Revision of a Self-Sabotage Group Based on Cognitive Behavioural Therapy Techniques for Adult Males Seeking to Abstain from Drug and Alcohol Use.

By

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The procedures in the Staff Facilitators Notes are meant to be used by agency staff, as part of the Cognitive Behavioural Therapy group sessions they provide.
Dedication
I would like to dedicate this thesis to my family and friends who have supported and pushed me throughout my academic journey thus far.
Abstract

Approximately 8 million Canadians experience substance abuse issues within their lifetime (Smith, 2018). The effects substance abuse has on individuals include mental, physical, and behavioural concerns and the annual cost to society to support these behaviours is approximately $22.8 billion (Gifford & Humphreys, 2007; Rehm et al., 2007). The purpose of this thesis was to first evaluate the use of group Cognitive Behavioural Therapy (CBT) techniques in men’s residential programs for the treatment of substance abuse. Secondly, self-sabotaging behaviours were addressed in relation to substance abuse and CBT techniques. However, the main purpose of this thesis was to produce the updated Self-Sabotaging Behaviours Facilitators Notes used at the Addictions and Mental Health Services: Hastings Prince Edwards (AMHS: HPE) men’s residence program. The updated notes were created to ensure that best practice and up to date information is being used as well as to create a standard layout for future updated groups. This layout included a rationale, goals, time frame, materials, process, worksheets, and additional facilitator’s notes. Attached is the PowerPoint and a copy of the handout and worksheet needed to facilitate the group discussion. It is expected that by re-evaluating and incorporating newer, more detailed, and best practice policies for the self-sabotaging group facilitator notes, AMHS: HPE staff will be better equipped to lead the group session and improve the clients’ success rate of treatment. Additionally, strengths, limitations and challenges, multilevel challenges to service implementation, and contributions and recommendations for future research are discussed.
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Chapter I: Introduction

The use of illegal substances or abuse of legal substances is a concern that society has faced for a long time. A self-report survey conducted in 2012 displayed that approximately 21.6% (about 8 million) of Canadians have met the criteria for substance abuse within their lifetime (Smith, 2018). Society’s concern stems from the mind and body altering effect these substances have on individuals and how substance use may lead to substance abuse. This abuse is also linked to both physical and mental health concerns as well as behavioural issues (Gifford & Humphreys, 2007). The effects on the body and mind these substances have on an individual varies, and assessing exactly how harmful drugs are is difficult. One drug that is commonly abused is alcohol. Some negative health problems associated with long-term and repeated use of alcohol include the increase of developing several different cancers, including liver cancer, and acquiring poor nutrition which may lead to brain damage and in some cases dementia (Grönbaek, 2009). Alcohol has also been linked to altering the mind during and between use. During use, individuals commonly experience euphoria but with excessive use, individuals may feel tired and confused (Grönbaek, 2009). Excessive and extended use of alcohol and drugs has also been linked to higher reports of depression (Hunter, Witkiewitz, Watkins, Paddock, & Hepner, 2012). Another way to show the devastating damage drugs cause comes from a study by Rehm et al. (2007). They found that substance use and misuse cost Canada’s health care approximately $8.8 billion in 2002 (Rehm et al., 2007). When incorporating all the other factors that are associated with substance abuse, like law enforcement and aftercare, the total taxpayer’s money spent increases to approximately $22.8 billion annually (Rehm et al., 2007). Due to the staggering costs of substance misuse, both individually and societally, it is important to offer effective interventions to address substance abuse.

Addictions and Mental Health Services: Hastings Prince Edwards (AMHS: HPE) offers a three-week residential treatment program for men aged 21 and older. The program is based on Cognitive Behavioural Therapy (CBT) and offers an intensive approach to group therapy. The program consists of two-three group sessions per day. The first two sessions of the day are two hours and 15 minutes in length and the following session is one hour and 15 minutes long. The topic of each session varies but always relates to the overall goal of harm reduction, psychoeducation, and abstinence maintenance. Some examples of group topics include; self-sabotage, coping strategies, positive self-talk, maintaining triggers, communication skills, cognitive modification, stress management, and more. The program also incorporates a strict schedule outside of the CBT group sessions furthering the intensity of the treatment program. With a set schedule, clearly stated house rules, and daily chores, the residence provides a safe setting that can help individuals adjust to a more productive and therapeutic daily routine. This program is free to clients and to gain access an individual must be referred to the agency by an addictions counsellor.

Due to the numerous group sessions offered by AMHS: HPE, there is a need for re-evaluating certain sessions to ensure the procedures and techniques used are up to date and considered best practice. The session being updated by the student is on self-sabotage. The reason for re-evaluating this session is that agency staff indicated it was outdated and lacking detailed facilitators notes. The hope is that by re-evaluating and incorporating newer, more detailed, and best practice policies for the self-sabotage group facilitator notes, AMHS: HPE staff will be better equipped to lead the group sessions and improve the client’s success rate of treatment, although it was not possible to determine this during the current placement.
This thesis includes; a literature review, methodology, the updated self-sabotage group, results, and a discussion.
Chapter II: Literature Review

Introduction

In Canada, 21.6% of individuals met the criteria for substance abuse disorders in their lifetime (Pearson, Janz, & Ali, 2015). With approximately one in five Canadians experiencing substance use disorders within their lifetime, it is important that effective and efficient treatments are made available (Pearson et al., 2015). The goal of this literature review is to outline and critically analyze Cognitive Behavioural Therapy techniques as well as the usefulness of CBT for individuals who display substance abuse behaviours. This literature review then focuses on self-sabotaging behaviour in relation to addictions and CBT.

Cognitive Behavioural Therapy

Cognitive Behavioral Therapy (CBT) is a treatment used in a variety of settings with diverse populations and has become a vastly used treatment within the field of Behavioural Psychology (Magill & Ray, 2009; McHugh, Hearon, & Otto, 2010; Kushner, 2013; Watkins, 2012). CBT incorporates three main principles including human behaviour, cognition, and emotion (Leichsenring, Hiller, Weissberg, & Leibing, 2006). These three principles are believed to be the driving force behind the actions of individuals (Leichsenring et al., 2006). People who incorporate CBT techniques in their daily life demonstrate how their thoughts influence their feelings and how their feelings affect their behaviour (Leichsenring et al., 2006). Two of the main CBT techniques include challenging negative thinking and evaluating patterns of thinking (Leichsenring et al., 2006). These two skills are useful because challenging negative thinking helps individuals differentiate between facts and fiction, whereas evaluating patterns of thinking helps individuals identify and stop or suppress problematic thought patterns in early stages. The skills taught during CBT can transfer to a wide range of mental health concerns or common life struggles including depression, low self-efficacy, and anxiety (Butler, Chapman, Forman, & Beck, 2006). The ability for CBT skills to generalize to other aspects of life makes the treatment even more effective (Butler et al., 2006). Some of the topics covered in CBT include relaxation, coping strategies, cognitive modification, assertiveness, problem-solving, stress management, healthy diet, plan development, self-sabotage, and more (Leichsenring et al., 2006). One of the main limitations of CBT is the complexity of the techniques the clinicians use (Caroll & Onken, 2005; Payne & Myhr, 2010). This complexity leads to the current deficit of CBT trained staff in the workforce (Payne, & Myhr, 2010). A possible solution to cut down on the clinician’s time is to provide CBT in a group session. A study by Marques and Formigoni (2001) found that both individual and group CBT sessions had similar results. They discovered their findings by comparing the results, including abstinence and relapse rates, of several group and individual based CBT treatments (Marques & Formigoni, 2001).

Use of Cognitive Behavioural Therapy for Substance Abuse

CBT techniques are commonly used by mental health professionals to aid individuals seeking support for substance abuse. Magill and Ray (2009) wrote a meta-analysis of 52 controlled trials of both individual and group CBT and found that there is a significant improvement to client’s ability to refrain from substance abuse behaviours. The participants of the studies were all above the age of 18 and a criteria for admission included a diagnosis of substance abuse or dependence (Magill & Ray, 2009). Of the 52 studies analyzed in this meta-analysis, 75% were conducted in the United States of America and the mean client population
was 179 (Magill & Ray, 2009). Magill and Ray found that 58% of patients that received CBT managed their addiction better than the comparison conditions. Comparison conditions included the use of other treatments or no-treatment (Magill & Ray, 2009). The effectiveness of CBT increased to 69% when looking at participants whose substance of choice was specifically Marijuana (Magill, & Ray, 2009). Another study with 299 participants by Watkins et al. (2012) focused on the effects of CBT residential treatments in relation to depression and substance use. They noted that the diagnosis of depression increased the likelihood of co-occurring substance abuse to 20% (Watkins et al., 2012). Knowing that approximately 20% of people who seek substance abuse treatments are likely to also exhibit depressive symptoms, Watkins et al. suggest that residential substance abuse programs either address or have training in other mental health fields like depression. One way they suggest this is to train staff on the use of CBT (Watkins et al., 2012). The results of this study displayed positive effects of the CBT substance abuse residential treatment on the client’s substance use behaviours (Watkins et al., 2012). They also found that the CBT substance abuse residential treatment programs were a suitable treatment for co-occurring major depression (Watkins et al., 2012). One reason CBT treatments are effective is the emphases on learning-based skills that focus on maladaptive behavioural patterns (McHugh, Hearon, & Otto, 2010). The learning-based approaches also help clients build on any skill deficits that may exist (McHugh et al., 2010). Secondly, CBT highlights the driving force behind the problematic behaviours. McHugh, Hearon, and Otto (2010) suggest that substance use is strongly related to the reinforcement individuals receive from using drugs. One way CBT motivates clients to change their substance abuse behaviours is to teach them ways to seek positive reinforcement from prosocial relationships or activities that do not allow the use of drugs (McHugh et al. 2010). Lastly, when it comes to the duration and intensity of CBT treatments, there is a positive trend suggesting that more sessions and higher intensity leads to greater success rates of treatment (McHugh et al., 2010).

**Effectiveness of Residential Treatments for Substance Abuse**

Residential treatment for substance abuse is also referred to as inpatient treatment. Inpatient treatment means that the clients will be admitted to the program for a specified duration. This approach to treatment has shown to be effective by providing an intensive form of therapy to the clients by maximizing the time the clients spend with professionals and by providing plenty of time for therapy to occur (McKay, 2009). The structure itself is also known to be beneficial to the clients as well (McKay, 2009; Ness & Oei, 2005). By filling the client’s day with therapy and other social or proactive activities, it limits their ability to use or think about their drug of choice and illustrates how their daily structure should be when they leave (McKay, 2009). One downside of residential treatment is the cost. The amount of money and professional’s time needed for residential treatment is a difficult barrier to overcome (McKay, 2009). This commonly limits the availability of residential treatment to high-risk individuals or to individuals willing to be put on a waitlist for usually an unspecified amount of time. One way to cut down on the cost is to provide more standardized and group forms of treatment at the residence (McKay, 2009). As mentioned earlier, Marques and Formigoni (2001) found that providing CBT in a group setting had little to no effect on the effectiveness of the CBT being provided. As for standardizing the CBT, the use of worksheets and homework can be a time saver for the staff running the CBT group session and can help the clients retention of the material being taught (Gonzalez, Schmitz, & DeLaune, 2006).
Self-Sabotage
Self-sabotage, also known as self-defeating or standing in your own way, is a common behaviour expressed by individuals desiring to change. Learning to identify this sabotaging behaviour and avoiding events that may initiate it helps keep plans on track and in return lowers the risk of relapse (Selby, Pychyl, Marano, & Jaffe, 2014; Alshawashreh, Alrabee, & Sammour, 2013). Some actions seen as self-sabotaging include not having a plan, negative thinking, procrastination, continuing negative relationships, and any other behaviors that may sabotage treatment progress (Alshawashreh et al., 2013). A study by Bramante (2015) examined the correlation of self-sabotaging behaviour with other negative behaviours like low self-esteem and self-efficacy along with the fear of success. The results showed that individuals with low self-esteem and self-efficacy or a fear of success were more likely to engage in self-defeating behaviour (Bramante, 2015). Another reason for individuals to self-sabotage is because they find it difficult to see how well they can do under desirable conditions (Leahy, 2008). Individuals may find ways to sabotage themselves to provide an excuse for why they failed (Leahy, 2008). It is important in a therapeutic relationship that further attempts to self-sabotage are anticipated, addressed, and discussed in order to limit or extinguish this undesirable behaviour (Leahy, 2008).

In a study by Zuckerman and Tsai, (2005) college students were analyzed to address potential reasons for drug and alcohol use. Among the reasons provided, a newer function of the behaviour was discussed. Zuckerman and Tsai state that the self-handicapping behaviour of substance abuse may be a function of people wanting to protect themselves from future distress. What this means is that individuals my purposely handicap themselves with the use of drugs in order to provide an excuse for their behaviour (Zuckerman, & Tsai, 2005). Continued use of this excuse can contribute to the development of substance abuse (Zuckerman, & Tsai, 2005). This study displays an important point for why self-sabotaging behaviours are an important topic to cover in the treatment of substance abuse (Zuckerman, & Tsai, 2005). This is that substance abuse can become a positive reinforcer for individuals by giving themselves or others an excuse for their undesirable behaviours. If a person is fearing their success, substance use may have got them off the hook short-term, but long-term the individual may begin to hold lower standards for themselves and their abilities (Zuckerman & Tsai, 2005). Acknowledging this harmful thought pattern could be one of the changes someone needs to make in order to refrain from drug use in the future.

Summary
Overall, CBT offers clients a treatment that not only addresses substance use, but also provides a generalizable set of skills the individuals can use to cope with everyday issues (Caroll, & Onken, 2005; Kushner, 2013; McHugh, Hearon, & Otto, 2010; Magill, & Ray, 2009; Leichsenring, Hiller, Weissberg, & Leibing, 2006; Watkins, 2012). The skills include relaxation techniques, coping strategies, cognitive modification, assertiveness, problem solving, stress management, healthy diet, plan development, self-sabotage, and more (Leichsenring et al., 2006). These skills provide a good base that the clients can further expand on when they implement the topics in their normal environment outside of treatment (Leichsenring et al., 2006). Although CBT seems to be the preferred treatment in the field, there is no reason to believe that other treatments cannot be pursued before, during, or after the CBT treatment. In fact, it is encouraged that clients seek alternatives like AA meetings or family counselling in addition to CBT (Caroll, & Onken, 2005; McKay, 2009). The treatment setting that would best suit individuals struggling with substance abuse are residential treatments (McKay, 2009).
setting promotes an intensive form of therapy by providing support around the clock and offering plenty of time for individuals to participate in therapeutic and prosocial activities like CBT group sessions or group board games (McKay, 2009). The 24/7 monitoring of the clients deters substance use and the daily structure and rules create a living situation that models desirable conditions they should seek after leaving the residence (McKay, 2009). Considering the above, it is predicted that CBT offered within a residential treatment facility will give clients a strong chance of an effective treatment.
Chapter III: Methodology

Target Population/Participants

Staff Personnel: The updated session notes were developed to aid the AMHS: HPE addiction resident’s staff during the implementation of group CBT sessions. The updated notes provide best practice methods as well as a more standardized platform for staff to learn and then facilitate the group session. The updated notes also aid the staff by setting the layout that future updated groups should follow. The number of staff that may use the updated notes is approximately 11. There are about five full time staff at the residence and about six casual or part-time staff. There will be no need for staff to undergo specialized training to implement the updated session. The staff notes along with the PowerPoint and worksheets were provided to the staff well in advance to them being asked to present the new content. There should be no issue with the staff presenting new information as their job position involves learning and then leading a group session on new content regularly.

Clients: The intended population participating in the session are the client residents of AMHS: HPE. These individuals are 21 years of age or older, male, and have a history of substance use issues. The history may be current or in the past and the amount or type of substance use matters little. To be admitted to the program, clients must be referred by an addiction counsellor that is certified to complete the required assessments. The client population size is anywhere between 0-18. This number is subject to change weekly due to the three-week rotation of clients and the intake of clients being every Thursday. The residence aims to have 16 participants each week, but the average is closer to 10-14.

Consent

Formal consent and confidentiality procedures for clients or staff was not developed for this project. For the purposes of this thesis the self-sabotage group session was updated, but the implementation of the updated material will be conducted by agency staff under the supervision of Josh Oenema (Supervisor of AMHS: HPE). There will be no release of client information in this project.

Consent to use the organizations name, information, and logo (Appendix A) for the use of the student’s described thesis project was signed by Josh Oenema on December 5th, 2018.

Design

The updated group session focuses on effective strategies and best practice when addressing self-sabotaging behaviour. Best practice is determined by analyzing current literature and following the procedures that produce the most desirable results. The project is considered a non-experimental research design due to the lack of manipulating conditions.

The staff notes for the updated group session are comprised of seven key aspects. The notes include a rationale, goals, time frame, materials, process, worksheets, and additional facilitator’s notes. Attached at the end of the facilitators notes is the Power Point and a copy of the handout and worksheet needed to facilitate the group discussion (Appendix C).

Settings

The Addictions and Mental Health Services: Hastings Prince Edwards residential treatment is in Belleville Ontario and is available to locals of Belleville as well as other Canadian citizens. The three-week treatment is mostly confined to the residence, but morning walks,
volunteer positions, and free leisure time permit clients to experience other locations within Belleville Ontario. The daily group sessions take place in a room behind the residence and is fitted with everything the staff and clients need for each session. It includes a smart board, computer, flip chart, and writing utensils. The seating is set up facing the front of the room, behind desks, in sets of two, and the seating is assigned for the clients each day. There are usually three classes each day in this room with two classes lasting two and a half hours and the third lasting one hour and 15 minutes. The class on self-sabotage is one hour and 15 minutes long. The sleeping quarters are located on the second floor of the residence and each room can accommodate two residents. There is a resident chef that prepares lunch and supper for the clients. For breakfast there is boiled eggs, cereal, and toast available. Finally, the residence resembles a large house giving clients a comfortable and familiar setting while attending the program.

Measures
To assess the impact of the updated group session a Staff Evaluation of the Updated Session form was created by the student (Appendix B). This survey provides feedback on the effectiveness of topics like the time frame, relevance of the information, how up to date the information is, and if the facilitator’s notes were thorough. The agency supervisor along with any other staff that wished to participate were asked to rate these categories on a scale of 1 (poor) to 5 (excellent). This quantitative feedback collected was organized with the use of a table. Qualitative data was also collected from the college and agency supervisor with a brief questionnaire on the same Staff Evaluation of the Updated Session form. This data was summarized on a table for ease of use and further discussed in the results section of this thesis. Assessment of the updated material highlights areas of improvement that further enhance the effectiveness of the group session and the overall treatment of the clients.

Procedures
The selection of the group session to be updated was a group effort. The student met with four of the full-time staff as well as the agency supervisor to discuss what session would most benefit from being updated. Some deciding factors when evaluating the sessions included: is the session outdated, was the content relatable to the clients, are the staff notes easy to comprehend and facilitate, and did the session incorporate best practices? The staff and student chose the self-sabotage group based on the parameters listed. To find literature for the Self-Sabotage group, the student used both the St. Lawrence online library database (Psyc-INFO and PsycBOOKS) and Google Scholar. The main search terms included; self-sabotage, cognitive behavioural therapy, substance use, residence program, self-efficacy, negative thinking, and more. The final step was to request feedback from the agency supervisor and willing staff using the Staff Evaluation of the Updated Session form. The data from the evaluation was displayed in a table for ease of use.
Chapter IV: Results

Final Product

The final product of this thesis is an updated CBT group session on self-sabotage (Appendix C). The updated group consisted of a rationale, goals, time frame, materials, process, worksheets, and additional facilitator’s notes. Attached is the Power Point and a copy of the handout and worksheet needed to facilitate the group discussion. The updated facilitator notes on self-sabotage mainly focused on providing detailed information necessary to help a new facilitator become familiar with the content and ensure each facilitator incorporates the needed information for each group. The updated notes included content on self-sabotaging behaviour in relation to drug abuse, followed best practice, and utilized current research on self-sabotaging behaviour.

Feedback Received

Feedback on the updated self-sabotage facilitator notes was first collected from the agency supervisor after the first draft. Time was given for the supervisor to suggest changes, but no changes were suggested. The updated notes were then evaluated by the Staff Evaluation of the Updated Session form (Appendix B). Three staff evaluated the updated notes including the agency supervisor and two other full-time staff. The Staff Evaluation of the Updated Session form was designed to provide two forms of data. It collected quantitative data using a five-point scale and qualitative data by asking five prudent questions to be completed as short written answers. Both the qualitative and quantitative data was transcribed into two tables to display the results (Appendix D). For the most part, all three of the evaluators marked the updated session as excellent for the quantitative questions. There was only three marks given to a good rating and no marks to the other three categories (satisfactory, fair, and poor). The quality of the handout was marked as good two times out of three and the quality of the worksheet was marked good once out of the three. All three evaluators marked the comprehensiveness and relevance of the new notes as excellent. There was a unanimous mark as excellent for the expected time frame and design of the Power Point as well. The qualitative data showed that the updated notes were a positive change to the original. All three evaluators touched on how the added worksheet will benefit the group and all three stated that they would feel comfortable leading the group based on the new facilitator notes. When asked what could be changed or added, one evaluator mentioned that there could be more information on the Forms of Self-Sabotage hand out. Overall, the
feedback given was positive and the supervisor has replaced the old group with the newly developed one. The first implementation of the group will be in January 2019.
Chapter V: Discussion

Thesis Summary

The purpose of this thesis was to provide Addictions and Mental Health Services: Hastings Prince Edwards with an update to one of their original CBT group sessions. The session that needed updating was “Self-Sabotaging Behaviour” in relation to addictions. The session lacked specific detail in the facilitator notes and the information provided was lacking and outdated. It is expected that by re-evaluating and incorporating newer, more detailed, and best practice policies for the self-sabotage group facilitator notes, AMHS: HPE staff will be better equipped to lead the group sessions and improve the client’s success rate of treatment. Due to this thesis not including the implementation of the updated notes, the outcome could not be directly tested. Instead, a satisfaction form was created to collect several staff’s thoughts regarding the updated notes (as displayed in section IV of this thesis). The overall opinion of the staff was that the updated notes were an improvement to the original while also including best practice measures and up to date procedures. The updated session was set to be first implemented in the New Year, but client data will not be collected. The updated facilitators notes were also designed to be the desired layout for all future updates of all the groups to follow. This is to ensure ease of use for current and new staff at the agency. The sections of the facilitator notes included a rationale, goals, time frame, materials, process, worksheets, and additional facilitator’s notes. The Power Point and a copy of the handout and worksheet needed to facilitate the group discussion are attached separately.

Strengths

The greatest strength of this thesis was the detailed notes provided in the updated facilitators notes. The notes gave a step by step outline for leading the CBT group session with a timeline and additional information that may be needed. A lack of detail was the most noted complaint from staff regarding the original notes, but with the updated notes, all the staff stated they would feel comfortable leading the group based on the updated notes.

A second strength of the thesis was the development of an outline for the facilitator notes that can be generalized across all the other groups over time. By keeping the format the same, it should be easier for staff to find the information they need quickly. It also ensures each updated group adds something to each required section in the outline.

Limitations and Challenges

The most difficult challenge to overcome was also the main limitation of this thesis. This was the fact that the timeline was four months. The initial goal of the thesis was to get at least two groups updated, but this goal was not met due to time restraints. While developing the second updated facilitator notes and group, the agency supervisor decided to cancel the endeavor. The short timeline also meant that data could not be collected after the implementation of the group. This prevents gathering information on the effectiveness of the group and how staff may have rated it differently after leading the group.

Another limitation of the updated notes is that they were designed with the knowledge that the group would be one hour in length. This presented the challenge of deciding what information was the most important to include because there was only so much time for the facilitator to teach new content. During an hour group, facilitators may aim to talk for only 25% or less of the time.
There was also a limitation regarding client data collection for the thesis due to the three-week cycle of clients. Due to the short stay for clients, data collected during their stay was not an option and data collection once they left was not an option either because the clients were no longer part of the program once they left the facility.

**Client Level.** When addressing the motivation for some of the clients entering the addictions residential program, it was apparent that some of them lacked internal motivation. Some individuals came to the agency to satisfy family wishes while some of the others came to show the courts their desire to change. This lack of inspiration to change showed when clients chose to sit quietly at their desk, not volunteering to participate, and completing the minimum amount of work to get by and leave the program with a completion report. This created a challenge for staff at the agency to find a way to motivate these individuals before their low morale possibly began to affect not only themselves, but also the other clients.

**Program Level.** Although the program offered at the residence was intensive and around the clock, it was still three weeks long with minimal follow-up. The program provided many outside resources for the clients when they left, and part of the program was the development of a relapse prevention plan, but maintenance of the lifestyle, skills, and drug abstinence is essentially left up to the clients. This situation left certain clients on their own after the three weeks. There is no adjustment period for the clients. They spend three weeks in a safe and supportive environment, then the three weeks end and they find themselves back in the real world.

**Organization Level.** The staff at the residence are not therapists, they do not attempt to be therapists, and the agency does not wish for the staff to be therapists. With this said, spending three weeks at the residence together often leads to a strong rapport between the clients and staff. Having a trusting relationship between the staff and clients is a good thing, but it may also lead the clients to become dependent on the staff. The main purpose of the staff is to educate the clients on CBT skills and harm reduction. They are not trained to deal with therapeutic relationships with the clients and this has led to challenges in the past where clients felt reliant on the staff and were devastated when the three weeks ended and they had to lose communication. This issue is more noticeable with newer staff that are not trained and have no previous experience distancing themselves from clients in a professional manner.

**Societal Level.** Much of society labels individuals with substance abuse behaviours with certain stigmas. Society is not always welcoming of individuals with a history of substance abuse and funding of programs to help these individuals is not at the top of society’s priority list. This negative perception of these individuals adds an additional barrier for substance users to overcome. Providing encouragement and resources helps individuals obtain and maintain abstinence, but it is still common for these individuals histories to keep them feeling ostracized by society.

**Contributions and Recommendations for Future Research**

The updated facilitator’s notes were not implemented during this thesis; therefore, data was not collected on the effectiveness of the new content. It is recommended that the updated notes be used in future studies before confirming the success of the updated material. This study should also include follow-up on the clients to measure their relapse rate and other relevant information. Future consideration could be made to update the other group sessions to fully
understand how the standardized format, up to date procedures, and best practice methods affect the clients’ success rates.

This study benefits the field of Behavioural Psychology by adding to literature on self-sabotaging behaviours in relation to substance abuse. It seems there is a lack of research on the effectiveness of CBT on self-sabotaging behaviour for drug abusers. The updated facilitator notes on self-sabotage provide the potential for formal evaluation in the future which would add to the current literature.

This thesis benefits Addictions and Mental Health Services by providing staff with updated and more thorough notes on how to run the Self-Sabotage CBT group session. The notes also provide a layout to help standardize other group notes in the future.
References


Appendix A

Date: ______________

CONSENT FOR USE OF AGENCY LOGO

I ____________________________ consent to the use of the logo of Addictions and Mental Health Services: Hastings Prince Edwards in Drake Deline’s applied thesis poster for the Honours Bachelor of Behavioural Psychology program at St. Lawrence College.

__________________________  ____________________________
Agency Staff Signature       Student Signature

__________________________  ____________________________
Printed Name                Printed Name

LOGO
Date: ____________

Consent for Use of Agency Name

I __________________________ consent to the use of the name of Addictions and Mental Health Services: Hastings Prince Edwards in Drake Deline’s applied thesis for the Honours Bachelor of Behavioural Psychology program at St. Lawrence College.

________________________________  __________________________
Agency Staff Signature               Student Signature

________________________________  __________________________
Printed Name                          Printed Name
Appendix B

Staff Evaluation of the Updated Session

Group Session __________________________

<table>
<thead>
<tr>
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<th>1 Poor</th>
<th>2 Fair</th>
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Do you believe the updated notes are an improvement to the original?
______________________________________________________________________________

What works well regarding the updated notes?
______________________________________________________________________________

______________________________________________________________________________

Would you feel comfortable leading the group based on the updated notes?
______________________________________________________________________________

What could be added or changed to improve the updated notes in the future?
______________________________________________________________________________

______________________________________________________________________________

Do you have any additional comments?
______________________________________________________________________________

______________________________________________________________________________
Appendix C

Self-Sabotage

Rationale
Self-sabotage, also known as self-defeating or standing in your own way, is a common behavior expressed by individuals looking to change. This includes people who consider eliminating their substance use behavior. Learning to identify this sabotaging behavior and avoiding events that may initiate it helps keep plans on track and in return lowers risk of relapse.

Goals
- To identify common forms self-sabotaging behaviour may take
- To identify behaviours that may interfere with the change process
- To learn techniques to avoid or manage self-sabotaging behaviour

Time 1 Hour

Process
1. Review session goals and rationale (3 min)
2. Warm up (4 min)
3. Discuss what self-sabotage is and people’s experience with it (15 min)
4. Discuss forms of self-sabotage and strategies to avoid it (15 min)
5. Hand out, complete, and discuss How I Self-Sabotage worksheet (20 min)
6. Wrap up (3 min)

Materials
Flip Chart and Markers
Handouts:
1. Forms of Self-sabotage
2. Strategies to Avoid Self-Sabotage
Worksheet:
1. How I Self-Sabotage
**Self-Sabotage**

Page 1 of 3

**PROCESS**

1. **Review Session Goals and Rationale (3 min)**

2. **Warm up (4 min)**
   - Have everyone give an example of how they occasionally get in their own way.

3. **Discuss what self-sabotage is and people’s experience with it (15 min)**
   - On the flip chart write out self-sabotage and ask the group to define it.
   - Ask the group why people self-sabotage.
   - Ask the group to talk about their experience with self-sabotage. Ask the clients to share examples of situations in their lives where they have sabotaged themselves and what they have learned from the experience.
   - If they get stuck, you can offer a definition for self-sabotage – personal behaviour that creates problems that interfere with growth towards their long-term goals.

4. **Provide information on forms of self-sabotage and strategies to avoid (15 min)**
   - Review different forms of self-sabotage using Handout 1: Forms of self-sabotage. As you review the handout, ask clients for examples of what each form looks like for them.
   - Brainstorm client’s ideas for strategies to avoid self-sabotage then review handout 2: Strategies to avoid self-sabotage

5. **Hand out, complete, and discuss How I Self-Sabotage worksheet (20 min)**
   - Hand out and explain the worksheet.
   - Give the group approximately 10 minutes to complete it.
   - End with a 5-10 minute discussion on their answers.

5. **Wrap up (3 min)**
   - Ask each client to identify one reason to avoid self-sabotaging. (e.g. to stay on plan, to live a more positive life, to see the best in themselves…)
**Self-Sabotage**

**Page 2 of 3**

**FACILITATOR’S NOTES**

**PROCESS STEP 3: Discuss what self-sabotage is and people’s experience with it**

- **One Definition:** personal behaviour that creates problems that interfere with growth towards their long-term goals.
- Opposite of self-care
- An act or process that hampers/hurts.
- Is a common/normal behaviour.

**PROCESS STEP 4: Provide information on forms of self-sabotage and strategies to deal with it**

- Additional information on the forms of self-sabotage:
  - Low Self-Worth: feeling you do not deserve the success or happiness you receive. Relates to your perceived self-efficacy.
  - Desire to Control: to some it is easier to control their failure by pre-emptively initiating it than to allow the possibility of failure to surprise them.
  - Perceived Fraudulence: anxiety brought on by not feeling worthy of the increasing level of responsibility you obtained and that you will be called out as a fake or fraud for acquiring it. Feeling that the more you gain, the more you will inevitably lose.
  - Scapegoat: finding someone or something else to blame rather than accepting responsibility. May blame actions rather than accepting accountability (e.g. of course I failed, I am not smart enough to…).
  - Familiarity: choosing the dysfunctional life you know, and are oddly comfortable with, rather than striving for positive change.
  - Boredom: some people initiate instability and chaos in their life to experience the familiar feeling or to create stimulating drama.
  - Birds of a Feather: you are persuaded by the company you keep. Try surrounding yourself with individuals who represent the change you desire.
  - Martyrs: doing everything for others but not accepting help in return. Martyrs just give, give, give. Someone like this is bound to burn out.
  - Cognitive distortions: an irrational thought pattern that you may have that when investigated further may not hold up to scrutiny.
  - Negative thinking: it takes approximately seven good thoughts to counter one bad.
  - Alcohol and drug abuse
  - Abusive relationships
Self-Sabotage

Page 3 of 3

- Procrastination
- Having no purpose/plan: If you fail to plan than you plan to fail.
- Focusing on what’s not working: this is not solution oriented.
- Being stuck in fear
- Comparing self to others: you do not always know how others struggles. You may compare you worst attributes to others best attributes.

Additional information on strategies to avoid self-sabotage:

- Goal setting: touch on how goals should be SMART (Specific, Measurable, Attainable, Relevant, and Time Bound).
- Positive self talk: Three important parts. Listen to what you tell yourself, challenge it, then change it. This can be difficult at fist, but like most things it gets easier with practice.
- Challenging or stopping negative thinking: challenge the thinking by investigating the thought and seeing if it holds up to scrutiny. You can do this by keeping a thought journal and reflecting on previous thoughts.
- Reminding yourself of your accomplishments: keep certificates of achievement where you can see them, pictures of accomplishments like graduation pictures
- Utilize your support network: ask for positive feedback from trusted family, friends, or work peers if you need a boost in motivation at times. Some people find that hearing their positive changes from others is more powerful motivationally than trying to tell themselves.
Self-Sabotage

Forms of Self-Sabotage

**Low Self-Worth**: feeling you do not deserve the success or happiness you receive.

**Desire to Control**: to some it is easier to control their failure by pre-emptively initiating it than to allow the possibility of failure to surprise them.

**Perceived Fraudulence**: anxiety brought on by not feeling worthy of the increasing level of responsibility you obtained and that you will be called out as a fake or fraud for acquiring it. Feeling that the more you gain, the more you will inevitably lose.

**Scapegoat**: finding someone or something else to blame rather than accepting responsibility. May blame actions rather than accepting accountability (e.g. of course I failed, I am not smart enough to…).

**Familiarity**: choosing the dysfunctional life you know, and are oddly comfortable with, rather than striving for positive change.

**Boredom**: some people initiate instability and chaos in their life to experience the familiar feeling or to create stimulating drama.

**Birds of a Feather**: you are persuaded by the company you keep. Try surrounding yourself with individuals who represent the change you desire.

**Martyrs**: doing everything for others but not accepting help in return. Martyrs just give, give, give. Someone like this is bound to burn out.

**Cognitive distortions**: an irrational thought pattern that you may have that when investigated further may not hold up to scrutiny.

**Negative thinking**: it takes approximately seven good thoughts to counter one bad.

**Other Forms of Self-Sabotage:**
- Alcohol and drug abuse
- Abusive relationships
- Procrastination
- Having no purpose/plan
- Focusing on what’s not working
- Being stuck in fear
- Comparing self to others
Strategies to Avoid Self-Sabotage

Identify ways you self-sabotage

Don’t judge yourself and use it to fuel more self-sabotage

Have a plan/strategy

Set realistic goals

Use positive self-talk

Remind yourself of your accomplishments

Challenge or stop negative thoughts

Utilize your support network
How I Self-Sabotage

Identify two forms of self-sabotage you display and explain.

**One:** Form of self-sabotage: ______________________________________

Explain: _______________________________________________________

_________________________________________________________________

**Two:** Form of self-sabotage: ______________________________________

Explain: _______________________________________________________

_________________________________________________________________

Chose one form of self-sabotage above and answer the next two questions. Form of self-sabotage chosen from above (circle): **One or Two**

Write down two ways you can avoid or manage this form of self-sabotage?

One: __________________________________________________________

_________________________________________________________________

Two: __________________________________________________________

_________________________________________________________________

Think of two barriers that may obstruct your ability to manage or avoid this self-sabotaging behaviour.

One: __________________________________________________________

_________________________________________________________________

Two: __________________________________________________________

_________________________________________________________________
Copy of the PowerPoint Used

Self-Sabotage
Addictions and Mental Health Services
Hastings Prince Edward
Residential Treatment Program

Goals
- To increase awareness of behaviors that might interfere with your process of change.
- To learn techniques to avoid or manage self-sabotaging behaviour.

Warm Up
- How do you get in your own way?

Definition
- An act or process that hampers/hurt
- Opposite of self-care
  * You know it’s happening when your progress toward achieving your goals grinds to a halt.

Forms of Self-Sabotage
- Self-Worth
- Control
- Perceived Fraudulence
- Scapegoat
- Familiarity
- Boredom

Forms of Self-Sabotage
- Alcohol and drug abuse
- Abusive relationships
- “Birds of a feather”
- Drama
- Procrastinations
- Martyrs
**Forms of Self-Sabotage**
- Having no purpose/plan
- Cognitive distortions
- Negative thinking
- Focusing on what’s not working
- Being stuck in fear
- Comparing self to others

**How To Avoid Self-Sabotage**
- Identify ways you self-sabotage
- Don’t judge yourself and use it to fuel more self-sabotage
- Have a plan/strategy
- Set realistic goals
- Use positive self talk
- Remind yourself of your accomplishments

**How I Self-Sabotage (Worksheet)**
- Identify two forms of self-sabotage you display and explain.
- Chose one form of self-sabotage and think of two ways to avoid or manage it.
- What are two barriers to avoiding or managing the self-sabotaging behaviour?
Appendix D

Quantitative and Quantitative Data

<table>
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Qualitative Data

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<tr>
<th>Question</th>
<th>Person 1 Answer</th>
<th>Person 2 Answer</th>
<th>Person 3 Answer</th>
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<tbody>
<tr>
<td>Do you believe the updated notes are an improvement to the original?</td>
<td>Yes! More comprehensive</td>
<td>Yes, very well done.</td>
<td>Yes. The original lacked explanation. Worksheet is a great addition.</td>
</tr>
<tr>
<td>What works well regarding the notes?</td>
<td>A tone more info to present which is helpful.</td>
<td>The definitions are excellent.</td>
<td>Worksheets!!! Handout now explains each sabotaging behaviour which is helpful.</td>
</tr>
<tr>
<td>Would you feel comfortable leading the group based on the updated notes?</td>
<td>Yes.</td>
<td>Yes.</td>
<td>Yes! I always loved the group and think this will enhance it.</td>
</tr>
<tr>
<td>What could be added or changed to improve the updated notes in the future?</td>
<td>I think given the time frame, this works well.</td>
<td>Nothing.</td>
<td>“Forms of self-sabotage” handout could explain all forms.</td>
</tr>
<tr>
<td>Do you have any additional comments?</td>
<td>Worksheets are engaging and helpful, great idea to incorporate</td>
<td>Job well done.</td>
<td>Great Job! I am really excited about the worksheet.</td>
</tr>
</tbody>
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