**ISTDP Drug Rehabilitation Manual**

**Structured Therapy Groups**

**Version three**

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**Summary of Structure**

**Setting**: inpatient and outpatient ISTDP drug rehabilitation groups

**Members**: eight patients in drug rehabilitation

**Therapists**: two ISTDP therapists

**Structure**: daily meetings for one and one half hours. Since process groups have been associated with poorer outcome for drug addicts, this group therapy format focuses first on anxiety regulation to make it possible for patients to tolerate a group experience without regression. Further, all exploration is graded and structured to fit the anxiety regulation and affect tolerance of the group. Thus, unlike most unstructured process groups, this group is structured, all exploration is graded, and all roles are clearly defined at all times.

**Goals of a Structured Graded Therapy Group**

This group therapy format achieves goals in a specific order. Do not go on to the next step unless the previous step has been achieved. This model builds the ingredients of a therapeutic alliance step by step, systematically:

1) anxiety regulation;

2) ability to ask for help;

3) ability to declare the will to work on a problem; and

4) the ability to explore. Develop these capacities in this order to help patients develop a therapeutic alliance that will lead to recovery.

***Goal one***: *Anxiety regulation*. Regulate anxiety of each member of the group and deactivate projections so that each member has a realistic relationship to the group leader and to the group. This is the precondition that must be achieved before going on to the following steps in treatment.

***Goal two***: *Declaring an internal problem to work on*. Help the patient declare an internal problem he wants to work on, without flooding with anxiety while declaring it.

***Goal three***: *Declaring will to work on an internal problem*. Help the patient declare *his* will to work on *his* problem to achieve *his* goals, without flooding with anxiety and without projecting his will onto others.

***Goal four***: *Building affect tolerance*. Help patients see the triangle of conflict (feelings, anxiety, and defenses) that generates their suffering, while ensuring that anxiety is regulated at all times.

**Task**: *explore feelings gradually while anxiety is regulated*.

**Framing the task**: “All of us are addicts: we are addicted to avoiding what we need to face: reality and our feelings about it. Our task is to face what we usually avoid.”

**Structure: Step One---Anxiety Regulation**

***Rationale***: Nearly every patient in drug rehabilitation suffers from excessive anxiety. Their anxiety will rise as soon as they enter a group. Their anxiety will rise even higher when they sit in the “seat of courage”: being the patient. Their anxiety will almost always be too high for any group therapy or exploration during the first two weeks. Therefore, the task of structured group therapy is helping the patient identify the signs of anxiety in the body, regulate anxiety in the body, and deactivate any projections onto the therapist or the group that sustain the anxiety. This step must be accomplished first before exploring feelings and conflicts within the group.

**Introduction to the Group: Forming a Culture of Compassion**

Leader begins: “To help each other means that we have to form a culture of compassion. After all, we won’t feel safe sharing with each other unless we commit to being compassionate with each other. Raise your hands if you have made mistakes in your life. Me too. None of us is in a position to judge. Would you be willing to be compassionate and kind with your colleagues here? Raise your hands. Look around. How many of you would be willing to be compassionate with yourselves? Ok. That’s the hard one isn’t it. How many of you would be willing to help your colleagues be more compassionate with themselves? Raise your hands.”

***Format of the task***: ***Introduction to the task***

The leader will continue as follows: “During our group therapy over the coming weeks, each of you will sit in the seat of courage. It takes courage to sit in this seat because it means you want to face your feelings in order to overcome your addiction. Whenever you are good to yourself, your anxiety will rise. Why? Because doing something good for you means you are disobeying the inner judge that says you should be addicted to suffering.

We will not explore any feelings at first. We will not explore any issues you have at first. We have no right to explore any issues here unless it is your will to explore your issues. Our first task is this: to help you notice signs of anxiety, so you can regulate it as a first step toward recovery. Each of you will take turns sitting in the seat of courage. Then all you have to do is describe how your body is reacting when you sit in that chair. That’s all we will do these first few weeks. Who would like to start?”

**Structure of roles at this stage:**

1. The therapist will invite one patient at a time to sit in the “seat of courage.” The therapist will invite the patient to identify and describe anxiety symptoms in the body.
2. Group assessment of anxiety: After the patient describes each anxiety symptom, the therapist will ask the group if the anxiety is too high or ok.
3. Anxiety regulation: After the patient has described each of his anxiety symptoms, the therapist will help the patient regulate his anxiety.
4. Summary of process: Once the patient’s anxiety is regulated, the therapist will offer a summary, “So we see that just the wish to do something good for yourself triggers this overwhelming anxiety. As if it is against the law to do something good for yourself. What’s it like to see that?”
5. Group assessment of the process: Then the therapist will ask the group if they feel anxious now about doing something good for themselves.
6. Invitation to the task: After this discussion, the therapist will return to the patient and ask, “Would you like to break that law?”
7. Regulate anxiety: After the patient agrees, then the therapist will invite the patient to pay attention to any anxiety that arose. Once it is regulated, the therapist thanks the patient and then invites another person to sit in the seat of courage.
8. Continue this same sequence with each patient during the group during the first few weeks until everyone can sit in the “seat of courage” while identifying anxiety, regulating it, and no longer flooding with anxiety. This underlying capacity of the group is the precondition for going on to the subsequent goals.

All group discussion must be on the task in this moment, e.g., anxiety regulation, anxiety assessment, assessment of anxiety over doing something good for oneself. All other discussion is off-task and must be redirected to the task.

***Format of the task: Anxiety Identification***

*Intervention one*: “Welcome X. By sitting in this chair, you decided to do something good for yourself. Now, let’s step back for a moment and observe how your body is reacting. What sensations do you see as you step back, notice, and observe these bodily reactions?”

*Intervention two*: Each time the patient lists a symptom that indicates anxiety is too high, label it for the patient. “You notice you are sick to your stomach. Wonderful you notice. That’s a sign your anxiety is too high. So, your body reacts as if you are breaking the law to do something good for yourself. What’s that like to notice that reaction your body has?” “Ok. As we step back again to notice and observe these bodily reactions, what’s another symptom you notice in your body?”

***Format of the task: Defenses against Anxiety Identification***

**Rationale**: Patients with a history of profound neglect lead lives of profound self-neglect, drug-abuse being only one of the ways these patients have neglected themselves. Therefore, all rehab work initially must help patients see how they neglect themselves so that they can begin to engage in the acts of self-care known as psychotherapy and recovery.

 Given their history, most patients in the first days of rehab will not easily or willingly take the time to identify or regulate their anxiety. Instead, they will engage in self-neglect. And they will invite the therapist and the group to neglect them as well. This must be identified and turned around so that the group becomes a group of self-care rather than a group of self-neglect and relapse behavior.

*Intervention one*: *Point out Self-Neglect*

Patient: “This is ridiculous. I don’t want to pay attention to my anxiety.”

Therapist: “That makes sense. Not paying attention to anxiety is a way to neglect yourself. And you are here because you have a history of neglecting yourself, treating yourself badly. Is this a pattern you would like us to help you overcome?”

Since these patients have a history of being cruel and severely self-judgmental, it is essential that the therapist simply describe patient behaviors but not judge them. Since we are encouraging patients to have compassion for themselves, it’s essential that you, your voice, and your words are always conveying compassion for your patient.

*Intervention two: Point out Self-Dismissal*

Patient: “It’s no big deal. I feel like this all the time.”

Therapist: “Notice how you say it’s no big deal. That’s a way to say *you* are no big deal, your suffering is no big deal. Do you notice how you dismiss yourself and your anxiety?”

Patient: “I think you are making too much of it.”

Therapist: You think I am making too much out of your anxiety, too much out of your suffering, too much out of you. Do you notice how you invite me to ignore your anxiety? Why do you invite me to ignore you?”

Patient: “I’m not inviting you to ignore me. I just don’t think my anxiety is that big of a deal.”

Therapist: “You don’t think your anxiety is that big of deal, that your suffering is not that big of a deal. This is how you dismiss yourself, and it’s how you invite me to dismiss you. Would you like us to help you treat yourself better?”

*Intervention three: Point out how resistance to recovery is a wish to Relapse*

Patient: “I don’t want to do this. I don’t want to look at this anxiety.”

Therapist: “Ok. I have no right to ask you to do what you don’t want to do. But do you notice how you are asking me not to help you with your anxiety? Do you notice how you are asking us to just sit back and watch you suffer and relapse again? Why do you ask us to abandon you?”

Patient: “I just don’t want to do it.”

Therapist: “That’s ok. I completely understand. You come here so you can recover. And at the same time, you go on strike so you can relapse. Since everyone else here has the urge to relapse at times, can we make room for your wish to relapse---since it is here anyway? It must be really important for that wish to be here. What do you notice feeling as you let yourself feel this wish to relapse and just let it be here without having to make it go away, without having to change it, without having to justify it, without having to explain it away? What happens as you let this wish to relapse just be here without having to do anything about it?” [This might seem risky to the clinician. However, since the wish is here, we need to help the patient let it be here so he can observe it, notice it, and sit with it ***without having to do anything about it***. The problem isn’t his wish; the problem occurs ***only if he acts on it***. Being able to sit with a wish, observe it, notice, and feel it without having to turn it into action is an essential capacity to build in this group of patients. Further, if you as the therapist can hear about the wish, explore the wish, and sit with the wish without treating it like an emergency requiring urgent action, the patient can learn from your example!]

*Intervention four: Point out how resistance to recovery is a wish to relapse*

Patient: “I don’t want to do this. I don’t want to look at this anxiety.”

Therapist: “Obviously, you don’t have to look at your anxiety if you don’t want to. But if we don’t work together to help you regulate your anxiety in some way other than using drugs, will this avoidance help you recover, or will it lead to relapse?”

*Intervention five: Build self-compassion*

Patient: “I don't want to do this. I don’t want to look at this anxiety.”

Therapist: “Although you came here to recover, notice how you ask us not to help with your anxiety? Is this a kind or a cruel way for you to treat yourself?”

Patient: “I don't know if I would say it is cruel.”

Therapist: “And if I collude and say, “It’s ok that she doesn’t want to work on her recovery. It’s ok if she doesn’t get any help with her anxiety. It’s ok if she suffers, would that be a kind or cruel way to treat you?”

Patient: “It wouldn’t be nice.”

Therapist: “So I wonder why an intelligent person like you asks me to hurt you like that? Why do you ask me and the group not to help you?”

*Intervention six: When identifying anxiety* ***appears*** *to raise anxiety*

Patient: “I’m getting even more anxious. I don’t want to do this anymore. I think it’s making me worse!”

Therapist: “Imagine that a doctor gave you a CAT scan that revealed cancer. Would you say the CAT scan gave you cancer or did it reveal the cancer that was already there? By helping you pay attention to your body, we’ve revealed the anxiety you didn’t see before. We didn’t create any more anxiety, just like the CAT scan didn’t create any cancer. It’s just a shock to realize to realize how much anxiety has been going through your body all the time and you never knew it. It’s just like someone who thought they were fine, but they had never known the cancer was inside. But now that we can see that anxiety, it can’t secretly control your life anymore. Now that we can see the anxiety, we can start to help you regulate it, so you are in charge instead. Would you like us to see if we can help you regulate this anxiety?”

*Intervention seven: Giving up and inviting the therapist to give up*

Patient: “This won’t help. Nothing has helped. This is pointless.”

Therapist: “Although you came here to recover, notice how you are tempted to give up on yourself? And notice how you are inviting me and the group to give up on you? Is this a way you abandon yourself and invite us to abandon you?”

Patient: “I’ve screwed up so many times, I might as well give up.”

Therapist: “It sounds like since you jumped onto the garbage truck, you want to ride it all the way to the dump. On the one hand, you have come here to get off the dump truck. And on the other hand, you want to ride the dump truck all the way to the dump and live in the garbage pile. Why do you treat yourself like garbage? Why do you invite us to treat you like garbage?”

Patient: “I feel like I am a piece of garbage.”

Therapist: “Oh, now I see. You hate yourself. And then you invite us to hate you too. This is how you treat yourself like a piece of garbage. Is that the problem you would like us to help you with?”

***Format of the task: Anxiety Regulation***

*Intervention one*: Once you and the patient have surveyed all the anxiety symptoms and the patient can observe and sense them without ignoring them, we can teach anxiety regulation. “Now that you are able to identify your anxiety, shall we see if we can help you regulate your anxiety?”

*Intervention two*: “As we step back again, let’s notice and observe the sensations in your stomach. Describe what kind of temperature you notice there. If it is moving, describe how it moves. As you notice the sensation, describe how big it is. Just keep noticing the sensations there and describe any subtle changes you notice in your stomach.” Continue in this gentle, encouraging way for five minutes until the anxiety comes down. If the anxiety does not come down, we will deactivate projections (Later section in this manual.) In this intervention, we build the patient’s capacity to keep his attention on an anxiety symptom long enough that it will drop. Do not pick a symptom of tension, since the patient will regress with a loss of tension. Instead, pick one of the signs of smooth muscle activation, e.g., a stomach ache.

***Format of the task: Defenses against Anxiety Regulation***

**Rationale**: Anxiety regulation is an act of love that will trigger complex mixed emotions in personality disordered drug addicts. After all, your compassion will trigger their love and longings for compassion and it will trigger the rage toward people in the past who offered compassion but also disappointment and, at worst, trauma and betrayal. Thus, we should almost always expect defenses against anxiety regulation because of the feelings this act of kindness triggers. The most common defenses will be self-neglect, self-hatred, and projection. Unless those defenses are addressed, the patient will be unable to regulate his anxiety and his risk for relapse will remain elevated.

*Intervention one: Resistance to the task*

Patient: “I don’t want to pay attention to my anxiety. That will just make it worse.”

Therapist: “Is attention in this moment making your anxiety worse, or is it making your awareness greater?”

Patient: “More aware, but I’m afraid it will get worse.”

Therapist: “Would you like to be more aware of your anxiety so you could regulate it? Then it couldn’t get worse.”

*Intervention two: Denial*

Patient: “I think you are wrong. I’m not anxious. I feel like this all the time.”

Therapist: “I could be wrong. From my perspective, if you feel like this all the time, you are too anxious all the time. Shall we take a look at this? And if we see there’s a pattern we’ll know there’s anxiety. And, if not, we’ll know there’s not. Shall we take a look?” [Deactivate any will battle. Do not argue. Explore and let the evidence accumulate that both of you can see and both of you can then think about.]

***Format of the task: When Anxiety Regulation Doesn’t Work***

**Rationale**: When anxiety regulation does not work, usually patients are using defenses that sustain the anxiety. For instance, a patient projecting that the therapist is angry, will be chronically afraid of the therapist. A patient who projects that the therapist wants to get inside her, will fear the therapist, not realizing she has projected her desire to explore her inner life onto a therapist whom she now fears as a potential invader!

 If the patient has delusions or hallucinations which she temporarily believes, she will be in a chronic state of reactive anxiety. If the patient’s boundary between feelings or between feelings and thoughts break down, she will flood with anxiety. In cases like this, we need to deactivate defenses that are sustaining the anxiety, or we have to help the patient strengthen certain weaknesses that are perpetuating her anxiety.

*Intervention one: Anxiety regulation does not work and the patient reports racing thoughts*

Patient: “I’m still anxious. My thoughts are racing.” [*Cognitive/perceptual disruption which did not drop in response to anxiety regulation*.]

Therapist: “Since you are still anxious, could we take a look and see what thoughts and ideas you might be having about the therapy that could be making you anxious.”

Patient: “I’m just wondering, ‘what is he going to ask me?’” [*Projection of his wish to ask himself questions*.]

Therapist: “First of all, I have no right to explore anything you don’t want to explore. So, just to get clear. Is it your wish to be in rehab?”

Patient: “Yes.”

Therapist: “And is it your wish to recover?”

Patient: “Yes.”

Therapist: “And is it your wish to get to the bottom of this anxiety so you can recover?”

Patient: “Yes.”

Therapist: “And are there questions you have that you would like answers to?”

Patient: “Yes.”

Therapist: “And would you like answers to those questions so you have better information so you can make better decisions for yourself?”

Patient: “Yes, that makes sense.” [*Patient calms down with deactivation of the projection*.]

Intervention two: Anxiety sustained by self-condemnation and projection

Patient: “I’m still anxious. I’m not feeling any better. Maybe we should stop.”

Therapist: “Since you’re still anxious, let’s see what could be driving the anxiety. What thoughts and ideas are you having about the therapy that could be making you anxious?”

Patient: “I’m just afraid I won’t please you like in the previous rehab.”

Therapist: “So there’s an idea I wouldn’t be pleased with you. Can you elaborate on that idea a bit?”

Patient: “I’m just afraid you’ll yell at me like he did.”

Therapist: “So, even though you sitting here with me, it’s like the shadow of the former therapist falls on me. Does that sound right?”

Patient: “Yes.”

Therapist: “First of all, I have no right to judge you. In my experience, people have already experienced too much judgment before they came here. I’m not aware of judging you. Is there any evidence that I am judging you that you are noticing so far?”

Patient: “No, not so far.”

Therapist: “So far, there is no evidence I’m judging you. Sometimes, people who are afraid I would judge them suffer from too much self-judgment. Is that something you are suffering from?”

Patient: “Yes.”

Therapist: “Would you like me to help you overcome that problem of excessive self-judgment?”
Patient: “Yes. I’d like that. It’s been really bad recently.”

Therapist: “I see. So, a lot of self-punishment over that last relapse?”

Patient: “Yes. I hadn’t seen that connection. But, yes, that’s what I’ve been doing.”

Therapist: “So a tendency to misuse the relapse for the purpose of punishing yourself. And would you like us to help you not misuse that relapse to beat yourself up with?”

Patient: “Yes.”

**How to Introduce the Task to the Group in Step Two**

Start with the powerpoint summary of the group task.

“In this group, we will help you learn to identify what feelings trigger your anxiety, symptoms, cravings, and drug use. If we can help you recognize and tolerate your feelings, you won’t have to feel anxious, use drugs, or have symptoms instead. But we will explore your feelings only as long as your anxiety is not too high.

For this, I will need your help. I am good at recognizing anxiety. But if your anxiety is getting too high and I don’t notice it, please let me know. Then we can work together to help you regulate your anxiety. If we can reduce your anxiety, we can reduce your cravings.

Our task is to help you face what you usually avoid, but while your anxiety is regulated. We are addicted to avoiding what makes us anxious. But if we avoid what makes us anxious, anxiety becomes in charge. If we face what makes us anxious, we can become in charge. Our task here is to help each other face what we avoid, so we can give up our addiction to avoidance.

**What We Will Do**

You are probably wondering what we will do. First of all, this won’t be a chit-chat group. This won’t be an unstructured anything goes group. We have a job to do.

 Each of you will do therapy with me, one person per meeting. I will explore issues with you. For instance, I will ask about the problem you want me to help you with. Once you respond, I will ask the group to let me know if you have answered my question, if you became too anxious, or if you avoided answering my question. Then I’ll intervene again. You will respond. And then I’ll ask the group to let me know if you answered my question, became too anxious, or avoided answering my question. In this way, we will learn what feelings trigger our anxiety, and we will learn what we do that causes our symptoms and suffering. Our goal? To help you face whatever you avoid, so you don’t have to feel anxious, use drugs, or have symptoms instead.

 Now here’s the deal. Any time you are too anxious, tell us. Then we will regulate your anxiety. We don’t want your anxiety to be too high.

 At the end of each group, I will ask you to tell us what you have learned about the feelings you have, the anxiety you have, and the ways you avoid feelings that cause you problems. If you leave anything out, I’ll ask the group to fill in any details you forgot. Are there any questions any of you have before we begin?”

**Structure---Step Two: Declaring a Problem to Work On**

**The therapeutic issue at this stage**: Once patients can sit in the “seat of courage” without flooding with anxiety, we can ask what the internal emotional problem the patient wants to work on. When the patient shares a problem to work on, he is admitting he needs to depend on you for your help. Most drug addicts, however, have a history of being hurt by the people they depended upon, however. As a result, they may begin treatment by hiding the problems they have. Of course, any problems they hide, we can’t help them with.

 So, once we ask patients what problem they would like help with (Implicitly, “how would you like to depend on me?”), drug addicts often flood with anxiety or avoid declaring a problem. If the addict becomes too anxious, regulate anxiety and then ask about the problem again. If the addict avoids declaring a problem, address his avoidance strategy and ask for the problem again.

**Structure of roles at this stage**:

1. At this stage, the therapist invites a patient to sit in the “seat of courage.”
2. The therapist asks the patient, “What is the problem you would like us to help you with?”
3. The patient responds with a problem, anxiety, or defense against declaring a problem.
4. The therapist asks the group: did X declare a problem? Did he become too anxious? Or did he avoid declaring a problem?
5. The group has to figure out the answer to this question.
6. Then the therapist intervenes either to explore whether it is the patient’s will to work on that problem, to regulate anxiety, or to block the patient’s defense and ask for the problem again.
7. The patient responds either with will to work on the problem, anxiety, or a defense against declaring a problem.
8. The therapist asks the group: did X declare a problem? Did he become too anxious? Or did he avoid declaring a problem?
9. The group has to figure out the answer to this question.
10. Then the therapist intervenes again as before until the patient declares an internal problem to work on in therapy.

This is the structure for the group at this phase and later phases. The group’s discussion is only on the question that the therapist poses. This helps the group begin to see the difference between declaring a problem and a defense, and helps the group see anxiety in others, and thus in themselves.

 Notice that this allows exploration to be at a slow pace so that feelings and anxiety do not become too high for the patient. And it allows the group to observe, reflect, and cognize about psychological processes in others and in themselves. A patient sits in the “seat of courage” at this phase for the entire hour and a half.

 If any member of the group becomes flooded with anxiety at any point, the therapist helps the entire group engage in anxiety regulation. Once everyone’s anxiety is regulated again, then exploration resumes where it left off with the patient.

 This monitoring of anxiety is essential in order to keep patients thinking and reflecting about the feelings that are aroused. That way, they do not regress into splitting, projecting, acting out, and relapse. The role of low anxiety tolerance has other implications for working with drug addicts as well.

 Since their anxiety tolerance is low, when they experience a low rise of feelings, any feelings they cannot tolerate inside, they project outside onto others. Thus, if you challenge or confront these patients, this will trigger a sharp rise of feelings they cannot tolerate inside. As a result, they will project more, lose more reality testing, become more paranoid, and act out more. Therefore, in this model, we do no challenging or confrontation of patients. It leads to regression, acting out, and drop out. Instead, we help patients see what they do and we help them see the price of what they do. But we do not confront them. Confrontation is reserved only for late phases of treatment when patients have much higher levels of affect tolerance.

 For examples of how to work with defenses against declaring a problem, see the skill building exercises for working with fragile patients.

**Structure---Step Three: Declaring One’s Will**

**to Work on a Problem**

**The therapeutic issue at this stage:** To build a therapeutic alliance, the patient’s anxiety must be low enough that it feels safe for the patient to face what he usually avoids and so that his thinking processes will not be impaired. Once his anxiety is regulated, the patient must declare a problem, otherwise there is nothing to focus on in therapy. Once the patient has declared a problem, we need to find out if it is his will to work on this problem. Otherwise, no therapeutic alliance is possible. Therapy requires two people whose will it is to work on a problem. A therapist cannot do all the work by herself!

 When a patient shares his will to work on the problem, he is revealing his desire. Unfortunately, many drug addicts come from abusive families or tyrannical families where the expression of will was judged, crushed, and punished. As a result, when patients express their will to form a healing relationship, feelings, anxiety, and defenses will arise.

 Thus, once the patient declares a problem, the therapist will ask if it is the patient’s will to work on this problem. This phase is usually overlooked. And, when overlooked, the result is that there is no real therapeutic alliance. The patient seemingly follows the therapist’s will. But then the patient is a passenger in his therapy, rather than its driver. This pattern leads to defeat. No exploration of the patient’s presenting problem is possible unless it is his will to explore this problem. Do not move forward, do not explore anything unless the patient has declared his will to do so.

**Structure of roles at this stage**:

1. At this stage, the therapist asks the patient, “Is it your will to work on this problem?”
2. The patient responds with his will, anxiety, or defense against declaring his will.
3. The therapist asks the group: did X declare his will? Did he become too anxious? Or did he avoid declaring his will?
4. The group has to figure out the answer to this question.
5. Then the therapist intervenes either to explore the problem (if it is the patient’s will), to regulate anxiety, or to block the patient’s defense and ask for the patient’s will again.
6. The patient responds either with will to work on the problem, anxiety, or a defense against declaring his will.
7. The therapist asks the group: did X declare his will? Did he become too anxious? Or did he avoid declaring his will?
8. The group has to figure out the answer to this question.
9. Then the therapist intervenes again as before until the patient has declared his will to work on the problem.

The group’s discussion is only on the question that the therapist poses. This helps the group begin to see the difference between declaring one’s will and a defense against declaring one’s will. And it helps the group see conflicts about declaring one’s will to do something good for oneself in others, and thus in themselves. When patients divert from the task, return them to the question in this moment.

 Most therapists are unable to assess whether the patient’s will is truly on line to do the work of therapy and rehab. Therefore, let’s take a moment to review the elements that are necessary:

1. First, the patient must say clearly that it is his will. Anything less is a defense.
2. Second, if it is the patient’s will to explore his problem, it is his will to form a deeply healing relationship with you. Thus, we should see a rise of feelings and anxiety. The absence of anxiety means that the verbal “yes” is a non-verbal no. His will is not online.
3. Third, if it is the patient’s will to explore his problem, he will be engaged with you and with his problem. Thus, if he is sitting in a detached, uninvolved manner, his will is not online. If his voice is detached, his will is not online. If he is sitting with you in a passive, expectant manner, his will is not online.

For examples of how to work with defenses against declaring a problem, see the skill building exercises for working with fragile patients. Any time your work is stuck, check on the presence of will. Absence of will is the primary reason therapy and rehab is not working with drug addicts. Your will is not enough!

**Structure: Step Four---Building Affect Tolerance**

**by Exploring the Internal Problem**

**The therapeutic issue at this stage**: When we treat the psychological determinants of drug abuse, we must address the excessive anxiety that patients try to numb away through drug use. And we must address their defenses: their search for self-punishment, suffering, and death which they pursue through life-threatening drug use.

To treat anxiety, we must first regulate it, then explore what feelings are triggering the anxiety. To address self-destructive defenses, we must help patients see those defenses, then examine the feelings underneath which those defenses ward off. If patients can learn to face their feelings, those feelings will no longer trigger anxiety, and they will no longer have to use self-destructive defenses to ward off those feelings.

To explore the patient’s issues and feelings:

1. We ask the patient what problem he has.
2. We ask if it is his will to explore that problem.
3. We ask for a specific example of that problem.
4. We ask for the feelings he had toward a person in that example.

**Structure of roles at this stage**:

1. At this stage, the therapist asks the patient, “What is the feeling toward X?”
2. The patient responds with his feeling, anxiety, or defense against declaring his feeling.
3. The therapist asks the group: did X declare his feeling? Did he become too anxious? Or did he avoid declaring his feeling?
4. The group has to figure out the answer to this question.
5. Then the therapist intervenes either to explore how the patient experiences the feeling (if the patient declared a feeling), to regulate anxiety, or to describe the patient’s defense and ask for the patient’s feeling again.
6. The patient responds either with his feeling, anxiety, or a defense against declaring his feeling.
7. The therapist asks the group: did X declare his feeling? Did he become too anxious? Or did he avoid declaring his feeling?
8. The group has to figure out the answer to this question.
9. Then the therapist intervenes again as before until the patient has declared his feeling. Then the therapist will ask how the patient experiences that feeling physically in his body. And the same sequence of questions above will apply.

When we ask addicts about their feelings, they become anxious and use defenses to avoid their feelings and anxiety. The most common defenses drug addicts use are self-attack, projection, acting out, and drug use. Therefore, our task is to build the patient’s capacity to bear increasing amounts of feelings without anxiety, so that defenses are not necessary to ward off the feelings. If patients can learn to bear their feelings and channel them into effective action rather than self-destructive defenses, we can reduce the risk of relapse.

 To understand this pattern more clearly: an addict who cannot tolerate being angry at another person he loves, may turn the anger onto himself and criticize him or punish himself. Another addict who cannot tolerate his anger inside, may project and imagine you or other group members are angry with him and want to hurt him. Another patient who cannot tolerate his anger, may punish himself through an overdose. A patient who cannot tolerate his guilt over how he hurt others or cannot tolerate the loss of a loved one may choose to kill his feelings by killing himself through an overdose.

***Format of the task***:

 A patient agrees to do therapy with the therapist. (Each member of the group takes turns being in therapy, one per day. No one gets to avoid.) The therapist asks about the problem the patient wants to explore. *After each patient response, the therapist asks the group to assess whether the patient’s response was a problem, anxiety in the body, or a way to avoid declaring a problem*.

 After the group makes the assessment, the therapist intervenes. *After the next patient response, the therapist asks the group to make the next assessment*. This is the structure: therapist intervention, patient response, group assessment; therapist intervention, group assessment. Continue to repeat this pattern throughout the session.

 If any group member becomes too anxious, regulate the entire group’s anxiety until all members are regulated. Then resume exploration with the patient where you left off. If the entire group’s anxiety is not regulated, keep regulating anxiety. If that’s what you do most of the session, that’s what you do.

 At the end of each meeting, ask the patient to summarize what he learned. Then ask the group to summarize what they learned. Ask the group to add anything the patient may have forgotten.

**Rationale**: Since these patients experience excessive anxiety, leading to symptoms such as acting out, drug use, and projection, do not trigger high levels of anxiety that will increase symptoms and the risk of relapse. Instead, regulate anxiety each time it gets too high. Then explore what patients usually avoid, but while their anxiety is regulated.

 For examples of how to work with defenses against declaring a problem, see the skill building exercises for working with fragile patients.

**Instructions for the Therapist:**

**Specific Issues**

**How to Explore**: in each group meeting a person volunteers to explore a problem. You ask, “Who would like some help with their problems today?” A patient volunteers and is invited to sit in the patient chair before the therapist’s chair.

Use the following format:

1. “***What is the problem you would like me to help you with?***”

When the patient responds, ask the group, “Is this a problem, is he becoming too anxious in his body, or is this a way to avoid declaring a problem?”

 After the group responds, intervene in one of three ways:

1. If the patient offered a problem, ask, “Is it your will to look at this problem?”
2. If the patient became too anxious, say, “You are anxious. So something about exploring a problem makes you anxious. Can we take a look at your anxiety, so we can help you regulate it?”
3. If the patient avoided declaring a problem, repeat what the patient said and say, “This is a way to avoid declaring a problem. Could we look at a problem you would like us to help you with?”

Invite the group to assess each patient response, and then address either anxiety or defense until the patient declares an internal emotional problem to work on in therapy. In this way, the group is constantly learning how to see whether they offer problems, whether they are anxious, and what defenses they use.

Once the patient declares a specific problem to explore, go to step two.

1. “***Is this a problem you would like me to help you with?***”

When the patient responds, ask the group, “Is the patient declaring his will to work on his problem, is he becoming too anxious in his body, or is he avoiding declaring his wish to work on his problem?”

After the group responds, intervene in one of three ways:

1. If the patient offered his will, ask, “Could we look at a specific example of this problem?”
2. If the patient became too anxious, say, “You are anxious. So, something about declaring your wish to do something good for yourself makes you anxious. Can we take a look at your anxiety, so we can help you regulate it?”
3. If the patient avoided declaring his will, repeat what the patient said and say, “This is a way to avoid declaring your wish to work on this problem. We have no right to work on this problem unless it is your wish to do so. Is it your will that we work together to help you overcome your problem?”
4. Continue to invite the group to assess each patient response, and then address either anxiety or defense until the patient declares an internal emotional problem to work on in therapy.

Once the patient declares his problem and his will, go to step three.

1. “***Could we look at a specific example where this problem comes up?***”

When the patient responds, ask the group, “Is this a specific example of the problem, is he becoming too anxious in his body, or is this a way to avoid declaring a specific example?”

 After the group responds, intervene in one of three ways:

1. If the patient offered a specific example, ask, “What is the feeling toward him/her?” [*A specific example of a problem will involve a relationship where somebody did something that triggered feelings. Ask what feelings he has toward that person in the example*.]
2. If the patient became too anxious, say, “You are anxious. So, something about exploring a specific example makes you anxious. Can we take a look at your anxiety, so we can help you regulate it?”
3. If the patient avoided declaring a specific example of the problem, repeat what the patient said and say, “This is a way to avoid declaring a specific example. If we don’t have a specific example, we can’t get a clear look at your problem. Could we look at a specific example of the problem you would like us to help you with?”

Continue to invite the group to assess each patient response, and then address either anxiety or defense until the patient declares a specific example of the problem to work on in therapy.

Once the patient declares a specific example of the problem, we move to stage four.

1. “***What is the feeling toward him/her for doing that?***”

When the patient responds, ask the group, “Is this a feeling, is he becoming too anxious in his body, or is this a way to avoid declaring a feeling?”

 After the group responds, intervene in one of three ways:

1. If the patient offered a feeling, ask, “How do you experience this feeling toward him/her in your body?”
2. If the patient became too anxious, say, “You are anxious. So, your feeling makes you anxious. Can we take a look at your anxiety, so we can help you regulate it?”
3. If the patient avoided declaring a feeling, repeat what the patient said and say, “This is a way to avoid declaring a feeling. If we don’t know what your feeling is, we can’t find out what is triggering your anxiety and cravings. Can we see what the feeling is toward him/her?”

Continue to invite the group to assess each patient response, and then address either anxiety or defense until the patient declares the feeling he has toward the person in the example.

Once the patient has declared a feeling, we move to stage five.

1. “***How do you experience that feeling toward him/her physically in your body?***”

When the patient responds, asks the group, “Is this how he experiences the feeling in his body, is he becoming too anxious in his body, or is this a way to avoid declaring how he experiences this feeling in his body?”

 After the group responds, intervene in one of three ways:

1. If the patient offered an experience of the feeling in his body, ask, “As you let this feeling build in your body, how else do you experience this feeling toward him/her in your body?”
2. If the patient became too anxious, say, “You are anxious. So your feeling makes you anxious. Can we take a look at your anxiety, so we can help you regulate it?”
3. If the patient avoided declaring how he experienced this feeling in the body, repeat what the patient said and say, “This is a way to avoid declaring how you experience this feeling in your body. Could we see how you experience this feeling in your body so you don’t have to have anxiety and symptoms instead? How do you experience this feeling in your body?”

Continue to invite the group to assess each patient response, and then address either anxiety or defense until the patient declares how s/he experiences the feeling in his body that he has toward the person in the example.

**How to Address Resistance in the Patient**:

If the patient says he does not want to continue, ask the following questions in the following order:

1. “Excellent! Tell us how you experience this urge not to go further.”
2. “What do you notice feeling as you ask us not to help you?”
3. “We have no right to help you with something you don’t want help with. What do you notice feeling as we respect your wish that we not help you?”
4. “How little would you like the group to help you?”
5. “What do you notice feeling as we accept your wish not to receive our help?”
6. “Notice your addiction to not getting help.”

If the patient still insists that he does not want to go further, say,

1. “Ok.” Then wait. If the group gets agitated, you can say, “The group gets anxious when X asks us not to help him. Can we accept his wish not to be helped? Can we accept this reality? After all, we have no right to make him do something he doesn’t want to do?” Then wait in silence until X or the group responds.

If the patient projects onto the group, “I know you think I should look at this, but I don’t want to!” You can say:

1. “We have no right to make you look at something you don’t want to look at. If you don’t want to see what is driving your anxiety and symptoms, we have to respect your wish not to know.” Then wait.
2. If the group gets agitated, the therapist can say, “The group gets anxious when X asks us not to help him. Can we accept his wish not to be helped? Can we honor his wish not to know what is driving his anxiety and symptoms? After all, we have no right to help him see what he does not want to see.”

**Question for the group**: “Why does the group become so anxious when X has a self-sabotaging thought?

Is there anyone here who has not had that thought?

Is there anyone here who has not wanted to hurt himself or herself?

What if X is reminding us of our universal wish to give up on ourselves rather than face what makes us anxious?

Could it be that X deserves a “thank you” for saying out loud what each of us has thought?

How could each of us thank X for reminding us of our wish to avoid what makes us anxious?”

Could we go around the group and ask everyone to share a moment when you wanted to give up on yourself?

Thank you X, for reminding the group that we are a Twelve Step Group: Avoiders Anonymous.

**Stance regarding Resistance**:

Accept all signs of resistance, and encourage the patient to notice that thought without having to do anything about it. “***Can we let that thought be here without having to do anything about it, without explaining, justifying, or changing it? What do you notice feeling as you just let that thought be here?***” [*This experiential exercise helps the group tolerate impulses without acting on them, a key capacity for decreasing acting out and relapse*.]

“***What do you notice feeling as we just let that thought be here without having to do anything about it?***”

We must allow resistance to be in the room since IT IS. We must help our patients notice this thought and allow this thought to be here without treating it like an emergency. When they can notice a thought without treating it like an emergency, without treating it like it is anything we have to do anything about, then acting out disappears. Resistance is just a thought. It requires no action from the patient. And IT REQUIRES NO ACTION FROM THE THERAPIST. Resistance is just a thought, not a call to action.

 Welcome any comments indicating resistance to the group. For example, “I hate this group!”

“Thank you for sharing your dislike for the group. We can progress only through being honest about what we like and don’t like. Thank you for collaborating this way. What do you notice feeling as you let yourself hate group therapy?”

 The more patients can put their negative feelings into words with you, the less they have to put those feelings into actions. The more you can accept their feelings, anxiety, and urges without panicking, the more they can accept their feelings, anxiety, and urges without needing to do anything about them. Remember: our goal is to help patients tolerate feelings and anxiety *without having to do anything*. This is how we decrease their impulsivity and their risk of relapse. If they can tolerate their experience, they won’t have to drug it away.

**How to address Anxiety in the Group**:

If the group shows signs of anxiety (interrupting, zoning out, rapid speech, talking over others, fidgeting), intervene as follows:

1. “I notice (interrupting, zoning out, rapid speech, talking over others, fidgeting). That’s a sign of anxiety. How is the group experiencing anxiety right now in your bodies?”
2. “What did you notice triggered your anxiety?”
3. “So we notice that X triggered your anxiety as a group?”
4. “What feels scary about this topic for the group?”
5. “What happens as we let the anxiety be here without having to do anything about it, without having to make it go away, without having to explain it away? What happens as we let the anxiety be here as we just sit back and watch it?”
6. If anxiety is still not coming down, then do an anxiety regulation exercise with the group as a whole.

We must allow anxiety to be in the room since IT IS in the room. We must help our patients notice this anxiety and allow this anxiety to be here without treating it like an emergency. When they can notice anxiety without treating it like it is anything we have to do anything about, then acting out disappears. Then anxiety is just a sensation in the body: old information. It requires no action from the patient. And IT REQUIRES NO ACTION FROM THE THERAPIST. Anxiety is just information about the past, not a call to action in the present.

 When anxiety is too high for any group participant, regulate the group’s anxiety. Don’t explore anything until all patients are regulated. This is essential to prevent regression and acting out.

**Deactivating Shame**

When you help a patient see her defenses and self-destructive behavior, she may attack herself by shaming herself, or she may project that others shame and judge her. To deactivate this process, ask the group, “How many of you have done this?” Ask them to raise their hands, and make sure you raise your hand too. Then ask, “How many of you have judged yourselves for this mistake?” Ask them to raise their hands, and make sure you raise your hand too. Then ask the group to discuss their experiences using this defense and their shame about.

**Principle**: whenever a shameful defense arises that could trigger self-attack and projection, universalize the defense---it’s something all of us do. In this way, you deactivate the patient’s self-attack and build self-compassion through identifying with a group of fellow, flawed human beings.

**Common Resistances**

Since group therapy triggers feelings, it will trigger anxiety and defenses in the members. Thus, we will always encounter patients who flood with anxiety, patients who project, or patients resist group therapy openly. This doesn’t mean you are doing anything wrong. It means you are doing something right: you are mobilizing mixed feelings in the group. The problem is that they are dealing with their anxiety with treatment-destructive behaviors: the same behaviors they have used before that got them into addiction.

 Let’s look at some of the most common signs of resistance.

“This is ridiculous.” [*Devaluation to avoid depending on the group*.] [“*When you say this is ridiculous, do you notice how you devalue the group and our work? That’s ok. I can’t stop you. It’s just if you devalue the group and our work, this will become just another useless rehab for you, and you will be at a higher risk of relapse*.”]

“Wasn’t that game with the Knicks amazing?” [Diversification to change the topic and avoid the task: facing what we usually avoid. It’s also a test: will you bring us back to the task, or will you give up so we can make this into an anti-task group?] [“*Notice how you talk about basketball rather than your recovery? Notice how you ignore yourself right now? Shall we come back to the task now, so we can help you recover?*”]

“Everyone is judging me, and I don’t trust them.” [Projection of one’s self-judgment onto the group.] [“*People who are afraid of being judged often suffer from too much self-judgment. Is that something you suffer from sometimes? Would you like us to help you be more accepting of yourself?*”]

Whispering to another patient in a private conversation. [Ignoring the group and devaluing the task.] [“*Jill and Rachel, when you whisper to yourselves, do you notice how you distance from the group and from our task? That would defeat your ability to use the rehab to get better. Shall we come back to the task?*”]

Habitual lateness. [Self-deprivation and self-neglect.] [“*Jim, notice how you have been coming in late? This is how you deprive yourself of the help you came here to get. Is it possible you have been addicted to self-deprivation and self-neglect? Would you like us to help you take better care of yourself?*”]

**Goals and Structure for Each Meeting**

 This is the structured format for each group. We must build the group’s capacity to recognize the conflicts they have, face the feelings they usually avoid, and regulate the anxiety that is mobilized. But, given their fragile character structure, we must explore the problem, will, specific example, and feelings gradually while keeping anxiety regulated. Go no further than the patient wants to go. Avoid will battles.

 In this structured therapy group, the task is very clear. Help the group learn to observe their feelings, anxiety, and defenses. Help them learn to tolerate feelings, anxiety, defenses, and impulses without acting upon them. Help them intellectualize about their feelings rather than pursue deep levels of feeling. Help them face avoided feelings, which trigger anxiety, without triggering acting out or relapse.

 By inviting the group to declare where each response is on the triangle, the entire group is involved and mentalizing. At the same time, this creates structure for the group, and it prevents regression since the pace provides inherent grading to the level of feelings and anxiety in the group.

 For the final ten minutes of each meeting, ask the group to talk about their reactions. When group members share a reaction, ask them whether their reaction is a feeling, anxiety, or a way to avoid feelings. During the last minute, summarize the patient’s triangle of conflict and the group’s triangle of conflict as revealed during the session, if necessary.