Family and Social Support Workbook

Developed by:
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Available online at www.missionmodel.org

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The MISSION materials mentioned within the document in addition to all versions of the MISSION treatment manual and their corresponding workbooks are available for download on the MISSION website at www.missionmodel.org. You may also contact the MISSION team through the website or Dr. David Smelson directly (see contact information below) regarding any questions about the MISSION Model and/or the materials.

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INTRODUCTION

When a family member experiences homelessness, substance use, mental health disorder, a co-occurring substance use and mental health disorder (COD), and/or legal problems, one of the most important things to do is to take the time to learn about what your loved one might be going through and get support. You are not alone. Millions of individuals and families are struggling with similar problems. They are also experiencing similar thoughts, feelings, and questions as you might be experiencing right now. The issues related to your loved one's current challenges do not only affect the individual and his/her family members, but also friends, partners, etc. In this workbook, we use the terms family member and social support interchangeably to refer to someone giving emotional, financial, and/or practical support to a homeless person, or person at risk of homelessness, with a COD. Family members can be an invaluable resource and by educating yourself as much as you can, you can take an active and supportive role in your family member's path to stable housing and recovery.

Your loved one has embarked on a journey towards recovery from mental health, substance use, and other related issues such as homelessness. They have decided that you are an invaluable support to that journey and have invited you to participate in a MISSION family meeting. MISSION helps people on the road to recovery by offering and teaching new skills, and helping them identify and get connected to needed community resources.

INTRODUCING MISSION

MISSION (Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking) is an integrated treatment platform, meaning that it addresses mental health and substance use problems simultaneously and recognizes the relationship between these two issues. It also recognizes that many people who have these issues also have some related problems, like homelessness, and this may also impact recovery. Your loved one is working closely with his/her MISSION case manager (CM) and peer support specialist (PSS) team to achieve his/her goals. The MISSION CM and/or PSS will facilitate family meetings and will help you process the materials contained in this workbook. They will also integrate exercises from the MISSION Participant Workbook, which is a workbook that your loved one is using to learn and practice new recovery skills. To learn more about MISSION, go to our website: www.missionmodel.org.

USING THIS WORKBOOK

The Family and Social Support Workbook was designed to complement MISSION family support meetings. The goal of the workbook is to provide resources and psycho-education focused on increasing family members' understanding of issues that their loved one may be experiencing; provide selected tools to begin to cope and communicate with your loved one; and next steps for continued support.

The workbook contains selected information and exercises, compiled from multiple resources such as the *How You Can Help: A Toolkit For Families (*British Columbia Partners for Mental Health

and Addictions Information, 2010) and National Alliance on Mental Illness (NAMI). Exercises are a way to practice a new skill and become stronger with that skill. Each exercise begins with some basic information that has been found to be helpful for family members. Reading and discussing this information with a MISSION staff member before you start an exercise will help you understand the purpose of the exercise and how you can use it to support your loved one's recovery and take care of yourself. Whether you're providing a lot of support or very little, the information and exercises here and in the MISSION family meeting can help you and your loved one.

MODULE 1: *UNDERSTANDING HOMELESSNESS*

THIS MODULE PRESENTS AN OVERVIEW OF FACTORS CONTRIBUTING TO HOMELESSNESS AND WAYS IN WHICH THE FAMILY CAN PROVIDE SUPPORT ON THE JOURNEY TO STABLE HOUSING AND RECOVERY.

INTRODUCTION

The U.S. Department of Housing and Urban Development's (HUD) 2016 Annual Homeless Assessment Report to Congress states that on any given night there are 549,928 people experiencing homelessness. Of these adults, 1 in 5 had chronic patterns of homelessness (U.S. Department of Housing and Urban Development [HUD], November 2016).

WHY ARE PEOPLE HOMELESS?[1]

Housing

A lack of affordable housing and the limited scale of housing assistance programs have contributed to the current housing crisis and to homelessness.

Poverty

Homelessness and poverty are inextricably linked. Poor people are frequently unable to pay for housing, food, childcare, health care, and education. Difficult choices must be made when limited resources cover only some of these necessities. Often it is housing, which absorbs a high proportion of income that must be dropped.

Two factors help account for increasing poverty:

1. Lack of Employment Opportunities – With unemployment rates remaining high, jobs are hard to find in the current economy. Even if people can find work, this does not automatically provide an escape from poverty.
2. Decline in Available Public Assistance – The declining value and availability of public assistance is another source of increasing poverty and homelessness.

OTHER MAJOR FACTORS, WHICH CAN CONTRIBUTE TO HOMELESSNESS

Lack of Affordable Health Care

For families and individuals struggling to pay the rent, a serious illness or disability can start a downward spiral into homelessness, beginning with a loss of employment, depletion of savings to pay for care, and possible eviction.

Domestic Violence

Battered spouses/partners who live in poverty are often forced to choose between abusive relationships and homelessness. For those that sought out emergency shelter or transitional

[1] The National Coalition for the Homeless, 2009

housing to escape domestic violence, 63% of the requests were unmet (National Network to End Domestic Violence, 2016).

Mental Health Disorders

Traditionally, rates of mental health disorders among homeless individuals are twice the rate of the general population (Bassuk, Buckner, Perloff, & Bassuk, 1998). Of the homeless population, 26.2% have a serious mental health disorder (Annual Homeless Assessment Report to Congress [AHAR], 2010). About 24.3% of individuals entered homelessness from institutional settings such as psychiatric hospital stays or substance use treatment centers. Of those living in permanent supportive housing 32.5% had a mental health disorder (AHAR, 2015).

Addiction

The relationship between addiction and homelessness is complex. Some people who are addicted to alcohol and drugs never become homeless, but people who are poor and addicted are at increased risk of homelessness.

Co-Occurring Mental Health and Substance Use Disorder (COD)[2]

Co-occurring substance use, mental health, and medical disorders are a particularly significant issue within the homeless population. The rate of homelessness among those with a co-occurring disorder is 23% (Foundations Recovery Network, n.d.).

Gender Identity and Sexual Orientation

Relative to other groups, LGBT individuals are at increased risk for experiencing homelessness. A number of contextual factors can thrust LGBT youth and adults into homelessness including family rejection, violence/victimization, and institutional discrimination (e.g., in schools, housing, and workplaces).

[2] A co-occurring disorder (COD) is the co-existence of both a substance use and mental health disorder (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016).

EXERCISE 1.1
IDENTIFYING CONTRIBUTING FACTORS

What's it for?
The following exercise will help you identify and begin to understand that there are several factors that can impact and contribute to your loved one's homelessness and his/her ability to get back on his/her feet. It is also a key step in providing support on your loved one's journey to stable housing and recovery. By identifying what caused these factors to contribute to your loved one's homelessness, you will gain a better understanding of which areas you can provide him/her with support.

How to Use it?
Write down and discuss any relevant factors that you believe may have contributed to your family member's homelessness. Be mindful that not all factors may apply.

IDENTIFYING CONTRIBUTING FACTORS EXERCISE

Factor	Contribution to Homelessness
Housing	
Poverty	
Employment	
Public Assistance	
Affordable Healthcare	
Domestic Violence	
Mental Health	
Addiction	
Co-Occurring Mental Health and Substance Use Disorder (COD)	
Discrimination	
Other: _____	

PROVIDING SUPPORT

When a family member or friend with a COD is homeless or at risk of homelessness[3], it is not only difficult for the individual, but also his/her friends and/or family members. Many people feel a range of emotions, from sadness, fear, anger, disappointment, rejection, to hopelessness. Many question what they should do, can do, or feel emotionally prepared to do. Many also experience difficulty in coping with those feelings and identifying effective ways to provide support to themselves and their loved ones. Below are some types of support to consider when you feel this way.

TYPES OF SUPPORT

Counseling

Meeting with a trained counselor and/or attending a support group for Families of Homeless Adults will help in addressing the range of emotions you are experiencing. These meetings will provide specific and informed advice on how to provide help, and also establish appropriate healthy boundaries. These meetings will also help you find healthy ways to cope and address the complex feelings you may have about your loved one. NAMI, the National Alliance on Mental Illness, may provide assistance in finding groups in your local area.

Engage in Your Family Member's Treatment

If your family member requests that you attend a meeting or session at MISSION, the shelter, treatment program, hospital, etc. and you are able, do attend! Research shows that family awareness and involvement in treatment can bolster treatment and housing outcomes.

Stay in Touch

Keep in touch with your family member and stay in his/her life until he/she is back on track. Now is when they need support and need *you*. Spend free time doing positive things you always enjoy doing together. If you are geographically far away from your loved one, research shows that even staying in touch by phone and/or online (via email, social media, etc.) can help.

Focus on Positive and Motivational Aspects of Life

Try to make the time you spend with your loved one a renewal of your relationship as family or friends. Most of all treat your family member as you would like to be treated with dignity and respect. Anyone can have tough luck in his or her life, even if it came from a bad decision. It is

[3] If the individual/family is not literally homeless, they may meet criteria for being at risk for homelessness by having an annual income below 30% of the median income in an area; and they do not have available supports to prevent the need of emergency shelter; and they have moved 2 or more times in 60 days, or living in a shared place due to economic reasons, or have been notified of eviction in 21 days, or live in a hotel/motel and the cost is not being paid for by charity or federal programs, or they reside in an efficiency apartment with more than 2 persons, or is exiting a public funded institution, or lives in housing that can be characterized as instable (U.S. Department of Housing and Urban Development, 2012).

natural to want to help your loved one by spending your time together trying to talk about and solve problems related to his/her COD, homelessness, etc., but by focusing only on problems this may drive your loved one away. “Table” problem focused and solving discussion for MISSION family meetings and/or the support groups/counseling sessions you attend.

Encouragement

Being homeless is extremely stressful. You don't feel safe, you don't have much privacy, and you may experience constant worry about a multitude of basic needs. These factors may lead to depression and/or worsen an existing illness such as a COD. It’s important to remind your family member how valuable they are as a person, no matter what he/she is going through. Encouragement and love are some of the most important necessities you can provide and can go a long way in supporting your loved one’s path to recovery.

Get/Give an Inexpensive Pre-paid Cellphone

These phones help your family member arrange for transportation, make appointments, secure employment, and contact help agencies. All of these things can reduce risk factors for chronic homelessness. Due to the instability related to homelessness, there is a risk that the phone may get lost or stolen. Some families have found it helpful to also purchase pre-paid phone cards, which can support long distance calling. Instead of giving your loved one the pre-paid card, you may email them the card’s access and pin number, and also a list of family members’ phone numbers. This allows your loved one the ability to access this information anywhere (i.e., via a computer in the library or shelter).

Keep a Copy of Records/Vital Information

Due to the abrupt movements, your family member may lose important records (i.e., license, family members’ phone numbers, etc.); offer to keep a copy of these records or information.

EXERCISE 1.2
IDENTIFYING TYPES OF SUPPORT

What's it for?
Homelessness can be accompanied by periods of significant instability and uncertainty. Knowing ahead of time what type of support you can provide as a family member and for your loved one knowing what type of support he/she can count on from you is important in recovery. Support can come in many different shapes and sizes. This exercise helps families set clear expectations around support. Whether addressing or setting boundaries, or determining which forms of support are most helpful for your loved one and also feasible for you, this exercise can be helpful in supporting your loved one through their recovery.

How to use it?
Using the list of supports on pages 11-12 as a guide, complete and discuss the following questions with your family member and the MISSION staff member. Please keep in mind that the list on pages 11-12 is non-exhaustive.

IDENTIFYING TYPES OF SUPPORT EXERCISE

What support(s) do I currently provide and utilize?

What support(s) would I like to provide and utilize?

What are a few barriers in providing and utilizing support?

How can we address these barriers?

MODULE 2: *UNDERSTANDING CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS*

MODULE 2 DESCRIBES CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS (COD). IT ALSO IDENTIFIES COMMON ISSUES FAMILIES FACE IN PROVIDING SUPPORT TO A FAMILY MEMBER WITH A COD.

WHAT ARE CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS?

People with **substance use disorders** as well as **mental health disorders** are diagnosed as having **co-occurring disorders**. A substance use disorder is when substance (i.e., alcohol and/or drug) use interferes with functioning at work, at school, and in social relationships; substance use creates or worsens a medical condition; when substance use occurs in dangerous/risky situations; and people experience failed attempts to abstain from or control their use of substances. In some cases, physiological dependence may also exist, which is indicated by heightened tolerance[4] and withdrawal[5].

Mental health disorders consist of a range of specific disorders which affect a person's thoughts, feelings, actions, and mental functioning (e.g., memory). There are different types of disorders, such as depression, post-traumatic stress disorder (PTSD), schizophrenia, etc., with their own related impact. CODs are quite common, very distressing, and can impact a person's ability to cope and function. Unfortunately if left untreated, symptoms can extend over a lifetime, ranging in severity, and at times the symptoms can come and go and lead to early death. With proper treatment and recovery support, people can manage many of the symptoms well and improve their functioning.

WHY DO THEY "CO-OCCUR"?

It is now believed that in most cases, both genetic and environmental factors play a role in the development or onset of a COD:

1. Drugs of use can cause one to experience one or more symptoms of another mental health disorder. For example, the increased risk of psychosis in some marijuana users has been offered as evidence for this possibility.

[4] Tolerance – a need for markedly increased amounts of a substance (i.e., alcohol and/or drug) to achieve intoxications or desired effect and/or a markedly diminished effect with continued use of the same amount of the substance (American Psychiatric Association [APA], 2013)

[5] Withdrawal – the cessation of heavy or prolonged substance use; experience of symptoms after stopping the use of the substance (i.e., autonomic hyperactivity, increased hand tremor, insomnia, nausea, hallucinations, psychomotor agitation, anxiety, seizures); the substance is taken to relieve or avoid withdrawal symptoms (APA, 2013)

2. Mental health disorders can lead to drug use. Individuals may use drugs as a form of self-medication to address an underlying mental health disorder. For example, a person may use heroin (i.e., opiates) to numb the pain or experience of distressing PTSD symptoms like flashbacks, nightmares, etc.
3. Both substance use disorders (SUDs) and other mental health disorders can be caused by overlapping factors such as underlying genetic vulnerabilities, early exposure to stress or trauma, etc. Below are some selected overlapping factors:

    Overlapping Genetic Vulnerabilities – It is estimated that 40-60% of an individual's vulnerability to addiction is attributable to genetics; most of this vulnerability arises from complex interactions among multiple genes and from genetic interactions with environmental influences. Several of these same genes have been linked to increased risk of both substance use and mental health disorders.

    Involvement of Similar Brain Region – Some areas of the brain are affected by both substance use and other mental health disorders. For example, drug use that precedes the first symptoms of a mental health disorder may produce changes in brain structure and function that spark an underlying risk to develop that mental health disorder. If the mental health disorder develops first, associated changes in brain activity may increase the vulnerability to abusing substances by enhancing their positive effects, reducing awareness of their negative effects, or alleviating the unpleasant effects associated with the mental health disorder or the medication used to treat it.

IMPACT ON THE FAMILY

Co-occurring substance use and mental health disorders have a significant impact on the whole family. In addition to disturbing symptoms (e.g., hallucinations, black outs, delusions, etc.), families must cope with troubling behaviors that often accompany the onset of a mental health and/or substance use disorder (e.g., self-neglect, suicide, trouble with the law, lack of awareness about having a problem). How everyone in the family copes with the illness will have a significant effect on the family member's recovery and ability to live a fulfilling life.

EXERCISE 2.1 PART 1
IDENTIFYING COD SYMPTOMS CHECKLIST

What's it for?
It is important to know what COD symptoms look like. By being able to identify and understand symptoms, you will feel more confident in your ability to support your loved one during times of distress. You will also be able to recognize when your loved one needs help immediately and what supports to provide.

How to use it?
This checklist includes some symptoms you may have observed that are related to your loved one's disorder(s). Please check all that apply. Be mindful that not all symptoms apply. The MISSION team member may include some psycho-education about your loved one's diagnosis as part of this exercise to put these symptoms in context (i.e., hypervigilance as a symptom of PTSD).

COD SYMPTOM CHECKLIST

Area	Symptom	✓
Thinking	Thoughts are disorganized/don't make sense	
	Thoughts seem to be coming very quickly or slowly	
	Thoughts impact communication - statements don't make sense, it doesn't seem like they are paying attention, etc.	
	Substance use triggers paranoid thinking	
Mood	Angry	
	Depressed	
	Anxious/Nervous	
	Scared	
	Rapid shifts between moods	
Behavior	Signs of intoxication - staggering, "nodding off", slurred speech	
	Withdrawing from family	
	Hypervigilance - constantly tense and "on guard", scanning the environment	
	Restlessness - Not being able to sit still	
	Excessive energy, spending	
	Self-harm/cutting	
	Suicide attempts	
	Aggressive - getting in fights	
	Secretive/lying	
Perception	Hearing voices that aren't there	
	Seeing things that aren't there	
	Exaggerated sensitivity to sound	

EXERCISE 2.1 PART 2
UNDERSTANDING AND COMMUNICATING AREAS OF IMPACT

What's it for?
The treatment team will help you understand COD symptoms and provide some tools for communicating with your loved one about his/her disorder(s). This exercise will help you feel confident in addressing and communicating with your loved when during difficult times.

How to use it?
For each checked symptom in part 1, discuss with the treatment team how to develop an understanding of the symptom (i.e., paranoia may be a sign of my loved one's mental health disorder). Then discuss ways to communicate with your loved one when he/she is experiencing them.

UNDERSTANDING AND COMMUNICATING AREAS OF IMPACT EXERCISE

Area/Symptom	Understanding	Communicating

WHAT SHOULD I DO?

If your loved one is presenting with these symptoms, it can be difficult to know what to do, what to say, and how to help. It can be difficult to cope with someone who is suffering and possibly refusing to get help. If you suspect your family member is deteriorating or relapsing, it is important to have an open and honest conversation with him/her about your concern.

EXAMPLES OF POSSIBLE CONCERNS YOU MAY HAVE AND WHAT TO DO

Seek help immediately if…

- the person appears to be in danger to themselves or others.
- the person appears to be experiencing signs of an overdose (e.g., alcohol poisoning) or withdrawal (e.g., delirium tremens).

Expressing Concern

- Let the person know that you have noticed changes in their feelings and behavior, and that you understand they are having difficulties.
- Listen to what they have to say and try to solve the problem together. Note: Do not engage in problem solving if the person is heavily intoxicated or highly agitated.
- Encourage the person to talk with their counselor or doctor. Agree to help with transportation and attend the appointment with them.

If the person does not believe they are having problems…

- Encourage them to talk to someone they trust.
- Allow the person to stay in control by offering choices on how you can help them.
- Offer the person help in finding resources.
- Reassure them that it's okay to seek help, even if they think they can cope without it.
- If your loved one has signed a release, you can contact their counselor directly.

What can you do?

- Stay positive about the future and reassure them that things will improve.
- Attend a support meeting with your loved one.
- Many family members have found it beneficial to join a support group or speak with another family who is also dealing with similar issues. Counseling may also be helpful.

EXERCISE 2.2
EXPRESSING CONCERN

What's it for?
The times that your loved one experiences COD symptoms or relapses, may be very stressful. Being able to better communicate and express concern also helps manage the strong emotions that may arise during these times. You will be able to use the action plan as another tool to communicate your concern to your loved one. As you become accustomed to expressing concern, you will develop habits of healthy ways to feel concerned for your loved one.

How to use it?
Utilizing the list on page 21 as well as the symptom checklist from Exercise 2.1, develop a plan with your loved one and his/her MISSION team about what to do when you have a concern about symptoms. It is suggested that this action plan is updated regularly.

EXPRESSING CONCERN ACTION PLAN

"The next time I am concerned about my loved one's COD symptoms, I will…"

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

MODULE 3: *SUPPORTING RECOVERY FROM A CO-OCCURRING DISORDER*

THIS MODULE PROVIDES INFORMATION AND PRACTICAL RESOURCES THAT CAN HELP CLIENTS AND FAMILIES UNDERSTAND AND PREVENT RELAPSE.

WHAT DOES RECOVERY MEAN?

Recovery is a process—it is learning to successfully identify warning signs, cope differently with triggers, manage lapses/relapses, and gain control over symptoms and one's life. It involves managing the negative impact of mental health and/or an addiction despite its continued presence. Research indicates that with a proper treatment plan and support, most people recover. Recovery involves sticking with the treatment or service plan and working with the MISSION team and other treatment providers to make adjustments if something is not working. Encourage your family member to be involved in his/her treatment planning and also check in with your family member about his/her treatment plan. A common factor in recovery is social support. This is where you as a family member can play a significant role.

SLIPS AND RELAPSE

Slips and relapse are common for people with mental health disorders, substance use disorders, or co-occurring substance use and mental health disorders. It is important that you and your loved one recognize this. Slips or a relapse *does not* mean failure. Instead, they should be seen as opportunities to learn how to better handle the illness.

Slips and relapses are different concepts. For example, for substance use disorders, a slip refers to a situation where an individual briefly returns to alcohol or drug use but managed to stop again before they slip back into addiction. If the person can identify the slip and what triggered it, they will be able to prevent a slip turning into a relapse. Relapse is most often used to describe "slipping or sliding back to a former condition like substance use or state of poor mental health, especially after improvement or seeming improvement."

EXERCISE 3.1
IDENTIFYING TRIGGERS FOR SLIPS AND RELAPSE

What's it for?

Triggers are events, stressors, and/or situations that can set the stage for slips and relapse. Knowing and understanding the triggers help you and your loved one come up with a plan to manage known triggers differently and more effectively.
Being mindful and knowing what may trigger your loved one can help you react in a way that can help him/her avoid slips and relapse. When your loved one is feeling triggered, this action plan can help you and your loved one manage the situation and engage in helpful steps to avoid slips or relapse. Triggers may change, so it is also important to review your management plan together and with your MISSION team member.

How to use it?

Think back to previous episodes and what was going on just prior to your family member becoming ill. What was going in their life – at home, work, or school? Were there any important events or unusual stressors at the time? Can you or your family member identify any situations that were 'high-risk'—highly stressful or led them to engage in problematic behaviors (e.g., drinking, stopping medication, etc.)?

SLIPS AND RELAPSE TRIGGER MANAGEMENT PLAN

Trigger	Ways to Manage the Trigger
	What can I do?
	What can my loved one do?
	What can I do?
	What can my loved one do?
	What can I do? **What can my loved one do?**
	What can I do?
	What can my loved one do?
	What can I do?
	What can my loved one do?

FAMILY MEMBER RELAPSE PREVENTION CONTRACT

Families sometimes feel they ride an emotional roller-coaster—when their family member is doing well, they're hopeful and optimistic; when their family member relapses, they are often devastated and hopeless. As a family member, you may become depressed, angry, and begin to engage in your own negative behaviors.

Have you been on a plane and heard the flight attendant tell you to put on your oxygen mask first in a case of emergency? What does that request really mean? Simply put: If you don't put your mask on first, you won't be there for all those other people when they need you.

Our natural tendency is to do for others, because we are caring, loving, nurturing, responsible, supportive, and competent people. However, just like the oxygen mask, we need to take care of ourselves so we can effectively take care of our loved ones.

Taking care of one's self is self-care. It is the act of restoring and maintaining physical, emotion, and spiritual wellness. Self-care can range from exercise, taking a nap, having a support system, praying, etc. It's important because if you don't do it, you can experience depression, resentment, and even physical illness. Leaving you little to no resources to help others.

Self-care is the oxygen mask you need. It is an opportunity to breathe in new life and energy. Self-care often is the first thing to disappear during a time of crisis, like a family member's hospitalization or arrest; the times you need it the most. Therefore, it is strongly encouraged to practice a bit of self-care everyday so it becomes so routine that you can count on it even during the "tough" times.

EXERCISE 3.2
SELF-CARE FAMILY RELAPSE PREVENTION ACTION PLAN

What's it for?
Think about your own needs as a family member of a person with a COD. It is essential for you to take good care of yourself and to develop a self-care regimen. Increased stress, anxiety, depression, fatigue, or other symptoms may accompany your family member's relapse, it is important for you to identify these signs and take steps to take care of yourself. In the event that your loved one suffers a relapse, it is important to develop a healthy way to manage it. Working with the MISSION team, you can put a plan in place to use to remind yourself of the steps you need to take to care for yourself. During your past experiences with your loved one during a relapse you may not have known how to balance supporting your loved one and caring for yourself; this action plan may assist you in finding that balance.

How to use it?
Write down a personal self-care plan to follow in the event that your family member suffers a relapse. You may perhaps do this for other family members impacted by the mental health and/or substance use disorder(s) experienced by your loved one.

SELF-CARE FAMILY RELAPSE PREVENTION ACTION PLAN

"If my family member suffers a relapse, I will take the following steps to care for my…"

Physical Well-Being:

Emotional Well-Being:

Social Well-Being:

Spiritual Well-Being:

MODULE 4: *COMMUNICATION*

THE GOAL OF THIS SECTION IS TO PROVIDE FAMILIES WITH THE SKILLS THEY NEED TO DISCUSS THEIR THOUGHTS, FEELINGS, NEEDS, AND PROBLEMS – CONSTRUCTIVELY AND SUCCESSFULLY. THIS WILL HELP TO ENSURE THAT ISSUES ARE DISCUSSED AND THAT ACTION IS TAKEN TO RESOLVE PROBLEMS. THIS MODULE MAY ALSO INCLUDE COMMUNICATION AND PROBLEM SOLVING ACTIVITIES FROM THE MISSION PARTICIPANT WORKBOOK.

COMMUNICATION OF PRAISE

Letting others know that what they do pleases us and encourages them to do more of those actions. Praise involves communication of positive feelings for specific good behavior. We all need compliments about our behaviors that are pleasing, kind, or helpful. Hearing you have done something well builds self-esteem. Small accomplishments are important, especially when someone is struggling with issues such as depression, substance use, unstable housing, etc.

SOME TIPS FOR PROVIDING PRAISE

- ✓ Look the person in the eye
- ✓ Use a friendly and warm tone
- ✓ Be specific about what exactly you are pleased with (i.e., "*I really appreciate you shoveling Mom's driveway. It meant the world to her and it really helped me out.*")
- ✓ State how it made you feel
- ✓ Be sincere and authentic

EXAMPLES OF POSITIVE BEHAVIORS TO PRAISE

Looking good/healthy
Going out with non-using friends or to substance-free events
Handling a difficult situation well
Showing interest and being present
Being on time
Honoring commitments
Being considerate
Pushing beyond his/her comfort zone
Getting out of the house

EXERCISE 4.1
PRACTICING PRAISE LOG

What's it for?
Think about something positive your loved one has done and practice giving praise. The MISSION CM and PSS will model how to do this and then you and your family member can practice in session. During the week or at any time of contact, continue practice of giving praise. Giving praise is another way to keep the positivity during the challenges your loved one is experiencing.

How to use it?
Use the following log to keep track of what your family member or partner did and how you gave praise in return.

PRACTICING PRAISE LOG

Day	What Exactly Did They Do	What Exactly Did You Say

RESOURCES FOR FAMILY MEMBERS

HOMELESS AND MISSING: A GUIDE FOR RELATIVES[6]

People with co-occurring substance use and mental health disorders cannot always communicate their thoughts clearly or understand what others are saying to them. In confusion, some will retreat. Others have grandiose ideas and cannot make sound judgments. Sometimes they leave secure surroundings, such as the shelter, and they become missing. They can be gone for days, weeks, months or years. Often they leave behind distraught families, whom are desperate to return their loved ones to another safe place.

The following information provides some helpful tips to assist you in locating a missing homeless relative with COD. If you have a missing loved one with COD, the following steps and information may be helpful:

1. Notify your local police immediately of your missing loved one and provide them with all the information you can. If the person remains missing more than three (3) days, ask the police to place them on the FBI's National Computer (NCIC) list as an ***endangered adult***. This computer network provides information nationwide. The network will give you a police number to use when searching for your relative.

2. When a missing person with a mental health disorder who is 21 years of age or older is located the police and other agencies cannot hold or ask that they be held against their will if they have not committed a crime. No one has the authority to force the person to seek aid or medical care against his or her will unless there is a medical guardianship or court order specifying what action to take when the individual is found.

3. Prepare a one-page flyer which includes a picture of the missing person, along with his or her vital statistics (age, height, weight, hair color, eye color, clothes last seen wearing, last known location, etc.).

The following list of groups, agencies, and organizations might be able to help if you contact them:

- **Local NAMI Affiliates**
  Each local affiliate has a NAMI Affiliate Directory. Call your local affiliate and ask for a NAMI contact person in the state where the person was last seen. Send a description sheet or flyer to the local NAMI affiliate for circulation at their meetings.
- **Churches, Synagogues, & Houses of Worship**

[6] National Alliance on Mental Illness (Gwinnett, 2000)

Houses of worship are often used as shelters and soup kitchens. Many homeless individuals contact the church they were affiliated with during their childhood. Ministers, priests, rabbis or other clergy may well recognize an adult who was once a child of their congregation.

- **College Campuses**
  Colleges and technical schools have lounges and cafeterias. Some of them are considered comfortable hangouts because they offer a place out of the cold or heat, food is available, there is human contact, and anonymity can be found among the crowd. Take a picture of the missing individual to the cafeteria and ask a staff member to help you. There may be a bulletin board where notices can be posted. Students have been known to be mistrustful of parents looking for their kids, so emphasize the nature of your search.
- **Community Health Centers**
  Community health centers often treat people regardless of income or insurance. If your family member is traveling without insurance or cash and needs medical attention they will usually use the local hospital emergency rooms. If the medical attention is not an emergency, they may be referred to a local community health center. The community health centers have all kinds of names: free clinics, Health Care for the Homeless, Blue Bus, Health Network, AIDS Center, etc. They usually have community bulletin boards where you can hang the missing person's picture or your flyer.
- **Creditors**
  The person may have relocated and may be making payments on a loan or applying for credit. Get a list of previous creditors.
- **Hospitals**
  Get a list of the public and private psychiatric wards from the local mental health administrator. Emergency room personnel usually remember people who come in from the streets. Be aware that they may not give you any information due to confidentiality laws, but you can notify them that you are a relative of the missing person who is interested in their welfare.
- **Public Library**
  The local library is a comfortable place for many people who are homeless. Many of the homeless shelters are not open during the day so people often use local libraries to stay warm, use the bathrooms, read, hang out, and blend in with everyday life. The janitors know who uses the building for more than just reading.
- **Mass Transportation Centers**
  Bus and train stations are somewhat similar to libraries in comfort and convenience for the homeless. Unlike libraries, however, bus and train depots are not as easy to hang out in. The bathrooms aren't as clean and loitering is frowned upon. Airports are the least used unless of course the missing individual has access to airfare.
- **Free Meal Sites**
  Most urban areas have well-organized meal sites. Find one and ask about the others. People use meal sites most often near the end of the month and may travel from site to site. Everyone seems to know the regulars by name and face.
- **Red Cross**

Check your local phone directory for contact information.

- **Salvation Army**

  For a small fee the Salvation Army will file a missing person's report in their national computer system. A missing person's report will not be filed for anyone missing less than 3 months. Many Salvation Army locations also have shelters. Call the nearest Salvation Army regional office for further details:

  - Southeast US: 800-939-2769
  - Northeast US : 800-315-7699
  - Central US: 847-294-2088 (Chicago)
  - Western US : 800-698-7728

- **Shelters**

  There are public and private homeless shelters. Call your local Salvation Army, YWCA, YMCA, or Social Service Agency for a list of shelters in the area. Most shelters maintain a list of those persons who have used the shelter and will usually tell you if they are currently living there or not.

- **Social Service Agencies**

  Someone who is homeless will often be referred to the Social Service Agency for General Assistance (welfare). The local Health and Human Services Office almost always runs these programs. Call an intake worker and ask who you would see if you came to town with no money and no housing. Most public agencies will tell you if your family member has been on assistance. However, your contact person at a homeless shelter may ask the same questions and get more answers.

4. In your first meeting with the MISSION CM and/or PSS you may have been asked to sign a release of information form that allows you to contact them in the case of an emergency. Contact your loved one's MISSION CM and PSS if you have a concern that they have gone missing. The staff may help you problem solve ways in which you can find your loved ones. Please keep in mind they will not be able to provide details about your loved one's treatment and/or whereabouts.

WHAT TO DO WHEN THE MISSING PERSON IS FOUND

1. **General Information**

   Services for persons with mental health disorders vary widely from area to area. Finding appropriate services for the missing individual at a distance will probably be a frustrating experience. Your approach should be tailored to the missing individual's condition and wishes, as well as to the reality of inadequate services in many areas. Once a police report has been made in your city and the person has been found in another city, the police in the receiving city may be willing to transport the individual to the hospital for evaluation and treatment. They may also have a social service department themselves or provide linkages to other sources of assistance. Some states have interstate pacts between Mental Health Systems which may provide transportation

from one system to another. Call and ask your Mental Health Center or state Mental Health office for more information.

2. **Telephone Calls**
   When accepting a collect call from a missing person you may first want to ask where the call is coming from. This may not be advisable in all cases.

3. **Money** While NAMI or MISSION does not recommend or endorse the following companies, this information may be helpful when trying to get money to a missing relative.
   - **Western Union –** If a person is out of funds and you feel comfortable sending them money, you may do so through a Western Union Office using a prearranged code. Professionals suggest that you send as little money as possible at a time. This encourages on-going communication.
   - **ComCheck –** ComCheck, a company of Comdata Network Holdings, Inc., allows people to send money to over 6,000 truck stops throughout the United States. ComCheck takes only Visa, MasterCard, or cash at designated locations. In order to pick up money, the person receiving it at the truck stop will need to show identification. The toll-free number for Com Check is 1-800-833-9110. They will be able to answer any other questions you may have about their service.

4. **Travel**
   - **Airlines –** A pre-paid ticket can be purchased with cash or credit card from your local travel agent, over the internet, by phone, or directly from the airline counter at the airport. There is a non-refundable service charge. On the ticket you may specify who has the right to a refund (if any) if the ticket is not used, or whether it is exchangeable (in accordance with the rules and regulations set by the airline). Ask your travel agent for details.
   - **Train –** A pre-paid ticket may be purchased from your travel agent or ***Amtrak*** counter. There is a non-refundable service charge. This service is not available at all locations. In order to purchase a pre-paid ticket, both the point of origin and local Amtrak counters must be open. An I.D. is necessary for ticket pick-up. I.D. can be any legal document with the name of the traveler on it. Call your local Amtrak office for more details.
   - **Bus –** A pre-paid ticket may be purchased from your local ***Greyhound*** station. There is a non-refundable service charge. This service is not available at all locations. In order to purchase a pre-paid ticket, both the point of origin and the local Greyhound station must be open. I.D. is preferred, but the ticket can be picked up with a prearranged code. Other bus companies may have similar arrangements.
   - **Travelers' Aid International (TAI) –** A **TAI** office is usually located in a bus or train station. Try to locate the one nearest to you and become familiar with this organization. They can prove to be your best source of help with transportation needs. . TAI can sometimes get charity-rate bus tickets (25% off the regular price). Although policy varies from state to state, in many cases it is possible to send a person home at no cost, although this may

take a few days. TAI can generally provide for the person's basic needs during this interval. In addition, TAI can also board your relative on the bus, train or plane (during working hours) and make protective travel arrangements with other TAIs in route. TAI suggests that when at all possible send very little actual cash. If your relative is currently delusional, he or she may use very poor judgment in spending it or get robbed or "conned" out of the money. If possible, work through a TAI office and deposit money (in your city) or make arrangements with a TAI in the city in which the missing individual finds him/herself. They will disperse the funds to assist in buying food, getting a hotel room or buying a ticket.

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APPENDICES

The following are exercises that were extracted from the MISSION Participant Workbook. These are exercises that your loved one has worked through or is working on as part of their recovery process with his/her MISSION team. You may also find these exercises helpful in improving your relationship with your loved one or you may even find it useful to work through them together (the corresponding page numbers for the exercise in the MISSION Participant Workbook have been provided). The MISSION Participant Workbook along with other resources can be found at: http://www.missionmodel.org/manuals-1/ .

APPENDIX A: LIFE PROBLEM AREAS

What's it for?
To help you see where the problems are in your life that you want to change.

Why does it work?
Sometimes things can seem overwhelming, but just naming them can help.

When to use it:
You can consult the list you did in DRT sessions anytime so you can see how things are changing for you and what areas need more work.

How to use it:
Every few months, you might want to look at the problems you listed in session and ask yourself:

1. What's getting better? What helped me change?
2. What's about the same? Why? What else could I do to make it better?
3. What's worse? Why? What can I do to change that? Who could help?

Corresponding Pages
Found on pages 65-67 of the MISSION Participant Workbook.

PERSONAL LIFE PROBLEM AREAS WORKSHEET
(*SAMPLE*)

LIFE AREAS	PROBLEMS
Substance Use	*Use cocaine every weekend for 2 months; must stop* *Drink heavily* *Wife objects to occasional marijuana*
Family	*Arguments with wife – frequent!* *Very angry with my wife* *Don't get along with Ben (15 year old stepson)*
Financial	*Mother ill with cancer* *Last job was 5 months ago due to coke use – so money is very tight* *Wife is working but paying the bills is tough*
Psychological	*Angry a lot* *Feels depressed*
Social	*No problems*
Legal	*No problems*
Employment	*Unemployed – looking for work*
Health	*No problems*
Spiritual/Religious	*Anger at higher power* *Lack of meaning in life*

PERSONAL LIFE PROBLEM AREAS WORKSHEET

LIFE AREAS	PROBLEMS
Substance Use	
Family	
Financial	
Psychological	
Social	
Legal	
Employment	
Health	
Spiritual/Religious	

APPENDIX B: DECISIONAL BALANCE

What's it for?
If it were easy to make changes in our behavior, we probably wouldn't be doing a lot of the things that make trouble in our lives. It isn't easy because the same things that cause problems also have some benefits. We have to look honestly at what we're getting out of the behavior and what's driving it. Then maybe we can think of another way to meet the same need that doesn't cause us so much trouble.

Why does it work?
We can't just change by snapping our fingers. We have to decide. This tool helps us lay out and look at why we're doing what we're doing, what benefits it gives us, and what problems it's causing.

When to use it:
When there is a behavior you feel ambivalent about changing, even though it has a definite down side.

How to use it:
Identify the behavior you're thinking about changing (for example, substance use) and write down honestly the benefits and the negative consequences of that behavior.

Corresponding Pages
Found on pages 73-75 of the MISSION Participant Workbook.

SHOULD I STAY THE SAME OR CHANGE MY BEHAVIOR? WORKSHEET *(SAMPLE)*

Description of the Behavior: *Drinking*

	Maintaining My Current Behavior	Changing My Current Behavior
BENEFITS	*I can keep the same friends and enjoy hanging out with them.* *I like getting loose and letting it all go.*	*I could probably hold a job.* *I wouldn't lose my temper and hurt people.*
NEGATIVE CONSEQUENCES	*I keep getting fired.* *Sometimes I get into fights.* *I hit George pretty hard once and he's just a kid.*	*I couldn't hang out with the same friends in the same places because I'd need to drink.* *I'd have to find some other way to relax and let go.*

SHOULD I STAY THE SAME OR CHANGE MY BEHAVIOR? WORKSHEET

Description of the Behavior: _____

	Maintaining My Current Behavior	Changing My Current Behavior
BENEFITS		
NEGATIVE CONSEQUENCES		

APPENDIX C: DEVELOPING STRONG COMMUNICATION SKILLS

What's it for?
As we become stronger in recovery we are increasingly able to have healthy relationships. A critical element in relationships that work well and feel good is skillful communication. The better we are able to communicate what we think, what we need, and what we are experiencing, the more likely we are to be understood and to have our needs met. The better we are at listening well to others, the more likely it is that others will show us the same empathy and respect in return.

Why does it work?
The simple lists that follow can do nothing on their own. But if you read them through thoughtfully and relate them to your own life, they can help you identify areas where you can make improvements that will help you have better relationships with the people that matter to you.

When to use it:
It is especially helpful to review this material when you're working on improving communication with people who are important in your life – whether they are your significant other, family members, friends, MISSION case manager or peer support specialist, counselors or clinicians or co-workers.

How to use it:
Review the "Elements of Good Communication" and "Elements of Poor Communication." Which patterns of good communication would you like to adopt? Which elements of poor communication apply to you?

One way to change your patterns of communication for the better is to pick just a couple of changes to practice at a time. Stay conscious of them as you interact with other people and keep it up until the new behavior becomes a part of you. Then try to fix more new ones. You may want to record your experiences in your journal.

It is important to remember that people who are stressed or who have some problems of their own may not respond to your efforts to communicate well with healthy communication. They will make their own choice, just as you make yours. Don't give up. Keep your commitment to a strong recovery and strong, respectful, honest relationships

Corresponding Pages
Found on pages 76-78 of the MISSION Participant Workbook.

ELEMENTS OF GOOD COMMUNICATION

Be polite and considerate. Treat your partner with the same basic respect you show towards acquaintances!

Stop and think before commenting on things that bother you. Decide not to bring up issues unless they are really important.

Decide not to "kitchen sink" or bring up other problems when discussing one problem. Try to resolve one issue at a time.

Make sure to **express lots of positive feelings** and to reward your partner rather than taking things for granted when they are going well.

Decide on **fun activities** together.

Go out of your way to **offer to do tasks around the house.** Give to the other without expecting anything back and without saying "I'll do it only if you do."

Avoid destruction criticism or complaining. Phrase change requests in a positive way. Avoid complaining just for the sake of complaining.

Use good **listening skills**. Look at your partner when he/she speaks to you. Don't interrupt! Take turns talking and listening. Validate what your partner says even if you don't agree ("I can understand why you're worried about my spending a lot of money. Maybe we can decide together how much cash I should have each week.").

Try to be **assertive – not aggressive**. Think about what you want before you speak. Start with a positive statement and then use "I" statements. For example, instead of, "You're spendthrift and we'll end up in the poorhouse. Try being a responsible adult!" try, "I'm very worried about the amount of money we're spending. I would like to try to figure out a way we can stop spending money and start saving. What do you think?"

ELEMENTS OF POOR COMMUNICATION

1. **Not listening:** Not looking at your partner when he/she is speaking or ignoring what he/she said.

2. **Mindreading:** Assuming you know what the other person is thinking, and basing your response on that rather than checking out what they are really thinking or what they mean.

3. **Cross-complaining:** Complaining in response to your partner's complaint. "I hate it when you don't come home when you say you will." "Well I hate when you complain all the time."

4. **Drifting away from the point of the conversation:** Bringing up another issue before resolving the first one.

5. **Interrupting:** Talking over your partner or not letting him/her finish a sentence.

6. **"Yes, butting":** Agreeing yet avoiding the issue. "Yes, but what about when you embarrassed me that day" or "yes but you've embarrassed me lots of times…"

7. **Heavy silence (standoff routine):** Trying to punish the other person by ignoring him/her.

8. **Escalate arguments:** Becoming louder and louder, and more and more vicious.

9. **Never calling a time out or asking for feedback:** Forgetting to stop the conversation if it is getting too heated. Forgetting to ask your partner what he/she really meant.

10. **Insulting each other (character assassination):** Calling each other names, such as "you always…you never…you're a…"

11. **Not validating:** Saying things like "That's ridiculous…" You're crazy creating problems. If you would just leave me alone everything would be okay." "You're crazy to think that."

12. **"Kitchen sinking":** Throwing in more and more accusations and topics until you don't know what it is you are arguing about.

13. **Not taking responsibility:** Always talking about what your partner is doing wrong instead of what you may be doing wrong.

APPENDIX D: RELATIONSHIP-RELATED TRIGGERS

What's it for?
To help identify some of the things that other people do that can trigger your substance use and understand why you react the way you do.

Why does it work?
Sometimes we don't really "get" what's happening with people we care about. They can always get under our skin. It helps to get specific about what the triggers are that really get to us and say honestly what it is we are really feeling when those things happen or those words are said.

When to use it:
When you feel an urge to use, you can think about what just happened that set it off. If there's another person involved you care about, maybe they will be willing to change what they're doing in some way so it doesn't get to you so much.

How to use it:
Fill out the first three questions on the worksheet. When you're feeling calm and ready to listen, approach the other person. Explain the trigger and how it makes you feel. Find out if the other person sees a way to change what they are doing. Or maybe you'll understand why they do this better and it will not bother you so much.

Corresponding Pages
Found on pages 93-97 of the MISSION Participant Workbook.

RELATIONSHIP-RELATED TRIGGERS WORKSHEET
(SAMPLE)

List some Relationship-Related Triggers that you can think of:

1. *My girlfriend Aliyah won't lend me money when I really need it.*
2. *My brother Malik keeps trying to get me to go back to school.*
3. *My children keep asking me to buy them things that I can't afford.*

What kinds of things do you think and feel when faced with these triggers?

1. *I get furious when I can't get money. Also frustrated, helpless, and alone.*
2. *I get stressed out when I think about school. Maybe it would help me get a better job, but I wasn't a good student before. I don't want to be humiliated. I feel jealous of Malik, I guess – things always seemed so much easier for him.*
3. *I feel guilty and ashamed that I can't buy my kids what they want. Sure, they have the necessities, but sometimes I feel like they just keep paying for my mistakes*

What might you typically have done then?

1. *I usually yell at Aliyah and leave the house.*
2. *I told Malik to just shut up and leave me alone.*
3. *I eventually give in to the kids, then get even more stressed out about whether or not we'll have enough money to make it through the rest of the month.*

To Spouse, Family Member, or Friend:

Can you change anything about these triggers to make them less important?

1. *I shared this page with Aliyah and asked her why she doesn't want to lend me money when I need it. She told me she couldn't lend me money and have me drink it away. But she says after I've been sober at least 6 months, she could help me out a little if I need it sometimes, just as long as I get a job and pay it back.*

2. *I explained to Malik that I'm just not ready to think about school right now, and he agreed to stop asking me about it.*

3. *I spoke to my kids about our need to budget and encouraged them to get a paper route and mow lawns in the neighborhood. This can be a good opportunity to teach them about the value of a dollar.*

RELATIONSHIP-RELATED TRIGGERS WORKSHEET

Spouses, friends, and family members may have strong emotions about your substance use: anger, frustration, desperation, and sadness. They may use a variety of methods to cope with it. Sometimes the ways they choose to cope "backfire" – that is, increase the chances that you will go use or use more.

Sometimes, situations that involve spouses, friends, or family members serve as triggers for use, such as attending a social function together and facing an open bar.

REMEMBER:

- Spouses, friends, and family members are not to "blame" for these triggers!
- Ultimately, it is the personal responsibility of the substance user to control his or her use behavior, regardless of the trigger!

BUT:

- Is there anything the spouse, friend, or family member can do differently to eliminate or change certain triggers for the user?

EXAMPLE: Partner related Chains

> One of the children was suspended from school today for fighting another child. The wife received the call from the school, had to pick up her son, and is angry at him for his attitude about the event, which seems to be "Good – I get the day off." The husband walks in the door, and she starts to tell him what happened. His reaction is "It's no big deal, and it's good that he stood up for himself." She yells at him, "That is so typical of you. No wonder your son is in trouble – he's just like you – no respect for rules or laws. If you hadn't been using drugs for so long, maybe you'd realize that this is a bad situation." He stares at her, feeling more and more edgy and angry as she continues to yell. Then he turns around, leaves the house, and goes to his cousin's, who always has some dope that he can cop.

In this example, the partner complaining about irresponsibility because of drug use is a trigger for further drug use. This is a partner-related trigger. After using, short-term positive consequences might include avoiding dealing with the household problems and not being bothered by his wife. Long-term negative consequences might include feeling depressed, guilty, and angry with himself for having no self-control over drug use and being lazy or for not dealing with family problems as they come up.

List some Relationship-Related Triggers that you can think of:

1_____

2_____

3_____

4_____

What kinds of things do you think and feel when faced with these triggers?

1_____

2_____

3_____

4_____

5_____

What might you typically have done then?

1_____

2_____

3_____

4_____

To Spouse, Family Member, or Friend:

Can we change anything about these triggers to make them less important?

1_____

2_____

3_____

APPENDIX E: CHANGING UNHEALTHY THINKING PATTERNS

What's it for?
To help think about and change the ways you think about your problems.

Why does it work?
The thinking patterns we get used to can keep us from changing, undermining our attempts to change. But if we build new ones and practice them, we can feel better.

When we change the way we are thinking, we change the way we feel and act. But we cannot pull this off until we go through an exercise of listening to ourselves and really hearing what we are telling ourselves – and questioning it. We need to begin to recognize when we are giving ourselves friendly counsel and when the old ways of thinking can keep us in a trap.

When to use it:
This is a good exercise to use every once in a while as you move through recovery to see where you are making progress, where you need to remind yourself of something you want to change, and where you are falling back into old habits.

How to use it:
Read through the examples of old ways of thinking from your DRT sessions, and read through the worksheet in which you thought about how you wanted to change. How are you doing? Have you had the old negative thoughts lately? Are you beginning to use the new messages more? If not, it is time to bump up the level of consciousness of what you want to change and let it happen.

Corresponding Pages
Found on pages 98-108 of the MISSION Participant Workbook.

TYPES OF UNHEALTHY THINKING

- **ALL OR NOTHING THINKING:** You see situations in black or white terms – if your performance is not perfect, you see yourself as a total failure.

- **OVERGENERALIZATION:** You see one negative event as part of a never ending pattern of defeat.

- **MENTAL FILTER:** You pick out one negative detail and dwell on it exclusively.

- **DISQUALIFYING THE POSITIVE:** You reject positive experiences by insisting that they "don't count."

- **JUMPING TO CONCLUSIONS:** You make negative interpretations even though there are no definite facts to support the conclusion. (This includes mind reading and the "fortune teller error" in which you anticipate things will turn out badly and are absolutely certain that you are right.)

- **CATASTROPHIZING OR MINIMIZING:** You exaggerate the importance of things (such as your own mistakes or another's accomplishments), and then either magnify your own faults or minimize your own strengths.

- **"SHOULD" STATEMENTS:** You have rigid categories of what you should and should not do, and you feel guilty if you do not live up to your standard. You may also feel angry, resentful, and frustrated with others if they do not live up these same standards.

- **LABELING:** You attach labels to yourself and others because of errors (for example, "I'm a loser").

- **"WHAT IF":** You spend time and energy worrying or thinking about possible events that might happen. "What if my wife is in an accident?" "What if I get sick and can't work?" It is appropriate to plan for things that really might happen, but it is not helpful just to worry.

Common types of thinking errors that spouses of individuals with substance use may use:

- **ALL OR NOTHING THINKING:** "My partner is being good, or he's being bad."

- **OVERGENERALIZATION:** "If he has one urge to use, or has one bad day in which he uses he's hopeless (or unmotivated)."

- **"SHOULD" STATEMENTS:** "I should be able keep him from going back to prison."

- **PERSONALIZATION:** "His drug problem is all my fault."

- **IDENTIFYING "STINKING THINKING" WORKSHEET**
  (SAMPLE)

Experts believe that how we think about things affects the way we feel. Mental health professionals call this cognitive distortion; Twelve Step programs call it "stinking thinking." Negative and self-defeating ways of thinking can make you depressed or anxious, and can set you up for relapse. It can also lead you to put impossible demands on your relationships. Below are some examples of stinking thinking – how many are typical of you? Write some examples from your own experience.

Black and White Thinking: Does everything seem absolutely true or false? Right or wrong? Great or awful?

Example: *"I relapsed again; I am a total failure. I can't do anything right."*

Examples from my experience: *I've relapsed so many times in the past, I'll never be sober for any decent length of time.*

Projecting: Do you always predict the worst? If one bad thing happens, do you imagine the worst possible outcome? Or as they say in AA, do you "dwell in the wreckage of the future."

Example: *"If I open my mouth everyone will think I'm stupid and they'll hate me."*

Examples from my experience: *In group yesterday, I just couldn't find the words for what I wanted to say. After that, I kept telling myself the other guys in the group think I'm a fool.*

I-can't-take-it!: Do you convince yourself you can't tolerate frustration or discomfort? Do you think you are going to fall apart if you feel unhappy or anxious?

Example: *"I have to use when I get mad or I will just fall apart."*

Examples from my experience: *When I went through my divorce, I convinced myself that I couldn't live without my wife, and I was a complete wreck.*

Emotional Reasoning: Do you think that your moods always reflect reality? If you feel angry does it mean that others are wrong? As they say in AA, "how I feel is not the best indication of how I am doing."

Example: *"I just know that things aren't going to work…I can feel it."*

Examples from my experience: *I was really upset with my boss for giving me fewer shifts. I thought she was dissatisfied with my work, and I was scared that I was going to get fired.*

IDENTIFYING "STINKING THINKING" WORKSHEET

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_____

_____

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_____

_____

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Examples from my experience: _____

_____

_____

COMBATING "STINKING THINKING" WORKSHEET
(SAMPLE)

Black and White Thinking

Example: *"I relapsed again; I am a total failure. I can't do anything right."*

Healthier Response: *"Relapse is serious, but doesn't mean I am a total failure."*
OR
"I have a choice about whether I use drugs today."

Projecting

Example: *"If I open my mouth everyone will think I'm stupid and they'll hate me."*

Healthier Response: *"Why do I care so much what other people think of me? I am here to help myself, not to keep them happy."*
OR
"Everyone makes mistakes sometimes when they talk. People won't hate me for it."
OR
"I don't need to be so hard on myself. People probably aren't judging me that harshly."

I-can't-take-it!

Example: *"I have to use when I get mad or I will just fall apart."*

Healthier Response: *"I can deal with this. I am stronger than I think I am."*
OR
"I may feel bad, but that doesn't mean I have to use. I have a choice."
OR
"Relapsing will feel worse than getting mad."

Emotional Reasoning

Example: *"I just know that things aren't going to work…I can feel it."*

Healthier Response: *"Just because things feel bad doesn't mean they are bad."*
OR
"I can control my behavior, but not the results."
OR
"I need to live in today. Most things I worry about will never happen."

COMBATING "STINKING THINKING" WORKSHEET

Black and White Thinking

My Example**:** _____

_____

_____

My Healthier Response**:** _____

_____

_____

Projecting

My Example**:** _____

_____

_____

My Healthier Response**:** _____

_____

_____

I-can't-take-it!

My Example**:** _____

_____

_____

My Healthier Response**:** _____

_____

_____

Emotional Reasoning

My Example**:** _____

_____

_____

My Healthier Response**:** _____

_____

_____

PRACTICING NEW WAYS OF THINKING WORKSHEET
(SAMPLE)

Situation or Event	Automatic Thoughts	Emotion(s) Felt During the Situation or Event	Behavioral Response	Adaptive Thoughts	Potential Emotion Associated with the Adaptive Thoughts	Potential Behavioral Response
Describe the situation or event that was upsetting.	What were you thinking at the time of the event?	What emotion(s) did you feel at the time?	How did you react to the situation?	What are some other ways of thinking about the event?	What emotion(s) might be associated with this new way of thinking?	How would this new way of thinking and feeling affect how you might react to a similar event in the future?
I saw my old boyfriend at a wedding with a really nice looking girl.	*I'm a loser. I'm fat. I'll never find someone who really loves me.*	*Rejected, sad, hopeless.*	*I wanted to take some drugs. I didn't but I left the reception early and went home and cried.*	*He's just one guy. I will find someone else. Being in recovery will help.*	*Patience. More confidence.*	*I might be able to stay and have fun – and maybe meet someone new, who knows?*

PRACTICING NEW WAYS OF THINKING WORKSHEET

Situation or Event	Automatic Thoughts	Emotion(s) Felt During the Situation or Event	Behavioral Response	Adaptive Thoughts	Potential Emotion Associated with the Adaptive Thoughts	Potential Behavioral Response
Describe the situation or event that was upsetting.	What were you thinking at the time of the event?	What emotion(s) did you feel at the time?	How did you react to the situation?	What are some other ways of thinking about the event?	What emotion(s) might be associated with this new way of thinking?	How would this new way of thinking and feeling affect how you might react to a similar event in the future?

APPENDIX F: CHANGING IRRATIONAL BELIEFS

What's it for?
To help notice and change things that we believe get in the way of recovery.

Why does it work?
Human beings are pretty smart, but we're also smart enough to lie to ourselves and get away with it sometimes. We just have to catch ourselves at it and say, "no way!"

When to use it:
This is good to do whenever we just did something self-destructive or hurtful to someone else. That's usually when we tell ourselves something that isn't true to justify what we did, or to make sense of an action that really just wasn't a good or fair choice.

How to use it:
Read through the list of irrational beliefs and you'll get the idea. Think about which ones ring true and put them in your own words, or think of other things you tell yourself. Write them down, just the way you think them sometimes. Then write down a true statement, one that will be healthy and help you recover.

Corresponding Pages
Found on pages 109-112 of the MISSION Participant Workbook.

TEN POPULAR IRRATIONAL BELIEFS

When we live by rigid, irrational rules, we set ourselves up for disappointment, overreaction to problems, and needless unhappiness. When we challenge those beliefs and think of how we want to change, we take another step toward recovery and make our lives a little easier. In fact, a lot easier. And more fun!

Here are ten irrational beliefs that people often believe anyway.

1. I must be loved, or at least liked, and approved of by every significant person I meet.
2. I must be completely competent, make no mistakes, and achieve in every possible way, if I am to be worthwhile.
3. Some people are bad, wicked, or evil, and they should be blamed or punished for this.
4. It is dreadful, and feels like the end of the world, when things aren't how I would like them to be.
5. Human unhappiness, including mine, is caused by factors outside of my control, so little can be done about it.
6. If something might be dangerous, unpleasant, or frightening, I should worry about it a great deal.
7. It is easier to put off something difficult or unpleasant than it is to face up to it.
8. I need someone stronger than myself to depend on.
9. My problem(s) were caused by event(s) in my past, and that's why I have my problem(s) now.
10. I should be very upset by other people's problems and difficulties.

PERSONAL IRRATIONAL BELIEFS WORKSHEET
(SAMPLE)

Irrational Belief	Possible Modification of Belief
If my father hadn't left, I'd be different today. He left because I wasn't a good enough kid. A kid that didn't have a father just doesn't have a chance. Nothing will make it right.	*It was hard to lose my father so young, but it wasn't my fault. I have found other people to admire and help me, and I've really accomplished some things. It's up to me now.*

PERSONAL IRRATIONAL BELIEFS WORKSHEET

Irrational Belief	Possible Modification of Belief

APPENDIX G: ACRONYMS

Acronym	Phrase
AA	Alcoholics Anonymous
AHAR	Annual Report to Congress
APA	American Psychiatric Association
CM	Case Manager
COD	Co-occurring Disorder
DRT	Dual Recovery Therapy
FBI	Federal Bureau of Investigation
HUD	Housing and Urban Development
LGBT	Lesbian, Gay, Bisexual, Transgender
MISSION	Maintaining Independence and Sobriety through Systems Integration, Outreach, and Networking
NAMI	National Alliance on Mental Illness
NCIC	National Crime Information Center
PSS	Peer Support Specialist
PTSD	Post-traumatic Stress Disorder
SUD	Substance Use Disorder
TAI	Travelers' Aid International

APPENDIX H: GLOSSARY

ADLs- An acronym for activities of daily living, such as shaving, showering, budgeting, and grocery shopping.

Bias- Unintentional or intentional preference, sometimes discriminatory.

Community integration- Working with individuals to comfortably introduce, or reintroduce, them into the community, or communities, of their choice.

Co-occurring disorders (COD) - The existence of both mental health and substance use disorders.

Empathy- The ability to understand another's feelings from their point of view or by placing yourself in their shoes.

Estranged relationship- A relationship that has been distant for a long time to the point of alienation.

Grandiose- In mental health terms, grandiose refers to an individual with a mental health disorder who's thoughts are clouded by the false belief that he/she is significantly superior to others and/or having a lack of empathy towards others.

Harm Reduction Theory - An approach which uses practical strategies and ideas to reduce the negative consequences associated with risky behaviors. Some examples are needle exchanges, methadone or SUBOXONE programs, and condoms/dental dam availability. Organizations that institute this theory do not demand full abstinence, but rather meet people where they are at with the goal of reducing harm. You can find more information at http://harmreduction.org/about-us/principles-of-harm-reduction/.

Institutional Discrimination- Prejudiced views and/or mistreatment of an individual or group, in this case for example an individual who is in recovery from substance use, from society and institutions.

Intervention- An action, such as a treatment, therapy, or skill, to improve a situation.

MISSION (Maintaining Independence and Sobriety through Systems Integration, Outreach and Networking) - A wraparound service intervention designed to meet the needs of those experiencing homelessness and co-occurring disorders.

Psycho-education- Education that can be provided to those seeking treatment for a mental health disorder or for those who are supporting an individual who has a mental health disorder.

Resistance- An individual's refusal to agree or comply.

SAMHSA (Substance Abuse and Mental Health Services Administration) - The agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance use and mental health on America's communities.

Self-care- Daily practices a person engages in to take care of him/herself. This includes meeting one's own needs. This link will take you to TED talks of how people manage their own self-care and the importance https://www.ted.com/playlists/299/the_importance_of_self_care.

Self-determination- A person's right to make their own decisions.

Self-medication- The use of misuse of prescription drugs, or use of illegal drugs and/or alcohol to ease or relieve emotional or physical pain that an individual may be experiencing.

Stigmatization- Generic negative labeling of a group of people based on an assumed characteristic or trait.

Strengths-based- A practice that emphasizes a person's strengths rather than their deficiencies.

Tolerance- In recovery terminology, this refers to when a person no longer experiences the desired effects of the drug with the current amount, so there is a need to increase the amount of drug being used to experience the desired effect.

Trauma-Informed Approach - A model that maintains that providers should presume going in to every relationship that there may have been some form of trauma (e.g., use, neglect, loss, etc.) in the person's life and then act accordingly when meeting with them. Some examples are letting the person choose where to sit, leaving the door open during meetings, not coming up behind someone, not hugging, and not touching without permission. You can find more information at http://www.samhsa.gov/nctic.

Withdrawal- In recovery terminology, this refers to the negative symptoms a person experiences when he/she stops using or decreases the use of a drug.