be comprehensive, including social, psychological, criminal and medical issues. One major topic of evaluation is motivation for change and treatment expectancies.
2. **Motivation for change.** Once the participants' motivation level has been assessed, the intervention should enhance their readiness for change via motivational interviewing and using appropriate interventions which support positive behaviour change. Motivational intervention post treatment can reinforce treatment gains and build motivation for sustaining changes on Social Rehabilitation Units.
3. **Drug Education.** Provide information regarding general concepts about drugs, their effects and risks as well as the health-related consequences of drug abuse generally lead to a major self-awareness of the problem and its consequences. The primary objectives are to promote an understanding as to how and why individuals abuse substances or become addicted and to facilitate understanding of the effects that continued abuse can have on one's health and life.
4. **Social skills.** Group pressure has a key role in the onset and maintenance of substance misuse. Therefore, participants should learn basic social skills to cope with risky group situations, like assertiveness. Furthermore, participants should learn different positive skills to create a new social life.
5. **Anxiety control and emotional self-management.** Anxiety and other negative emotions are common during recovery process. The participants probably are used to cope with these emotions through substance use. Therefore, new

self-management techniques are necessary, such as relaxation, stress inoculation or thought control.

6. **Cognitive therapy.** Distorted thoughts and beliefs about drugs and the self are a key therapeutic goal. In addition to this, cognitive therapy will be also useful to cope with emotional dysregulation.
7. **Comorbid mental health problems.** Several psychiatric disorders are highly comorbid with drug use. The so-called dual pathology is a common problem, and the program will address it explicitly. Participants with psychopathological problems would benefit from interventions like psychoeducation or adherence to treatment.
8. **Craving coping skills.** Intense desire of drug use is a normal experience during recovery, but also a major risk factor for relapse. The program will help participants to cope with this phenomenon through cognitive and behavioral techniques.
9. **Relapse prevention.** The maintenance of changes induced through therapy requires of a specific intervention. Here the Marlatt and Gordon's model will be used. The emphasis is on training drug users to a range of skills to identify, anticipate, avoid and/or cope with high risk situations and triggers for relapse. Components would include managing cravings, preventing a single failure becoming a full relapse in drug use, rehearsing skills and developing relapse prevention/management plans, identifying and beginning positive fulfilling alternative activities, coping with stress and instilling a belief in the drug user's own self efficacy.
10. **Health education.** The promotion of health is important protective factor in drug treatment programs. The objective is to positively influence the health behavior of the participants developing healthy habits relating diet, physical activity, sleep habits, etc.
11. **Leisure and organization of time.** An adequate use of free-time in a positive way is another protective factor to prevent the risk of relapse. Physical activity and sports, e.g., are effective in reducing stress and managing anxiety and depression.

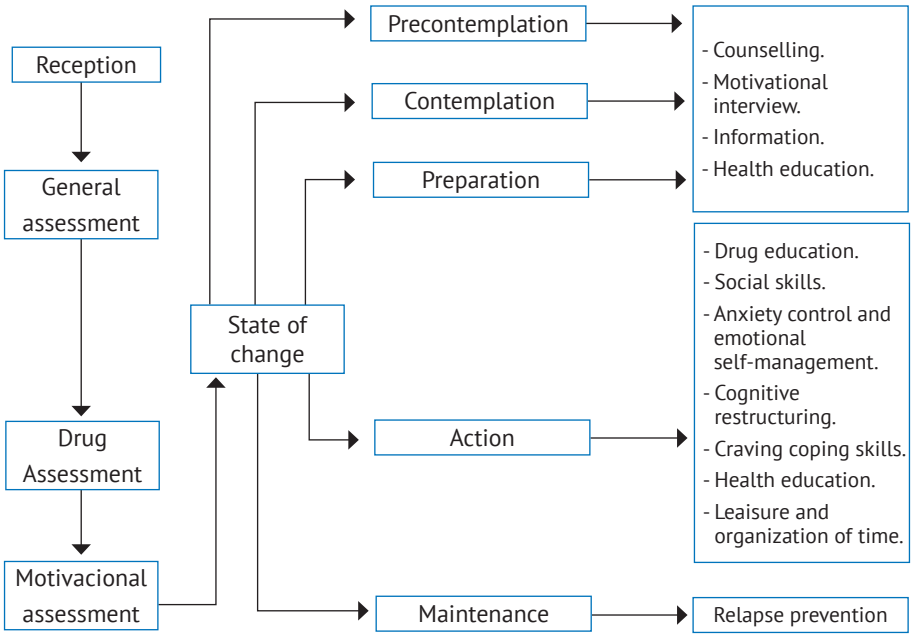
Motivation is a key factor in drug abuse therapy. Motivation has been described as a process including several steps, rather than as a dichotomy. Therefore, a treatment program must explicitly consider the fact that participants may differ in their awareness of their substance misuse problem, and in the goals that they expect from treatment. Participants should be grouped according to their motivational level. In order to reach this goal, the transtheoretical model of change, suggested by Prochaska and DiClemente, is a fruitful theoretical framework. According to the motivational stage, two different therapeutic pathways are suggested. The general structure of the proposal is depicted in Figure 1.

During quarantine after admission to a correctional colony a comprehensive evaluation of the inmate is conducted. This evaluation should include several aspects

related to drug use, and in particular motivational aspects. According to this evaluation, the inmate would be assigned to a stage of change.

The level of motivation would be associated to a particular therapeutic itinerary. The program contemplates two different pathways.

Figure 1. General structure of the program



Pathway I is a **risk reduction/motivation to change pathway**. The three first stages in the Transtheoretical Model (precontemplation, contemplation and preparation) would be included in a first pathway, which could be labelled as risk-reduction/motivation to change. It includes ten therapeutic sessions. The main features of this pathway would be:

1. Abstinence to drugs is not the main goal. This intervention is aimed to help participants to cope with their personal situation, and to provide them with useful information regarding drug use and other associated health issues.
2. During this educational and counselling process, motivational issues will be addressed. The program will promote a positive change in the motivational stage of the participants.

Pathway II is a dishabituation/relapse prevention. The main features are:

1. Here participants in an action motivational stage would be included.
2. Abstinence to drugs is the main goal.
3. In order to achieve this goal, participants will be trained in several positive coping skills, in order to promote an adaptive approach to risk situations.
4. The main goal is to promote strategies for the maintenance of positive changes. The general theoretical framework would be the relapse prevention model, suggested by Marlatt & Gordon.

The units and number of sessions of every pathway are described in Table 1. Two units from Pathway I are also included in Pathway II. These units are drug information and healthy lifestyle. The contents and activities of these units are exactly the same in both pathways. For this reason, in this manual the sessions are presented only in the section devoted to Pathway I, but these contents are mirrored in Pathway II.

Table 1. Contents and number of sessions of Pathways I & II

PATHWAY I	SESSIONS PER UNIT	PATHWAY II	SESSIONS PER UNIT
Session 0	1	Presentation and motivation.	2
Drug information	3	Drug information.	3
Motivation for change	3	Emotional self-management.	4
		Thinking and well-being.	3
		Social skills.	4
Healthy lifestyle.	4	Healthy lifestyle.	4
		Craving coping skills.	4
		Relapse prevention.	4
		Closing and summary.	1
Total	11		29

Structure of therapeutic units

Each unit of the program has been structured in the following way:

- **Introduction**: the need to work therapeutically on the content addressed in the unit is explained.

- **Therapeutic objectives**: the objectives that the therapist must achieve during the sessions are highlighted.
- **Therapeutic sessions**: the units have been divided into a number of sessions determined according to the extent and difficulty of the topic addressed. Each session has the following structure:

  – Welcome and introduction.
  – Psychoeducational exposition: narration that the therapist can use to explain the psychoeducational contents of the unit. The therapist should avoid giving this information in a unidirectional way as a "lecture". Some recommendations include: to use questions to introduce the topic and generate discussions, to start a brainstorm on a concept, to ask what ideas come to mind after listening to a word or a sentence or ask for personal examples of a particular situation.
  – Exercises and dynamics: exercises that the therapist will develop with the participants to address the objectives of the unit.
  – Closing and dismissal.

This programme has been designed to be applied in group format (the facilitating effect that the group supposes in the psychotherapeutic change has been mentioned before) but it could be adapted to an individual format.

In case of individual format, the therapist will choose the activities that best suit the participant.

On some occasions, it is more effective to start the sessions with the dynamics and exercises, to advance later towards the psychoeducational conclusions of the unit. This format will be chosen by the therapists when the contents to work, the profile of the participants, as well as their own therapeutic style advise it.

Motivation for change and therapeutic alliance

The creation of the therapeutic alliance is a key factor in the success of the intervention and its construction will condition and lay the foundations of the process of change of attitudes of the participant. To create an appropriate alliance the therapist must take into account the following dimensions:

Connection with the intervention process

If the participants perceive the contents of the program as alien, they will maintain a passive attitude that will diminish their participation. In order to achieve this

connection, it is necessary that the tasks and goals of the intervention have meaning for the participants, be constructed with them and be perceived as an advantage and opportunity for improvement.

When one of the participants openly expresses that the intervention does not work or is indifferent, the therapist should explore this discomfort, work on the motivation of the participant, change the strategy and create a new working alliance.

Confidence in the intervention process

Intervention attempts will be useless if the therapist fails to create a trusting relationship with the participant. If the participants trust in the intervention process, they will be safe, open to new learning, flexible, will openly express in the group and will have the expectation that their participation in the program will have positive consequences.

Sometimes, participants perceive the intervention as a punishment and, often, the therapist as an enemy. The misgivings are based on the fear that their privacy could be violated or that what they say in session could be used against them. For the creation of trust in the intervention process, the therapist should provide the participants with a detailed explanation of all aspects of the Program, contents of the sessions and interviews and reports to third parties. During this explanation, the therapist should encourage the participants to talk about the misgivings and reticence they may have, emphasizing at all times that the main objective is to support and help them.

Confidentiality, confidence and limits

The therapist should make clear to what extent the confidentiality of the sessions should be maintained and establish what the limits are: the way of communicating must adapt to the context in which the intervention takes place and the specifics of the SCES; the need to report on some aspects of what happens in the sessions; the consequences that may have their participation and evolution within the program, etc.

Hostility management

It is usual that during the intervention process and, especially, in the first steps of the program, participants express some hostility and complaints.

The therapist should be receptive to these complaints and the participant should feel understood and respected. The reformulation of this complaint through the understanding of the prisoner's personal history and the definition of the real

problem must be focused as a demand for help that must be answered professionally. The therapist must be receptive to the participant's complaints and concerns; its reformulation is decisive in the intervention process.

The therapist will focus on:

- Emphasize the positive aspects of participating in the program.
- The possibility of improvement.
- Opposition to the idea of all or nothing.
- The refocusing of the conflict.
- The uselessness of static and passive positioning and constant complaint.

Personal relationship

The elements of the relationship that have to do with the success in the intervention and that are essential to create the basis of a good personal relationship are:

- Mutual respect.
- The clarity of the limits.
- The clear perception of providing help.
- The reinforcement.
- Availability, receptivity and understanding in the expression of feelings.
- The use of a sense of humour.

When the participant's cordiality, performance and receptivity are responded with the authenticity, warmth, acceptance and empathy of the professional, the level of intimacy and the degree of directivity possible is increased. Similarly, if there is a good relationship, errors are tolerated more easily and the degree of acceptance of new learning is increased.

On the other hand, the therapist who uses a language that is too technical, despises, prejudges or is hostile to the participants, that is authoritarian and controlling or is cold or irritable, has many possibilities of not achieving anything in the intervention process and exponentially increase the feeling of discomfort in the group. The indicators of little connection are clear: avoid eye contact, refuse to speak, respond in a hostile manner, call incompetent or question the value of aid, etc.

Gender issues

Women constitute a small minority of the population in prison systems throughout the world, but within the last years, the number of women in prison is increasing at

a much greater rate than the number of men in prison. Most women serve short sentences and are mostly imprisoned for non-violent offences such as property or drug related offences

There are specific issues that women experience when they are imprisoned. In most societies, women have the major responsibility for childcare and related issues which has particular consequences for other members of her family. Women prisoners are a particularly vulnerable group and are often subject to stigma and gender discrimination both in prison and also in the community. Therefore, it is important to be are aware of the rights and needs of women and not to ignore them (UNODC, 2008).

There are many challenges that women who use drugs must face. Worldwide, drug services and treatment in the community and in prison are not tailored to meet their needs, regardless of empirical evidence that indicates that their substances abuse and criminal trajectories show distinctive characteristics in comparison with male population (Pierce et al, 2015).

It is difficult to get exact data about the number of women with problem drug use. It is estimated that at least 75% of women in prison have had some sort of drug- or alcohol-related problem at the time of arrest.

In addition, drug use amongst women is increasing and there is a rapid increase amongst women injecting drug users (IDUs) sharing injecting equipment. This increase in problem drug use amongst women means that some of these women will end up in the prison populations. Once there, they will need access to services to reduce drug related harm, including the spread of infectious diseases through contaminated injection equipment and high risk sexual behaviour associated with drug use (UNODC, 2014).

Imprisoned women are significantly more likely to have been physically or sexually abused than men. There is also evidence that indicates that male drug users are more frequently involved in intimate partner violence than the general population (Radcliffe & Gilchrist, 2016). Violence against women is a critical issue that deserves special attention when considering barriers and obstacles to adequate services and support. These women experience high rates of intimate partner violence (UNODC, 2014).

Abuse, that can often take the form of women being forced by their partners to participate in the sex industry, and resulting trauma are directly linked to female pathways of crime. Additionally, such experiences might contribute to marginalisation and problem drug use, with the latter possibly resulting in criminal behaviour. Abuse

experienced in an intimate partnership can also be linked to engagement in criminal activities.

Prison authorities throughout Europe pay very little attention to women prisoners' specific needs despite the high numbers who have experienced abuse and its related negative outcomes. There is a high demand for capacity building in the criminal justice system throughout Europe, in particular within the prison system, which addresses the needs of this specific group.

Alarmingly high rates of mental health problems such as PTSD (post-traumatic stress disorder), depression or anxiety are found among the women prison population as well as a tendency to self-harm and suicide. Furthermore, high prevalence of alcohol and drug dependence is found among the female prison population.

As women represent a small percentage of prison populations, they tend to have less access to education and training compared to male prisoners. Often the work they can engage in is limited and includes activities such as cleaning and sewing. There is often limited access to vocational training. It can be beneficial to prison administrations to involve NGOs to augment women's access to training and education both in prison and on release.

Women prisoners are likely to face stigma when they return to the community and other difficulties such as negotiating the return of their children. As a result, they will require support at this time.

Women with substance use disorder also need post release support. These services should include such measures as information relating to community needle exchange, access to drug treatment, referral to sexual and reproductive health services, housing and child support. Such services will also need to address issues including loneliness, low self-esteem or perceptions of self-efficacy, guilt, depression and difficulties in social and family relationships (including children).

In conclusion, female inmates with drug abuse problems are a vulnerable subgroup among prison population.

In the present program, gender issues are explicitly considered as a cross-cutting issue. In order to help therapist to adapt some aspects of the program to female offenders, technical tables with recommendations are included where necessary.

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INITIAL EVALUATION

INDIVIDUAL MOTIVATIONAL INTERVIEW

The initial interview model that is presented below is a possible script to be followed by the therapist based on the principles of Motivational Interview suggested by Miller and Rollnick (2002 and 2015). The objectives would be, on the one hand, to promote a positive view and engagement of the participant with the intervention and, on the other hand, to create the first bonds of trust between the participant and the therapist, thus arousing the therapeutic alliance.

This script will require adaptations according to the answers given by the interviewed. For example, they can show resistance, deny their drugs problem, show ambivalence regarding the possibility of changing or not, etc. In all these cases the therapist will need to adapt to the person's messages and explanations.

The interview presented below has three different parts: at the beginning the therapist and the participant analyze the drug problem and its consequences (awareness) and also the future plans of the participant; the second part will be devoted to promote motivation to change and, finally, the third part tries to make the inmate aware of the usefulness of the program to reach positive goals. Likewise, in the first moments, professionals will strive to create the most positive therapeutic environment possible (engaging).

Opening of the interview: create a therapeutic link

The motivational interview begins with the introduction of the therapist and the inmate, calling the inmate by their name and initiating the interview with an informal topic that reduces the tension. The interaction could occur in the following way:

You wonder why I called you ... I've called you to chat with you for a few minutes and to offer you something that I think it is going to be very good for you, personally and in the near future ...

We are going to start a new treatment program for inmates like you that have or have had in the past problems with drugs...what do you think about that?

IDEAS/RECOMMENDATIONS

The therapist must provide a warm, empathetic and emotionally connected environment that promotes open and honest expression of thoughts and the extended development of messages to foster emotional connection and reflection on what is being told. In order not to convert the interview into an interrogation, we suggest that the therapist interface paraphrases, summaries, or empathic and humorous comments.

First phase of the interview: awareness and future plans

The next group of questions are aimed to encourage the reflection of the participant in relation to drug use behavior and its consequences.

But if you want, before talking about this in more detail, we can talk a little about your current situation and the plans you have for the future...

Now, some questions to encourage the participant's reflexion are made:

How is the sentence affecting your life (family, work, economic, friendship, leisure, personal, privacy ...)?...

...In what way do you think that you or other people have been affected by the problem that has brought you here? (Children, partner, other relatives)...

...How do you feel about the way events have occurred?...

Sometimes, the participants will not admit any negative consequence of their drug abuse. To work with resistances comments as the following could be introduced (**evoke**):

So, you say that your drug abuse is your choice but you mentioned also that your wife didn't like...

...You mentioned that sometimes you crossed the line and you felt bad...

Repeat the arguments given by the inmate (**reflect**). It's not about giving him the reason but rather to give him the opportunity to listen to his own arguments and, also, that he feels understood.

The next part of the interview is devoted to talk about future plans. We assume that at this point the inmate will make reference to values and personal goals.

We can start with your near future ..., keep in mind that the date for your (conditional) release is getting closer and closer...

I would like to know how you look a few years from now when you are free; for example, from here to X years ... (quote according to the time left to the prisoner for probation or release).

Or:

How would you like your life to be within ... years?

IDEAS / RECOMMENDATIONS

At this time, when talking about future plans, the inmate will probably present personal goals of change (focus). This way personal values and goals are made explicit. Most likely they will see themselves close to their families, working, in the company of new friends, etc. It is unlikely they will tell us that within X years they see themselves in prison or with drug use problems, etc.

I see that something very important for you is to be with your family, take care of your children, get a job, do not get into trouble, leave the world of drugs, etc., (Quote based on the answer given to the previous question.)

Really, what is the most important thing to you in life? What do you value most? (eg, take care of your children, protect your family, work on something you like, be accepted by your family, have a comfortable life, take care of your health, etc.).

When the interviewee refers to their personal values (family, work, health, etc.,) the following statement is made:

... Okay, what you say, your family, your friends, etc. (quote according to the inmate's values, make a summary of what has been said) *seems to be in contradiction with your drug use isn't it true? "*(**Reflect**).

And is also in contradiction with the fact of being here in prison ... you don't see yourself in prison within X years, right?

I share that goal with you... What is more, the treatment activity of which we will talk later is also meant to avoid that you return to prison for problems similar to those you had in the past and help you to control your drug abuse problems.

I also think that deciding to do something about your drug use problems brings you closer to the future you want (taking care of your family, maintaining a good health, having a job ...)

IDEAS / RECOMMENDATIONS

Around 10 to 15 minutes will be devoted to talk about future plans and the values of the inmate, promoting the idea that goals are shared by the therapist. Inmate`s values would be contradictory to past criminal and addictive behavior.

Second phase of the interview: motivation to change

Once a therapeutic link with the inmate has been created, awareness of the problem has been increased and plans for the future, expectations, values and hopes, have been discussed, the second phase of the interview begins. This phase has a main goal: empower the intention to change.

From the projection to the future, the search of situations in which the problem has not been present and the construction of hypothetical scenarios where the problem does not appear, a perspective of attractive change can be drawn for the participant. This would be a first approach to the motivation to change. This aspect will not be analyzed in depth, since it will be treated more intensively in the first pathway of the program.

Some illustrative questions would be:

Imagine that you wake up one morning and your problem has disappeared ... How are you going to notice that the problem has disappeared? What things would you do differently? How would the situation change...? And how will your partner / your family react when you tell them ...? (Miracle question).

What would be some of the positive things about the possibility of changing? What are the reasons you see to change? What makes you think that if you decide to introduce a change, you could do it?

Have you ever been abstinent? (If they have never been, before starting to take drugs) *How did you feel then? How was the relationship with your family during the time you did not use drugs?*

Third phase of the interview: show the utility of the program

Here some summary information about the objectives of the drug addict's treatment program can be provided.

This program will help you understand your drug use behavior, the role of emotions and thoughts, control the desire to consume...

In short to help you get out of the drug problem and thereby prevent you from going back into prison... It can also help you obtain certain benefits in prison..

It will also improve other personal skills and help you to grow personally...

What do you think of this proposal?

Would you be willing to participate in this program?

Do you have any questions or do you want to ask me something else in relation to the program that I'm offering?

STATE OF CHANGE	COMMENTS OF THE THERAPIST
PRECONTEMPLATION The user is not considering change, is aware of few negative consequences. Examples: "I used to take drugs because I like them, it's my choice...", "I don't need any treatment programme but I agree to talk about it to make my wife feel reassured".	
CONTEMPLATION The user is aware of some pros and cons of substance abuse but feels ambivalent about change. This user has not yet decided to commit to change. Examples: "Sometimes I think that this isn't good for my health...", "I should do something about it one day but I can't imagine never shooting up again...".	

STATE OF CHANGE	COMMENTS OF THE THERAPIST
PREPARATION The user has decided to change and begins to plan steps toward recovery (ask for information about programs, stop taking drugs for 24 hours, etc.). Examples: "I need help to give up drugs...", "I can't continue like that...", "what can I do?"...	
ACTION The user tries new behaviours, but these are not yet stable. This stage involves the first active steps toward change (they have started in a program or is keeping themselves abstinent, for instance). Examples: "I think this program is helping me..."	
MAINTENANCE The user establishes new behaviours on a long term basis. Examples: "I haven't taken drugs for 1 year now...", "I feel that I'm progressing toward recovery, but I'm still wondering whether abstinence is really necessary..."	
RELAPSE The user has experienced a recurrence of symptoms and must now cope with consequences and decide what to do next. Examples: Similar comments to the ones in previous states	

Date: / /
The attitude that predominates in relation to the problem of drug use is:
Precontemplation.
Contemplation.
Action.
Maintenance.

Date: / /
The attitude that predominates in relation to the problem of drug use is:
Precontemplation.
Contemplation.
Action.
Maintenance.

PATHWAY I
RISK REDUCTION

SESSION 0

Goals

- TO GET TO KNOW THE MEMBERS OF THE GROUP.
- TO FOSTER GROUP COHESION.
- TO BE FAMILIAR WITH THE REHABILITATION PROGRAM CONTENTS.
- TO ENHANCE MOTIVATION ON THE REHABILITATION PROCESS.

Activities

- INTRODUCE YOUR PARTNER.
- MOTIVATIONAL SHORT STORIES.

Psychoeducative presentation

The therapist, after a brief introduction, welcomes everyone to the group and tells the group members that they will introduce themselves (first names only).

Subsequently, the overall objective of the program will be explained requesting feedback from the participants. For example: what do you think about it? How do you see it?

After this, the therapist and the members of the group introduce themselves using the proposed introduction in exercise 1.1.

At this point it is important that the professional insists and clarifies his/her role in the group. Let them know that his/her task is to help achieve positive changes, that is, help achieve those objectives and goals that are important for the participants.

To increase participants' motivation and to help them to understand the rehabilitation process, the therapist can introduce here the exercise 1.2.

Then the different units that will be worked during the intervention and the methodology to be used will be presented (days of the week in which there will be sessions, duration, structure of the sessions, methodology,...). All the doubts and questions should be clarified.

Finally, therapist will ask participants to add, to the general rules of the program (annex 1.3), the rules that they consider important to create a safe work environment. This exercise can help them to reduce resistance and increase the compliance of the rules thanks to the identification with them.

Group dynamics and materials

1.1. Introduce your partner

Goals

To make possible that the members of the group get to know each other.

To foster group cohesion.

To "break the ice".

Materials

None.

Guide for the exercise

Participants are sitting in pairs.

They should get to know each other by asking any questions they like. A time limit, such as 15–20 minutes is assigned. Examples of questions: What's your name? Where are you from? What do you like to do in your free time?

When everyone is finished, each participant introduce their partner to the rest of the group. They can give as much information as they want or, depending on the time, we can limit their talking time by saying something like, "Tell us three interesting things that you learned about your partner."

1.2. Motivational short stories

Goals

To foster the motivation of the members of the group. To reflect on the importance of the program for themselves.

Materials

Annex 1.2.

Guide for the exercise

The participants read the two stories proposed and debate. The therapist can provoke the group discussion. Some questions that could be asked would be:

- What do these stories tell us?
- What is the moral of the stories?
- What does this have to do with your problem?
- What does this have to do with the rehabilitation program?

Annex 1.2. Motivational short stories

BUDDHA AND THE FARMER WITH 83 PROBLEMS

There is an old story about a man who came to see the Buddha because he had heard that the Buddha was a great teacher. Like all of us, he had some problems in his life, and he thought the Buddha might be able to help him straighten them out. He told the Buddha that he was a farmer.

"I like farming," he said, "but sometimes it doesn't rain enough, and my crops fail. Last year we nearly starved. And sometimes it rains too much, so my yields aren't what I'd like them to be."

The Buddha patiently listened to the man.

"I'm married, too," said the man. "She's a good wife… I love her, in fact. But sometimes she nags me too much. And sometimes I get tired of her."

The Buddha listened quietly.

"I have kids," said the man. "Good kids, too… but sometimes they don't show me enough respect. And sometimes…"

The man went on like this, laying out all his difficulties and worries. Finally he wound down and waited for the Buddha to say the words that would put everything right for him.

Instead, the Buddha said, "I can't help you."

"What do you mean?" said the man, astonished.

"Everybody's got problems," said the Buddha. "In fact, we've all got eighty-three problems, each one of us. Eighty-three problems, and there's nothing you can do about it. If you work really hard on one of them, maybe you can fix it – but if you do, another one will pop right into its place. For example, you're going to lose your loved ones eventually. And you're going to die some day. Now there's a problem, and there's nothing you, or I, or anyone else can do about it."

The man became furious. "I thought you were a great teacher!" he shouted. "I thought you could help me! What good is your teaching, then?"

The Buddha said, "Well, maybe it will help you with the eighty-fourth problem."

"The eighty-fourth problem?" said the man. "What's the eighty-fourth problem?"

Said the Buddha, "You want to not have any problems."

THE "WADE THROUGH THE SWAMP" METAPHOR

Suppose you love mountain climbing and one day you set out to summit a peak you've been admiring for years. But when you get close to the mountain's base you discover it's completely surrounded by a swamp. This is a big surprise. No one told you about it. Now you'll have to trudge through this icky mess before you can even start your climb.

You don't like this situation, but you decide to suck it up and wade through the swamp because getting to the top of this mountain really matters to you.

All of us have things that are important to us: families, careers, causes. However, we inevitably have times when we face negative emotions related to these things: fear for our loved ones, uncertainties about our careers, and anger towards those who don't support our causes.

But if these things really matter to us we persevere. We understand that sometimes we have to wade through the swamp of negative emotions to get to the mountain top.

Don't let unpleasant emotions stop you. They're part and parcel of living a full life.

DRUG INFORMATION

1. Introduction

It is a proven fact that drug addicts in general have a great lack of information regarding the different types of substances, how they work in the organism and its effects at a physical, psychological and social level. In addition, much of this information is biased or wrong.

It is important to increase the addicts' awareness of how a drug can affect their minds, bodies, relationships, and functioning. This awareness can help them realize the potential damage that could occur, or the damage that has already occurred and thus motivate them to start or continue a rehabilitation process. It is widely considered that a person in rehabilitation must understand alcohol or drug addiction and their causes before they can be overcome. It should be kept in mind that the factors that lead to substance abuse and addiction are different for each person.

In this unit participants will be provided with accurate information about the signs, symptoms and side effects of all the drugs, how drugs affect people's body and life, the consequences of addiction and finally some misconceptions and myths in relation to drugs.

This unit is distributed in 3 therapeutic sessions.

2. Therapeutic goals

1. Provide accurate, reliable and truthful information about drugs, their signs, symptoms and side effects.
2. Explain to t he participants the addiction process and its different states.
3. Understand the biological, psychological and social consequences of addiction.
4. Refute myths and false beliefs about drugs.

SESSION 1

Goals

- TO LEARN BASIC CONCEPTS ABOUT DRUGS.
- TO DISTINGUISH AMONG USE, ABUSE AND DEPENDENCE.
- TO LEARN THE CLASSIFICATION OF DRUGS AND THEIR EFFECTS.

Activities

- SYMPTOMS OF DEPENDENCE.
- CARDS GAME: MATCH A DRUG WITH ITS DESCRIPTION.

Psychoeducative presentation

NOTE

Here general information about drugs that is considered basic is presented. The therapist can use other sources of information available or add another type of material (brochures, texts, documentaries,...).

Drug and addictive disorder

The World Health Organization (WHO, 1994) defines:

Drug as any substance which, introduced into the living organism can modify one or more of its functions. A drug of abuse is said to be so when we refer to a substance that has psychoactive effects, capable of being self-administered, and the consumers generally does not take for therapeutic purposes, but for recreational or experimental ones.

Drug addiction or Addictive disorder as the set of physiological, behavioral and cognitive manifestations in which the use of a drug is a priority for the individual. This term is usually linked to tolerance, or the need to consume more of a substance to achieve the effects of previous consumption.

Consumption Patterns

A first differentiation to take into account is the distinction between drug use and drug abuse and dependence.

- **Drug use** or consumption involves consumption that does not adversely affect health. For example, there are no adverse health effects that an adult accompany a meal with a glass of wine, if he/she does not have to drive later.
- **Abuse** is defined as that consumption that harms the health consumer in the short or long term. Examples of abuse are drinking alcohol until intoxication, or consuming a dose of cocaine.
- **Dependence**, also known as addiction, is a pattern of use that results in which you may be unable to stop drinking or using drugs, and have physical withdrawal symptoms when you try to quit.

    – *Physical dependence* is a state of adaptation of the organism to the presence of the drug and is manifested by the appearance of intense physical discomfort (tremors, chills, insomnia, vomiting, pain in the muscles and bones, etc.) when consumption of the substance is stopped.

– *Psychological dependence* refers to the situation in which a person feels an emotional need and urge to consume a drug (craving) on a regular basis in order to feel good, be satisfied (obtain pleasure or avoid discomfort) although he/she does not need the substance physiologically.

According to this distinction between use, abuse and dependence, we can speak of different **kinds of consumers**. Barriga (1996) differentiates four types:

a. **Experimental**: they live the consumption experience as a trial; driven by curiosity, they are mainly stimulated by the context in which they find themselves.

b. **Occasional**: they consume based on the surrounding circumstances. The drug is used as an element of celebration and as a means to achieve euphoria.

c. **Habitual**: they approach establishing a certain dependence on the drug. In their consumption, they can find refuge from difficulties or problems.

d. **Dependent**: compulsive consumers who if deprived of the drug would experience withdrawal syndrome.

Criteria for Substance Use Disorders (DSM-V, APA 2013)

Substance use disorders span a wide variety of problems arising from substance use, and cover 11 different criteria:

1. Taking the substance in larger amounts or for longer than you're meant to.
2. Wanting to cut down or stop using the substance but not managing to.
3. Spending a lot of time getting, using, or recovering from use of the substance.
4. Cravings and urges to use the substance.
5. Not managing to do what you should at work, home, or school because of substance use.
6. Continuing to use, even when it causes problems in relationships.
7. Giving up important social, occupational, or recreational activities because of substance use.
8. Using substances again and again, even when it puts you in danger.
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.
10. Needing more of the substance to get the effect you want (tolerance).
11. Development of withdrawal symptoms, which can be relieved by taking more of the substance.

Others concepts associated with addiction

- **Tolerance** occurs when the person no longer responds to the drug in the way that initially responded. Stated another way, it takes a higher dose of the drug to achieve the same level of response achieved initially.
- **Abstinence Syndrome** is a set of symptoms and physical effects that result from depriving an addict of the drug to which he or she is habituated.

Drug classification

Drugs can be classified in many ways. Here a common way of classifying drugs in proposed, according to their common effects and actions on the mind and body.

Depressants

Depressants are substances that suppress or slow down the activity of the central nervous system. They include the following classes of narcotic drugs and medicines: sedation and sleeping drugs, opiates and their analogues, barbiturates and benzodiazepines, anticonvulsants and antipsychotics, as well as alcohol. Some of these are used to treat anxiety disorders, phobias and insomnia, but despite their prescription for treatment, they carry high addictive potential. The withdrawal effects from long-term depressant use can be life-threatening and produce some of the worst consequences of any other drug classifications. Keep in mind: this includes alcohol.

Examples include: alcohol, Valium, Xanax, Librium, and barbiturates.

Opioids (also belong to the group of depressants)

Opioids are substances that have a powerful painkilling effect. They are made from opium poppy or opium alkaloids (opiates). They can have synthetic and semi-synthetic origin. Opiates produce a quick, intense feeling of pleasure followed by a sense of well-being and calm. Long-term opiate use of opioids changes the way the brain works by changing the way nerve cells communicate with one another. If opiates are taken away from opioids-dependent brain cells, the work of the nerve cells is disturbed, they became excessively overactive while other abstinence symptoms are launched. Eventually, cells will work normally again if the person recovers, but they cause wide range of chronic withdrawal symptoms that affect the mind and the body. As with many other drugs, opioids possess very high addictive potential.

Examples include: heroin, morphine, codeine, acetylated opium and Oxycontin.

Stimulants

Stimulants are any substances that activate and stimulate the central nervous system. It is a class of drugs that both elevate mood, increase alertness and feelings of well-being and energy. Stimulants can cause the heart to beat faster and will also cause blood pressure and breathing to elevate. Repeated use of stimulants can result in paranoia and hostility. Stimulants change the way the brain works by changing the way nerve cells communicate with one another. As with many other drugs, stimulants possess very high addictive potential.

Examples include: cocaine, methamphetamine, amphetamine, MDMA (Ecstasy), nicotine, and caffeine.

Hallucinogens

Hallucinogens are drugs which cause altered perception and feeling. Hallucinogens have powerful mind-altering effects and can change how the brain perceives time, everyday reality, and the surrounding environment. They affect regions of the brain that are responsible for coordination, thought processes, hearing, and sight. They can cause people to hear voices, see things, and feel sensations that do not exist.

Hallucinogens change the way the brain works by changing the way nerve cells communicate with one another. Hallucinogens possess a moderate potential for addiction with very high potential for tolerance, moderate level of psychological dependence, and low potential for physical dependence. Most of the risks associated with hallucinogen use are associated with the risk for personal injury and life-threatening accidents.

Examples include: LSD, PCP, MDMA (Ecstasy), marijuana, mescaline, and psilocybin.

Group dynamics and materials

1.1. Symptoms of dependence

Goals

To know and identify symptoms of substance dependence based on their own experience.

Materials

Paper sheets, pencils, flipchart/board.

Guide for the exercise

Split up the participants into small groups. Provide each group with paper and pencils. Ask participants to discuss the following questions within the group:

- When do you think a person can be considered as drug dependent?
- What symptoms and behavioural patterns does this person show?

Answers should not be reduced merely to the fact of being intoxicated. Ask each group to write down five statements on the paper. If necessary provide an example.

Ask each group to present their results and write their answers on the flipchart /board.

After having finished the activity, present the symptoms of dependence listed by DSM-V (or ICD-11 if the therapist prefers it) to the participants.

1.2. Cards game: Match a drug with its description

Goals

To increase knowledge about the characteristics and effects of more common drugs and groups of drugs.

Materials

Cards with the name of a drug or a type of drug. Cards with the effects and description of each drug (see annex 1.2).

Guide for the exercise

Cards with the name of a drug or a type of drug written on them are distributed among the participants. On a table, there will be cards with the effects and description of each drug written on them. The participants should match each drug or type of drug with their description. Different variants of this game can be made:

- Organize a "competition" among small groups.
- Simulate a memory game where all the cards are face down and they must match the pairs (in this case, the pairs are the name of the drug and its description).

- Distribute the cards among the participants that will move around the room, the task is to find the participant with the matching card.

Once the activity is finished, the content of the cards will be reviewed in the big group. The therapist can ask questions such as: Have you learned anything new/ what have you learned from the game?

Annex 1.2. Cards game

Heroin	Opium containing psychoactive substance made from poppy straw. Common street names include: Big H, H, Smack, Nose Drops; Garik, Herbalife, Barbados, Gera, Gerasym, Moody, Gerych (in Ukraine).
Alcohol	Substances containing ethyl alcohol, made through (rotting) fermentation of grains, grapes, berries, etc. Belongs to depressants.
Depressants	A group of drugs that slow brain and body reactions.
Stimulants	Drugs that speed up the activities of the central nervous system.
Methamphetamine	This is a man-made substance, normally made in a lab. It is derivative of amphetamines, this is a stronger more powerful substance. Its main form may look like crystals. Common street names include: Meth, Crystal, Ice, Glass, Crank, Tina, Speed and Chalk.
Amphetamines	Prescription drugs that are sold illegally. Common street names include: Speed or Uppers.
Cocaine	A powerful short-acting drug that is highly addictive. It comes from coca leaves. This drug was originally developed as a painkiller and was used as an additive in Coca Cola. Common street names include: Coke, Crack, Blow, and Snow;Koks, flour, nyuhara, cake, ticker, snow (in Ukraine).
Hallucinogens	Drugs that change perception, thought and mood.
LSD	The strongest known hallucinogen, this substances effect is unpredictable. It can either stimulate of depress the body. It is made from a fungus that grows on rye and other grains. Common street names include: Acid, Battery Acid, Boomers, and Looney Tunes; Acid (in Ukraine).

Marijuana	This drug acts as a hallucinogen. This is one of the most frequently abused substances. This drug is known as a "gateway drug" to many other harder drugs. This substance produced from the leaves, stems, and flowering tops of the hemp plant. Common street names include: Mary Jane, Weed, Pot, Grass, Hemp, Reefer, and Dope; Plan, Grass, Gandzhubas (in Ukraine)
Ecstasy	The active ingredient of this man-made substance is MDMA. Known today as a club drug this small colourful pill can contain a wide mixture of substances such as rat poison, various other drugs, and animal deworming substances. Common street names include: E, MDMA, Molly, Love Drug, X; E, Yeshka, wheels, fun candy, X-T-C (In Ukraine).

SESSION 2

Goals

- TO INCREASE KNOWLEDGE ABOUT THE BIOLOGICAL, PHYSICAL AND SOCIAL CONSEQUENCES OF DRUG USE AND ADDICTION AT SHORT-TERM AND LONG-TERM.

Activities

- CONSEQUENCES OF DRUG USE IN MY LIFE.

Psychoeducative presentation

When substance abuse occurs there are many effects that this activity can have. These may be short term, long term, or both of these, depending on which substance is abused, what amounts are used on a regular basis, and how long the abuse has continued.

Start the session with a brainstorming about the negative consequences of drug use and drug addiction.

Short-term effects of drug use

The short term effects that can occur are usually physical, although some drugs and alcohol can cause mental illness symptoms even if they are only used for a short period of time. These can include:

- High blood pressure.
- Paranoia.
- Changes in heart rate.
- Changes in mood.
- Dizziness.
- Shakes and muscle tremors.
- An inability to think clearly.

Long-term effects of drug use

Long term effects and dangerous symptoms that may occur with some substances even if used only one or two times can include:

- Psychosis.
- Heart attack.
- Stroke.
- Organ damage.
- Deficiencies in the immune system.
- Abscesses and infections at injection sites.
- Depression.
- Paranoia.
- Suicidal thoughts.
- Dementia or permanent brain damage.

There are many other possible effects and symptoms that can also be caused by short term or chronic substance abuse. As we saw in the previous session, over time

you will start to develop a tolerance for the drug or alcohol and this means that you must use more of the substance to achieve the same effect. Addiction follows, and you may experience intense cravings for the substance. Withdrawal symptoms can be physical as well as mental with a number of drugs as well as alcohol. Those addicted to heroin will feel physically ill when they cannot access the drug as they start to come down, and these individuals even refer to it as being sick.

Other negative consequences include social problems in several areas:

- Relationships.
- Home/family life.
- Education.
- Employment.
- Financial issues.
- Law and order.

At this point, we ask participants to think of an example for each of the mentioned areas.

Group dynamics and materials

1.2. Consequences of drug use in your life

Goals

To increase awareness of the negative consequences of drug use at a physical, psychological and social level.

Materials

Pencils. Hand-out "The consequences of drug use in your life".

Guide for the exercise

Think about the negative effects of drug use throughout your life. In the first column describe a negative effect of the drug (at short or long term), then write if it is an effect on your body (physical), your mind (psychological) or social (work, family and social relationships, education,…).

Annex 1.2. Consequences of drug use in your life

CONSEQUENCE	TYPE: PHYSICAL, PSYCHOLOGICAL, SOCIAL

SESSION 3

Goals

- TO LEARN BASIC CONCEPTS ABOUT DRUGS.
- TO DISTINGUISH AMONG USE, ABUSE AND DEPENDENCE.
- TO LEARN THE CLASSIFICATION OF DRUGS AND THEIR EFFECTS.

Activities

- SYMPTOMS OF DEPENDENCE.
- CARDS GAME: MATCH A DRUG WITH ITS DESCRIPTION.

Psychoeducative presentation

Addiction is surrounded by myths and misinformation, even more than other topics. Substance abuse is a hugely emotional issue and opinions about it vary widely. In this session we will try to demystify and dispel some myths and misconceptions about drugs that are taken for granted through the promotion of group discussions and exchange of ideas.

The session can start by asking participants to complete the exercise 1.3 individually. Then they will share their answers with the group inviting the rest of the participants to discuss the answers, thus encouraging the group discussion. The therapist, by means of questions, will dismantle one by one the misconceptions and the myths present in the members of the group.

Group dynamics and materials

1.3. Fact or myth quiz

Goals

To evaluate the participants' initial knowledge about drugs and drugs effects.

To increase awareness of myths and misconceptions about drugs that they have.

Materials

Pencils. Hand-out "Fact or myth quiz".

Guide for the exercise

The therapist will hand out the questionnaire to the members of the group to be completed, first individually. Then, the answers are shared and discuss with the whole group.

Annex 1.3. Fact or myth quiz

Answer T if you think the following statements are true or F if you think they are false.

FACT OR MYTH QUIZ

Consuming hashish makes you more creative and imaginative.	T/F
Alcohol improves mood and helps overcome problems.	T/F
You can stop using drugs anytime.	T/F
Cannabis is a natural and harmless product.	T/F
You have to use drugs for a long time before they can really hurt you.	T/F
Cocaine helps to relate to others.	T/F
If you're pregnant and use drugs, your body protects the baby.	T/F
It is easy to control the consumption of cocaine, it does not cause dependence.	T/F
Taking synthetic drugs such as ecstasy is harmful, even if you only consume weekends.	T/F
If you smoked pot on the weekend, you'd be fine by Monday.	T/F
As soon as a person feels normal, all the drug is out of the body.	T/F
Alcohol consumption is good for the heart.	T/F
Cannabis does not cause addiction, its consumption can be controlled.	T/F
If you get drunk, coffee will sober you up.	T/F
Cocaine is consumed by those who succeed, the winners.	T/F
Cocaine is only addictive if you inject it.	T/F
Pot isn't as bad for you as cigarettes.	T/F
Drugs relieve stress. They help deal with problems.	T/F
Synthetic drugs, such as ecstasy, have aphrodisiac effects.	T/F
Mixing alcohol and cocaine increases the tendency to behave violently.	T/F

FACT OR MYTH QUIZ (Answers)

1. Consuming hashish makes you more creative and imaginative. **FALSE.**
   It's a widespread misconception. It really reduces the ability to perform tasks that demand concentration and coordination such as driving, practicing sports or studying. It affects to brain functioning, although there is a sense of mental clarity.

2. Alcohol improves mood and helps overcome problems. **FALSE.**
   Drinking alcohol does not make the problems disappear, on the contrary, it will reduce our ability to face them and make them worse or others arise.

3. You can stop using drugs anytime. **FALSE.**
   Withdrawal sickness, believing you must have drugs, and being around people who use can make stopping drug use difficult. But there are people and programs that can help.

4. Cannabis is a natural and harmless product. **FALSE.**
   It is a misconception. Cannabis is of natural origin but its effects are harmful to health, as is been seen in previous sessions, affecting brain function.

5. You have to use drugs for a long time before they can really hurt you. **FALSE.**
   Drugs can cause the brain to send the wrong signals to the body. This can make a person stop breathing, have a heart attack or go into a coma. This can happen the first time the drug is used.

6. Cocaine helps to relate to others. **FALSE.**
   It is true at first, but 20 or 30 minutes after consumption an intense comedown appears with decay and fatigue. Sociability would increase, but, after its first effects, it produces decay.

7. If you're pregnant and use drugs, your body protects the baby. **FALSE.**
   Drugs affect an unborn child as much or more than the mother. Drug use during pregnancy can cause the baby to die or be born too early. It can damage the baby's mind and body.

8. It is easy to control the consumption of cocaine, it doesn't cause dependence. **FALSE.**
   Misconception, cocaine is very addictive, even more than heroin.

9. Taking synthetic drugs such as ecstasy is harmful, even if you only consume weekends. **TRUE.**
   Misconception. Even consuming only on weekends it carries an obvious risk, even some serious risks regardless of the time of consume.

10. If you smoked pot on the weekend, you'd be fine by Monday. **FALSE.**
    The effects of pot (marijuana) can last for up to 3 days. It impairs memory, reflexes and coordination.

11. As soon as a person feels normal, all the drug is out of the body. **FALSE.**
    Long after the effects of the drug stop being felt, the drug can still be in the body. For example, cocaine can be found in the body up to one week and marijuana up to 3 months after a single use.

12. Alcohol drinking is good for the heart. **TRUE.**
    Alcohol consumption in healthy adults decreases the percentage of heart conditions. But always making moderate use and in healthy adults.

13. Cannabis doesn't cause addiction, its consumption can be controlled. **FALSE.**
    Continued and prolonged consumption produces tolerance, dependence and withdrawal syndrome.

14. If you get drunk, coffee will sober you up. **FALSE.**
    Once alcohol is in the bloodstream, only time will make a person sober.

15. Cocaine is consumed by those who succeed, the winners. **FALSE.**
    This was a widespread idea years ago. Consumers belong to all social groups, including the most socially disadvantaged.

16. Cocaine is only addictive if you inject it. **FALSE.**
    Cocaine is quickly addictive any way it is used: smoking, snorting or injecting.

17. Pot isn't as bad for you as cigarettes. **FALSE.**
    Marijuana smoke has more cancer causing chemicals than tobacco.

18. Drugs relieve stress. They help deal with problems. **FALSE.**
    Drugs only make people forget and not care about their troubles. When the drug wears off, the problem is still there.

19. Synthetic drugs, such as ecstasy, have aphrodisiac effects. **FALSE.**
    Misconception. Synthetic drugs hinder orgasm and increase the appearance, in males, of occasional impotence. The continued use of these substances reduce the interest in sex and decrease its pleasure.

20. Mixing alcohol and cocaine increases the tendency to behave violently. **TRUE.** The mixture of both substances causes a high excitation. Empirical studies show the association between cocaine-alcohol and violent behavior, although moderated by environmental and personal circumstances.

MOTIVATION FOR CHANGE

1. Introduction

In order to induce positive changes in addictive behaviour, drug users need to be ready, willing and able to change. The stages of change model that will be discussed in the first session is a way of understanding how ready and willing a person is to make changes in his/her substance use behavior.

Being ready and willing to reduce or stop substance use is related to the perceived relevance of change. Ambivalence about substance use will be a common feature of group participants. They will be able to see both the good things and the not so good things about their substance use. Or maybe they are partially aware of the problems associated with substance use and may be weighing up the advantages and disadvantages of their current substance use pattern. In session 2 ambivalence to change will be addressed, and participants will be encouraged to find and talk about their own reasons to cut down or stop substance use (decisional balance).

However, thinking that change is important is not always enough for a person to move into the action phase. Sometimes a person is willing to make a change but is not confident that they are able to do so. In session 3 self-efficacy (confidence) will be addressed.

This unit is distributed in 3 therapeutic sessions.

2. Therapeutic goals

1. To assess and discuss readiness to change.
2. To help the participants to identify and verbalize the most salient cons of using and benefits of quitting (discrepancy and decisional balance).
3. Help participants to enhance their self-efficacy expectations to quit.

SESSION 1

Goals

- TO EXPLAIN THE CONCEPT OF CHANGE OCCURRING AS A PROCESS OVER TIME.
- TO DESCRIBE THE 5 STATES OF CHANGE.

Activities

- THE “READINESS RULER”.

Psychoeducative presentation

States of change

In or out of treatment, people seem to go through similar stages as they work on making changes. This goes for many kinds of changes. The same stages seem to apply to people who want to lose weight as they do to people who want to cut down or stop their drinking or drug use.

The first stage of change is called the **Pre-contemplation Stage**. During this stage people are not thinking about making a change. This may be because they have never thought much about their situation, or they have already thought things through and decided not to change their behavior. Sometimes people may want to change, but do not feel capable of doing it successfully. People in this stage might find useful to get more information about their situation.

When people start thinking about their situation, they begin the second stage called the **Contemplation Stage**. During this stage, people are unsure about what to do. There are both good and not-so-good things about their present situation. People in this stage also struggles with the good and not-so-good things that might come with change. During this stage people often both want change and yet want to stay the same at the same time. This can be a bit confusing for people as they feel torn between these options.

At some point, when people have been thinking through whether or not to change, they may come to feel that the reasons for change outweigh the reasons not to change. As weight increases on the side of change, the person becomes more determined to do something. This is the beginning of the next stage, called the **Preparation Stage**. During this stage, people begin thinking about how they can go about making the change they desire, making plans, and then taking some action toward stopping old behaviours and/or starting new, more productive behaviours. People often become more and more ready and committed to making changes.

During the next stage of change, called the **Action Stage**, people begin to implement their change plans and trying out new ways of being. Often, during this stage people let others know what's happening and look for support from them in making these changes.

Once people have succeeded in making and keeping some changes over a period of time they enter the **Maintenance Stage**. During this stage, people try to sustain this changes to prevent returning to their old habits. Frequently the person is able to keep up the changes made and then makes a permanent exit from the wheel (or

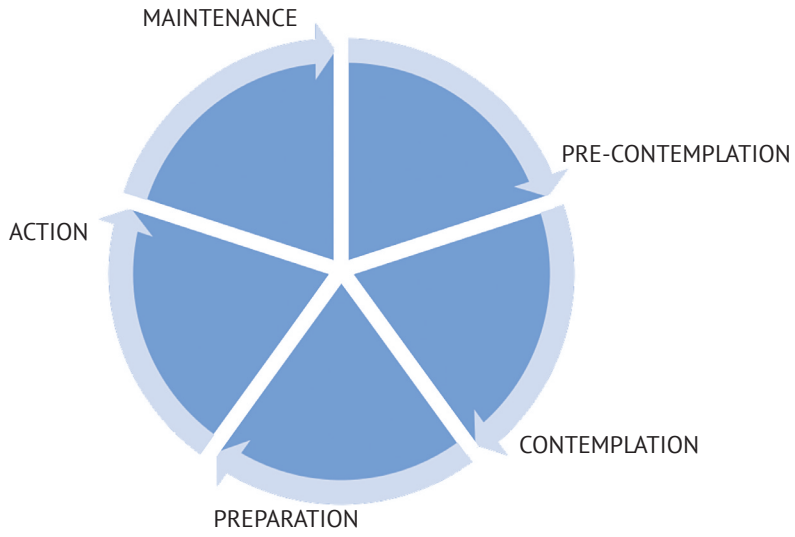
spiral) of change. During this stage it is also common for people to have some slips or lapses where old habits return for a short time.

Sometimes people also have relapses which may last a longer period of time. When a person has a relapse, he or she typically returns to the precontemplation or contemplation stages. The person's task is to start around the wheel of change again rather than getting stuck. Keep in mind that relapses, slips, and lapses are normal as a person tries to change any long-standing habit. Often people go around the wheel of change 3 or 4 (or more) times before permanent change takes hold.

It is important for you to know which stage you're in and what things you need to do to move to the next stage.

The therapist can show or draw an image similar to Figure 2 and ask the participants to determine in which state they think they are currently and discuss de reasons why the think so.

FIGURE 2



To reflect on their personal history of change and to find examples for other participants, we ask each person to relate the states of change they think they have gone through in their lives paying attention to the following aspects: their thoughts, their feelings and their behaviors in each moment.

To increase the awareness of the psychological processes by which the individual has gone through the therapist can ask questions of the type: *What do you think that*

made you move to a more advanced state? What do you think that made you go back to a previous state?

Group dynamics and materials

2.1. The readiness ruler

Goals

To find out how important the person finds to achieve drug use reduction.

To encourage the person to start to talk about reasons for change.

Materials

Pencils. Hand-out "The readiness ruler" (annex 2.1).

Guide for the exercise

Follow the instructions in annex 2.1.

Annex 2.1. The readiness ruler

How important is to you to cut down or stop your substance use?

On a scale of 0 to 10, where 0 is not at all important, and 10 is extremely important, how would you rate yourself?"

0	1	2	3	4	5	6	7	8	9	10
Not at all important										Extremely important

Why is your motivation where it is? Why not lower?

Even if you marked only a "2" or a "3," there must be a reason you didn't write "1". List some of your motivators.

_____
_____
_____
_____
_____
_____

SESSION 2

Goals

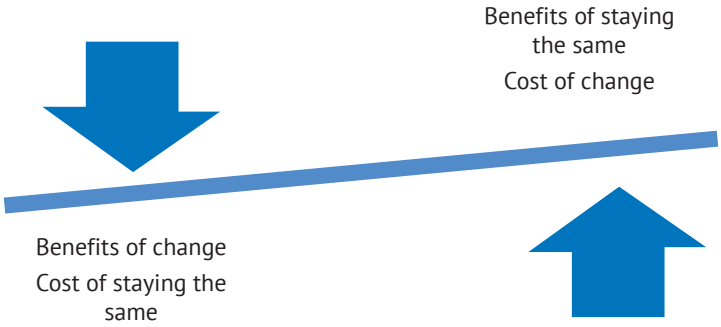
- TO INCREASE PARTICIPANTS' AWARENESS OF THEIR AMBIVALENCE ABOUT SUBSTANCE USE.
- TO INCREASE PARTICIPANTS' AWARENESS OF THEIR AMBIVALENCE ABOUT CHANGE.

Activities

- AWARENESS WINDOW.
- DECISIONAL BALANCE.

Psychoeducative presentation

Ambivalence about substance use can be seen as a balance. On one side of the balance are the benefits to the person of their current substance use behavior and the costs associated with changing it (reasons for remaining the same), while on the other side are the costs of current substance use and the benefits of change (reasons for change). Change is unlikely to occur until the reasons for change outweigh the reasons for staying the same.



Sometimes, we get into habits without ever really thinking about it. Sometimes, the habits are harmless, or have unwanted consequences. Today we are going to think about drinking and using drugs, and talk about the role those habits have played in our lives. We are going to talk about the good things and not-so-good things about using substances. You might be surprised that we want to hear about the good things about using. But the truth is, nobody would use if there were no good things about using and we want you to be realistic about your choices.

The therapist can introduce here the exercise 2.2.

Because most of the things we choose to do have both good and not-so-good consequences, we often experience ambivalence when we face change. **Ambivalence** is a term that means you have mixed feelings about the same issue, and those different feelings are competing or in conflict with each other. When people are ambivalent, they have a harder time making decisions because nothing they do will meet all of their needs. One way to help this is to look at both sides of our feelings at the same time.

The therapist can introduce here the exercise 2.3.

Group dynamics and materials

2.2. Awareness window

Goals

To explore group members' awareness of the good things and not-so-good things about substance use (ambivalence about drug use).

Materials

Pencils. Hand-out "Awareness window".

Guide for the exercise

Let's take a few minutes now, starting with the good things (BENEFITS), and write down at least one good thing about drinking, and using drugs in each area on the left. Then we are going to look at another side of the picture. On the right side of the window, list some of the not-so-good things, for you personally (CONS).

There are no right and wrong answers to the exercise. Encourage group discussion.

Now that you are seeing both the pros and cons about changing or staying the same, how are you reacting to this topic? How are you feeling in general about exploring these issues?

Annex 2.2. Awareness window

	GOOD THINGS	NOT-SO-GOOD THINGS
Short-Term Social Emotional Financial		
Long Term Health Work Relationships Legal		

2.3. Decisional balance

Goals

To explore group members' ambivalence about change.

Materials

Pencils. Hand-out "Decisional balance" (annex 2.3).

Guide for the exercise

Distribute the hand-out. Ask the members to share their responses. Write appropriate responses on the board/flipchart. Point out to the group members where most of the their responses fall, in a non-judgmental tone.

Explain that the costs of change and the benefits of not changing influence a person to stay the same. Similarly, the benefits of change and the costs of not changing influence a person in favor of trying something new.

Annex 2.3. Decisional balance

	BENEFITS / PROS	COSTS / CONS
Making a change		
Not changing		

SESSION 3

Goals

- TO ENHANCE PARTICIPANTS' SELF-EFFICACY.
- TO ENCOURAGE MEMBERS TO BE HOPEFUL ABOUT THE POSSIBILITY OF CHANGE.

Activities

- THE CONFIDENCE RULER.
- REMEMBERING MY SUCCESSES.

Inter-sessions activities

- EXPLORING STRENGTHS.

Psychoeducative presentation

Self-efficacy can be defined as the belief the individual has in their own ability to achieve a goal. If the individual has high self-efficacy it means that they have a strong belief in their ability to achieve something. Those who have a low self-efficacy expect that they will fail. The concept of self-efficacy is important because if people do not believe that they have the ability to achieve something they are unlikely to put in the necessary work to make it happen. The therapist's belief in the patient's ability to change their behaviour is also important and can become a self-fulfilling prophecy.

The session can start asking participants to complete the confidence ruler (annex 2.4).

This scale can be used to assess how confident patients are in their hability to cut down or stop substance use. The confidence ruler is also used here as a hypothetical question to encourage patients to talk about how they would go about making a change.

Then tell the members that we are going to talk about **successful changes**. Ask members what that means to them. Record appropriate responses. Each of us has some success stories, but sometimes we forget them, especially if we unhappy or frustrated about where we've gotten to in life. For example, members in the group may have experienced some of the following successful changes:

- Attending the motivational groups.
- Completing school.
- Improving sports performance.
- Developing a trade or skill (such as: beautician, barber, construction).
- Becoming a better parent or partner.
- Practicing safer sex techniques.

Many of these changes represent a time when you moved through the stages of change - from not even thinking about changing, to thinking about it but having mixed feelings, to taking action, to maintaining the new habit or behavior.

The therapist can introduce here the activity 2.5.

People's identities sometimes get lost in the midst of their substance or/and alcohol use. It becomes easy to lose track of past and future goals and personal qualities one possesses to achieve them. Remind that there is more to you than your substance use. Explain the exercise 2.6 to be done for the next session. They should take enough time to complete each section.

Group dynamics and materials

2.4. The confidence ruler

To find out how confident the person is about being able to stop or reduce their substance use.

To enhance participants' confidence about making the change.

Materials

Pencils. Hand-out "The confidence ruler" (annex 2.4).

Guide for the exercise

Follow the instructions in annex 2.4.

Annex 2.4. The confidence ruler

"How confident are you that you could cut down or stop your substance use if you decided to do it? On a scale of 0 to 10, where 0 is not at all confident and 10 is extremely confident, how would you rate yourself?"

0	1	2	3	4	5	6	7	8	9	10
Not at all confident										Extremely confident

How can the group, your family or friends, help you increase your confidence (or desire) for making this change?

_____

_____

_____

_____

_____

_____

2.5. Remembering My Successes

Goals

To enhance self-efficacy by reminding participants of past successes.

Materials

Pencils. Hand-out "Remembering my successes".

Guide for the exercise

Distribute the hand-out. Leave some minutes to complete it. Ask the group members to share one story of success each. Ask each participant after they share their success story. How does it feel to remember this now? Encourage any self-motivational statements.

Ask the group to discuss the Stages of Change the person cycled through. Question the client about their recollection of what helped and/or motivated him/her to change, using reflective listening skills.

Annex 2.5. Remembering My Successes

It is easy to become discouraged when we forget the times when we were successful at making some change in our lives, or at achieving something we wanted to achieve. Everyone has made a successful change at some time in his or her life. Let's remember your successes.

1. List some positive changes you have made in your life.

2. Pick one of the changes above, perhaps the one that was hardest to achieve, and list the following:

- When did you first start thinking about making a change? What was going on in your life at the time?

- Did you achieve the change all at once, or take small steps?

- What were some of the steps?

- How do you feel about the change today?

2.6. Exploring Strengths

Goals

To foster awareness among group members about their strengths, goals and personal qualities.

Materials

Pencils. Handout "My strengths".

Guide for the exercise

Complete the hand-out trying to write something on each quadrant.

Annex 2.6. Exploring Strengths

Something important from my past	Something I hope to be doing in the future
Something I enjoy doing	Something I do well

HEALTHY LIFESTYLE

1. Introduction

The prison population, although younger than the general population, has overall poorer health. Many come from a background of social deprivation and economic disadvantage and, as a result, have significant health needs. Many of these needs are related to unhealthy lifestyles.

Drug users when entering the prison system frequently suffer from severe health problems, i.e. withdrawal symptoms, abscesses, infectious diseases and mental health problems. The prevalence of infectious diseases like HIV/ AIDS and/or hepatitis A, B and C in prisons is often higher than in the general population and this proportion is higher in drug-dependent inmates.

One of the aims of a risk reduction strategy, such as the one developed in this first pathway, is to address problems such as the use of injectable drugs, unprotected sexual contacts and tattooing with non-sterile equipment, lack of knowledge about transmission of viral hepatitis, HIV/ AIDS and the dynamics of addiction. But in addition to preventing the risks associated with the consumption of substances, it is also relevant to reach the objective of developing healthy habits and lifestyles incompatible with substance abuse that constitute factors of protection against consumption and can serve as triggers to motivate the beginning of a dishabituation program.

Health can be defined as optimum physical, emotional, social, spiritual, and intellectual health. Health promotion is the science or art of helping people change their lifestyle to move towards a state of optimal health.

This unit will focus on the prevention of the risks associated with drug consumption, fundamentally the transmission of diseases. On the other hand, healthy habits in relation to diet, physical activity and sleep habits will be promoted. Another aspect of this unit has to do with the use of free time and positive leisure. Finally, factors related to psychological well-being will be addressed, such as the control of anxiety and stress reduction and the promotion of self-esteem.

This unit is distributed in 4 therapeutic sessions.

2. Therapeutic goals

1. Raise awareness of health problems connected to drug use and drug-related infectious diseases.
2. Sensitize the participants to the different challenges related to drugs, risk behaviours and infectious diseases.
3. Become aware of unhealthy lifestyle habits in relation to diet, exercise, sleep and hygiene and replace them with a healthier lifestyle.
4. Promote positive activities of leisure and free time away from the world of drugs.
5. Improve psychological well-being including the control of anxiety, stress reduction and the promotion of self-esteem.

SESSION 1

Goals

- TO INCREASE PARTICIPANT'S KNOWLEDGE ABOUT RISK BEHAVIOURS, INFECTIOUS DISEASES AND HOW THESE ARE RELATED.
- TO PREVENT ADVERSE CONSEQUENCES OF DRUG USE.

Activities

- RISK BEHAVIOURS DISCUSSION.
- HIV TRANSMISSION GAME.

Psychoeducative presentation

This session will increase participant's knowledge about risk behaviour and related harm. By the end of the session participants will have a clear understanding of the key issues related to problem drug use. Problem drug use can be associated with a number of harmful consequences being infectious diseases among the most serious health consequences related to drugs.

The therapist can introduce here the activity 3.1.

Infectious diseases

HIV/AIDS

The abbreviation **HIV** stands for "Human Immunodeficiency Virus". Human means that this is a form of a disease appearing only in human beings. The term immunodeficiency refers to a decline in the ability of the immune system to protect the body against infections or other diseases.

The abbreviation AIDS stands for "Acquired Immunodeficiency Syndrome". Acquired means that the deficiency can be contracted at any point in life and is not congenital. The term immunodeficiency again refers to the decline in the ability of the immune system to protect the body against infections or other diseases. The term syndrome refers to a series of signs and symptoms of the disease.

What is the difference between HIV and AIDS?

An infection with the HI virus leads, after a certain time (that can be up to several years or decades) to the disease AIDS.

General information on HIV:

- Injecting drugs use is a contributor to the spread of HIV/AIDS.
- Rates for HIV/AIDS are significantly higher for prisoners.
- HIV can be transmitted via infected blood or sexual contact and from mother to child.
- Unlike infections such as hepatitis B and C, a comparably higher amount of viruses is needed for infection with the disease, i.e. a person must be exposed to a certain amount of viruses in order to get infected.
- The HI virus can only survive outside the human body for a limited period of time.
- There is no natural or acquired resistance against the HI virus: anyone can become infected.

- New-born children are more sensitive to the virus due to the lack of maturity of their immune system.
- Despite better medication and success in therapy, HIV/AIDS is treatable but not curable and an HIV-vaccine is still at a research level.

Hepatitis

Hepatitis is a general term meaning inflammation of the liver. In most cases, it is a viral infection that attacks the liver. Viral hepatitis can be caused by a variety of different viruses such as hepatitis A, B, C, D and E. Each type of hepatitis is transmitted and treated differently. Hepatitis affects the liver and negatively influences its function with sometimes serious health consequences such as liver cirrhosis and liver cancer.

A common and often the first symptom of liver diseases is when the skin turns yellow and the whites of the eyes become bright yellow-orange (jaundice).

- The most common ways in which hepatitis B, C is transmitted are as follows:
- Unprotected sexual contact.
- Sharing of injecting equipment by drug users.
- Sharing tattooing/piercing equipment.
- Using contaminated and non-sterilized medical instruments.
- Sharing objects used for personal hygiene, like razors, nail files, but also toothbrushes that might be infected with blood from small wounds in the mouth.

Transmission during pregnancy to the foetus does not occur. Mother-to-baby transmission during birth is uncommon for hepatitis C, but very common for hepatitis B. Vaccinating a new born child of a hepatitis B-positive mother within the first 12 hours after birth can reduce the risk of an infection by 95%.

Activities without risk of transmission of the infection include: use of toilets, goughing, sneezing, hugging, sharing eating utensils or drinking glasses, shaking hands, caresses. There is a small risk of transmission of hepatitis B by kissing.

Other health problems

Besides blood-borne viruses, poor hygiene when injecting drugs as well as the injection of contaminated drugs and using contaminated injecting equipment may lead to bacterial infections. Local infections like abscesses are common among injecting drug users.

Overdose

Opioids are most often associated with drug related deaths but it also occurs with other drugs and alcohol. Consumption of drugs like amphetamines, methamphetamines, ecstasy and cocaine can lead to life threatening and serious emergencies.

Other drug related harm

Other drug related harm include mental health problems, economic problems, social problems, family break-down, neglect of children, open drug scenes (i.e. public places where drug user congregate) affecting real and perceived safety of people, drug related crime, imprisonment.

Group dynamics and materials

3.1. Risk behaviours

Goals

To raise awareness about risk behaviours in the prison setting.

Materials

Paper sheets, pencils, flipchart/board.

Guide for the exercise

Split participants into small groups and ask them to write down on paper risk behaviours in the prison setting that can lead to the transmission of HIV. If necessary, provide an example. Ask the small groups to present their results.

Write down the answers on the left side of a flipchart. Respond to incorrect answers by stating the correct ways of HIV transmission. Respond to answers not relevant to the prison setting, but remind participants only to refer to risk behaviours within prison.

Risk behaviour that can lead to the spread of infectious diseases in prison includes:

- Sharing injection equipment.
- Unprotected sexual activity.
- Sharing tattooing needles.
- Body piercing.

3.2. HIV transmission

Goals

To use a simple experiment to sensitize participants to the ways of HIV is transmitted, misconceptions about HIV and protection mechanisms.

Materials

Cards for each participant: 3 of them marked with a small "X" on their back, one with the letter "P" and one with the letter "O", the rest of the cards blank; pencils.

Guide for the exercise

Provide each of the participants with a card and a pencil, without giving any further details.

Provide the participant that was given the card with the letter "O" with a little note saying "Do not shake hands with anyone". (Discretely) communicate with that participant that s/he should avoid by all means shaking hands with other people.

Ask the participants to take their cards and pencils and to move around the room and shake hands with at least three different people. Every time a participant shakes hands with someone, s/he will ask that person to sign on his/her card and they will sign in turn on theirs, without seeing what is written on the back. After some minutes, ask participants to go back to their seats.

Now ask those participants who had the "X"-marked cards, to stand up. Explain that the three of them symbolize someone that is HIV infected. Ask all those people who have shaken hands with these three (and have their signature on their cards) to stand up as well. Finally, ask all the people sitting on their chairs who have the signatures of those standing up to stand up as well. At the end of the exercise most participants will be most likely standing up.

Tell the participants that the handshake symbolized unprotected sexual contact. Ask who has the "P"- marked card. Explain that that person was not at risk of getting infected with HIV because s/he had used protection, so invite this person to sit down. All those who are standing up may be infected with HIV.

State that there was a person in the group who did NOT shake hands with anyone and tell them that anyone had the right to refuse doing that, even if they were not instructed to do that.

Now, ask participants to reflect on the exercise and pose the following questions. Try to direct participants towards the answers given below.

What conclusions can be drawn from this exercise?

- The HIV virus can be easily transmitted.
- One cannot tell whether a person is HIV-infected or not just by the way they look.
- The use of a condom during sexual contact may cut down the risk of HIV infection.
- Sexual contact with only one person poses an equal risk of contracting HIV as it would by having sexual contact with all that person's previous partners ("when you sleep with one person, it is as if you were sleeping with all the partners he/she had before you").

How could the risk of HIV infection have been prevented?

- Participants could have refused to shake hands with the others (abstinence).
- Participants could ask to see what was written on the card of those they had shaken hands with in order to check if they had a "clean" card (HIV test).
- Participants could have shaken hands with only one person (fidelity).

SESSION 2

Goals

- TO INCREASE PARTICIPANT'S LITERACY ABOUT HEALTHY HABITS (EATING, PHYSICAL ACTIVITY AND SLEEP).
- TO LEARN SOME STRATEGIES TO MANAGE THEIR PERSONAL HEALTH EFFECTIVELY.

Activities

- FIVE CHANGES IN MY EATING HABITS.
- MY PERSONAL FITNESS PROGRAM.

Psychoeducative presentation

NOTE

In this unit, basic general information regarding healthy habits is presented. As mentioned in previous units, this information can be complemented with other sources of information and materials.

Healthy eating

Healthy eating is consuming the right quantities of foods from all food groups in order to ensure an individual's body is appropriately nourished and capable of functioning appropriately, dependent on lifestyle and activity levels. Healthy eating is vital for a person's mental and physical wellbeing.

Get a variety of nutritious foods and beverages

Eating a variety of foods and beverages is very important. It helps you get the range of nutrients you need to be healthy.

Eat a mix of foods across all food groups (vegetables, fruits, grains, dairy, and proteins — not just 1 or 2 of them).

Try to eat and drink the right amounts for you

How many calories you need to eat depends on your age, sex, height, weight, and how active you are.

Limit foods and beverages higher in saturated fats, added sugars, and sodium

Aim to get:

- Less than 10% of calories each day from saturated fats.
- Less than 10% of calories each day from added sugars.
- Less than 2,300 milligrams of sodium each day.

Here there are some tips for healthy eating habits:

- Eat regularly, three main meals with one or two small snacks daily.
- Watch your portion sizes.
- If eating out, choose either a starter or a dessert with a main meal, not both.

- Eat slowly, chew your food and swallow each bite before taking another.
- Pause and put down your knife and fork in the middle of a meal.
- Always sit down when eating.
- Avoid eating when watching T.V., reading or listening to the radio.

Physical activity

How do I do it?

It's your choice. Pick an activity that's easy to fit into your life. Do at least 10 minutes of physical activity at a time. Choose aerobic activities that work for you. These make your heart beat faster and can make your heart, lungs, and blood vessels stronger. Also, do strengthening activities that make your muscles do more work than usual.

How many times a week should I be physically active?

It is up to you, but it is better to spread your activity throughout the week and to be active at least 3 days a week.

How do I build up more physical activity?

Do a little more each time. Once you feel comfortable, do it more often. Then you can trade activities at a moderate level for vigorous ones that take more effort. You can do moderate and vigorous activities in the same week.

Some recommendations (some relate to post release period):

	MODERATE ACTIVITY	VIGOROUS ACTIVITY
Type of Activity	Walking briskly, biking on flat ground, line dancing, gardening.	Jumping rope, basketball, soccer, swimming laps, aerobic dance.
Amount	If you choose activities at a moderate level, do at least 2 hours and 30 minutes a week.	If you choose activities at a vigorous level, do at least 1 hour and 15 minutes a week.

Healthy Sleep Habits

Your behaviors during the day, and especially before bedtime, can have a major impact on your sleep. They can promote healthy sleep or contribute to sleeplessness.

Your daily routines – what you eat and drink, the medications you take, how you schedule your days and how you choose to spend your evenings – can significantly

impact your quality of sleep. Even a few slight adjustments can, in some cases, mean the difference between sound sleep and a restless night.

The term "sleep hygiene" refers to a series of healthy sleep habits that can improve your ability to fall asleep and stay asleep.

Quick Sleep tips

Follow these tips to establish healthy sleep habits:

- Keep a consistent sleep schedule. Get up at the same time every day, even on weekends or during vacations.
- Set a bedtime that is early enough for you to get at least 7 hours of sleep.
- Don't go to bed unless you are sleepy.
- If you don't fall asleep after 20 minutes, get out of bed.
- Establish a relaxing bedtime routine.
- If possible , use your bed only for sleep.
- Limit exposure to bright light in the evenings.
- Turn off electronic devices at least 30 minutes before bedtime.
- Don't eat a large meal before bedtime.
- Exercise regularly and maintain a healthy diet.
- Avoid consuming caffeine in the late afternoon or evening.
- Avoid consuming alcohol before bedtime.
- Reduce your fluid intake before bedtime.

Group dynamics and materials

3.3. Five changes in my eating habits

Goals

To make the participants think about healthy eating habits that can be carried out either in prison or in freedom. Once the reflection is foreseen, develop your own catalog of healthy eating habits.

Materials

Paper sheets, pencils, flipchart/board.

Guide for the exercise

Ask the participants to write down on a paper 5 small changes they can carry out to make their eating habits healthier. If necessary, provide an example. Ask the participants to present their results.

Write down the answers on a flipchart/board.

With all the answers elaborate a catalogue of healthy eating habits that they can put into practice. You can make two columns one for the prison setting and another one for freedom.

3.4. My personal fitness program

Goals

To establish a commitment to oneself in relation to the initiation and maintenance of a continuous physical activity.

Materials

Annex 3.4.

Guide for the exercise

Split the group into pairs. A member of each pair will act as a counselor and through questions will try to complete the information requested in the document helping the person to establish their goals. Once the information is completed, the person will sign it the contract. Then the roles change and the patient act now as the "counselor".

Annex 3.4. My personal fitness program

PERSONAL FITNESS PROGRAM PLAN AND CONTRACT

A. I, _____, am contracting with myself to follow a physical fitness program to work toward the following goals:

1. _____

2. _____

3. _____

4. _____

5. _____

B. My program plan is as follows:

ACTIVITY	FRECUENCY (CHECK ✔)							INTENSITY	TIME
	M	TU	W	TH	F	SA	SU		

C. My program will begin on (date)_____. My program includes the following schedule of minigoals. For each step in my program, I will give myself the reward listed.

Minigoal 1_____Date_____ reward_____

Minigoal 2_____Date_____ reward_____

Minigoal 3_____Date_____ reward_____

D. I sign this contract as an indication of my personal commitment to reach my goal.

Date and signature_____

SESSION 3

Goals

- TO VALUE AN ACTIVE AND POSITIVE CONCEPT OF LEISURE AS BALANCING FACTOR IN A HEALTHY SYSTEM OF LIFE.
- TO TURN LEISURE AND FREE TIME INTO INSTRUMENTS FOR ENRICHMENT AND PERSONAL DEVELOPMENT.
- TO HELP THE PARTICIPANTS FILL THE FREE TIME THEY PREVIOUSLY DEVOTED TO ADDICTION-RELATED BEHAVIORS WITH POSITIVE LEISURE ACTIVITIES.

Activities

- PLANNING AN ENOYABLE LIFE.
- LEISURE TIME MANAGEMENT.

Psychoeducative presentation

Drug use and free time

Many addicts end up living situations in which they either have excessive free time (they do not work, eat little and badly and sleep worse) or they do not have free time at all (14-hours work days, working week-ends,..). In both situations the addict devotes a long time to behaviors surrounding their addiction and, when abstinence is established, that time remains empty and they do not know how to fill. That invites boredom, apathy and, in many cases, relapse due to the fact that one of the consequences of addictions is the lack of vitality.

The amount and quality of leisure time is important for people's well-being due to the direct satisfaction it brings. Additionally, leisure, taken in certain ways, is important for physical and mental health. Leisure also contributes to the well-being of people other than the person directly enjoying it. When a person engages in positive leisure activities, the benefits gained are shared with others in a multitude of ways, including improvements in personal relationships or family functioning.

When talking about leisure and free time it is necessary to differentiate both concepts. Thus, **free time** would be the amount of time that is not used to work, eat or sleep. It has a virtual capacity because it is time available that the subject can use properly or waste it.

If it is used creatively to enjoy, develop your own capacities, promote your personal balance and enrich your personal experience becomes **leisure**. Leisure would then be the free time that we devote to what we like and to our psychological growth.

Taking into account the above mentioned definitions, we must then banish the idea of that "leisure is doing nothing" because, rather, leisure implies activity but activity aimed at improving the individual and their ability to enjoy.

It is important for you to put some interesting activities in your life, to find fun things to do that can take the place of substance use. You might try returning to old activities you used to enjoy before you started using substances or gambling.

The therapist can introduce here the activity 3.5.

New activities and hobbies are an excellent way to support your recovery while you meet new people. You can take a class, learn a new skill, try your hand at making art, take up a new sport, do volunteer work, or try out other new interests. Ask your friends about hobbies that they enjoy. See about adult classes; consult your local

community's directory for listings of activities and classes. Check the newspaper for lectures, movies, plays, and concerts.

It is important to remember that not all new activities will be fun right away. It may take a while before you can really enjoy a new activity or become proficient at a new skill. Old activities that you enjoyed may not feel the same after you're abstinent or in recovery. Regardless of how new or old activities feel, you need to make them part of your life.

Time management: the importance of schedule activities

Managing your time is a skill that —when done effectively— can decrease the sensation of overwhelming through the development of a strategy to manage the various tasks that often build up day-to-day. Learning to schedule activities and staying busy is important for several reasons. Often relapses begin in the head of a person who has nothing to do and nowhere to go.

A small amount of unstructured time is not bad. But when there is too much unstructured time that is not balanced by healthy activity, then it produces several negative effects. These effects include: boredom, inappropriate behaviours which can lead to involvement in harmful activities, poor physical health and appearance, lack of friends, etc.

Group dynamics and materials

3.5. Planning an enjoyable life

Goals

To make the participants reflect about their free time and leisure.

To identify what the participant is presently doing and has in the past done for their leisure.

Materials

Hand-out "Planning an enjoyable life". Annex 3.5.

Guide for the exercise

Ask the participants to complete the document.

When document is completed, you may find clues on activities that can be restarted or areas which have not been explored. You can help the participants to identify the barriers to start or resume an activity and how to overcome them.

Annex 3.5. Planning an enjoyable life

PLANNING AN ENJOYABLE LIFE
1. Write three activities that you used to enjoy and that you no longer engage in.
2. Write three activities that you currently enjoy and would like to do more often.
3. Write three activities that you engage in and want to stop.
4. Write three activities that you have not done but would like to start.

3.6. Leisure Time Management

Goals

To be aware of your leisure time and avoid unstructured time.

To help participants plan time to devote to leisure interests.

Materials

Hand-out "Leisure time management" (Annex 3.6.).

Guide for the exercise

Color each box a different color. For example: you can use red for prison school or work, black for sleep, green for exercise, blue for workshops, orange for eating, and yellow for other (adapt to their own activities).

Annex 3.6. Leisure Time Management

TIME	SUN.	MON.	TUE.	WED.	THURS.	FRI.	SAT.
6.00							
7.00							
8.00							
9.00							
10.00							
11.00							
12.00							
13.00							
14.00							
15.00							
16.00							
17.00							
18.00							
19.00							
20.00							
21.00							
22.00							
23.00							
24.00							

SESSION 4

Goals

- TO LEARN WHEN AND HOW TO USE BASIC ANXIETY MANGEMENT SKILLS.
- TO LEARN TO BREATHE IN WAYS THAT WILL PROMOTE CALM AND RELAXATION.
- TO LEARN A MUSCLE RELAXATION TECHNIQUE.
- TO LEARN THE PRINCIPLES AND PRACTICE OF MINDFULNESS.

Activities

- SLOW DIAPHRAGMATIC BREATHING PRACTICE.
- PROGRESSIVE MUSCLE RELAXATION PRACTICE.
- MINDFULNESS PRACTICE.

Psychoeducative presentation

The Link between stress/anxiety and Substance Abuse

Numerous studies have linked anxiety and stress to alcohol and drug addiction. In fact, chronic stress is a well-known substance abuse risk factor. Not only do anxiety and substance abuse happen to frequently be found together, but that anxiety may cause substance abuse – there may be causation as well as correlation.

Studies also suggest that stress levels also contribute to the success of substance abuse recovery. This is likely because the cravings and compulsions of a person in recovery can manifest themselves as stress, thus becoming a trigger for relapse.

In this session, we will learn some **Basic Anxiety Management Skills**. You can think of each skill as a tool that you need to develop in order to help manage your anxiety. It`s important to remember that these skills work like any other skill set; in order to get the most out of these tools you need to practice them.

Do you know how to drive a car? Think about learning how to drive. When you first get behind the wheel of a car there are so many things to keep in mind: the steering wheel, a whole bunch of mirrors, the back window, signals, traffic around you… It's very difficult to keep all of these different things in your working memory at once.

Now think about driving after practicing for a long time. You can get from point A to point B without even thinking about it. It becomes much easier because the skill set of driving moves from your working memory (which is very limited!) to your long-term memory (which is very vast!). It becomes automatic. Learning Basic Anxiety Management Skills follows the same principle. In the beginning, these skills are awkward and difficult and may not seem all that helpful but in time it gets easier, more automatic, and more effective.

It is important to practice the following Basic Skills when your stress isn't at its highest (when you're on "the back roads" instead of on "the highway"), and to maintain a consistent practice in order to make these skills more automatic and more effective. Practicing during "down times", or when our body is not at a high level of stress, helps make the techniques routine, and will have a greater effect on decreasing the anxiety reaction when you actually need it!

Breathing Skills

Slow diaphragmatic breathing is a developed technique that involves slowing down the breath to communicate "safety" to the brain.

While we do not recommend that you use breathing techniques to try to eliminate anxiety when you are feeling anxious, it can be a way to get through a tough situation and calm the body some so that we can make a good decision about what to do next.

The therapist can introduce the exercise 3.7. This first practice will be guided. The participants will receive a handout (annex 3.7 to practice it every day on their own).

Relaxation Skills

One of the more discrete changes that happen in our body when we are stressed or anxious is muscle tension. One way to think about relaxation is that it is the absence of tension in the body's muscles because deep muscle relaxation is incompatible with our body's anxiety response. **Progressive Muscle Relaxation (PMR)** created by Jacobson, a Chicago physician, in the 1920´s shows that by consciously working to reduce muscle tension, we can actually influence how anxious we feel.

The aim of PMR is to gradually learn to release tension in the muscles through daily exercises. This communicates calm and safety to our body, reducing the body's need to activate the "fight or flight" response.

The therapist can introduce the exercise 3.8. This first practice will be guided. The participants will receive a handout (annex 3.8 to practice it every day on their own).

Mindfulness

Mindfulness is non-judgmental, purposeful attention to the present moment. This may seem simple enough, but take a moment to reflect on how often you find yourself doing some sort of mundane activity —like having a shower or walking to class— where you realize that you are "on autopilot", "a million miles away", "off in space", or just not really paying attention to what you're doing.

Mindfulness is an important tool for anxiety management because it teaches us to observe our thoughts. Thoughts are critical in anxiety; they happen all of the time and are difficult to control. Mindfulness works by allowing us to view our thoughts in a more objective, or non-judgmental way. Mindfully noticing our thoughts can be looked at as the first step in recognizing the connection between our thoughts and our feelings or our behaviours, and also as a way to minimize the impact of negative emotions attached to harmful or anxious thoughts.

Why should I practice mindfulness?"

- Trying to "control" the mind is a futile endeavor. In fact, trying to control the mind often makes us feel worse, because we keep failing at it!
- Mindfulness helps us practice observing but not reacting to anxiety and other emotions. We learn to accept or tolerate these emotions, rather than trying to eradicate them.
- When we stop and pay attention to the present moment, we listen to our anxiety "alarm." If we give it time and keep from "fueling" the anxiety, the body can eventually learn that it does not need this alarm any longer, so it can turn it off.

The therapist can introduce the exercise 3.9. This first practice will be guided. The participants will receive a handout (annex 3.9 to practice it every day on their own).

Group dynamics and materials

3.7. Slow diaphragmatic breathing

Goals

To learn a simple breathing technique to manage anxiety.

Materials

Annex 3.7.

Guide for the exercise

Follow the instructions in annex 3.7.

Annex 3.7. Slow diaphragmatic breathing

"SLOW DIAPHRAGMATIC BREATHING"
1. Sit comfortably in a chair with your feet on the floor. You can lie down if you wish.
2. Fold your hands on your belly.
3. Breathe in slowly and calmly. Fill up the belly with a normal breath. Try not to breathe in too heavily. The hands should move up when you breathe in, as if you are filling up a balloon. Avoid lifting the shoulders as you inhale; rather, breathe into the stomach.
4. Breathe out slowly to the count of "5." Try to slow down the rate of the exhale. After the exhale, hold for 2-3 seconds before inhaling again.
5. Work to continue to slow down the pace of the breath.
6. Practice this for about 10 minutes.
7. This works best if you practice this two times each day for 10 minutes each time. Try to find a regular time to practice this each day.

TIPS

1. The speed of the breath is more important than the depth of the breath. Avoid trying to "catch" your breath by taking really deep breaths.
2. Don't use breathing exercises to "get rid of" the anxiety; use the breath to help get you through a tough situation, or practice it daily to "train in" a slower, calmer breathing style over time.
3. Practice! It takes time to learn how to calm the body using the breath.

3.8. Progressive Muscle Relaxation

Goals

To learn a set of exercises aimed at helping us reduce anxiety and tension in the body.

Materials

Annex 3.8.

Guide for the exercise

Through the practice of tensing and relaxing groups of muscles, we learn to feel the difference between tension and relaxation and release muscle tension when we feel it. It works best if practiced regularly. As with any skill, relaxation takes time and practice to master.

This practice can be complemented with other relaxation techniques in imagination for example *Autogenic training* developed by Schultz.

Follow the instructions in annex 3.8.

Annex 3.8. Progressive Muscle Relaxation

Before You Begin

1. **Pick a spot**. Find a quiet, private spot where you can practice this exercise. As this exercise typically takes about 15–30 minutes, you want to find a place where you will likely not be disturbed for this length of time.

2. **Get comfortable**. Ideally, you want to be seated in a comfortable chair that can support your legs, arms, head, and neck. It is also possible to practice PMR when you are lying down, but make sure that you are not practicing in your bed (according to rules of sleep hygiene, your bed is only for sleeping!

3. **Set a timer**. Make sure to set an alarm in order to remove the need to worry about keeping track of time. If you are really prone to worrying, set two alarms!

Getting Started

4. **Tensing**. In order to truly relax each muscle group, you will first need to tense it as hard as you can. This is so that your body can recognize the contrast between tense and relaxed muscles. You will go in order from the tip of your toes to the top of your head (see in next page a full list of the muscle groups to focus on in your PMR exercise). Make sure that you are isolating your tension to only one muscle group at a time; don't let the tension seep into another muscle group. For example, if you are tensing your chest, make sure that your shoulders are not creeping up to your ears. Watch that your jaw is not tensing with other muscle groups, as well (it has a tendency to do that!).

As you tense each muscle group, focus on all of the sensations your body creates. Does it feel warm? Cold? Does the muscle feel strong? Is the muscle shaking? Does it feel pleasant or not so nice? Stay with all of the feelings. Remember to squeeze as hard as you can for the entire time you are tensing the muscle group, but not so hard that it causes serious pain or injury. Continue to hold the tension for about 10 seconds.

5. **Relaxing**. Once you are done tensing, completely let go of all tension. Let that body part drop back down or feel that body part sink deeper into the chair/couch/

floor that it's resting on. Imagine that all of the tension is flowing out of that muscle group like water (e.g., picture the tension dripping from your fingertips, or flowing down your legs to the floor). Focus on the new sensations that your body creates as the tension seeps out of that muscle group. See if you can contrast the feelings of relaxation with the sensations you experienced when the muscles were tense. What temperature is the muscle group now? Continue to release all tension for about 15 seconds (longer than the time you tensed it).

6. **Repeat**. Follow the same format for each muscle group in order from your toes to your head. Use the list below, and tense each muscle group one at a time. Remember to keep the tension isolated just to a single muscle group.

7. **Final check**. Once you've gone through flexing and relaxing all of the muscle groups, scan your body one last time. Is there any area that is still holding tension? If so, repeat the tensing and relaxing procedure a final time on those muscle groups. Once all of your body is feeling relaxed, take the remainder of your 15-30 minutes to sit with this sensation of full-body relaxation.

LIST OF MUSCLE GROUPS

1. **Toes and feet**. Tense the toes by curling them down into the bottom of your foot and rolling your ankles to point your feet as far down as your can.
2. **Calves** (lower legs). Flex your toes and ankle upward, as if you are trying to reach your calves with the tip of your toes.
3. **Thighs** (upper legs). Squeeze the muscles in your thighs as tightly as you can.
4. **Glutes** (buttocks). Pull your glute muscles towards each other. You should notice you are rising in your seat.
5. **Lower back**. Arch your back by tilting your pelvis forward, focusing on your low back. Note that this step should be skipped if you have chronic low back pain.
6. **Stomach**. Suck your stomach in; try to pull your bellybutton back to touch your spine.
7. **Chest.** Take a big, deep breath into your chest; puff out your ribs.
8. **Shoulders**. Pull your shoulders up and back; try to touch your ears with your shoulders without moving your neck.
9. **Biceps** (upper arm). Draw your fists up towards your shoulders, bending at the elbow. Squeeze the muscles in your biceps as tightly as you can.
10. **Triceps** (lower arm). Stretch your arms out and lock your elbows; reach your triceps up to the ceiling without moving your arms up.
11. **Wrist and hands**. Tighten your hands into a tight fist; draw your wrist up and back as if you're trying to touch your wrist with your knuckles.
12. **Neck.** Push your head into whatever your head is laying on as hard as you can. Note that this step should be skipped if you have chronic neck pain.
13. **Jaw**. Open your mouth as wide as you can, stretching your jaw out as much as you can.
14. **Face**. Scrunch your face up as tightly as you can. Purse your lips, scrunch up your nose, close your eyes as hard as you can, and scrunch down your eyebrows as far as they will go.

3.9. Mindfulness practice

Goals

To practice a basic mindfulness exercise.

Materials

Annex 3.9.

Guide for the exercise

Follow the instructions in annex 3.9.

Annex 3.9. Mindfulness practice

Mindfulness Exercise

1. Sit quietly with your feet on the floor, or lie down, and relax your body. Begin with some slow, diaphragmatic breathing. Focus your mind on your breath as it flows in and out of your nostrils. Continue to follow your breath to whatever extent you can.

2. As you breathe, notice the tendency of the mind to wander. Instead of trying to focus just on the breath, just notice what the mind does. It may wander to a worry, or a memory, or to what you plan to do later today. You may notice sensations in your body, such as a pain or itch. You may hear or smell things. Just notice whatever happens and then gently bring yourself back to your breath. You can remind yourself that you will tend to these other things later, and for now you will just spend time paying attention to your breath and to your mind.

3. Allow the mind to wander as it will, time after time. Avoid the tendency to try hard to focus on something. Simply allow your mind to wander and then bring yourself back to your breath. Notice the tendency of your experience to change. Imagine that each thought, sensation, emotion— anything— is like a cloud floating through the sky, soon to be replaced by another one.

4. Continue to practice this for about 10 minutes. Depending on your schedule you can add time to your practice if you want. Practice once or twice a day.

5. Remember that there is no "right" way to do this, other than to just notice whatever comes into your consciousness. It is impossible to "fail" at mindfulness—just let your mind wander!

HAVING TROUBLE GETTING "MINDFUL?"

Try this: pretend your mind is like a movie screen. You are sitting in the movie theater, observing what is projected on the screen, but you are not in control; you just watch and follow what you see.
Try closing your eyes and just notice what images, thoughts, or memories get projected on that screen. They may be related or not —whatever gets projected is fair game!
If you start feeling attached to the content of the "movie," just notice that attachment and then let the movie continue to something else.

PATHWAY II. DISHABITUATION AND RELAPSE PREVENTION

PRESENTATION AND MOTIVATION

1. Introduction

In the first unit of the program we will work in orientating the participants on the program giving them information on the contents of the intervention and explaining what the objectives of the program are. In addition, we will try to make them an active part of the intervention and change process by asking them to establish their own group rules and their goals of change.

We must bear in mind that this is a sensitive moment; the participants do not know each other, they can be anxious and resistant to the intervention. Therefore, it is very important that the therapist creates a work environment that fosters empathy among the participants, establish rapport/alliance/connection with each person that will allow them to increase their understanding of the treatment process and increase their motivation to learn about and work on change.

It is necessary to create a safe and welcoming group environment in which addiction can be discussed non-judgmentally.

This unit is distributed in 2 therapeutic sessions.

2. Therapeutic goals

1. To create an adequate work environment and foster group cohesion.
2. To present the modules that form the program and the methodology that will be used in the sessions.
3. To clarify the general objectives of the program, disclaiming erroneous and false expectations.
4. To reflect on the need for change and on the positive consequences of that change but also on the difficulties of the process.
5. To work on personal values and building discrepancy between those values and their addictive behaviour.
6. To set personal goals for each participant.

SESSION 1

Goals

- TO GET TO KNOW THE MEMBERS OF THE GROUP.
- TO FOSTER GROUP COHESION.
- TO BE FAMILIAR WITH THE REHABILITATION PROGRAM CONTENTS.
- TO ENHANCE MOTIVATION TO THE REHABILITATION PROCESS.

Activities

- INTRODUCE YOUR PARTNER.
- MOTIVATIONAL SHORT STORIES.

Psychoeducative presentation

The therapist, after a brief introduction of themselves, welcomes everyone to the group and tells the group members that they will introduce themselves (first names only).

Subsequently, the overall objective of the program will be explained requesting feedback from the participants. For example: what do you think about it? How do you see it?

After this, the therapist and the members of the group introduce themselves using the proposed introduction in exercise 1.1.

In these moments it is important that the professional insists and clarifies his role in the group. Let them know that their task is to help achieve positive changes, that is, help achieve those objectives and goals that are important for the participants.

To increase participants' motivation and to help them to understand the rehabilitation process, the therapist can introduce here the exercise 1.2.

Then the different units that will be worked during the intervention and the methodology to be used will be presented (days of the week in which there will be sessions, duration, structure of the sessions, methodology,...). All the doubts and questions should be clarified.

Finally, we will ask participants to add, to the general rules of the program (annex 1.3), the rules that they consider important to create a safe work environment. This exercise can help them to reduce resistance and increase the compliance of the rules thanks to the identification with them.

Group dynamics and materials

1.1. Introduce your partner

Goals

To make possible that the members of the group get to know each other.

To foster group cohesion.

To "break the ice".

Materials

None.

Guide for the exercise

Participants are sitting in pairs.

They should get to know each other by asking any questions they like. A time limit, such as 15–20 minutes is assigned. Examples of questions: What's your name? Where are you from? What do you like to do in your free time?

When everyone is finished, each participant introduce their partner to the rest of the group. They can give as much information as they want or, depending on the time, we can limit their talking time by saying something like, "Tell us three interesting things that you learned about your partner."

1.2. Motivational short stories

Goals

To foster the motivation of the members of the group. To reflect on the importance of the program for themselves.

Materials

Annex 1.2

Guide for the exercise

The participants read the two stories proposed and debate. The therapist can provoke the group discussion. Some questions that could be asked would be:

- What do these stories tell us?
- What is the moral of the stories?
- What does this have to do with your problem?
- What does this have to do with the rehabilitation program?

Annex 1.2. Motivational short stories

BUDDHA AND THE FARMER WITH 83 PROBLEMS

There is an old story about a man who came to see the Buddha because he had heard that the Buddha was a great teacher. Like all of us, he had some problems in his life, and he thought the Buddha might be able to help him straighten them out. He told the Buddha that he was a farmer.
"I like farming," he said, "but sometimes it doesn't rain enough, and my crops fail. Last year we nearly starved. And sometimes it rains too much, so my yields aren't what I'd like them to be."
The Buddha patiently listened to the man.
"I'm married, too," said the man. "She's a good wife… I love her, in fact. But sometimes she nags me too much. And sometimes I get tired of her."
The Buddha listened quietly.
"I have kids," said the man. "Good kids, too… but sometimes they don't show me enough respect. And sometimes…".
The man went on like this, laying out all his difficulties and worries. Finally he wound down and waited for the Buddha to say the words that would put everything right for him.
Instead, the Buddha said, "I can't help you".
"What do you mean?" said the man, astonished.
"Everybody's got problems," said the Buddha. "In fact, we've all got eighty-three problems, each one of us. Eighty-three problems, and there's nothing you can do about it. If you work really hard on one of them, maybe you can fix it – but if you do, another one will pop right into its place. For example, you're going to lose your loved ones eventually. And you're going to die some day. Now there's a problem, and there's nothing you, or I, or anyone else can do about it".
The man became furious. "I thought you were a great teacher!" he shouted. "I thought you could help me! What good is your teaching, then?".
The Buddha said, "Well, maybe it will help you with the eighty-fourth problem".
"The eighty-fourth problem?" said the man. "What's the eighty-fourth problem?".
Said the Buddha, "You want to not have any problems".

THE "WADE THROUGH THE SWAMP" METAPHOR

Suppose you love mountain climbing and one day you set out to summit a peak you've been admiring for years. But when you get close to the mountain's base you discover it's completely surrounded by a swamp. This is a big surprise. No one told you about it. Now you'll have to trudge through this icky mess before you can even start your climb.
You don't like this situation, but you decide to suck it up and wade through the swamp because getting to the top of this mountain really matters to you.
All of us have things that are important to us: families, careers, causes. However, we inevitably have times when we face negative emotions related to these things: fear for our loved ones, uncertainties about our careers, and anger towards those who don't support our causes.
But if these things really matter to us we persevere. We understand that sometimes we have to wade through the swamp of negative emotions to get to the mountain top.
Don't let unpleasant emotions stop you. They're part and parcel of living a full life.

Annex 1.3. Ground rules

GROUND RULES
1. As a group, we will maintain the **confidentiality** of each member. What is shared in group will stay in group.
2. I will attend group with an open attitude and **willingness** to participate and be a part of the group.
3. I will **allow others to express** their thoughts and feelings without trying to solve their problems, interrupt them, or change the subject in order to avoid uncomfortable topics.
4. As group members, we may disagree, but we will accept and **respect** each other. We understand the importance of maintaining an atmosphere of trust and respect for each individual in the group.
5. I won't use **physical or verbal violence** against other members of the group.
6. I understand the importance of **being sober** during the group. I will not attend the group under the influence of any substances.
7. _____
_____
8. _____
_____
9. _____
_____
10. _____
_____

SESSION 2

Goals

- TO ENHANCE THE NEED FOR CHANGE.
- TO EXPLORE MEMBERS' VALUES AND GOALS.
- TO DEVELOP A SENSE OF HOPE FOR THE FUTURE AN DEVELOP DISCREPANCIES WITH CURRENT CHOICES.

Activities

- BUILDING DISCREPANCY.
- LOOKING FORWARD.

Inter-sessions activities

- MY CHANGE PLAN.

Psychoeducative presentation

Personal values

Values are qualities or principles that people consider to be important and wish to personify. Your values represent what you view as most meaningful in life. Values often translate to the standards of behavior a person wants to demonstrate—to him- or herself, as well as to others. Our values help define the kind of person we want to be and the kind of life we want to live.

Everyone has values, or standards they believe in. However, sometimes we act in ways that do not match our values, because we forget about them, we get tired, or we are distracted by other things.

The following questions are intended to help us remember our values and share them with others.

What are some of your life settings or qualities which your consider as valuable?

For example, some people believe "do unto others as you would have them do unto you". Other people value telling the truth above all, or using their talents and energy to benefit others. Others see being a good friend or parent as an important value. Think of some values that are meaningful for you (leave some minutes to complete the task, then they share the answers with the group). To help participants clarify their values, a list of terminal and instrumental values based on Rockeach methodology has been included in the annex 1.7.

What gets in the way of living by your values? What would it take for you to live in a way that is closer to your most important values?

Active addiction usually takes people away from their values. In their quest to get what they want, be accepted by others, or just feel good or feel better, practicing addicts often go against their own values in ways that start out as subtle but become more blatant over time.

You may value honesty, but in order to continue to use alcohol and drugs and avoid the consequences, you have to be dishonest with your family, partner, employer, etc.

You may value responsibility, but the progression of active addiction renders you increasingly less capable of acting responsibly.

You may value being healthy and physically fit, but active addiction makes that less and less important.

When our actions are consistent with our values we participate in life in a way we can feel good about, regardless of external circumstances. Conversely, when our behavior violates our values it's almost impossible to feel good about ourselves—no matter the outcome or external circumstances.

The therapist can introduce here the exercise 1.4.

Now, we are going to look ahead to the past. First, let's start by putting ourselves back into childhood. I'd like you to think for a minute about what you wanted to be when you grew up. How did you imagine your life would be? What were your dreams about your future?

Even though we are adults, most of us still have dreams and hopes for the future. It may even be possible for you still to achieve some of those dreams.

Introduce the exercise 1.5.

Group dynamics and materials

1.4. Building discrepancy

Goals

To understand how current behavior may differ from ideal or desired behavior and values.

Materials

Pencils. Handouts of the worksheet "building discrepancy" (Annex 1.4).

Guide for the exercise

Complete the worksheet. Try to write at least one thing in each column in every area.

Annex 1.4. Building discrepancy

MY CAREER, SCHOOL OR PROFESSIONAL LIFE WILL BE AFFECTED...	
If I continue using...	If I quit using...
MY RELATIONSHIPS WITH MY FAMILY AND FRIENDS WILL BE AFFECTED...	
If I continue using...	If I quit using...
MY LONG-TERM GOALS WILL BE AFFECTED...	
If I continue using...	If I quit using...
MY FINANCES WILL BE AFFECTED...	
If I continue using...	If I quit using...
MY HEALTH WILL BE AFFECTED...	
If I continue using...	If I quit using...

1.5. Looking forward

Goals

To assist members to look forward and think about their possible futures. To develop discrepancy with current life and behavior.

Materials

Pencils. Handouts of the worksheet "looking forward" (Annex 1.5).

Guide for the exercise

Complete the worksheet. Then, the members will share their responses to the questions on the handout. Help the group to feel the emotional impact of their dreams.

Annex 1.5. Looking forward

Sometimes it is helpful to take time to look ahead in our lives. Having a picture of how we would like things to be can help us deal with the stress of everyday living, help us hang on in times of crisis or temptation, and help us structure our free time so that we move closer to our hopes and wishes.

1. What are some of your hopes for the future?
2. What are you doing now that's helping you to make these things come true?
3. What other things could you do (or do more of) to help your hopes come true?

Inter-session activities

1.6. My action plan

Goals

To develop a concrete plan to change one thing in the member's life.

Materials

Pencils. Handouts of the worksheet "My action plan" (Annex 1.6).

Guide for the exercise

Complete the worksheet for the next session.

Next session, group members share their plans. The therapist should reinforce at least one positive aspect of each person's plan.

Annex 1.6. My action plan

The changes I want to make (or continue making) are:
The reasons why I want to make these changes are:
The steps I plan to take in changing are:
The ways other people can help me are:
I will know that my plan is working if:
Some things that could interfere with my plan are:
What I will do if the plan isn't working:

Annex 1.7

VALUES LIST OF MILTON ROCKEACH

This classification system was based on the result of a survey of the social psychologist, Milton Rokeach that proposed a list including two sets of values, the *terminal* values and *instrumental* ones: **Terminal Values** refer to desirable end-states of existence; the goals that a person would like to achieve during their lifetime and may vary among different groups of people in different cultures. **Instrumental Values** refer to preferable modes of behavior.

These are preferable modes of behavior, or means of achieving the terminal values.

Terminal Values

- A world at Peace (free of war and conflict).
- Family Security (taking care of loved ones).
- Freedom (independence, free choice).
- Equality (brotherhood, equal opportunity for all).
- Self-respect (self-esteem).
- Happiness (contentedness).
- Wisdom (a mature understanding of life.
- National security (protection from attack).
- Salvation (saved, eternal life).
- True friendship (close companionship).
- A sense of accomplishment (a lasting contribution).
- Inner Harmony (freedom from inner conflict).
- A comfortable life (a prosperous life).
- Mature love (sexual and spiritual intimacy).
- A world of beauty (beauty of nature and the arts).
- Pleasure (an enjoyable leisurely life).
- Social recognition (respect, admiration).
- An exciting life (a stimulating active life).

Instrumental Values

- Ambitious (Hard-working, aspiring).
- Broadminded (Open-minded).
- Capable (Competent, effective).
- Cheerful (Lighthearted, joyful).
- Clean (Neat, tidy).
- Courageous (Standing up for your beliefs).

- Forgiving (Willing to pardon others).
- Helpful (Working for the welfare of others).
- Honest (Sincere, truthful).
- Imaginative (Daring, creative).
- Independent (Self-reliant, self-sufficient).
- Intellectual (Intelligent, reflective).
- Logical (Consistent, rational).
- Loving (Affectionate, tender).
- Obedient (Dutiful, respectful).
- Polite (Courteous, well-mannered).
- Responsible (Dependable, reliable).
- Self -controlled (Restrained, self discipline).

EMOTIONAL SELF-MANAGEMENT

1. Introduction

Emotions are part of our lives, both in positive and negative ways. An adequate management of emotions is considered to be a protective factor against several negative outcomes, like antisocial behaviour, psychopathology or drug use. Emotional self-management is an umbrella term that includes several internal processes that enable a person to know, recognise and adjust emotions. This includes personal emotions and the emotional life of other people. It involves at least four skills:

1. Self-awareness of the emotional state, and being able to identify and name these emotions.
2. Adjustment of emotional expression to the environmental circumstances.
3. Understanding of the role of emotions in the creation of intimate relationships.
4. Being able to experiment adequate emotions in certain situations.

Emotional self-regulation is developed since early childhood, both through personal experiences and vicarious learning. Through this learning experiences, we get to know what we are feeling, what other people is feeling, and how to control our emotions. When this process is successful, we grow up as stable adults with normal emotional lives. But if the process of emotional self-regulation is dysfunctional, this could lead to several adult problems. For instance, if a child is reared in a home with a violent father, he may learn that expressing anger in a violent way is something adequate to cope with interpersonal conflicts. Or if this child grows up in a home where emotional expression is forbidden and punished, he will become an adult with significant difficulties to create intimate relationships. Another relevant learning is how to cope with negative emotions. Adequate expression, social support or acceptance of emotions are adaptive coping skills. But negative emotions can also be managed in dysfunctional ways, for instance using drugs or alcohol.

2. Therapeutic goals

1. To increase participants' emotional awareness.
2. To link emotions with thoughts and behaviour.
3. To train effective emotional self-regulation skills.

SESSION 1

Goals

- TO INTRODUCE THE CONCEPT OF EMOTION.

Activities

- BRAINSTORMING.
- PERSONAL LIST OF EMOTIONS.
- THE JAR OF EMOTIONS.

Inter-sessions activities

- SELF-OBSERVATION.

Psychoeducative presentation

The nature of emotions

Through this unit we will try to increase our emotional self-awareness, this means to increase the attention that we devote to emotions and their influence in our lives. It is a first step in a process of self-knowledge that will help to cope better with your drug problem.

First, what are emotions? Emotions are feelings or moods that appear as a consequence of the way that we interpret a situation. It is an internal experience different from thoughts. Thoughts are in our heads, but emotions could be located in our whole body. Which emotions have you felt during your life? There are many different emotions, but some of them are considered to be basic and universal. These basic emotions are fear, rage, surprise, disgust, sadness and happiness. Some other relevant emotions are in Table 3.1.

Table 3.1. Essential emotions

HOPE	ATTRACTION	PLEASURE	RAGE	SADNESS	DISSAPOINTMENT
Attonishment	Relief	Love	Unhappyness	Depression	Nerveusness
Fascination	Pride	Fun	Envy	Fear	Concern
Entusiasm	Happyness	Passion	Suffering	Hate	Shame
Satisfaction	Compassion	Tenderness	Reject	Pain	Humiliation
Surprise	Happyness	Euphoria	Insecurity	Remorse	Regret

Positive and negative emotions

Some emotions are positive because they make us feel good. We all want to feel these emotions. Some others are negative, because experiencing them is unpleasable. But there are not good and bad emotions. Both positive and negative emotions are essential parts of our emotional life. If we lose a close relative, the normal and healthy reaction is to feel pain. We cannot expect to feel always positive emotions. That is not realistic nor healthy. Our goal is to feel emotions adequate to the situation that we are living, and to manage them in an appropriate way.

Emotions, thought and behavior

We usually say things like "I feel upset because something happened to me". We tend to associate emotions with external events. This is only true in some extend. Does everybody feel the same emotion in the same situation? Are there different responses in front of similar situations? There is one intermediate factor that mediates the relation between events and feelings: the thoughts. Depending on how we interpret a situation, we will feel in different ways. For example, if our girlfriend/boyfriend leaves us because he/she does not love us anymore we could think "this is terrible, the worst thing in the world". And, of course, we would feel sad and depressed. But we could think "ok, this is a sad thing, but I know that I can overcome this loss and go ahead with my life". Would you feel the same? Therefore, the way we think about the events in our life mediate how we feel about them.

Group Dynamics and materials

3.1. Brainstorming

Goals

To clarify the distorted ideas that participants may have about the concept of emotion.

Materials

A blackboard or flipchart.

Guide for the exercise

Participants will be asked **to explain what an emotion is** and to say all that they think about their characteristics. Probably they will confound emotions with thoughts and situations. The therapist should clarify these concepts, while writing all suggestions made by participants in a blackboard or flipchart. The therapist should pay attention to clarify incorrect uses of the term "emotion", keeping in mind that it is an abstract concept and that it will take some time to the participants to understand its meaning. The first activities of this unit are aimed to create an emotional vocabulary that will be useful through the rest of the program.

3.2. My personal list of emotions

Goals

To explore the past emotional life of the participants.

Materials

A blackboard or flipchart.

Guide for the exercise

Participants will be asked to draw a list with all the emotions that they remember to have experienced in their lives. Initially this list will be individual. Later, during group discussion, all emotions will be written in the blackboard/flipchart. Once the list is finished, the group can explore which relevant emotions were absent. For instance, the therapist could note the absence of common emotions like love or happiness. It is important to take some time to analyze the reasons for these absences. It is also interesting to analyze if emotions in the list are positive or negative. Participants should incorporate to their personal list those emotions that could arise during the group discussion which they may have forgotten to include in their first list.

3.3. The jar of emotions

Goals

To improve the emotional identification skills of the participants.

To help participants to recognize situations where they have felt certain emotions.

Materials

A cardboard box.

Guide for the exercise

Therapist will introduce in a box little papers with different emotions written on them. Papers are wrapped, so participants cannot see the emotion. He/she will explain to the participants that the box contains all sorts of emotions that human beings can feel. Every participant will take a paper. After that, everyone will explain what role that emotion played in his/her life, in which situations he/she felt it, and

the frequency of that emotion. This process will repeat twice, so the participants have the opportunity to talk about different emotions.

The therapist will highlight how different people can experience different emotions at similar situations. The key factor to explain this fact is the relation between thought and emotion. The way we interpret reality leads to different emotional responses. It could be useful to use the metaphor of the glasses. We all wear different glasses that make us see reality in a certain way. Sometimes these glasses are defective and our perception is biased. But we are not aware of this fact, and we think that out perception is the reality.

Inter-session activities

3.4. Self-Observation

Goals

To increase the emotional identification skills of the participants.

To help participants to recognize situations where they have felt certain emotions.

Materials

Annex 3.4. Self-observation sheet.

Guide for the exercise

Therapist will ask participants to complete before the next session the Self-Observation sheet. They have to register a daily life situation and complete the different questions from Self-observation sheet (Annex 3.4). Through this exercise they will gain a better understanding of the thoughts and internal experiences that are associated with certain emotions.

Annex 3.4. Self-Observation sheet

WHAT HAPPENED?	WHAT DID I THINK ABOUT THAT?	HOW DID I FEEL?	WHAT DID I DO?

SESSION 2

Goals

- TO CREATE A LINK BETWEEN OUR PAST EXPERIENCES AND OUR EMOTIONS.

Activities

- THE HISTORY OF MY EMOTIONS.

Inter-sessions activities

- TRUE OR FALSE?
- SELF-OBSERVATION.

Psychoeducative presentation

The origins of our emotions

How did we learn to manage our emotions? And how did we learn to understand the emotions of other people? Probably our past experiences helped us to learn which emotions are appropriate, and how to express them. Our first models were our parents. And progressively we moved to the social world, where we found friends, colleagues, romantic partners, etc. Our adult emotions are, at least in part, the result of these early experiences.

Drugs and emotional avoidance

All human beings experience a wide array of negative emotions. Nevertheless, sometimes we do not want to recognize these emotions. In fact, we want to avoid them, and we look for all sorts of strategies to avoid them. One clear strategy of emotional avoidance is drug use. Have you ever used drugs to avoid the negative feelings associated with a problem? One short-term consequence of this strategy is that you feel good and avoid coping with difficulties. This is a learning process, and in the future probably the person will use drugs again to avoid facing emotional problems.

But negative emotions are part of our lives. We cannot avoid feeling sadness, boredom or frustration. Sooner or later they will come. Our goal should be to feel negative emotions in the adequate situations, and to tray to minimize the duration of these feelings.

Group Dynamics and materials

3.5. The history of my emotions

Goals

To help participants to understand the biographical nature of our emotions, through the process of emotional learning.

Materials

Annex 3.5.

Guide for the exercise

Participants will answer questions in Annex 3.5 individually. During group discussion the therapist will help participants to explore how their relations with their parents were, and the emotional expression (with special relevance of love and anger) in their families.

IDEAS/ RECOMMENDATIONS

The high prevalence of victimization experiences in female offenders could influence this exercise. Negative emotions could be associated with traumatic experiences, like domestic or sexual violence. It is important to give the participants the opportunity to talk about these experiences if they want to take this opportunity. This program is not oriented to trauma therapy, but it would not be appropriate to ignore these experiences and their role in the substance abuse problem.

Annex 3.5. The history of my emotions

Please, answer the following questions

- How did my mother express her emotions when I was a child?
- How did my parents deal with their mutual emotions?
- What did I learn from my parents about expressing emotions?
- What did I learn as a child about coping with painful situations?
- How do these memories make me feel?

Inter-session activities

3.6. True or false?

Goals

To help participants to explore attitudes that support emotional avoidance

Materials

Annex 3.6.

Guide for the exercise

Participants have to answer individually (true or false) to a set of items. Later, during group discussion, they will be asked about the reason of their answers. Group discussion and self-disclosure will be encouraged by the therapist. This exercise is an opportunity to discuss inappropriate beliefs about emotional expression and the relation between emotions and behavior. Beliefs related with the uncontrollability and unpredictability of emotions tend to weaken the expectancies of behavioral self-control and emotional self-management. Beliefs that support emotional avoidance block a healthymotional expression and preclude participants from using adaptive coping strategies. Therefore, therapist should encourage the following ideas:

1. Emotions are predictable and controllable.
2. There are no unnecessary emotions. All emotions are necessary when they emerge in the right situation. We should feel sad when sad things happen to us.
3. Expressing our emotions in an appropriate way can help us to overcome negative situations, or to fully enjoy happy moments.

Annex 3.6. True or false?

Please, answer True or False to the following items:

1. To express your emotions is a sign of weakness.
2. Emotions come and go without any reason.
3. Emotions can't last forever.
4. If you feel something, it means that it's true.
5. There are emotions that I can't stand.
6. There are emotions that I can't control.
7. There are emotions that I do not want to feel.

3.7. Self-Observation

Goals

To increase the emotional identification skills of the participants.

To help participants to recognize situations where they have felt certain emotions.

Materials

Annex 3.4. Self-observation sheet.

Guide for the exercise

Therapist will ask participants to continue using the the Self-Observation sheet. They have to register a daily life situation and complete the different questions. During group discussion, the therapist will promote a deeper analysis of the emotions, highlighting points like the following:

1. The same person could have different emotions in similar situations, depending on how they are interpreted.
2. Different people can experience different emotions in the same situation.
3. Thoughts modulate the way we feel.
4. Emotions tend to decline and lose intensity. We could feel that an emotion is extremely intense at a certain point, but if we wait enough time it will fade.

SESSION 3

Goals

- TO TRAIN EMOTIONAL SELF-REGULATION SKILLS.

Activities

- MY NEGATIVE EMOTIONS.
- I WISH I HAD SAID.

Inter-sessions activities

- FIVE STEPS FOR EMOTIONAL REGULATION
- SELF-OBSERVATION.

Psychoeducative presentation

Accepting negative emotions

We have learnt to differentiate our emotions. This does not mean that we know how to manage and express then in an acceptable way. It is a first step, but we have to continue working. We have spoken about negative emotions, and how we tend to repress them. When we finally express these emotions, we do it in inappropriate ways. For example, anger can be repressed until we cannot do it anymore, and then violent behavior appears. As we said before, negative emotions are part of our lives. We have to accept them and let them flow normally. Emotions are like energy. If we do not express them, we create an emotional blockage. Have you ever repressed an emotion? We all have done it for different reasons, like fear or shame. At the short term, it seems to be an effective strategy, but at the end these repression leads to psychological distress.

Emotional expression

Repressing our emotions is a way of isolating us from relevant others. Therefore, it is positive to express our emotions in a controlled and adequate way. Our culture influences which emotions should be expressed and the way to do it. We usually do not accept feeling jealous or hate. But we all have felt both emotions. Since our childhood we have learnt that some emotions are socially unacceptable. We learn to hide them, but not to manage them in a healthy way.

The opposite can also be true. There are emotions which, under certain circumstances, seem to be normative. We should feel that way. That is what it is expected from us. If you have a new born baby, you should feel happy. Otherwise you are a strange or selfish person. In order to fit with these cultural expectations, we pretend to feel in a certain way. But maybe we do not feel the normative emotions, maybe we feel the opposite.

Five steps for emotional self-regulation

We rule over our emotions. We know that emotions are not a random phenomenon. We generate our emotions through the interpretation of our world. As you can see, emotions are a complex thing. Through the program we will learn techniques to cope with negative emotions. In this unit we will focus on a simple way to approach them, but emotions will be addressed in future sessions.

Now, we will present you five steps that will help you to control your emotions:

1. Find out what are you really feeling. Ask yourself questions like:

   – What am I feeling in this moment?
   – Is it really that emotion or am I wrong?
   – Is the only thing that I am feeling?

2. Acknowledge your emotions. Remember that there are not good or bad emotions. They are there for some reason. Try to listen to their message.

3. Try to explore the emotions. Ask yourself:

   – Am I interpreting the situation in the right way? Am I exaggerating?
   – How do I want to feel right now?
   – How can I switch from my current emotion to the one that I would like to experience?

4. Increase your self-confidence: Remember similar situations and how you managed them. Ask yourself:

   – What did I do in that moment?
   – Did it work?
   – What consequences followed my decision?

5. Learn:

   – What can I learn from this experience?
   – How can I avoid future mistakes?

Group Dynamics and materials

3.8. Unpleasant emotions

Goals

To help participants to identify the negative emotions that they experience more frequently.

Materials

Annex 3.8.

Guide for the exercise

Participants will complete the Annex 3.8 individually. Later, during group discussion, the therapist will promote the exchange of information about which emotions they repress and why they do it.

Annex 3.8. Unpleasant emotions

Which of the following emotions do you experience more frequently?

Rage	Anxiety	Shame
Sadness	Fear	Distress
Disappointment	Concern	Pain
Hopelessness	Envy	Humiliation
Depression	Nostalgia	Regret
Reject	Hate	Frustration

Why do you think that you feel like that?

How do you try to feel better when those emotions appear?

3.9. I wish I had said

Goals

To help participants to identify the emotions that they have more difficulties to express.

Materials

Annex 3.9.

Guide for the exercise

Participants will complete Annex 3.8 individually. Later, during group discussion the therapist will ask questions about the situations where they had difficulties to express their emotions, and the reasons for that. These reasons could include factors like shame, cultural gender beliefs, or early learning experiences. Furthermore, the therapist will highlight that some emotions are harder to express than others, especially those that are negative.

Annex 3.9. I wish I had said

This activity is about emotions that you did not express. Think about a situation when you did not express something that you were feeling:

1. Describe the situations.

2. Which emotions you wish you had expressed?

3. What stopped you from expressing those emotions?

4. What did you want to say?

5. What did you want the other person to know?

6. Do you regret something?

Inter-session activities

3.10. Five steps for emotional self-regulation

Goals

To help participants to begin to manage emotions.

Materials

Annex 3.10.

Guide for the exercise

During the time until the next session, the participants will use the five steps in Annex 3.10 to analyze a negative emotion that they should experience through the week.

Annex 3.10. Five steps

1. Find out what are you really feeling. Ask yourself questions like:

    a. What am I feeling in this moment?
    b. Is it really that emotion or am I wrong?
    c. Is the only thing that I am feeling?

2. Acknowledge your emotions. Remember that there are not good or bad emotions. They are there for some reason. Try to listen to their message.

3. Try to explore the emotions. Ask yourself:

    a. Am I interpreting the situation in the right way? Am I exaggerating?
    b. How do I want to feel right now?
    c. How can I switch from my current emotion to the one that I would like to experience?

4. Increase your self-confidence: Remember similar situations and how you managed them. Ask yourself:

    a. What did I do in that moment?
    b. Did it work?
    c. What consequences followed my decision?

5. Learn:

    a. What can I learn from this experience?
    b. How can I avoid future mistakes?

3.11. Self-Observation

Goals

To increase the emotional identification skills of the participants.

To help participants to recognize situations where they have felt certain emotions.

Materials

Annex 3.4. Self-observation sheet.

Guide for the exercise

Therapist will ask participants to complete before the next session the Self-Observation sheet. They have to register a daily life situation and complete the different questions. Through this exercise they will gain a better understanding of the thoughts and internal experiences that are associated with certain emotions. The therapist will promote a deeper analysis of the relations between though and emotions. During group discussion, the therapist will help participants to find alternative thoughts to the ones they have registered, in order to promote more appropriate and healthier emotions.

SESSION 4

Goals

- TO TRAIN EMOTIONAL SELF-REGULATION SKILLS.

Activities

- THE TRAIN OF TROUGHTS.
- PLEASANT EMOTIONS.

Psychoeducative presentation

Accepting our emotions

In a previous session we talked about drugs and emotional avoidance. Drugs are a way to evade from negative feelings. But, as we have said many times, negative feelings are part of us. Sometimes we can try to cope with them, changing the emotion or ameliorating it. But sometimes we just have to accept it. Something happened to me, and I evaluate that event as negative, and it makes me feel sad. In that situation maybe sadness is the healthiest thing that we can feel. Just accept it. Always remember that:

1. Emotions do not last forever. Sooner or later they fade away.
2. Feeling something does not necessarily involve that I have to behave according to that feeling. I can feel angry, but at the same time I choose not to be violent.
3. Emotions are not the real world. They are internal experiences, something that we feel. But they are not the reality.

Positive emotions

Emotional life is rich and complex. There are plenty of positive emotions that we can feel. For example:

Joy	Serenity
Relief	Safety
Love	Surprise
Harmony	Tenderness
Calm	Interest
Compassion	Pleasure
Hope	Curiosity
Optimism	Patience

Positive emotions provide us with psychological well-being, self-esteem and physical health. It is easier to be creative or to find solutions to our problems when we are feeling in a positive way.

Group Dynamics and materials

3.12. The train of thoughts

Goals

To help participants to understand emotional acceptance.

Materials

Annex 3.12.

Guide for the exercise

Participants will close their eyes and relax. It is advisable to reduce the light in the room. The therapist will read the instructions in Annex 3.12.

Annex 3.12. The train of thoughts

Try to remember an unpleasant situation, and the way it made you feel. What do you think about that situation? Now try to focus for a few seconds on the feelings you have right now.
Now, imagine a train.
You are sitting on a field, just watching the train go by.
Every wagon has a sign (represented by a phrase or image), and in every sign you can read one of your thoughts about the problem you have.
The only thing you have to do is observing the train moving away.
Do not make it stop, and do not jump into the train. Just let it flow, and watch how your thoughts simply go away.
Every time you feel bad, do not try to fight with it, just imagine the train with your thoughts in the wagons, going away from you.

3.13. Pleasant emotions

Goals

To help participants to identify the positive emotions that they experience more frequently.

Materials

Annex 3.13.

Guide for the exercise

Participants will complete the Annex 3.13 individually. Later, during group discussion, the therapist will promote the exchange of information about which emotions they experience, and which ones they would like to feel. Afterwards, group discussion should highlight the ways to increase positive emotions in the participant's daily life.

Annex 3.13. Pleasant emotions

Which of these emotions do you experience more frequently?

Joy	Serenity
Relief	Safety
Love	Surprise
Harmony	Tenderness
Calm	Interest
Compassion	Pleasure
Hope	Curiosity
Optimism	Patience

Why do you think that you feel like that?

In which situations in your daily life do you experience these positive emotions?

THINKING AND WELL-BEING

1. Introduction

The link between thoughts, feelings and behaviour has been illustrated by the cognitive model (Ellis, 1975). We know that the way we think influences the way we feel and behave. Events/situations that occur in the outside world do not usually cause feelings or behaviour; rather it is an individual's interpretation (or thoughts) about those events that will directly lead to our feelings and subsequent actions. In the present unit we will help participants to understand the link between cognition, feelings, behaviour, craving and the use of drugs.

In some cases, the negative thoughts that drug users have about a particular situation can be quite unhelpful, and lead to feeling the urge to use drugs to cope with them. This **maladaptive thoughts** and ways of thinking (**cognitives distorsions**) associated with addictive behaviour will be also addressed in this unit.

Often, the negative thoughts happen so quickly in response to trigger events that people do not even realise what is happening. That is why these **thoughts** are often referred to as '**automatic negative**'. Usually, addictive people suddenly realise that they are experiencing a craving/urge to use. These feelings are often a signal that they have slipped into "automatic pilot" and allowed a trigger situation to lead to an unhelpful thought about that situation, which has then resulted in a craving.

Another factor present in substance and alcohol users is the network of **dysfunctional beliefs** around drugs and alcohol. Some examples of these beliefs would be: "I cannot be happy unless I consume drugs/alcohol", "I'm more confident when I have a few drinks".

All people who are dealing with drug/alcohol use will have thoughts about using, and will increasingly experience urges to seek it out. These thoughts and feelings are quite common, and in themselves do not create problems. Rather, it is important to focus on how they deal with and respond to these thoughts and feelings. For that reason, the second session of this unit will be devoted to the application of cognitive strategies (rational debate, types of thinking) in order to build functional belief systems generators of well-being and personal balance.

In the last part of the unit we will work on how to change participant's thoughts and ways to think in order to improve their self-esteem.

This unit is distributed in 3 therapeutic sessions.

2. Therapeutic goals

1. To help participants understand the connections among thoughts, emotions, and behaviour.
2. To identify cognitive elements (cognitive distortions, irrational beliefs, automatic thoughts) that modulate the construction of meaning and can lead to distorted interpretation of everyday events.
3. To understand that responses to thoughts and emotions can be controlled.
4. To introduce some cognitive strategies in order to build functional belief systems generators of well-being and personal balance.

SESSION 1

Goals

- TO UNDERSTAND THE CONNECTIONS AMONG THOUGHTS, EMOTIONS, AND BEHAVIOUR (A-B-C MODEL).
- TO IDENTIFY THE ROLE OF COGNITIVE ELEMENTS AS WAYS OF INTERPRETING REALITY.

Activities

- GUESS WHAT PEOPLE THINK.
- INTERPRETING REALITY.

Psychoeducative presentation

In this unit we will talk again about how you think about yourselves, the world and other people and how what you do, your behaviour, affects your thoughts and feelings.

Let's start with a practical exercise: think about a pleasant situation and an unpleasant one that you have lived recently:

Do you think that this situation is the cause of emotions? Why? Does that same situation produce the opposite emotion? What other elements influence the situation?

All answers are recorded on the board, and the ABC scheme is followed to analyse all the elements.

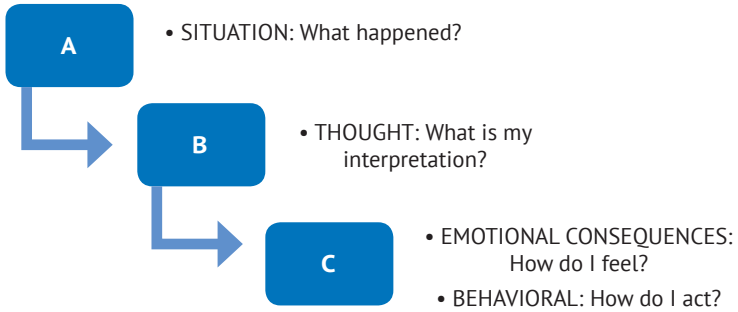
From this exercise we can draw three conclusions:

- What we think helps us to interpret reality.
- What we think conditions what we feel, behave, and
- With our way of thinking we justify what we do and feel.

As we saw in unit 3, the same reality can be interpreted from multiple points of view, although in many occasions we think that our way of interpreting reality is correct. Different interpretations will give rise to different thoughts and these will generate different emotions and behaviors.

Returning to the scheme outlined in unit 3, the sequence *Situation -> Thought -> Emotion -> Behaviour* translates into cognitive Model $A \rightarrow B \rightarrow C$, where:

- A represents the events observed by the person (triggers).
- B represents "Belief" (rational or irrational thoughts), the interpretation of the observed event.
- C represents the emotional and behavioral consequences of the interpretations (which may be desired or unwanted).



Therefore different reactions of each person can be given to the same situation ... And why do I usually react in the same way in similar situations even if time passes? Any ideas?

Irrational thoughts

We build our way of thinking and our scale of values through the experience and learning that we accumulate throughout life. Reality can be interpreted in a more or less accurate way. Learning to differentiate rational thoughts from irrational is decisive to achieve balance, well-being and personal harmony.

Rational thinking: It is based on reality. It emphasises seeing things as they really are, keeping them in perspective, preferring rather than demanding, and self-acceptance. Rational thinking is realistic thinking. It is concerned with facts. For example: "I would like my partner to accompany me to this party", "I would prefer not to have to fulfil this drug program", etc.

Irrational thinking: Beliefs or thoughts of an absolute and dogmatic nature (All / nothing, Always / never). Is an absolutist, defeatist and unrealistic thought. We express them in the form of a requirement: *I should ...*, *I am obliged to* ..., *I have to* ... Examples: "*My partner should accompany me to the party, if he doesn't, it's clear that he doesn't love me*"; "*I mustn't carry out this program because what I have done doesn't matter and nobody cares what I do with my life*". If we do not achieve these desires / demands, the generated emotions can be very negative (anger, anxiety, guilt, suffering). They can influence the achievement of other goals in the short, medium and long term, and even lead to isolation behaviours and pathologies as toxic substance abuse.

Cognitive distortions

Beliefs or personal schemes have an adaptive function, but sometimes, when we encounter a situation that does not fit our beliefs, we "force" reality to adapt to our personal scheme and not the other way around. This is known as "cognitive distortions". Cognitive distortions are mistakes we make when we think irrationally. We

use them without almost realizing it, believing that they help us and yet they can make us feel maladjusted and upset.

Some types of cognitive distortions are:

DICHOTOMOUS THINKING	Viewing situations on one extreme or another instead of on a continuum, in all-or-nothing terms. Good-bad, all-nothing, black-white.
MAGNIFICATION	Giving proportionally greater weight to a perceived failure, weakness or threat.
MINIMIZATION	Giving lesser weight to a perceived success, strength or opportunity, so that the weight differs from that assigned by others.
OVERGENERALIZING	Drawing a very broad conclusion from a single incident or a single piece of evidence. Even if something bad happens only once, it is expected to happen over and over again.
JUMPING TO CONCLUSIONS	Reaching preliminary conclusions (usually negative) with little (if any) evidence.
FORTUNE-TELLING	Predicting outcomes (usually negative) of events without having the necessary evidences. We make guesses of the future without waiting for them to happen.
MIND READING	Inferring a person's possible or probable (usually negative) thoughts from his or her behaviour and nonverbal communication; taking precautions against the worst suspected case without asking the person.
SHOULDS	Doing, or expecting others to do, what one should to do morally-irrespective of the particular case the person is faced with.

After presenting the different types of distortions the group is asked to put a personal example of each of them.

Group dynamics and materials

4.1. Guess what people thing

Goals

To distinguish between situation, thought and emotion.

To know the importance of interpretation in the relationship between thoughts and emotions.

To identify thoughts that generate unpleasant emotions.

Materials

Pencils. Annex 4.1.

Guide for the exercise

Annex 4.1 is presented, and participants are asked to infer what thoughts correspond to different emotional and behavioral reactions. Each participant will be able to deduce some thoughts or interpretations of the situation. Upon completion, trainer initiates a group discussion and makes participants to focus on some of the most important issues listed below.

Key points to debate.

Do situations generate our reactions?

Despite living the same situation, people react differently, depending on how we interpret that specific situation. The way in which we interpret reality and the thoughts we have of events are important determinants of our behavior. Negative interpretations are associated with unpleasant emotions and problematic behaviors. Positive interpretations are associated with emotions and behaviours that improve our relationships.

Self-talk is what we say to ourselves about situations and which influences our interpretation of the things that happen to us every day.

Facts or opinions?

Many times we interpret our thoughts as absolute truths and behave as if they were irrefutable facts. But this is not true. People can have different explanations and thoughts in the same situation.

Annex 4.1. Guess what people thing

SITUATION	THOUGHT	EMOTION / BEHAVIOUR
I say goodbye to my son and he doesn't kiss me		I get angry and I make him come back to kiss me
		I smile and say goodbye with a wink.
I had a horrible day, I feel bad. My friend proposes to me to get "high".		I accept and I go with him
		I go home with my family
My father has an important medical appointment and my brother doesn't come with us.		I get angry and I refuse to give him information about test results
		I worry and I'll call him to know what happened to him.
I discover that someone in my family has taken 500 hryvnia from my portfolio		I get angry and I call him/her by phone screaming to get the money back.
		I'm worried and I'll call them to know the reason.

4.2. Interpreting reality

Goals

To distinguish between situation, thought and emotion.

To know the importance of interpretation in the relationship between thoughts and emotions.

To identify thinking patterns and irrational thoughts in our everyday decisions.

Materials

Pencils. Annex 4.2.

Guide for the exercise

Two parts of a situation are related below.

Once the first part of the situation is read aloud, participants answer the questions.

Then we proceed to read the second part of the exercise.

The therapist can use similar points to debate that the ones used in exercise 4.1.

Annex 4.2. Interpreting reality

Part one

You are riding a bike on the outskirts of the city, on a quiet road. There is a very steep slope. When you get up to the peak you can see a group of kids about six or seven years old. They have seen you and you think that they will then stay on the side of the road when you start downhill at full speed. You start the descent, faster and faster, everything goes well until you pass the group of children. Suddenly, a stone comes flying and hits you on the side of the head. You cannot believe it: one of those children has thrown a stone at you when you were faster going down and you could have lost your balance and been seriously injured.

How would you feel after what happened? What would you do?

Part two

You stop, jump off the bike and run towards the group of children. On the way you see how one of them leaves the group crying. He speaks frankly to you: "I'm sorry, I threw the stone at you," he says, "I didn't know what to do, my brother was bitten by a bee and he's very sick. We need help, and when I saw you I thought that if I could stop you, maybe you could help us to call my mother with a cell phone. "

What feelings do you have after reading the second part? What would you do in this situation?

SESSION 2

Goals

- TO IDENTIFY AUTOMATIC THOUGHTS.
- TO PRACTICE WAYS OF THINKING THAT GENERATE WELL-BEING.

Activities

- PRACTICING RATIONAL DEBATE.

Inter-sessions activities

- WELL-BEING/DISCONFORT.

Psychoeducative presentation

Automatic thoughts

As you all know, throughout the day, we have a thousand talks with ourselves. Most of the time we ponder some concern and we give us different reasoning about one or another solution. These are called **Automatic Thoughts**. They are called automatic because they appear spontaneously, they cannot be controlled but they burst into the mind and, however absurd, they are totally believed even if they do not resist the slightest rational analysis.

First of all, we must learn to analyze our Automatic Thoughts and distinguish which distorted thoughts appear more frequently, increasing awareness of how we let ourselves be led by those distorted thoughts.

Thoughts that generate well-being

Now, we will practice some skills related to our way of thinking. Well will continue working on a more flexible way of thinking, constructing thoughts that help us to feel better and have a more balanced life and, above all, a life without addictions.

The following, are types of thinking that help us interpret reality in a more reflective way, preventing cognitive distortions from generating thoughts:

- **Causal thinking**: Ability to diagnose where the problem is. Causal thinking could be simplified in the question: What is the problem?

- **Alternative thinking**: Ability to generate as many possible solutions to a problem.

- **Consequential thinking**: Ability to foresee the consequences of what we say or do in others and in the medium What would happen if ...?

- **Perspective thinking**: Ability to put yourself in another person's place and understand what happens to them and how they feel. How does that person feel? How do things look from their point of view?

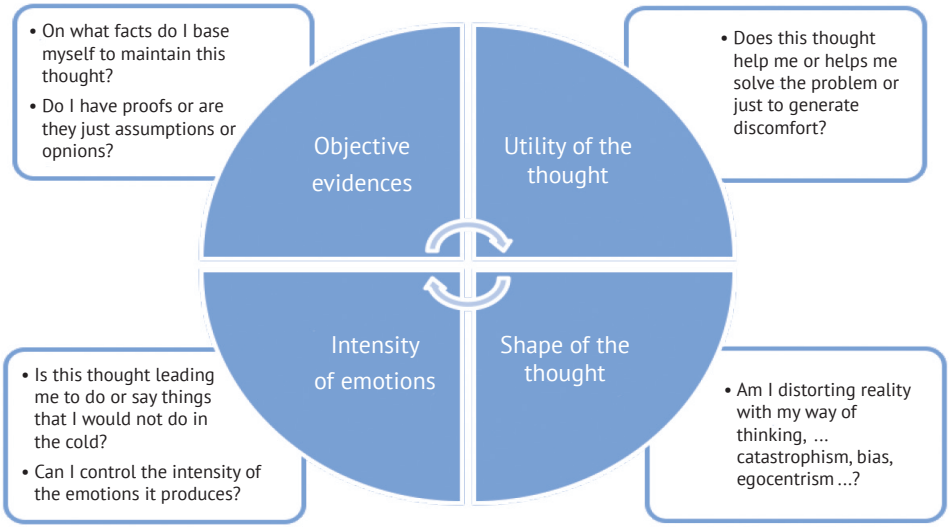
- **Thought means-end**: Ability to set a goal and choose the best means to achieve it. What can I do to get ...?

Rational Debate

We are now going to learn a new technique to be able to question that kind of irrational beliefs and distorted thoughts, it is called the RATIONAL DEBATE. What we achieve through rational debate is to stop to think about a certain idea, analyse it and see if it is based on objective information. If not, we will look for an alternative idea that is based on objective facts and therefore is more useful in our daily lives.

Before practicing rational debate, let's see what the criteria of rationality are. If our own beliefs and values may be limiting our development and our well-being and that of the people around us, we must make an effort to initiate a process of reflection that leads us to distinguish between rational and irrational thoughts.

It is our responsibility to act as "Wellness Specialists", having to prove the degree of realism of those thoughts, to accept them or to reject them and propose other alternatives. In addition to training our abilities to solve problems, we must establish criteria that act as filters that only allow the passage of realistic and rational thoughts.



The steps to carry out a rational debate are the following:

1. Detection of the wrong idea.
2. Search for arguments in favour of that idea.
3. Debate on that idea applying criteria of rationality.
4. Search for arguments against de idea.
5. Identification of cognitive distortions and irrational ideas at play.

Group dynamics and materials

4.3. Practicing Rational Debate

Goals

The objective of this exercise is to train participants in the rational debate and begin the deconstruction of irrational ideas related to their addictive behavior.

Materials

Pencils. Annex 4.3.1 and 4.3.2.

Guide for the exercise

Submit to rational debate some common irrational ideas that drug users usually have. For this, a list of some of the most common irrational beliefs is suggested but other ideas suggested by the participants can be used. A table is also proposed to guide the debate (Annex 4.3.1.).

Annex 4.3.1. Practicing Rational Debate

Usual distorted thoughts regarding the use of drugs:

- "I need drugs to not feel pain".
- "It doesn't matter if I take drugs or not, since my life will not improve in any way".
- "The only thing I want is to get high."
- "I'm strong; I can stand the drugs".
- "I work hard all week. I deserve to get high on weekends".
- "I cannot go on without some occasional sniffing of cocaine."
- "I'm basically a pretty good man".
- "I cannot be happy unless I consume".
- "If I use drugs, I can handle my problems better".
- "The fact that I smoke (or get high) will make life more pleasant".
- "I need a drink to overcome my anxiety".
- "I can do it this time and then stop".
- "Drugs make me more creative".
- "I have a very successful career, so it's not possible that I have a problem with alcohol/drugs".
- "Anyway, my life is disgusting, so drugs cannot make it any worse."
- "If I stop using drugs, I will get depressed".

- "I will fall apart if I cannot have a dose".
- "Nobody would give anything for me".

Annex 4.3.2. Practicing Rational Debate

Rational debate table

IDEA TO CHECK	
ARGUMENTS IN FAVOR	
DEBATE	
ARGUMENTS AGAINST	
NEW IDEA	

4.4. Well-being / Discomfort

Goals

To identify thoughts associated with well-being.

To identify thoughts that generate discomfort.

Materials

Annex 4.4.

Guide for the exercise

The therapist will address the group as follows:

"As we have seen, there are daily situations where we can experience pleasant or unpleasant emotions, it will depend on what thoughts occupy our mind ... Now we will concentrate throughout the week in identifying situations in which we have experienced pleasant emotions (WELL-BEING) and others in which we have experienced unpleasant emotions (DISCOMFORT)".

During the week describe what situations have caused you well-being or discomfort, what your thoughts were, what emotions you felt and how your behaviour in that situation was.

Key points for the debate:

Do situations generate our reactions?

Despite living the same situation, people react differently, depending on how we interpret that specific situation. The way in which we interpret reality and the thoughts we have of events are important determinants of our behavior. Negative interpretations are associated with unpleasant emotions and problematic behaviors. Positive interpretations will detract from our life and improve the relationships we have with the people who refer to us and who are important to us.

The responsibility to control ... It's mine:

If I identify my thoughts I can better control my reactions and my way of dealing with the situations that arise in my life. In my life I'm the one who controls my reactions, it's not the situations that drive me.

Annex 4.4. Well-being / Disconfort

Well-Being situations

SITUATION	WHAT DID I FEEL?	WHAT DID I DO?	WHAT DID I THINK?

Discomfort situations

SITUATION	WHAT DID I FEEL?	WHAT DID I DO?	WHAT DID I THINK?

SESSION 3

Goals

- TO UNDERSTAND WHAT SELF-ESTEEM IS AND ITS ROLE IN SUBSTANCE ABUSE.
- TO PRACTICE SPECIFIC WAYS TO RAISE SELF-ESTEEM.

Activities

- IMPROVING SELF-ESTEEM.
- THE SELF-ESTEEM TREE.

Psychoeducative presentation

What is self-esteem?

Self-esteem is the assessment or judgment that a person makes about themselves. It has to do with the acceptance of oneself, with loving and accepting oneself with one's own qualities, defects and limitations.

We can say that self-esteem is "the window through which we look at life". If the glass is clean, we see everything clearly, otherwise, we see it blurred. In addition, it contributes to the construction of our identity and decisively influences all aspects of our lives.

Self-esteem affects how you feel and how you act. For example, a person with low self-esteem may have trouble overcoming negative thoughts or feelings and therefore turn to outside experiences or activities to change those negative thoughts into positive ones. Drugs can be one of the outside activities they turn to in a negative situation or state of mind.

Is it possible that sometimes you are not too fair with yourselves? Do you criticize yourself excessively? Or perhaps too little?

We have seen in previous sessions that the "internal dialogue" is the talk we have with ourselves and depending on how this dialogue is, it will provoke in us a positive or negative emotional atmosphere. Thus, a positive internal dialogue is like an oxygen ball for our self-esteem and an internal negative and defeatist dialogue will act as a toxic for it.

Some typical internal dialogues in people with problems of substance use that affect your self-esteem are related to the following aspects:

- **Personal stability**. A person may feel like they have no stability in their life. Most of the time these people feel as if they have no control over their own life and things are not stable.
- **Insignificant**. A person who has an addiction to drugs or alcohol may feel like they are insignificant, especially in the eyes of others. They may feel like there is a lack of attention and affection from other people.
- **Bad person**. A person who has low self-esteem may feel like they are not ethically or morally a good person. They may feel like they are unloved, unappreciated, and unwanted. As a result, they conclude that they must not be a good person and therefore, are not worthy of love and appreciation.

- **Incompetent**. People who have a low self-esteem often hold themselves as being incompetent in one or more areas in life. They may feel like they are unable to maintain any control of their life.

In addition, the consumption of drugs and alcohol fulfills the function of "eliminating" these negative dialogues while maintaining the vicious circle.

Thus, it is very important that the person develops the habit of maintaining positive self-communication and speaks to himself as he would to his best friend or to the person dearest to him.

Group dynamics and materials

4.6. Improving self-esteem

Goals

To encourage participants to learn to describe themselves, to value themselves and to define themselves.

Materials

Paper sheet. Pencils.

Guide for the exercise

We ask participants to define themselves in a general way and in each of the following sections (see annex 4.6).

Then, they answer the following questions:

- Are you being fair with your own assessment?
- Do you really esteem yourself?
- Surely you have negative aspects that you could modify. Think about it and look for ways to improve.
- In relation to those negative aspects that you cannot change, try to be fair and accept them.
- Does your way of defining affect your way of behaving?

Annex 4.6. Improving self-esteem

AREAS TO EXPLORE	NEGATIVE ASPECTS	POSITIVE ASPECTS
Physical appearance (e.g.: height, weight, image,...)		
Personality (e.g.: I am happy, I am very shy...)		
Mental ability (memory, certificates of studies...)		
Relationships (e.g.: People like me, don't like me; I avoid people...)		
Emotional behavior (e.g.: I am affectionate, I do not usually show affection,...)		
Work (e.g., I have a job; I get along well with the boss...)		

4.7. The self-esteem tree

Goals

To promote positive thoughts about personal capabilities and achievements increasing self-esteem.

Materials

Pencils. Paper sheet.

Guide for the exercise

We explain to the participants that we are going to use the metaphor of a tree to explain their own capacities and achievements.

You will be drawing a tree. Your own kind of tree. Leave enough space for the branches and the roots too.

- In the roots you must write their positive capacities and their main strengths.
- The branches of the tree will be the achievements that have come from those roots.
- The flowers are things in your life that makes you feel good about yourselves.
- The leaves are significant event in your lives. A significant event is anything that happened that changed you or your lives in some way.

SOCIAL SKILLS

1. Introduction

Substance misuse is a problematic behavior associated with social factors. Those from the close environment that surrounds the addict are particularly relevant. Through the evolution of a drug use problem, all relevant areas of the addict's life are affected, and that includes social relationships. This involves several points. First, the onset of drug consumption usually takes place in the context of a dysfunctional peer group. In the case of incarcerated offenders, drug use is part of a broader antisocial pattern. Drugs turn into a key element of a criminal subculture that embeds the whole lifestyle. Second, the drug users progressively move from normalized and positive relationships to antisocial and dysfunctional ones. These kinds of relationships involve attitudes, conversations and habits that result shocking and inappropriate to the mainstream culture. Third, the drug user that has completed a treatment program and strives to build a new life, finds that creating positive and normative relationships is a major challenge. This person feels like an alien in a foreign country, surrounded by a strange culture where is very difficult to fit. Fourth, group pressure is a major relapse risk factor. Antisocial peer groups do not tolerate a positive change in one of their members.

The general goal of this unit is to train participants in those skills that enable them to relate with their social environment in a more adaptive way. Through this training they should be able to create positive relationships that would promote a positive change in their lifestyle.

From a methodological point of view, social skills will be trained using a structured learning scheme, which includes:

1. Explanation of the skill.
2. Modelling.
3. Role playing.
4. Feedback.

2. Therapeutic goals

1. To increase the awareness of the participants about the relevance of their social environment in the onset and maintenance of drug use.
2. To improve participants non-verbal communication skills.
3. To train participants to express and identify non-verbal messages.
4. To start and maintain conversations.
5. To use assertiveness.

SESSION 1

Goals

- BASIC CONCEPTS ABOUT SOCIAL SKILLS.
- RELEVANCE OF SOCIAL WORLD IN DRUG USE.

Activities

- RELEVANT PEOPLE IN MY DRUG AUTOBIOGRAPHY.
- CIRCLES OF INTIMACY.

Psychoeducative presentation

The influence of important people in our behavior

Most people begin to use drugs during their adolescence or even younger. During this period of our lives we are still immature, with a developing personality which is still not fully established. Social influence is a powerful factor during these early years. What our family or friends do strongly influences our behavior. This is true for several facets of our life, and also for drug use. The influence of close friends, relatives or peers is a key factor in the process of starting to use drugs. What about relapse? Group influence is also relevant when someone tries to quit using drugs but finally relapses. Drug users usually exert a powerful group pressure when someone tries to quit drugs.

Positive relationships

Social life can also be a protective factor. To create positive relationships is a key factor during recovery process. A new not addicted friend, or a new romantic relationship support recovery through different mechanisms. First, a positive relationship is a source of emotional and practical support. During hard times, when relapse is an option, positive relationships can make the difference. For instance, when we have to face a difficult situation, our closer relationships could help us to cope with the negative emotions associated with the problem, and they also provide us with advice and support. Second, social life is part of most leisure activities. To create a positive network will be helpful to fill free time with drug free activities, like sports, painting, etc.

Social skills can be trained

Social skills can be defined as the adequate behaviors to reach a goal in specific social situations. Are social skills a fixed part of our personality or can we learn how to be more socially effective? Fortunately, social skills can be trained and improved. Of course, there are people more skilled than others. But that is true for every aspect in life. For example, some people are naturally talented for sports, but that does not mean that we cannot improve our performance through training and hard work. Maybe we will never be that good, but we will be better than before.

What is the point of learning social skills?

1. To perform adequately in a different lifestyle than the one we had before.
2. To reach social reward, and to be rewarding for relevant others.
3. To reach a higher psychological adjustment and well-being.

Group dynamics and materials

5.1. The relevant people in my drug use autobiography

Goals

To help participants to identify the role of their social relationships in the onset and maintenance of their drug use problem.

Materials

Annex 5.1 & 5.2.

Guide for the exercise

Participants will be asked to write a short autobiography (one or two pages). One key aspect is the onset and evolution of their drug problem. With this information they have to answer the questions in Annex 5.2.

IDEAS/RECOMMENDATIONS

When conducting this activity with female inmates, it is important to explore the role of past romantic partners in the onset and maintenance of drug use. Past romantic partners could also have been a key factor in HIV infection. Other people could have a positive influence. For instance, the experience of becoming a mother may also be a major life event that could have promoted a positive change in values and goals.

Annex 5.1. My drug autobiography

Please, write a short autobiography with the most relevant events in your life. It is especially important to describe how you began to use drugs, and how your life has been since then.

Annex 5.2. The relevant ones in my drug use autobiography

Read again the drug autobiography that you wrote in the exercise? Now answer the following questions.

1. Which was the role of your parents and brothers in the beginning of your drug problem?

2. Who was the first person that you saw using drugs or under the effects of drugs?

3. Who was the first person that offered you drugs?

4. Who was with you every time that you relapsed?

5.3. Circles of intimacy

Goals

To help participants to analyze the degree of intimacy of their social relationships, and how satisfied they feel with them.

To analyze the association between the different relationships and drug use.

Materials

Annex 5.3.

Guide for the exercise

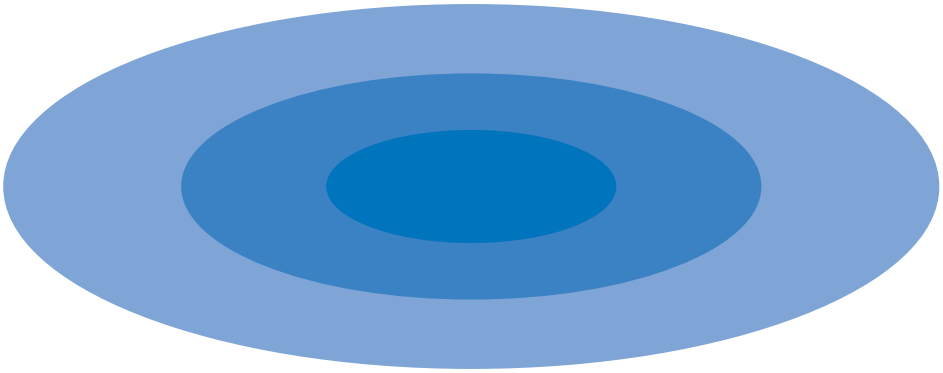
The aim of this exercise is to organize in a visual way the personal relationships of the participants. The Annex 5.3 depicts three concentric circles. The center of the

figure is the participant. First circle includes relationships with a high degree of intimacy. Next circle includes people with an intermediate level of intimacy. Last circle is focused on formal or superficial relationships. Participants must fill the different circles with the people in their lives that they would classify as belonging to every category.

During the group discussion, some interesting parameters to analyze are:

1. Number of people in every circle.
2. Absence of common significant relationships (i.e parents, sisters, brothers, romantic partner).
3. Empty circles.

Annex 5.3. Circles of intimacy



SESSION 2

Goals

- TO IMPROVE VERBAL AND NON-VERBAL COMMUNICATION SKILLS.
- TO IMPROVE ACTIVE LISTENING SKILLS.

Activities

- THE END OF THE WORLD.
- JUST CHATTERING.
- ACTIVE LISTENING SKILLS.

Psychoeducative presentation

Non-verbal communication

Communication is a basic process that enables information exchange between people. Communication can be verbal (expressed through words) and non-verbal (all that is not expressed through words).

Non-verbal communication involves all those observable behaviors that we use during communication. They are not part of language, but they support the verbal content.

Non-verbal signals can express:

1. Repetition: Reproduction with gestures of what is verbally expressed.
2. Contradiction: Oppositional relation between verbal and non-verbal aspects (i.e to say that you are very happy while your face has a sad expression).
3. Substitution: Non-verbal behavior substitutes verbal messages through the use of gestures (i.e eat, money).
4. Complementarity: Non-verbal behavior works as a signal of the attitude of one person towards the other. They are indicators of emotion, attraction, aggressiveness. They can be expressed through smile, body posture, etc.
5. Regulation: Non-verbal behavior can be used to regulate the flow of information during a conversation.

Most relevant non-verbal behaviors are:

1. Eye contact.
2. Facial expression.
3. Head movements.
4. Spontaneous gestures, like hand movement.
5. Physical contact.
6. Posture.
7. Distance.
8. Volume, tone and rhythm of voice.

Active listening

Active listening is a group of communication skills that promote a high quality communication with relevant others. Some of the advantages of using these skills are:

1. To learn in a more effective way about the information that we are being offered, and to show that we are interested.

2. To check if we are being understood.
3. To make the other person feel understood.
4. To be rewarding.

The key components of active listening are the following:

Non-verbal components:

1. Visual contact.
2. Facial expression: attention, interest.
3. Straight position, body oriented to the other.
4. Non-verbal rewards: nod, smile.

Verbal components:

1. Repeat the last words of the sentence that the other person just finished.
2. Verbal signals of approval ("aha", "mmm").
3. Acknowledgment and support responses ("yes, of course", "you are right").
4. Brief summaries ("then, what you mean is...").
5. Short questions to clear a point that we did not fully understood.
6. Empathetic responses ("I can imagine how you feel").

Always remember:

1. Do not judge.
2. Do not interpret.
3. Do not make any other activity while the other person is speaking.

Some relevant obstacles to communication are:

1. Inadequate moment or place.
2. Intense emotional estates.
3. Demands, accusations (YOU messages, "you did..", "you must...".
4. Inconsistency.
5. Generalizations and labels.
6. To give advices which were not demanded.
7. To ignore relevant information.
8. Not to listen.

Some factors that facilitate communication are:

1. Ask open questions.
2. Ask for opinions.
3. Express ideas and opinions (I messages like "I think").
4. Accept criticism.
5. Be rewarding.
6. Express feelings.

Group dynamics and materials

5.4. The end of the world

Goals

To make participants aware of the relevance of good communication and its difficulties.

Materials

Annex 5.4.

Guide for the exercise

Two participants leave the room while the therapist explains the activity to the rest of the group. The two volunteers will be given a paper with instructions about their task. Both papers have a similar content, but they are slightly different. This leads to a situation where the only solution is effective communication. Instruction 1 indicates that the only solution for the situation is to obtain the skin of the only orange left in the world. On the other hand, Instruction 2 states that the only solution is the juice of an orange. Therefore, both participants have needs that are apparently incompatible, but actually they are not.

After informing the group, both volunteers enter the room and are given the paper with the instructions. After they read then, they have to sit and try to find a solution for the problem. Once the simulation is over, the group analyzes the communication between both volunteers.

Annex 5.4. The end of the world

INSTRUCTION

Imagine that society has disappeared after a natural disaster caused by climate change. You have a disease that can only be cured drinking the juice of an orange, but there is only one left and your group partner also wants it.

Try to find a solution

5.5. Just chattering

Goals

To make participants more aware of verbal and non-verbal aspects of communication.

To create a positive group atmosphere oriented to active participation.

Materials

Just paper and pencil.

Guide for the exercise

The exercise has two different moments. At moment one, two participants volunteer to simulate a normal conversation in front of their partners. The rest of the group draws a list of the verbal and non-verbal aspects of the conversation.

After group discussion, two different participants will have another conversation, but this time they will stand at the back of each other. This means that they will not be able to see each other and they will lack all non-verbal aspects. During group discussion, the relevance of non-verbal component of communication will be highlighted.

5.6. Active listening

Goals

To train participants in active listening skills.

Materials

None.

Guide for the exercise

First, the therapist will make a role playing with one of the participants. The participant will explain the therapist some serious issue (something invented) and the therapist's response will be very inadequate (not paying attention, without eye contact, etc). After that the simulation will be discussed in the group. After this, the therapist will repeat the same conversation, but with an adequate performance. The group will discuss about the differences between both situations.

After this, the participants will work in couples, simulating a situation of active listening. The therapist will check the performance of the participants and provide adequate feedback.

SESSION 3

Goals

- TO IMPROVE CONVERSATIONAL SKILLS.

Activities

- START AND MAINTAIN CONVERSATIONS.

Psychoeducative presentation

Why are conversations important?

It is important to be able to have conversations. It is something that enables us to know other people, and to let them know us. Through conversations we start and maintain social contacts that could be practical, rewarding, and that after some time could even lead to higher levels of intimacy. We should not be concerned about the depth or level of expertise that we show during a conversation about a particular topic. Both deep and superficial conversations are important.

How to start a conversation

Some rules to start a conversation are:

- Non-verbal aspects: eye contact, smile.
- Verbal component:

    a. Make a statement followed by an open question. For example "That coat is quite expensive. Do you think that it is worth buying it?" This structure can have different modalities:

    i. Rewarding statement: "I like your dog. Where did you buy it?"
    ii. Personal declaration: "It is the first time that I attend this class. How is it?
    iii. Expression of a positive feeling: "I like football very much. Which is your favorite sport?"

Once the conversation is started, the following challenge is how to keep it going. There are three possible strategies:

1. **Use open questions**: Yes or no questions do not support a conversation. Open questions involve structures like "why?" or "what do you think about..?" This forces the other person to offer information that we can use to keep the conversation alive.
2. **Give free information**: This technique involves the exchange of information about opinions, preferences, etc. This information exceeds the limits of the question. It enables us to find common topics and promotes self-disclosure. It is also a way to find new topics.
   Therefore, the initiations of a conversation involve the following structure:

   STATEMENT + OPEN QUESTION

Once the question was answered:

FREE INFORMATION + OPEN QUESTION

For example:

A: I always go to work in subway but today it was crowded. How do you go to work?
B: I go on foot. My work is quite close to my house.
A: That is most convenient. I chose my apartment because I have a dog and I needed some extra space [FREE INFORMATION]. Which pet do you have? [OPEN QUESTION].

3. **Move to another topic**: Sometimes a topic has been fully explored and it is necessary to move to a different one.

5.7. Start and maintain a conversation

Goals

To train participants in conversational skills.

Materials

A ball.

Guide for the exercise

One participant starts the exercise throwing the ball to a partner. He has to initiate a conversation using the structure STATEMENT + OPEN QUESTION. The other participant will answer the question. Then, the one who initiated the conversation will respond using the structure FREE INFORMATION + OPEN QUESTION. If necessary, the therapist will correct their verbal and non-verbal behavior. After this, the participant who received the ball will throw it to another participant, and initiate the same cycle.

SESSION 4

Goals

- TO IMPROVE ASSERTIVENESS.

Activities

- BRAINSTORMING.
- YES, I CAN SAY NO.

Psychoeducative presentation

What is assertiveness?

Assertive behavior is the direct expression of your own feelings, needs, rights and opinions, without threatening or punishing other people, and without violating their rights. There are three different interpersonal styles: inhibited, assertive and aggressive. Inhibited individuals do not reach their goals, and their rights are not respected by others. They tend to feel frustrated and anxious. Others make decisions for them. The aggressive individual does not respect other people's rights, and tends to have a defensive interpersonal style, attacking and humiliating.

The assertive individual has the following characteristics:

1. Respects other people's rights.
2. Reaches his/her own goals.
3. Has a high self-confidence.
4. Makes his/her own choices.

All human beings have several personal rights. Assertiveness is the best way to defend them. Some of these rights are:

1. I have the right to make mistakes.
2. I have the right to accept my own feelings.
3. I have the right to have my own opinions, and to change them.
4. I have the right to protest.
5. I have the right to request help or emotional support.
6. I have the right to ignore advices.
7. I have the right to say NO.

What is the relation between assertiveness and drug use?

As we have mentioned before, group pressure is a risk factor for drug use and relapse. The first strategy to deal with this factor is avoidance of contact with other drug users. But sometimes this is not possible, and we have to learn to say NO when someone offers us drugs. Assertive behavior is the best way to deal with this pressure when we cannot avoid it.

Group pressure can lead us to do stupid things, just to feel accepted by our peers. This pressure can be exerted through different strategies (Table 5.1).

Table 5.1. Strategies of group pressure

STRATEGY	Example
RIDICULE	"you are a coward"
DARING	"you don't have what it takes"
FLATTERING	"you are a smart guy, you can do it if you want"
THREAT	"you don't want to know what will happen to you"
PROMISES	"I will give you anything you want"

How to say NO

We all have the right to say no to something that is negative for us. Self-assurance should not lead to a conflict. To say NO does not involve a criticism or a hostile reaction. It is only an expression of our will. If we say NO, it will lead to an increase in our self-esteem. Otherwise we would feel manipulated and frustrated. When we confront group pressure, we have to listen carefully to what the group is requesting from us. Once this is clear, we have to compare this request with our own desires and make a decision.

If we decide to refuse, there are different techniques to say NO in an assertive way. First of all, we have to follow these rules:

1. Find the appropriate moment and place.
2. Use clear verbal expressions.
3. Try to use also a clear non-verbal language (firm voice, eye contact).

Scratched disc

It involves expressing our will repeatedly, without getting angry. We will not look for excuses or argumentations. We simply do not want to do something, and we will express it repeatedly without further explanations, even if the other requests them. For example:

A: Take this, drink with us.
B: I am sorry. I don't want.
A: Come on! Try a little.
B: I am sorry. I don't want.
A: You will feel great.
B: I am sorry. I don't want.

Offer alternatives

This technique involves suggesting something positive, that everybody may like to do. Follow these steps:

1. Find something attractive and make an enthusiastic proposal.
2. Insist, regardless of the other people reaction.
3. Try to find support in another person.

For example:

A: Let's try this together.
B: Why don't we go to play football? Today the weather is nice.

For you-for me

This technique is useful when we receive pressure or criticism after expressing our opinion. We accept the other person's point of view, and then express ours. For example:

A: Take this dose of heroin and give it to my friend.
B: No, I won't.
A: You are a coward, I feel disappointed.
B: FOR YOU I may be a coward, but FOR ME I am making the right decision.

Fog bank

This technique is used to cope with manipulative criticism. Sometimes we can receive emotional pressures in order to change our behavior. It involves acknowledging the part of the message that may be true, without going any further. It can involve several levels:

1. Agree with the truth: You acknowledge the part of truth that is included in what the other person is telling you.
   For example:
   A: "I have helped you many times and now you let me down".
   B: "It is true that you have helped me many times".
2. Agree with the possibility: You accept that the other person may be partially right, but without accepting the personal implications.
   A: "I think that you are a disappointing person".
   B: "Maybe some people sometimes feel disappointed for my behavior".

3. Preliminary agreement: You delay a decision about something that other person wants to impose you.
   A: "You must do what I am telling you".
   B: "I will think about it".

"I" messages

These kinds of messages switch the responsibility of the decision to us, not to the other person. We are the ones who have made the decision of refusing a request. Therefore, we do not blame the other for requesting something for us.

A: "I could go to your place later and drink some beers there".
B: "I understand, but sorry, I CAN'T MEET YOU TODAY".
C: "Why? Do you have something to do?".
A: "Sorry, but I DON'T WANT TO MEET YOU TODAY".

In all techniques it is very important not to give any kind of justification, because it may work as the basis for new pressures.

A: "Lend me your car, I need it".
B: "Eeeeh, well, I can't because I ran out of gas".
A: "No problem. I will fill the tank for you".

IDEAS/RECOMMENDATIONS

Female inmates, whose life has been embedded in antisocial groups, may have been socialized to have a passive attitude towards their partner`s will. In this population, probably a more intense effort to change this attitude will be required.

5.8. Brainstorming

Goals

To help participants to identify personal situations where they should have behaved in an assertive way.

Materials

Blackboard or flipchart.

Guide for the exercise

The participants will be asked to explain personal situations where they were not able to say NO, and that finally led them to a problematic result.

5.9. Yes, I can say NO

Goals

To train participants in assertiveness skills, tailoring the exercise to individual factors.

Materials

None.

Guide for the exercise

First, the participants will draw a list of high risk situations for drug use. Afterwards, these situations will be rehearsed through role-playing. The participant will play his own role, and one or more group peers will play the additional roles. Assertive techniques will be used to cope with negative social pressure. Every participant will practice at least one situation from his/her list. The therapist will provide with feedback about the use of the techniques.

CRAVING COPING SKILLS

1. Introduction

Drugs activate brain reinforce circuits in a similar way than natural rewards like food, water or sex. These stimuli access naturally the reward circuits through senses. Drugs stimulate directly the neural networks without the need of sensorial stimulus. Through repeated experience, drugs turn into the main reward in the user's life, and are the only option to fight against boredom or sadness.

It is important to understand this phenomenon as a learning process. The problem behaviour (drug use) has antecedent stimuli and consequences. External antecedents are situational factors (places, smells, music, people). Internal antecedents are thoughts and feelings. Consequences are everything that happens after the problem behaviour, and that it is related with it.

When someone start using drugs, the short term consequences are positive (pleasure, getting high). After repeating this behaviour several times, the psychological association between drug and pleasure is well stablished. Another association is created between drug use and antecedents. If drugs are used always in the same (or similar) environments, under certain circumstances, these situational factors are associated with substance use. Something similar happens with internal antecedents. Frequently drugs are used to elude boredom and sadness, or as a response to happiness (celebration). When the person is confronted with both internal and external factors, the idea of using drugs and the desire associated will be elicited. The process is summarized in Figure 7.1.

Figure 7.1 Drug use and learning

Therapeutic goals

1. To educate participants about the nature of craving.
2. To provide participants with strategies to cope with external and internal stimulus associated with craving.

SESSION 1

Goals

- TO EXPLAIN THE NATURE OF CRAVING.

Activities

- BRAINSTORMING.
- LIST OF ANTECEDENTS.

Psychoeducative presentation

Why do I use drugs?

Most of you have been using drugs for a long period of time. Some of you even tried to quit, but you were not able or finally relapsed after a period of abstinence. Why is so difficult to quit using drugs? We will explain drug dependence as a learning process that affects the brain activity, and this ultimately leads to disorders in the behavior.

How did you feel when you started using drugs? Frequently, the short term consequences are positive (pleasure, getting high). After a period of time you created a habit. This means that there were many situations, feelings, thoughts and behaviours associated with drugs. Probably you used drugs at the same place, or under similar circumstances. These factors became associated with drugs. Something similar happens with internal experiences. Maybe you used drugs to avoid negative feelings like sadness or frustration. Or when you were worried about something. After some time, these feelings or thoughts made you experience the desire of using drugs. We will call this desire **craving**.

This learning is powerful and lasting. After many years of abstinence, a stimulus like a smell, a song, a person, a feeling or a thought can make you experience a strong desire of using drugs. Probably this will happen to you, sooner or later. The aim of this unit is to help you to cope with this craving.

Group dynamics and materials

7.1. My antecedents

Goals

To help participants to identify the role of internal and external stimulus in craving.

Materials

Annex 7.1.

Guide for the exercise

First, the group will do a brain storming about the stimuli that they think that could elicit craving in them. Afterwards, participants will be asked to read the list of

antecedents in Annex 7.1 and to choose those that they think that apply to them. Afterwards, in group discussion, these factors will be analyzed. The therapist will analyze if they are internal or external factors, and the role that they play in the participants' drug problem.

Annex 7.1. List of antecedents

Please, read this list and choose those factors that you consider that were relevant in your drug problem.

1. Talk about the effects of drugs.
2. Feeling anger.
3. Argument with relatives.
4. Feeling lonely.
5. Feeling bored.
6. To have many debts.
7. To hang around with friends who use drugs.
8. To have plenty of work.
9. To have plenty of money.
10. Thinking that you do not have a solution for your problems.
11. To have legal problems.
12. To have plenty of responsibilities.
13. To go out of prison.
14. To see someone buying drugs.
15. To see a syringe.
16. To be offered drugs.
17. Breaking a romantic relationship.
18. Walking though places where people use drugs.
19. To disagree with home rules.
20. To see the drug dealer.
21. To see something on TV related with drugs.
22. To dream with drugs.
23. Feeling anxious.
24. Thinking that nothing happens if I use drugs just one time.
25. To feel sad.
26. To have physical pain.
27. To feel anxious with new people.
28. To be very happy.

SESSION 2

Goals

- TO ANALYZE DIFFERENT FORMS OF CRAVING.

Activities

- MY EXPERIENCE WITH CRAVING.

Psychoeducative presentation

Different forms of craving

Craving has different forms. It is a phenomenon that evolves along with your drug problem, and it is not the same during active drug use periods than after a period of abstinence. It is important to understand that craving is a risk factor that adopts different forms and that can remain hidden for long periods. We will differentiate three forms of craving:

1. Craving reinforced by drug use: It takes place during addiction periods. It starts after the person has been some time without taking drugs (hours, days). At an initial stage, it is associated with psychological (anxiety, distress) and physical (withdraw symptoms) responses. In the case of cocaine, the desire starts as soon as the person has taken the last dose.
2. Signal associated craving: It is associated with the presence of physical sensations, like increased heart rate or sweat which usually preceded drug use. These internal responses usually are associated with external factors (meeting with another drug user, walking through a place where you used to take drugs). Sometimes this form of craving is elicited by drug related fantasies.
3. Covert craving: This form of craving usually takes place after a period of abstinence. It involves the cognitive denial of craving, along with a physical experience of anxiety. The person THINKS that the drug problem is solved, but at the same time FEELS internal experiences that are associated with drug use.

Group dynamics and materials

7.2. Brainstorming

Goals

To make participants aware of their own experience with craving.

Materials

Annex 7.2.

Guide for the exercise

Participants complete individually the Annex 7.2. Afterwards, during group discussion, the therapist will highlight the positive experiences, when participants were

able to cope efficiently with craving. It is important to stress the fact that craving is a dynamic process, and that it changes as the drug use problem evolves. They may think that they will not experience craving anymore, but they probably will. The goal is to learn skills to cope with it effectively.

Annex 7.2. My experience with craving

Please, answer the following questions:

How was the last time that you experienced craving? Describe the situation and how it made you feel.

What did you do to cope with craving? What have you done in other occasions?

SESSION 3

Goals

- TO TRAIN CRAVING COPING SKILLS APPROPRIATE FOR EXTERNAL RISK FACTORS.

Activities

- BRAINSTORMING.

Inter-sessions activities

- A NEW HABIT.

Psychoeducative presentation

How to cope with external stimuli associated with craving?

After a period of abstinence, you may think that you will not experience craving anymore. An excess of self-confidence is a risk factor, and you may expose yourself to high risk situations, because you think that you are strong enough to cope with them. But sometimes that is not the truth, and relapse takes place. Some relevant points that we have to highlight are:

1. High risk situations elicit craving.
2. In this group we can identify high risk situations, using your experiences.
3. Gradually, the influence of this situations decline, but only if we have a new positive lifestyle.

The coping strategies that we have to use to deal with external factors are:

Evitation

Always remember that during your addiction period your mind learnt to associate many external stimuli with drugs. There are places, sounds, people, smells, songs etc that were present when you were using drugs, and that now are associated with these experiences. If you expose yourself to them, probably you will experience craving. Sometimes, ex addicts say that it is good to test yourself confronting these stimuli. It is a bad idea. This contact with drug related stimuli could lead you to a powerful craving experience and promote relapse. Therefore, avoid these situations. It sounds simple, but it is the first step.

Escape

Sometimes it is not possible to avoid certain situations. Maybe you do not notice that you are in a high risk situation until you are in it. This does not mean that there is nothing you can do. If you find yourself feeling the urge to take drugs in a risky situation, just leave. Escape from the situation. The craving will not disappear immediately. Maybe you will feel distressed for hours or days. But if you have not failed, it means that you coped effectively with the situation. Sooner or later the urges to take drugs will disappear.

Stimulus control

Try to remove from your daily life all stimuli associated with drugs. This involves finding new places to go and new things to do. To start doing new activities takes several steps:

1. Draw a list of activities.
2. Select from this list those that you want to do next week.
3. Set a list of goals that you want to reach during the week.
4. Reach these goals.
5. Evaluate the results.
6. Adjust these goals for next week.

7.3. Brainstorming about high risk situations

Goals

To make participants think about high risk situations where escape, evitation and stimuli control could be useful.

Materials

A blackboard or flipchart.

Guide for the exercise

The participants will suggest all situations from their own experience, where escape/evitation/control coping skills could be useful. The therapist will draw a list in the blackboard, and request their opinion about the most appropriate skill for every situation.

Inter-session activities

7.4. A new habit

Goals

To make participants plan a new positive habit.

Materials

Annex 7.4.

Guide for the exercise

The participants will complete Annex 7.4, thinking about something new that they can start doing before next group session. It must be something feasible in the correctional colony.

Annex 7.4. A new habit

This activity will help you to create a new habit. Follow the next steps

1. Draw a list of feasible activities that you could start doing next week.

2. Select those that you prefer (one or two).

3. Set realistic goals (for example reading five pages of a book everyday)

   3.1. _____
   3.2. _____
   3.3. _____
   3.4. _____
   3.5. _____

4. Which goals did you accomplished after a week?

5. How satisfied are you with your performance?

6. Changes for next week.

SESSION 4

Goals

- TO TRAIN CRAVING COPING SKILLS APPROPRIATE FOR INTERNAL RISK FACTORS.

Activities

- SELF-INSTRUCTIONS.

Psychoeducative presentation

How to cope with internal stimuli associated with craving?

Craving could be elicited by external factors, but also by thoughts and fantasies. This session will be focused on techniques that can be useful to control the cognitive part of craving.

Stop disturbing thoughts

Sometimes we feel like we cannot control what we are thinking. It is like riding a carousel that you cannot leave. We can say that these thoughts are intrusive and obsessive. We need a stimulus that can help us to stop. This stimulus can be for instance a word (STOP) and a behavior like clapping your hands, or hitting a table with the palm of your hand. Something that makes noise, that makes us stop thinking. After this, it is advisable to do something that distracts our mind. Otherwise we could start again with our thoughts. For example, you can count backwards, or think about a poem or a song.

Self-instructions

We all talk to ourselves, in order to direct our behavior. This self-talk can be used to help us to cope with craving. For instance, we can have negative expectations about a high risk situation we have to go through. We cannot avoid it or escape from it. And we feel anxious, thinking that "I cannot do it, I will fail". But if we change these thoughts, and substitute them with useful and rational instructions, our emotions will also change. There are three steps we have to take:

1. Before the high risk situation: positive self-instructions that anticipate success, acknowledging the difficulties of the situation.
2. During the situation: acknowledgment of the goals that we have reached, practical instructions about what we should do to cope with the situation.
3. After the situation: self-reward.

7.5. Talking to myself

Goals

To help participants to generate positive self-instructions to cope with distressing situations.

Materials

Annex 7.5.

Guide for the exercise

The participants will be asked to complete Annex 7.5. They will choose a high risk situation and the associated negative thoughts. Then, they will draw a list of positive self -instructions for the different stages of the situation. It is important that these instructions are generated by the participants, not by the therapist.

Annex 7.5. Talking to myself

Choose a situation that you consider to be high risk.

Think about positive instructions to use BEFORE the situation.

Think about positive instructions to use DURING the situation.

Think about positive instructions to use AFTER the situation.

RELAPSE PREVENTION

1. Introduction

It is a well-established fact that overcoming a substance misuse problem is a complex process. Once the drug-dependent person has gone through a disintoxication period, begins the task of overcoming psychological and social difficulties. These factors could finally lead to a relapse. In fact, specialized literature accepts that relapse if part of a normal recovery process. Therefore, a key element of drug treatment should be to educate participants in the characteristics of a relapse process and to train skills to cope with it.

Through the previous units, several coping skills have been trained (social skills, emotional self-regulation, cognitive skills). In this last unit of the program they will be considered in the context of relapse prevention.

Therapeutic goals

1. To educate participants in the characteristics and stages of relapse.
2. To identify thoughts, emotions and situations that could be associated with relapse.
3. To identify the appropriate coping skills for these risk factors.
4. To create an individualized relapse prevention plan.

SESSION 1

Goals

- TO EXPLAIN THE NATURE OF RELAPSE.

Activities

- BRAINSTORMING.
- THE PROCESS OF RELAPSE.

Psychoeducative presentation

Failure and relapse

To reach drug abstinence is a difficult goal. You all have struggled (and continue working everyday) to stay out of drugs. But once you reach abstinence the work is not finished. Unfortunately, drug use is a problem difficult to overcome, and even after years of abstinence a certain degree of risk is present. Once you have made a change in your lives, the next challenge is to make it stable.

That is the goal of this last unit. We will explain you how relapse takes place, and how to stop this process.

First, we have to explain two different concepts: failure and relapse.

A **failure** is a short and occasional return to addictive behavior. It is just a concrete episode of drug use in the context of a long period of abstinence. It is a mistake that takes place during a learning process. It is also an opportunity to learn new things. Why did it take place? How to avoid it in the future?

A **relapse** is a longer process, which starts when drug-free lifestyle is destabilized, and that finally leads to an addictive problem. It usually takes place when the person does not cope appropriately with a risk situation. The failure is part of a relapse process.

Both phenomena are a mistake, but also an opportunity to learn.

A relapse takes several steps:

1. Destabilization in the drug-free lifestyle: The causes could be both internal and external. They include negative events, losses, low rate of reinforcing activities, or an excess of responsibilities.
2. Wish of immediate gratification: When the person confronts these negative factors, the need of some immediate reward could appear. Your life is hard, and you want to feel good as soon as possible. Usually, the method to reach this gratification belongs to your former lifestyle.
3. Positive expectancies about the drug effects: memories about past situations where you enjoyed drugs return to your mind.
4. Justifications: You begin to think in a way that legitimates drug use.
5. Apparently irrelevant decisions: These are actions that apparently are not related to drug use. They seem irrelevant, but the truth is that they finally lead you to a high risk situation.

6. High risk situations: These are situations where the likelihood of a failure is high. If the person does not cope effectively with them, a failure could finally occur.
7. Failure: Is a first use of a substance, and therefore an interruption of abstinence.
8. Effect of abstinence violation: These are some consequences of the failure, like:

   a. Feeling the effects of the drug.
   b. Decrease in self-esteem.
   c. Loss of confidence in your possibilities of remaining drug-free.
   d. False feeling of self-control, if after the failure follows a period of abstinence.

9. Continuous drug use.
10. Relapse.

Group dynamics and materials

8.1. Brainstorming

Goals

To help participants to understand the differences between relapse and failure.

To identify personal experiences of both relapse and failure.

Materials

Blackboard or flipchart.

Guide for the exercise

The therapist will request from participants examples of personal experiences of failure and relapse. The differences between both problems will be highlighted.

8.2. The process of relapse

Goals

To help participants to understand the steps of relapse.

To use the process of relapse with the participants' personal experiences.

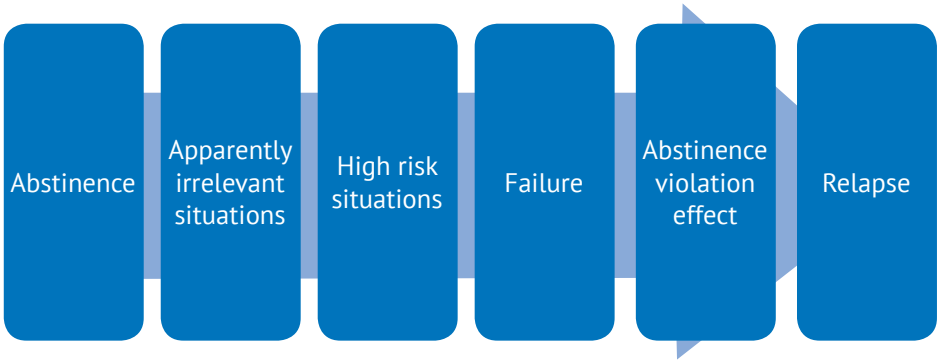
Materials

Annex 8.2.

Guide for the exercise

Participants have to fill the several stages of the relapse process using a personal experience. This is an initial contact with the concept of relapse. Therefore, the most relevant goal is to make clear all doubts that participants may have. Indicate participants that they should keep this document, because it will be used and reviewed in several moments of the unit.

Annex 8.2. The process of relapse



SESSION 2

Goals

- TO ANALYZE FALSE BELIEFS ABOUT RELAPSE.
- TO IDENTIFY PERSONAL ANTECEDENTS FOR DRUG USE.
- TO UNDERSTAND THE ROLE OF ANTECEDENTS IN RELAPSE.

Activities

- GROUP DISCUSSION.
- LIST OF ANTECEDENTS.

Inter-sessions activities

- ANTECEDENTS AND RELAPSE.

Psychoeducative presentation

Distorted thoughts about relapse

There are many false beliefs about relapse. These wrong ideas only help to worsen relapse when it occurs. Today we will analyze some of them.

1. Relapse is a sign of failure in recovery. Relapse means that you made a mistake. But you can learn from it. But the usefulness of relapse depends on your attitude. If you openly accept your mistake, you will be able to learn from what has happened. If you lie and try to hide your problem, relapse will be useless.
2. Relapse is indicative of low motivation to change. Nobody is risk-free, regardless of the level of motivation.
3. Relapse is unpredictable, and unavoidable. There are many alarm signs that warn you of a possible relapse. Through the unit we will try to find yours.
4. Relapse is concerned exclusively with one kind of drug. Relapse remains becoming an addict to a substance, regardless of your previous experience with it. If you are a former cocaine user, and begin to drink alcohol until you become and alcoholic, then you have relapsed.
5. Relapse destroys the previous recovery process. A period of abstinence involves plenty of positive learnings. Relapse does not make you forget these positive habits and behaviors.
6. If relapse is not the end of recovery, then it is not that bad. Relapse is a bad thing. We have to try to prevent it. Recovery after a relapse is not easy.

Identification of antecedent stimuli

During Unit 7 I explained that we can make a simple explanation of human behavior using three components: behavior, antecedents and consequences. Antecedents are all preceding stimuli associated with a behavior. They can be external (situational) and internal (thoughts, emotions). Consequences are all stimuli that follow behavior. They can be positive or negative, and occur in the short or long term.

Drug use is a behavior that is associated with antecedents and consequents. If we manage to break the chain of stimuli that lead to drug use, the risk of relapse will be lowered. Furthermore, you will increase your self-esteem and self-confidence. The presence of drug-related antecedents in our lifestyle could lead us through the relapse process. Their presence would foster our apparently irrelevant decisions. The frequency of antecedents is a key feature of a high risk situation. Therefore, it is most relevant to identify our own personal antecedents in order to cope effectively with them.

Group dynamics and materials

8.3. Group discussion

Goals

To make participants aware of their own distorted ideas about relapse.

Materials

Annex 8.3.

Guide for the exercise

Separate your group in two subgroups. Participants will discuss about the myths in Annex 8.3. They must explain to what extend they agree with every of these ideas. Their opinion must be supported by arguments. In a second stage, both groups share their opinion in a group discussion. Therapist will initially promote the free expression of ideas, regardless of their inadequateness. It is useful to write all opinions in a blackboard. Once discussion is over, the therapist will analyze every opinion, indicating their level of inaccuracy.

Annex 8.3. Group discussion

Please, give your opinion about the following ideas:

1. Relapse is a sign of failure in recovery.
2. Relapse is indicative of low motivation to change.
3. Relapse is unpredictable, and unavoidable.
4. Relapse is concerned exclusively with one kind of drug.
5. Relapse destroys the previous recovery process.

8.4. List of antecedents

Goals

To make participants aware of their own internal and external drug-related antecedents.

Materials

Annex 8.4.

Guide for the exercise

Provide participants with the list in Annex 8.4. They have to decide if every antecedent is internal or external. In addition to this, they have to select those that they consider to be applicable to their personal case.

If they think that any relevant antecedent is not present in the list, they can write it in the final blank space. Once the exercise is over, the results can be analyzed through group discussion.

This exercise is similar to 7.1. There are different reasons to make a similar activity. First, the list of antecedents is significantly longer. Second, participants will analyze these factors with more depth, considering their internal or external nature. Third, in the following exercise antecedents should be considered in the frame of the relapse process.

Annex 8.4. List of antecedents

Read the following list and indicate (a) if every one of these antecedents is internal or external, and (b) select those that you think that are applicable to your personal case.

1. Talk about the effects of drugs.
2. To be very angry.
3. Argument with relatives
4. Feeling lonely.
5. Feeling bored.
6. To have plenty of debts.
7. To think that life is terrible.
8. Hang around with friends who use drugs.
9. To think that I can't change.
10. To go out of prison.
11. To see someone buying drugs.
12. To be offered drugs.
13. To know that I have to go to court.
14. To see a syringe.
15. To argue with a stranger.
16. To walk through a neighborhood were people use drugs.
17. To disagree with domestic rules imposed by my relatives.
18. To argue with my partner.
19. To have plenty of money.
20. To have problems with my children.
21. To see another drug user.
22. To see a film related with drugs.
23. Dreaming with drugs.
24. To think that using drug only one time is not bad.
25. To feel anxious.
26. Meeting new people.
27. To feel pressured at home because my relatives do not trust me.
28. To have physical pain.
29. To drink alcohol.
30. To feel sad.
31. To think that I need drugs to have sex.
32. To think that I need to relax.

33. Feeling very hapy.
34. To think that I have remained drug-free for enough time to worry about relapse.
35. To feel rejected by relevant people in my life.

Are there any antecedents that you think that are missing in this list? Please, indicate them:

Inter-session activities

8.5. Antecedents and relapse

Goals

To reframe drug-related antecedents in the context of the relapse process.

Materials

Annex 8.2.

Guide for the exercise

Participants should take their personal list of antecedents and indicate in which stages of relapse could be present. Through this activity, participants will further tailor the personal relapse process that they initiated in activity 8.2. If necessary, provide participants with new copies of Annex 8.2.

SESSION 3

Goals

- TO IDENTIFY PROTECTIVE BEHAVIORS.

Activities

- LIST OF PROTECTIVE HABITS.
- COPING WITH HIGH RISK SITUATIONS.

Psychoeducative presentation

How to cope with the initial stages of relapse

Relapse is a process that it is initiated by changes in our lifestyle. These changes affect us in a way that initiates a cascade of events that finally could lead to a relapse. For instance, we could lose our job, and this could lead to feelings of depression and conflicts with our partner. Or we could become friends of someone who promotes unhealthy habits, like drinking too much alcohol. There are many different examples. The way to cope with this initial stage of relapse is to have a positive lifestyle with well-established habits that may resist all changes that may come.

How to cope with risk situations

If we do not cope appropriately with the initial stages of relapse, the process will lead us to a high risk situation, in which a failure is very likely. This is the moment where the skills that we have learned in the program are most useful. Social skills will be necessary to resist group pressure. Emotional management will be useful to control our desire to avoid negative emotions using drugs, or to manage craving. Cognitive skills will help us to question those thoughts that promote drug use.

8.6. List of protective habits

Goals

To make participants think about positive habits which are protective against relapse.

Materials

A blackboard or flipchart.

Guide for the exercise

The participants will suggest all habits that promote abstinence. It could be done individually or through group discussion. The therapist should provide feedback about the appropriateness of all proposals.

8.7. Coping with high risk situations

Goals

To make participants plan a positive strategy to cope with high risk situations.

Materials

Annex 8.7.

Guide for the exercise

The participants will complete Annex 8.7, using personal examples. They have to describe a high risk situation and the coping skills that they consider that would be useful. The skills that could be used in this exercise are the ones that have been trained through the program. The following table provides examples of some of these skills.

EMOTIONAL SKILLS	COGNITIVE SKILLS	SOCIAL SKILLS	OTHER STRATEGIES
Relaxation techniques. **Five steps for emotional self-regulation.** **Acceptation of the emotion. (train of thoughts).** **Expression of the emotions you are feeling.**	Distraction. Rational debate of irrational thinking. Self-instructions.	Assertive responses to resist group pressure. Start new conversations.	Avoidance of situations. Escape. Creation of new healthy habits.

Annex 8.7. Coping with high risk situations

Think about a situation that you consider that would be of high risk for you, and complete the following exercise.

SITUATION (describe the situation).	HOW TO COPE WITH IT? Emotional skills: Cognitive skills: Social skills: Other options:

SESSION 4

Goals

- TO TRAIN HOW TO COPE WITH A FAILURE.

Activities

- COPE WITH FAILURE.

Psychoeducative presentation

How to cope with failure?

If you cope effectively with high risk situations, you will feel an increase in your self-confidence. But sometimes things go wrong and you can have a failure. By failure we mean using drugs at a single moment. This could lead to feelings of guilt, and to negative thoughts focused only in failure. This is what we call effect of the violation of abstinence. Some of the effects of failure are:

1. To experience the effects of drugs.
2. Loss of self-esteem.
3. Loss of self-efficacy.
4. Distorted feeling of self-control.
5. Fear of the reaction of our relatives and friends.

After a failure, we have to analyze the situation that preceded it. Failure indicates that something went wrong. Our goals are (a) to learn from the experience and (b) to gain control and return to abstinence as soon as possible. When a failure takes place, follow these steps:

1. Stop and think about what happened: Try to reconstruct the chain of events that led to failure.
2. Keep calm: You may feel initially guilty. This is part of the effect of abstinence violation. But guilt can have two effects (a) make us lose any hope of recovery or (b) be the engine of change.
3. Do not pay attention to your negative thoughts. Focus on the long term benefits of recovering abstinence.
4. Think about a recovery plan.

    a. Get rid of all drugs you may have.
    b. Avoid the high risk situation that led to failure.
    c. Analyze the high risk situation. What happened? Which alarm signals did you ignore? Did you try to cope with the situation? What can you do next time?

5. Ask for help. Tell your family what has happened. Look for professional help. There is people around you who is willing to give you support.

8.8. Coping with failure

Goals

To help participants to generate positive coping skills after a failure occurs.

Materials

Annex 8.8.

Guide for the exercise

The participants will be asked to complete Annex 8.8. using their personal experience with failure. During group discussion the therapist will highlight the relevance of (a) learning from failure and (b) control it as soon as possible to avoid full relapse. Participants should be aware of the relevance of coping with failure in a positive way. A failure is not a full relapse, but it could be the beginning of it. Negative emotions associated with the failure could be an obstacle for an appropriate management of the situation. All past successes are positive learning experiences that do not disappear after failure. Failure itself is also a learning opportunity:

1. Participants should ask themselves what went wrong, which wrong decisions they made and when did the process that led to the failure begin. Probably they made some apparently irrelevant decisions that led them into a high risk situation. They should try to analyze this using the relapse prevention process.
2. What changes should they make in their environment? For instance, which situations and people they should avoid. They also should get rid of drugs and drug related items (i.e syringes).
3. They should pay some attention to their thoughts and feelings. What are they thinking? For instance, thoughts like "I am a complete failure, I will never change" and the negative feelings associated could lead the person to a full relapse.
4. After failure, drug users are highly vulnerable. Therefore, social support and external help are of main relevance. Who can help them after failure? They should look for close friends and relatives who are not involved in a drug related lifestyle.
5. Sometimes professional help could be necessary. It depends of the availability of this help and on the reaction of the drug user after failure. If the person feels that it is impossible to deal with failure and the risk of relapse is high, then look for professional counselling.

Annex 8.8. Coping with failure

Please, try to remember one occasion when you failed after a period of abstinence, and complete the following exercise.

DESCRIBE THE SITUATION	HOW DID YOU FEEL?	COPING STRATEGIES FOR THE ADVERSE CONSEQUENCES OF FAILURE

CLOSING AND SUMMARY

1. Introduction

After a long program, participants need to close the therapeutic process in a meaningful way. Furthermore, the program involves both individual and group processes. The end of the program means the end of a personal learning, but also the dissolution of a group. This process requires a certain degree of professional guidance.

Therapeutic goal

1. To help participants to reach meaningful conclusions regarding their participation in the program.

SESSION 1

Goals

- TO HELP PARTICIPANTS TO REACH CONCLUSSIONS REGARDING THEIR PARTICIPATION IN THE PROGRAM.

Activities

- A LETTER TO MYSELF.

9.1. A letter to myself

Goals

To help participants to reach positive conclusions about their participation in the program.

Materials

Annex 9.1.

Guide for the exercise

The participants will be asked to write a letter to the person they were before they started the program. In this letter, they should explain to their old self why they should attend the therapy sessions and what they will learn. After letter completion every participant will read it to the group. The rest of the participants will provide them with feedback. Therapist will highlight the following points:

1. Goals accomplished during the program. In what points every participant has experienced a positive change.
2. Difficulties and how they were overcome.
3. Positive aspects of group dynamic.
4. Which goals were not accomplished? Challenges for the future.

Annex 9.1. A letter to myself

Think about the person you were before the program. Think about how you are now. Write a letter to your old self. In this letter you should explain to your old self the reasons for participating in this program, and what you have learned.