Treatment for Substance Use Disorders for Adults with Learning Disabilities
by
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A thesis submitted to the School of Community Services in partial fulfillment of the requirements for the Honours Bachelor of Behavioural Psychology

St. Lawrence College
Kingston, Ontario
Canada
Friday, April 14th, 2017
Dedication

To my late dog Lilo – I miss you.
To my family – Thank you for always being proud of me.
To Nicholas – For always being the most supportive.
Abstract
Individuals seeking treatment for a substance use disorder (SUD) frequently have secondary diagnoses, and often these diagnoses can have negative impacts on the individual’s reading and comprehension skills. Many primary care settings do not provide alternative treatments for individuals with a learning disability, and are not able to offer extra attention to assist these individuals as they navigate their substance use disorder treatment. Asking the counselors in these settings to provide more individual attention would be adding extra strain on the counselors and their resources, and typically is not possible. This issue highlights a significant gap in substance use disorders treatment. As a result, this thesis focused on bridging this gap at the Addictions and Mental Health Services – Hastings and Prince Edward County Residential Treatment Centre. A set of guidelines was created and applied to modify existing therapy related documents to be more accessible to individuals with reading and comprehension difficulties. This method, and these guidelines were based on empirical evidence as determined through a thorough search of the literature. A major limitation of this thesis is that the modified documents were not implemented during the development of this thesis, nor was the efficacy of this method measured. A recommendation for future research would be the empirical testing of these methods, and the effectiveness of the modifications for improving comprehension for individuals with an SUD and an intellectual or learning disability.
Acknowledgements

I would like to acknowledge all the staff I had the pleasure of meeting while on placement with Addictions and Mental Health Services of Hastings and Prince Edward County. Thank you for inviting me into so many learning experiences.

A special thank you to my agency supervisor, Josh Oenema, who despite his busy workload, was always willing to help me learn. You were always available to field my questions and you provided me with so many opportunities. Thank you for introducing me to new people and new experiences, and thank you especially for providing me with independence in the process. You’ve allowed me to grow in my skills, and confidence.

Finally I would like to give special acknowledgement to my college supervisor Stacey Dowling. You provided the best guidance imaginable in the process of creating this thesis. Thanks to you I have done something I can truly take pride in.
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Chapter I: Introduction

Addictions treatments and associated services are required to be diverse and accommodating to be able to effectively address the often co-occurring, mental health disorders. According to a study by Barrett and Chang (2016), a large portion of individuals seeking treatment for a substance use disorder (SUD) in a primary care setting, have other co-occurring diagnoses. It is estimated that two thirds of patients entering addictions treatment also present intellectual or learning disabilities; however, not all agencies are adequately prepared for accommodating clients with varying degrees of reading and comprehension needs (Yu, Buka, Fitzmaurice, & McCormick, 2006). According to Howell, Rogers, and Wilcock (2000), few interventions have been directed at teaching coping skills to adults within group or community settings. This identified gap in services is one that affects the AMHS-HPE Residential Treatment Centre.

In a cognitive behavioural setting clients are presented with information, given opportunities to engage personally with the information, and then provided with materials for future reference (Somers, 2007). The AMHS-HPE Residential Treatment Centre applies this method in their services; however, their materials do not currently vary with the different levels of reading and comprehension. Increasing effectiveness of this type of treatment involves accommodating the learning needs of all the adults seeking treatment. The literature that will be explored in this project suggests the efficacy of providing different methods and tools for teaching adults with varying levels of intellectual and/or learning disabilities. Evidence-based, cognitive behavioural methods exist, and are proven to be effective in teaching all ages and all levels of comprehension. It is important in all learning, including adult learning, that the differing learning needs and styles be identified and accommodated (Cartney, 2000). However, these methods are infrequently researched and applied as they pertain to addictions treatment and services for adult learners (Hanlon & Cantrell, 1991).

The purpose of this project is to compile evidence-based research on the best practices for teaching adults with intellectual/learning disabilities. Cognitive behavioural therapy as a treatment modality applied to addictions treatment, has been explored to examine how it can be applied for treating male adults with marked delays in reading and comprehension. For the purposes of this project, literature regarding both intellectual and learning disabilities will be included as both disabilities may cause challenges with reading and comprehension of materials. According to a publication by the Journal of Learning Disabilities a learning disability can be identified as memory or cognitive deficits that interfere with a person’s ability to learn concepts and/or procedures in multiple settings (Geary, 2004). Alternatively, an intellectual disability can be defined as a disability originating before age 18 that significantly limits intellectual functioning and adaptive behaviour (Schalock, Luckasson, & Shogren, 2007). Both intellectual disabilities and learning disabilities have been noted to impact conceptual, social, and practical adaptive skills. Through the application of this research, existing agency handouts and exercises will be modified to provide versions of the material to accommodate the varying levels of reading and comprehension. In a study on the relationship between literacy and cognitive abilities, the majority of struggling adult readers were able to read between a third and a fifth grade level (Hall, Greenberg, Laures-Gore, & Pae, 2014). In accordance with this research, the documents will be modified to meet a fourth grade reading level, making them more accessible to the widest range of clients’ abilities, while not being too simplistic (Hall, et. al, 2014).
At the Addictions and Mental Health Services of Hastings and Prince Edward County (AMHS-HPE) Residential Treatment Centre, the clients participate in a 21-day structured treatment that focuses on cognitive behavioural group sessions. The agency provides approximately 50 group sessions with varying topics that address irrational thoughts and help the clients to create and learn additional coping skills to apply to life after treatment. At any given point the residence could be home to an average of 16 male adults. Due to the length of treatment, the turnover rate is high with new clients entering or leaving treatment every week. As a result of the frequent turnover and numerous clients, the agency has found there is a gap in services when accommodating various levels of reading and comprehension. The first goal of this project is to compile peer-reviewed research showing the necessity and effectiveness of accommodating the different learning needs of clients. The second goal of this project is to review existing documents and handouts for accessibility. By the end of this project the agency will have the research on best practices for addictions treatments with intellectual disabilities, as well as handouts and documents revised to be more accessible to all clients.

Chapter II: Literature Review

Learning Disabilities in Adult Learners

A majority of the research involving the education of individuals with a learning disability (LD), revolves around the identification, education, and remediation of learning and intellectual disabilities in children (Hall, Greenberg, Laures-Gore, & Pae, 2014). However, there has been little research put forward to discuss the same difficulties as they pertain to the adult learner (Hanlon & Cantrel, 1999). There is a clearly identifiable gap in research surrounding adult literacy, specific characteristics of reading impairment in adults, and the relationship between literacy and other cognitive abilities in adults (Hall et al., 2014). Hall et al. (2014), explored the relationship between expressive vocabulary and reading skills for struggling adult readers. Expressive vocabulary was broken down into phonological representations and semantic information. Hall et al. found that of the 232 adults in the study, all participants read between a third and a fifth grade level. More research has been done on this relationship in children and adolescents, but little has been done in this area for adults (Hall et al., 2014). Strothers and Klein (2010), conducted research to attempt to provide some clarity on the extent to which LDs impair reading comprehension in adults. The purpose of their study was to investigate the impact of basic cognitive functioning on reading ability for adults with a learning disability (Strothers & Klein, 2010). The core cognitive factors that typically underlie reading ability in adults were identified in this study to be phonological awareness and perceptual organization (Strothers & Klein, 2010). Phonological awareness is the conscious awareness an individual possesses of the separate sounds that make up words (Fracasso, Bangs, & Binder, 2016). Phonological awareness is measured based on a person’s ability to break words into separate sounds, recombine the sounds back into words, and the ability to identify when words have common sounds (Fracasso et al., 2016). Perceptual organization refers to components of intelligence, such as nonverbal concept formation and visual memory, which were formally known as performance IQ (Strothers & Klein, 2010). There is conflicting information provided by studies on what differs in reading comprehension between adult learners with learning disabilities, and those without. However, impairments in phonological awareness are indicated universally as playing a large part in reading comprehension, particularly for those with dyslexia (Strothers & Klein, 2010). Reading comprehension is a complex skill that requires the application of multiple cognitive processes,
and it plays a large role in knowledge acquisition and understanding of concepts (Tighe & Schatschneider, 2016). Cognitive behavioural therapy involves a lot of reading and writing for the treatment to be effective, thus an individual is required to actively engage with and understand the materials for competency in the materials and learning.

Many studies cite the need for further research and application of treatment for this population, but very few suggestions for treatment have been made, and even fewer have been tested. Applying the same intensive learning models used for children is not possible in adult education due to the limited time available to adults outside of their other responsibilities (Fracasso et al., 2016). In an analysis of the components of literacy skills in the adult learner population, it was stated that phonological awareness is one of the most prominent predictors of reading comprehension (Fracasso et al., 2016). Following an investigation of the components of literacy, it was noted that phonological and morphological awareness are key contributors in reading comprehension (Fracasso et al., 2016).

Increasing literacy in adults remains an important goal in the research areas of disabilities and literacy. In a National Adult Literacy Survey in the U.S., 50% of all adults surveyed performed in the two lowest levels of functional literacy, illustrating that there is a need for access to services in this population (Hock, 2012). According to Gregg (2012) the population of adults struggling with literacy will continue to grow, as adolescents with learning disabilities (LD), tend to drop out of school more often than their peers. Gregg (2012) also states that the adolescent and adult population with LDs will continue to be underserved, and consequently underprepared, for continuing postsecondary education. In a review of the literature on adult education, Gerber (2012) states that there is no adult-specific definition for LD. Since there are no specific parameters for defining and identifying LD in adults, the suggestions for treatment and treatment outcomes vary greatly (Gerber, 2012). A learning disorder will present itself differently for every individual depending a wide range of functioning abilities (Gerber, 2012). The varying presentations and functioning for individuals with an LD, means that treatment and services cannot effectively be provided with a “one size fits all” approach (Gerber, 2012). The process of improving literacy and language skills acquisition in all individuals, including adults, is a long-term process that requires considerable time and effort (Anastasiou & Michail, 2013). Due to the time it would take to improve literacy, adult learners are rarely able to access adequate services while maintaining their other ongoing responsibilities (Fracasso, Bangs, & Binder, 2016). This illustrates that efforts will need to be made to accommodate this population when they are seeking treatment for other disorders.

It is suggested in the research that fluency and accurate reading are essential for learning success, as inaccurate and broken fluency interferes with comprehension and consequently will impede treatment success (Mellard, Fall, & Woods, 2013). It is the hope that by modifying the existing documents in use at AMHS-HPE, fluency will improve for individuals experiencing difficulties in literacy. In cognitive behavioural therapy, as it is executed at the AMHS-HPE Residential Treatment Centre, a large component of treatment are handouts and exercises, that require a level of reading at which some individuals may not function. Comprehension of these materials is an essential part of treatment efficacy. Ideally, there would be more tried and tested methods for effectively supporting students, of any age, with learning or intellectual disabilities (Watt, Watkins, & Abbitt, 2016). According to a review investigating the teaching of algebra to students with disabilities, further emphasis needs to be placed on skills, content, and instructional practices when providing education to students with a LD (Watt et al., 2016). This review
suggests that studies fall short on developing and testing best practices for addressing varied learning needs, and optimizing education for students with disabilities.

In any educational setting efforts should be taken to increase the overall achievement of all students, and equally so, students with disabilities (Watt et al., 2016). In accordance with this review, the goals of this project are to provide tools to help optimize the learning experiences and treatment outcomes for those individuals seeking treatment at the AMHS-HPE Residential Treatment Centre.

In 2002 an adult male attended a residential treatment facility to receive services to treat his substance abuse. The program he entered was a 90-day intensive recovery program that required him to complete many rigorous reading and writing tasks (Beverstock & McIntyre, 2008). The authors indicated that like many of his peers receiving treatment at this centre, he had difficulties with literacy and lacked the skills he needed to be successful in the program. At this particular institution a secondary program was offered to help students improve their literacy, with the overall target of using their new skills to successfully complete the recovery program (Beverstock & McIntyre, 2008). The literacy program, called “Project Read”, accesses simple strategies and tools to improve clients’ abilities to read. Some simple techniques used were highlighters, clustering, reading aloud, reading backwards, and revision. The techniques that will be implemented in the current project were inspired by the strategies used in the Project Read program. The result of the Project Read program was that participants in both programs were 50% more likely than their peers, who were not in Project Read, to complete the 90-day residential recovery program (Beverstock & McIntyre, 2008). The mentioned individual graduated both programs, completed his GED, and was eventually employed at the residential treatment centre as a counselor. He was later promoted within the agency, indicating the importance of being able to apply adequate literacy skills within the programs designed to treat an SUD.

**Substance Use Disorders and Comorbidities**

Although the body of research on effective treatments for individuals with a substance use disorder (SUD) is growing, few studies have examined the relationships between SUDs and learning disabilities (Beitchman, Wilson, Douglas, Young & Adlaf, 2001). Substance use disorders and intellectual or learning disabilities often co-occur and share many risk factors (Beitchman et al., 2001). Overlapping risk factors include; behaviour problems, low family socioeconomic status, and low self-esteem (Karacostas & Fisher, 1993, as cited in Beitchman et al., 2001). According to a study on predictive and concurrent relationships between an SUD and a learning disability, participants with a learning disability were found to have an increased risk of developing an SUD by age 19, when compared to the neuro-typical population (Beitchman et al., 2001). The study measured for learning disorders, psychiatric disorders, anxiety disorders, and substance use disorders in 236 young adults across various points in time (Beitchman et al., 2001). After analyses of the data, there were significant correlations between learning disorders and substance use disorders at age 19 (Beitchman et al., 2001). This research suggests that improving literacy may be able to improve outcomes for individuals with SUDs and potentially provide early intervention for individuals with learning/intellectual disabilities at risk for developing an SUD.

Dance and Galvani (2014), suggested that despite conflicting research on comorbidity between learning disabilities and substance use disorders, there is merit in workers in the field trying to understand how to best treat this population. While there is no clear and definite link
between a learning disability and an increased likelihood of developing an SUD, the movement for those with intellectual disabilities to be more independent and included socially, will likely create more opportunities for this population to use alcohol or other drugs (McGillicuddy, 2006 as cited in Dance & Galvani, 2014). It was also noted that individuals with a learning disability are often more susceptible to suggestibility and have a more difficult time breaking habitual behaviours (Dance & Galvani, 2014). Consequently, the researchers suggest it would be practical for all future clinicians to make efforts to understand the diverse needs of clients with learning and comprehension difficulties.

Another study was conducted using Mexican American teenagers with identified learning disabilities (Maag, Irvin, Reid, & Vasa, 1994). The authors found that links exist between the rates of adolescents’ perceived self-esteem and rates of substance abuse (Maag et al., 1994). Increased concerns of adolescent alcohol and drug use led to research discovering that one of the most frequently cited risk factors for substance abuse was low self-esteem (Maisto & Carey, 1985; Werry, 1986, as cited in Maag et al., 1994). Typically, the lower an adolescent’s self-esteem, the more susceptible they are to developing a SUD (Maag et al., 1994). The study found that substance use began because adolescents experienced increased enjoyment in social interactions as a result of using. Consequently, students who viewed themselves as different, were more vulnerable to developing a substance use disorder in the process of trying to fit in socially. Mexican American students with a learning disability present with increased risk factors. Being an ethnic minority impacts self-esteem, while having a learning disability also contributes to viewing themselves as psychologically different. This research suggests that providing accommodations to improve literacy can impact self-esteem, thereby potentially intervening before an SUD even forms.

The increased risk factors, combined with the different educational needs, create an area for treatment that requires further development. While there is conflict in the literature on whether or not a larger percentage of individuals with intellectual disabilities develop an SUD, the increased risk factors make clear that they are equally, if not more susceptible to drug and alcohol abuse. This population presents clinicians with the challenge of creating a more accessible method for providing equally positive treatment outcomes for those with substance use disorders and co-occurring learning/intellectual disabilities.

Substance Use Disorders Treatment

In 2009 a study was conducted to research the efficacy of behavioural treatments for substance use disorders (SUDs) for individuals with comorbid post-traumatic stress disorder (PTSD). McGovern et al. (2009), found that approximately 35% to 50% of individuals seeking treatment for an addiction also have a lifetime diagnosis of PTSD. The symptoms of both an SUD and PTSD have a compounding effect, and consequently lead to a negative impact on psychiatric health, medical health, social functioning, and employment (McGovern et al., 2009). Research measured PTSD severity, substance use, and retention of participants. Measures were taken for 11 participants at baseline, post CBT treatment, and at a 3-month follow-up. This study conducted research on a three component CBT treatment and compared those findings to those of other studies that used four other approaches. The alternative methods were; Seeking Safety, Transcend, Concurrent Treatment of PTSD and Cocaine Dependence, and Substance Dependence PTSD Therapy (Triffleman, Carroll, & Kellogg, 1999; Back, Dansky, Carroll, Foa, & Brady, 2001; Brady, Dansky, Back, Foa, & Carroll, 2001; Donovan, Padin-Rivera, & Kowaliw, 2001; Najavits et al., 1998; Najavits, 2002 as cited in McGovern et al., 2009). The
study was designed to compare the effectiveness of five behaviourally based addictions programs that were designed to improve outcomes for both diagnoses (McGovern et al., 2009). Among the tested methods, cognitive behavioural therapy was noted to be the most effective in reducing substance use when used to treat post-traumatic stress disorder (McGovern et al., 2009). When comparing rates of retention of participants to other methods used to treat co-occurring PTSD and SUD, retention rates of CBT were higher (McGovern et al., 2009). The main challenges facing clients within these programs, continued to be treatment engagement and completion (McGovern et al., 2009). However, among the 65% of the original sample that completed the study (11 completed participants), PTSD, and PTSD symptoms were either eliminated or decreased at both the post-treatment measure, and at the 3-month follow-up measure (McGovern et al., 2009).

Petitjean et al. (2014), conducted a study comparing the efficacy of cognitive-behavioural therapy (CBT) alone, versus CBT combined with a prize-based contingency management (prizeCM), in treatment of cocaine dependence. Of the 60 total participants, 31 were in the CBT only group, and 29 were in the combination CBT/prizeCM group. Both groups were 24-weeks in duration. Throughout treatment duration and at 6-month follow-up, the retention of clients was recorded, and urine tests were taken to determine cocaine use. Among the 63% of the clients who completed treatment, there were no major differences in cocaine presence in urine samples across the groups. The outcome from both groups supported previous studies and showed overall reductions in cocaine use during treatment, and at 6-month follow-up. The addition of the prize-based contingency management led to the enhancement of treatment effects in the beginning weeks of treatment, but otherwise had the same results as the CBT group. The results of this study mirror the results of previous studies, indicating that CBT is among the most recommended therapies for treating an SUD as well as treating a SUD with a co-occurring diagnoses.

A case study was conducted using two individuals, both presenting with a SUD, as well as comorbid attention-deficit hyperactivity disorder (ADHD) (van Emmerik-van Oortmerssen, Vedel, van den Brink, & Schoevers, 2015). The first participant was a 31-year-old male diagnosed with ADHD and problematic alcohol use whom had attempted, but did not complete, two different therapies prior to the study. The second participant was a 25-year-old male who was referred to the program due to heavy cannabis use and the presentation of several ADHD symptoms. Based on various screeners at intake to the program, both clients were recommended for outpatient programming at the facility to help them improve functioning and cease the use of their specific substances. For both clients the method used was integrated cognitive behavioural therapy (ICBT). The purpose of ICBT was to help improve the symptoms associated with ADHD, while still addressing the need for cessation of substance use. The conclusion from both participants was that the integrated approach is a promising new way to treat individuals with a SUD that are presenting a secondary diagnosis. The key to success for both clients was noted to be the simultaneous treatment of both disorders, rather than treating the disorders sequentially.

Research on providing treatment for a substance use disorder is ongoing and gaining momentum. However evidenced-based psychotherapies like CBT are still being underutilized despite the flexible nature and cost effective treatment delivery options for CBT (Curran, Woo, Hepner, Lai, Kramer, Drummond, & Weingardt, 2015). Program delivery is impacted heavily by staff attitude and instruction technique. The process through which information is delivered is a key factor for many individuals receiving treatment for various disorders. Those receiving treatment for a substance use disorder are no different. In a research study on the attitudes of
staff teaching adult basic education, it was stated that staff attitudes towards program delivery and clients are likely to play a large role in the success of their students (Reynolds & Hitchcock, 2014). If the educators utilize assessment and instruction appropriately they will be able to foster successful student learning (Berninger & May, 2016). A method through which educators can use appropriate instruction techniques is by identifying individual learning styles (Cartney, 2000).

The program at the AMHS-HPE Residence is only 21 days in duration, and consequently assessment and instruction cannot be addressed thoroughly on an individual basis. However, by providing a secondary option for information delivery to clients, specifically more than one version of the take-home material, the staff will improve comprehension and efficacy of the treatment.

**Cognitive Behavioural Therapy**

Making Cognitive Behavioural Therapy (CBT) accessible for individuals at all levels of comprehension is a key component in the effectiveness of the therapy. CBT is a very structured and collaborative treatment method that requires the participants to comprehend the materials well enough to be able to set goals in session, and independently complete homework between sessions (Somers, 2007). According to a core information document from the Centre of Applied Research in Mental Health and Addictions (CARMHA), CBT explores the relationships between thoughts, feelings, and behaviours and how they feedback into, and effect, each other. The therapist’s main function in this therapy is to provide expertise in the practice, while providing guidance to the individual seeking treatment, as the individual alone is the expert on his or her own thoughts and feelings (Somers, 2007). These interactive components place a lot of the responsibility for treatment outcomes on the individual themselves. To effectively participate in the goal setting, and homework components of this type of programming, the individual is required to be able to read, write, and comprehend the materials provided in therapy. The demand for CBT to treat various populations is growing, and within the field of addictions treatment that need remains consistent. Cognitive behavioural therapy is proven to be effective in treating substance use disorders (SUDs), reducing relapse rates, and for individuals with co-occurring mental health problems seeking treatment for SUDs (Somers, 2007; McGovern et al., 2009). Individuals seeking treatment for a SUD are often presenting with a variety of mental health and developmental disorders at the same time (Beitchman et al., 2001). CBT is known to be effective in treating the symptoms of many individual disorders, and is also shown to be effective for treating individuals with concurrent multiple disorders (Somers, 2007). As a result of the frequency of co-occurances including learning and intellectual disabilities, it is important to provide accessible treatment (Beitchman et al., 2001; McGovern et al., 2009). To best meet the unique needs of all individuals seeking cognitive behavioural therapy to treat a SUD, accessibility of documents and reading materials will be key to treatment efficacy (Somers, 2007).

**Summary**

Many of the researchers cited above have pinpointed the limited amount of research and studies conducted in the area of adult education. Adult literacy within the SUD population is an area that requires much more research before the most effective methods for treatment can be identified and tested (Fracasso, Bangs, & Binder, 2016). The level of comprehension of
treatment materials directly impacts the efficacy of treatment received. Adult basic education requires time and effort that most working adults cannot afford to contribute, and as a result these individuals may never be able to adequately address their reading deficits (Fracasso et al., 2016). This factor alone is enough to highlight the need for accommodations to be made in the delivery of CBT based SUD treatments. Consequently, by altering the materials to be more accessible to the clients receiving CBT, treatment outcomes should be improved for those individuals with reading comprehension deficiencies and learning disabilities.

Chapter III: Method

Participants
Given the research-focused nature of this project, there are no participants, as there will be no one asked to participate and no information will be gathered on the clients. No consent procedures were required.

Research Design
The design of this project requires the gathering and compiling of peer-reviewed information on the general topics of substance use disorders and learning disabilities, as well as the treatment and accommodation of both topics. There will also be a review of existing agency documents. The handouts and exercises from specific group sessions will be reviewed and may consequently be edited and modified to be more appropriate for various reading and comprehension levels. The original versions of the handouts and exercises will be kept and used as the default material. The revised documents will be given to clients that either disclose a learning disability, or to those who struggle with the original material.

Setting and Apparatus
Research will take place predominantly outside of the agency. Revising and rewriting the agency documents will take place both within the agency as well as other locations.

Materials
The materials for this project include agency handouts, and any research compiled. Research will be gathered using peer-reviewed articles and books, located using the St. Lawrence College library, and EBSCO online databases. The resources will provide peer-reviewed, empirical literature necessary for creating a useful source of information for the agency. Information will be kept on a password secured laptop computer.

Procedures
The author will search the data-bases (EBSCO Host and Google Scholar) for relevant peer reviewed research on the topics of concern. The following keywords were searched in multiple varying combinations: adult learning, disability, reading, comprehension, grade 4 reading standards, intellectual disability, learning disability, substance used disorder, substance use disorder treatment, and addictions treatment. The procedures consist of using peer-reviewed,
empirically supported research, to provide an organized literature review of relevant information to the staff at the AMHS-HPE Residence.

Group session handouts and exercises will be reviewed with the following concerns in mind: length of sentences, length of paragraphs, complexity of concepts, number of syllables per word, and commonness of words. Identified documents will then undergo modifications specific to thesis guidelines. A literature review was conducted to locate an evidence-based procedure for standardizing documents, however no specific standards were found. As a result a standardization procedure was created. Documents will be modified based on the following structure.

i) Words consisting of more than five syllables will be replaced with shorter synonyms.
ii) Words that cannot be replaced will be defined in “Key Terms” boxes within the documents. (Appendix A)
iii) Words that encompass important concepts will be defined in “Key Terms” boxes within the documents. (Appendix A)
iv) Sentences consisting of more than ten words will be shortened.
v) Paragraphs consisting of more than five sentences will be shortened. (Appendix B)

Originals of the modified documents will be kept in a filing cabinet with the originals of the default documents. An electronic copy of the modified documents will also be kept at the agency.

Chapter IV: Results

This project consisted of two main goals. The first goal was to summarize the research regarding accommodations for adult learners with issues with reading comprehension and literacy, or a learning disability. The second goal was to produce a useful set of modifications the agency can use in future group session documents, as well as provide modified versions of existing group documents. The modified documents can be implemented in the case of individuals entering the program with declared intellectual disabilities, or to individuals who identify that they are struggling with the material. The final product created in this project is the modification of ten of the Residence’s group sessions being modified according to the Procedures. The modified group sessions can be found in Appendix C. The steps outlined in the Procedures section were applied to the following groups:

- ABCs of Substance Use
- Addiction and the Family
- Anger Introduction
- Assertive Communication
- Communication Basics
- Conflict Resolution
- Coping with Fears
- Coping with Depression and Anxiety
- Coping with Triggers Cravings
- Defense Mechanisms

The agency will be provided a copy of this project, which includes the steps to modify the documents. This will allow the agency apply these same steps to remaining and/or future group materials.
Chapter V: Discussion

Overview

Adult education is a growing research field (Howell, Rogers, & Wilcock, 2000). Within the field of addictions treatment the gap in addictions treatment for individuals with learning or intellectual disabilities can create additional obstacles for individuals seeking treatment for a SUD. A large part of cognitive behavioural therapy (CBT) as it is implemented in addictions treatment, requires commitment and engagement from the clients. Often reading skills and comprehension can be a factor in how effective treatment can be.

This project was designed to provide relevant research with regards to learning disabilities in adult populations, substance use disorders and comorbid learning disabilities, substance use disorders treatment, and CBT as it applies to addictions. The research was compiled so as to provide a meaningful reference for the agency and to provide a solid foundation for the remainder of the project. Remaining time was committed to creating a set of procedures for modifying agency materials. The goal was to modify as many group materials as possible; however, only ten of the groups were modified.

Strengths

A notable strength of this project was the scope of research. Information was drawn not just from fields involving adult learning disabilities, but rather various areas surrounding this population. Another strength is that this project was designed to address the gap in effective combined treatment for adults with learning disabilities seeking services for a substance use disorder. The process for improving accessibility is simple and inexpensive, meaning that the agency will not have to put forth extra funding to purchase tools or provide extra training to staff. Once the documents are modified they can be kept on file and easily accessed whenever necessary. An additional strength is the reduction of barriers to service for clients with learning disabilities. The process of modifying documents to improve accessibility, can be improved as research continues and, as more research is completed and the field expands techniques for improving accessibility can be refined and applied in new ways.

Limitations

The scope of this project was limited by time constraints. The project was to be completed over the course of a single college semester. The time constraint prevented the modification of all the agency’s group documents. Another shortcoming is that there was no client feedback available on the modified documents. Clients only receive the programming over the course of 21 days, and only experience each group topic once. This prevented the set-up of a process for obtaining feedback on how helpful the modifications are, compared to the original documents.

The largest limitation was the lack of structured and tested methods for improving the readability of documents. Specifically, no method was located for how to improve the readability of therapy related documents for adults with learning disabilities. This proved to be very difficult during the research stages of this project. A set of procedures was designed based on the reading
comprehension expected after successful completion of grade 4. Additionally, no research was conducted to see the effectiveness of this process.

**Contributions and Recommendations for Future Research**

The field of addictions treatment is ever changing, and the population requiring treatment is growing both in size and dynamic needs. The development and application of the procedure from this project will seek to improve accessibility within agencies applying CBT to treat SUD’s. Additionally, the documents that have already been modified will be kept on file for use at the agency for anyone who is identified as requiring extra assistance. The modified documents will be implemented at the agency to increase accessibility.

During the research portion of this project it was noted that there are few to no existing tested methods for modifying documents for specific levels of reading. This is particularly true for the adult population. In future applications of this procedure the effectiveness of this method can be verified by seeking feedback from clients on how helpful the modifications are. Furthermore, research should be conducted pre and post application of these recommendations to assess whether or not there are improvements to comprehension.

**Multilevel Challenges**

**Client level.** When working with adults receiving treatment for a SUD, they are often experiencing extended sobriety for the first time in a long time. As a result, they can often struggle with remaining attentive and engaged during group sessions. Due to the nature of the population, clients may experience difficulty with tasks that require reading and comprehension, or may even have acquired injuries during times of using that have long-term effects on their learning. Clients are referred to the residential treatment program from a variety of sources and not all clients are there due to a desire to achieve change. Consequently, clients entering the program are at different stages of change and may have no desire to engage with the programming in a meaningful way.

**Program Level.** During the intake process it is not possible to known with certainty the needs of the clients entering the program. Consequently, there is no clear way to know before treatment starts whether a client needs modified documents; specifically assistance with reading and comprehension. This means that in most cases there is no way to know if a client needs help until treatment has already started, at which point clients will still need to ask for assistance themselves. The nature of the programming provided at the residence is very group specific. There is very little one-to-one attention available for the clients and there is no funding available to allow for more individual attention to be given. Attempting to incorporate more individual work would lead to higher caseloads for existing staff.

**Organizational Level.** At the organizational level, there is no mandatory training or extra equipment available to help educate staff on how to provide treatment to adults with learning disabilities. Addictions and Mental Health Services is a large organization with a broad spectrum of services offered to those populations, however, no concentrated efforts have been made to accommodate adults with learning disabilities. Many clients seeking services through AMHS may have intellectual disabilities that may, or may not, be identified. The services offered are broad and vary in their delivery. However, there are no special guidelines or recommended approaches when providing services to these individuals. For example, a crisis intervention counselor retrieves materials based on the client’s initial presenting issue. The job of
this counselor is mainly to defer clients who frequent emergency rooms from doing so. For some of these clients isolated incidents can trigger a variety of reactions that may bring a person to seek assistance at a hospital emergency room. In most cases, the outcome sought by the client can be attained from other sources (the crisis intervention counselor) and they do not need to increase strain on hospital staff and resources. It is possible, and it frequently is the case, that these individuals have intellectual disabilities. The crisis intervention counselor is not treating the disability, and is not necessarily factoring in the disability when treating the client.

**Societal Level.** The population of adults with substance use disorders can be scrutinized and stigmatized by society. The general population often misunderstands addictions as a genuine disorder that requires treatment. Consequently, individuals with substance use disorders are seen negatively and often as people who refuse to help themselves. Individuals within this population often experience trauma in their lives and are dealing with so much more than just their addiction. They need to be granted the autonomy, dignity, and treatment available for any other disorder. The roots of each client’s issues are deep and require full assessment and treatment.
References


Appendix A: Sample of Key Terms Modification

Below is a sample of one of the handouts from the *Addiction and the Family* group. Modifications based on the procedural guidelines are highlighted.

**Consequences of Substance Abuse for Family Members**

- **Unpleasant emotions:** confusion, shame, anger, guilt, fear, feeling helpless, feeling alone or isolated
- **Stress related illness:** due to high levels of anxiety and improper care
- **Role imbalance:** children parenting parents, parents over protecting their adult children, one parent performing work that previously belonged to both parents
- **Lack of closeness:** can include absence of sexual intimacy between partners, feelings of not being included among all family members - due to treated betrayals, broken promises and breaches of trust, there is a loss of security and trust within the family unit
- **Loss of self and privacy, lack of boundaries:** energy is spent in "survival mode", trying to protect self and space. Instead of having these as a given, and being able to spend time learning and growing
- **Chaotic* environment:** safety comes and goes, inconsistent messages, everything is urgent and dramatic
- **Loss of honesty and integrity:** the environment is one of survival, and one survives by being strategic and manipulative. Being open with truth or sharing genuine thoughts and feelings is not advisable
- **Increased family abuse:** this can come in the form of physical violence, verbal abuse, threats, withholding love
- **Poor self care:** family members often become so focused on the substance user that they neglect caring for themselves and some forget how to care for their physical and emotional health
- **Adoption of Unhealthy Coping Strategies:**
  - Perfectionism
  - Rescuing
  - Obsessed with controlling things
  - Magical thinking
  - Disassociate*, check-out
  - Aggressive or passive
Key Terms:

* Chaotic: messy, confusing, hectic, disorganized

* Disassociate: disconnect, detach, isolate, separate
Appendix B: Sample of Shortening of Paragraphs

Discussion on Anger

PASSIVE STYLES:

Minimization*/Deflection*: A process of discounting anger - saying "something isn't a problem, it doesn't matter", or finding a way to justify a situation so that anger isn't warranted.

Passivity: An inability to get one's own wants and needs met. This inability to be self-serving is often justified by considering such behaviour to be virtuous.

Somatising/Avoiding: Forms of somatising* and avoiding can be seen in frequent illness or physical pain. Pain may include such things as headaches, ulcers, indigestion, high blood pressure, heart problems, back problems, etc. Also, seen in such things as boredom, stubbornness, jealousy, confusion, etc.

Turning Against Self: With any anger there is blame or fault finding; in this case, it turned inward against one's self - often referred to as "beating self up".
Appendix C: Modified Group Documents

Functions attributed to alcohol and/or drug use

Alcohol and/or drug use continues because it serves a purpose and continues to have purpose. The function is the pay off, benefit or reward which results from use.

Some examples of functions that are attributed to alcohol and/or drug use

1. **Reduce unpleasant feelings** – depression, anxiety, boredom, etc.
2. **Aid in doing something** – express anger or affection, socialize, etc.
3. **Production of pleasure** – enjoy taste or effects for the substance
4. **Conform to expectations of others** – difficulty refusing invitation to use, feeling social pressure
5. **Self-medication** – decrease physical pain, avoid withdrawal symptoms, sleep, etc.
6. **Non-specific** – habitual or routine, time, place or people
Process for Changing Substance Use

**Step One:** Establish Alcohol/Drug Use Pattern

a) Identify all types of substances used
b) How you use your substance
c) Frequency of use – days per week/times per day
d) Quantity

**Step Two:** Identify the Antecedents or Triggers of Use

a) Social: who you’re with, how you are relating
b) Situational: where, what you see/hear
c) Physiological: how you feel physically, what can you feel in your body
d) Emotional: how you feel emotionally
e) Cognitive: what you think about and say to self

**Goal:**
1) To understand triggers for use
2) Develop strategies or plans to avoid/eliminate/cope with triggers
3) Rehearse non-substance use responses to triggers

**Step Three:** Identify the Consequences of Use

a) What happens that you like as a result?
b) What gets better? What gets worse?
c) What do you get rid of that you don’t like?
d) How do you think or feel differently?

**Goal:**
1) Develop alternative ways to achieve positive pay-offs
**ABC’s of Substance Use Exercise**

1. What are three negative short or long term consequences that motivated you to stop using alcohol/drugs?

   a) __________________________________________
   
   b) __________________________________________
   
   c) __________________________________________

2. List three antecedents or triggers (Remember: situation/event → thoughts → feelings) that triggered your use or desire for the substance’s effects.

   a) __________________________________________
   
   b) __________________________________________
   
   c) __________________________________________

3. For each trigger you listed in Question # 2, think of a different way, instead of using substances that you could cope with the situation/ event, thoughts or feelings.

   a) __________________________________________
   
   b) __________________________________________
   
   c) __________________________________________

4. Name three pay-offs or rewards (positive consequences) of your substance use that reinforced your continued use or made it more difficult for you to stop.

   a) __________________________________________
   
   b) __________________________________________
   
   c) __________________________________________
5. For each pay-off (positive consequences) you listed in Question # 4, think of a different way (instead of using substances) that you could achieve the pay-off.

   a) _______________________________________________________________

   b) _______________________________________________________________

   c) _______________________________________________________________
Benefits Of ABC Analysis

• Increase awareness and understanding of the process leading to substance use.

• Helps identify and understand:
  
  1) Triggers and patterns of use
  
  2) Results of use – problems and pay-offs

• Provides a basis for treatment goals:
  
  1) Develop plans to avoid or eliminate antecedents/triggering events
  
  2) Develop non-drug using strategies to manage or cope with triggers
  
  3) Plan alternative ways to get the desired pay-offs
Addiction and the Family

My Substance Abuse and My Family

Complete the chart below. The purpose of this exercise is to increase your awareness about how your using impacted your family. Knowledge about this topic will help you "own" what you are responsible for. It will also begin to shape the role and extent to which you can influence change within your family system.

<table>
<thead>
<tr>
<th>In what ways did my substance using behaviour impact on my Family System?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship with spouse or partner</td>
</tr>
<tr>
<td>Relationship with my children</td>
</tr>
<tr>
<td>Security (financial, emotional, etc)</td>
</tr>
<tr>
<td>Communication patterns</td>
</tr>
<tr>
<td>Relationships with extended family</td>
</tr>
<tr>
<td>Leisure/family time together</td>
</tr>
<tr>
<td>Activities in the community</td>
</tr>
<tr>
<td>Violence, threats aggression, abuse</td>
</tr>
<tr>
<td>Other areas</td>
</tr>
</tbody>
</table>

Now think about what conditions or behaviours in your family system influenced or triggered your choice to use substances. These are issues that you will likely need to deal with when changing substance use behaviours.
**Do’s and Don’ts That Will Be Hard For Me**

Using the Handout about Do’s and Don’ts as a reference, write below three “Do’s and Don’ts” you will have the most difficulty with but that you recognize as important and would want to work at.

1. ___________________________________________________________________

2. ___________________________________________________________________

3. ___________________________________________________________________

Think about what would help you to address these issues. What resources would you need – inside yourself, or from outside sources? Write down your thoughts.

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________
Consequences of Substance Abuse for Family Members

- **Unpleasant emotions**: confusion, shame, anger, guilt, fear, feeling helpless, feeling alone or isolated

- **Stress related illness**: due to high levels of anxiety and improper care

- **Role imbalance**: children parenting parents, parents over protecting their adult children, one parent performing work that previously belonged to both parents

- **Lack of closeness**: can include absence of sexual intimacy between partners, feelings of not being included among all family members - due to treated betrayals, broken promises and breaches of trust, there is a loss of security and trust within the family unit

- **Loss of self and privacy, lack of boundaries**: energy is spent in "survival mode", trying to protect self and space. Instead of having these as a given, and being able to spend time learning and growing

- **Chaotic* environment**: safety comes and goes, inconsistent messages, everything is urgent and dramatic

- **Loss of honesty and integrity**: the environment is one of survival, and one survives by being strategic and manipulative. Being open with truth or sharing genuine thoughts and feelings is not advisable

- **Increased family abuse**: this can come in the form of physical violence, verbal abuse, threats, withholding love

- **Poor self care**: family members often become so focused on the substance user that they neglect caring for themselves and some forget how to care for their physical and emotional health

- **Adoption of Unhealthy Coping Strategies**:
  - Perfectionism
  - Rescuing
  - Obsessed with controlling things
  - Magical thinking
  - Disassociate*, check-out
  - Aggressive or passive

**Key Terms**:

*Chaotic: messy, confusing, hectic, disorganized
*Disassociate: disconnect, detach, isolate, separate
Some Do’s and Don’ts
When Working with Family

- Do expect that family members may not be as committed to change as you are
- Do expect not be trusted for some time, and even to be suspected of using
- Do expect that others may be angry or resentful about what happened to the family. Accept that their feelings may not go away just because you stopped using. It will take time; and for some, it may never go away
- Don’t blame your family for your using
- Do "own" what you are responsible for
- Do expect to have to let some things go - there will be loss and consequences* for your using that you will need to deal with
- Do recognize that both you and other family members have a grieving* process to go through
- Do change that which needs changing, if you can
- Don’t be responsible for trying to change others
- Do be honest
- Do take risks to foster change
- Do know what your intentions are when you act
- Do be assertive
- Do know why you are saying you’re "sorry". If your only motive is for you to feel better, reconsider.
- Do get support from someone you trust – a counselor or a non-using friend– to help you go work through your family issues
- Do know what you’re feeling

Key Terms:
*Consequences: penalty, cost, result
*Grieving: mourning, hurting, feeling sad or upset because of the loss of something/someone important
Communicating as a Family

1. Be a good listener: do not make a statement, interrupt, or answer until the other person is finished. Make sure that you understand what the other person is saying.
2. Think first. Think before you speak. Do not be hasty in offering your opinion.
3. Speak in such a way that the other person can understand you.
4. Speak the truth, but in a kind way.
5. Be clear about your facts before you speak.
6. Be smart. Will what you have to say help you or hurt you?
7. Timing is important. Is this the best time to say whatever it is you have to say?
8. Do you have the right attitude?
9. Is your motivation positive or do you have a hidden agenda?
10. Do not use what you have to say or what you withhold from saying as a punishment.
11. Always try to think in terms of what is the best way of saying something.
13. Be willing to acknowledge what role you may play in difficulties when you are talking through issues.
14. Avoid using emotions to hurt others or speaking in extremes such as “always” and “never”.
15. Take responsibility for your own emotions, words, actions, and reactions. Do not blame others for what you feel, say, and do.
16. Do not recycle old arguments. Resolve the issue or let it go. Choose your battles carefully.
17. Do not bring up the past. Deal with here and now issues. Use the past to learn from and increase understanding about feelings and differing points of view.
18. Deal with one problem at a time. Be clear on what the identified issue is and resolve it. If another problem exists, then work on resolving it but do not confuse things by talking about several issues at one time.
19. Focus on positives instead of negatives. Focus on what works, not what doesn’t.
20. Pay close attention to how others experience you. Remember that the words you choose are only part of communication. Other parts of communication include how your body looks when you say it (body language), tone of voice, and facial expression.
21. Part of good listening is the effort to understand what is being said to you so that you can respond appropriately.
22. Take responsibility for responding instead of reacting. This means that if you start getting upset, take a time out and think about how to respond.
23. Admit when you are wrong. Also, accept the apologies of others.
## How to Reach a Win-Win Resolution

<table>
<thead>
<tr>
<th>Approaches that help achieve a win-win outcome</th>
<th>Approaches that hinder achieving a win-win outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Stick to the subject</td>
<td>• Refer to other problems</td>
</tr>
<tr>
<td>• Stay in the present</td>
<td>• Talk about the past</td>
</tr>
<tr>
<td>• Have a positive goal</td>
<td>• Aim for superiority</td>
</tr>
<tr>
<td>• Use the statement – “It’s our problem”</td>
<td>• Use the statement – “It’s your problem”</td>
</tr>
<tr>
<td>• Listen to the answer</td>
<td>• Think of next question while the other is talking</td>
</tr>
<tr>
<td>• Use statement like – “I feel … when you…”</td>
<td>• Use statement like – “Why did you…”</td>
</tr>
<tr>
<td>• Keep the issue in perspective</td>
<td>• Make the issue more important than it really is</td>
</tr>
<tr>
<td>• Confront the problem.</td>
<td>• Dominate the other person</td>
</tr>
<tr>
<td>• Work for a solution</td>
<td>• Take an all or nothing attitude</td>
</tr>
<tr>
<td>• Speak clearly and simply</td>
<td>• Be silent; withdraw</td>
</tr>
<tr>
<td>• Seek realistic solutions</td>
<td>• Threaten drastic action</td>
</tr>
<tr>
<td>• Learn about each other</td>
<td>• Guess at feelings</td>
</tr>
<tr>
<td>• Check out meanings</td>
<td>• Assume you know</td>
</tr>
<tr>
<td>• Accept the answer</td>
<td>• Psycho-analyze</td>
</tr>
<tr>
<td>• Clarify emotions often</td>
<td>• Let problems fester</td>
</tr>
<tr>
<td>• Make an appointment</td>
<td>• Pick another’s weak moment</td>
</tr>
<tr>
<td>• Present a time limit</td>
<td>• Carry on indefinitely</td>
</tr>
<tr>
<td>• Reach a settlement</td>
<td>• Recycle issue</td>
</tr>
<tr>
<td>• Level with each other</td>
<td>• Be too tactful or too harsh</td>
</tr>
<tr>
<td>• Express yourself calmly</td>
<td>• Over-react</td>
</tr>
<tr>
<td>• Respect others dignity</td>
<td>• Belittle the other person</td>
</tr>
<tr>
<td>• Air grievances often</td>
<td>• Hold back then unload</td>
</tr>
<tr>
<td>• Attempt to understand</td>
<td>• Prove yourself right</td>
</tr>
<tr>
<td>• Fight for relationship</td>
<td>• Fight for self</td>
</tr>
</tbody>
</table>


Time-Outs

- Take a time-out when you recognize your cues and before your anger level escalates.
- Take a time-out when you feel like you are going to lose control and may become abusive.
- Tell your partner you are taking a time-out.
- Tell your partner how long you will be gone.
- Do not drink, use drugs, or drive.
- Call a friend or counsellor.
- Do calming exercises like walking, shooting free throws at a basketball court, or meditating.
- Think positive thoughts. Do not dwell on the problem that caused you to become angry.
- If you are still agitated and need more time than you agreed to, call your partner and let them know.
- Your partner is not obliged to take a time-out; you take a time-out for yourself.
- If your partner indicates that they are afraid of you, stay away. Find an alternative place to stay until things have calmed down.
- When you return, do not insist that you and your partner should solve or resolve the conflict you were having.
- If you notice your cues again, take another time-out.
- Whenever you follow the time-out rules, make a note of the positive way you handled the situation and its results.

An Important Note:

If you are going to use time-outs in your relationship, review this section and the previous one with your partner. You want to practice a time-out when you are not angry so that you and your partner understand the process and each other’s expectations. Your partner needs to know the rules of the time-out so he or she knows what to expect.
The Negotiation Guide

- Regardless of how angry or hurt I feel I will remain non-violent.
- If I disagree with my family/partner’s position I will still be respectful toward them.
- I will remain seated during the discussion.
- I will not yell, scream, or use my voice in an intimidating manner.
- I will not threaten my partner in any way.
- I will not use put-downs, call my partner names, or be sarcastic or belittling.
- I will not bring up past incidents to prove a point.
- I will avoid blaming or shaming statements.
- I will strive not to get defensive.
- I will listen to my family/partner’s position and refrain from interrupting.
- I will commit to working towards a compromise.
- I will be willing to explore my own issues and take responsibility for mistakes I have made.
- I will respect my family/partner’s wishes to end the discussion.
- I will talk about my feelings but will not use them as a way to manipulate my family/partner.
Anger Introduction
Anger Preference Questionnaire

Purpose: This questionnaire has been designed to increase client awareness with respect to their anger style.

Using a number between 0 and 10, indicate to what extent each of the following statements applies to you (where 0 – means never, and 10 – means always)

1. I use my anger as a means to get what I want

2. I find myself looking for reasons to get angry

3. When in a restaurant, if I don't get what I want, I won't say anything. I show that I am unhappy by not leaving a tip and/or never coming back

4. If I've been treated unfairly, I am able to go to the person and express my feelings calmly and in an up front way

5. When things go wrong for me, I tend to blame myself

6. I tend to be a stubborn person

7. Because I am afraid I will get hurt or someone else will get hurt when I am angry, I don't allow my self to get angry

8. After a stressful day, I will work out my frustrations by exercising, playing sports, doing housework, etc.

9. I find life gets boring if I haven't been angry in a while

10. When I feel angry, I am able to say so. I am also aware of other feelings, I may be experiencing like hurt or sadness

11. When people do things that bug me, I generally keep my resentments to myself

12. I tend to have a lot physical problems like: headaches, ulcers, skin disorders, high blood pressure, heart problems

13. I find that I tend to hurt myself a lot (accident prone)

14. I find myself frequently giving people the "silent treatment"
15. I get so mad sometimes that I just explode
16. Sometimes I use my anger to scare people
17. When I start to feel angry at something, I frequently find myself saying "that it's nothing to get upset about"
18. Frustrations and tensions tend to build up for me, and eventually I lose my temper
19. I am able to be insistent about getting my wants and needs met without losing my temper
20. I often feel bored and restless
21. When asked if I am upset about a situation, I find myself saying things like; "no, I'm not angry, just disappointed that's all"
22. Imagining revenge can help me get over being angry at someone
23. When I think people deserve it, I enjoy telling them off
24. I use my anger to manipulate people
25. Normally I am not an angry person, although my anger does come out when I'm driving
26. I frequently find myself saying, "I don't have time or I'm too busy to get angry"
27. I find myself often feeling depressed
28. Getting angry gives me a feeling of power
29. I find that if I am really angry about something, it gives me extra energy to get work done
30. I am proud to say I never get angry
# Anger Preference Questionnaire – Answer Sheet

In the appropriate box (the one corresponding to the number of the question) enter the numeric value (0-10) that you recorded by each question on the questionnaire. Add the three values for each category to get a total for the style (maximum 30), the higher the score the more that particular values apply to you.

## PASSIVE STYLES:

<table>
<thead>
<tr>
<th>Minimization/Deflection:</th>
<th>#17 ___</th>
<th>#21 ___</th>
<th>#26 ___</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passivity:</td>
<td>#7 ___</td>
<td>#11 ___</td>
<td>#30 ___</td>
</tr>
<tr>
<td>Somatising/Avoiding:</td>
<td>#6 ___</td>
<td>#12 ___</td>
<td>#20 ___</td>
</tr>
<tr>
<td>Turning Against Self:</td>
<td>#5 ___</td>
<td>#13 ___</td>
<td>#27 ___</td>
</tr>
</tbody>
</table>

## AGGRESSIVE STYLES:

<table>
<thead>
<tr>
<th>Explosive:</th>
<th>#15 ___</th>
<th>#18 ___</th>
<th>#23 ___</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intentional:</td>
<td>#1 ___</td>
<td>#16 ___</td>
<td>#24 ___</td>
</tr>
<tr>
<td>Addictive/Habitual:</td>
<td>#2 ___</td>
<td>#9 ___</td>
<td>#28 ___</td>
</tr>
</tbody>
</table>

## PASSIVE-AGGRESSIVE STYLE:

| Passive-Aggressive:      | #3 ___  | #14 ___ | #25 ___ |

## ASSERTIVE/HEALTHY STYLES:

<table>
<thead>
<tr>
<th>Assertiveness:</th>
<th>#4 ___</th>
<th>#10 ___</th>
<th>#19 ___</th>
</tr>
</thead>
<tbody>
<tr>
<td>Channelling/Displacing:</td>
<td>#8 ___</td>
<td>#22 ___</td>
<td>#29 ___</td>
</tr>
</tbody>
</table>
Costs/Benefits/Masks

This exercise is intended to help you identify more specifically how your current anger style works. How it helps you, and how it hurts you.

As part of a brainstorming exercise with the group write down your own personal answers to the questions below.

1. My anger gets me ....

2. My anger prevents me from getting ....

3. If I didn't get angry, I would...

4. If I got angry, this would happen...

5. What masks my anger ....
Changing Thoughts

Changing thoughts changes behaviour. Complete the chart below using several examples of situations that would normally provoke your anger

<table>
<thead>
<tr>
<th>Identify Situation Provoking Anger</th>
<th>Usual Anger Thoughts</th>
<th>Usual Behaviour</th>
<th>Revised Anger Thought</th>
<th>Changed Behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
Discussion on Anger

PASSIVE STYLES:

*Minimization*/Deflection*: A process of discounting anger - saying "something isn't a problem, it doesn't matter", or finding a way to justify a situation so that anger isn't warranted.

**Passivity:** An inability to get one's own wants and needs met. This inability to be self-serving is often justified by considering such behaviour to be virtuous.

**Somatising/Avoiding:** Forms of somatising* and avoiding can be seen in frequent illness or physical pain. Pain may include such things as headaches, ulcers, indigestion, high blood pressure, heart problems, back problems, etc. Also, seen in such things as boredom, stubbornness, jealousy, confusion, etc.

**Turning Against Self:** With any anger there is blame or fault finding; in this case, it turned inward against one's self - often referred to as "beating self up".

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**Key Terms:**

*Minimization: underestimating or down playing the importance or effect of a situation or action
*Deflection: distract or redirect from something or some situation to something else
AGGRESSIVE STYLES:

**Exploding:** Temporary surges of anger, feels like a pressure cooker "blowing top".

**Intentional:** Using anger to get what you want, to control others, to intimidate. This type of anger differs from exploding in that it is planned.

**Addictive/Habitual:** Using anger to regularly alter mood, to produce feelings of power and well being, to create a "high".

PASSIVE-AGGRESSIVE STYLES:

**Passive-aggressive:** Often, initially passive, not getting wants and needs met, but the finding "sneaky" and manipulative ways to get even. This tends to provoke anger in return and creates an on-going cycle of passive aggressiveness.

ASSERTIVE STYLES:

**Assertiveness:** Able to get wants and needs met without stepping on the wants and needs of others.

**Channelling*/Displacing*:** As long as it is not used as a way of continually avoiding frustration or conflict, channelling and displacing can be healthy ways to release angry energy when it is otherwise impossible to do in assertive ways. For some, channeling and deflecting can lead to escalation* of anger.

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**Key Terms:**

*Channelling: direct towards a specific thing
*Displacing: shift or redirect elsewhere (in this context if you are mad at a person release the angry energy by exercising rather than fighting)
*Escalation: increase
Discussion on Anger

1. SUMMARY OF STYLES

<table>
<thead>
<tr>
<th>TYPE</th>
<th>RESULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passive</td>
<td>not getting wants and needs met</td>
</tr>
<tr>
<td>Aggressive</td>
<td>getting wants and needs met at the expense of someone else</td>
</tr>
<tr>
<td>Assertive</td>
<td>getting wants and needs met without stepping on the wants of others</td>
</tr>
<tr>
<td>Passive-aggressive</td>
<td>not getting wants and needs met, but then finding indirect ways to subvert wants and needs of others</td>
</tr>
</tbody>
</table>

The above, is a generalization only. On the face of it there appear to be benefits to an aggressive style, and costs to a passive style. Underneath there are benefits to passivity and costs to aggressiveness. Often people flip flop between being passive and aggressive, or simply adopt on-going passive-aggressiveness.

2. HOW DID OUR ANGER STYLE EVOLVE: CONTRIBUTING FACTORS

There are several influences that typically contribute to the development of one's anger style. These include:

1. Our genetic predisposition* – this effect can be seen where siblings born and raised in the same environment, are often so different in personality.

2. How we were re-enforced as children – did we get what we wanted by yelling and screaming or were we denied what we wanted by acting this way? Did we have to find more subtle ways of getting our wants and needs met? How did we feel safe and protected? How did we get our power?

3. What did we learn from our role models? What were our parents or other role model's anger styles? Where did they get their power? What results did their styles achieve?
Key Terms:
*Genetic Predisposition: things determined, or effected by traits you inherit in your DNA from your family
3. THE IMPORTANCE OF IDENTIFYING ANGER STYLES

1. To begin to develop an acceptance of one's own style and the style of others.

2. To begin to become conscious of our style and its consequences.

3. To recognize that we have a choice about which style we choose to employ.

4. The steps required to change a style vary from person to person, depending on the original style. As an example venting anger might well be useful for someone who normally avoids anger, it may not be particularly helpful for someone who is already good at venting - it may only serve to escalate anger.

5. When in a group, by recognizing each other's anger styles, people will be able to appropriately support and challenge each other.

6. Our style will dictate what steps are helpful in preventing relapse. For some getting angry may lead to relapse, while for others suppressing or denying anger may lead to relapse.

7. Some people may experience similarities between substance use and the experience of anger. In substance use, there is the initial awareness, craving or need, followed by ensuing excitement, leading to actual use, often followed by the crash.

   For people who express anger aggressively, getting angry can mimic this cycle of feelings and can be a trigger for relapse. There is also a risk that aggressive anger can become a substitute behaviour for wanting to use.

8. For the passive person, anger avoidance may create a risk of relapse. Substances may have been an important tool for suppressing anger that they don’t feel safe expressing. Without that tool, people may experience considerable emotional discomfort.

   As a relapse prevention technique, these people need to start feeling and expressing their anger in a healthy way.
4. WHAT IS ANGER?

Anger is a cue, an indicator that something is amiss. Anger is a feeling, and like all feelings, it is not right or wrong. Anger, and how we handle it, is a choice.

Note: Anger is not rage; except in the extreme.

5. HOW DOES ANGER ARISE?

- For anger to arise, generally two things are in place:
  1. Blaming or unrealistic expectations
  2. Underlying feelings

- Examples of blaming or unrealistic expectations:
  "It's not fair"
  "You shouldn't do that"
  "You shouldn't be like that"
  "I'm right, you're wrong" (often we need to justify our anger by being right)
  "People who hurt me should be hurt back" (punished)
  "I'm entitled"
  "You should change for me"
  "I can make you change"
  "you must give me what I want or meet my expectations …or else"

- Examples of underlying feelings:
  Stressed   Lonely
  Fearful    Not being heard
  Shamed     Abandoned
  Hurt       Ignored
  Sad        Tired
  Powerless  Guilty

- Often these underlying feelings are uncomfortable - moving to anger is a way of getting away from them, especially for those comfortable with anger (aggressive style). It is also easier to place the fault on someone else for the way "I" feel, which is exactly what anger accomplishes.
• It is necessary to begin accepting "that nobody can make me feel", that in fact "I'm in charge of how I feel". This is my choice. By continuing to blame others for how you feel, you give them power that belongs to you, which feeds into anger and lack of power. We need to "own our feelings"

6. THE MASKS OF ANGER

Anger that is not directly and assertively expressed can be masked by other behaviours. Examples of behaviours that may mask anger include:

- Confusion
- Boredom
- Frustration
- Pre-occupation with task
- Silence
- Being critical
- Sarcasm
- Blaming, finding fault
- Indifference
- Depression
- Smiling in situations that would not normally call for smiling
- Jealousy
- Staying busy
- Staying in bed
- Acting-out: orally, sexually, driving, criminally
- Isms: racism, sexism, homophobia, ageism, etc

7. SUGGESTIONS FOR CHANGE

For the passive style:
• The main thing for the passive person is to start to bring anger into awareness.
• Begin to name your anger "say I feel angry", even if it's just to yourself.
• Ask yourself the question, "What keeps me from my anger?"
• Or ask, "What would happen if I got angry"

Suggestions for the aggressive style:
• The main thing for the aggressive person is to move focus away from anger and begin to look at what's behind the anger
• Ask the question, "What does my anger keep me from?"
• Or ask, "If I didn't get angry, what would happen?"
Time-outs

The purpose of a time-out is to help you stay in control so that you can make choices about how you express your anger, rather than being a ‘reactor’.

Time-outs take discipline and commitment, planning and practice. For some people, time-outs go against natural instincts; this is the case in particular for the people who need to use them most. Time-outs do work if you make a commitment and learn how to use them.

Anger is a choice, and what we do with our anger is a choice. Many anger problems are rooted in feeling stuck or powerless. It is the result of feeling that the power to get needs met has been lost. If you hope to regain that power, you need to start making choices about anger while still in control. Once anger escalates, it will be extremely difficult to take appropriate and responsible action.

Note: Time-outs are a respectful choice for both parties involved.

Warning: Don’t allow your shame, bravado, or that critical voice inside you to say: "that taking a time-out is un-cool or not necessary".

Tips for time-outs:

1. Take time-outs when only mildly "triggered", when just slightly irritated.

2. Take time-outs when you are aware that you’re exhibiting what is an "anger mask" for you.

3. Practice time-outs with those you are most likely to get angry with.

4. Plan what you will do when taking a time out -be specific - share your plan with the people likely to be involved.

A time-out can also be utilized in a different way for passive people who tend to bottle up anger or turn it within. It can be an opportunity for them to acknowledge their anger to themselves.
Steps in a Time-out:

1. Tell others about your intention to start taking time-outs. Explain to them what will happen when you do (refer to the steps that follow). By letting people know in advance, they may be more willing to support you in your process. If they don’t know the may make it harder for you to take a time out which will only result in your anger escalating.

2. Begin to recognize your cues to anger, your "anger masks", feeling irritated, uncomfortable, frustrated and losing control. Be aware of your body language. When you become aware of these earlier signs, take the time out – now; it only gets harder as the anger escalates.

3. Tell the other person, of what you’re feeling and that you are going to take a time-out. If you have previously told them of your plan to use time-outs, refer them back to this.

4. Tell them where you’re going, how long you'll be gone, when you'll be back, and what you plan to do while you're gone. It may be helpful to describe this to people you've already told about taking time-outs.

5. While away, take time to centre yourself, look at the problem, consider other feelings that may be behind your anger, feelings like sadness, fear, shame, etc. This is not a time to avoid. Some channelling (exercising, walking, etc) may be necessary to "cool down". However, channelling is not simply used as a means to making anger go away. The purpose of the time-out is to avoid the abusiveness - not to avoid the anger.

This is not a time to allow your anger to simmer or escalate. This is a time to move away from blaming and towards ownership and acceptance of the feelings which accompany your anger.

The time-out is a time for learning and grounding one's self.

6. As you’re finishing your time-out, consider what is appropriate to bring back to the other person. Say/do what feels respectful to both parties. This not a time to go back and apologize for your anger, or to try and make things better. You took the time-out as the respectful step, don't lessen it with apologies. Reward yourself for taking the time out.
How to Relieve Tension

Tension* and anxiety* are our normal reactions to defend against threats to our safety, well-being and happiness. Accidents, violence, financial trouble, job problems, family relations often cause a normal increase in anxiety and tension.

Sometimes, however, we become overly tense and anxious when no real danger exists. We become frazzled and on edge - unable to reason things out or control our feelings.

Below are 12 suggestions for dealing more effectively with your tensions. You'll need persistence and determination, but the results will be worth it.

1. **Talk it Out**
   When something worries you, talk it out. Sit down with a level-headed person you trust; spouse, parent, good friend, clergyman, family doctor, teacher, or school counsellor.

2. **Escape for a While**
   Often it helps to escape from the problem for a short time: lose yourself in a movie or book, or take a drive in the country. It's realistic to escape punishment long enough to recover breath and balance. But be prepared to come back and take on the problem when you're more composed.

3. **Work off your Anger**
   While anger may give you a temporary sense of righteousness, or even power, it will probably leave you feeling foolish. If you have the urge to lash out, wait until tomorrow. Do something constructive with the pent-up energy... shape the garden, clean out the garage, play a game of tennis, take a long walk. A day or two later you'll be better prepared to deal with the problem.

4. **Let it go**
   If you find yourself getting into frequent arguments and feeling defiant, remember that frustrated children behave in the same way. Stand your ground, but do it calmly and remember that you could be wrong. Even if you're dead right, it's easier on your system to let it go now and then. You'll relieve some tension and have a feeling of satisfaction.

5. **Doing Something for Others**
   If you find that you're worrying about yourself all the time, try doing something for somebody else. The steam will go out of your own worries, and instead you'll have a good feeling.

6. **Take One Thing at a Time**
   For people under tension, an ordinary workload may seem unbearable. The tasks loom so large that it becomes painful to tackle any part. To work your way out of it, take a few of the most urgent tasks and pitch into them. Leave everything else aside. Once you have cleared a few away, the others won't seem like such a "horrible mess."
7. **Shun the "Superman" or "Superwomen" Role**
Some people expect too much of themselves. They strive for perfection in everything they do. The frustration of failure leaves them in a constant state of worry and anxiety. Decide what you do well and put your major effort in this direction. These are probably things you like to do, ones that give you the most satisfaction. Then, perhaps, take on the ones you can't do so well. Give them your best, but don't criticize yourself if you don't achieve the impossible.

8. **Go Easy With Your Criticism**
Expecting too much of others can lead to feelings of frustration and disappointment. Each person has his or own virtues, shortcomings, values - his own right to develop as an individual. Instead of being critical, search out the other's good points and help him or her to develop them. This will give both of you satisfaction, and help you gain perspective of yourself.

9. **Give the Other Person a Break**
People under emotional tension often feel they have to "get there first" - to edge out the other person. It can be something as common as highway driving.

10. **Make Yourself Available**
Many of us have the feeling that we are being left out, slighted, neglected, and rejected. Often we just imagine that other people feel this way about us. They may be waiting for us to make the first move. Instead of shrinking away and withdrawing, it's much healthier to continue to "make yourself available". Of course the opposite - pushing yourself forward at every opportunity- is equally futile. This can be misinterpreted and lead to real rejection. There is a middle ground. Try it.

11. **Schedule Your Reaction**
Some people drive themselves so hard that they allow themselves almost no time for reaction – an essential for good physical and mental health. Set aside definite hours for a hobby or sport that will absorb you completely – a time to forget about work and worries.

12. **Remember Your Basic Rights**
You may assert yourself by expressing your basic human rights. Four of these are:
- The right to refuse requests without having to feel guilty or selfish
- The right to have one's own needs be as important as the needs of others
- The right to make mistakes
- The right to express ourselves as long as we do not violate the rights of others
Key Terms:
*Tension: emotional strain, barely contained anger or hostility
*Anxiety: nervousness, worry, apprehension, fear, concern
Changing Behaviour

The following is a list of suggestions that may help in changing your anger style. What approaches you use will depend largely on your existing style.

- Recognize and listen to irritation, frustration and anger
- Change the anger message
- Recognize and respect underlying feelings
- Set boundaries and limits
- Be assertive
- Take time-outs
- Channel your anger to another activity
- Vent your anger in a safe appropriate way
- Accept yourself
- Take appropriate risks
- Balance openness and safety
- Respond assertively to anger directed at you
- Change the tangible things that cause stress
- Name and talk about anger with a trustworthy person
- Stop judging and blaming
- Own your own reactions, problems and consequences
- Keep balance in your life
- Use humour to shift your mood or perspective
- Recognize your ambivalence and complexity
- Stop seeking perfection in yourself or others
- Get beyond all-or-nothing thinking
- Educate yourself – learn about anger
- Practice relaxation techniques, meditation, breathing
Keep Your Cool When You Express Anger

Some Do’s:

- **Calm Down** before you discuss the issues. Shouting matches rarely lead to effective solutions.

- **Understand Your Motives** before you express your anger. Are you trying to defeat the person, or are you trying to solve the problem? If your motive is negative, the results are more likely to be, too.

- **Be Assertive** – not aggressive. Assertive people express themselves firmly and clearly without making insulting remarks. They understand the importance of negotiating and compromising to resolve differences.

- **Seek Help** if you’re having trouble communicating your anger in a constructive way or if you’re getting angry too often. Talk with a friend about your problem and/or see a counselor for help.

Some Don’ts:

- **Don’t Get Personal** by resorting to insults and name-calling. These methods only cause more anger.

- **Don’t Avoid the Issue** by hiding what you truly believe. Be direct, be straightforward, but don’t get physical or violent. Avoid hitting or pushing the person with whom you’re angry. Don’t throw or break objects either.

- **Don’t Make Accusations** that you’ll regret later. Listen carefully to what the other person has to say before you draw any conclusions.

- **Don’t Sulk** in silence. That method won’t do anything to help you solve your problem.
Learn How To Manage Your Anger

1. **Recognize Your Anger** and admit it to yourself. Remember that anger is a normal human emotion, so there’s no need to feel ashamed or guilty about it. Pay attention to the signs of hidden anger - tensed muscles accident-proneness, feelings of frustration or disappointment and a tendency to use sarcasm.

2. **Identify The Cause** of your anger. Sometimes it may be obvious (for example, a careless driver backs into your car.) At other times, the cause of your anger may not be what it seems at first. For example, you may kick the tire because it's flat. But you're really angry at yourself for not getting the broken jack fixed.

3. **Decide What To Do** and follow through. What you do will depend on the situation, but in general, you should:
   - Decide which options will resolve the problem or situation that caused your anger. For example, consider whether a direct expression of anger will do more harm than good.
   - Take positive steps to implement your options.
   - Learning ways to avoid getting angry over unavoidable annoyances – traffic jams, long lines, etc. can also be helpful.
Some Coping Thoughts to Handle Anger

- Take a deep breath and relax.
- Getting upset won't help.
- Just as long as I keep my cool, I'm in control.
- Easy does it - there's nothing to be gained in getting mad.
- I'm not going to let him/her get to me.
- I can't change him/her with anger; I'll just upset myself.
- I can find a way to say what I want to without anger.
- Stay calm - no sarcasm, no attacks.
- I can stay calm and relaxed.
- Relax and let go. There's no need to get my knickers in a twist.
- No one is right, no one is wrong. We just have different needs.
- Stay cool, make no judgments.
- No matter what is said, I know I'm a good person.
- I'll stay rational - anger won't solve anything.
- Let them look all foolish and upset. I can stay cool and calm.
- His/her opinion isn't important. I won't be pushed into losing my cool.
- Bottom line, I'm in control. I'm out of here rather than say or do something dumb.
- Take a time-out. Cool off, then come back and deal with it.
- Some situations don't have good solutions. Looks like this is one of them. No use getting all bent out of shape about it.
- It's just a hassle. Nothing more, nothing less. I can cope with hassles.
- Break it down. Anger often comes from lumping things together.
- Good. I'm getting better at this anger management stuff.
- I got angry, but kept the lid on saying dumb things. That's progress.
- It's just not worth it to get so angry.
- Anger means it's time to relax and cope.
- I can manage this; I'm in control.
- If they want me to get angry, I'm going to disappoint them.
- I can't expect people to act the way I want them to.
- I don't have to take this so seriously.
Assertive Communication

Four Functions of Assertive Communication

#1 Being able to ASK for something

#2 Being able to DENY something someone else has asked for

#3 Being able to EXPRESS NEGATIVE FEELINGS when you are unhappy with something or someone

#4 Being able to EXPRESS POSITIVE FEELINGS when you like something or someone
Assertive Communication

Assertive Behaviour

Body language (non-verbal expression) – sets the tone for communication

Eye Contact – looks directly at the person being spoken to

Body Posture – faces the person, stands or sits appropriately close, leans towards the person, holds head erect

Facial Expression – agrees with and enhances the message being verbally conveyed, appears open and empathetic

Voice Tone – a level, even toned, and even loudness conversation statement rather than a whisper or a shout; shows confidence and respect for others

Timing – allows spontaneous expression, selects appropriate occasions, is sensitive to other’s needs

Content – expresses own feelings and thoughts directly and accepts responsibility for them

Negotiation – seeks workable solutions and compromise if one’s needs conflict with the needs and rights of others
Assertive Communication

Components of Assertive Communication

Acting in your own best interest
- ability to make decisions, take initiative, trust own judgement, set goals and work towards achievement

Displaying assertive behaviour
- eye contact, erect body posture, appropriate gestures, facial expression consistent with message

Standing up for self
- can say no and set limits

Expressing honest feelings
- can disagree, express anger, affection

Expressing personal rights
- can express opinions that may differ from others

Respecting the rights of others

Assertion is not aggression
Assertive Communication

The Six C’s of Correct Assertiveness

1. **Correct** timing

2. Keeping **Cool**

3. **Considering** the other person’s side of the matter

4. **Communicating** what your feelings are

5. **Clarifying** (make clear in a simple way) how you would like the other person to behave.

6. Stating the **Consequences** to the other person – negative if his/her behaviour continues, and positive if it stops
Assertiveness Quiz

Use these three scenarios to practice assertive responses:

Scenario 1
You are at a house party and you do not intend to drink/use. An old friend is urging you to drink/use, because you have drank/used with him in the past. The person is being loud, and, in your opinion, causing a scene…

Please give examples of what the following responses might be for this situation:

1. A passive response:

2. An aggressive response:

3. An assertive response:

Scenario 2
You are at a restaurant with some friends for a night out. These friends know you are not drinking. An old friend you have not seen in a long time happens to be at the restaurant and buys you a drink as a friendly gesture…

Please give examples of what the following responses might be for this situation:

1. A passive response:

2. An aggressive response:

3. An assertive response:
Scenario 3:
For this question, come up with your own scenario based on your own experiences and personal triggers. Following the same format as questions 1 and 2, briefly describe the situation and then identify the passive, aggressive and assertive response.

Scenario:

Responses:

1. A passive response:

2. An aggressive response:

3. A correct assertive response:
Your Personal Rights

I have the right:

To ask for what I want
To say “No” and not feel guilty
To make mistakes
To express my thoughts and feelings
To ask questions
To change my mind
To say “I don’t know”
To think before I act
To ask for help
To be treated with respect
To feel good about myself
To decide if I want to assert a personal right
COMMUNICATION STYLES

A Model of a **Passive** Style of Communication

**Looks like:**
- little or no eye contact
- rounded shoulders
- may appear withdrawn – hiding with pillows, jacket or props like a cigarette
- nervous gestures, fidgeting
- quiet, keeping to yourself

**Sounds like:**
- use of “we” statements (maybe we could..?)
- unsure, hesitant (“kind of...” “sort of..” statements)
- apologetic, self-critical
- overly agreeable (“sure”, “whatever”)

**Why I might use a passive communication style:**
- to avoid conflict
- out of fear
- to be liked
- to avoid making decisions, taking responsibility
- as a way to survive, avoid being abused

**What happens to my personal rights:**
- I believe I don’t have any rights, but other do
- I believe others’ rights are more important than mine

**Impact on me when I am passive:**
- I lose myself
- I am taken advantage of
- I feel resentful, angry and lonely
- I stuff my feelings and they build up
- my needs are not met

**Impact on others when I am passive:**
- they are frustrated, unclear of where I stand
- they find it hard to trust me
- they are confused, unsure of my needs and feelings
- they make all the decisions, its unfair
- they may question whether or not I care

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*I recognize that after being passive over time, I may eventually explode and move into the aggressive zone. Afterwards, I may feel regret and remorse, and swear not to be aggressive again. However, if I continue to stuff my feelings it can become a vicious cycle between passive and aggressive, neither of which are direct and honest expressions of my needs.*
A Model of an Assertive Style of Communication

**Looks like:**
- naturally eye contact
- relaxed, upright posture
- comfortable, expressive gestures
- respectful of personal space

**Sounds like:**
- calm, even toned, even loudness voice
- natural breathing
- open, honest direct communication
- “I” statements (“I need”, “I feel”, “I believe”)

**Why I might be assertive:**
- to express my needs, feelings and beliefs
- to work towards change
- to negotiate, to compromise
- to feel good about myself
- to be respectful of others

**What happens to my personal rights:**
- I believe I have rights and so do you
- I believe our rights are equal

**Impact on me when I am assertive:**
- I become more aware of my needs, feelings and beliefs
- I realize I have rights and deserve to ask for what I want
- I take responsibility for myself, instead of others
- I feel more confident and able to work through conflicts
- I increase the likelihood of getting what I ask for
- my self esteem increases

**Impact on others when I am assertive:**
- they are clear about where I stand
- they feel safe and respected
- they are more likely to express their needs
- they may communicate more openly and directly

*When I am with someone who is violent or abusive, the most assertive thing I can do is to make myself safe. In this situation, the other person is unable to communicate safely and assertively, so the best thing I can do is end the discussion. I may want to try talking with them later - if they are willing and able to be assertive.*
A Model of an Aggressive Style of Communication

Looks like:
- fixed gaze (stare), glaring eyes, frowning
- expansive, threatening posture
- intimidating gestures (drumming fingers, pointing)
- invading personal space

Sounds like:
- yelling, swearing
- quiet threatening, intimidating ("do it or else...")
- annoyed, heavy sighs
- demanding, bullying
- blaming, insulting, guilt-tripping
- sarcasm, making jokes at the expense of others
- generalizing, exaggerating ("you always...", "you never...")
- "you statements ("YOU SHOULD...")"

Why I might use an aggressive style of communication:
- to control others
- to get what I want at all costs
- when I am feeling insecure
- to release the intensity of my stuffed feelings

What happens to my personal rights:
- I believe I have rights and others do not
- I believe my rights are more important than your

Impact on me when I am aggressive:
- I say or do things I regret later
- I feel guilty, remorseful
- I hurt others, and myself ultimately
- I lose relationships
- I don't feel good ABOUT MYSELF

Impact on others when I am aggressive:
- they feel afraid, anxious, tense
- they don't feel safe
- they withdraw, shut down to protect themselves
- they find me unpredictable and hard to trust
- they aren't honest with me anymore

I can not simply"tone down" aggressive behaviour to become assertive. The two are very different. Aggressiveness comes from a place of control, where I ultimately believe that my needs are more important and I demand I get my way. Whereas assertiveness is not about winning at all costs, it is about compromising.
A Model of a Passive-Aggressive Style of Communication

Looks like:
- shifty eyed, diverted eyes, or empty eyes
- superficially friendly or passive facial expression
- may appear cooperative or agreeable
- may appear manipulative, foggy, or indirect

Sounds like:
- superficially or overly agreeable

Why I might use a passive communication style:
- the other person feels too powerful to cope with directly
- to punish the other person or defeat their power by withholding what they want
- to covertly block change or progress
- to avoid showing that you are angry or resentful, but covertly express it

What happens to my personal rights:
- I give up my right to say what I think or to bargain honestly with the other person

Impact on me when I am passive-aggressive:
- I may feel a temporary victory, but I sacrifice my own power in order to undermine the other person
- I feel both powerful and weak
- I become dishonest
- I lose trust from others

Impact on others when I am passive-aggressive:
- they are frustrated, unclear of where I stand
- they lose
- they also lose trust in me
- they move away from me

*When I am feeling passive-aggressive, I feel like I am in a power struggle with the other person. Instead of getting what I need and want, I end up being dishonest and trying to frustrate and hurt the other person. It’s akin to the expression – “biting off my nose to spite my face”.*
## Comparison of Behaviour Styles

<table>
<thead>
<tr>
<th></th>
<th>Passive</th>
<th>Aggressive</th>
<th>Passive-Aggressive</th>
<th>Assertive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behaviour</strong></td>
<td>- Self-denying</td>
<td>- Expressive (at the expense of others)</td>
<td>- Indirect</td>
<td>- Honest and direct</td>
</tr>
<tr>
<td></td>
<td>- Avoids conflict</td>
<td>- Creates conflict</td>
<td>- Avoids</td>
<td>- Willing to compromise</td>
</tr>
<tr>
<td></td>
<td>- Allows others to choose</td>
<td>- Chooses for others</td>
<td>- Confronting real issue</td>
<td>- Makes choices for self</td>
</tr>
<tr>
<td></td>
<td>- Neglects own needs</td>
<td>- Insensitive to other’s feelings and wishes</td>
<td>- Allows others to choose, but lets them know objections</td>
<td>- Considers other’s rights and feelings</td>
</tr>
<tr>
<td></td>
<td>- Intimidated by others</td>
<td></td>
<td>- Sarcastic and cynical*</td>
<td>- Respectful of others and self</td>
</tr>
<tr>
<td><strong>Feelings</strong></td>
<td>- Frustrated</td>
<td>- Righteous</td>
<td>- Resentful</td>
<td>- Feels good about self</td>
</tr>
<tr>
<td></td>
<td>- Anxious</td>
<td>- Hostile</td>
<td>- Feels</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Hurt</td>
<td>- Superior</td>
<td>vindicated*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Resentful</td>
<td>- Guilty later (sometimes)</td>
<td>(when obtains revenge)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Inferior</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Results</strong></td>
<td>- Does not achieve desired goal</td>
<td>- Achieves goal by hurting others</td>
<td>- Does not usually achieve goals</td>
<td>- May achieve desired goal</td>
</tr>
<tr>
<td></td>
<td>- Victim for aggressor</td>
<td>- Alienates others</td>
<td>- Relationship</td>
<td>- Satisfying and caring</td>
</tr>
<tr>
<td></td>
<td>- Relationship breaks down</td>
<td></td>
<td>breaks down</td>
<td>relationships</td>
</tr>
<tr>
<td><strong>Feelings of Others Involved</strong></td>
<td>- Pity</td>
<td>- Hurt</td>
<td>- Confusion</td>
<td>- Respect</td>
</tr>
<tr>
<td></td>
<td>- Irritation</td>
<td>- Humiliated</td>
<td>- Frustration</td>
<td>- Feels valued</td>
</tr>
<tr>
<td></td>
<td>- Dominance</td>
<td>- Defensive</td>
<td>- Feels</td>
<td>- Satisfied</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Angry</td>
<td>manipulated</td>
<td></td>
</tr>
<tr>
<td><strong>Position</strong></td>
<td>I’m not O.K.</td>
<td>I’m O.K.</td>
<td>I’m not O.K.</td>
<td>I’m O.K.</td>
</tr>
<tr>
<td></td>
<td>You’re O.K.</td>
<td>You’re not O.K.</td>
<td>You’re not O.K.</td>
<td>You’re O.K.</td>
</tr>
<tr>
<td><strong>Result</strong></td>
<td>You win</td>
<td>I win, you lose</td>
<td>You win</td>
<td>We both win</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>How could you do that to me, poor me.</td>
<td></td>
</tr>
</tbody>
</table>

### Key Terms

- *Cynical: pessimistic, assumes the worst, negative view of everything*
- *Vindicated: justified, correct, right*
Do’s and Don’ts of Assertive Behaviour

1. Do begin being assertive in low-risk situations
2. Don’t expect instant success
3. Don’t expect to always get what you want
4. Don’t beat up on yourself. Learn to distinguish between risk-taking and torture
5. Don’t expect other people to love your assertive behaviour
6. Do acknowledge your strengths and the situations you handle well
7. Do learn to reward yourself. Praise yourself for any success
8. Don’t dwell on “failure”. Learn from your mistakes and try again (You get chances to correct mistakes)
9. Don’t expect you will be guilt and anxiety free
10. Do learn to assess a situation and respond appropriately
### Tips for Assertive Behaviour

1. You are in control of your feelings. No one makes you feel angry, happy or any other way. This is your decision. It is better to say “I feel angry when you talk that way” than to say “You make me angry”.

2. Your best defense against angry, non-productive argument is calm, forceful tone of voice. You want the other person to listen to what you are saying. If you get irritated or angry, you allow the other person to react to how you are saying something, instead of what you are actually saying.

3. Other non-verbal communications are also helpful in being assertive. Maintain eye contact with the person and sit or stand so that you are facing the person directly. This will give the other person the impression that what you are saying is important and that you mean it.

4. Assertion is not aggression. Aggression is a negative way of dealing with a problem. It causes you and/or the other person to be aggressive or very defensive. Either way, it is much less likely that the problem will be solved.
Communication Basics

Key Concepts of Communication

- Communication is the foundation of social interaction/contact
- Everyone communicates, but some are more skilled
- Effective communication is a skill acquired through learning and practice
- Communication can be intentional or unintentional
- It is impossible to not to non-verbally, non-verbal communications (body language) are always a part of your communications
- Communication involves both speaking and listening
Non-Verbal Communication

- Sometimes called ‘body language’
- Plays a large part in messages we relay
- Provides information about feelings and intentions (may convey more than a dozen words)
- Is more powerful and subtle than verbal communication
- Can positively or negatively effect your message
- People are often unaware of nonverbal messages they send – may act in automatic or habitual ways
- Body posture
- Facial expression
- Personal space
- Gestures (Example: Hand motions or nodding)
- Tone of voice
Listening Skills

- The most important communication skill
- More than just sitting quietly while someone is speaking
- An active skill that involves trying to understand the other person. It helps to ask questions.
- Use body language to show that you are listening (Example: by nodding your head)
- Tune into body language of speaker (not just words)
- Goal is to accurately receive the message that another is trying to convey and to let another know that you are listening
- One good way is to try to say back to them what you heard, repeat the message you received and ask if that is the intended message – e.g. “What I hear you saying is . . . is that correct?”
‘I’ Messages

▪ Express feelings, thoughts and perceptions from the first person.

▪ Show that you take responsibility for your reactions to another person’s behaviour.

▪ Make it clear that the feedback you are giving is based on your feelings, observations, and thoughts.

▪ Are an important tool for assertive communication.

▪ I-messages open up communication. You-messages create roadblocks.

▪ I-messages focus on feelings and behaviour. You-messages can carry a message of judgement, blaming or criticizing.
Personal Filters

What we say and what we hear is filtered through:

- The beliefs we have about ourselves and the world
- The feelings we have about the message, ourselves and the sender
- Expectations we may have in a given situation
- Cultural differences
- External factors – the time of day, background noise
Barriers to Communication

Sending Messages

- Unclear or manipulative* messages
- ‘You’ messages instead of ‘I’ messages
- Assuming others will understand the message as intended - not considering other possible interpretations of what you are saying
- Cultural differences
- Different frame of reference

Receiving Messages

- Pre-occupied, not listening, distracted by external or internal factors
- Prematurely judging the sender or the message
- Prejudice or attitude towards sender
- Not willing to show when you don’t understand & not clarifying the message
- Cultural differences
- Different frame of reference
Barriers to Communication

1. Review the behaviours below and check off those that you can identify with:

Barriers to Sending Messages
- _____ Unclear or manipulative messages
- _____ ‘You’ messages instead of ‘I’ messages
- _____ Assuming others will understand the message as intended - 
  not considering other possible interpretations of what you are 
  saying
- _____ Cultural differences
- _____ Different frame of reference

Barriers to Receiving Messages
- _____ Pre-occupied, not listening, distracted by external or internal factors
- _____ Prematurely judging the sender or the message
- _____ Prejudice or attitude towards sender
- _____ Reluctant to show ignorance & don't clarify message
- _____ Cultural differences
- _____ Different frame of reference
2. Now think of three situations where you have found it difficult to communicate with another person – could be in personal relationships, at work or school, or in another setting. Fill in the chart:

<table>
<thead>
<tr>
<th>Situation</th>
<th>Barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td></td>
</tr>
</tbody>
</table>

3. Think about what you can do to improve communication in each of these three situations. How can you overcome or remove the barriers? Write your ideas in the chart below.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Ways to Improve</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td></td>
</tr>
</tbody>
</table>
GUIDELINES FOR EFFECTIVE LISTENING

1. **STOP TALKING:** you cannot listen if you are talking
2. **REDUCE DISTRACTIONS:** remove noise & don’t do other activities
3. **CLEAR YOUR MIND:** you can’t listen well if you are pre-occupied
4. **BE AWARE OF YOUR BIASES:** try to set prejudices and preconceptions aside
5. **SHOW THAT YOU ARE LISTENING:** to look and act interested and attentive
6. **BE RECEPTIVE:** open yourself to the other person’s perspective
7. **BE PATIENT:** allow the sender to finish their message
8. **LOOK FOR KEY IDEAS:** restate or summarize message
9. **ASK QUESTIONS:** to clarify and gain more knowledge
10. **BE GENUINELY INTERESTED:** you might learn something!

GUIDELINES FOR EFFECTIVE SENDING

1. **SPEAK YOUR MIND:** others cannot be expected to know what you think if you do not tell them.
2. **MAKE YOUR MESSAGE CLEAR AND SPECIFIC:** focus on the behaviour – avoid generalizing
3. **SPEAK FOR YOURSELF:** describe your own thoughts, feelings, and needs, use ‘I’ messages.
4. **STAY CALM:** deliver your message in a firm, level tone.
5. **DO NOT JUDGE OTHERS:** describe others behaviour without judging if this behaviour is ‘right or wrongs’ or make assumptions about their motives or personality.
6. **MAKE THE MESSAGE RELEVANT TO RECEIVER:** choose words to express yourself clearly and that the receiver will understand.
7. **ASK FOR FEEDBACK:** check to ensure the receiver understood the message. (Example: “Can you tell me what you took away from what I just said?”)
8. **SEEK EYE CONTACT.**
9. **NON-VERBAL AND VERBAL MESSAGE TO BE CONSISTENT:** messages are misinterpreted when words used are inconsistent with the presentation.
10. **REPEAT MESSAGE:** summarize main point, or use more than one way to communicate.
Conflict Resolution

Benefits of Resolving Conflict

Step 1:
Select a partner and move away to a space by yourselves.

Step 2:
Take turns telling your partner about a time in your past when there was a good outcome as a result of working through conflict.

Note:
It is important not to analyze what happened or for the person listening to provide feedback. The intention here is to simply remember a time when working through a conflict was worthwhile.

If you are unable to remember such a time, consider the following suggestions:

- Perhaps there was a time you studied for a test, but had not wanted to; and ended up doing well in the test
- or perhaps a time at work with a fellow worker
- or a friend, and how after working through the conflict, the friendship was stronger

If you’re unable to recall a time where working through a conflict was beneficial – do not worry, this is common.

Step 3:
Return to the larger group and have a brief discussion about the exercise.
Conflict Resolution
Page 1 of 2

Personal Style Questions

Answer "yes" or "no" to the following questions.

1. ____ I wouldn't say I like conflict but I do appreciate what it can give me
2. ____ I find I want to make people happy and for them to like me
3. ____ I sometimes use my size or physicality to get what I want
4. ____ When I'm in conflict, I try and put myself in their shoes
5. ____ I get nervous when others are angry at me
6. ____ I seem to be in conflict all the time, always fighting with everyone
7. ____ I don't trust people very much, even myself
8. ____ I feel scared when I tell people what I want
9. ____ I'd rather numb out than have to deal with conflict and problems
10. ____ I often find myself saying, "no big deal", "I don't see any problem"
11. ____ I'm okay with whatever you decide
12. ____ When in conflict, I think that I should listen to the other person for at least as long a time as they listened to me
13. ____ I think I am right almost all the time when in an argument
14. ____ I only trust myself
15. ____ I like for everyone to benefit in resolving a conflict
16. ____ I just want to avoid the whole thing, nothing is ever gained
Conflict Resolution
Page 2 of 2

Personal Style Questions – Answer Grid

Circle the numbers corresponding to your "yes" answers on the previous page.

<table>
<thead>
<tr>
<th>Defer*</th>
<th>Declare*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 5 8 11</td>
<td>1 4 12 15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deny*</th>
<th>Demand*</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 9 10 16</td>
<td>3 6 13 14</td>
</tr>
</tbody>
</table>

Key Terms
Defer* - to put off until another time, postpone
Declare* - to announce officially, to declare
Deny* - to state something is not true
Demand* - to ask for with authority, to claim as right
Conflict Resolution
Page 1 of 2

Personal Styles for Dealing with Conflict

People to react to different situations in different ways. For example, defending a family member will make you experience different feelings and responses than will dealing with a rude stranger in a store. There is no right or wrong way – but there are ways of dealing with conflict that are more effective.

1. **Non-assertive:**
   - unable to express thoughts or feelings due to lack of confidence and/or skills
   - ignore their needs or claim a problem doesn’t exist
   - may acknowledge needs are not being met but, accept the situation and hope it changes

   **Problem:** approach is likely to result in needs not being voiced or met, likely loss of self-confidence or self-respect, feelings of dissatisfaction or deprivation

2. **Aggressive:**
   - direct overly strong expression /reaction
   - demand for needs to be met
   - my way or the highway
   - needs are met at the expense of others

   **Problem:** aggression may achieve desired ends in the immediate term, but also leads to others feeling anger, hurt, or humiliated, and to strained relations and further conflicts

3. **Passive Aggressive:**
   - expression of needs and feelings indirectly (anger, resentment)
   - tries to save face, and protect self by manipulating the situation
   - likely needs are not met – if met, others are likely to feel resentful

   **Problem:** others may not be aware of real concerns; others may respond to the manipulation by refusing to do anything

4. **Assertion:**
   - clear and direct expression of thoughts/feelings and needs
   - respectful of others – no judging or dictating to others
   - greatest potential for win-win situation: needs are met but not at the expense of others

   **Problem:** none, but lots of benefits

   **Benefits:** increased chance of reaching goals; maintains the self-respect of both parties; build relationships; improves self-efficacy
**Conflict Resolution**

*Page 2 of 2*

### Personal Styles for Dealing with Conflict

<table>
<thead>
<tr>
<th>DEFER (1) (Passive)</th>
<th>DECLARE (4) (Assertive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>someone wins and someone loses</td>
<td>everyone wins</td>
</tr>
<tr>
<td>cautious approach</td>
<td>parties act mutually</td>
</tr>
<tr>
<td>feel intimidated</td>
<td>trust self and others</td>
</tr>
<tr>
<td>is forced or willingly trusts other</td>
<td>expects no guarantee</td>
</tr>
<tr>
<td>seeks dependence</td>
<td>seeks interdependence</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DENY (3) (Passive-Aggressive)</th>
<th>DEMAND (2) (Aggressive)</th>
</tr>
</thead>
<tbody>
<tr>
<td>everyone loses</td>
<td>someone wins/someone loses</td>
</tr>
<tr>
<td>indirect, uses manipulation</td>
<td>uses force/conviction</td>
</tr>
<tr>
<td>mixed messages about trust</td>
<td>always right, domination</td>
</tr>
<tr>
<td>avoids resolution</td>
<td>trusts only self</td>
</tr>
<tr>
<td>seeks dependence on the surface</td>
<td>seeks dominance</td>
</tr>
</tbody>
</table>

Others can solve the conflict
Conflict Resolution

Steps for Resolving Interpersonal Conflict

Step 1: Identify Your Problem and the Needs Not Being Met
- **Ownership**: recognition that the problem is yours; you are the person dissatisfied
- **Identify** what you need, what would be a good outcome for you

Step 2: Make a Date to Discuss Concerns
- **Establish** when and where to address the conflict
- This acknowledges that you have choices - the present may not always be the best time for either or both of the parties
- **Pick** a place and time that works for both you and the other person
- It also starts the resolution process off on a collaborative basis (both parties have agreed to work towards resolution and agreed on a time)

Step 3: Describe Your Problem and Needs
- **Describe** the problem as specifically as possible
- **Identify** (from your perspective, using ‘I’ statements) the behaviour, thoughts or interpretation, feelings, consequences, and intentions
- **Avoid** blaming and shaming

Step 4: Consider the Other Person’s Point of View
- **Confirm** that the other person heard the message – clarify or re-state if helpful
- **Ask about and listen** to the other persons point of view, needs and wants
- **Confirm** what you heard to make sure you understood.

Step 5: Negotiate a Win-Win Solution
- **Find** a way to meet some of each other’s needs/wants
- **Develop** as many potential solutions as possible
- **Evaluate** possible solutions
- **Decide** which solution best benefits both parties
- There may be times when it is impossible to fully meet both party’s needs
- Negotiating a solution has to include some compromises.

Step 6: Follow Up the Solution
Conflict Resolution

Communication Skills for Effective Conflict Resolution

- Focus on the person’s **behaviour, not their personality**; don’t make judgements about the person
- Focus on behaviours that **one can change**
- Focus on **specific situations** rather than comments like "you always do this"
- Focus on the **present** not the past
- Share your **own opinions and feelings** rather than give **advice**
- Do not **force your thoughts** on others, believing you have to make them see it your way. There is room for differing opinions
- **Listen** to what the other person has to say, both **verbally and covertly (body language)**
- Use **empathy** (empathy needs to be genuine) to understand the other person’s point of view
- Be **responsible (take ownership)** for your own **action/reaction**
- **Clarify expectations** in advance
Conflict Resolution

Barriers to Effective Conflict Resolution

1. Assuming that facing conflict will be hurtful
   - People who use substances to avoid conflict frequently come from situations where conflict meant getting hurt or hurting someone else; this belief is a barrier to successful resolution

2. Being individualistic or self centred
   - Seeking to satisfy one's own gain and eliminate one's own loss without regard for others outcome

3. Being too competitive
   - The outcome that matters most is winning, this may even supersede what was at issue in the first place

4. Being too passive or accommodating
   - Not speaking your mind in an effort to please others or to avoid getting hurt in some way results in seldom getting what you need or want
Conflict Resolution

Questions to Consider in Resolving Conflict

Considering these questions can help you to make appropriate decisions about options for resolving conflict

- Are all the parties in conflict willing to try and resolve it?
- Is it necessary to resolve it?
- What is the other person’s investment in the idea? How is it important to him or her?
- What is my investment?
- How do our positions compare? Where do we agree?
- What is he or she trying to tell me?
- How does he or she feel about the situation?
- How does he or she feel about me?
- How would I think and feel if I were in the other person’s position?
Conflict Resolution

Options for Effective Conflict Resolution

The following are options that are used to resolve conflicts. The goal is to select the alternative which is most likely to reduce and resolve the conflict and avoid destructiveness. A win-win alternative is always preferred whenever possible.

1. Legal Intervention
   - Example: obtain a peace bond or restraining order, press criminal charges, sue for damages

2. Give In
   - Choose to cut your losses, pick your battles

3. Negotiate a mutually acceptable compromise: The Social Exchange Process:
   - Make sure that both parties win
   - Resolve through negotiation
   - Be aware of what’s most important to you (non-negotiable) and what you can be flexible on
   - Be open to compromise

4. Some situations end without active resolution
   - One player may walk away from the situation or end the interaction (e.g. divorce, quit your job)

5. Seek a neutral person to mediate
   - Can be helpful for difficult interactions (marriage counselling, arbitration)
   - May be needed if there is a stale mate

Research indicates that conflicts are resolved if another is merely present even when not actively involved.
Coping with Fears

Self Talk Exercise

1. This isn’t easy but I can cope with this

2. If I fail it is not the end of the world

3. People will likely be understanding if a problem occurs

4. I am hardest on myself

5. Others can be helpful if I reach out to them
Coping with a Fear

1. Select something that you may be afraid to deal with when changing your substance use behaviour (do not choose something overwhelming).

2. What part of that situation are you specifically afraid of? Be specific. Cut it down to size.

3. How can you learn more about the situation and the thing that you fear? Where can you find that information?

4. List three small steps that you can take to begin to do the thing that you are afraid of or cope with in the situation.
   1. ______________________________________
   2. ______________________________________
   3. ______________________________________

5. Who can support you in or around this situation? What kind of support could you ask for from them? (Tell them what you need)
6. What realistic, positive thoughts could you have about your ability to cope with the situation or its result?

7. What stress management technique could you practice in or around this situation?

8. What realistic, positive next step could you take to deal with this?
Calming Breath Exercise

This exercise is adapted from the ancient discipline of yoga. It is a very efficient technique for achieving a deep state of relaxation quickly.

1. Breathe from your abdomen (stomach) and inhale (breathe in) slowly through your nose to a count of five. (One .... Two .... Three .... Four .... Five).

2. Pause…and hold your breath to a count of five.

3. Slowly exhale (breathe out) through your nose to a count of five.
   
   As you exhale let your shoulders drop and say the word “calm” to yourself.
   
   (Be sure to exhale fully)

4. Pause to a count of five.

   Practice this exercise 5 minutes per day.
Strategies to Reduce Anxieties and Fears

1. **Try to understand what you are “really” afraid of**
   Try to understand what exactly it is that makes you feel anxious about something. If you can pin down the main sources of your anxiety, it will help you cut your fear down to size and you will see it more clearly. When you can see something clearly, it is likely that you’ll see how to handle it better.

2. **Learn about the thing that you are afraid of or uncomfortable with**
   Information reduces anxiety. We are mostly afraid of the unknowns. There are large amounts of information available now – in books, for free on the internet, from other people, etc. You are not alone. Whatever you are experiencing, someone has gone through before. They know a lot.

3. **Break the problem down into small manageable steps**
   This is what most successful people do to overcome fears. Take one step at a time.

   **Example:** If you are afraid of driving, you might first plan to just sit in the car and learn to relax there. Next you might start the car and leave the engine running without going anywhere and just do that until you are more comfortable. Then you might put the car in gear, but only drive back and forth in your yard. Then go just around the block many times on a quiet street, etc.

4. **Spend time in the feared situation**
   Often, fears and anxieties go away as you spend time in the feared situation and discover that you can deal with it. This is especially true if the fear is unrealistic. Just avoiding fearful situations doesn’t change them. If you rate the level of your fear at the start and then after you have spent time in the feared situation, it will be less.
5. **Arrange support from others**  
   Your control will increase when you can get other people to support you. That can be a powerful thing to do. Your job is to arrange your world so that it supports you.

6. **Apply coping thoughts to dealing with the feared situation**  
   Give yourself realistic, positive messages about what you can do in the situation.

   **Example:** “I can cope with this, however it comes out.” “It won’t destroy me.” “I’m entitled to take my time with this.” “Everything takes learning.” “I can make mistakes.”

7. **Apply stress management techniques to dealing with the feared situation**  
   Practice relaxing in the feared situation. You need to try different techniques to find out what will work best for you after you become skilled at it.

   **Example:** breathing to relax, calming imagery, yoga, meditation, listening to music etc.

   It is important to eat well, get enough sleep, not drink too much coffee or smoke too many cigarettes. Don’t do things that wind you up. Take control.

8. **Rehearse, Rehearse, Rehearse**  
   Practice the thing that you are afraid of doing, or your response to facing the feared object. Most anxieties and fears go away if you are well prepared or practiced in what you are going to do.
Coping with Depression and Anxiety

How to Handle Depression and Anxiety

Next time you feel stuck in depression or are experiencing anxiety, use this hand out to help.

Everyone gets depressed at times. You can expect it. It is part of life, and it’s not always a bad thing. Often it’s a signal that you need to deal with something because sometimes depression stems from other causes.

**How to Handle Depression**

- After stopping alcohol or drugs, people who feel depressed may be tempted to return to use in an attempt to get back to feeling better again and escaping the depression.

- Most people who are dependent on a substance are somewhat depressed in the early weeks or months after quitting, as full physical readjustment in your body may take a long time.

- When someone becomes dependent on a substance there are often losses. For example loss of job performance or job security, loss in relationships, loss of a sense of control over yourself, loss of self-esteem, etc. Not having dealt with these losses may contribute to depressed feelings.

A lot of people who abuse substances have a history of depression before they ever use alcohol or drugs. They may have initially used substances to help manage depression.

**How to Handle Anxiety**

- Many people may have used substances to cope with their anxieties and may be tempted to return to use as a way to escape.

- Learning strategies to cope with anxieties will be important as it is easy to slip back into old behaviour.

- Learn to challenge irrational thoughts and seeking support is important to begin to recognize you are not alone in what you are experiencing.

- Practice what you will do to cope in the anxiety provoking situation, practicing the steps will give you confidence in dealing with these difficult situations.

- If anxiety is keeping you from reaching your goals, or is affecting you in many areas of your life, you may need to talk to your doctor for extra help.
Coping with Depression

- Antidepressant medications: It is possible to experience deep ongoing depression. Some people experiencing depression will return to using to stop the depression. If this happens to you it can be helpful to review your physical or emotional condition with a doctor.

- It is possible that antidepressant medications may be needed. These medications may not be right for all people and they can have some negative side effects. They are slow acting and usually take a few weeks of use to build up in your body to be effective. Antidepressants are not addictive.

- In all types of depression people have the sense that things are hopeless, that they won’t get fixed, and that they will feel this way or be this way forever. But that idea is not real.

- Often we make ourselves more depressed by the way we think about things, or by having unrealistic thoughts about them. We can often get out of depression by making ourselves look at things in a more realistic way.

- Sometimes, even if you do nothing about depression, you will feel better in time. But you can get often out of depressions more quickly if you look at what may be making you depressed. By knowing what is happening it is easier to plan and take some helpful actions around it. This will help you to have more control over your life and feel stronger as a person.

- There is a beginning list of strategies on the next page. You may add other strategies as you go along.
Strategies to cope with depression and Anxiety

To start with there are some general simple things that you can do to feel better.

1. **Physical exercise or activity is extremely helpful.** When most people feel depressed they don’t want to move but research clearly shows that most people will get a lift in their mood from regular physical activity or exercise.

2. **It’s helpful to talk with someone you trust about your depression or what’s bothering you.** Maybe try a family member, a friend, or a counselor. Just to say what is bugging you can help you to see more possible ways of dealing with the problem, and also help you feel less alone with problems. If you talk to enough people, someone will be helpful.

3. **Remind yourself that everyone has problems.** When you are depressed or feel anxious it feels like you are the only one with a problem. Be careful not think that you are different from other people because of having a problem. That will just make you feel worse.

4. **If you find that your depression is based on realistic guilt for things that you have done, you may need to plan some ways of dealing with your guilt.** Talking to someone supportive may be helpful.

5. **Develop a schedule of things to do and start doing them, big or small.** The more you structure your day the less depressed or anxious you will feel.
   - **Human contact:** like talking to friends and family, talking to a counselor, or volunteering.
   - **Physical self-care:** like cooking a healthy meal and eating it, exercising, or cleaning.
   - **Pleasurable activities:** like watching a movie, playing ping pong, visiting an old friend, or a thousand other things, big or small that you used to enjoy or would enjoy if you did. When you keep doing things that you enjoy you feel less depressed, even if you don’t enjoy them as much at first because of your depression. No matter what you think or feel you should allow yourself to have some pleasure in the day, if you can, for your own health.
Depression, Anxiety and thinking
We know that the way people feel is very strongly influenced by the thoughts that they have. Your thinking can make you depressed or anxious.

When you think something over and over, or hear it from others many times it often becomes what we call an automatic thought. We just assume that it’s true. For example, suppose you were told over and over as a child you were a loser and that you would never succeed at anything. That is a false idea. It is a false thought about yourself that is likely to make you depressed, especially if you internalize it and continue to repeat it to yourself.

If automatic thoughts are fueling your depression or anxiety, you need to recognize them and replace or counter them with realistic thoughts. For example, it’s realistic to think “I am not a loser. I have failed at some things, but I also have succeeded at things in my life, and I can succeed at more.”

After you have created some more realistic thoughts, to counter your own, automatic thoughts, it’s helpful to:

• practice them several times a day in order to learn them and make them be powerful for you
• set up a practice schedule and keep a record of your practice
• maybe writing about them in a journal, and
• examine situations where the negative thoughts get triggered

Remember, You have control over what you think, and therefore over what you will feel.
Coping with Triggers and Cravings  
Defining Triggers

There are 8 categories for risk when discussing triggers. These categories are listed below. Describe a trigger you have faced or could face in each of these categories.

1. Unpleasant Emotions

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

2. Physical Discomfort

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

3. Pleasant Emotions

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

4. Testing Personal Control

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
5. Urges and Temptations

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

6. Conflict with Others

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

7. Social Pressure

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

8. Pleasant Times with Others

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________
COPING WITH CRAVINGS

1. Identify a craving that you experienced in the past.

2. What was the trigger – or triggers?

If the same situation occurs in the future:

3. Who can you seek support from?

4. What can you do to distract yourself?

5. What positive self-talk can you give yourself?

6. What else can you do to cope with the situation?
COPE ALERT CARD

The cope alert card is a wallet sized card that you carry with you for fast action. The card will help to remind you of coping strategies when unexpected events do occur and coping strategies do not readily come to mind.

Use this paper to draft a message to yourself, and transfer your message to the card when ready.

__________________________________________________________________________
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__________________________________________________________________________
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Anger Session
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**Five Tips for Handling Cravings**

**Tip #1: Think beyond the use**
Think of the negative consequences of using, as it is happening (immediate) and in the future (delayed). Think of the benefits of not using. Challenge your excuses and justifications for using.

List 3 immediate negative consequences.

a) ______________________________________________________________

b) ______________________________________________________________

c) ______________________________________________________________

List 3 delayed negative consequences.

a) ______________________________________________________________

b) ______________________________________________________________

c) ______________________________________________________________

List 3 positive benefits of not using drugs and/or alcohol.

a) ______________________________________________________________

b) ______________________________________________________________

c) ______________________________________________________________

What excuses have you used to justify using when you have had cravings?

______________________________________________________________

______________________________________________________________

______________________________________________________________
Tip #2: Change or leave the situation
Remove yourself from the situation that is triggering or making your craving worse. Distract yourself with pleasant thoughts and activities.

List 3 positive/constructive activities you could immediately turn to in response to a craving.

a) ___________________________________________

b) ___________________________________________

c) ___________________________________________

Tip #3: Get help!!
Reach out to someone in your support system. Talk out your craving with that person. Keep a list of people and phone numbers with you at all times. List names and phone numbers of 3 people you could call when having a craving.

a) ___________________________________________

b) ___________________________________________

c) ___________________________________________

Tip #4: Don’t give up, no matter what!
Remember cravings are temporary. They don’t have to lead to drug use. None of your current problems will be solved by using drugs. Recall and restate your reasons for being drug free.

_____________________________________________

_____________________________________________

_____________________________________________
Tip #5: Delay your decision!
Put off your decision to use drugs/alcohol for even 20 minutes. Remember urges are like waves. They crest and then recede. Ride out the urge until it recedes.

What type of thoughts and activities might help you ride out the craving until it recedes?

Thoughts:
______________________________________________________________
______________________________________________________________
______________________________________________________________

Activities:
______________________________________________________________
______________________________________________________________
______________________________________________________________
STAGES OF CRAVINGS

Cravings can occur in three stages (levels):

**Stage 1: Set-up behaviours** that lead to craving – a combination of physical, psychological* and social factors that lower resistance so that the craving overcomes us much more easily:

- **Physical Set-ups:**
  - Brain dysfunction* from drug use
  - Poor diet
  - Excessive use of caffeine and nicotine
  - Lack of exercise
  - Poor stress management
  - Withdrawal symptoms

- **Psychological Set-ups:**
  - Euphoric* recall
  - Awfulizing* sobriety
  - Magical thinking about future use
  - Denial and Evasion*
  - Drug and Alcohol dreams

- **Social Set ups:**
  - Lack of communication
  - Social conflict
  - Socializing with drug using friends
  - Poor planning of social events – having a plan B in place (i.e.: way out before you go into an event like a wedding, Christmas party, etc.)

**Stage #2: Trigger events** for Craving

- A trigger event is anything that directly causes a craving. While set-up behaviours increase the risk of relapse, trigger events actually turn on the craving.

- Most drug cravings are triggered by a sensory cue – we see, hear, smell, touch or taste something that can instantly activate a craving.

- Trigger events do 3 things simultaneously:
  1. They create a compulsion* or an irrational urge to use drugs.
  2. They cause intrusive thoughts about drug use to invade our mind. These thoughts can be so powerful that we can’t turn them off even though we are trying to think of something else.
  3. They turn on a “tissue hunger” for the drug. Tissue hunger is when we want drugs badly and our body lets us know it. We sweat, hearts beat rapidly, we get short of breath, and our joints ache.
The compulsion, intrusive thoughts (obsession) and tissue hunger (physical craving) can activate drug-seeking behaviour. We begin to seek out drug using people and drug related places and things. This may just happen and not as a conscious action (Example: we decide to go for a ride just for fun and end up driving past the dealer’s house or past a bar where drug using friends hang out).

A trigger event might first lead us to use something other than the drug of choice (Example: what’s the harm of having a drink if my drug of choice is cocaine). Using a mood altering substance lowers resistance and suddenly the craving for the drug of choice kicks in.

Any person, place, mind set, mood or sensation that we strongly associate with drug use can become a powerful trigger. Experiencing these things clean can instantly cause a craving.

We can identify our potential triggers for cravings by examining in detail the kinds of things we did and what our state of mind was while using drugs.

Stage #3: A craving can take many forms. Some of these are:

- **Flashback Euphoria**: We feel as if we have used drugs when we have not, usually at night when asleep. We may wake up and actually feel as if we have used. Sometimes we wake up feeling hung over the same as when we used. Sometimes we think we see drug paraphernalia, but it is not really there.

- **Physical Symptoms**: A feeling of achiness in the joints or feeling queasy all over, or a crawling of the skin. This can make us irritable or overactive. You may experience heart palpitations, elevated blood pressure, rapid pulse, sweating, and shortness of breath.

- **Drug Dream**: Vivid dreams in which we sense the taste, smell or body feeling associated with using drugs.

### Key Terms:

*Psychological*: mental, of the mind  
*Dysfunction*: malfunction (failure) of an organ or system of the body  
*Euphoric/Euphoria*: a (sometimes exaggerated) state of intense happiness and self confidence  
*Awfulizing*: focusing on the negatives of a situation rather than the whole picture, not able to see the positives/benefits
Coping with Cravings

Quitting drinking or drug use is likely to generate cravings, especially in high risk situations. Learning to deal with urges and temptations is a very important part of preventing relapse. We experience urges to use at different levels of intensity and these can be thought of as being on a continuum*.

Mild --------------------------- Moderate --------------------------- Severe
(fleeting thoughts) (very strong urges)

Cravings for alcohol and other drugs can be decreased by using specific coping strategies. Remember that cravings do not last forever, and that they will decrease in number and strength over time. Here are some suggestions to help:

<table>
<thead>
<tr>
<th>Behaviour (What I do)</th>
<th>Cognitions (What I think)</th>
</tr>
</thead>
<tbody>
<tr>
<td>→ Self monitor – write out your thoughts/feelings</td>
<td>→ Normalize the craving: “I am experiencing an urge to use. It is O.K. to feel like using”</td>
</tr>
<tr>
<td>→ Seek Support – tell someone what you are experiencing</td>
<td>→ Use imagery, e.g. visualize the craving as a wave that rises and falls and you are riding it out</td>
</tr>
<tr>
<td>→ Distract yourself – do something unrelated to substance abuse</td>
<td>→ Use positive self-talk such as “I can cope with this. I have been clean for 2 weeks and I don’t want to spoil it now”</td>
</tr>
<tr>
<td>→ Substitute another behaviour (e.g. eat or drink something)</td>
<td>→ Use thought stopping, e.g. picture a STOP sign</td>
</tr>
<tr>
<td>→ Leave or change the situation</td>
<td>→ Think of the negative consequences of using alcohol or other drugs</td>
</tr>
<tr>
<td>→ Take deep breaths (in through your nose, out through your mouth) to relax yourself</td>
<td>→ Think of the benefits of not using alcohol or other drugs</td>
</tr>
<tr>
<td>→ Delay the response – put off the decision to use for 15 minutes, an hour, a day</td>
<td></td>
</tr>
</tbody>
</table>

Key Terms:
Continuum*: range or scale
Early Coping Strategies

✓ Throw out alcohol, drugs, and other paraphernalia. If this is difficult for you, let a supportive non-using friend help.

✓ Break off all contact with heavy drinkers, users, and dealers. This can be done by telling these people clearly that you wish to have no further contact with them.

✓ Move your home to a more substance free area and do not tell drinking buddies, users, or dealers where you have moved.

✓ Change your telephone number and/or throw out numbers of dealers.

✓ Have cheques automatically deposited into your bank account. Throw out 24 hour cash cards. Have someone hold your money for you.

✓ Try a new drug/alcohol free activity.

✓ Give self help groups a try. This means trying out a number of different types and locations of meetings so that you can make an informed decision about whether self help groups can be helpful to you.

✓ Talk to supportive friends, family or health professionals about difficult situations for you.

✓ Tell supportive friends (those who will not encourage you to use drugs and alcohol) that you are no longer using substances.
Six Facts about Cravings

1. **Cravings are impulsive or spontaneous* desires to use drugs.** They are often accompanied by feelings of anxiety or restlessness, thoughts of how good it would feel to use, and a hunger or compulsion* to use drugs. Cravings are a natural result of chronically* and habitually using drugs to alter your mood.

2. **Cravings are usually triggered by something - people, places, things, feelings associated with your use.** Cravings can also be triggered by drug dreams. When cravings appear to be totally unrelated to what’s going on around you, they are usually caused by what’s going on inside you - your emotional state. Cravings on their own can lead directly to relapse and/or thoughts of the same.

3. **Cravings tend to be strongest and occur most frequently in the first weeks after you have stopped using drugs.** Cravings get weaker as abstinence continues. It is said that “cravings lose their power as we become stronger in our sobriety”. Using drugs, even after a long abstinence, renews cravings and increases their strength and frequency.

4. **The intensity of a craving does not fade merely with the passage of time, but as a result of not reinforcing* the cravings with use.** Cravings lose power, little by little, each time you respond to the craving by not using. This process in known as extinction*.

   Complete abstinence from all drugs will ensure the most rapid and complete extinction of cravings. It is very dangerous to intentionally expose yourself to triggers, as a way to test how committed you are to stopping. This is likely to backfire by overwhelming you and causing you to relapse and return to accelerated drug use.

5. **Cravings are always temporary and tend to disappear quickly, especially when immediate action is taken to short-circuit them.** Most cravings are like waves – they peak, stay there for a short time, then rapidly fall off.

6. **Ignoring cravings is a poor defense against them.** Specific action must be taken to deal with cravings and to prevent them from leading to use. Action means doing something, anything. Get up and move around - walk - call someone - but change/action alters the thinking pattern.
**Key Terms:**
- Spontaneous*: unplanned, impulsive
- Chronically*: frequently, consistently
- Reinforcing*: strengthening, supporting, when a consequence of a behaviour increases the likelihood of the behaviour happening again
- Extinction*: loss, when a behaviour no longer occurs
ABC’s for Coping with Cravings

A’S: Affective – Feelings
B’S: Behaviours – Actions
C’S: Cognitive – Thoughts

The “A’s” – Affective

- Be honest with yourself and your friends/family
- Give yourself permission to feel
- Acknowledge and recognize your feelings
- HALTS – if you are hungry, angry, lonely, tired, or sick – find a safe place to recharge yourself.
- Express your feelings (cry, laugh, smile)
- Seek support
- Talk to someone about your feelings
- Do something to change your body feeling – do push-ups, eat an orange, drink water, take a shower
- Channel feelings into artwork (drawing, painting, sculpting, carpentry)
- Give yourself a pat on the back for a job well done
- Use stress management or relaxation techniques to feel more grounded
- Feel good about how far you’ve come
- Find a safe outlet to express hurt or anger

The “B’s” – Behaviours

- Get rid of booze, drugs, and paraphernalia
- Talk about your cravings and thoughts of using with a counsellor, friend, or family member.
- Write your thoughts and feelings in a journal or craving log
- Keep an index card in your wallet that lists some common sense strategies for coping with cravings or thoughts of using
- Put off using for an hour, several hours, or a day so that you “buy yourself time”
- Avoid high-risk people when possible (dealers, people who use, etc.)
- Avoid high-risk places and events when possible (parties, bars, clubs, etc.)
- Take a support person to events that cannot be avoided where some pressure may be felt to drink/use (wedding, work party, family picnic)
- Assertively say straight out that you are not using anymore
- Leave situations where the pressure is hard to handle and seek support

The “C’s” – Cognitive
- Think of the positive aspects of remaining abstinent ("look how far I’ve come"); “feel good just the way I am”
- Remember the negative consequences of using (financial problems, health, relationships, legal problems)
- Remind yourself “I have control over my actions, and I choose not to drink/use drugs”
- Stop and ask yourself “Is it worth it?”
- Tell yourself the craving will go away
- Distract yourself and think of something totally different
- Recognize and challenge self-defeating rationalizations (Example: “I’m only going to have one”…Is it really true?…Remind yourself “one leads to another”)
- Think about your future goals and how you plan to achieve them
- Change the focus of your activities away from drinking/drug use
- Tell yourself “Today, I am not going to drink/use drugs”
- Remind yourself of your worst possible moments when you were drinking/using drugs
- Tell yourself “you don’t need this” (drugs/alcohol)
- Tell yourself to “cancel” those thoughts about drinking/drug use
- Remind yourself how far you’ve come – do you really want to go through all that again?
- Ask yourself – what makes you think it will be different this time?
Defense Mechanisms

Denial
- Refusing to admit that which is true.
- Ignoring an unpleasant fact or situation.
- Failure to accept the reality that certain events have occurred or are occurring.
- Common in early stages of substance abuse.
- Easier to deny a problem exists – then you don’t have to do anything about it!

Rationalization
- Justifying actions with illogical explanations.
- Making excuses for inappropriate behaviour.

Minimization
- Attempts to reduce the degree or severity of a problem or situation.
- Actions or words intended to make something seem not as bad or less negative.
- To downplay the realities of a situation.

Blaming
- Sometimes called projection
- Stating that someone else or something else is the cause of your problems.
- Attributing* the fault to someone or something else.
- Diverting* the responsibility from yourself.

Key Terms:
*Attributing: giving a quality or characteristic to a particular person or thing
*Diverting: distract from, turn from one course to another
Intellectualization

- A type of rationalization yet more intellectual
- Not dealing with the emotional part

Projection

- Thinking / assuming someone else has your thoughts or feelings.
- You feel this way, you cannot state someone else’s feelings.

Displacement

- You redirect your feelings to another target
- For example: You are not really angry with your children but using anger in a different situation.

Procrastination

- Putting off a task or action to a later date
- Is usually counterproductive, needless, and delaying
List of Defense Mechanisms

Denial Completely rejecting a thought or feeling. “I don’t have a drinking/drug problem.”

Rationalization Justifying actions with illogical explanations. “I drink/use drugs because there’s nothing else to do around here.”

Minimization To downplay the reality of a situation. “I only use a few lines a day.”, or “I only drink beer.”

Blaming Stating that someone or something else is the cause of your problems. “Living with you pushed me into it”

Displacement Redirecting your feelings to another target. Example: A person is angry with his boss so he goes home and yells at his partner.

Intellectualization Avoiding unpleasant feelings or emotions by focusing on the intellectual aspects. “Research has shown that I can’t be addicted. It doesn’t fit my personality.”

Projection Placing unpleasant feelings in yourself onto other people. Example: An individual feels angry with himself, therefore believes that everyone else is angry at him too.

Procrastination Putting off a task or action to a later date. “I'll stop using next week.” “I'll deal with that problem tomorrow.”
Ted’s Story

Ted had promised to spend the weekend with his family, as he is trying to make changes to his alcohol use. He had plans to take his son fishing, and to have a barbeque with his wife and children afterwards as a positive way to fill leisure time. Ted’s wife got called into work Saturday at the last minute, so regrettably she would not be able to join her family for the barbeque.

When Ted’s son appeared at the garage door with his fishing gear in hand, Ted told him they wouldn’t be going fishing today, “We’ll do it another time, maybe next weekend”. Upset and confused, Ted’s son questioned why in which Ted responded “It’s your mother’s fault, she knew we had family plans today but went in to work anyways. She ruined our day”. Since he was unable to go fishing with his dad, Ted’s son spent the rest of the day on his computer looking up different kinds of fish and different lakes that are nearby to fish in.

Ted spent the morning cutting the grass, and by the afternoon he was starting to think about picking up a drink. “Besides”, he thought, “I’ve been working all morning, I deserve this”. Ted thought back to the promise he had made his family, and his reasons for wanting to make changes to his alcohol use. Ted decided that it was only when he switched to hard liquor that he becomes angry and irrational, “so I’ll just stick to beer” he told himself, “no harm in that.”

Ted continued to drink into the evening, all the while feeling guilt and shame for doing so as he is not following through with the changes he promised his family he would make. Still experiencing these negative emotions, Ted picks a fight with his wife almost immediately when she returns home from work. “We’re all mad at you” Ted shouted, “the kids are too, thanks for ruining our day!”
Defense Mechanisms

Describe a situation in the past in which you have used each defense mechanism. See if you can now construct a more helpful thought or response for that situation.

**Denial:** Completely rejecting a thought or feeling.
(e.g. “I don’t have a drinking/drug problem”)

Your example: ____________________________________________________________

More helpful thought or responses: _______________________________________

**Rationalizing:** Justifying actions with illogical explanations.
(e.g., “I drink/use drugs because there’s nothing else to do around here.”)

Your example: __________________________________________________________

More helpful thought or responses: _______________________________________

**Minimizing:** To downplay the reality of a situation.
(e.g., “I only use a few lines a day”, or “I only drink beer.”)

Your example: __________________________________________________________

More helpful thought or responses: _______________________________________

**Procrastination:** Putting off a task to a later date.

Your example: __________________________________________________________
More helpful thought or responses: ________________________________

________________________________________________________________________

**Blaming:** Stating that someone or something else is the cause of your problems
(e.g., “Living with you pushed me into it.”)

Your example: ________________________________

________________________________________________________________________

More helpful thought or responses: ________________________________

________________________________________________________________________

**Displacement:** Redirecting your feelings to another target
(e.g., A person is angry with his boss so he goes home and yells at his partner.)

Your example: ________________________________

________________________________________________________________________

More helpful thought or responses: ________________________________

________________________________________________________________________

**Intellectualizing:** Avoiding unpleasant feelings by focusing on intellectual aspects.
(e.g., “Research has shown that I can’t be addicted. It doesn’t fit my personality.”)

Your example: ________________________________

________________________________________________________________________

More helpful thought or responses: ________________________________

________________________________________________________________________

**Projection:** Placing unpleasant feelings in yourself on to other people
(e.g., An individual feels angry at himself, therefore believes that everyone else is angry at him too.)

Your example: ________________________________

________________________________________________________________________
More helpful thought or responses: ________________________________

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**Defense Mechanisms**

**What is a Defense Mechanism?**

- Distortions* of the reality of a situation.
- Unconscious strategies for avoiding/reducing threatening feelings, such as fear or anxiety.

**Purpose of Defense Mechanisms**

- Serve a protective purpose for people by allowing them, temporarily, to avoid directly dealing with or managing a situation or emotion.
- Can protect a fragile self-image or self-esteem. Example: may not want to identify as having a problem because you see addicts as “bad” people, so you rationalize the substance use: “I only use because I’m in pain.”
- Used when a person is having an emotional experience that feels too difficult to handle.
- Can also have constructive uses, such as, helping someone through an initial trauma.

Example: Not wanting to believe the news of the death of a relative. Thinking and saying “it isn’t true” is acceptable at a very early stage (for minutes and hours) but can be destructive to mental health if a person refuses to believe it for weeks or months later.

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**Key Terms:**

*Distortions: a twist of the natural or normal conditions, changing from the original in a way that is misleading*
Advantages

- When used appropriately, defense mechanisms are a natural way of adjusting to different experiences and situations.
- They can help to channel a negative impulse into a healthy outlet. Example: Sublimation—angry person working out
- Can help in coping with stress.

Disadvantages

- Relying on defense mechanisms prevents people from constructively solving problems.
- Reduction of stress can be so appealing that the defense mechanisms are maintained and become habitual.
- Excessive dependence of defense mechanisms can produce social isolation and distortion of reality.

Role of Defense Mechanism

- Defense mechanisms are often used more intensely by those with a substance use problems as a way to cope with emotional pain and anxiety about using, and the problems that using brings.
- Defense mechanisms make it difficult for an individual to accept that he has a problem

As the addiction progresses, these defenses grow stronger.