CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

SUBSTANCE ABUSE PREVENTION PROGRAM

FOR NATIVE AMERICAN YOUTH: A HANDBOOK

A thesis submitted in partial fulfillment of the
requirements for the degree of Master of Science in

Marriage, Family and Child Counseling

by

Emmanuelle Lipsky

December 1993

The graduate project of Emmanuelle Lipsky is approved:

Dr. Bernie Nisenholz, Ed.D. Date

Dr. Hal Forman, Ph.D. Date

Dr. Stan Charnofsky Ed.D. Chair Date

California State University, Northridge

To my father and mother
Claude and Janine
for their constant support and love,
and to my sister, Laurence,
who will always be my best friend

ABSTRACT

SUBSTANCE ABUSE PREVENTION PROGRAM
FOR NATIVE AMERICAN CHILDREN: A HANDBOOK

by

Emmanuelle Lipsky

Master of Science

in Marriage, Family and Child Counseling

While there is an awareness of the drug and alcohol problem among Native American tribes, little has been done to understand why these problems persist.

The first part of this thesis identifies the ongoing problem of the alcohol and drug abuse in Native American tribes and further concludes that present alcohol and drug abuse programs have not been successful. It also gives a history of the alcohol and drug abuse problem among Native American tribes. This first part was written in order to give the future group leaders a background, and a cultural sensitivity, of the Native American people and their substance abuse history.

The second part is the handbook and consists of four sections:

1) The role of the group leader
2) The 10 group sessions
3) Handouts for each session
4) Possible supplements for the sessions

This handbook was written in a "user friendly" format and is ready to be used by any interested group leaders.

TABLE OF CONTENTS

PAGE

APPROVAL PAGE ii

DEDICATION iii

ABSTRACT v

CHAPTER

I. INTRODUCTION 1

Background of the Problem 1

Statement of the Problem 2

Purpose of the Study 2

Objective of the Study 3

Theoretical Assumptions 3

Importance of the Study 4

Definitions of Terms 4

II. REVIEW OF THE LITERATURE 6

Introduction 6

Reasons for Abuse 7

Characteristics of Abusers 8

Historical Overview of Treatment Programs 9

Possible Prevention/Intervention

Counseling Problems 10

Intervention Approaches 16

Improvements/Suggestions 17

III. SUBSTANCE ABUSE PREVENTION PROGRAM HANDBOOK . . . 21

SELECTED BIBLIOGRAPHY 115

CHAPTER ONE

INTRODUCTION

BACKGROUND OF THE PROBLEM

Alcohol and substance abuse is a major problem for many Native American youth, both on and off the reservation (Nofz, 1988). The reasons for such abuse are many: stress, social values, and powerlessness (Schinke, Botvin, Trimble, Orlandi, Gilchrist, & Locklear, 1988). As a result, there is a need for intervention.

Although many Indian alcoholism and substance abuse programs have been attempted, most have been short lived and politically motivated (Levy & Kunitz, 1981). Most lack monies, qualified staff, and are limited to outpatient clients (May, 1986). Despite this, there are currently over 190 reservation and urban alcoholism treatment programs for Native Americans in existence (Mason, Mail, Palmer, & Zephier, 1985). Unfortunately, these programs do not share equal success stories.

In 1979, the Navajo Health Authority documented results of an extensive evaluation of nine Indian alcoholism programs for Navajos and delineated what were found to be the major problems of such programs. The programs were characterized by such problems as inadequate funding, low pay, unqualified staff, neglect of Indian culture, and no guiding philosophy. Further, most failed to provide youth services.

In order to curtail increasing substance abuse among this population, treatment programs must be improved. The major target of these programs should be Native American youth (May, 1986).

STATEMENT OF THE PROBLEM

While intervention programs are currently in use with Native American youth, they are not proving to be very successful. There exists several key components that need to be incorporated into these programs in order to increase success rates. First, youths need factual information. Second, such youths need to be shown the advantages of obtaining natural highs from cultural activities such a dancing, singing, and drumming (Amoss, 1978). Lastly, counselors need to be aware themselves of cultural-bound issues, values, and beliefs that may hinder the helping process.

PURPOSE OF THE STUDY

The purpose of the study will be to develop a handbook for use by substance abuse counselors which will be cultural specific for use with Native American youth, in particular, Native American youth. The user-friendly handbook will provide counselors with a workable intervention program and will also alert them to cultural differences which need to be addressed when working with this population.

OBJECTIVE OF THE STUDY

The behavioral objective of the study is to develop a substance abuse prevention program handbook for use with Native American youth (ages ten to fifteen) which could serve as a model for other similar substance abuse programs.

THEORETICAL ASSUMPTIONS

1) Prevention programs decrease the possibility of substance abuse (alcohol and/or drug) in youth.

2) Incorporating a culturally specific component into a substance abuse program will yield a higher success rate when used with the target population. Although there are few related research studies which include a cultural component, of those which do, the cultural component was found to be an essential feature of the substance abuse program. Parker (1990) found that prevention programs which incorporate cultural tradition serve to strengthenthe bonds between the larger community and these youths. Further, Parker found that these youth experienced an increase in self-perception when a cultural heritage component was incorporated into the program.

3) There exists a great need for improvement in the substance abuse prevention programs used with Native Americans, especially those designed for youth (May, 1986).

IMPORTANCE OF THE STUDY

The success of prevention programs among Native American youth is vital to the well-being of this population. While many programs have been implemented in schools, hospitals, and re-hab centers, a search of the literature reveals that most of these prevention programs have met with limited success (May, 1986). Traditionally, such programs have not been culturally sensitive. In general, Native American Indians have followed substance abuse programs designed for other populations (usually whites or blacks). These programs are not applicable to Native American groups because they lack a culturally sensitive component (May, 1986). Hence, it is important that the implementation of a culturally aware program be investigated. Hopefully, such a program will prove to be successful and a means of combatting the looming problem of substance abuse among Native American youth.

DEFINITION OF TERMS

To increase understanding of the content of the study, the following definitions are offered:

Alcohol/Substance Abuse: the misuse of alcohol or other drugs whereby schooling, interpersonal relationships, and health are negatively affected (as determined by school records, medical records, etc.)

"At risk" youth: those youth who have demonstrated behaviors which may lead to delinquency (e.g. truancy, gang affiliation, failure to meet school/home responsibilities) or who have

family or friends exhibiting these behaviors (as determined by school records, police records, etc.)

Culturally sensitive: that which takes into account the customs, values, and beliefs of a culture

Native American Indian: an individual born on or off a reservation who is of Native American descent

CHAPTER TWO

REVIEW OF THE LITERATURE

Research into drug abuse among Native American adolescents has not received adequate attention, and possible preventative measures have received even less. However, the prevalence of use is quite high. Literature (May, 1982; May, 1986) shows that more Indian youth (41-62%), report use of marijuana than other U.S. youth (28-50%), and do so at a far earlier age. Beauvais, Oetting, Wolf, & Edwards (1989), found that "by the time they are in the 7th grade, 28 per cent of Indian youth report at least one episode of getting drunk, 44 per cent have tried marijuana, 22 per cent inhalants, 12 per cent stimulants, and 72 per cent cigarettes"(p. 635). Clearly, a problem exists, and a solution needs to be found.

This literature review will look at the following aspects of this problem and its possible solutions:

1. Reasons for Abuse
2. Characteristics of Abusers
3. Historical Overview of Treatment Programs
4. Possible Prevention/Intervention Counseling Problems
5. Intervention Approaches
6. Improvements/Suggestions

REASONS FOR ABUSE

Although a plethora of explanations exists to account for Native American substance abuse, it cannot be narrowed down to one simple answer. However, one of the most pressing factors is the family.

Alcohol and substance abuse is frequently part of the complex myriad of problems faced by dysfunctional families. This multiproblem phenomenon is quite often found among Native American families and communities (DeBruyn, 1992). In her study of Native American inmates in the Nebraska Department of Corrections, Grobsmith states that there is little question that parental substance abuse plays a major role in introducing children to alcohol and drugs at a fairly young age (Grobsmith, 1989). Further, young substance users from dysfunctional families often feel that their families provide fewer sanctions against drug use (Oetting, Beauvais, & Edwards, 1988).

Further explanations include the spiritual values of psychoactive substances, acculturation, peer pressure, and drugs as indicators of adulthood (Schinke, Botvin, Trimble, Orlandi, Gilchrist, & Locklear, 1988). Although all are likely explanations, a key indicator of susceptibility appears to be related to the degree of integration (into the majority culture) the individual feels. According to May (1982), those Native Americans with the highest risk for misuse are marginal to both Indian traditional and modern culture.

Acculturation theory holds that youths from minority

backgrounds experience greater stress than the majority in that they will not develop the necessary skills to comfortably interact within both the minority and majority cultures (Moncher, Holden, & Trimble, 1990). Lacking these skills, the minority youth is more susceptible to the escapism that substance abuse provides.

CHARACTERISTICS OF ABUSERS

McBride and Page (1980) found that "Indian drug users were more likely to have unpleasant home situations, deteriorating relationships with their parents, strong dislike for school, perceptions that the teachers disliked them, and strong peer support for use (of alcohol)." Further, youth who do use almost always start as a reflection of the peer cluster. A Native American youth will join with a close friend or gang to form a "peer cluster". This group shares similar values and will determine whether or not to use alcohol or drugs, which kind, and how much. The use, then, will generally take place within the context of this peer cluster (Oetting & Beauvais, 1986). Hence, youthful substance abusers more often than not associate with other users.

Unfortunately, the negative characteristics of youthful substance abusers are not static: without intervention, they can affect the individual's entire life. Substance abuse among Native Americans has been viewed as contributing to educational setbacks for children, criminal acts by adults, and economic difficulties for families (Moncher, Holden, &

Trimble, 1990). LaFromboise found that Native Americans dwelling in urban areas are taken into police custody for violations committed under the influence of alcohol or drugs ten times as often as Whites (LaFromboise, 1988). These are all serious consequences.

HISTORICAL OVERVIEW OF TREATMENT PROGRAMS

Although substance abuse has long been a problem among Native Americans, alcohol treatment programs for Native Americans is a relatively new development. The first reservation-based alcoholism programs did not begin until the late 1960's (May, 1986). By 1985 there were over 190 programs both on and off the reservations. It was at these programs that drug abuse was addressed. However, due to the scope of substance abuse among Native Americans, innovative programs were necessary.

In 1987 the staff of the Rhode Island Indian Council put into action a substance abuse prevention program (Parker, 1990). The major theme of these programs involved providing a cultural base and a sense of community for individuals and families that lived apart from their tribes (RIIC, 1989:3). A major goal was to assist in the development of greater self-esteem among the participants and facilitate pride in their ethnic background.

"Project CHARLIE" (CHemical Abuse Resolution Lies in Education) was implemented in a Minnesota school system and met with favorable results. In 1987, it was cited by the

Indian Health Service as being one of the four most widely used prevention programs among Native Americans. This program centered upon four main themes: self-awareness, relationships, decision-making skills, and chemical use in society (Parker, 1990).

Another successful prevention program was the Indian Drug Prevention Program (IDPP) of Washington State. This program emphasized skills training for its participants and made use of the schools and community in its efforts (Tharp, 1991).

POSSIBLE PREVENTION/INTERVENTION PROBLEMS

One of the major obstacles facing counselors working with Native Americans is the attitude of Native Americans toward mental health professionals (Everett, Proctor, & Cartmell, 1983). Traditionally, Native Americans lived in extended families, with members having responsibilities to and for one another, and it was to the family that one would turn to in times of need. For many, this idea still holds true. The Navajo family unit, for example, is an extended one with grandparents, aunts, uncles, etc. helping to provide for and take care of the young ones (McWhirter & Ryan, 1991). As a result of this extended family, it is, for the most part, not acceptable for the Navajo to seek outside assistance for problems; the extended family works together to solve problems.

For many Native Americans, there exists the belief that conventional Western psychology is at odds with traditional

Indian cultural beliefs. As a result, many will turn to their own families or tribes for guidance and assistance. Hence, for the Native American youth suffering from substance abuse, many supports may be available; many Native Americans will turn to professional help only when community help is not available (LaFromboise, 1988). Another stumbling block in the treatment of substance abuse among Native American youth is that many Native American parents are unaware of the services that are available to their children. What is worse, those who are aware often do not use the services because of preconceptions that the services are not responsive to their particular needs. Services that are available include the Indian Health Service, urban programs, private or public mental health service, university counseling centers, and tribally based mental health care programs. However, none of these options will be very beneficial unless the counselor is attuned to the specific needs of the Native American population.

Probably the most important aspect of any sort of counseling relationship, no matter what the race or cultural background of the client, is the trust the client has in the counselor. Without trust, the chances of the client's feeling comfortable enough to be open and self-disclosing is very low. According to Rotter (1967), many of the problems in race relations are concerned with one group's feeling that the verbal statements of the other group cannot be trusted. This problem can be easily applied to the framework of

prevention/intervention with Native American youth.

According to LaFromboise and Dixon (1981), authors of articles concerning counseling Native Americans often conclude that trust and understanding are valued by Native Americans more than almost any other counselor attribute. In their study, LaFromboise and Dixon determined several variables which may constitute a trustworthy role and deem a counselor (Indian or non-Indian) trustworthy by a Native American client. These behaviors include topic consistency, confidentiality, cultural understanding, and self-disclosure by the counselor. When these behaviors are present, the Native American client is more likely to respond positively to the counselor.

After trust between the counselor and client has been established, the counselor needs to be sensitive to and aware of certain Western values and expectations which may not be shared by the Native American client as he or she may not have been socialized to display them. In general, counselors expect clients to establish good eye contact, to discuss inner feelings, and to verbalize concerns (Sue & Sue, 1981). However, Native Americans often to not express these behaviors. As a result, professionals involved in substance abuse programs need to understand the cultural reasons for the absence of these behaviors. According to Everett, Proctor, & Cartmell (1983), lack of cultural awareness typically results in conflicts and frustrations for both the client and the therapist which may ultimately lead to the Native American not

receiving appropriate mental health services.

With regard to the establishment of eye contact, a counselor may become frustrated by the lack of eye contact made by a Native American youth. However, among many Native American groups, eye contact between and adult and child is viewed as a display of disrespect (Sue & Sue, 1981).

Another possible concern for a counselor may be the lack of discussion of inner feelings on the part of the Native American. While many youth find this difficult, for the Native American youth, this is also a cultural issue. Many Native Americans are not raised to express inner thoughts or feelings (Sue & Sue, 1981). Hence, the counselor may find his or herself at a real stumbling block if the client is pressed into discussion of such thought too early in the counseling experience. The youth may not feel free to express such topics until he or she feels that the counselor can indeed be trusted.

Once the youth has chosen to reveal his or her inner thoughts, the counselor needs to tread lightly as language use and communication patterns exhibited in Native American cultures often vary from what the counselor may be accustomed to observing in the counseling arena outside of the Native American setting.

Among many American Indian groups when individuals are grouped together, for example, in a council setting, an individual is able to speak without interruption since the other people in the group know that they will have a turn to

talk also. This is true of the Navajo tribal government setting (McWhirter & Ryan, 1991). This aspect of communication is important for the counselor to know. The counselor needs to be particularly careful not to talk over or interrupt the client. This, obviously, would apply to clients of any ethnic background. However, when applied to the counseling of Native Americans, there exists somewhat of a hindering mechanism - it is not uncommon for Native Americans to take rather long pauses between statements or thoughts. Hence, the slow and deliberate speaking pattern often evidenced by Native American Indians. Unlike the Anglo society where people will often say whatever comes to mind without giving much serious thought to what is being said, Native Americans tend to refrain from this habit. To further complicate matters, the counselor may feel uncomfortable during these periods of thought and may try to fill the silence with talk. This should be avoided as much as possible; the counselor should let the youth set the pace of the conversation. Along these same lines is the possibility that the counselor may find that the youth is not proficient at vocalizing concerns. For example, many Navajo do not have the English vocabulary needed to establish a successful means of communication with the counselor. Further, because the Navajo language is quite descriptive, important meanings may be lost when translating from Navajo into English (McWhirter & Ryan, 1991).

Other factors which may impede the therapeutic process

include the Native American characteristic of being reserved, the counselor's lack of knowledge about Native American culture, and quite possibly, a lack of understanding of what exactly "should" happen at a counseling session and what the expectations of the counselor are. Studies have shown that the expectations, goals, and attitudes toward therapy of Native Americans may differ significantly from those of non-Indian clients (Trimble & Fleming, 1989). As such, Sue and Sue (1981) feel that perhaps counselors should provide the Native American client with information concerning the roles of the counselor and client, the importance of talking to help lead to a solution, and the general course of counseling. By providing this sort of preparation, the counselor may find the sessions to be much more productive.

The notion of counseling preparation, however, may have a flaw. There is the possibility that the youth may feel forced to act in a particular fashion because he or she believes this is what the counselor wants. Here again, it is helpful for the counselor to have an understanding of the general values held by most Native American Indians. With regard to the subject at hand, one of the most important values is the idea that the welfare of the group or tribe is far more important than that of the individual. As a result, Native American Indian children, for example, often do not behave as would be expected in the classroom situation because they are less competitive. With regard to the counselor-client relationship, the youth may find it easier to agree

with the counselor than to oppose him or her and thereby cause friction or disharmony.

Another potential problem therapists may face is that despite the youth's agreement with a counselor's suggestions, he or she may not actually follow through with the suggestion. One reason for this lack of action may be due to the youth's or parent's concern that the Western psychological solution may lead the youth in a direction that conflicts with the Indian cultural life-style (LaFromboise, 1988). Native Americans are daily faced with the decision of deciding how much of the "old" to hold on to and how much of the "new" to accept (McWhirter & Ryan, 1991). Native American clients may fear that the counselor will try to influence American Indian value structures rather than helping the client solve his or her problems, and thereby alienate the individual from his own people and traditions (LaFromboise, Trimble, & Mohatt, 1990). Nonetheless, the counselor must be aware of this conflict and sensitive to it when suggesting methods of treatment. Despite these pitfalls, Native American adolescents have been found to hold positive expectations for the therapist and the counseling process.

INTERVENION APPROACHES

In general, substance abuse programs have had their frameworks rooted in four types of strategies: a fear strategy, a cognitive strategy, a developmental strategy, and a socio-cultural strategy (Moskowitz, 1983). According to

Globetti (1988), substance abuse prevention programs need to be attuned to the whole "life situation" of the participants, and not address only the issue of substance abuse. Hence, a socio-cultural approach may be the strategy of choice when working with minority youth.

May (1986) believes that prevention programs should focus upon 1) reducing the adverse medical consequences of substance misuse, 2) community-based preventative education, and 3) multifaceted rehabilitation for chronic misusers. Further, these goals should be integrated into programs targeted at youth.

According to Bach and Bornstein (1981), youth-oriented prevention programs should emphasize a model based on social learning whereby youth can learn coping skills and build their self-esteem. This can be facilitated through such techniques as peer participation and value reinforcement.

With the aforementioned models in mind, a workable program integrating cultural components can be developed for use with this population.

IMPROVEMENTS/SUGGESTIONS

The primary component that appears to be lacking in most prevention programs is the incorporation of a cultural component. According to Parker (1990), substance abuse prevention programs which incorporate teaching cultural material have been well received and have had positive results when implemented. The presentation of cultural material

appears to be instrumental in invoking and maintaining interest in prevention programs. Encouraging participation in such tribal activities as dance societies, intertribal sports, and powwows assists in fostering a healthy and positive attitude toward the child's identity formation. Further, the teaching of cultural heritage provides youth with a means of developing and identifying their role with the community. This is particularly important for substance abuse prevention. Teaching cultural traditions can serve to strengthen ties between youth and their tribal community as a whole. This, in turn, allows for greater transmission of rules and norms concerning substance use and promotes healthy behavior (Parker, 1990); a strong cultural identification can help to inoculate a youth against alcohol/drug involvement (Oetting, Beauvais, & Edwards, 1988).

According to McWhirter & Ryan (1991), counselors working with Native American clients would be well advised to reach out to the family of a client and use their strong belief in kinship relationships to help the individual during the therapeutic process. With the high incidence of substance abuse within families, youth-oriented prevention programs should take this into consideration. Edwards & Edwards (1988) believe that interventions should include as many family members as possible and should identify and work through non-drinking family members. They also suggest the possibility of the use of contracts between youth and their parents to encourage a drug-free lifestyle and to foster better

interpersonal relationships within the family.

Not only should family members be enlisted to assist in prevention programs, but so too should the community. The community as a whole can provide a message to discourage substance use. In this "network" approach (LaFromboise, 1990), family, friends, and community members are organized to assist in the process. In essence, the youth and their problems are treated within the framework of a larger family and community social system. When treating substance abuse among Native American youth, such networks have been found to be quite effective in prevention of substance abuse as family and community foster nonabusive life-styles (Schinkle et al., 1985).

The fundamental utilization of community members is through the development of task groups (Edwards & Edwards, 1988). Task groups should be comprised of youth, tribal leaders, community leaders, professionals, and mental health workers with an aim of discouraging substance use among the youth of the community. Task groups can work on developing and providing alternatives to substance use (e.g. after school activities) and encouraging tribal values. Not only do the youth benefit, but so does the community. Further, such task-centered groups are in keeping with the Native American philosophy of "self-determination" (Nofz, 1988).

Within the realm of a substance abuse prevention program itself, a means of promoting adhesiveness of the system is to make use of social learning therapy in the form of group

therapy. Group therapy serves to help alleviate problems mentioned earlier such as a lack of eye contact on the part of the child client and difficulty in voicing concerns as the child is not made to feel isolated but, rather, is able to rely on encouragement and support of natural support systems (Everett, Proctor, & Cartmell, 1983).

Effectiveness of group work appears to be related to a couple of variables, one of which is the opportunity for modeling (Kahn, Lewis, & Galvez, 1974). Group therapy which includes modeling and rehearsing everyday skills have proven to be quite effective, particularly in the reduction of substance abuse and adolescent suicide (LaFromboise, 1988). The youth learn communication and coping skills which are helpful in adaptive living. Finally, group therapy taps into the Native American value of putting group welfare first.

CHAPTER THREE

SUBSTANCE ABUSE PREVENTION

PROGRAM HANDBOOK

TABLE OF CONTENTS

PAGE

INTRODUCTION xx

STAGES OF GROUP DEVELOPMENT xx

EFFECTIVE COMMUNICATION xx

COMMUNICATION STYLES xx

CLEAR SPEAKER CHECKLIST xx

EFFECTIVE FEEDBACK xx

HELPFUL LEADING QUESTIONS xx

SCREENING MEMBERS xx

TIPS FOR GROUP LEADERS xx

THE IDEAL FACILITATOR xx

SESSION ONE xx

SESSION TWO xx

SESSION THREE xx

SESSION FOUR xx

SESSION FIVE xx

SESSION SIX xx

SESSION SEVEN xx

SESSION EIGHT xx

SESSION NINE xx

SESSION TEN xx

APPENDIX 1 xx

APPENDIX 2 xx

APPENDIX 3 xx

APPENDIX 4 xx

APPENDIX 5 xx

APPENDIX 6 xx

APPENDIX 7 xx

APPENDIX 8 xx

APPENDIX 9 xx

APPENDIX 10 xx

INTRODUCTION

This handbook was written in order to be "user friendly". It is geared toward any individual who would like to make a difference in the lives of "at risk" Native American children. He/she can pick up this handbook and begin the group process (referrals and interviewing). Group leader(s) will most likely be working with either schools or other Native American organizations. Those individuals working with such schools or organizations should be sure to obtain the appropriate permission forms to be signed by the group members' parents.

This handbook consists of four sections. The first section will help the facilitator become acquainted with his/her role as a group leader, his/her expectations for the group, and also offer helpful tips in order to run the group. The second section is the handbook itself, comprised of ten lessons. The third section consists of handouts needed for each of the lessons. These worksheets will need to be duplicated for the group members. The fourth and final section contains extra activities or related worksheets that can be used as supplements to the lessons.

STAGES OF GROUP DEVELOPMENT

Although not all groups go through each stage of development, it is important for group leaders to be aware of potential problems that may arise. The following gives the characteristics of each stage, and the role of the leader during each stage.

Stage I: Orientation and exploration

A. Characteristics

1. Orientation and exploration
2. Determining the structure of the group
3. Getting to know one another
4. Looking at expectations
5. Feeling insecure or anxious
6. Inclusion and identity
   a. Do I want to belong?
   b. How much do I want to risk?
   c. How safe is it to risk?
   d. Can I trust the people in the group?
   e. Will I be accepted or rejected?

B. Role of the Leader

1. Carefully select members for appropriateness
2. Promote an atmosphere conducive to trust
   a. Characteristics: open, genuine, supportive
3. Discuss individual rights of members, ground rules and confidentiality

Stage II: Transition and Dealing with Resistance

A. Characteristics

1. Anxiety: stems from allowing other people to see the individual beyond his/her public image. "What will they think of me now?"
2. Conflicts: must be dealt with and worked through. If ignored in group, conflict can destroy the chance for genuine contact.
3. Challenging the leader(s): many members struggle with dependence vs independence. Challenging the leader may be the first step toward autonomy. Leader(s) must deal with the challenge in order to move to the next level of development.
4. Resistance: it is the leader's role to raise the awareness of the group to any resistance that may surface. Some common forms of resistance include:
   a. avoidance
   b. nonparticipation
   c. monopolizing
   d. story telling
   e. dependency
   f. hostility

B. Role of the Leader: the leader must provide encouragement and the challenge that is necessary to deal with conflict. Conflict can serve to be a

roadway to a more cohesive group, so long as it is recognized and worked through.

Stage III: Cohesion

A. Characteristics

1. There is a sense of solidarity, belonging, and inclusion among group members.
2. Cohesion can only occur when people open up and are willing to take risks.
3. Members become less dependent upon the leader, and can take responsibility for the goals of the group.
4. Self-exploration increases.
5. Members are willing to work outside of the group to achieve behavioral changes.

B. Role of the Leader

1. Step back, let group members take ownership of the group's direction.
2. Keep modeling by revealing & self-exploring in the group.

Stage IV: Termination

A. Characteristics

1. Consolidation of leaving
2. Fear of termination (members may distance themselves)
3. Sadness and anxiety
4. Concerns for one another
5. Evaluating the impact of the group

B. Role of the Leader

1. Assist members in dealing with any feelings they may have about termination.
2. Provide an opportunity to deal with unfinished business.
3. Reinforce changes members have made.
4. Provide an opportunity for members to give each other constructive feedback.
5. Assist members in determine how they will apply specific skills in their daily life.

EFFECTIVE COMMUNICATION

In order to facilitate effective communication, interpersonal contact, and enhance the process of self discovery in group, group leaders need to be aware of a number of guidelines related to language. Group leaders should direct their own language, and the language of group members, along these lines:

1. Translate questions into statements beginning with "I". Questions are often disguised statements or demands for support from the other person.
2. Discourage the use of "why", "because", "but", "it", and "can't".
3. Personalize pronouns:
   - Use "I"
   - Change "you" to "I"
   - Use "I" not "we" to avoid speaking for others
4. When speaking, use specific examples, not global expressions.
5. When expressing feelings, use the expression: "I feel".
6. Use feedback statements such as:
   - "I noticed..."
   - "I'm aware of..."
   - "I'm struck by..."

COMMUNICATION STYLES

1. PLACATING: I am PLACATING when:

- I don't stand up for myself
- I give excuses
- I discount myself and my feelings
- I feel that I can never do anything right
- I may say "yes" when I want to say "no", even when "no" is in my best interest

2. BLAMING: I am BLAMING when:

- I push other people around
- I ridicule, threaten, or judge
- I put others down
- I discount others

3. IRRELEVANT: I am IRRELEVANT when:

- I change the subject
- I talk about everything except the issue
- I try to distract the other person

4. SUPER-REASONABLE: I am SUPER-REASONABLE when:

- I give a lecture instead of stating my feelings
- I play smart
- I sound like a computer

5. LEVELING: I am LEVELING when:

- I stand up for my rights without stepping on the rights of others
- I state my decision without excuses
- I honor my deepest wishes
- I express my feelings

CLEAR SPEAKER CHECKLIST

1. ASK TO BE HEARD
   - "Do you have a minute to listen to an idea I have?"
   - "Can I talk to you about something?"
2. DO NOT LOOK DIRECTLY AT THE LISTENER
   - maintaining eye contact is considered rude in the Native American culture
3. CHECK FOR UNDERSTANDING/ALLOW QUESTIONS
   - "Do you understand?"
   - "Do you see what I mean?"
4. LISTEN TO CONSTRUCTIVE IDEAS
5. USE CLEAR TONE OF VOICE
6. THANK THE LISTENER
   - "Thanks for listening to me."
   - "You really helped me out."

EFFECTIVE FEEDBACK

Feedback is information about the way a person affects another person, or appears to another person. When an individual gives feedback, the giver tells the receiver how he/she is reacting to the individual. When the individual receives feedback, he/she has an opportunity to see if his/her behavior matches his/her intentions. Feedback can increase self-awareness and is often effective in creating a closeness to other people. If feedback is not handled properly, it can be destructive. In order to facilitate effective feedback, following are some guidelines for receiving constructive feedback and giving constructive feedback.

Receiving feedback:

1. Acknowledge the feedback.
2. Ask for further clarifications, if needed.
3. Be receptive, not defensive.
4. Share your reactions to the feedback, responding with an "I" statement.

Giving feedback:

1. Use an "I" statement that describes for the receiver what you have observed.
2. Be specific.
3. Constructive feedback is given in small amounts, focusing on behavior the person can change, not who the person is.
4. Constructive feedback should not to be thought of as an absolute truth, it is an opinion, and is tentative.
5. Constructive feedback is asked for, not imposed. If it

has been asked for, the receiver will be more likely to "hear" the feedback.

6. If you are giving negative feedback, "sandwich" it between two layers of positive feedback as this makes it easier for the receiver to receive.

HELPFUL LEADING QUESTIONS

1. What else can you tell be about that?
2. What was your reaction to that?
3. How did you feel afterward?
4. What happened then?
5. Have you ever thought about the possibility that...?
6. How do you think things might have been different in that situation?
7. Where did you go then?
8. What do you like about that?
9. What did you mean by...?
10. What are some of the reasons why you did that?
11. If you could do it over, what would you do differently?
12. Are you glad/sad about that? What are the reasons?

SCREENING MEMBERS

A potential group member should not be allowed to join a group until he/she has been seen by one or both of the group leaders for a screening interview. This screening interview will help evaluate whether or not the group will be beneficial to the prospective member. Allow the interviewee to interview the group leaders if he/she feels the need to do so. Group applicants should be invited to ask questions concerning any aspect of the group. The following guidelines are helpful for conducting a screening interview:

1. Introduce yourself, explain your role as group leader(s), and find out how this individual came to be interviewed by you. Explain the purpose of the interview.
2. Explain confidentiality, making sure to be very thorough in explaining this concept. Be certain that the interviewee understands that you will need to involve others if, at any time, you fear for the individual's health or safety.
3. Get to know your interviewee. Ask about possible chemical involvement and assess his/her motivation level. Try to avoid "yes" or "no" questions. Rather, ask open-ended questions such as:
   - "What made you decide to join the group?"
   - "Whose idea was it for you to join the group, yours, your parent's, a teacher?"
   - "What do you expect to get out of the group?"
4. Answer any questions the interviewee may have.

TIPS FOR GROUP LEADERS

1. Be clear about the group's purpose.
2. Be flexible. Change according to group needs.
3. Use group member's names.
4. Keep rules few and simple.
5. Acknowledge your own feelings and model feeling words.
6. If asking for opinions, give yours last.
   If asking for feelings, give yours first.
7. Don't ask group members to do anything you wouldn't be willing to do.
8. Keep track of the time. Help the group move along and provide time for closure.
9. Think of group members as individuals.
10. Silence is okay.
11. Aim for total and equal participation (but don't always expect it).
12. Avoid judgmental responses.
13. Remember that your energy (low or high) often sets the tone for the group.

THE IDEAL FACILITATOR

"The best facilitator has unobtrusive, chameleon-like qualities; gently draws group members into the process; deftly encourages them to interact with one another for optimum synergy; lets the dialogue flow naturally with a minimum of intervention; listens openly and deeply; uses silence well; plays back group member statements in a distilling way which brings out more refined thoughts or explanations; and remains completely nonauthoritarian and nonjudgmental"

- author unknown

SESSION ONE

Group Formation & Getting to Know Each Other

The first group focuses on getting acquainted, promoting self disclosure in a non-threatening way, and creating a comfortable atmosphere. Group leader(s) will explain the purpose of the group, give members an overview of topics to be covered in group, and discuss group rules.

Agenda

I. Opening statement and rounds (10 minutes)
   - explanation of opening statement, group rules, & rounds
   - (see Appendix 1A)

II. Working phase (30-40 minutes)
   - "Getting to know each other"

III. Processing and evaluating (10 minutes)
   - (see Appendix 1B)

IV. Closing statement
   - (see Appendix 1A)

Procedure

I. Opening statement and rounds

The opening statement is read by one group member. Leader(s) will explain that this statement allows the group to focus on the group's energy and set the tone for what will follow.

Group Rules:

1) Be accepting of group members
   - Each group member has the obligation to listen to others and show respect for them by avoiding put-downs, threats, and interruptions. Non-verbal put-downs such as facial expressions or gestures are also unacceptable.

2) Speak for yourself
   - Use "I" statements to show how you feel.
   - Be aware of your feelings and try to express them.

3 Each member is responsible for his or her own experience in group
   - You get out of the group what you put into it.
   - You have a responsibility to yourself to take risks, to discover yourself, and to try to trust other group members.

4) Confidentiality
   - What is shared in group stays within the group unless you are planning on hurting yourself, or someone else, physically.

Explanation of Rounds:

A round is usually done at the beginning or at the and of a group session. The rounds give everyone in the group an opportunity to hear from each member about how they are feeling, and about who needs time, in group, to discuss concerns or problems. Please remember that any member may pass at any time.

II. Working phase: "Getting to know each other"

Have each member take out a piece of blank paper. Ask them to think of approximately 10 words or phrases that answer the question "Who am I?". Their list can include colors, adjectives, objects, songs, or proper names. When they are done, ask them to rank the words from most to least central to who they are right now. After they are done, have each member take turns reading their list to the group.

III. Processing and evaluating

Leader(s) should invite group members to ask more questions and share how they felt when other members shared their lists. Leader(s) should encourage members to speak directly to one another.

IV. Closing statement

The closing statement is read by a group member at the end of group.

* for additional material, see Appendix 8

SESSION TWO

Feelings

In this session, group members will explore some feelings they have had, and are currently having, in relation to drug or alcohol use by themselves or someone close to them. The purpose of this session is to explore feelings that are more complex than "happy" or "sad" and to give the group members the words to express their feelings.

Agenda

I. Opening statement and rounds (10 minutes)

II. Working phase (30-40 minutes)

- "Working through problems"

III. Processing and evaluating (10 minutes)

IV. Closing statement

Procedure

I. Opening statement and rounds

Group leader(s) ask a group member to read the opening statement, and begin the round. For rounds, leader(s) may want to ask group members to finish the following sentence: "A time in my life when I felt the happiest was..."

II. Working phase: "Working through problems"

Part I

Give group members index cards and ask them to think of three problems that someone their age might experience that could cause uncomfortable feelings. Point out that they can make up problems or that they can think of real problems from home, school, sports, or relationships, that cause uncomfortable feelings which they would like to solve. Leader(s) may want to give an example (i.e.: "A friend won't talk to you anymore because she thinks you told a secret she had told you").

Part II

Ask group members to get into pairs and to read e a c h other's "problem cards". Have members help each other identify the feelings they had and to discuss possible solutions for each problem. When everyone has had time to discuss their "problem cards" with their partners, ask them to come back to the group circle and ask for volunteers to share a problem and possible solutions. Open to a whole group discussion. Discuss what types of

feelings the member is having in each particular situation. Explain that many of the feelings shared were "uncomfortable" feelings, and that people sometimes bury such feelings because they are uncomfortable. Also, explain that these feelings often are a signal that something is wrong and needs attention; uncomfortable feelings tell a person that he or she must talk to someone and must change some thought, behavior, or attitude, or take some kind of action, or those uncomfortable feelings will continue.

III. Processing and evaluating

Have children discuss what it was like to share feelings. Do they have a sensation of being "lighter" - to not feel as heavy? Explain that sharing feelings is very important to all human beings, and that keeping feeling locked up inside often leads to a lot of anger.

IV. Closing statement

A group member should read the closing statement at the end of group.

* for additional material, see Appendix 9

SESSION THREE

Your Family of Origin

This session will focus on the children's family of origin. Group members will explore where they fit in their families, how they react to other family members, as well as how they have been affected by them.

Agenda

I. Opening statement and rounds (10 minutes)

II. Working phase (40-45 minutes)

- family drawings

III. Processing and evaluating (10 minutes)

IV. Closing statement

Procedure

I. Opening statement and rounds

Group leader(s) should ask one member to read the opening statement. One round is done to enable group members to express an immediate or future need to discuss a concern.

II. Working phase

Part I (10-15 minutes)

Using paper and colored markers or crayons, ask the group members to draw their own family in a "typical" family situation. When they are done, ask members to pair up with someone in the group. Have them take turns explaining the relationships they have with different family members. Encourage them to ask each other questions. Model by telling them they can ask who is close, who is distant, and how it feels to be a part of that family.

Part II

Ask members to return to the group circle and ask them to share their picture with the group. Remember that they have the right to pass. Those who do want to share may be stimulated to self-disclose more by asking questions such as:

- "Do you feel that there are some needs that nave not been met by your family? Which ones?"
- "Is there a family member that you feel you resemble most? Why?"

- "Would you choose to be a part of this family if you had a choice?"

III. Processing and evaluating

Encourage children to discuss what it was like to share their feelings about their families. Remind them that what is shared in group is confidential.

IV. Closing statement

A group member should read the closing statement at the end of the group. Hand out the Adolescent Alcohol Involvement Scale (see Appendix 2) to be filled out before the next group session.

* for additional material, see Appendix 9

SESSION FOUR

Looking at Your Own Use/Personal Assessment

The purpose of this session is to enable group members to explore the extent to which their own use of chemicals has affected them. Group members who have not been directly affected by chemical dependency will be asked to identify how they might have been affected by other forms of compulsive or dysfunctional behavior in themselves. Members will discuss how the Adolescent Alcohol Involvement Scale has contributed to a greater awareness and understanding of themselves.

Agenda

I. Opening statement and rounds (10 minutes)

II. Working phase (30-40 minutes)

- structured activity: Personal Assessment

III. Processing and evaluating (15 minutes)

IV. Closing statement

Procedure

I. Opening statement and rounds

Group leader(s) should ask one of the group members to read the opening statement. A suggestion for rounds may be to ask group members to finish the following sentence: "When I was filling out the Adolescent Alcohol Involvement Scale, I felt..."

II. Working phase

Part I: Dyad Discussion (10-15 minutes)

Ask group members to take out their Adolescent Alcohol Involvement Scale (AAIS) questionnaires, choose a partner whom they have not yet been paired with, and discuss what their results on these inventories have revealed to them.

Part II: Large group discussion (10-20 minutes)

When everyone has had a chance to talk in pairs, ask group members to again form a large circle and invite individual members to share what the personal assessment exercise has revealed to them. Encourage members who have not been directly affected by their own use to describe how they have been affected, whether positively or negatively, by the significant relationships in their lives, or by other forms of compulsive or dysfunctional behavior (perhaps by the use by a family member, friend, etc.). Please remember that only those members who feel comfortable doing so need self-disclose to the large group. Remember also to encourage interaction among

group members, personal disclosures, spontaneity, and the expression of here-and-now feelings.

III. Processing and evaluating

Allow group members to share what it felt like to listen to others share in group today, and also to share what it felt like to self-disclose to the group.

IV. Closing statement

The closing statement should be read aloud by one of the group members at the end of the group.

SESSION FIVE

When Alcohol Takes Over

This group session will focus on giving group members information on alcoholism and helping group members understand how other problem drinking behaviors affect individuals, their families, and society.

Agenda

I. Opening statement and rounds (10 minutes)

II. Working phase (40-55 minutes)

- Alcohol information sheets (see Appendix 3)

III. Processing and evaluating (20 minutes)

IV. Closing statement

Procedure

I. Opening statement and rounds

Group leader(s) should ask a group member to read the opening statement. For rounds, a possible suggestion may be to have group members complete the following sentence: "When I think of the word alcoholism, I think of..."

II. Working phase

Distribute and discuss the Alcohol Information Sheet with group members, making sure to correct any misconceptions that become apparent. Group leader(s) should stress that young people are likely to experience harmful physical and social effects from even small amounts of alcohol because their bodies and brains are still developing and growing. Emphasize that this is the primary reason that the use of alcohol is illegal for people under the age of 21. Continue to discuss the handouts with the group, leaving time for discussions and question. Remind group members that young people can develop alcoholism in only 6-18 months.

III. Processing and evaluating

Allow time for group members to share how they <u>feel</u> about what they have learned during session. Many members will probably want to share during this processing session, so more time has been allotted for this to occur. Allow members to share personal experiences, fears, and hopes.

IV. Closing statement

The closing statement should be read by a group member at the end of the session.

SESSION SIX

Drug Information

The purpose of this session is for group members to obtain a better understanding of the harmful effects of marijuana, crack, and cocaine. During this session, group members will be asked to share personal experiences.

Agenda

I. Opening statement and rounds (10 minutes)

II. Working phase (45-50 minutes)

- Marijuana, crack, and cocaine information sheets (see Appendix 4A)
- Thinking Ahead worksheet (see Appendix 4B)

III. Processing and evaluating (10-15 minutes)

IV. Closing statement

Procedure

I. Opening statement and rounds

Group leader(s) should ask one of the group members to read the opening statement. Allow the group members to develop their own statement, or have them finish a sentence which the group leader(s) has chosen.

II. Working phase

Part I: Large group discussion (30-35 minutes)

In the context of the large group, encourage group members to volunteer to read aloud the information sheets on marijuana, crack, and cocaine. The group leader(s) should also encourage discussion of this information.

Part II: Dyad activity (10 minutes)

Ask group members to pair up with another member and share with each other three things they learned in the large group that they did not know before. When finished, ask group members to fill out the "Thinking Ahead" worksheet, and have them share with each other what they have written.

Part III: Large group (5 minutes)

Allow group members to share with the large group what they wrote on their "Thinking Ahead" worksheet. Remember that members do not have to share if they do not want to do so.

III. Processing and evaluating

Allow group members to share what it was like to be in

group this session. Encourage members to stay in the "here-and-now" and to share their feelings while working on this session's topic.

IV. Closing statement

The closing statement should be read aloud by one of the group members at the end of the group.

SESSION SEVEN

How Chemical Dependency Affects the Family

This session focuses on how families are affected by the chemically dependent family member. Group leader(s) will read and explain "The Family Trap". Group members will share experiences about being affected by chemical dependency in their own family.

Agenda

I. Opening statement and rounds (10 minutes)

II. Working phase

- The Family Trap (see Appendix 5)

III. Processing and evaluating (10-15 minutes)

IV. Closing statement

Procedure

I. Opening statement and rounds

Group leader(s) should ask a group member to read the opening statement. For rounds, a suggestion may be to ask group members to finish the following statement: "I wish my parents knew..."

II. Working phase

Part I

Distribute the handout "The Family Trap". Group leader(s) will read and explain the handout to the group, being sure to encourage questions during the explanation.

Part II

Ask group members to share how it felt to have the family dynamics of their families explained to them. Discussion may be stimulated by asking questions such as:

- "Whether you use or someone else uses, did you see any resemblances between some of your family members and those described in the handout?"
- "Where do you see yourself in your family?"
- "What role do you see yourself playing now?"

If appropriate, share with the group members the "3 C's" rule of children from a chemically dependent family:

1) You didn't cause it.
2) You cannot control it.
3) You cannot cure it.

Explain that the roles described in "The Family Trap" usually come about because family members believe they caused someone else's drinking, or because they believe they "should" be able to control it for them. Further explain that only the person using can decide to cure themselves.

III. Processing and evaluating

Allow group members to share personal experiences of the session. Encourage their personal disclosures, and the expression of "here-and-now" feelings.

IV. Closing statement

Group leader(s) should choose a group member to read the closing statement.

SESSION EIGHT

Defenses and Self-Disclosure

The focus of this session is a discussion about defenses, self-disclosure, and feelings. Group leader(s) will describe how defenses are used to protect self-esteem. Group members will participate in a structured experience designed to help them identify and express their feelings. Members will have an opportunity to share some of the defenses they have used in group and receive feedback as to how they are seen by others in the group.

Agenda

I. Opening statement and rounds (10 minutes)

II. Working phase (45-50 minutes)

- structured experience (see Appendix 6)

III. Processing and evaluating (10-15 minutes)

IV. Closing statement

Procedure

I. Opening statement and rounds

Group leader(s) should ask a group member to read the opening statement. A suggestion for rounds may be to ask group members to finish the following sentence: "Something very few people know about me is..."

II. Working phase

Group leader(s) will distribute and discuss the handout "Defense Mechanisms". Group members may volunteer to read the handout aloud. After the different styles of defense mechanisms have been explained, have the group members think about the types of defense mechanisms they may have used during group sessions. Allow for "here-and-now" feelings group members may be experiencing toward others in the group.

Group leader(s) may want to use the following questions to encourage group members to talk about themselves and their defenses:

- "Which topics or situations in group have brought up the strongest feelings in you?"
- "What are some of the feelings or situations that have been the easiest to talk about? the most difficult to talk about?"
- "Which topics have elicited the most resistance in you?"
- "What forms has this resistance taken?" (Have members name the defense they have most often used

in group to protect their self-esteem or block the expression of their feeling. Allow them to refer back to their "Defense Mechanisms" handout.)

- "How are the defenses that you used in group similar to the defenses used in you personal life?" Allow an opportunity for individual group members to ask for feedback from other members as to how the rest of the group perceives him/her.

III. Processing and evaluating

Allow time for group members to process the session's activity, encouraging members to share personal reactions.

IV. Closing statement

Group leader(s) should choose a group member to read the closing statement.

SESSION NINE

On Your Own

This session will focus on the group members' individual support networks. Members will be given the names of agencies they can contact should they feel the need and will be encouraged to talk about who they can go to for support, who they can trust, and why.

Agenda

I. Opening statement and rounds (10 minutes)

II. Working phase (45-50 minutes)

- "Sources of Help" (see Appendix 7A)
- "Support Network Scale" (see Appendix 7B)

III. Processing and evaluating (10 minutes)

IV. Closing statement

Procedure

I. Opening statement and rounds

Group leader(s) should ask one of the group members to read the opening statement. A possible rounds starter might be to ask group members to finish the following sentence: "When I really need a friend, I know I can always count on..."

II. Working phase

Part I

Distribute the "Sources of Help" handout (see Appendix 7) and discuss each organization on the list. Group leader(s) should have telephone books for their area available so that group members can fill out the necessary telephone numbers. Explain that these organizations are there to give support in times of need and that group members should feel free to contact such agencies at any time.

Part II

Distribute the "Support Network Scale" handout. Ask group members to answer the questions and compute their score. Ask members to think about their individual score and whether they feel it fits with how <u>they</u> see their support network. Encourage members to share with the group their scores and how they feel about their support network.

Allow and encourage members to talk about what qualities make someone reliable, and why. Ask members to share

experiences of friends, or family members, they thought were reliable but who ended up letting them down in one way or another. Make sure everyone in the group shares at least one person they can count on. Group members should also be encouraged to discuss how they plan to utilize additional resources in the school and community to maintain a support network.

III. Processing and evaluating

Allow group members to evaluate the session and to share what they have learned about support networks.

IV. Closing statement

Group leader(s) should choose a group member to read the closing statement.

* for additional material, see Appendix 10

SESSION TEN

Closure

The last session enables group members to evaluate each other's progress as well as their own, to acknowledge what has happened in group, and to say good-bye to one another. Group members will be asked to discuss any decisions they have made about substance-related issues in their lives.

Agenda

I. Opening statement and rounds (5-10 minutes)

II. Working phase (40-50 minutes)

III. Closing statement

Procedure

I. Opening statement and rounds

Group leader(s) should pick a group member to read the opening statement. A possible rounds starter may be to have group members finish the following statement: "When I think about this group ending, I feel..."

II. Working phase

Part I

During this last session, group leader(s) should encourage group members to look at their own growth and the growth of other group members. Allow for a discussion of members' goals and decisions, with an opportunity for feedback. Group leader(s) should also encourage a discussion of how group members plan to use additional resources in their school and/or community to maintain an adequate support network.

Part II

Give group members paper and pens and ask them to write their name in the middle of the paper. Pass the papers clockwise, allowing time for each member to write a message, a good-bye note, or simply something about the person whose name is written on that sheet. When everyone has written on all group members' papers, group leader(s) will declare the group ended.

III. Closing statement

The closing statement will be read one last time by a group member.

APPENDIX 1

OPENING STATEMENT

CLOSING STATEMENT

PROCESSING AND EVALUATING

Appendix 1A

OPENING STATEMENT

"We welcome you to this group and hope that it will provide you with a positive experience. We are here to discover what it is like to be members of a group and to honor our Native American culture. We ask that you be willing to invest yourself emotionally in the group, and to examine your own alcohol and drug-related attitudes, feelings, behaviors, and beliefs. Remember that you get our of the group what you put into it."

CLOSING STATEMENT

"The things that you heard spoken in our group today were spoken in confidence. Please remember to keep them within the walls of this room. We hope that you have felt the warmth that we have in our heart for you, and that you have benefited from your group experience today."

* idea taken from dePaul Training Institute

Appendix 1B

PROCESSING AND EVALUATING

The time allotted each group session for processing and evaluating should be used to solicit voluntary reactions of group members concerning what happened in group during that session. Remember to be flexible -- group members may need more time than 5-10 minutes to process if the group has been particularly emotional. Group leader(s) will want to make sure that no one leaves the group feeling discouraged.

The following are some examples of questions the group leader(s) may find useful in processing and evaluating the group:

- "What was most valuable to you about today's group?"
- "What do you need to do to support yourselves after you leave group today?"
- "What do you think happened during our group today?"
- "Does anyone want to make a statement to another group member before we close?"

APPENDIX 2

ADOLESCENT ALCOHOL INVOLVEMENT SCALE

Appendix 2

ADOLESCENT ALCOHOL INVOLVEMENT SCALE (AAIS)

John Mayer & William J. Filstead

For each question below, please circle all answers that describe your feelings, behavior, and experiences related to you chemical use.

1. How often do you drink?
   A. Never.
   B. Once or twice a year.
   C. Once or twice a month.
   D. Every weekend.
   E. Several times a week.
   F. Every day.
2. When did you have your last drink?
   A. Never drank.
   B. Not for over a year.
   C. Between six months and one year ago.
   D. Several weeks ago.
   E. Last week.
   F. Yesterday.
   G. Today.
3. I usually start to drink because:
   A. I like the taste.
   B. I want to be like my friends.
   C. I want to feel like an adult.
   D. I feel nervous, tense, full of worries or problems.
   E. I feel sad, lonely, sorry for myself.

4. What do you drink?

   A. Wine.

   B. Beer.

   C. Mixed drinks.

   D. Hard liquor.

   E. A substitute for alcohol: paint thinner, sterno, cough medicine, mouthwash, hair tonic, etc.

5. How do you get your drinks?

   A. Supervised by parents or relatives.

   B. From brothers or sisters.

   C. From home without parent's knowledge.

   D. From friends.

   E. Buy it with false identification.

6. When did you take your first drink?

   A. Never.

   B. Recently.

   C. After age 15.

   D. At ages 14 or 15.

   E. Between ages 10-15.

   F. Before age 10.

7. What time of day do you usually drink?

   A. With meals.

   B. At night.

   C. Afternoon.

   D. Mostly in the morning or when I first awake.

   E. I often get up during my sleep and drink.

8. Why did you take your first drink?

   A. Curiosity.

   B. Parents or relatives offered.

   C. Friends encouraged me.

   D. To feel more like an adult.

   E. To get drunk or high.

9. How much do you drink, when you do drink?

   A. One drink.

   B. Two drinks.

   C. Three to six drinks.

   D. Six or more drinks.

   E. Until "high or drunk".

10. Whom do you drink with?

   A. Parents or relatives only.

   B. With brothers or sisters only.

   C. With friends own age.

   D. With older friends.

   E. Alone.

11. What is the greatest effect you have had from alcohol?

   A. Loose easy feeling.

   B. Moderately "high".

   C. Drunk.

   D. Became ill.

   E. Passed out.

   F. Drank heavily and the next day didn't remember what happened.

12. What is the greatest effect drinking has had on your

life?

A. None, no effect.

B. Has interfered with talking to someone.

C. Has prevented me from having a good time.

D. Has interfered with my schoolwork.

E. Have lost friends because of drinking.

F. Has gotten me into trouble at home.

G. Was in a fight which destroyed property.

H. Has resulted in an accident, an injury, arrest, or being punished at school for drinking.

13. How do you feel about your drinking?

A. No problem at all.

B. I can control it and set limits for myself.

C. I can control myself, but my friends influence me.

D. I often feel bad about my drinking.

E. I need help to control myself.

F. I have had professional help to control my drinking.

14. How do others see you?

A. Can't say, or, a normal drinker for my age.

B. When I drink, I tend to neglect by family and friends.

C. My family or friends advise to control or cut down on my drinking.

D. My family or friends tell me to get help for my drinking.

E. My family or friends have already gone for help for my drinking.

AAIS SCORING PROCEDURE

(Developed by Terrence T. Gorski)

Instructions: Review the completed questionnaire and circle the numerical score that corresponds to the checked answer. Enter the number of the circled item in the column labeled "Score." Total the scores and enter in the appropriate box. Turn to the interpretations at the bottom of this page.

Question:	A	B	C	D	E	F	G	H	Score
1	0	2	3	4	5	6			
2	0	2	3	4	5	6	7		
3	1	2	3	4	5				
4	1	2	3	4	5				
5	1	2	3	4	5				
6	0	2	3	4	5	6			
7	1	2	3	4	5				
8	1	2	3	4	5				
9	1	2	3	4	5				
10	1	2	3	4	5				
11	1	2	3	4	5	6			
12	0	2	3	4	5	6	7	8	
13	0	2	3	4	5	6			
14	0	2	3	4	5				
						TOTAL SCORE:			

Normal Adolescents:

0 Total abstainer

1-19 Rarely uses alcohol

Adolescent Heavy Users:

20-41 Adolescents who drink but do not have ADDA-related behavior problems. (Adolescent heavy users MAY require outpatient services for education and prevention. If there is a coexisting adolescent disorder, outpatient

therapy will be indicated.)

Adolescent Misusers:

42-57 Alcohol misuse

58-79 Alcoholic-like drinkers. (Adolescent misusers will typically require inpatient treatment followed by outpatient services. Length of stay will be determined by the presence and severity of coexisting adolescent disorders.)

APPENDIX 3

ALCOHOL INFORMATION SHEET

Appendix 3

ALCOHOL INFORMATION SHEET

DESCRIPTION

Alcohol is a depressant, a drug that slows down the body's functioning. It's made from fermented grapes or grains and is part of beer, wine, wine coolers, and many forms of liquid, including whiskey, gin, vodka, rum, and brandy.

A 12-ounce can of beer or ale contains about the same amount of alcohol as a 5-ounce glass of wine, a 12-ounce wine cooler, or a shot glass (1.5 ounces) of liquor. Each has about one-half ounce of alcohol.

People over a certain age can legally buy and use alcohol. However, it is illegal for people under this age to buy or use alcohol.

EFFECTS ON THE BODY AND HEALTH

How alcohol travels through the body: Alcohol goes down the esophagus to the stomach and intestines. It undergoes little digestion and is absorbed directly into the bloodstream, which carries it to each cell in the body.

The body gets rid of a small amount of the alcohol in the breath, sweat, and urine. The liver slowly breaks down the rest of the alcohol.

Brain

Alcohol affects the cerebrum first, slowing thinking, affecting judgment, and dulling senses. Next to be affected are the centers controlling emotions. The person may get silly, angry, worried, or sad.

As alcohol builds up in the bloodstream, it also affects the cerebellum, interfering at first with coordination and reaction time. Then it affects vital body functions, such as the heartbeat, breathing rate, and digestion. Alcohol can slow the brain's functioning enough to cause unconsciousness or death.

Drinking alcohol while using other drugs, especially depressants like sleeping pills and tranquilizers, is extremely dangerous and can be fatal. Many people are hospitalized or killed every year because they didn't realize that alcohol increases the effects of other depressants and other medication, including some nonprescription allergy medicines.

Eyes

Alcohol relaxes the eye muscles, making it difficult for the user to focus and see clearly.

Heart

Long-term use of alcohol can weaken the heart muscle, decrease the amount of blood the heart pumps, and produce dangerous changes in the heartbeat. Drinking can lead to high blood pressure. Alcohol use also widens blood vessels in the skin, causing loss of heat.

Lungs

Small doses of alcohol can increase the breathing rate, while large doses may slow it down.

Digestive System

Alcohol irritates the lining of the entire digestive

system. It can cause problems ranging from vomiting to ulcers to cancer. The risk of cancer of the esophagus is higher among heavy alcohol users, especially those who smoke.

The liver suffers most, as it must slowly eliminate 95 percent of the alcohol from the bloodstream, at the rate of about one-half ounce each hour. Drinking more alcohol, exercising, or drinking coffee does not speed up this rate.

If the person keeps drinking, alcohol builds up in the bloodstream faster than the liver can break it down. Drinking very quickly ("chugging") can result in alcohol poisoning and sometimes death.

As the level of alcohol in the blood rises, it increasingly interferes with the drinker's ability to function physically and mentally.

Drinking over a long period of time can lead to a disease called cirrhosis of the liver. The damaged liver cells can't break down poisons, so these substances build up and create problems throughout the body. Cirrhosis is a leading cause of death among alcoholics.

Muscles

Long-term use of alcohol can lead to muscle weakness.

EFFECTS ON THE FETUS

If a pregnant woman drinks, her bloodstream carries alcohol directly to her unborn baby. This can cause fetal alcohol syndrome, a pattern of birth defects that may include low birth weight, facial abnormalities, and mental retardation. There is no safe amount of alcohol to drink

during pregnancy.

EFFECTS ON BEHAVIOR

Because alcohol affects judgment, drinkers tend to do and say things they usually wouldn't do or say. Alcohol also interferes with coordination, reflexes, and reaction time, causing problems in walking, talking, operating machines, and driving. As a result, drinkers often become more confident of their skills, including their driving skills, while their ability to use those skills decreases dramatically.

Some drinkers become silly, while others become depressed, angry, violent, or even suicidal. Alcohol is frequently linked with crime and violence.

DID YOU KNOW...?

How often does alcohol injure or kill people on our highways? Alcohol is harmful to young people not only physically, but also emotionally and socially. In too many cases, drinking - or riding with a drinking driver - is fatal. Alcohol is a factor in a greater number of fatal crashes involving teenage drivers than in any other age group. About four out of every ten teenage deaths in the United States occur in traffic crashes. Fortunately, each year fewer and fewer young people drink and drive. In the United States in 1982, about one in three 15-to-17-year-olds involved in fatal crashes had been drinking. By 1989 that number had dropped to about one in five.

Still, nearly half the total number of car crashes and six out of ten fatal crashes in the United Stated involve a

driver who has been drinking. In Canada, half of the drivers killed in crashes had been drinking, although that percentage may also be decreasing.

A fatal alcohol-related crash occurs about every 20 minutes in the United States. The number of people in the United States killed in car crashes involving alcohol is higher than the number of United States soldiers killed in the Revolutionary War, Civil War, Spanish-American War, World Wars I and II, Korean War, and Vietnam War combined.

In the United States about 22,000 people die in these crashes every year. In 1987, 4,800 passengers riding with drinking drivers were killed. And every year more than 1,800 Canadians are killed and 56,000 are injured.

What are some other ways alcohol can harm or kill people?

Alcohol doesn't just cause deaths on the highway. At least 3 out of every 100 deaths in the United States and 6 out of every 100 deaths in Canada are related to the use of alcohol. This includes people who die from cirrhosis, heart disease, suicides, car crashed and other accidents, and other alcohol-related causes.

In the United States, alcohol is involved in more than 55 percent of arrests, 70 percent of murders and violent crimes, 20 to 36 percent of suicide attempts, 80 percent of spouse abuse, 48 percent of serious burns, 26 percent of fire deaths, and 38 percent of drownings.

* adapted from Lions-Quest *Skills for Adolescence*

APPENDIX 4

MARIJUANA, CRACK AND COCAINE INFORMATION SHEET

THINKING AHEAD WORKSHEET

Appendix 4A

MARIJUANA, CRACK, & COCAINE INFORMATION SHEET

MARIJUANA

DESCRIPTION

Marijuana is a drug that can act as a stimulant(speeding up the heart rate), a depressant (slowing down messages from the brain), and a hallucinogen (causing the user to see or hear things that aren't really there).

It comes from *Cannibis* sativa, the Indian hemp plant. It is made from the crushed leaves, twigs, and seeds and hand-rolled into a cigarette or "joint".

It is illegal to buy or sell any form of marijuana. Currently, marijuana has no accepted medical use.

EFFECTS ON THE BODY AND HEALTH

How marijuana travels through the body: There are over 421 chemicals in marijuana that enter the lungs and quickly pass into the bloodstream. The bloodstream takes these chemicals to all the body parts, including the brain. The liver and kidneys break down and filter out some of the toxic chemicals.

More that 61 of the chemicals in marijuana are called cannabinoids. The most damaging one is the main active ingredient, THC, which is many times stronger than 20 years ago. Cannabinoids, including THC, are absorbed by fatty tissues- especially in the brain, nerves, and reproductive organs. These chemicals become incorporated into cell membranes and slow down the functioning of cells by blocking

the passage of nutrients into the cell and waste products out of the cell. When cell membranes in brain tissue become completely saturated with THC, the cells die. Brain cells cannot be replaced.

Marijuana stays in the body and keeps affecting the user days and weeks later. A week after THC enters the body, nearly half of it remains. Traces may stay in the body for several weeks or even months. This means the harmful effects of marijuana on the body continue even after the person has stopped using marijuana.

Because the chemicals in marijuana are so slow to leave the body, smoking two joints a week for six months can completely saturate the fatty areas of the body with cannabinoids. Marijuana use can lead to physical or psychological addiction.

Brain

Cannabinoids clog the brain cells and make it difficult for messages to get through. Users have problems with thinking, judgment, and memory. Because the most complex brain functions are affected first, the user may not realize he or she has lost some "brain power". Users become sluggish and have trouble paying attention and understanding what they read.

This drug also interferes with coordination, perception, ability to sit erect, and control of hand movements. Marijuana can cause users to hallucinate. Their sense of time and distance may be distorted

Because marijuana remains in the body, including the brain, for long periods, it can affect the user's ability to think for months after he or she has stopped using the drug.

Lungs and respiratory system

Along with cannabinoids and other dangerous chemicals, marijuana smoke contains extremely harmful tars, infection-producing funguses, and more carbon monoxide than tobacco smoke. Smoking marijuana has five times the potential cancer risks as smoking ordinary cigarettes. In addition, 80 percent of marijuana users also smoke tobacco cigarettes, thereby exposing themselves to the dangers of both drugs.

Heart and circulatory system

Marijuana makes the heart beat faster and can increase blood pressure. Smoking one marijuana cigarette causes the same amount of narrowing of blood vessels as do about 20 tobacco cigarette. These changes contribute to heart and circulation problems.

Digestive system

Users may fill sick to their stomach or suddenly hungry. A dry mouth and throat are common.

Reproductive system, hormones

Hormones in both females and males can be seriously affected by marijuana, which is stored in the sex organs. In females, chronic use of marijuana causes the chemicals in the drug to accumulate in the ovaries and may interfere with the menstrual cycle and damage or destroy ova (eggs). In males, it can reduce sperm production and damage or destroy sperm.

Both effects cam make it difficult to have children. Damaged sperm and ova cause birth defects.

The most important hormone, testosterone, decreases by 25 to 35 percent within three hours after smoking marijuana. For males, using marijuana can interfere with the growth of facial and body hair and the normal development of muscles and other male characteristics.

For females, using marijuana during pregnancy can cause babies to be born underweight, with cannabinoids already in their brain cells. The babies may have seizures, visual problems, and other physical disorders.

Immune system

Marijuana can damage the immune system that helps protect the body from disease. When the immune system isn't working properly, a person gets sick much more easily. A study by Columbia University showed that the immune response of marijuana users was 40 percent less than that of people who did not use marijuana.

Other side effects include bloodshot eyes, shaking, headaches, and a drop in body temperature.

EFFECTS ON BEHAVIOR

Marijuana affects the user's memory, attention span, speaking, listening, thinking, reading comprehension, problem solving and decision making. One effect of regular marijuana use is a decline in school performance.

People who use marijuana regularly are often described as "burnouts" because they have trouble with normal, everyday

activities. People who are heavy users may lose all desire to achieve anything in life. They have problems making plans and thinking about the future or its consequences.

While this drug decreases motivation, it increases anxiety. Marijuana can make emotional problems worse. Some marijuana users become fearful and confused, and others grow suspicious or aggressive. Paranoia and panic attacks are frequent.

DID YOU KNOW?

People once thought marijuana was a harmless drug. Since 1964, thousands of studies of marijuana have been done, and not one of them has found it to be harmless.

Young people who smoke tobacco cigarettes are five times more likely to smoke marijuana. Many who use marijuana go on to use other illegal drugs. People who never use marijuana are less likely to use any other illegal drug.

Surveys have found that 60 to 80 percent of marijuana users sometimes drive after using the drug. Experts believe many traffic deaths involve marijuana because it affects the user's timing and judgment. That's why it's important never to ride in a car with a driver who has been using drugs, including marijuana.

More and more young people are saying "No" to marijuana. The percentage of United States high school seniors who use marijuana has declined steadily since it peaked in 1978. In Ontario the percentage of student users fell from 25.1 in 1977 to 15.9 in 1987. The reason students most commonly give for

not using marijuana is that they have learned about its health hazards.

COCAINE & CRACK

DESCRIPTION

Both cocaine and crack are stimulants that make the body work faster. They come from the coca plant, grown in South America. Cocaine is a white powder. Smugglers and dealers often mix it with other ingredients ranging from powdered sugar to amphetamines.

Crack is a form of cocaine that looks like small, light brown "rocks". The rocks make a crackling sound when used, hence the drug's name.

It is illegal to buy or sell cocaine or crack. Both forms of this drug are highly addictive.

EFFECTS ON THE BODY AND HEALTH

How cocaine and crack travel through the body: Cocaine and crack usually enter the body through the mouth, nose, and throat. Then they pass into the lungs and the bloodstream and within seconds are in the brain. There, they affect certain centers in the brain and produce a strong desire to use the drug again.

Brain, central nervous system

Crack affects the brain's chemistry. It causes the brain to release too much of the chemicals that are involved with the transmission of nerve signals. This causes overstimulation. Cocaine use causes headaches, memory loss,

depression, and problems with concentration. Long-term use can lead to hallucinations, restlessness, sleeplessness, paranoia, convulsions, and strokes.

Eyes

Dilated (widened) pupils are a common side effect.

Nose, throat

Sniffing cocaine can cause the user to have a chronic stuffy nose and numbness in the nose and the throat. Use may destroy the lining of the nose. Serious bleeding and other problems in the nasal passages may require surgery to repair. Other problems include chronic bronchitis, hoarseness, and complete loss of voice.

Lungs

Crack smokers risk serious damage to their lungs, including diseases similar to pneumonia.

Heart and circulatory system

Using cocaine or crack causes blood vessel constriction, rapid or irregular heartbeat, and an increase in blood pressure, sometimes resulting in a heart attack and death.

Digestive system

Problems include severe dehydration, stomach pains, nausea, loss of appetite, weight loss, and malnutrition resulting from poor eating habits.

Reproductive system

Using either cocaine or crack early in a pregnancy can kill the fetus(unborn baby). Using these drugs later in the pregnancy can result in the birth of an addicted baby with

kidney, respiratory, visual, coordination, or developmental problems. These babies may have a stroke before birth or seizures or a heart attack after delivery. They may spend the first three weeks of their lives in a agonizing withdrawal from drugs. As these children grow older, they tend to have temper tantrums, are overly active, and are indifferent to the people caring for them.

Other effects on the body

Use of cocaine and crack can also worsen existing medical conditions such as bronchitis, asthma, anxiety, depression, poor blood circulation, heart problems, diabetes, and epilepsy.

EFFECTS ON BEHAVIOR

Anxiety is a common effect of using any form of cocaine. Wild mood swings, delusions, paranoia, and other problems in thinking also occur. Users frequently become hyperactive, out of control, and violent.

When the cocaine or crack wears off, the user crashes, feeling severely depressed, worthless, and sometimes suicidal. Users counteract these feeling by taking another dose of crack or cocaine, so they are driven to keep using the drug. Often, they must use more and more of the drug to get the same effect.

Some use the drug every few hours until they completely lose contact with reality - or collapse from exhaustion. Their lives become committed to their drug addiction and they do not care about anything else, including friends and family.

DID YOU KNOW?

Both crack an cocaine are so addictive that users become slaves to these drugs and will often do anything they can to obtain more. Monkeys in experiments chose cocaine over food, to the point of starving themselves to death. Crack is more addictive than heroin and more powerful than cocaine in its powder form. Users can become addicted to crack after trying it once or twice.

Cocaine use affects young people more quickly and even more seriously than it affects adults. Teenagers who use cocaine begin to have problems functioning much more quickly than adults. Young people also are less able to hide the results of their cocaine use - or to afford to buy drugs without turning to crime. They experience more brain seizures, suicide attempts, and violent behavior.

Some users combine crack or cocaine with heroin to try to avoid the depression they feel when crack wears off. Using a stimulation and a narcotic together taxes the body organs, especially the heart. Users often end up in the emergency room, where doctors may not realize that a potentially fatal combination of drugs is involved. By the time the truth is known, it may be too late to save the patient.

Young people are learning about the dangers of these drugs, however. According to the Household Survey of Drug Use, in 1985 only 31 percent of young people believed that trying cocaine posed a great risk. In the 1988 survey, 53 percent felt that trying cocaine posed a great risk.

Although crack use is a very serious problem in inner cities, it occurs in all parts of the country, from affluent suburbs to rural communities.

Another survey found that users of cocaine are likely to have used most of the other harmful drugs, including alcohol, marijuana, hallucinogens, other stimulants, and depressants. Crime is an important part of the cocaine and crack epidemic. In a cocaine hotline study, 39 percent reported selling cocaine to support their habit. Another 29 percent reported stealing from work, family, or friends to be able to buy more cocaine. Twelve percent had been arrested for dealing or possession.

Illegal drug sales amount to hundreds of millions of dollars every year. A 1987 estimate set illegal profits at $25 billion a year. People who buy and use cocaine or crack aren't just breaking the law themselves; they're helping to support criminals and murderers throughout the world.

* adapted from Lions-Quest *Skills for Adolescence*

Appendix 4B

THINKING AHEAD

Below list four goals you have for yourself in the future. After the goal is written, write how becoming a substance abuser would get in the way of reaching that goal.

1. Goal: _____

_____

How my goal would be affected: _____

_____

2. Goal: _____

_____

How my goal would be affected: _____

_____

3. Goal: _____

_____

How my goal would be affected: _____

_____

4. Goal: _____

_____

How my goal would be affected: _____

_____

APPENDIX 5

THE FAMILY TRAP

Appendix 5

THE FAMILY TRAP

NO ONE ESCAPES FROM A CHEMICALLY DEPENDENT FAMILY

The family is affected greatly by the chemically dependent person. His relationship to the mood-altering chemical contributes to the family illness before he goes to treatment. It also greatly influences the family during the after treatment. The chemically dependent person, on the other hand, is also greatly affected by the members of his family. To understand the phenomenon of chemical dependency occurring in a family we must look at what a family is in itself.

The family is an organism. Its parts are interdependent. The members of a family operate in a system. A system is a body of parts that work together. They may work together for peace and harmony. They may work together for destruction. They may work together for survival.

A family resembles a mobile. A mobile is an art form made up of rods and strings upon which are hung various parts. The beauty of the mobile is in its balance and flexibility. The mobile has a way of responding to changing circumstances such as wind. It changes position but always maintains connections with each part. If I flick one of the suspended parts and give it kinetic energy, the whole system moves to gradually bring itself to equilibrium. The same thinking is true of a family. In a family where there is stress, the whole organism shifts to bring balance, stability or survival.

This is the type of dynamic each of us entered into when we came into a family.

In a chemically dependent family, each of these individual parts is affected by the chemically dependent person. Each family member adapts to the behavior of the chemically dependent person by developing behavior that causes the least amount of personal stress. Just as the chemically dependent person is suffering from self-delusion in regard to the use, as the chemical disease progresses each family member compulsively represses his-her feelings and learns to react with a survival behavior. This behavior serves to build a wall of defenses for protection from pain.

The Chemically Dependent Person

The chemically dependent person develops a unique defense system to protect the painful storehouse of repressed feelings. The persons living around the dependent person live with two types of messages coming from the dependent person. There are the internal messages which are the uncomfortable sensations coming from the repressed feelings and the obvious set of defenses which are seen and heard by each family member.

Because of the system balance, each member of the family begins to respond to the dependent from a double level position. Family members, like, the dependent, begin to regress their feelings and also develop a set of defenses to protect them from further pain. Each family member finds a survival role. Because the repressed feelings are unavailable

to the dependent, there is very little chance that the rest of the family will be any more aware of their feelings. This growing action/reaction of the dependent and family is a self-deluded process. The family grows more out of touch with reality. As the compulsion grows between the dependent and the chemical, so does the compulsion grow between the dependent's behavior and the family's reaction. Each family member becomes locked into a set of rigid survival defenses and needs help to become aware of these compulsive behavior patterns.

Survival roles within the system can be characterized as follows:

- CHIEF ENABLER, SPOUSE, PARENT, CO-WORKER
- FAMILY HERO, SCHOOL JOCK, COMPANY MAN, SOCIAL NICE GUY
- FAMILY SCAPEGOAT, SCHOOL PROBLEM, COMPANY TROUBLE MAKER, SOCIAL JERK
- FAMILY LOST CHILD, SCHOOL DAY-DREAMER, COMPANY DRONE, SOCIAL LONER
- FAMILY MASCOT, SCHOOL CLOWN, COMPANY JOKER, SOCIAL CUT-UP

The Chief Enabler

The chief enabler is often the spouse or the parent of a chemically dependent person. It is the person who is closest and most depended on by the dependent. As the illness grows, so does the involvement of the enabler. With the growth of the illness comes the increased repression of feelings and the development of a set of survival defenses for the enabler.

The role of the chief enabler in the system is to provide responsibility. As the dependent increasingly loses control, the chief enabler makes more choices to compensate for the dependent's lack of power.

The Family Hero

The family hero is the person who can see and hear more of what is really happening in the family and begins to feel responsible for the family pain, if only the family would listen. The hero tries hard to make things better for the family and works diligently to improve the situation. The hero is always losing ground and feels consistently inadequate. The role of the hero is to provide self-worth for the system.

The Scapegoat

The scapegoat is the one who is in the family public eye. The scapegoat has already learned in this family that one is not regarded for who one is...but rather for how one performs. This person does not want to work as hard as the family hero just to prove himself worthy, so decides to pull away from the family and look for good feelings of belonging elsewhere. Because of the repressed anger in the feeling the need for this withdrawal, the scapegoat often gets much attention for the destructive ways in which this withdrawal takes place. Often it is in running away, refusing to be part of the family, getting pregnant, using chemicals or just being stubborn and withdrawn. The role of the scapegoat is to provide distraction and focus to the system.

The Lost Child

The lost child is one who has learned not make close connection in the family. This person spend much time being alone or quietly busy. It's the safest role and likely not to cause trouble for self or others. Most people do not notice lost children very often as they are not usually given much attention, either positive or negative. They are just there. They suffer pain and loneliness. The role of the lost child is to offer relief. This is one child the family does not have to worry about.

The Mascot

The mascot is the family member who brings a little fun into the family. No one takes the mascot too seriously because it is believed there would be a limited understanding of anything too serious. Mascots are often cute, fun to be around and able to use charm and humor to survive in this very painful family system. The role of the mascot is to provide fun and humor. The wall of defenses compulsively covers up the true feelings and the mascot lives in the trap of self-delusion.

* adapted from The Family Trap

APPENDIX 6

DEFENSE MECHANISMS

Appendix 6

DEFENSE MECHANISMS

	DEFENSES		ATTITUDIANAL POSTURE	
SURVIVAL STYLE	The spontaneous response to a feeling that blocks awareness of it in oneself and others.		How others see the person who is locked into these defenses.	
SUPER REASONABLE	Debating Analyzing Rationalizing Intellectualizing	Denying Explaining	Controlled Shallow Unfeeling	Cool Critical Rigid
BLAMING	Arguing Attacking Sarcastic	Belittling Criticizing Glaring	Hostile Angry Judgmental	Critical Negative
PLACATING	Fragility Stalling Flattering	Smiling Pouting Seducing	Compliant Insincere "Nice guy"	Fragile Phony
IRRELEVANT	Daydreaming Fantasizing Sleeping	Silence Joking Avoiding	Depressed Mascot Invisible	Tired Clown Shy

* adapted from When Chemicals Come to School by Gary Anderson, (1987)

APPENDIX 7

SOURCES OF HELP

SUPPORT NETWORK SCALE

Appendix 7A

SOURCES OF HELP

ALCOHOLICS ANONYMOUS (AA)

-- This group helps people who want to stop drinking

AL-ANON

-- This group offers help and support for families and friends of alcoholics

ALATEEN

-- This group offers help and support for older children and teenagers from alcoholic families

NARCOTICS ANONYMOUS (NA)

-- This group offers help to recovering drug addicts

Alcohol hotline:

Cocaine hotline:

Counseling services in our area:

Name:

Address:

Phone:

Name:

Address:

Phone:

Appendix 7B

SUPPORT NETWORK SCALE

Circle one response for each item. Add the scores next to each item you circled and put the total on the line.

1. How many persons do you talk to about a school/work problem?
   (0) none
   (3) one
   (4) two or three
   (5) four or more
2. How may friends do you trade favors with, such as loan items, share meals, help with tasks?
   (0) none
   (1) one
   (2) two or three
   (3) four or more
3. Do you have a close friend or best friend?
   (0) no
   (2) several different friends
   (6) one steady friend
   (10) many friends, one best friend
4. How often do friends and close family members visit you at home?
   (0) rarely
   (1) about once a month
   (4) several times a month
   (8) once a week or more

5. How many friends or family members do you talk to about personal matters?

   (0) none

   (6) one or two

   (8) three to five

   (10) six or more

6. How often do you participate in a social, community, or sports group?

   (0) rarely

   (1) about once a month

   (2) once a week or more

TOTAL SUPPORT SCALE _____

If your support network score is:

Less than 10:

Your support network has low strength and probably does not provide much support. You need to consider getting closer to people.

15-29:

Your support network has moderate strength and likely provides enough support except during periods of high stress.

30 or more:

Your support network has high strength, and it will probably maintain your well-being even during periods of high stress.

* adapted from *Mental Health: The Youth Award Handbook*

APPENDIX 8

THE WEB

Appendix 8

THE WEB

Objective

Members will share information about themselves with the group and be able to remember on item someone else shared

Materials

A ball of yarn

Procedure

Group members sit on the floor in a circle. The facilitator holds onto the end of a ball of yarn and states something personal. The yard is then passed to group members, who also hold onto the yarn and state something about themselves. As the yarn moves from person to person, a web is formed. Members get a visual picture of how they are joined together as a group. Members are asked to try to remember what someone else said.

Suggested topics, moving from nonthreatening to self-disclosing, include:

1. If you could be an animal, what would it be?
2. What is something you do well?
3. What do you enjoy doing in your spare time?
4. What is your favorite color, song, place, food, etc?
5. Who is someone important to you? Why?
6. What is something you wish for or hope to do?

APPENDIX 9

FEELINGS VOCABULARY

FEELINGS IN THE ALCOHOLIC FAMILY

Appendix 9A

FEELINGS VOCABULARY

Aggravated
Angry
Annoyed
Antsy
Anxious
Astounded

Babyish
Bashful
Blue
Bored
Brave

Calm
Cheated
Cheerful
Confused
Cooled-off
Cross
Cruel

Disappointed
Disgusted
Disturbed
Down
Droopy

Embarrassed
Energetic
Enraged
Excited
Exhausted

Fascinated
Fearful
Fine
Frantic
Foolish
Forgotten
Frustrated
Free

Good
Glad
Glorious
Great
Grouchy
Grumpy
Guilty

Happy
Hateful
Helpless
Homesick
Horrible
Hurt

Jealous
Joyful
Joyous
Jumpy

Kind

Lazy
Leftout
Lonely
Lonesome
Lost
Low

Mad
Mean
Miserable
Mixed-up

Naughty
Nervous
Nice
Numb

Overwhelmed

Panicked
Peaceful
Petrified
Pick-on
Playful
Pleased
Pretty
Proud

Quiet

Refreshed
Rejected
Relaxed
Relieved
Rested
Restless

Sad
Scared
Shocked
Shy
Silly
Sober
Sorrowful
Sorry
Special
Spooky
Sunny

Tearful
Tense
Terrible
Tired

Uncertain
Unhappy
Upset
Up-tight

Violent

Worried

Yucky

Zany

*Note to group leaders: This list may be used as a handout for group members who feel "stuck" and who cannot find descriptive feeling words.

Appendix 9B

FEELINGS IN THE ALCOHOLIC FAMILY

I feel that it is somehow my fault that my parent is an alcoholic.
I am angry a lot.
I sometimes act nasty with other people, but can't seem to control myself.
I have trouble concentrating at school.
I get angry that I have to do things at home that my parents should be doing.
I am jealous of the kinds of families that my classmates have.
I am afraid that people won't like me if they really get to know me.
Sometimes I wish I were dead.
I often wish I were someone else.
I'm beginning to think that it would be nice to take drugs to forget my problems.
I'm often afraid of the future.
I g out of my way to get people to like me.
I feel terrible when friends get mad at me.
When people get angry with me I feel as though they don't like me any more.
No one could ever understand how I feel.
I feel terrible when my parents fight.
I stay out of my house as much as possible because I hate it there.
I worry about my parents.
I am nervous and scared a lot.
I feel as though no one really loves me or cares about me.
Sometimes I want to do weird things to get attention.
I sometimes cover up my real feelings be pretending I don's care.
I feel like I've got it worse than most people.
I hate my parent(s).
I feel guilty for hating my parents.
I have lost respect for my alcoholic parent.
I feel like getting even with my parents.
I am ashamed of my home.

Author Unknown

APPENDIX 10

ORGANIZATIONS

Appendix 10

ORGANIZATIONS

A.A.
Alcoholics Anonymous
General Service Office
P.O. Box 459
Grand Central Station
New York, NY 101063
(212) 686-1100

Addiction Research
Foundation
33 Russell Street
Toronto, Ontario M5S 2S1
(416) 595-6056

Al-Anon Family Group
Headquarters
1372 Broadway
New York, NY 10018-0862
(212) 302-7240

Alateen
1372 Broadway
New York, NY 10018-0862
(212) 302-7240

American Council for
Drug Education
204 Monroe Street
Rockville, MD 20850
(301) 294-0600

Chemical People Project/
WQED-TV
4802 Fifth Avenue
Pittsburgh, PA 15213
(412) 622-1491

COAF
Children of Alcoholics
Foundation, Inc.
200 Park Avenue, 31st Floor
New York, NY 10166
(212) 351-2680

Families Anonymous
World Service Office
P.O. Box 528
Van Nuys, CA 91408
(818) 989-7841

Families in Action Drug
Information Center
2296 Henerson Mill Road
Suite 204
Atlanta, GA 30345
(404) 325-5799

Hazeldon Foundation
Box 11
Center City, MN 55012
(800) 328-3330

IBCA
Institute on Black Chemical
Abuse
2614 Nicollet Avenue South
Minneapolis, MN 55408
(612) 871-7878

Johnson Institute
7151 Metro Boulevard
Minneapolis, MN 55439-2122
(800) 231-5165

NaCOA
National Association for
Children of Alcoholics, Inc.
31582 Coast Highway, Suite B
South Laguna, CA 92677-3044
(714) 299-3889

Narcotics Anonymous
World Services Office, Inc.
P.O. Box 9999
Van Nuys, CA 91409
(818) 780-3951

National Coalition for the
Prevention of Drug and
Alcohol Abuse
537 Jones Road
Granville, OH 43023
(614) 587-2800

National Federation of Parents
for Drug-Free Youth
8730 Georgia Avenue, Suite 200
Silver Spring, MD 20910
(301) 585-5437

NCA
National Council on
Alcoholism, Inc.
12 West 21st St., 7th Floor
New York, NY 10010
(800) NCA-CALL

NCADI
National Clearinghouse for
Alcohol/Drug Information
P.O. Box 2345
Rockville, MD 20852
(301) 468-2600

NIAAA
National Institute on
Alcoholism Abuse and
Alcoholism
Room 16-105
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857
(301) 443-3885

NIDA
National Institute on Drug
Abuse
Room 10-05
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

PRIDE
National Parents Resource
Institute on Drug Education
Robert W. Woodruff
Volunteer Service Center,
Suite 1002
100 Edgewood Avenue
Atlanta, GA 30303
(404) 651-2548

SADD
Students Against Drunk Driving
P.O. Box 800
277 Main Street
Marlboro, MA 01752
(800) 521-SADD

BIBLIOGRAPHY

Amoss, P. (1978). *Coast Salish Spirit Dancing: The Survival of an Ancestral Religion*. Seattle: University of Washington Press.

Anderson, G. (1987). *When Chemicals Come to School*. DePaul: Community Recovery Press.

Bach, P.J. & Bornstein, P.H. (1981). A social learning rationale and suggestions for behavioral treatment with American Indian alcohol abusers. *Addictive Behaviors*, **6**, 75-81.

Beauvais, F.B., Oetting, E.R., Wolf, W., & Edwards, R.W. (1989). American Indian youth and drugs, 1976-87: A continuing problem. *American Journal of Public Health*, **79**, 634-636.

Corey, M.S. & Corey, G. (1987). *Process and Practice*. Pacific Grove: Brooks/Cole Publishing Company.

DeBruyn, L.M., Lujan, C.C., & May, P.A. (1992). A comparative study of abused and neglected American Indian children in the Southwest. *Social Science & Medicine*, **35**(3), 305-315.

Devencenzi, J. & Pendergast, S. (1990). *Belonging, A Guide for Group Facilitators*.

Doyle, P. & Behrens, D. (1986). *The Child in Crisis*. New York: McGraw-Hill.

Edwards, E.D. & Edwards, M.E. (1988). Alcoholism prevention/treatment and Native American youth: a community approach. *The Journal of Drug Issues*, **18**(1), 103-114.

Everett, F., Proctor, N., & Cartmell, B. (1983). Providing psychological services to American Indian children and families. *Professional Psychology: Research and Practice*, **14**(5), 588-603.

Gibbs, Jeanne. (1987). *Tribes, A Process for Social Development*. Santa Rosa: Center Square Publications.

Globetti, G. (1988). Alcohol education programs and minority youth. *Journal of Drug Issues*, **18**(1), 115-129.

Grobsmith, E.S. (1989). The relationship between substance abuse and crime among Native American inmates in the Nebraska Department of Corrections. *Human Organization*, **48**(4), 285-314.

Kandel, D. (1975). On processes of peer influences in adolescent drug use: a developmental perspective. *Alcohol and Substance Abuse in Adolescence*, **4**, 139-163.

Kahn, M.W., Lewis, J., & Galvez, E. (1974). An evaluation study of a group therapy procedure with reservation adolescent Indians. *Psychotherapy: Theory, Research and Practice*, **11**(3), 239-242.

LaFromboise, T.D. (1988). American Indian mental health policy. *American Psychologist*, **43**, 388-397.

LaFromboise, T.D. & Dixon, D.N. (1981). American Indian perception of trusworthiness in a counseling interview. *Journal of Counseling Psychology*, **28**(2), 135-139.

LaFromboise, T.D., Trimble, J.E., & Mohatt, G.V. (1990). Counseling Intervention and American Indian tradition: an integrative approach. *The Counseling Psychologist*, **18**(4), 628-654.

Lefkowitz, B. (1987). *Tough Change: Growing Up on Your Own in America*. New York: Free Press.

Levy, J.E. & Kunitz, S.J. (1981). Economic and political factors inhibiting the use of basic research findings in Indian alcoholism programs. *Journal of Studies on Alcohol*, Supplement 9, 60-72.

Lions-Quest. (1990). *Skills for Growing*. Granville: Quest Publishing.

McBride, D.C. & Page, J.B. (1980). Adolescent Indian substance abuse: ecological and sociocultural factors. *Youth and Society*, **II**(4), 475-492.

McWhirter, J.J. & Ryan, C.A. (1991). Counseling the Navajo: cultural understanding. *Journal of Multicultural Counseling and Development*, **19**, 74-82.

Mason, R.D., Mail, P.D., Palmer, I., & Zephier, R.L. (1985). *Briefing Book for the Alcoholism Program Review*. Albuquerque, NM: Indian Health Service Alcoholism Branch.

May, P.A. (1977). Substance abuse and American Indians: prevalence and susceptibility. *International Journal of Addiction*, **17**, 223-232.

May, P.A. (1982). Substance abuse and American Indians: prevalence and susceptibility. *International Journal of Addiction*, **17**, 1185-1209.

May, P.A. (1986). Alcohol and drug misuse prevention programs for American Indians: needs and opportunities. *Journal of*

Studies on Alcohol, **47**(3), 187-195.

Moncher, M.S., Holden, G.W., & Trimble, J.E. (1990). Substance abuse among Native-American youth. *Journal of Consulting and Clinical Psychology*, **58**(4), 408-415.

Moskowitz, J. (1983). Preventing adolescent substance abuse through drug education. In Glynn, T., Leukefeld, C., Ludfor, J. (eds), *Preventing Adolescent Drug Abuse: Intervention Strategies*. Rockville, MD: National Institute on Drug Abuse, Research Monograph 47, 233-249.

Nofz, M.P. (1988). Alcohol abuse and culturally marginal American Indians. *Social Casework: The Journal of Contemporary Social Work*, **69**, 67-73.

Oetting, E.R. & Beauvais, F. (1986). Peer cluster theory: drugs and the adolescent. *Journal of Counseling and Development*, **65**(1), 17-30.

Oetting, E.R., Beauvais, F., & Edwards, R. (1988). Alcohol and Indian youth: social and psychological correlates and prevention. *Journal of Drug Issues*, **18**(1), 87-101.

Parker, L. (1990). The missing component in substance abuse prevention efforts: a Native American example. *Contemporary Drug Problems*, **17**, 251-270.

Rhode Island Indian Council. (1989). *The Council Magazine 1* (Providence RI), 2-16.

Rotter, J.B. (1967). A new scale for the measurement of interpersonal trust. *Journal of Personality*, **35**, 651-665.

Satir, V. (1972). *Peoplemaking*. Palo Alto: Science and Behavior Books, Inc.

Schinke, S.P., Botvin, G.J., Trimble, J.E., Orlandi, M.A., Gilchrist, L.D., & Locklear, V.S. (1988). Preventing substance abuse among American-Indian adolescents: a bicultural competence skills approach. *Journal of Counseling Psychology*, **35**(1), 87-90.

Schinke, S.P., Schilling II, R.F., Gilchrist, L.D., Barth, R.P., Bobo, J.K., Trimble, J.E., & Cvetkovich, G.T. (1985). Preventing substance abuse with American Indian youth. *Social Casework: The Journal of Contemporary Social Work*, **66**, 213-217.

Sue, D.W. & Sue, D. (1981). *Counseling the Culturally Different* (2nd ed.). New York: John Wiley & Sons, Inc.

Tharp, R.G. (1991). Cultural diversity and treatment of children. *Journal of Consulting and Clinical Psychology*,

59(6), 799-812.

Thompson, C. & Rudolph, L. (1988). *Counseling Children*. Pacific Grove: Brooks/Cole Publishing Company.

Trimble, J.E. & Fleming, C. (1989). Providing counseling services for Native American Indians: client, counselor and community characteristics. In Pederson, P., Draguns, J., Lonner, W., & Trimble, J. (eds), *Counseling Across Cultures*, (3rd ed., 145-168). Honolulu: University Press of Hawaii.

Wegscheider, S. (1976). *The Family Trap*. New York: Free Press.