“We are what we think.
All that we are arises with our thoughts.
With our thoughts, we make the world.”

Shakyamuni Buddha (563–483 BCE)
The Dhammapada
Contents

Introduction 1

SECTION 1: PRINCIPLES OF INTERVENTION 3
  Cognitive behavioural therapy 3
  The stepped care approach 6
  The therapeutic relationship, engagement and rapport building 6
  Clinical judgement 7
  Integrated treatment 7
  Readiness for treatment 7

SECTION 2: PRACTICE GUIDELINES 9
  Negotiating the PsyCheck Intervention practice guidelines 9
  Pre-PsyCheck Preparation: Assessment, formulation and treatment planning 10
  Session 1: Psychoeducation 18
  Session 2: Identifying unhelpful thoughts 30
  Session 3: Managing unhelpful thoughts 36
  Session 4: Relapse prevention 40
  Post PsyCheck activities 45
  Other considerations 45

SECTION 3: EXTENSION MATERIAL 49
  Session 1 Extension material 50
  Session 2 Extension material 53
  Session 3 Extension material 64
  Session 4 extension material 68

List of figures and tables

Figure 1: Case formulation process 14
Figure 2: CBT model example 22
Figure 3: CBT model for young people 28
Figure 4: Simple CBT model 50
Figure 5: The ABCs 51
Figure 6: The four general communication styles according to the two dimensions of force and directness of communication 64
Introduction

The *PsyCheck* Clinical Treatment Guidelines were designed to be used in conjunction with the *PsyCheck* Screening Tool. Their implementation is supported by the *PsyCheck* Service Implementation Guidelines and by training and clinical supervision as detailed in the *PsyCheck* Training and Supervision Clinical Guidelines. These clinical guidelines contain a manualised version of the recommended *PsyCheck* Intervention, which is based on brief cognitive behavioural therapy. A stepped care model has been used, based on the *PsyCheck* Screening Tool.

The *PsyCheck* Clinical Treatment Guidelines are arranged into three sections:

- **Section 1** outlines principles that support the *PsyCheck* clinical guidelines. They include an outline of the stepped care approach and of integrated treatment, a summary of the cognitive behavioural principles included in the intervention, and a review of the fundamental skills of engagement, rapport building and using clinical judgement.

- **Section 2** outlines the *PsyCheck* Intervention, comprising four treatment modules that are designed to be integrated into existing AOD treatment. This section is laid out in a step-by-step format so that clinicians just starting out have a basis from which to start their integrated treatment. However, the modules are also designed so that experienced clinicians can utilise the material as they require, without following a strictly manualised program.

- **Section 3** contains additional (‘extension’) material that may be used as an adjunct for additional sessions if required, or in place of some of the tasks in Section 3 if clinical judgement suggests an alternative technique is required.

Worksheets are also included. Clinicians should use clinical judgement when deciding whether to use some or all of these worksheets. They have been designed to support and reinforce learning from the sessions.

These guidelines provide a structure by which AOD clinicians can identify and appropriately refer clients who are in need of more intensive or specialised treatment (e.g. those with a psychotic disorder, those at high risk for self-harm) to mental health services.
SECTION 1:

Principles of intervention

Cognitive behavioural therapy
Cognitive behavioural therapy (CBT) is an umbrella term that encompasses many different therapies with a cognitive and/or behavioural focus. Cognitive and behavioural therapies are often combined in clinical practice, despite their different theoretical bases (Hollon et al., 2002). Clinicians in drug and alcohol treatment use cognitive behavioural strategies every day. Some treatments that fall into this category are relapse prevention, relaxation, monitoring, contingency (behavioural) management and urge surfing.

Behavioural therapies
Behavioural therapies are based on the assumption that dysfunctional behaviour has been learned because it serves a purpose or has been reinforced. Examples of how dysfunctional or unhelpful behaviours can be reinforced include: classical conditioning, operant conditioning and modelling.

Classical conditioning
This is also called ‘Pavlovian conditioning’ and occurs when two events that are already connected with each other occur so frequently with a third that eventually they become unconsciously associated. Pavlov’s dogs salivated when they saw their food (a natural automatic response to food); when the food was paired with a bell, eventually the bell alone was able to trigger salivation without the food being present. In a similar way, drug use produces a number of physical reactions: for example, feelings of euphoria. If an object (e.g. a needle) or an emotion (e.g. depression) is frequently paired with drug taking, then eventually the needle or the feelings of depression can trigger feelings of euphoria (interpreted as ‘craving’) on their own, without any drugs being present.

Operant conditioning
Operant conditioning is based on the principle of reinforcement. This suggests that behaviours with positive consequences are more likely to occur again, while behaviours that have negative consequences are likely to cease. Positive consequences include both a positive consequence (known as positive reinforcement) and the removal of a negative consequence or aversive state (known as negative reinforcement). Examples of positive reinforcers include the euphoria experienced during drug taking and the positive social aspects of using or drinking. A negative reinforcer is, for example, the removal of withdrawal by using again. Reinforcers that are aversive or have negative consequences are known as punishment. For example, feeling sick or having bad hallucinations.
Modelling
This is also called vicarious or observational learning. Behaviours are learned through watching others. The learning may take a number of forms, including duplicating new behaviour that may not have otherwise occurred (e.g. initial drug use after seeing friends using at a dance party), duplicating a sentiment that was expressed in a different behaviour (e.g. volunteering for a charity after hearing that a celebrity donated $20,000 to Greenpeace), engaging in a known behaviour that was previously inhibited (e.g. speeding after seeing other cars speeding without getting a fine) or refraining from a behaviour that results in negative consequences (e.g. tripping over a hole in the footpath). Modelling frequently has a strong influence for a drug-using population, as alcohol and other drug use is often a very social activity involving many models. It can also have a strong influence on mental health symptoms: for example, the biggest risk factor for suicide is having a friend or relative make an attempt. Modelling is particularly important for CBT because the clinician acts as a model for the client during sessions by demonstrating skills and homework tasks.

Cognitive therapy
Cognitive therapy is based on the cognitive model, which hypothesises that people's emotions and behaviours are influenced by their interpretation of situations and events. It is not the situation itself that determines how people feel, it is how they perceive that situation (Beck, 1995). Beck's theory of depression hypothesises that people are depressed because they consistently distort their experiences negatively. Early experience is thought to lead to 'core beliefs' or 'schemas'. These are usually established in childhood through negative or damaging experiences, but can be modified and added to in adulthood. Negative core beliefs can lie dormant until a trigger, such as a critical event, activates them. In day-to-day situations, these activated core beliefs negatively bias how the person interprets a situation. These negative patterns of thinking (unhelpful thoughts) trap the person in a cycle of feelings, behaviour and thoughts that reinforce and maintain the negative beliefs, even though they may be inaccurate or dysfunctional.

Cognitive therapy focuses on changing two main types of 'cognitions' or thoughts: unhelpful (automatic) thoughts that occur day to day and the core beliefs that drive these thoughts.

A modified version of the cognitive model (based on an example case to illustrate the model's use in practice) is presented in Section 2 of these clinical treatment guidelines (see Figure 2). Alternative versions of this model are presented in Section 3 and include a simple CBT model and one adapted for use with young people.

The theoretical basis of CBT
The underpinnings of CBT can be represented through 10 principles outlined by Beck (1995):

**Principle 1:** Cognitive therapy is based on an ever-evolving formulation of the client in cognitive terms.

**Principle 2:** Cognitive therapy requires a sound therapeutic alliance.

**Principle 3:** Cognitive therapy emphasises collaboration and active participation.

**Principle 4:** Cognitive therapy is goal oriented and problem focused.

**Principle 5:** Cognitive therapy initially emphasises the present.

**Principle 6:** Cognitive therapy is educative, aims to teach the client to be their own therapist, and emphasises relapse prevention.

**Principle 7:** Cognitive therapy is time limited.

**Principle 8:** Cognitive therapy sessions are structured.
PRINCIPLES OF INTERVENTION

Principle 9: Cognitive therapy teaches clients to identify, evaluate and respond to their dysfunctional thoughts and beliefs.

Principle 10: Cognitive therapy uses a variety of techniques to change thinking, mood and behaviour.

Evidenced-based practice

Cognitive behavioural approaches have received widespread support in clinical trials and have been applied to a range of adult mental health problems, including co-occurring AOD and mental health problems. Cognitive behavioural therapy has been shown to have equivalent effectiveness to pharmacotherapy and may additionally ‘protect’ clients against relapse or recurrence after treatment termination.

A more detailed discussion of the evidence for cognitive behavioural approaches as an effective intervention for co-occurring AOD and mental health problems is presented in the Introduction to this program.

An understanding of, and commitment to, evidence-based practice is crucial for seeking to implement treatment based on the CBT model. Hypothesis testing, case formulation and monitoring are all interconnected with the importance of evidence-based practice in CBT. The PsyCheck Training and Clinical Supervision Guidelines present opportunities for clinicians to practise this approach as part of the Psycheck training and within a clinical supervision context.

CBT in practice

The PsyCheck Intervention (outlined in Section 2 of these guidelines) focuses on four core CBT strategies:

- psychoeducation about the CBT model and symptoms of anxiety and depression
- identifying unhelpful patterns of thinking
- modifying these thoughts by a process called cognitive restructuring
- developing strategies to prevent relapse and maintain healthier patterns of thinking

CBT aims to make the process of therapy understandable to the client – adhering to a standard therapy structure facilitates this objective. Most clients feel more comfortable when they know what to expect from the session and when they clearly understand the role that they are expected to play.

The PsyCheck Intervention incorporates the key elements of the standard CBT session. The main elements of a standard cognitive behavioural therapy session include:

1. Checking in and setting the agenda
   - Checking how the client has been in the past week
   - Checking the client’s perception and understanding of the previous session
   - Setting an agenda for what will be covered during the session

2. Theory and practice
   - Introduce the topic for the session
   - Relate topic to current concerns
   - Explore issues, concerns or reactions to the topic
   - Practice topic through role-play, asking client for example
SECTION 1

3. Summary of ‘homework’

- Summarise the session, recheck the agenda
- Discuss a homework task that will help the client reinforce the skill
- Elicit and discuss concerns; identify any barriers to action
- Plan for the next session

**Homework**

Practice outside each session is an essential part of CBT. Often it is referred to as ‘homework’ but it is also known as take home tasks, practice tasks, between-session practice, etc. Clinicians should use whatever term appeals to them and/or their client. The important point is that ‘homework’ is an essential component of CBT.

**The stepped care approach**

Since individuals with co-occurring problems are a very heterogeneous group in terms of type, severity and readiness to address their various problems in treatment, a stepped care approach to treatment can add flexibility to treatment and improve outcomes. In the stepped care approach, interventions are applied from the least to the most intensive, with each incremental step made available on the basis of the client’s response to the previous one (Kay-Lambkin et al., 2004). Stepped care approaches have demonstrated effectiveness in the treatment of depression (Scogin, Hanson & Welsh, 2003), anxiety (Baillie & Rapee, 2004), alcohol problems (Sobell & Sobell, 2000), smoking (Smith et al., 2001) and heroin dependence (King et al., 2002).

A stepped care approach involves the application of decision rules. The *PsyCheck* Program uses the Psycheck Screening Tool and the accompanying decision-tree for this purpose. A stepped care approach is necessarily individualised, evidence-based, supported by clinical judgement and begins with the least intensive intervention that is still likely to be effective (Sobell and Sobell, 2000).

A stepped care approach can:

- help to match the treatment to the client’s needs and readiness to change
- increase services to a greater number of people
- optimise use of resources such as clinician time

In this program, the intensity of treatment is guided by the client’s score on the *PsyCheck* Screening Tool. Clients scoring under 5 are routinely offered the pre-session preparation and one session of CBT, then reassessed. Those scoring 5 and above are routinely offered four sessions of CBT.

**The therapeutic relationship, engagement and rapport building**

An essential part of any therapeutic intervention involves the ability to establish rapport with the client and to engage them in a collaborative relationship with you as the clinician. Two fundamental principles underpinning CBT relate to the importance of the therapeutic relationship.

1. Cognitive behavioural therapy requires a sound therapeutic alliance, which includes all of the ingredients necessary in a counselling situation: warmth, empathy and genuine regard.
2. Cognitive therapy emphasises collaboration and active participation (Beck, 1995). The microskills of counselling – such as attending, actively and empathically listening, and understanding (Egan, 1998) – remain a core function of cognitive behavioural interventions.
Engaging young people

It may take longer to establish rapport and trust with a young person than with an adult. This is particularly the case if the young person is not willingly attending treatment, but is doing so under parental direction or other incentives. Young people are likely to be guarded around authority figures, such as adults or health providers, and may have concerns about the stigma associated with attending therapy. It is important to spend time getting to know the young person – asking about their interests, their social group and so on – in order to maximise engagement in the therapeutic process. Discuss potential barriers to engagement in treatment in a non-confrontational manner, by examining the reasons why the young person is in the room with you (threat, incentive, parental advice etc.). Issues of engagement and rapport may need to be continually revisited throughout the course of treatment.

Clinical judgement

Although this intervention is manualised, it is designed to be used flexibly in ‘real life’ clinical environments as part of routine alcohol and other drug treatment. Sensibly, clinical judgement and adherence to existing clinical procedures are required in order to implement the intervention therapeutically. Throughout the manual, the application of clinical experience, clinical judgement or adherence to existing protocols is encouraged. For example, the cut-off score for implementing the intervention is 5 on the \textit{PsyCheck} Screening Tool. However, if clinical judgement indicates a client would clearly benefit from the intervention despite falling below the cut-off, use of the intervention is appropriate. Similarly, if a client meets the cut-off but is not ready to undertake the intervention – perhaps they are precontemplative or in a state of high distress, for example – then it would be prudent to revisit the intervention (and the screening) at a later date, assuming they are not in immediate danger.

Integrated treatment

The intervention outlined in this manual is based on the assumption that it will be integrated into routine alcohol and other drug treatment. The sessions are brief and not designed as stand-alone sessions. The techniques used are deliberately similar to those used in alcohol and other drug treatment to facilitate integration of the intervention and so that clients are also familiar with the techniques.

Readiness for treatment

Just as it is now routine to consider whether a client is ready for AOD treatment, it is recommended that you carefully consider whether the client is ready to address their mental health problems. It is important to remember that they may be at different stages of change for their mental health and alcohol and drug issues. For example, an amphetamine user may go to their general practitioner for help with their growing feelings of anxiety, but not yet be ready to believe that their amphetamine use may be contributing or causing the anxiety. Similarly, someone may seek help for their heavy alcohol consumption without wanting to address an underlying depression that may be exacerbating the drinking.

If the client is initially reluctant to address their mental health issues during AOD treatment, there are several options open to you as the clinician, depending on the client’s stage of change. For mental health precontemplators, you can gently introduce the connection between their AOD use and mental health problems over several sessions at appropriate moments; you could also undertake some motivational interviewing to enhance their readiness for change. Precontemplation for change is not a reason to refuse or not offer treatment to a client. Clients should be engaged at a level that suits their readiness to change.
An understanding of the Stages of Change Model and Motivational Interviewing, and how they apply to mental health issues, will be as useful for implementing the *PsyCheck* Program as it is for AOD-only treatment. It is important to remember that *PsyCheck* in the manualised form is really most suited to the preparation or action stages of change. Modifications, such as a more gentle introduction to the concepts and techniques, will be required for those who are not ready for change. The pre-session planning and Session 1 will be useful even in the early stages of change. The other sessions and the extension material should be used with discretion for clients who may not be ready to address their mental health problems.
SECTION 2:

Practice guidelines

Negotiating the PsyCheck Intervention practice guidelines

These practice guidelines outline the two stages of the Psycheck Intervention.

Pre-session preparation is designed to ready you and your client to undertake a cognitive behavioural intervention. It consists of gathering of specific information to assist with developing a formulation and a reflective space to do this.

This information gathering can be undertaken over one or more sessions and ideally would be integrated into existing assessment and treatment planning. The cognitive behavioural formulation is presented to the client in the first session of the intervention. In the first instance, this formulation is best devised with your clinical supervisor.

The Psycheck Intervention itself involves four sessions incorporating cognitive behavioural techniques:

- Session 1: Psychoeducation
- Session 2: Identifying unhelpful thoughts
- Session 3: Managing unhelpful thoughts
- Session 4: Relapse prevention

Each intervention session is framed as follows:

- **Review and feedback** – review with the client the previous session and any homework tasks.
- **Information** – explain the topic or skill for the session and ensure the client understands the ‘theory’ of why this skill is important to their recovery.
- **Practice** – rehearse the skill in a safe environment in preparation for the ‘real world’.
- **Session summary** – round off each session with a summary and ensure the client understands the session and what is required for the homework.

Each session also includes a summary of:

- session aims
- materials required
- content for the session
- extension material
- where appropriate, specific suggestions on how to modify strategies for a young person and an adolescent audience
Pre-PsyCheck Preparation: Assessment, formulation and treatment planning

These pre-session activities can be conducted over several sessions, or as appropriate, and can be integrated into usual AOD practice.

Aims

- Collect sufficient information through the mental health screen and cognitive behavioural assessment to develop a cognitive behavioural case formulation

Materials

- *PsyCheck* Screening Tool

**Intervention checklist**

**Undertake screening**

**Undertake a cognitive behavioural assessment**

- Step 1: Introduce the cognitive behavioural approach to the client
- Step 2: Understand the onset and course of the problem
- Step 3: Understand the maintenance of the problem using the 7Ps
- Step 4: Identify other relevant information

**Prepare a preliminary case formulation**

**Develop a treatment plan**
Introduction

Before the cognitive behavioural intervention begins, there are a number of things you need to do in preparation for implementing the intervention. 'Data' are collected in early AOD sessions and prior to the first *PsyCheck* intervention session. Take some time to reflect on and develop a case formulation. It is an opportunity to establish the style of the therapeutic relationship (particularly if it differs from your current style of working). A very experienced cognitive behavioural therapist may be able to do this during the first session and present/discuss a formulation with the client at the end of that session. A clinician unfamiliar with CBT may take several sessions to put the information they have gathered together into a case formulation. However, clinicians of all levels of skill and confidence should review and reflect on their initial formulation regularly, especially as more information comes to them.

Undertake screening

After screening has been conducted, take some time to score the screening measure(s) and prepare feedback for the client about the meaning of the scores. Screening is designed as an early 'snapshot' of the clinical picture. It will guide a more comprehensive assessment and should form part of the client's general and ongoing assessment.

Undertake a cognitive behavioural assessment

After initial screening you will have a better sense of whether further steps are required. If there is an indication from *PsyCheck* screening that the client may have mental health symptoms that could be addressed, the next step is a more detailed cognitive behavioural assessment.

A cognitive behavioural assessment has different principles and aims to a diagnostic or structural assessment. It focuses on creating a functional analysis of the target problem that is sufficiently detailed to determine how the problem started and what is maintaining it. This is different from a diagnostic assessment, for example, which focuses on classifying symptoms against set criteria.

The central principle of a cognitive behavioural assessment is the assumption that the way in which an individual behaves is determined by immediate situations and their interpretations of these situations. These interpretations and situations are the major focus of the assessment. Although most of the assessment is undertaken in the first few sessions with a client, the assessment process continues and is revisited throughout treatment, consistent with a 'hypothesis-testing' approach. Conducting a cognitive behavioural assessment and the development of a cognitive behavioural formulation is the basis for treatment planning and is integral to cognitive behavioural interventions.

Step 1: Introduce the cognitive behavioural approach to the client

An initial part of the cognitive behavioural assessment involves setting the scene of the therapeutic relationship and the style of the treatment. This also serves to increase agreement between the clinician and clients’ expectations of treatment, which will strengthen the therapeutic alliance and assist to retain clients in treatment. An important focus of a cognitive behavioural intervention is that it emphasises the possibility of change, rather than dwelling on problems. This sense should be conveyed to the client during the assessment session and throughout treatment.

CBT is largely self-help and aims to be active and collaborative. The clinician's role is to help the client develop skills and tools that will assist them to overcome their current problem. These skills can also be utilised to combat future problems and prevent relapse. In the first few sessions, you will prepare the client for the active role they will have in treatment. This may involve the completion of homework tasks in the real life setting.
Alternatively, the client is encouraged to have an active role in counselling, including:

- contributing to the development of hypotheses regarding their problem
- coming up with homework exercises
- giving feedback on the exercises
- making suggestions about alternative strategies for coping

CBT acknowledges that, for behaviour change to be sustainable, new behaviours or tools must be practiced and implemented outside of the counselling room. The treatment is highly collaborative and the client is expected to have ‘expert’ information about their problem and the contexts in which it occurs.

Cognitive behavioural interventions also seek to educate clients about the nature of the problem and how external variables (situation and behaviours) relate to internal variables (thoughts and feelings).

**Step 2: Understand the onset and course of the problem**

The onset of the problem may have been clear (e.g. it was precipitated by a relationship break-up) or it may be general (e.g. late adolescence). For most clients, the development of the problem will have been gradual and precipitated by a series of stressful life events, which have contributed to it over time.

The way the problem has developed since its first onset should be established. It is important to determine if there have been fluctuations in the severity or impact of the problem, or variations in the description of the problem. For example: ‘*When I was working full time I was very stressed and drank too much, but since retiring it has become a real problem.*’

**Step 3: Understand the maintenance of the problem using the 7Ps**

The 7Ps is a common framework for understanding the main elements needed for a cognitive behavioural formulation. Ask clinical questions that will help you to understand these elements for each client.

**Presenting Problem**

Clients may present with a range of issues framed in a variety of ways including diagnoses, symptoms, cognitive, emotional or behaviour outcomes etc. *PsyCheck* takes a symptom focused approach, so detailed description of the target problem/s include:

- behaviours
- thoughts
- feelings and emotions
- physical experiences

**Pattern (onset and course)**

This is a description of the pattern of drug use and mental health problems currently and over time. How has the pattern of use or symptoms changed over time? Have there been any periods of abstinence or periods without mental health symptoms? When did the client first show signs of problematic use and/or dependence? When did the person first show mental health problems and was this before or after first drug use and problematic drug use?

**Predisposing Factors**

These are factors that occur early in life that make a person more vulnerable to a mental health and/or AOD problem. They include:

- family history
- genetic history
- early neglect, abuse or trauma
- other early events
**Precipitating Factors**
Precipitating factors are commonly known as triggers. They may be immediate (proximal) triggers that lead to a particular behaviour to they may be triggers that lead to a pattern of behaviour (distal).

An example of proximal trigger in CBT is some shocking news that leads to feelings of depression. An example of a distal trigger might be the deterioration of a relationship that leads to a progressive increase in drinking alcohol over several months.

**Perpetuating Factors**
A perpetuating factor is one that maintains a problem. A perpetuating factor may also be a precipitating factor, although it may be different. Areas to consider include:
- the purpose the problem may be serving in the persons life
- factors that increase or decrease the likelihood of occurrence of the problem
- factors (including people, events, emotions) that reinforce the problem
- context and modulating variables, including feelings, thoughts, situations and behaviours
- avoidance behaviours

**Protective Factors**
These are factors that are positive forces in a persons life that will help protect them against mental health and/or AOD problems. They include personal characteristics, social and family circumstances, such as:
- a resilient attitude
- a positive social group
- a satisfying job
- suitable accommodation

**Prognosis**
This is a clinical judgement about the prospect for the client’s future symptoms. Do their symptoms seem amenable to change? Are the person’s protective factors strong enough to help them overcome their AOD and mental health problems in the near future or the distant future? Do they show enough insight to benefit from intervention?

**Step 4: Identify other relevant information**
A number of other factors are also important in terms of treatment planning and devising a case formulation.

**Coping**
- Coping resources and assets
- Strengths

**Treatment history**
- Response to previous treatment

**Positive/negatives**
- Psychiatric
- Medical
- Alcohol and other drug use

**Other**
- Beliefs about the problem
- Psychosocial situation
In addition to a clinical interview, structured and standardised assessment tools are available and may assist in assessment. Dawe, Loxton, Hides, Kavanagh and Mattick (2002) provide a comprehensive review of the mental health and alcohol and other drug screening and assessment tools currently available.

**Prepare a preliminary case formulation**

Case formulation is an important way to link the information gathered from the assessment and screening phases with the treatment plan (Figure 1). It is more than a case summary or a summary of the presenting problems. It draws the elements of the case summary into a meaningful pattern. It is an interpretation of the information collected.

In a cognitive behavioural intervention, the information gathered from the screening and cognitive behavioural assessment are interpreted in terms of the cognitive behavioural model to inform a formulation. The case formulation then leads logically to an individualised treatment plan.

![Diagram](image)

**Figure 1: Case formulation process (adapted from Persons et al., 2001)**

In a cognitive behavioural case formulation, the clinician develops a description of the client’s target problem in terms of their beliefs, thoughts, feelings and behaviours. A formulation is then developed to hypothesise what maintains the target problem. A formulation will also hypothesise the interrelationship between these factors. Put simply, the formulation will help the client understand how their problem(s) developed and what is maintaining the problem(s) now. It will also shed light on how their AOD use impacts their anxiety, depression or somatic symptoms, and vice versa.

By the completion of the cognitive behavioural assessment, you may be in a position to devise a preliminary case formulation. This preliminary formulation can be reviewed during supervision, before it is presented to the client in Session 1. The case formulation should include the following elements:

- a description of relevant personal information
- a description of the target problem, including, behaviours, thoughts, feelings and physical experiences, focusing on these symptoms rather than the situations where the symptoms occur
- a description of how the problem developed (onset and course) and is maintained (the 7Ps)
A sample case formulation

Melinda is a 34 year old single woman. Her early childhood experiences included neglect from an emotionally cold and very strict father. This has led to strong beliefs about herself that she is worthless and to the belief that it is better not to open up emotionally to anyone because the likely outcome is emotional pain. After she experienced a traumatic break-up of a long-term relationship in her early 20s, her negative beliefs were activated and began more strongly influencing how she interpreted situations. These beliefs gave rise to other problems including relationship difficulties, social and emotional withdrawal, which have led to feelings of depression and have, in turn, reinforced her negative beliefs. Melinda started drinking because it helped her relax in social situations by managing her feelings of worthlessness, and helped her to forget her loneliness. However, this has led to further problems and exacerbated her depressed mood, anxiety in social situations and the need for alcohol to cope. As a result, Melinda's drinking and depressed mood have continued to worsen. She reports multiple active cognitive distortions mainly centred on feeling like 'an idiot' especially in social situations. Melinda recognises that her drinking is exacerbating her depressed mood and that her feelings of depression are maintaining her drinking.

This is a technical version suitable for file notes or case presentation. Following your completion of the preliminary case formulation, it should be presented to the client for further discussion and refinement, using lay terms.

What I think is happening, Melinda, is when you were young, not having your dad pay much attention to you made you feel unloved and you've carried this feeling with you into adult life. It's also made you wary of opening up to anyone in case you get hurt. So wind forward to your break-up, and all these beliefs that were, in a sense, unconscious, get triggered. You've had some thoughts like 'no-one will love me' and 'I'm a loser' that you told me about and probably a lot more negative thoughts that you aren't always aware of. Is this sounding feasible so far? So as a result of these beliefs you've been carrying from childhood and then the negative thoughts you have – probably every day - you start to feel sad and lonely. Sounds like drinking puts you at ease when you are feeling like this, especially in social situations, but then also later makes these feelings even worse. Does this sound reasonable? Is it making sense to you? Anything you would add or change?
Develop a treatment plan

A good case formulation will lead to an obvious cognitive behavioural treatment plan. In the above example, the key points for the treatment plan are:

- Melinda believes that she is worthless and will get hurt if she opens up emotionally to anyone – this suggests that dealing with these beliefs are at the core of improvement.
- She is now in a pattern of social and emotional withdrawal, depression and drinking – coping skills for social situations is a key area for intervention.
- Feelings of depression exacerbate her drinking – additional behavioural intervention for her depression in conjunction with modifying her core beliefs would be helpful, so the clinician might consider some of the extension material in the PsyCheck Intervention, for example.
- Drinking exacerbates her feelings of depression – clearly intervention to reduce her drinking would be beneficial.

Therefore, a brief treatment plan for Melinda might include:

- Work on identifying and modifying automatic thoughts that lead directly to drinking.
- Behavioural activation (increase pleasant activities).
- Begin coping skills therapy for drinking.
- Address social anxiety.
- Monitor progress and consider referral for short-term anti-depressant medication.

Addressed in this way, it is clear what is required and who should provide the interventions.
Young People

Assessment, case formulation and the young person

More than likely, the young person will present as irritable and angry about their current situation and will be unable to articulate the finer points of their emotions or feelings (e.g. distinguish anger from frustration, sadness, fear etc.). This is particularly the case for young people experiencing depression, who may present with an irritable or cranky mood instead of sadness or low mood. In addition, the young person may be more inclined than an adult to deny or explain away any symptoms they may be experiencing, and may more readily admit to somatic complaints, irritability and social withdrawal (e.g. withdrawal from involvement in sporting teams, attending school dances, talking on phone to friends etc.) than other psychological symptoms.

In completing screening and assessment tools with the young person, discuss any self-report measures with the young person, rather than leave them to complete the questions on their own, and explain each question to enhance the validity and accuracy of the information collected during this phase. This may also assist in building rapport with the young person. A relaxed chatty style is important and some deviation from the questionnaire may be required initially.

It is also important to acknowledge that a young person comes with a family background. Even an absent family can have a significant impact on a young person. A thorough assessment of the young person includes a comprehensive assessment of their current family situation (e.g. roles within the family, place of young person within the family, family history of mental health and AOD problems etc.). It may also be useful to have a joint session with the young person and their parent, in which expectations for the young person's behaviour, treatment goals and so on are explored. Tips are provided in the clinical treatment sessions for such an activity.

Sexual assault and self-harm issues may also be present, yet these concerns may not be disclosed until the young person has engaged with you as clinician and some rapport and trust has been established. Be mindful of these issues and mobilise appropriate supports when and if they arise. Formulation may take longer with a young person than with an adult due to these factors.

You may be limited in the extent to which you can discuss a case formulation with a younger client. Certainly this can be attempted if the young person has developed enough insight about their thoughts, feelings and behaviours to appreciate the influence of the above factors on their current situation. However, it is more likely that young people may not be so up-front as adults or in touch with their key issues. A style that is non-confrontational and works towards understanding what is motivating the young person is recommended, as is a collaborative approach to working through their most pressing problems with them.
Session 1: Psychoeducation

Session 1 can be used as a single session brief intervention for clients who score less than 5 on the SRQ and have no other significant mental health indicators.

Aims
- Assist the client to understand the nature of their symptoms
- Introduce the client to the CBT model to provide a context for treatment
- Assist the client to understand the links between the AOD and mental health symptoms
- Introduce self monitoring

Materials
- Symptom information worksheets (Worksheets 1 and 2)
- CBT model (Worksheet 35)
- Self-monitoring worksheet (Worksheet 4)
- Whiteboard or paper/pen

Intervention checklist
Discuss your preliminary case formulation with the client
Provide information about the client’s symptoms

Introduce the CBT model
- Step 1: Explain the CBT model to the client
- Step 2: Work through an example with the client

Develop a joint treatment plan with the client
- Step 1: Articulate the links between formulation and treatment
- Step 2: Develop a joint treatment plan
- Step 3: Finalise and record treatment plan

Introduce self-monitoring
- Step 1: Explain self-monitoring to the client
- Step 2: Work through an example with the client

Session summary
- Step 1: Summarise session content
- Step 2: Invite client feedback
- Step 3: Reinforce homework
- Step 4: Prepare for the next step in treatment
Homework

☐ Worksheet 4: Self-monitoring

Extension material

Extension material is provided for Session 1. These techniques can be used as well as, or instead of, the self-monitoring task. If the client is not ready to undertake more complex tasks, or if you feel they require more intensive intervention before moving on to Session 2, you might spend several sessions on the extension material.

Extension material includes information about:

• a simple explanation of the CBT model
• an alternative explanation of the CBT model – the ABCs

PsyCheck for young people

Alternative session 1 activities for young people are included for case formulation, psychoeducation, explaining the CBT model, and self monitoring.

Materials

☐ Worksheet 24: Important people
☐ Worksheet 25: The ABCs
☐ Worksheet 26: Checking your thoughts and feelings
☐ Worksheet 27: Feelings check – other people
☐ Worksheet 31: For carers – when to worry about adolescent behaviour
SECTION 2

Introduction
Session 1 is focused on psychoeducation about:

- the case formulation
- the clients symptoms and the link with their AOD use
- the CBT model
- the planned treatment
- self monitoring

By taking the time to fully inform the client about the approach you are taking, it enables the client to be involved from the beginning in their treatment and also allows you to determine whether this approach will be suitable. In particular, an explanation of the cognitive behavioural model can be a powerful agent of change itself. For many clients it provides a framework in which to understand how to use the skills they already have and, sometimes, is all the client needs to make some initial changes. For others, it is the important beginning to learning new skills that will assist them to manage their symptoms.

Discuss your preliminary case formulation with the client

Focus on presenting the preliminary case formulation to the client (asking them for feedback).

Developing the case formulation with the client and actively seeking their feedback involves the client in their treatment and encourages collaboration. The formulation and psychoeducation you provide for the client will help the client to understand how their problem(s) developed and what is maintaining the problem(s) now. It will also shed light on how their AOD use impacts their anxiety, depression or somatic symptoms, and vice versa.

The pre-session preparation section gives an example of formal case formulation and an explanation suitable for the client.

Present the case formulation to the client and ask for their feedback. It may help to frame the formulation as a theory that needs to be checked out with them. Adjust the formulation to incorporate their input as necessary. Active encouragement may be required for a tentative client to comment and offer their input throughout.

Below is an example of how to introduce the idea of case formulation:

Thank you for taking the time to go through what has been happening for you in the past few years, in relation to […] target problem […]. I’m going to present a theory I have come up with, about how I think you have come to be where you are now in relation to this problem. I think this theory might be close, but I need you to help me get it right, so we both know what’s going on and what we are working with.

Point to remember
The case formulation should be regularly revisited and revised throughout treatment as new information comes to light.
Provide information about the client’s symptoms

Focus on helping the client understand the context of their mental health symptoms.

In addition to the case formulation, it is also important to provide additional (usually written) information about the nature of the client’s problem in more general terms. Psychoeducation is an important part of the first treatment session and aims to:

- Empower clients by providing them with expert information about their problems and what can be done to address them.
- Normalise clients’ problems by letting them know how widespread co-occurring problems are.
- Motivate clients to address their problems by focusing on the possibility for change.
- Help clients understand the relationships between drugs or alcohol and anxiety, depression and somatic symptoms, and their options for treatment.

Provide information about the client’s symptoms, using the symptom information worksheets (Worksheets 1 and 2). Clients should be routinely offered self-help material relevant to their most pressing concerns, as well as contact numbers for emergency help lines and support groups that may be useful.

Point to remember

In order to maintain engagement, ask the client’s permission before you provide them with any psychoeducation material.

Introduce the CBT model

Focus on providing a context for treatment and helping the client to see how their symptoms are triggered and maintained.

Step 1: Explain the CBT model to the client

An essential part of educating the client about the nature of their problems and providing a framework for treatment involves helping them to grasp the CBT model. Explain the full CBT model to the client, using the example presented in Figure 2. It may help to use a whiteboard or Worksheet 3: The CBT Model.

Step 2: Work through an example with the client

Use your formulation of the client’s problem to demonstrate the CBT model. This may include an hypothesis about why the client has a tendency to interpret situations (unhelpful thoughts) in the way that they do. At this point, it is essential to refer back to your formulation of the client’s problem(s) and use a real example to demonstrate the cognitive behavioural model.

It may be helpful to explain the model in sections then put it together. If the client is having difficulty understanding this model, the extension material for this session has two other ways to introduce the cognitive model that you could try.
Develop a joint treatment plan with the client

Focus on developing a shared understanding of the goals of therapy and what the next few sessions will look like. It is important that the client feels that there is a good justification for treatment and understands what they are trying to achieve, so that they have a strong sense of involvement in their own treatment.

Step 1: Articulate the links between formulation and treatment

Explain how treatment leads on from the formulation. Explain to the client what the formulation means for treatment. For example, if social anxiety is one of the triggers for alcohol use then strategies to address the anxiety are likely to be helpful.

Step 2: Develop a joint treatment plan

The treatment plan should follow naturally from the formulation. Make a joint treatment plan with the client that is appropriate for the person's mental health symptoms, level of commitment, skills and
goals for treatment. Decide which aspects of the extension materials provided in these guidelines are relevant to the client’s formulation, and develop a treatment plan that includes the relevant sections. Also explain to the client how the treatment strategies selected can address each of the trigger situations and underlying thoughts identified in the case formulation, and how these can assist them in reducing their symptoms and AOD use.

The treatment plan is best devised with a supervisor in the first instance. However, as a general guide, cognitive techniques are used to target unhelpful thoughts and beliefs contributing to the problem, while behavioural techniques are used to target behaviours maintaining the problem.

Clients presenting with predominantly anxiety-related symptoms respond well to:

- treatments targeting avoidance behaviours
- relaxation strategies
- addressing thoughts that evoke feelings of fear
- distraction techniques

Fear of being judged badly, rejected or noticed by others are common sources of unhelpful thinking. Sensitivity or intolerance to emotional states can be another source of anxiety. Often distraction techniques (both cognitive or behavioural) are useful in targeting worrying or ruminating.

Clients presenting with predominantly depressive symptoms respond well to:

- behavioural interventions targeting low motivation, such as behavioural activation
- cognitive interventions targeting unhelpful thoughts that lead to feeling hopeless or sad

**Young people** may also be more responsive and able to grasp behavioural, concrete strategies. Assertiveness training and relaxation may also be warranted. Cognitive strategies to challenge unhelpful thoughts reflecting beliefs that the person is worthless or unlovable are commonly applied. The extension material is designed to allow flexibility in your choice of cognitive or behavioural techniques.

**Step 3: Finalise and record treatment plan**

Once the treatment plan is agreed on, record the plan in the clinical file. Any other issues that require intervention outside the scope of these guidelines (e.g. housing, financial, detoxification) should also be incorporated into the treatment plan and addressed according to the usual practice of your treatment setting. Refer to the example in the pre-session preparation section.

The treatment plan should form part of the overall AOD treatment plan, consistent with an integrated treatment style. Some services may already have a treatment plan pro forma which the mental health intervention can fit into. Otherwise a treatment plan can be as simple as a list of immediate and longer term intervention plans and referral options. It is also useful to provide a written treatment plan for the client. The treatment plan would usually come straight after the formulation in the case notes.
SECTION 2

Introduce self-monitoring

*Focus on emphasising the importance of self-monitoring, explaining how to use the self-monitoring sheet and how it will assist the client to manage their symptoms.*

**Step 1: Explain self-monitoring to the client**

Breaking events down into situation, unhelpful thoughts, feelings and behaviours can take practice. So, ask the client over the following week to formally practice separating their experiences into these four parts. By asking the client to ‘self-monitor’, they will begin to gain new awareness about their thoughts and feelings and how they lead to behaviours, including alcohol and other drug use. This new awareness will be the basis for adjusting the formulation and treatment plan if necessary. Explain to them that, after practice, they will be able to automatically self-monitor their thoughts without writing them down. It is essential to convey to the client how important monitoring is in the initial stages.

**Point to remember**

By simply monitoring unhelpful thoughts, an important change occurs: clients begin to recognise that their thoughts are simply their interpretation of events, and not an absolute truth. This reinforces the opportunity for change.

**Step 2: Work through an example with the client**

Use *Worksheet 4: Self-monitoring* and demonstrate its use, using the following explanation as a guide:

- **Communicate the importance and relevance of the homework activity to the client.**
  
  *This exercise is an important first step in taking control of your thoughts and feelings. It involves a ‘real world’ experiment. Over the next week, please complete the self-monitoring record on each day.*

- **Explain how to use the sheet.**
  
  *Over the next week, pay close attention to those times and situations when you find yourself feeling depressed or anxious. While you are still getting used to this activity, you might not recognise that an unhelpful thought has occurred until you feel anxious or depressed. So, over the next week when this happens, try to ‘stop the clock’. Say to yourself, ‘STOP, SLOW DOWN, and fill in this sheet.’*

  Ask the client to write down the situation that led to the feelings in the ‘Situation’ column. Then, write down the unhelpful thoughts they have about that situation in the ‘Thoughts’ column, writing down their words as if they were speaking them out loud. In the ‘Feelings’ column, ask them to describe the feelings or symptoms they are experiencing. Finally, ask the client to indicate in the ‘Behaviours’ column what they did: e.g. whether they used alcohol or drugs, avoided the situation etc.

- **Ask the client to bring in the completed worksheet to the next session.**
Session Summary

*Focus on summarising the session and motivating the client to undertake their homework tasks and return to further sessions.*

At the end of the session, revise what has been discussed using the following outline:

**Step 1: Summarise session content**

Review what has been discussed during the session. For example, you may begin:

*So what we have talked about today is …*

**Step 2: Invite client feedback**

Ask the client for feedback on the session content and discuss any obstacles, issues, uncertainties they may have. For example, you may invite their feedback by saying:

*There’s been quite a lot to take in today. I’m wondering how you found that … Is there anything that I went over too quickly? Is there anything you want to ask?*

**Step 3: Reinforce homework**

Briefly troubleshoot any anticipated obstacles to completing the take-home tasks with the client and develop a plan for completing homework. The following steps may help encourage compliance.

1. Briefly explain the value of just taking 5 minutes each day, at the same time each day, to complete homework tasks.
2. Ask the client to nominate a time of day in advance when they could complete worksheets and/or practice relaxation. Encourage them to think about ways to minimise interruptions during homework time, like finding a nice quiet place away from everybody else just for the 5 minutes it takes to do the homework task.
3. It may also help to brainstorm answers to any questions other family members/friends might ask when they see the client completing homework activities. This may help avoid embarrassment or awkwardness, which can impact on compliance.

**Step 4: Prepare for the next step in treatment**

This could include arranging the next session, a very brief outline of the next session topic or discharge as appropriate.
Young People

Case formulation for young people

An excellent way to start the young person talking about their current situation is to ask them to focus on the family members and friends in their lives, the relationships between them and their importance to the young person. Doing this formally early on in treatment is also likely to build rapport and facilitate engagement.

Worksheet 24: Important people contains an exercise that can be completed as an alternative to formal case formulation with the young person. This exercise involves asking the young person to nominate the six most important people (or key players) in their lives at present, and then writing down the names and descriptions of these people in the spaces provided.

Spend some time discussing with the young person why these people are important or ‘key’ in their life, how they may be connected, what their relationship is like with these people, and what has happened with these six people in the recent past. This provides an overview of what is currently happening in the young person’s life that can be revisited at various times during therapy to see how things have changed. Once they are engaged, you can introduce some of the strategies used with adults, monitoring their reaction closely.

Psychoeducation for young people

Information about mental health symptoms can be provided to a young person using Worksheets 1 and 2, as for adults. Important additional advice to provide to the young person is a harm minimisation approach to discussing AOD use. In particular:

- advice about avoiding the use of cannabis or amphetamines if a history of mental health problems is present in the young person’s family
- discussion of increased risk factors for AOD use if there is a history of AOD problems in the family
- other information to reduce harm
- messages about reasons for AOD use (e.g. strategies to avoid using AODs as a coping strategy)

Adolescence is a time for experimentation with alcohol and other drugs and, to a certain extent, this is considered ‘normal’ social adolescent behaviour, so advice about safe alcohol and other drug use may also be warranted.

Psychoeducation for carers of the young person will also be important, given they will play a key role in monitoring symptoms, responding to behaviour etc. Adolescence is a time of change associated with the testing of boundaries, rejection of authority figures, experimentation, mood changes, behaviour changes etc. So it will often be difficult for parents to decide which behaviours or activities to be concerned about and which are just a normal part of growing up. Although this will vary from young person to young person, Worksheet 31: For parents – when to worry about adolescent behaviour provides some general, broad guidelines for parents that will potentially help them to sort through these issues.
**Explaining the CBT model to a young person**

The young client is likely to need a more concrete example of the CBT model than an adult in order to grasp its meaning for their thoughts, feelings and behaviours. Use **Worksheet 25: The ABCs** to demonstrate the links between situations, thoughts and behaviours in the following way:

- Ask the young person to imagine the scenario: two brothers are lying in bed, sleeping peacefully. Suddenly, they are both woken up by a sound at the window. One brother jumps out of bed and runs into his parents' bedroom. The other brother rolls over and goes back to sleep.

- Ask the young person why he/she thinks the two brothers reacted so differently (prompt for the idea that they both thought that the sound at the window was something different: e.g. burglar, ghost, stick, cat etc.). Write the explanation given by the young person in each of the ‘thought clouds’ on the worksheet.

- Ask the young person to describe what he/she thinks the brothers are feeling in response to this situation (e.g. fearful, calm etc.) and write these down under each brother on the worksheet, next to the description of their behaviour.

- Explain to the young person that the reason the brothers reacted so differently to the same thing was because they had different beliefs about what the sound meant. It was these beliefs that led to them doing different things, because these different beliefs resulted in different feelings for each brother. Behaviours are just the way in which feelings are shown on the outside, so the behaviours were different because the feelings were different. And the feelings were different because the brothers’ beliefs were different. This is despite the situation that sparked off (or ‘activated’) their beliefs being exactly the same. This is true for every situation that happens every day … the same situation will activate different beliefs in different people or at different times and this will lead to different feelings and behaviours (or consequences). This is called the ABCs of our environment.

- Label the A, B and Cs for the young person on **Worksheet 25: The ABCs**

- Further explain the ABC model to the young person using the following:

  So, it is not really the activating situation itself (the sound at the window) that caused one brother to get scared, rather it was his BELIEF about that situation (his thought that it was a burglar or a ghost) that caused him to feel scared and run to his parents' bedroom. The other brother experienced the same situation and reacted very differently. At this point in time, we don't know which brother was correct about the activating situation. So, what we need to do is to go out and collect more evidence or data about the sound at the window, in order to work out which belief is the correct one. The same thing is true for all the different situations that we experience every day. The same situation will lead to very different beliefs and these beliefs will lead to very different feelings and behaviours.

- It may be useful to refer back to the **Worksheet 24: Six important people**, which was covered at the beginning of the session as a stimulus for this discussion.

The conceptual model in Figure 2 may be too abstract for a young person to comprehend, but if the young person is able to understand the ideas presented in this way, Figure 3 shows the CBT model, using an example that has been chosen for its relevance to a younger age group. Use this model to work through a similar example based on the young person's own situation and concerns.
SECTION 2

Figure 3: CBT model for young people

Provide an example when explaining the CBT model to a young person. For example, you might explain the situation outlined in Figure 3 by saying:

The model shows that early events, whether positive or negative, form our views about ourselves and the world. These are called ‘core beliefs’. We develop both helpful and unhelpful core beliefs. It’s obviously only the unhelpful core beliefs we need to worry about. At some point in life, a trigger situation (or a build-up of stress factors) may stir up these core beliefs and activate what we call unhelpful thoughts. Thoughts then lead to feelings, which in turn lead to behaviours. Often our chosen coping behaviour (e.g. getting drunk) reinforces our perception and we end up in a vicious cycle. For example, you may be even more self-conscious next time at a social gathering because you made a fool of yourself when drunk at the BBQ.
After developing a cognitive behavioural formulation, it is important to revisit the cognitive model and translate the model into the client's own situation and words.

**Self-monitoring for young people**

Self-monitoring for the young person can be introduced in a similar way as for adults, and involves encouraging the young person to identify the ABCs of the situations they encounter in everyday life for themselves. If the young person has adequately grasped the above rationale, and is comfortable with the ABC model, it is appropriate to assign a self-monitoring task for completion between Sessions 1 and 2. A simplified, pictorial version of a self-monitoring form is contained in **Worksheet 26: Checking your thoughts and feelings** and can be introduced to the young person using elements of the rationale presented for adults as appropriate.

It is important not to overwhelm the young person with ideas of 'homework'. A rationale that describes this activity as an 'experiment' to 'test out whether this ABC idea holds up' in the young person's life is likely to elicit a better response. The **Checking your thoughts and feelings (Worksheet 26)** only allows for one event to be described as per the ABC model. You may decide to provide the young person with several copies of Worksheet 26 (one for each day between Sessions 1 and 2) to encourage additional practice of the ABC concept.

If the young person is not ready to identify the ABCs of his/her own situations via a self-monitoring form, an alternative is suggested in **Worksheet 27: Feelings check – other people**. This activity involves the young person monitoring other people in his/her life at various times between Sessions 1 and 2, and asking these other people to identify the thoughts and feelings relevant to the situation in question. This alternative may be appropriate for young people who are not particularly in tune with their feelings sufficiently to distinguish between frustration, anger, fear, sadness etc. This activity can be particularly useful for young people who present as angry/irritable, as a way of helping them to collect information about the subtleties of emotions, which can then be applied to their own feelings later on in therapy.

- **Use the following as a guide to introducing Worksheet 27:**
  
  *This session, we’ve been talking about what’s behind a person’s actions or behaviour. Over the next week, I’d like you to do a bit of detective work for me. I’d like you to try to pay attention to your family members […] or substitute alternative […] and try to work out what is behind their behaviours.*

  *On each day over the next week, I’d like you to pick one of your family members […] or alternative […] and look for signs of emotions (or feelings) in their behaviour. They might be smiling or laughing (indicating happiness) or frowning (indicating anger) etc. When you see this happening, check in with the person to see what they are actually feeling inside and what they are thinking at the time. Write this information down on the worksheet.*

- **Ask the client to bring in the completed worksheet to the next session.**

It is also important to discuss appropriate times to complete this activity with the young person. For example, if someone is on the telephone or is particularly upset or in the middle of an argument with another person, this is not the best time to take out this activity and complete the worksheet. If the young person would still like to use this situation for their worksheet then it is more appropriate to wait until the situation has calmed down, later in the day, to check-in with the family member.
Session 2: Identifying unhelpful thoughts

Aims
- Identify unhelpful thoughts
- Commence formal thought monitoring

Materials
- Completed homework – Worksheet 4: Self-monitoring worksheet
- New blank self-monitoring worksheet (Worksheet 4)
- Worksheet 5: Identifying unhelpful thoughts
- Whiteboard or pen/paper

Intervention checklist

Review and feedback
- Step 1: Review previous week and set agenda
- Step 2: Review homework tasks – contingency management

Provide information about identifying unhelpful thoughts

Practise identifying unhelpful thoughts
- Step 1: Identify unhelpful thoughts
- Step 2: Label unhelpful thoughts

Session summary

Homework
- Worksheet 4: Self-monitoring
- Worksheet 5: Identifying unhelpful thought patterns

Extension material

Extension material is provided for Session 2. These techniques can be used as well as or instead of the practice of identifying thoughts. The extension materials are primarily behavioural interventions. Usually clients find the more concrete behavioural tasks easier. If the client is not ready to undertake more complex cognitive sessions, or if you feel they require more intensive intervention before moving on to Session 3, you can replace Session 2 with the extension material and return to it later.

Extension material includes information about:
- behavioural activation
- guidelines for better sleep
- relaxation (includes suggestions for young people)
Young People

PsycCheck for young people
Alternative session 2 activities for young people are included for reviewing the week with the young person and self monitoring.

Materials
- Worksheet 24: Important people
- Worksheet 26: Checking your thoughts and feelings
- Worksheet 27: Feelings check – other people
**SECTION 2**

**Introduction**

After Session 1, the client should have an understanding of their symptoms, understand and agree with the CBT model and know how their symptoms fit into the model. They should also have started monitoring their thoughts.

Session 2 follows on from the homework task of self monitoring by using the information gathered from this exercise to increase awareness of thoughts and their emotional and behavioural consequences. After practising monitoring in Session 1 and at home, this session uses the results of the monitoring to examine thoughts more closely. Self-awareness is the key to change in CBT, so this session is particularly important. Many clients already have the skills to modify their thinking when they notice it, but they may rarely notice negative thinking.

**Review and feedback**

*Focus on reviewing the previous week, setting the agenda and reviewing homework tasks.*

**Step 1: Review previous week and set agenda**

A review of what was covered in Session 1, briefly summarising the formulation and the cognitive model again, is a good way to orient the client. You may want to check the client’s understanding of what was discussed, in case there has been any misunderstanding or they have questions. It is also important to orient the client explicitly to what will happen in the session.

For about 5–10 minutes, ask the person to briefly talk about their week. Ask about:

- any reflections they may have about the content of Session 1
- any significant events that occurred since the last session
- how their mood/anxiety/somatic symptoms are currently
- any changes in their symptoms, functioning or AOD use they have observed

Look for how the issues raised here may lead into the development of an agenda for this session. It is often useful for both clinician and client to write down the agenda items for reference throughout the session. Some clinicians find it useful to use a whiteboard. You should incorporate into the session agenda any issues the client has raised from the discussion of the previous week that may need to be addressed.

The first item on the agenda should always be reviewing homework from the previous session. This often is a useful bridge between sessions and also reinforces the importance of completing homework tasks. Then briefly explain the other issues and activities to be covered during Session 2, including identifying and labelling unhelpful thoughts. Once your explanation is complete, work through the agenda items.

**Step 2: Review homework tasks – contingency planning**

The homework task from Session 1 forms the basis for Session 2. It is therefore important that the client has completed the self-monitoring exercise. It is inevitable that clients will forget or neglect to complete their homework activities. Some reasons why people don’t do their homework:

- they didn’t understand the task
- the task was too difficult
- the task was too time-consuming
It is important to address why a client has not completed the task, in a therapeutic fashion. Some tips:
- Re-emphasise the importance of the homework without compromising the client’s motivation for treatment.
- Brainstorm some ideas to make completing homework easier.
- Spend the first few minutes of this session completing the set homework activities together.

You can use the following as a suggestion in managing homework:

*Sometimes things will come up during the week that make it difficult to complete homework and that is totally understandable. However, homework is one of the most important parts of this program as it is a really good way to take all the things that you learn during these sessions and try them out in the real world. It’s a way to test whether this program really works. Let’s have a talk about some of the difficulties you’ve had in making time for your homework tasks over the past week and we can come up with some ideas to make it easier for you to get this done.*

**Provide information about identifying unhelpful thoughts**

*Focus on assisting the client to understand the process of identifying thoughts and how this exercise can help them manage their unhelpful thoughts.*

It is likely the client now has a grasp of the cognitive behavioural model. They may already be able to separate out the thoughts, feelings and behaviours that arise from situations in their everyday life. When reviewing their self-monitoring homework exercise (*Worksheet 4, or Worksheet 26 for young people*), point out their tendency to interpret situations in a particular way that leads to feelings of depression or anxiety. You may identify a clear negative bias in their thinking, which is perpetuating their depression. Explain to the client:

*People who are vulnerable to depression tend to interpret situations with a negative bias and in ways that are usually critical of themselves. These interpretations often result in conclusions such as ‘I am worthless’ or ‘I am a failure’ [as the client has probably been able to note from their thought monitoring homework activity]. As we have talked about before, once this negative bias sets in, it is very hard to get out of and we tend to only pay attention to those thoughts and those parts of events that fit in with our negative view of ourselves and the world around us. Quite often these thoughts and feelings also give us a reason to use alcohol or other drugs.*

*In almost every situation, there are lots of different ways to interpret or explain it. It’s just that when our negative bias sets in, our first explanation is usually negative and we ignore all the other possibilities that are just as likely to be true.*

**Practise identifying unhelpful thoughts**

*Focus on practising the ‘theory’ of identifying unhelpful thoughts in session. It is important for clients to be able to practise skills in a safe environment first, such as that provided by the counselling session. It will also help to identify any barriers to practise at home.*
Step 1: Identify unhelpful thoughts

Return to the self-monitoring homework worksheet (Worksheet 4, or Worksheet 26 for young people) that the client completed. Choose an example from the client’s self-monitoring and ask the client to generate as many different explanations for this event as they can think of. Write all these on the handout or on the whiteboard. Many clients will have difficulty generating alternative ways to interpret the situation they were in. You may need to prompt or brainstorm alternatives with them.

This exercise will link in later with identifying unhelpful thinking errors, e.g. catastrophising, personalising, black and white thinking, jumping to negative conclusions, should/oughts.

Then, ask the client to identify how they would feel or what they might do according to each alternative explanation you have generated together. Summarise by explaining that even this one situation generated a number of possible different explanations, each of which were just as likely to be true, but resulted in lots of different feelings and behaviours (some of which were probably better than others).

Step 2: Label unhelpful thoughts

You have already explained that people who are vulnerable to depression tend to think in a characteristically negative way about events. This is done automatically, without people really ever stopping to question their interpretations. So, while the first step in changing this habit was to identify those thoughts, the next step is to teach the client to become more aware of this negative bias and the patterns they are automatically falling into. An easy way to do this is to teach clients to label or categorise their thoughts.

Use Worksheet 5: Identifying unhelpful thought patterns to assist in the explanation of this activity. Explain to the client:

People with depression and/or anxiety tend to fall into some characteristic patterns of unhelpful thinking, as listed here on this form.

Take the client through the five types of thinking patterns listed on the worksheet, explaining each one. Then practise detecting unhelpful thought patterns, using an unthreatening example.

Apply this knowledge to the client’s real life examples by practicing detecting unhelpful thought patterns using their self-monitoring homework. Explain to the client:

An important part of managing your depression/anxiety/etc., and those situations that trigger low mood or anxious symptoms, is to become aware of your own unhelpful thinking patterns. You need to work out which ones on this list […] unhelpful thought patterns […] apply to you and your habits. This will also help you in the future to recognise the patterns associated with a relapse. So, let’s look back at your self-monitoring worksheet from the past week.

Once a client has identified the unhelpful thought patterns that apply to them, it is important to learn ways to identify them in real life situations. Over the next week, ask the client to complete the self-monitoring worksheet again (Worksheet 4, or Worksheet 26 for young people). Following this, ask the client to go back to the self-monitoring sheet they have just completed and label each of the thoughts in the ‘Thoughts’ column according to the unhelpful thought pattern in which they engaged.
Session summary

Focus on summarising the session and motivating the client to undertake their homework tasks and return to further sessions.

At the end of the session, you should revise what has been discussed, using the following outline:

- Summarise session content.
- Ask the client for feedback on the session content.
- Reinforce homework.
- Arrange ongoing monitoring of their symptoms, arrange feedback or discharge.

It is crucial at this time to:

- offer supportive, encouraging statements as in the last session
- encourage progress made already
- thank the client for completing their homework tasks from last session
- encourage them to complete the tasks set for the coming week

Affirming the client can be helpful as it:

- strengthens the work relationship
- enhances the attitude of self-responsibility and empowerment
- reinforces effort and self-motivational statements
- supports client self-esteem

Reviewing the week with a young person

Worksheet 24: Important people completed during Session 1 is a useful way of starting the session with a young person. Take out the completed worksheet and ask the young person to describe what has happened with these important people since the last time you were together. Make any amendment/additions to the information about the six important people as necessary. This may provide some ideas for the session agenda and can lead into a discussion about the young person themself (see Step 2: Review homework tasks – contingency planning).

Young people who did not complete self-monitoring for Session 1

If the young person completed Worksheet 27: Feelings check – other people instead of Worksheet 26: Checking your thoughts and feelings, process this activity with them and move on to an explanation of Worksheet 26, using the description in Session 1.

Assign Worksheet 26 as homework for Session 2.
Session 3: Managing unhelpful thoughts

Aims
- Assist clients to understand how to manage and challenge their unhelpful thoughts

Materials
- Worksheet 4: Self monitoring
- Worksheet 6: Steps in managing unhelpful thought patterns
- Worksheet 7: Managing unhelpful thought patterns
- Whiteboard or pen/paper

Intervention checklist

Review and feedback
- Provide information on challenging unhelpful thoughts
- Practise challenging unhelpful thoughts (cognitive intervention)
  - Step 1: Challenge unhelpful thoughts
  - Step 2: Practise acting on changed thinking

Session summary

Homework
- Worksheet 7: Managing unhelpful thought patterns

Extension material
Extension material is provided for Session 3. These techniques can be used as well as or instead of the practice of challenging thoughts. The extension material for this session, communication skills, is a more concrete task than challenging thoughts and may be easier for some clients. If the client is not ready to undertake more complex cognitive sessions, or if you feel they require more intensive intervention before moving on to Session 4, you can replace Session 3 with the extension material and return to it later. Or if a client completes Session 3 and appears to have a specific deficit in communication skills that might be affecting their ability to practise thought challenging, this session can be used in addition to Session 3.

PsyCheck for young people

Alternative Session 3 activities for young people are included for reviewing the week with the young person and information about challenging unhelpful thoughts.

Materials
- Worksheet 24: Important people
- Worksheet 26: Checking your thoughts and feelings
**Introduction**

Session 3 is designed to develop skill in managing unhelpful thinking once it has been identified. In this session, the client will move from practice of monitoring thoughts (Session 1) and practice of analysing unhelpful thoughts (Session 2) to the next step of modifying unhelpful thinking. It is important to allow time in the session to practise these skills as the activities in Session 3 are some of the more difficult and require the most change. It may be necessary to spend a few sessions on this material.

**Review and feedback**

*Focus on summarising the last session, reviewing the past week and homework tasks, asking the client to give feedback and setting the agenda.*

Ask the client to talk you through their monitoring using the self-monitoring worksheet (Worksheet 4, or Worksheet 26 for young people). Did they have any difficulties filling in the worksheet? If so, help them to troubleshoot by going through a few examples with them. If they used the worksheet successfully, ask if the procedure had any impact on their feelings about the situation.

**Provide information about challenging unhelpful thoughts**

*Focus on assisting the client to understand how to challenge their unhelpful thinking and why this is important.*

Once a client has identified the unhelpful thought patterns that apply to them, it is important to learn ways to identify and challenge them in situations. Explain to the client the main steps to changing unhelpful thought patterns:

1. Catch yourself thinking in this way.
2. Recognise the thought pattern for what it is.
3. Substitute it with a more helpful or reasonable set of thoughts.

The client has already had some training in identifying the thoughts that are triggered by situations, and the previous exercise started them in the process of recognising their negative thinking biases. You now need to teach the client a method of implementing this in practice in their everyday life. This involves several key steps as outlined below.

**Point to remember**

The aim is not to think in unrealistically positive ways about things, but to think more adaptively and to leave out the unnecessary negative distortions. In many instances, however, the client may be in a very negative situation. So it is important to look at a ‘more helpful or adaptive’ way of interpreting the situation. This may not mean challenging whether the situation is negative (e.g. relationship problems), but looking at a way to reduce anxiety or depression so the client can deal with the situation better.

Introduce Worksheet 6: Steps in managing unhelpful thought patterns and explain the steps to the client in the following terms:

1. The client needs to recognise when these unhelpful thoughts are occurring. Depressive/anxiety symptoms, negative feelings and cravings for alcohol or other drugs are all signs that these thoughts have been triggered.
2. The client then needs to ask him/herself: ‘Have I just had an unhelpful thought?’ The answer is most likely ‘yes’.
3. The next step is to teach the client to distance themselves from their thoughts so that they can see them for what they are. Explain that thoughts are just thoughts – events in the mind. Nothing more. Thoughts are not facts; all thoughts are just events in the mind. So, when a client detects an unhelpful thought, ask them to stop and step out of their automatic pilot and remind themselves:

‘Thoughts are just thoughts. They are not facts and I am not my thoughts.’

4. Next the client focuses on the content of their thoughts – they look at them objectively and ask themselves:

‘Which unhelpful thought has happened here?’

Encourage the client to label such thoughts as ‘catastrophising’, ‘personalising’, ‘jumping to negative conclusions’, ‘black/white thinking’ or ‘shoulds/oughts’.

5. Then, the client asks:

‘What are the facts here. What things in this situation do I know are 100% true?’

and then:

‘Do these thoughts fit with the facts?’

or:

‘What is the evidence that this is true?’

6. Finally, the client answers the questions:

‘If I take the facts into account in this situation, is there any other way of looking at what has happened? Which other way can I interpret this situation?’

If this alternative explanation is just as likely to be true, but does not result in the same negative or anxious feelings and/or cravings, then this alternative option is a better one for the client.

**Practice challenging unhelpful thoughts**

*Focus on practicing the ‘theory’ of challenging unhelpful thoughts. It is important for clients to be able to practice skills in a safe environment first, such as that provided by the counselling session. It will also help to identify any barriers to practice at home.*

Ask the client to practice the process of challenging unhelpful thoughts over the next week. Explain that this new process of monitoring and managing their thoughts will take practice and some time to get used to. So, to start with, it is important to formalise the process and write down each of these steps as they happen. Be sure to communicate the importance of this task to the person. Ask the client to complete Worksheet 7: Managing unhelpful thought patterns as homework, including each situation that triggers an unhelpful thought.

It is most likely that the previous week presented many opportunities for clients to identify their unhelpful thought patterns in relation to their depression, anxiety, other symptoms and their AOD use.

Because the unhelpful thoughts are automatic and have been practiced so often, they are usually more strongly believed by clients than the helpful thoughts are at first. In order to strengthen their belief in the helpful thinking, it is important for clients to practice this new thinking daily. To reinforce their belief in this new style of thinking, clients also need to start to collect evidence that supports these new patterns and begin to act according to the helpful thoughts.

Go through your client’s self-monitoring worksheets from the past few weeks and ask him or her to suggest ways of acting on the basis of their more helpful thinking in these situations. Set some specific tasks together that would test out their new thinking.
In addition, discuss the importance of continuing to complete Worksheet 4: Self-Monitoring and Worksheet 7: Managing unhelpful thought patterns on a weekly basis until the client is thinking and reacting more positively to the situations in their everyday life. Provide spare copies of these worksheets (Worksheets 4, 7 and 26 – for young people) to support this practice.

Session summary

*Focus on summarising the session and motivating the client to undertake their homework tasks and return to further sessions.*

At the end of the session, revise what has been discussed using the following outline:

- Summarise session content.
- Ask the client for feedback on the session content.
- Reinforce homework.
- Arrange ongoing monitoring of their symptoms, arrange feedback or discharge.

It is crucial at this time to:

- offer supportive, encouraging statements as in the last session
- encourage progress made already
- thank the client for completing their homework tasks from last session
- encourage them to complete the tasks set for the coming week

Affirming the client can be helpful as it:

- strengthens the work relationship
- enhances the attitude of self-responsibility and empowerment
- reinforces effort and self-motivational statements
- supports client self-esteem

If the client will be discharged from treatment after this mental health intervention is completed, foreshadow the cessation of treatment before the final session. Notice the client’s reaction at this point (e.g. discouragement, pessimism, greater reports of problems etc.). Terminating the clinician/client relationship may result in a certain level of emotional distress to the client and may, in turn, find expression through generalised negative feelings. Therefore, it is important to help the client to understand the process of termination so as to help them cope more effectively. Alternatively, discuss any plans to continue contact with the client once this intervention is completed and begin to make plans to monitor mental health symptoms and undertake booster sessions as needed.

**Young People**

**Reviewing the week with a young person**

*Worksheet 24: Important people*, completed during previous sessions, is a useful way of starting the session with a young person. Take out the completed worksheet and ask the young person to describe what has happened with these important people since the last time you were together. Make any amendments or additions to the information about the important people as necessary. This may provide some ideas for the session agenda and can lead into a discussion about the young person themselves.
Information about challenging unhelpful thoughts for young people

It may be useful to go back to the ABC model described in the extension material for Session 1, when explaining the above rationale to a young person. Essentially, challenging unhelpful thoughts involves adding one extra step to the ABC model, so that it now becomes the ABCD model (D = data). This final step is about the young person going out and collecting data (or evidence) about their thoughts/feelings with a view to testing their accuracy. You may find it useful to draw this new ABCD model on a whiteboard/sheet of paper for the young person, and highlight the A, B, C & D elements of Worksheets 6 and 7 to enhance their explanation of this cognitive intervention.

Session 4: Relapse prevention

Aims

☐ Help the client predict and manage relapse to both disorders

Materials

☐ Worksheet 7: Managing unhelpful thought patterns
☐ Worksheet 8: Breaking the rule effect
☐ Worksheet 9: Looking after yourself
☐ Whiteboard or pen/paper

Intervention checklist

Review and feedback

Provide information about relapse prevention

☐ Step 1: Identify triggers for relapse
☐ Step 2: Identify early warning signs
☐ Step 3: Explain the ‘breaking the rule effect’

Develop a relapse prevention plan

☐ Step 1: Explore ways the client can regulate thoughts and feelings
☐ Step 2: Emphasise the need for additional skills and supports
☐ Step 3: Remind the client to self-reward
☐ Step 4: Encourage the client to take care of themself

Session summary and treatment termination

Extension material

Extension material is provided for Session 4. The extension material for this session builds on the core material for the session. It is recommended that the extension material is used as a supplement rather than a replacement for Session 4 activities:

• problem solving
• seemingly irrelevant decisions
PsyCheck for young people

Alternative session 4 activities for young people are included for reviewing the week with the young person, information on preventing relapse and relapse prevention practice. There are also two additional areas to consider when undertaking PsyCheck with young people. These are:

- Managing deliberate self harm
- Offering advice for carers

Materials

- Worksheet 24: Important people
- Worksheet 28: What’s stressing you?
- Worksheet 29: Distraction techniques
- Worksheet 30: Uppers and downers
- Worksheet 32: When should carers worry about adolescent behaviour?

Introduction

Once clients have learned the skills and behaviours to help alleviate their mental health symptoms and their use of alcohol or other drugs, they are ready to begin to maintain the gains they have made. This session will help to anticipate situations in the future that pose risks to the client in terms of relapsing into depression, anxiety and alcohol or other drug use. This session can be a way of increasing the client’s confidence about how they will cope in these high-risk situations, perhaps circumventing a relapse in the process.

At this stage, both you and the client have the benefit of hindsight to assist in collaboratively preparing for future high-risk situations. That is, you should both now have a good understanding of how the client has responded to the different skills and techniques from previous sessions, as well as how they relate to events, thoughts and behaviours. In addition, the client will have incorporated some of the skills and techniques into their coping strategies, and will have a greater understanding of their problem.

The course of events that led the client to their current situation has already been discussed in the preceding three sessions. It is now time to work out an individualised relapse prevention plan that deals with future situations associated with relapse. Once the events that contribute to their feelings of anxiety and depression or problematic patterns of alcohol or other drug use have been identified, these events will form the basis for the development of a relapse prevention plan.

Review and feedback

Focus on summarising the last session, reviewing the past week and homework tasks, asking the client to give feedback and setting the agenda.

Review homework with the client as for previous sessions. Emphasise that they may need to continue practicing these homework tasks until they feel confident that these skills are well practiced. Review Worksheet 7: Managing unhelpful thought patterns. Praise their efforts and encourage them to persist, as it can take a while for the new rational thinking to become as strong and believable as their old negative thinking. Process the worksheet in the session with the client, using some of the following questions as applicable:
Were you able to detect your unhelpful thought patterns in situations?
How effectively were you able to turn off the ‘automatic pilot’ and challenge these thoughts?
What were the consequences (feelings, behaviours)?
Were there any problems?
What did you think about the activity?

**Provide information about relapse prevention**

*Focus on explaining the steps in making a relapse plan, re-emphasising the self-help nature of CBT.*

**Step 1: Identify triggers for relapse**

The behavioural analysis of triggers conducted in the preparation sessions is a good source of information regarding high-risk situations for relapse and it is useful to revisit these situations, symptoms or behaviours here. It is important that the client understands that the same tools they have learnt to use to treat their anxiety or depression in the past three sessions can be utilised to prevent relapse in the future. These tools can be used whenever the client needs them; they don’t necessarily have to re-engage in treatment to prevent relapse. Remind them that CBT is a self-help model.

Useful questions include:

* What situations do you consider to be high-risk for relapse?
* How will you know when a lapse occurs?
* Who can help you maintain the skills you have learnt?

If the client is familiar with these concepts from AOD treatment, draw a link here. Look at how alcohol or other drug use might contribute to relapse of mental health symptoms.

**Step 2: Identify early warning signs**

Early warning signs of relapse may include many of the symptoms the client will have identified at the beginning of the intervention on the PsyCheck. They may consist of behaviours, thoughts or feelings. Often clients identify signs of relapse too late, when the target problem has taken hold again. Intervening earlier and re-utilising the tools learnt during the intervention is the key to preventing relapse. Early warning signs will have been elicited in your formulation of the target problem. The key to identifying early warning signs is to devise concrete examples of when to utilise their new cognitive and behavioural tools. For example, if the client’s cognitive behavioural assessment showed they lose their appetite and need to sleep longer hours in the lead-up to feeling depressed, you may quantify how much sleep is ‘too much’ or how much weight they need to lose before they become concerned they might relapse.

**Step 3: Explain the ‘breaking the rule effect’**

It is important to talk with the client about something called the ‘breaking the rule effect’. Often people who have been trying to change their alcohol and other drug use, or their depression or anxiety conditions, will feel very bad about themself if they have a lapse. They will probably see it as the end of the world or a finish to their attempts at overcoming their old patterns of thinking and behaviour. Your client may have already had some of these thoughts.
Give the following explanation to your client:

*The ‘breaking the rule effect’ could happen if you have a slip-up and ‘break your rules’. These rules could be staying off [...] completely or cutting down to a lesser level. Or your rules might be about staying well and not getting depressed or anxious again. The ‘breaking the rule effect’ happens when you have slip-up and break your rules or goals for therapy, and then think something like: ‘Oh stuff it, I’ve had a [...] – broken my rule – might as well keep going’. Or you might notice on some days that you feel a bit more depressed or more anxious and run-down than others. In these cases, the ‘breaking the rule effect’ would be you thinking something like: ‘Here I go again – I knew this therapy wouldn’t work. I’m not good enough to change so, stuff it, I won’t try anymore’.*

In each of these cases, there are other ways of looking at the situation. Slip-ups will happen – everybody makes mistakes. It doesn’t mean that you have failed completely. You can stop at one [...] and go from there – start with a clean slate. With depression and anxiety, realise that your mood will sometimes be lower than at other times. It doesn’t mean you are getting worse or headed for a relapse, rather that you are experiencing what everybody does – a simple change in mood that won’t last forever. But, if you have a slip-up, it is more likely to turn into a relapse if you give in to the ‘breaking the rule effect’.

The main thing to help you cope with the ‘breaking the rule effect’ is to change those unhelpful thinking patterns that cause the effect. Just like in your monitoring record, you need to realise that you are falling into that pattern of unhelpful thinking. In particular, the ‘breaking the rule effect’ is an example of black and white thinking, catastrophising and jumping to negative conclusions. So, all you need to do is to develop other ways of thinking about your slip-ups – because everybody makes mistakes, everybody will have a slip-up. It is not the end of the world and it doesn’t mean that you have failed.

Give your client a copy of *Worksheet 8: Breaking the rule effect*. Go through the alternative patterns of thinking he/she could adopt in response to a slip-up.

**Develop a relapse prevention plan**

*Focus on tailoring the relapse plan to the client, helping them to think through some of the possible responses to real life situations that might trigger relapse to anxiety or depression symptoms.*

Remind your client of the importance of developing a lifestyle that supports the positive changes they have made and that fits in with their goals. Developing a relapse prevention plan in advance of problematic situations is essential. It is a lot easier for a person to recognise warning signs while their mood is stable.

A relapse prevention plan can be as simple as contacting their AOD counsellor or general practitioner for assistance when they notice early warning signs, or as complex as making lifestyle changes incorporating long-term behavioural change, like daily exercise and relaxation and stress management. There are some key elements that make up a relapse prevention plan (the following steps have been adapted from Kay-Lambkin, Hazell & Waring, 2000).

**Step 1: Explore ways the client can regulate thoughts and feelings**

It is important to explain to the client that it is normal for him/her to lapse and that it is common when attempting to change unhelpful thought patterns. Catastrophising normal mood and anxiety fluctuation is also a normal response when someone has recently recovered from experiencing severe anxiety and depression. Reassure the client that these thoughts and feelings are temporary responses to a situation that he or she can modify and learn from.
Useful questions include:

- What is a reasonable way to respond to this situation?
- What might be an unreasonable thought or feeling in response to this situation?
- What can you do to deal more effectively in this situation?

**Step 2: Emphasise the need for additional skills and supports**

Emphasise to the client the importance of taking stock of everything they have discussed and practiced in therapy. This is a good opportunity for you to ask the client whether they have any additional skills they think they may need. The additional sessions in this manual are a good place to start. When discussing relapse prevention, it’s important that the client considers involving a support person. This will ensure two things:

- that your client has shared his/her decision to make a positive change (this will provide an additional incentive to maintain the changes achieved)
- that your client can receive support from someone who they know well and who will support them to prevent/better manage relapses

**Step 3: Remind the client to self-reward**

Point out to the client that they need to create their own reward. It is unlikely that the client will receive any accolades for maintaining high levels of functioning from anyone other than from him/herself.

Useful questions include:

- How will you know that you are successful in maintaining your behaviour/thoughts?
- How can you reward yourself for a job well done?

**Step 4: Encourage the client to take care of themself**

Explain to the client that part of preventing a relapse for depression, anxiety and/or alcohol or other drug use is for them to gradually learn ways to take care of themself, as well as identifying early warning signs and triggers for relapse. Clients need to learn that, even when life seems too busy and full of things to do, it is essential to prioritise activities that they enjoy as well as those which provide a sense of achievement. It is important to continue to schedule those enjoyment and achievement activities into each day and to minimise involvement in activities that drain their energy reserves and mood.

Use **Worksheet 9: Looking after yourself** to discuss ways to ensure your client continues to include enjoyment and achievement activities in their day. Focus on minimising their participation in other activities that threaten to tax their resources.

**Session summary and treatment termination**

Summarise the client’s progress throughout the sessions and:

- reconfirm the most important factors motivating the client
- summarise the commitments and changes made so far
- affirm and reinforce changes already made
- elicit self-motivational statements for maintenance of change and further change
- support self-efficacy for maintaining change
Young People

Reviewing the week with a young person

The Important people worksheet (Worksheet 24) completed previously is a useful way of starting the session with a young person. Take out the completed worksheet and ask the young person to describe what has happened with these important people since the last time you were together. Make any amendments or additions to the information about the important people as necessary. This may provide some ideas for the session agenda and can lead into a discussion about the young person themselves.

Information on preventing relapse for young people

Young people will benefit from a discussion of the above steps. However, it may be useful to identify key ‘stresses’ in their lives prior to talking about ‘warning signs of relapse’. Additionally, this may be the young person’s first episode of illness and they may not have the experience of previous episodes to draw on, so framing the discussion of warning signs and stresses with this in mind will be more relevant. Worksheet 28: What’s stressing you? can be used to supplement this discussion if not previously used.

Relapse prevention practice for young people

For young people, Worksheet 30: Uppers and downers is an alternative way of representing this information. Using this worksheet, ask the young person to identify those things in their lives that ‘lift them up’ and write these things in the ‘balloons’ provided. Then discuss with the young person the things that ‘drag them down’ and write these things in the ‘rocks’ provided. Highlight the importance of making sure there are more ‘uppers’ than ‘downers’ in everyday life, using the above rationale.

Post PsyCheck activities

Although this is the end of the 4-session PsyCheck Intervention, it is important to:

- continue to monitor the client’s mental health symptoms
- refer to skills acquired in future contacts with the client
- consider offering booster sessions as required

Other considerations

When and how to refer to mental health services

There are four main reasons for making contact with a mental health service on behalf of your client. These are:

- If you suspect the client has an undiagnosed or untreated psychotic disorder. For example, if the client appears to hear or see things that others don’t (hallucinations) or to hold delusional beliefs or to demonstrate bizarre behaviour – especially if these symptoms persist after a period of detoxification and stabilisation.
- If you suspect that the client has an undiagnosed or untreated bipolar disorder, as indicated by the presence of manic symptoms such as a decreased need for sleep or food, a marked period of productivity, rapid flow of thoughts or speech and an exaggerated sense of self-esteem or invincibility.
- If the client has such a deep depression that there is a high risk of suicide or self-harm (see the section on Suicide/Self-Harm Risk Assessment in the PsyCheck User’s Guide).
- If the client has not responded to the brief interventions and you want a second opinion.
Who to contact for mental health services depends on what services are available in your State and region. You could contact:

- a psychiatrist, clinical psychologist or other mental health professional in your own service, if one is available
- a specialist dual diagnosis consultant, if available
- an intake or triage officer at the client’s nearest community mental health service
- if you are in a rural or remote area where mental health services are not easy to access, try your local general practitioner and ask if there is a visiting psychiatrist or clinical psychologist

Before you make contact with a mental health professional, explain to the client the reasons for the contact and ask the client’s permission to do so. Also discuss your plans with your supervisor if you have any questions or concerns.

When you make contact with a mental health professional, introduce yourself and your service and say that you suspect your client has one of the mental health problems described above and that you would like to arrange for a diagnostic assessment. Indicate that you would like to take a collaborative approach to the client’s treatment and clearly describe what role you would like to take in terms of what treatment interventions you can provide at your service.

Managing deliberate self-harm in young people

In young people, suicidal thoughts, attempts and other self-destructive behaviours occur 50–120 times as often as deaths from suicide (Martin, 1995).

Self-harm in young people is associated with lack of problem-solving skills and relationship difficulties within the family. Under extreme distress, young people’s focus will narrow until they have no sense of their past (and so are unable to access any helpful strategies they may have learnt) and no sense of future, thus negating any feelings of hope. Their only awareness is of their distress.

Tip: Reminders in the form of notes, lists and posters of strategies can be used to cope at times of distress.

Self-harm is most commonly used to alleviate emotional distress especially related to anxiety and anger (Krawutz & Watson, 2000). Successful intervention will lead to more adaptive ways of dealing with distress. You may suggest alternatives that are less harmful, distraction activities and self-soothing activities. These could include:

- physical activities such as going for a walk or run
- distraction such as reading a book, cooking, snapping an elastic band on the skin, holding ice cubes
- pleasurable activities

Worksheet 29: Distraction techniques lists some strategies that could also be used in these situations and this handout can be given to the young person.

It may also be necessary to offer the young person medication to assist them to deal with their distress.

Following an episode of deliberate self-harm, undertake a risk assessment to establish future suicide risk and the presence and nature of any mental illness or disorder. Explore with the young person the events leading up to the self-harm attempt (Whitehead & Royles, in Regel, 2002). Questions should identify significant events as well as the thoughts and feelings that accompanied them.
Offering advice for carers of young clients
You may find it useful to hold one or more joint sessions with the young person and their family/parents/carers. If not previously discussed, Session 4 – with its focus on planning for the future and preventing relapse – could present an ideal time to discuss issues around carer expectations for ‘normal’ behaviour and when they should become concerned enough about a young person’s symptoms or behaviours to mobilise treatment. Worksheet 32: When should carers worry about adolescent behaviour? contains an activity that can be used to structure a discussion about these issues during joint sessions and to develop a plan for carers to follow after formal treatment has ceased.

Explain to the carers of the young person that a collaborative approach to their care, particularly if mental health problems have been present, is to liaise with the young person’s doctors, case manager, counsellor and their teachers at school (if relevant) to decide whether any change in behaviour is worthy of concern.

Work through Worksheet 32 with the relevant carer(s) to decide what the limits are for the young person in terms of ‘normal’ physical health, mood changes, social functioning, school functioning and engagement etc., and when to raise the alarm.
SECTION 3
SECTION 3:

Extension material

These sessions are optional or additional sessions, which may be useful depending on your client’s needs. There are markers in the four-session *PsyCheck* Intervention outline indicating where these sessions may be appropriately implemented.

- You may wish to complete the four *PsyCheck* Intervention sessions and then come back and add sessions where required to address specific issues.
- If a client is not ready to move on to the next session, you may choose to include these sessions as a ‘holding technique’ or to maintain momentum without pushing the client.
- You may assess that the client requires further intervention at a particular step and use these additional techniques to enhance potential outcomes.

* This section is based on the work of Jarvis et al. (2002), Persons et al. (2001) and Segal et al. (2002)
Session 1 Extension material

Introduce the CBT model (alternative 1): Simplified version

Explain the CBT model to the client, by starting with the simple concept that the way in which we interpret situations determines how we feel and behave. To consolidate the concept, you may want to use a simple example as shown in Figure 4.

*Events or situations usually don't directly cause feelings or behaviour.*

<table>
<thead>
<tr>
<th>Situation</th>
<th>Thoughts</th>
<th>Feelings</th>
<th>Behaviour</th>
</tr>
</thead>
</table>

Instead, our interpretation of (thoughts about) the event or situation determines how we feel and how we behave.

*For example, imagine you are in a situation where a group of people near you at a BBQ is laughing. If your thoughts were, 'They're laughing at me', you may feel angry, upset or ashamed. You might then storm off or burst into tears or get drunk. However, if someone else was in the exact same situation but thought, 'They look like they're having a good time', they might feel happy or indifferent. Their behaviour would then be very different. They might even smile in the direction of the group or even go and join it.'*

Figure 4: Simple CBT model

Summarise by explaining:

*This process happens for every situation we encounter, especially those that trigger feelings of depression or anxiety. Quite often, this whole process happens so quickly we don't even realise that it has happened – it is almost automatic. Usually, we suddenly realise we are feeling bad or are having a craving to use alcohol or other drugs. These feelings are often the signal that we have had an unhelpful thought about the present situation that has resulted in a craving, anxiety, depression or other symptoms.*

It is important to highlight that a lot of the time we can't control the situation we are in, and so it makes sense that we need to change the way we think in order to change the way we feel and behave. If we can change our situation, then it is important to know the types of events that are likely to trigger unhelpful thinking, feelings and behaviours.
Introduce the CBT model (alternative 2): ABCs

The ABC cognitive model (Figure 5) is an alternative framework for explaining the cognitive behavioural process, and can assist the client in regaining some control over their environment (Beck et al., 1979; Ellis & Harper, 1975; Graham et al., 2000).

![Figure 5: The ABCs](image)

Explain the ABC model to the client in the following way:

*The ABC model shows that when particular situations happen (A = activating events), they trigger certain thoughts (B = beliefs), and these ‘B’s cause our feelings or control our behaviour (C = our consequences). The initial situation (A) doesn’t have much to do with our feelings at all, rather it is our interpretations and our response to that situation that controls how we feel. So, it is important to learn about the links between what happens out there in the world, our thoughts about those situations and our feelings and behaviour.*

**Step 1: Demonstrate the link between thoughts and feelings/behaviour***

Use Worksheet 10: Interpreting situations to lead the client through the following exercise. This exercise assists the client to demonstrate the link between thoughts and feeling/behaviour (utilising the ABC model) as it relates to their own lives.

Ask the client to imagine the scenario that appears on the handout:

‘You see a friend across the street and call out to him/her to say hello. Your friend keeps walking up the street...’

Ask the client to interpret this event. What is the first thought that comes into their mind? Write this down on the handout. Then, ask the client to identify how they would feel or what they might do in this situation, with this interpretation of the event.

Fit the ABC model to this exercise.

- A = the scenario (the activating event)
- B = interpretation or explanation the client generated to explain the event
- C = how they would feel or what they might do

Summarise by explaining:

*This process happens for every situation we encounter, especially those that trigger our depression or a craving to use alcohol or other drugs. Quite often, this whole process happens so quickly we don’t even realise that it has happened like this – it is almost automatic, a reflex. Usually, we just suddenly realise we are feeling bad, or are having a craving to use alcohol or other drugs. These feelings are often the signal that we have had an automatic thought about the present situation that has resulted in a craving, negative mood or other symptoms.*
Give the client an example that is relevant to using alcohol or other drugs, where the ‘C’ of the situation is drinking or using. For example:

*Jim is at home most days, with very little to fill his time. On a particular day he starts to get very bored and can’t find anything to do with his time (A). Then he starts to think: ‘Nothing good ever happens to me, I’ve got nothing to do and nobody to do anything with. Life sucks.’ (B). He gets very caught up in these thoughts and starts to feel depressed (C), then starts to drink to make himself feel better (C).*

Give the client a copy of the completed Worksheet 10 to take home and refer to over the next week. Keep your own copy of this completed worksheet, as you will refer back to it in Session 2.

Explain to the client:

*In working out how to manage thoughts and feelings, we first need to find out which situations are most likely to lead you to drink or use, or to feel depressed or anxious, and what you are thinking and feeling in those situations. We want to learn what kinds of things are triggering or maintaining your thoughts and feelings. Then we can try to develop other ways you can deal with these 'high-risk' situations.*

**Step 2: Monitoring the ABCs**

Breaking events down into their ABCs can take practice. So, over the next week, ask the client to formally practice identifying the As, Bs and Cs of situations. Explain clearly to the client that these situations can relate to when they are feeling bad or low or depressed as well as those times when they feel like drinking or using (having a craving). The same exercise can be applied to any of these experiences.

Introduce Worksheet 11: Monitoring the ABCs and demonstrate its use (using the following explanation as a guide):

*This exercise is an important first step in taking control of your thoughts and feelings. It involves a 'real world' experiment. Over the next week, please complete the self-monitoring record on each day.*

Be sure to communicate the importance and relevance of the homework activity to the client.

Explain how to use the worksheet:

*Over the next week, pay close attention to those times and situations when you find yourself feeling depressed and/or have the craving to use alcohol or other drugs. While you are still getting used to this activity, you might find that you don't realise such a situation has occurred until you get those feelings (the Cs) that are associated with depression or a craving for alcohol or other drugs. So, when this happens, try to 'stop the clock'. Say to yourself: 'STOP, SLOW DOWN, and fill in this sheet'.*

Using the worksheet, ask the client to write down the trigger situation that led to the feelings in the ‘Situation’ column. Then write down the automatic thoughts they have about that situation in the ‘Thoughts’ column, writing down their words as if they were speaking them out loud and using the words that actually come to mind. In the ‘Feelings’ column, ask them to describe the feelings or symptoms they are experiencing (including whether they experience a craving). Finally, ask the client to indicate in the ‘Behaviours’ column what they did (e.g. whether they used, drank, put themselves to bed, tried to switch off etc.).

Ask the client to bring in the completed form next session. Remind them:

*The main point of this activity is that, once we know about the situations and problems that contribute to your drinking/using/feeling bad, we can look for other ways to deal with those situations.*

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* This section is based on the work of Andrews et al. (2003).
Session 2 Extension material

Behavioural activation

Behavioural activation is a key behavioural component of CBT for depression. Particularly in the early stages of therapy, it is important to focus on behavioural interventions with a view to restoring a person's functioning to higher levels. Behavioural activation, as described below, can be used for young people.

When people are going through difficult times, it is rare for them to remember to engage in anything meaningful or fun throughout their day. This is particularly the case for people who are depressed. Their negative view of the world means they are more likely to focus on the things they have not done or have missed out on doing. In addition, when people are depressed, they tend to lose interest and pleasure in the activities that used to interest them and they often give up trying to do anything pleasant. This creates a cycle of less activity and less opportunity for positive reinforcement, which – in turn – contributes to further social withdrawal, low mood and lowered motivation. It is therefore very important that clients continue to give themselves opportunities for positive reinforcement, even if just for the distraction and the increase in physical activity. This is the first step in their recovery from low mood and a lack of energy and motivation.

In the case of people who are also using alcohol or other drugs, it is common for them to have narrowed their behaviours to those associated with drinking or using. They tend to over-emphasise the importance of using or drinking in their day, and it is difficult for them to imagine how else they could fill in their time. An activity schedule is a useful way of broadening the selection of activities in which they can be involved. In the longer term, if they decide to cut down or stop using alcohol or other drugs, planning specific tasks into their day means they may be able to distract themselves from thinking about using.

Behavioural activation encourages clients to identify activities that they find enjoyable, as well as those that give them a sense of achievement (i.e. things they have to do). Then, the client plans time in each day to carry out at least one of each of these types of activities. This encourages the client to increase their activity level (if appropriate) and increase their involvement in everyday life.

Identify enjoyment and achievement tasks

Use Worksheet 12: Activity list as a prompt for this exercise.

Look at the ‘Pleasant activities’ column on the worksheet. Ask the client to name any things that they like and enjoy doing, aside from taking alcohol or other drugs. For example, this could include going for a walk, having time to themselves, visiting friends, having a cup of coffee etc.

Make sure these activities are broken down into concrete things. For example, ‘time to myself’ needs to be broken down into the actual activities that constitute time to oneself. These could include listening to the radio, practice relaxation etc. If the client is having trouble thinking of things that they enjoy doing, suggest activities from the following list:

- Take a walk around the garden or a park nearby.
- Buy a piece of beautiful fresh fruit and eat it slowly.
- Write a card to a friend you haven’t seen for a while.
- Go swimming in a pool, lake or beach.
- Visit your local library and borrow a book, video or some music.
- Buy some flowers for your room.
- Borrow a dvd/video and watch it.
- Find a new recipe and try it out.
- Do one item of housework that you've been putting off.
- Have a bath or shower and get dressed up to go window shopping.
- Call someone to meet you for a coffee.
- Find out what adult education classes are available in your area and sign up for one.
- Look in the paper for a film or concert that you'd like to see and ask someone to go with you.

Add all appropriate activities to the 'Pleasant activities' column.

Next, ask the client to list the things they need to do. This could include attending treatment sessions, keeping appointments, therapy homework, looking after kids, housework etc. Again, break these activities down into discrete, concrete tasks. For example, break 'housework' down into all the different activities that need to be done around the house (e.g. washing dishes, washing clothes, vacuuming, make the bed). 'Looking after the kids' should also be broken down into concrete tasks (e.g. bathing, walking to/from school) and may also include doing fun things with them.

List these tasks under the 'Achievement activities' column.

Be sure to list ‘Relaxation practice’ in either the ‘Achievement activities’ or ‘Pleasant activities’ column – leave the choice about placement up to the client.

Encourage the client to add more activities to each column throughout the week as they become evident. That is, if they do something they find enjoyable or that gives them a sense of achievement over the next week, encourage them to add this item to the list in the appropriate column.

**Introduce the activity log**

The next step in behavioural activation is to plan time for each of these activities to occur. Explain to the client that it is important that each day has at least one enjoyable activity and at least one achievement activity scheduled in. This will increase their satisfaction with the way they spend their time. In addition, **Worksheet 13: Activity log** can be used to help the client break large, complex tasks down into more concrete, manageable steps that are less overwhelming.

Be sure to communicate the importance and value of this activity. Increasing the activity level of people with depression provides them with evidence contrary to their negative view of their environment.

Work through the following exercise within this session to teach the client how to plan their week in advance. Use **Worksheet 13** to help with this task.

Using the list of pleasant and achievement activities the client has already developed, help the client to complete a schedule for the following day. Ask them to select at least one pleasant activity and one achievement activity for that day. Mark each activity as 'P' (pleasant) or 'A' (achievement) as applicable.

You may want to start with the time of day or week that seems to be the most problematic for the client – those 'danger' times when people are most at risk of falling victim to their depressive or anxious thoughts and/or drinking or using – and plan pleasant or achievement activities for the client to carry out at these times.

By planning ‘pleasurable’ activities into the day, the client will realise that they can enjoy themselves and, by completing achievement tasks, can gain a sense of control or mastery over the things in their life that they need to do.

In the ‘Evening’ section of the log, schedule in time to complete the activity log for the following day, along with any other daily homework set for the client to complete over the following week. Mark these activities as ‘A’ tasks.

* This section is based on the work of Andrews et al. (2002).
Be sure to schedule in time to complete the relaxation practice (outlined in the next section) on at least one occasion each day.

Ask the client to sit down at the end of each day through the next week and complete the activity log for the following day, scheduling in at least one ‘P’ and one ‘A’ activity on each day. While in the session, schedule their next therapy session and enter this on their activity log. If the client is aware of any appointments they must meet through the week, add those into the activity log during the session.

Importantly, explain that it is impossible to plan every moment of every day in advance. Indeed there will be times when unpredictable things happen and the client will not be able to carry out the enjoyment and achievement tasks set down for that day. Discuss this with the client. Explain that the activity log is not a rigid plan and they should not feel guilty if they cannot stick exactly to the plan. In addition, clients are able to substitute alternative activities into the record if something prevents them from doing what they planned. For example, on the day a client plans to go for a walk it may be raining. So, explain to the client that, in these cases, they are free to substitute an alternative pleasurable task into that timeslot.

Some additional tips for the client in planning their day include:

- If you have trouble getting up in the morning, set an alarm clock and make sure you get to bed earlier in the evenings (see also Worksheet 23: Better sleep checklist).
- Review your Activity log the night before or first thing in the morning, so that you can leave enough time to get to the appointments and activities planned.
- Do at least one active thing before noon to make use of your morning energy. This will help you feel less depressed in the afternoon.
- Use the principle of making the more enjoyable activities a reward for getting the less enjoyable activities done: for example, don’t switch on the TV until the washing up is finished.

Ask the client to bring the completed Activity log to the next session.

**Review the activity log**

Ask the client how they went with planning their day (behavioural activation). Have a look at their activity log worksheet (Worksheet 13) and discuss whether the activities had any impact on their mood (and/or drug and alcohol use). If so, give plenty of praise for their efforts and ask them to nominate a different activity for this week.

If the client did not do any activities or did not find the technique useful, help them to troubleshoot any practical problems and encourage them to try again this week. Useful questions include:

- Were you able to carry out the activities you scheduled?
- Did you encounter any difficulties completing the log or doing the activities scheduled?
- Were you able to add any activities to your list of enjoyment and achievement tasks?
- What did you think of the exercise?
- Have you noticed any change in mood?
- What happened in those ‘danger’ or high-risk times?

Process the worksheet with the client, highlighting the importance of this activity, and assign another activity log for homework.

* This section is based on the work of Segal et al. (2002).
Relaxation strategies

Relaxation is an active process of eliminating negative emotional states such as stress, anxiety and anger. It can assist the client to cope with cravings for alcohol or other drugs. However, it is important to note that anxiety is a particularly diverse condition and not all types of relaxation lead to successful symptom relief. Many ways of doing relaxation have been developed and clients will generally choose the strategy that they feel most comfortable with.

Slow breathing, progressive muscle relaxation, mindfulness and imagery (visualisation) are the relaxation strategies outlined in these additional materials. The client is encouraged to choose the form of relaxation that they prefer. Young people will typically prefer more external forms of relaxation, such as progressive muscle relaxation and externally-focused mindfulness activities.

Relaxation practice 1: Slow breathing

This activity is designed to help the client deal with stressful situations and prevent hyperventilation (an increased breathing rate that can result in light-headedness, dizziness, shortness of breath, rapid heartbeat, panic etc.). An increased breathing rate is part of the body’s natural response to stress, as it allows for a greater amount of oxygen to enter the bloodstream for the purpose of burning energy in the muscles. It is an effective response to an immediate stress or emergency situation. However, if clients are constantly stressed in the absence of physical activity, they may be chronically overbreathing (hyperventilating). This results in too much oxygen being inhaled and too much carbon dioxide being exhaled. This can influence the balance of gases in the blood and contribute to feelings of anxiety and panic.

Slow breathing is designed for use at the first sign of increased tension or anxiety and also can be adapted to assist the client to cope with cravings for alcohol or other drugs. However, it is a skill that is most helpful if practised on a regular basis. The goal is to stay calm and prevent the fear, anxiety or tension from developing further into panic, anger etc.

Explain the use of slow breathing both as a coping strategy for stressful symptoms or cravings for alcohol or other drugs, and as part of regular daily relaxation practice. Run through the following slow breathing script during the remaining moments of this session.

Slow breathing – session practice

This type of breathing uses your diaphragm rather than your chest. Your diaphragm is a membrane located across the abdomen, just underneath your ribcage. It serves as a kind of plunger to move air in and out of the lungs. When you are relaxed, your diaphragm is doing most of the work in breathing, while your chest should remain relatively still – your chest should not really move much at all.

Sit comfortably in a chair with your head, back and arms supported. Uncross your legs and close your eyes if that feels comfortable.

Put one hand flat on your chest and the other hand over your stomach between the ribs and the navel. Remember that you want your bottom hand – the one on your stomach – to move during this exercise, not the hand on your chest.

Take a breath in and hold it as you count to 10. Don’t make this a really deep breath. Just breathe in normally, using your diaphragm, and hold it in for a count of 10.

When you get to 10, breathe out and mentally say the word ‘relax’ to yourself in a calm, soothing manner.

*This exercise is adapted from Segal et al. (2002, pages 179–180).
**Practise breathing in and out slowly in a 6-second cycle.** Breathe in for 3 seconds and out for 3 seconds (in-2-3, out-2-3). As you breathe in, use your diaphragm as opposed to your chest. Your hand on your chest should remain relatively still. Every time you breathe out, mentally say the word ‘relax’ to yourself in a calm manner.

**After every 10 breaths in and out, hold your breath again for 10 seconds, and then continue breathing in the 6-second cycle (in-2-3 and out-2-3).**

Each time you breathe in, imagine you are filling your stomach with air. Picture your stomach as a balloon that you are inflating with each in-breath and deflating with each out-breath. Observe your hands as you breathe. If you are relaxed, the hand over your abdomen should be moving more than the hand over your chest.

There is no need to slow down the rate of your breathing – this will happen naturally as you become relaxed. Try to breathe in through your nose and out through your mouth.

Allow the client to continue breathing for about 5 minutes and then gently bring them back to the ‘here-and-now’ and ask them to open their eyes.

Ask for feedback on whether the technique had any impact on their level of tension.

Give the client a copy of **Worksheet 14: Relaxation practice 1 – slow breathing** as a reminder of how to complete this activity. Ask them to practice this slow breathing technique every day over the next week, and to complete **Worksheet 18: Relaxation practice log** as a record of their practice.

Briefly explain the use of the Relaxation practice log (Worksheet 18), highlighting the section that asks the client to rate their levels of tension, anxiety or craving before and after the activity. This worksheet can be adapted for use as a record of the client’s practice for any relaxation practice activities.

**Common problems with slow breathing**

After the client has learned the slow breathing technique, it is important to ensure correct practice of the activity. Practicing the slow breathing technique in session is a good way of starting this process. During the client’s practice, watch closely for signs that the client is carrying out the exercise correctly. Count the client through each cycle and watch the movement of their hands to make certain that the hand on the stomach is moving more than the hand on the chest.

One common mistake people make with slow breathing is to breathe in too deeply or take very large breaths. This can actually increase the ‘overbreathing’ or hyperventilation that the client is trying to minimise. Signs that this is happening include significant rise and fall of the shoulders and overextension of the chest. If you observe this in your client’s practice, you should bring this to their attention and correct the technique.

Be aware that slow breathing will be difficult to maintain if the client is not using their diaphragm to breathe. If the client reports that the activity was difficult for them, check their technique, ensuring they are breathing through the diaphragm and with particular attention to reducing overbreathing.

If you notice the client beginning to hyperventilate (overbreathe) or begin to panic, move in to correct their technique and regulate their breathing pattern back to the 6-second cycle. Talk the person through the activity again and ask them to focus on your voice and breathe with your instructions. Make sure that you also get the client to hold every tenth breath, as this helps them to maintain the correct balance of blood gases in their body. Breathing in and out on a 6-second cycle aims to ensure a respiration rate that is slow and balanced.
Explain to the client that over each of the remaining sessions they will be trained in various relaxation techniques. Often it is easier to practise relaxation activities while listening to an instructional audiotape of the relaxation task. Suggest to the client that, if they wish, they may bring in a blank cassette tape to Session 2 and audiotape the relaxation practice during the session. This is, of course, provided that you have access to recording facilities at your service.

Relaxation practice 2: Progressive muscle relaxation (PMR)*

When people get scared or worried their body changes. Perhaps the client has noticed that their body starts doing something strange when they are really scared or anxious. These changes occur because the brain is sending the body a message that it needs to get ready to do something, like run away. This is called the ‘flight or fight’ response.

When people are in threatening or intensely stressful situations, this ‘flight or fight’ response activates all the muscles in the body, making us more alert and efficient. However, if people remain tense after a demanding or stressful period, the body and muscles remain more alert than necessary and this tends to turn into apprehension and anxiety. This makes people especially sensitive to all the happenings of the day and makes them more likely to react to smaller and smaller events.

By learning to recognise the signs of tension in the body, and then learning strategies to release that tension, people can gain more control over feelings of anxiety. PMR is an effective way of doing both of these things.

Summarise the above rationale for the client, and explain that PMR means that the muscles are tensed and then relaxed in a progressive manner.

Progressive muscle relaxation – session practice

Use the following script to teach the client how to use PMR.

**Step 1: Learn to relax**

The first thing that we are going to learn how to do is to teach your muscles how to relax. Close your eyes and listen carefully and do what I tell you to do. OK?

You can sit or lie to complete this relaxation. Make sure you are in a comfortable position with your eyes closed. I want you to listen to my voice and follow my instruction. When I tell you to RELAX, I want you to say ‘relax’ as you move your body into a relaxed position. OK?

**Step 2: Hands and arms**

I want you to imagine that you are squeezing a lemon with your left hand. Squeeze it really hard so all the juice runs out. Hold it for five seconds really tight. Now, RELAX. Notice what it feels like as your hand relaxes.

Now we are going to do the same thing with your right hand.

**Step 3: Arms and shoulders**

Now imagine that you are a cat stretching after lying in the sun. Stretch your arms high above your head. Reach as far as you can. Hold it for a few seconds. Now RELAX. Notice what your arms feel like when they are completely relaxed.

**Step 4: Shoulders and neck**

Imagine you are a turtle and you see someone coming. Try to push your head back down into your shell so that you can hide. Push your head down. Hold it for five seconds. Now RELAX. Let the tightness in your neck go completely.
Step 5: Jaw
Imagine you have a nut in your mouth and you are trying to crush it with your teeth. Bite down on it and try to break it. Hold it for five seconds. Now RELAX. Notice how good it feels to let your jaw relax completely.

Step 6: Face and nose
Imagine a fly has landed right on the tip of your nose but you can’t use your hand to shoo it away. Wrinkle your nose up to try and get rid of the fly. Now RELAX. Notice how good it feels to have a relaxed face.

Now the fly has come back and it has landed on your forehead. Wrinkle your forehead up as much as you can to try and get the fly to go away. Now RELAX. Notice how good your forehead feels when it is not wrinkled and tense.

Step 7: Stomach
Imagine someone is about to jump on your stomach. Try and make your stomach as hard as you can so that someone standing on it won’t hurt. Hold it for five seconds. Now RELAX. Notice how much better your stomach feels when it is completely relaxed and floppy.

Now imagine that you have to squeeze through a narrow gap in the fence. Suck in your stomach and make it really skinny so that you can fit through. Now RELAX. Your stomach should go completely relaxed.

Step 8: Legs and feet
Imagine that you are walking at the beach down where the sand is wet and squishy. Squish your toes down as far as you can in the sand. Keep squishing for five seconds. Now RELAX and notice how different your legs and feet feel.

Ask the client to practise this PMR activity once every day over the next week, and provide them with Worksheet 15: Relaxation practice 2 – progressive muscle relaxation as a summary of the activity.

Ask the client to complete the Relaxation practice log (Worksheet 18) for this activity after each PMR practice session.

Relaxation practice 3: Mindful walking
Segal et al. (2002) explain that mindfulness is an important skill, particularly when learning how to cope with the negative automatic thoughts that are associated with depression and anxiety. The central idea of mindfulness is not to prevent these thoughts from entering a person’s mind altogether, but rather to stop them setting in and taking control when they are triggered. Mindfulness is a way of ‘stepping out of’ this automatic thinking pattern (‘automatic pilot’). It teaches people to pay attention in a particular way to what is happening in the present moment and to do so without judgement.

Thoughts play a pivotal role in triggering and maintaining depression, anxiety and alcohol or other drug use. For example, the client may be plagued by thoughts such as: ‘Am I doing well enough?’, ‘Is my mood better today?’, ‘I think I’m feeling worse today, it’s happening again’ and so on. They may spend a lot of time and energy making these judgements. These thoughts, if left alone, can lead to a downhill slide into lower mood and, eventually, full-blown depression or episode of panic.

Mindfulness is a way of changing gears in the mind and can help to train the client to switch out of this judging and evaluating mode. The aim is to switch the mind into ‘being mode’, where there is no need for monitoring or evaluation, rather a focus on accepting and allowing thoughts and feelings to happen without feeling the pressure to change them.
Using mindfulness skills, the client can be taught to recognise how little attention they actually pay to their daily life activities (such as eating, showering, walking, driving etc.), namely because they are in their ‘automatic pilot’ mode. When in this mode, thoughts pass through their mind quickly, and this ‘mind wandering’ can allow negative thoughts and feelings to occur. Negative thoughts put people at risk of experiencing an episode of depression or anxiety and for using alcohol or other drugs. However, by using mindfulness skills, the client can be taught to recognise when they are in ‘automatic pilot’ and how to use mindfulness to ‘check in’ with themselves, to see which thoughts or judgements might be related to symptoms and AOD use problems.

In the following exercise, mindful walking is used to show the client how to pay particular attention to a routine activity (walking), using mindfulness skills. They will learn how to step out of ‘automatic pilot’ by choosing a physical activity they are likely to use every day. The same procedure can be applied to any situation or activity the client is involved in – routine activities (washing dishes, showering etc.), breathing and so on.

**Mindful walking – session practice**

Summarise the above rationale and explain that, in this session, mindful walking will be used to help the client pay more attention to their daily life activities.

Find a place where you and the client can walk up and down without worrying about who might see you (inside your office is fine, provided you can take about 10 steps).

Stand with the client in a relaxed posture at one end of your walk with your feet pointing straight ahead, arms hanging loosely by your sides. Look straight ahead.

Explain to the client that you are now going to start walking, but will practice paying attention to all the physical and other sensations that occur when you are walking – sensations that you probably would not otherwise be aware of. You will practice walking like it is the first time you and your client have ever walked.

Talk the client and yourself through the mindful walking exercise:

*Start by bringing your focus to the bottoms of your feet, noticing what it feels like where your feet and the ground make contact. Feel the weight of your body transmitted through your legs and feet to the ground. You may like to flex your knees slightly a couple of times to feel the different sensations in your feet and legs.*

*Next, transfer your weight into the right foot, noticing the change in physical sensations and your legs and feet as your left leg ‘empties’ of weight and pressure and your right leg takes over as support for your body.*

*With the left leg ‘empty’, allow your left heel to rise slowly from the floor, noticing the change in sensations in your calf muscles as this happens. Allow the entire left foot to lift gently off the floor until only your toes are still in contact with the ground. Slowly lift your left foot completely off the floor and move your left leg forward, noticing the physical sensations in your feet, legs and body change as your leg moves through the air.*

*Place your left heel on the ground in front of you and allow the rest of your left foot to make contact with the floor. As this happens, you are noticing the changes in physical sensations that occur as you transfer the weight of your body onto your left foot and off your right foot. Allow your right foot to ‘empty’ of weight.*

*Repeat this process with the right foot: first lifting your right heel off the ground, followed by the rest of your right foot, and then moving it slowly forward, noticing the changes in physical sensations that occur throughout this motion.*
Keep repeating this process as you slowly move from one end of your walk to the other, aware of the particular sensations in the bottoms of your feet and heels as they make contact with the floor, and the muscles in your legs as they swing forward.

Continue this process up and down the length of the walk for about 10 minutes. Encourage the client to appreciate the complexity of walking and being aware, as best they can, of the physical sensations in their feet and legs while keeping their gaze directed ahead.

Your minds will wander away from this activity during your 10 minutes of practise. Reassure the client that this is part of the exercise.

This is normal – it is what minds do. When you notice this has happened, gently guide the focus of your attention back to the sensations in your feet and legs, paying particular attention to the contact your feet have with the floor. This will help you stay in the present moment, concentrating on what is happening now, rather than worrying about the past or the future.

To begin with, walk more slowly than usual to give the client a better opportunity to practise this exercise. Once the client feels comfortable with the exercise, they may like to experiment with different speeds of walking. If the client is particularly agitated, you may like to start off walking fast, with awareness that this is what you are doing, and then to slow down naturally as they settle.

Once you have completed this activity, discuss with your client the experiences you both had during the exercise. Ask your client to describe their experience with this activity, including their thoughts, feelings and sensations. Allow them to comment on their experience with mindful walking.

The key message here is for the client to learn that there is no success or failure with this activity. Communicate to them that you are not aiming for any special state and not to try too hard to ‘get it right’. Rather, the task is to simply pay attention to what is happening in the present moment. If thoughts about ‘am I doing it right’ or worries are raised about what you might be thinking, the task for the client is to recognise that the thoughts are there (not to try to stop them coming) and, once recognised, to gently bring the focus of their attention back to the present moment (and their walking).

Ask your client to practise mindful walking once every day for 10 minutes, or more frequently if they prefer. Give your client a copy of Worksheet 16: Relaxation practice 3 – mindful walking to remind them of the basic elements of this exercise.

Ask the client to continue filling in their Relaxation practice log (Worksheet 18) for mindfulness practice as part of their homework.

Mindfulness review

Discuss with your client their impressions of the mindful walking activity they completed over the past week (if relevant). Ask them to describe their actual experiences of mindful walking, including their thoughts, feelings and the sensations they became aware of during their practice. Ask them for any comments on their experiences.

It is also important for you and your client to discuss any difficulties or barriers they experienced in practising mindful walking. Segal et al. (2002) describe some typical reactions to mindfulness activities as:

‘I don’t think I’m doing this right’, ‘I couldn’t find time’, ‘What’s the point of doing this, I don’t see what this has to do with my problems’, ‘My mind wouldn’t stay still’ or ‘I just got too upset’.

Each of these reactions is important to acknowledge and discuss with the client during this session, as they can undermine motivation to practise.
The important points to re-iterate to people in response to these issues are:

- **Mindfulness** is more about ‘being’, ‘allowing’ and ‘non-judgmental awareness’, rather than paying attention to thoughts about doing it properly, worrying about achieving a particular state, or judging whether it is doing anything beneficial. The key is to ‘step out of’ the tendency to evaluate and judge activities, and practise being in the moment.

- Sometimes the best way to deal with problematic thoughts and emotions is not to try to change them or to ‘think’ your way out of them. Interpretation of thoughts is often where people with depression run into problems and encounter their negative automatic bias. It is far more useful, at this point, to settle into each moment, to become aware of those times when your mind wanders off to other thoughts and worries, and to bring your focus back to the activity.

Segal et al. (2002) explain that regular practice is the best way to become accustomed to mindfulness, and so it is important for the client to continue to practise mindful walking on a regular basis every day over the next week. In addition, ask the client to try to incorporate mindfulness techniques into one other routine activity they are involved in over the next week.

A ‘mindful’ mindset can be used for virtually any activity. The following list of potential targets for mindfulness meditation may be useful, particularly for young people:

- smelling eucalyptus on a cotton ball
- washing your hands
- feeling grass under your feet
- touching something with an unusual texture or temperature
- eating a sultana

**Relaxation practice 4: Imagery**

Using imagery can increase relaxation by ‘transporting’ the client to a place they find peaceful. Consistent with classical conditioning principles, associating images with a feeling of relaxation can also make it easier to induce a relaxed state quickly, simply by drawing on the associated imagery.

**Imagery – session practice**

Explain to the client that they are going to be asked to imagine a pleasant and relaxing scene in order to evoke a physical sense of relaxation. Ask the client to tune in to all of their senses and their internal sensations while imagining the relaxed scene. The following is a script you could use.

**Sit comfortably in a chair with your head, arms and back supported. Close your eyes and take a few deep breaths. When you’re ready, I want you to clear your mind of thoughts and images as if it is a blank computer screen …**

(pause …)

**Now I want you to think of a place where you feel relaxed and safe. It could be a place you’ve been in the past or a place you can imagine being relaxed. When you think of a place, describe it to me in as much detail as you can.**

You could use the following questions to encourage the client to add more detail to their imagery:

- Is it night or day? What can you see around you? Are you alone or with someone else? What can you hear? Is there any characteristic smell of this place? What can you feel with your fingertips and on the surface of your skin?

(pause …)
Now stay in the relaxing place and tune in to your body sensations. What do you notice about your muscles? Are they tense or loose? What about your heart rate? And your breathing rate? Do you feel relatively warm or cool? Do you notice anything else about your body?

I’m going to leave you in this relaxed place for a few minutes, giving you time to just continue breathing and being in a state of relaxation.

(pause for a few minutes …)

I want you to remember this relaxed state so that you can enter it again later when you need to. Slowly clear your mind of images and thoughts again and bring your awareness back to the here and now. Turn your attention to the sounds in the room and perhaps outside the room. Stretch your arms and legs and yawn if you want to. When you are ready, slowly open your eyes.

Ask the client to give feedback about how it was for them to bring the relaxed place to mind. Ask if the imagery exercise had any impact on how they were feeling. Encourage any small changes in tension level and explain that the benefits will increase with practice.

Ask your client to practise imagery (visualisation) once every day over the next week or more frequently if they prefer. Give your client a copy of Worksheet 17: Relaxation practice 4 – imagery to remind them of the basic elements of this exercise.

Ask the client to continue filling in their Relaxation practice log (Worksheet 18) for imagery practice as part of their homework.

Choose a relaxation style that suits the client

You may refer back to the case formulation to decide which techniques are most appropriate for the individual client. For example, if the client is bothered with a stream of thoughts ruminating through their mind, mindful walking may be appropriate. These thoughts could be related to depressive, anxious or somatic symptoms, or to the desire to use alcohol or other drugs. Other clients who have previously meditated and used imagery/visualisation techniques with success may like to use imagery again in their relaxation practice. Anxious clients and those who report tension in various parts of the body (including headaches, neck/shoulder tension etc.) may benefit from PMR, where they learn to physically relax parts of the body.

It is important to note that not all forms of relaxation will suit all clients. For example, imagery/visualisation techniques may not be appropriate for clients who may have psychotic symptoms or for those who tend to dissociate. In addition, clients who feel anxious or unsafe in closing their eyes may not be suited to this task. In these cases, you should choose one of the other options for their intervention.
Session 3 Extension material

Communication skills
An underlying problem contributing both to negative mood states and alcohol and other drug use is poor or inconsistent communication. A lack of assertive communication skills is a relatively widespread problem but, like any skill, it can be learned and becomes easier with practice.

Styles of communication
Use Worksheet 19: Communication styles to assist in the following explanation. The four main communication styles can be conceptualised along two dimensions: directness of communication, and degree of force or influence used (see Figure 6).

![Figure 6: The four general communication styles according to the two dimensions of force and directness of communication.](image)

A passive aggressive communication style is one in which a lot of force or influence is used in an indirect manner. This could be by agreeing with someone and then disagreeing behind their back or failing to comply with their request, or by using emotional manipulation to get your needs met. People notice a lot of force but your message is unclear, so they end up feeling confused and angry.

An aggressive communication style is one in which a lot of force is used and the communication is quite direct. You make your needs and opinions known in a way that disregards other people’s needs and opinions. Although the communication is direct and open, the amount of force used tends to put other people on the defensive, leading them to withdraw or fight back rather than cooperate.

* This section has been adapted from Carroll (1998).
A submissive communication style is one in which you use a small amount of force and the communication is indirect. You yield to other people's needs and opinions while discounting your own. You tend to avoid asking for what you want or to feel guilty about conveying your needs to others. As a result, you probably don't have your needs met very often. You may become so used to suppressing your needs and opinions that you are no longer really sure what they are.

An assertive communication style uses a small amount of force and a direct manner of communication. You ask for what you want and tell others your opinions in a way that respects their feelings and opinions. Others tend to feel comfortable when you're assertive because they know where you stand and they have a chance to make their own needs and opinions known also.

Identify your own communication style

Go through the examples of communication styles and their consequences listed in Worksheet 20: Identify your communication style with the client.

Ask him/her to fill in the communication style that is being demonstrated in each situation and to suggest what the possible consequences of using that style might be in the short and longer term.

After summarising the above information for the client, ask them to suggest which communication style best describes their own approach. Some clients may need some help in identifying their predominant communication style. If giving feedback to a client with an aggressive, passive-aggressive or submissive style, give specific examples of their behaviour that you’ve observed or that they’ve reported in a previous session and ask which style they think they were using.

Use the following script as a guide:

Notice that the communication styles can lead to particular behaviours or consequences, and that also any one of the four communication styles could be used in any one of those situations. What particular style do you think you use most often?

If the client predominantly uses one style and it isn’t assertive, ask:

What would be the advantages and disadvantages of changing to a more assertive style of communication?

Consider the short-term and long-term consequences of each of the communication styles described.

Which styles are likely to get your needs met in the short term?

Which styles are likely to cause you problems in getting along with other people in the longer term?

Ask them to list the advantages and disadvantages of changing to a more assertive style of communication. Point out that an assertive style is likely to result in healthy relationships over the longer term.

* This section has been adapted from Carroll (1998).
**Assertive communication**

Go through the following steps that lead to a more assertive communication style (also outlined in Worksheet 21: Tips for assertive communication):

1. Be aware of your own feelings, needs and opinions so that you're able to express them clearly at the appropriate time.

2. Develop assertive non-verbal behaviour — open rather than guarded posture, eye contact, a clear voice. A guarded posture includes crossed arms, turning away from the other person; an open posture includes standing straight and front on to the other person a relaxed stance.

3. If there is an issue to sort out with someone, make sure you focus on your feelings and preferences rather than the other person's behaviour.

4. Ask for what you want in clear, specific terms (don't expect others to read your mind).

5. Be prepared for your request to be turned down. Being direct and honest about your needs doesn't mean they will automatically be met.

6. Set clear limits on other people's requests. If you're saying no, make sure you say the word 'No'. Repeat yourself if necessary, but don't escalate or get angry. You have every right to set your own limits.

7. Try again. If you think you have been too aggressive or submissive, there may be an opportunity to try to send the message again in a more assertive way.

8. Persist. If you are trying to be more assertive, you may feel guilty or anxious after the first few attempts. Don't let this stop you.

Remind the client that assertive behaviour is in other people's interests as well as their own, as it helps preserve healthy relationships over the long term.

**Guidelines for better sleep**

Sleep disturbances are common among people with depression, anxiety and/or somatic complaints, as well as among those using alcohol or other drugs. Sleep problems can also be among the most difficult to address. However, there are various strategies to help the client increase their chances of a reasonable sleep.

These habits are based on the behavioural idea of classical conditioning, in which being in bed is associated with being relaxed and sleeping, while being elsewhere is paired with being awake and active.

Go through Worksheet 23: Better sleep checklist with the client in detail.

Ask them to tick the options they will use over the next week when their sleep is disturbed and make a plan for better sleep.

Give them a copy of the Better sleep checklist (Worksheet 23).

Check in with them about their progress next session and keep monitoring throughout treatment.
**Young People**

**Communication skills for young people**

The above skills will be useful to the young person as they try to navigate their way through the various interactions they have with peers, teachers, family and other adults. In addition, a discussion that focuses on conflict resolution strategies is likely to prove useful for the young person, as a practical demonstration of ways to implement the communication techniques described above. The following tips for successful resolution of conflict could also be discussed during the session with the young person.

Go through the following conflict resolution tips with the client (as outlined in Worksheet 22: Tips for resolving conflict).

**Step 1. Identify your goal**

This will usually be to express a negative feeling, with the aim of reducing it.

* e.g. My goal is to let my Dad know that I don’t feel trusted.

**Step 2. Choose your moment carefully**

Don’t raise the issue after a fight. Wait until everybody is calm and you can talk to the person alone.

**Step 3. Raise the issue**

Use assertive non-verbal behaviour such as an open rather than guarded posture, eye contact and a clear voice to open the conversation.

* e.g. ‘Dad, I don’t feel like you trust me.’

**Step 4. Have the conversation**

Keep the focus on your feelings and don’t get side-tracked. Use the ‘When (an action) happens, I feel (a feeling)’ format.

* e.g.  
  
  **Me:** ‘I feel like you don’t trust me.’

  **Dad:** ‘I do trust you.’

  **Me:** ‘When you go through my room, I feel like you don’t trust me.’

**Step 5 Try to reach a conclusion**

Think about how to reach a conclusion that you are both comfortable with.

* e.g.  
  
  What do I have to do for Dad to trust me?

  What does Dad have to do to let me know that he trusts me?

**Remember**

Don’t get side-tracked. If you get side-tracked, you might say something to bring the conversation back on track.

* e.g. ‘I feel like I’m getting side tracked. I want to talk to you about not feeling trusted.’

Avoid questions that start with ‘Why?’ They sound like you’re asking for a justification and can make the other person angry as well as taking you off the topic.

Avoid blaming other people. This also puts them on the defensive and off your topic.
Session 4 Extension material

Problem solving

Over time, many clients’ repertoires of coping and problem-solving skills narrow so that they develop single, overgeneralised means of coping with problems: using alcohol or other drugs and/or ‘decompensating’ into depression or anxiety. Many clients are unaware of problems when they arise and ignore them until they become crises or are overwhelming. Many others are unaccustomed to thinking through alternative behaviours and consequences.

Problem-solving basics

Introduce the basic steps in problem solving to the client and why they are important to helping the client develop alternative means of coping with their problems. Explain that everyone has problems from time to time and that most can be effectively handled. Emphasise that, although having a problem may make one anxious, effective problem solving takes time and concentration, and that the impulsive ‘first solution’ is not necessarily the best.

Recognition of problems may come from several clues including worry, anger and depression; having problems pointed out by others; being preoccupied; and always feeling like one is in crisis. It is easier to solve problems that are concrete and well-defined than those that are global or vague. For large problems that seem overwhelming, it will help to break them down into smaller, more manageable steps.

It is important that the client considers a range of problem-solving approaches before choosing one. An effective way to do this is to brainstorm: that is, generate as many solutions as possible without considering, at first, which are good or bad ideas. It is more important to try for quantity, rather than quality, in the beginning. Writing these ideas down is very helpful in cases where the client may want to return to the list in the future. It is also important to recognise that not doing anything immediately is an option.

Once a range of options has been identified, it is time to review each approach, considering both the positive and negative consequences of all solutions. This may involve collecting more information and assessing whether some solutions are feasible (e.g. ‘Can I borrow Tom’s car to take the driving test?’).

Practise problem solving

Ask the client to identify two recent problems. Work through the problem-solving steps for both problems with the client, using Worksheet 33: Problem solving as a guide.

If necessary, help the client to ‘slow down’. Some clients will have difficulty recognising current problems; others will too quickly select a solution, since they lack practice with brainstorming and considering alternatives.

Select a problem, perhaps one that you recently encountered or a current one that does not have an obvious solution. Describe it accurately. Brainstorm a list of possible solutions. Consider the possibilities and number them in the order of your preference.

1. Recognise the problem – ‘Is there a problem?’

Recognise that a problem exists. Notice clues from your body, your thoughts and feelings, your behaviour, your reactions to other people, and the ways that other people react to you.

Note down the clues you got that there is a problem that needs solving.
2. **Identify and specify the problem** – ‘What is the problem?’

Identify the problem. Describe the problem as accurately as you can. Break it down into manageable parts.

3. **Consider various approaches to solving the problem** – ‘What can I do to solve the problem?’

Consider various ways to solve the problem. Think of as many solutions as you can. Consider acting to change the situation and/or changing the way you think about the situation.

List brainstorming solutions in your worksheet. Don't think too much about them, just note down all the ideas you can think of, good or bad.

4. **Select the most promising approach** – ‘What will happen if … ?’

Pick the three most promising options from your brainstorm list. Consider all the positive and negative things about each one and select the one you think is most likely to solve the problem.

5. **Assess the effectiveness of the selected approach** – ‘What did happen when I…?’

Now try putting your problem-solving approach into action. After you have given it a fair trial, think about how effective it was – did it solve your problem?

While some problems are easy to solve, others are more difficult. It may be necessary to repeat these five steps several times before a complex problem is solved.

Encourage the client to stick with it and keep working on finding an effective solution to their problem.

Ask the client to practise using these problem-solving skills outside of the sessions, using **Worksheet 33: Problem solving**.

**Seemingly irrelevant decisions**

Working with seemingly irrelevant decisions emphasises the cognitive aspects of treatment. Those who benefit most from this process tend to possess intact cognitive functions and some ability to reflect upon their cognitive and emotional lives. This session is also particularly helpful to individuals who have trouble thinking through their behaviour and its consequences, such as those with residual attention deficit/hyperactivity disorder, antisocial traits or difficulty with impulse control. For such individuals, the material in this session (as well as the session on problem solving) often takes some time to be understood and assimilated, but it is usually valued highly.

**Explain ‘seemingly irrelevant decisions’**

Explain to the client that they will inevitably encounter high-risk situations for both AOD use and mental health symptoms. Many of these will be out of their control and will need to be managed with the skills they have developed through the PyCheck Intervention. However, there are certain decisions that are under the full control of the client, but that are sometimes made unconsciously and may move them closer to a situation in which relapse is inevitable. These decisions are called ‘seemingly irrelevant decisions’. Seemingly irrelevant decisions are those decisions, rationalisations, and minimisations of risk that move the client closer to or even into high-risk situations, although they may seem unrelated to AOD use or mental health symptoms at the time.
SECTION 3

Provide examples of seemingly irrelevant decisions
The critical task is to teach the client how to recognise and interrupt seemingly irrelevant decision chains before the onset of mental health symptoms and/or AOD use. While it is possible to interrupt such a chain at any point prior to use or onset of symptoms, it is more difficult toward the end of the chain when they may already be in situations where they are starting to feel anxious or depressed. It is, therefore, important to detect the decisions that commonly occur toward the beginning of the chain where risk of relapse is lower.

Some examples of seemingly irrelevant decisions for depression and anxiety include:
- not feeling like getting out of bed, so staying ‘just a little longer’
- missing exercise or scheduled activity
- going to places that are near places or people associated with unhappy memories
- not planning to fill free time
- having a lot of unscheduled time on nights or weekends that can lead to boredom
- getting overtired or stressed
- making seemingly irrelevant decisions around alcohol or other drugs (such as keeping alcohol in the house) when AOD relapse might lead to feelings of depression or anxiety.

Assist the client to identify personal examples
Look at a previous relapse to depression and anxiety in the client’s past and go through the events leading up to the relapse.

Assist the client to identify any seemingly irrelevant decisions they made that may have contributed to the relapse. These decisions are usually very obvious in hindsight but, at the time, the client genuinely did not notice making them. It is important to make sure the client understands that you do not believe they made these decisions deliberately.

Practise safe decision-making
Stress the notion of safe decision-making with the client. Say something like:

Getting yourself into the practice of recognising all the small decisions you make every day, and thinking through safe versus risky consequences for those decisions, will make you less vulnerable to high-risk situations.

In the session, practise identifying seemingly irrelevant decisions and making safe decisions with the client using Worksheet 34: Practise safe decision-making.

Ask the client to self-monitor decisions over the course of several days and, for each one, identify safe versus risky decisions using the worksheet.
## Worksheets

1. Depressed mood and AOD use 73
2. Anxiety and AOD use 75
3. Somatic symptoms and AOD use 77
4. Self-monitoring 79
5. Identifying unhelpful thought patterns 81
6. Steps in managing unhelpful thought patterns 83
7. Managing unhelpful thought patterns 85
8. Breaking the rule effect 87
9. Looking after yourself 89
10. Interpreting situations 91
11. Monitoring the ABCs 93
12. Activity list 95
13. Activity log 97
14. Relaxation practice 1 – slow breathing 99
15. Relaxation practice 2 – progressive muscle relaxation 101
16. Relaxation practice 3 – mindful walking 103
17. Relaxation practice 4 – imagery 105
18. Relaxation practice log 107
19. Communication styles 109
20. Identify your communication style 111
21. Tips for assertive communication 113
22. Tips for resolving conflict 115
23. Better sleep checklist 117
24. Important people 119
25. The ABCs 121
26. Changing your thoughts and feelings 123
27. Feelings check - other people 125
28. What’s stressing you? 127
29. Distraction techniques 129
30. Uppers and downers 131
31. For carers – when to worry about adolescent behaviour 133
32. When should parents worry about adolescent behaviour? 135
33. Problem solving 137
34. Practise safe decision-making 139
35. CBT model 141
1: Depressed mood and AOD use

Depressed mood
Depressed mood is a central symptom of a number of mood disorders including major depression, dysthymic disorder and bipolar affective disorder. These disorders also have a number of other symptoms. People may experience depressed mood without having one of these disorders or the other symptoms.

Major depression
In major depression:
• the depressed mood is severe
• there is a marked change from the person’s usual mood for more than two weeks

Other symptoms include:
• loss of interest or pleasure in otherwise enjoyable activities (called ‘anhedonia’)
• lack of energy
• changes in the usual patterns of sleeping, appetite, weight and libido
• mental changes such as reduced concentration, loss of ability to make decisions, pervasive negative thinking and suicidal thoughts

Dysthymic disorder
In dysthymic disorder, depressed mood:
• may be less severe than in major depression
• may last much longer (months to years)

Bipolar disorder
In bipolar disorder:
• the person has periods of depressed mood
• the person has periods of manic or elevated mood
• depressed mood and elevated mood alternate

Rates of depression
Around 3.2 per cent of Australian adults currently have major depression¹. Depression is more common in women than men (7.4 per cent of women compared to 4.1 per cent of men). It is much more common among people who have a problem with alcohol or other drug use. For example, individuals with an alcohol use disorder are four times more likely to have a mood disorder than the general population. The rate of depressed mood that is not part of a diagnosed disorder is even higher.

Links with AOD use
Alcohol and other drugs act as central nervous system depressants, which can produce changes in mood and motivation. Both use and withdrawal from alcohol and other drugs can be associated with depressed mood. AOD use may exacerbate depressed mood and/or an underlying depression may contribute to increased AOD use.

Treatment options
Psychological therapies such as cognitive behvioural therapy and interpersonal therapy have demonstrated benefits in the treatment of depression. Antidepressant medication may also be an option for moderate to severe depression, and this should be discussed with your general practitioner or psychiatrist. Psychological therapy is as effective as medication in treatment of mild to moderate forms of depression and studies have found that a combined approach may be even more effective than either one alone for more severe symptoms.

¹ The Australian National Survey of Mental Health and Well Being
2: Anxiety and AOD use

Anxiety
In their most severe and prolonged form, anxiety symptoms can form part of a number of disorders including social phobia, generalised anxiety disorder, panic disorder, posttraumatic stress disorder and obsessive-compulsive disorder. These disorders also have a number of other symptoms in conjunction with feelings of anxiety. People may also experience feelings of anxiety and/or panic without having one of these disorders or the other symptoms.

Rates of anxiety
Around 7.1 per cent of men and 12.1 per cent of women in Australia have experienced an anxiety disorder in the past year1. People who have both anxiety and problematic alcohol or other drug use at the same time (co-existing) make up around 2 per cent of both men and women. The rate of anxiety that is not part of a diagnosed disorder is even higher.

Links with AOD use
Anxiety symptoms are similar in many ways to the anxiety experienced during acute intoxication with stimulants or during withdrawal from alcohol, sedatives and opiates. On the other hand, the use of alcohol or other drugs may be an attempt to reduce the tension of constant worrying and physiological arousal experienced by individuals with anxiety problems.

Treatment options
There is good evidence that psychological therapies for anxiety are effective. They include relaxation, coping skills training, and cognitive therapy aimed at modifying the worrying thoughts. Assertiveness training can help overcome social anxiety by improving communication skills and confidence.

Many medications are effective in the treatment of anxiety that is not complicated by comorbid alcohol or other drug use. At least one of these has also shown some promising results in the treatment of people with both generalised anxiety disorder and alcohol dependence, and in treating generalised anxiety disorder in individuals on methadone maintenance.

1. The Australian National Survey of Mental Health and Well Being
3: Somatic symptoms and AOD use

Somatic symptoms
Some individuals have a tendency to experience their emotional distress in the form of physical symptoms. These are known as 'somatic' symptoms. At their most severe, these symptoms may be diagnosed as a somatoform disorder such as hypochondriasis (also known as severe health anxiety – constant worry about having a serious disease), pain disorder or somatisation disorder (a combination of pain, digestive, sexual and pseudoneurological symptoms).

Rates of somatic symptoms
Most of the somatoform disorders are relatively rare, probably occurring in less than 2 per cent of adults. Hypochondriasis and pain disorders are more common, with estimates around 10–15 per cent. Somatic symptoms that don’t meet criteria for a diagnosis are quite widespread in the general population, and often go unrecognised and untreated.

Link with AOD use
Problematic alcohol and other drug use can cause somatic symptoms as side effects, such as abdominal discomfort, headaches and sleep disturbance. Conversely, people who experience chronic somatic problems may attempt to self-medicate using prescription or other drugs.

Treatment options
Psychological treatments for somatic symptoms focus on relaxation, increasing activity and better sleep. Cognitive behavioural therapy has been shown in recent clinical trials to be an effective treatment for a number of conditions with somatic symptoms, including hypochondriasis and chronic fatigue syndrome.
<table>
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<th>Situation</th>
<th>Thoughts</th>
<th>Feelings</th>
<th>Behaviours</th>
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<tbody>
<tr>
<td><strong>Example</strong></td>
<td>At party, didn’t know anyone. A group of people laughing near me. They’re laughing at me. No one wants to hang out with me. I’m a loser. I’m so lonely.</td>
<td>Anxious, sad, angry, embarrassed, worthless, lonely.</td>
<td>Kept drinking more. Got really drunk. Stormed off. Went home and kept drinking.</td>
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5: Identifying unhelpful thought patterns

People with depression and anxiety tend to ‘read into’ situations in ways that are often quite negative. These thought patterns can lead to stronger feelings of depression and anxiety, and often result in cravings to use alcohol or other drugs.

Do you have any of the following unhelpful thought patterns?

Are you a ‘black and white thinker’?
- Are things either all good or all bad – with nothing in-between? (no balance)
- Do you think that because something has gone wrong once, it will always go wrong?
- Do you have strict rules about yourself and your life? For example, do you think that in order to be good at something, you must do it perfectly or not at all?
- If things don’t work out perfectly, do you feel hopeless and like you have failed completely? For example: ‘If I fail partly, it is as bad as being a complete failure’, or ‘If a person is not a complete success, then life is meaningless’ or ‘I never get what I want so it’s foolish to want anything’.
- Have you ever thought: ‘Even if I use once this week, I’m a failure so why bother’ or ‘I can’t change, so it’s pointless trying at all’?
- Do you believe that in order to be a good person, everybody must like you all the time? Do you ever think: ‘People will probably think less of me if I make a mistake’ or ‘If a person I love does not love me, it means I am unlovable’?
- In thinking about your depression, do you think things like ‘Either I’m depressed or I’m completely happy – there is no in-between’ and ‘I’m a bad person – there is nothing good about me’?

Do you ‘jump to negative conclusions’?
- Do you automatically draw a negative conclusion about something more times than not?
- Do you sometimes act like a ‘mind reader’? That is, you think you can tell what another person is really thinking, often without really checking it out or testing it.
- Do you do a bit of ‘fortune telling’? That is, you believe that things will turn out badly and are certain that this will always be the case. For example: ‘Things just won’t work out the way I want them to’ or ‘I never get what I want so it’s stupid to want anything’ or ‘There’s no use in really trying to get something I want because I probably won’t get it’.
- In thinking about your alcohol or drug use, do you believe: ‘I’ll never be able to change my drinking/drug using. It’ll never be any different.”

Do you ‘catastrophise’?
- Do you tend to give too much meaning to situations, particularly negative ones?
- Do you convince yourself that, if something goes wrong, it will be totally unbearable and intolerable.
For example: ‘If I get a craving, it will be unbearable and I will be unable to resist it’.

- If you have a disagreement with someone, do you think: ‘That person hates me, doesn’t trust me, they’ll never talk to me again.’

Are you a ‘personaliser’?
- Do you blame yourself for anything unpleasant that happens?
- Do you take a lot of responsibility for other people’s feelings and behaviour, and often confuse facts with feelings? For example: ‘My brother has come home in a bad mood, it must be something that I have done’ or ‘I feel stupid, so I am stupid’.
- Do you often put yourself down or think too little of yourself, particularly in response to making a mistake. Do you often find yourself thinking things like: ‘I’m weak, stupid, ugly’ or ‘I’m an idiot’.

Are you a ‘should/ought’ person?
- Do you use ‘should’, ‘ought’ and ‘must’ when you think about lots of situations? This thinking could make you feel guilty if you don’t do the things you ‘should’.
- ‘Shoulds’, ‘oughts’ and ‘musts’ quite often set a person up to be disappointed, particularly if these thoughts are unreasonable. Do you set unrealistic expectations for yourself or other people? For example: ‘I must not get angry’ or ‘He should always be on time’.
- ‘Shoulds’, ‘oughts’ and ‘musts’ may make you feel angry if you feel others are not doing what they should, ought or must. Do you find yourself getting frustrated with people when they don’t do what you think they ‘should’?
Do you experience thought patterns that are ‘unhelpful’? These are ways of thinking that make you more depressed and anxious or result in cravings to use alcohol or other drugs? You can manage and overcome unhelpful thought patterns by following a few simple steps.

1. **Spot your unhelpful thought**
   Any of the following responses may be a sign that you’ve just had an unhelpful thought:
   - Depressive symptoms
   - Anxious symptoms
   - Physical symptoms
   - Negative feelings
   - Cravings for alcohol or other drugs

2. **Check your response**
   Ask yourself: ‘Have I just had an unhelpful thought?’
   The answer is most likely ‘yes’.

3. **Distance yourself from the thought and see it for what it is**
   When you recognise an unhelpful thought, STOP and step out of automatic pilot.
   Remind yourself: ‘Thoughts are just thoughts. They are not facts and I am not my thoughts.’

4. **Label the thought**
   Ask yourself: ‘Which unhelpful thought has happened here?’
   Label your thoughts as ‘catastrophising’, ‘personalising’, ‘jumping to negative conclusions’, ‘black/white thinking’ or ‘shoulds/oughts’ (see Worksheet 5: Identifying unhelpful thought patterns).

5. **Give yourself a reality check**
   Ask yourself: ‘What are the facts here? What things in this situation do I know are 100% true? Do these thoughts fit with the facts?’

6. **Allow yourself to think differently**
   Ask: ‘If I take these facts into account, how else could I interpret this situation? Is this explanation just as likely to be true? Does this explanation make me feel better?’
   Usually, the answer will be ‘yes’.
### 7: Managing unhelpful thought patterns

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<tr>
<th>Situation</th>
<th>Thoughts</th>
<th>Feelings</th>
<th>Which unhelpful thought is this?*</th>
<th>Does it fit the facts?</th>
<th>What is another explanation?</th>
<th>Feelings now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting at home, bored, nothing to do</td>
<td>I should be out doing something, but I've got nothing to do, nobody to do it with, life sucks</td>
<td>Sad, Angry, Useless, Worthless</td>
<td>Jumping to -ve conclusions, Personalising, Should/oughts</td>
<td>Not really – I've got some friends but they are at work, &amp; I do have some things to do that I like</td>
<td>My depression is telling me I don't have anything to do. It would be nice if I had someone to do stuff with, but I can choose to do something myself and still enjoy it.</td>
<td>A bit happier, a bit more in control, a bit more motivated, worthwhile</td>
</tr>
</tbody>
</table>

* catastrophising, personalising, jumping to negative conclusions, black/white thinking, shoulds/oughts (see Worksheet 5: Identifying unhelpful thought patterns)
8: Breaking the rule effect

The ‘breaking the rule’ effect is an unhelpful thought that might happen if you notice your mood is getting low again, you start feeling stressed, anxious or run down, or if you have a craving to use alcohol or other drugs. You may even have a slip-up and have a drink or use other drugs again.

The ‘breaking the rule’ unhelpful thought comes into these situations and says: ‘I knew you couldn’t do this, here you are back at square one’. It gives you permission to fall back into your old habits of thinking and behaving.

But if you know about the ‘breaking the rule’ effect, you can be ready for it when it happens. When you notice this effect, try these few simple steps:

1. Practice your relaxation skills to switch off your automatic pilot and concentrate on the moment.
2. Remind yourself that everybody has a slip-up. You haven’t failed completely and you are not back at square one.
3. If you notice yourself ‘breaking the rule’, try these more helpful thoughts instead.

**Breaking the rule effect:** ‘I’ve blown it, might as well keep going.’
**More helpful thought:** ‘I’ve just had a slip and I can get back on track.’

**Breaking the rule effect:** ‘I knew I wouldn’t be able to stop.’
**More helpful thought:** ‘I have been able to make a change … this is only a slip and I will keep on trying.’

**Breaking the rule effect:** ‘I’ve messed up already, so I might as well keep going.’
**More helpful thought:** ‘I’ve just made a mistake and I can learn from it and get back on course.’

**Breaking the rule effect:** ‘None of this therapy worked, I’m back at square one.’
**More helpful thought:** ‘This is only a change in my mood, I can handle this. I just need to handle each moment as best as I can.’
9:  Looking after yourself

Remember that part of preventing a relapse to depressive, anxiety or other symptoms or to alcohol or other drug use is to learn ways to take care of yourself. Even when life seems too busy and full of things to do, you still need to make an effort to do things that you enjoy, as well as those which give you a sense of achievement. Little by little you’ll notice it makes a difference.

What am I doing in my daily life that I enjoy or that gives me a sense of achievement?

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How can I make sure that I continue to do these things or become more aware of them?

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What am I doing in my daily life (or what have I done before) that drains my energy and lowers my mood?

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How can I make sure that these activities are done less often?

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Adapted from Segal et al. (2002)
10: Interpreting situations

‘It is up to me’

<table>
<thead>
<tr>
<th>Possible explanations or thoughts</th>
<th>Feelings</th>
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</thead>
<tbody>
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</table>

Imagine the following situation…

‘You see a friend across the street and call out to them to say hello. Your friend keeps on walking up the street…’
<table>
<thead>
<tr>
<th>Example</th>
<th>As – Situation or Trigger</th>
<th>Bs – Thoughts</th>
<th>Cs – Feelings</th>
<th>Cs – Behaviours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td>At home, bored, haven’t got anything to do</td>
<td>Nothing good ever happens, I’ve got nothing to do, nobody to do it with, life sucks</td>
<td>Sad, Angry, Useless, Wordless</td>
<td>Had a couple of drinks, Watched TV on the lounge</td>
</tr>
</tbody>
</table>

| Monday | | | |
| Tuesday | | | |
| Wednesday | | | |
| Thursday | | | |
| Friday | | | |
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| Sunday | | | |
SECTION 4
12: Activity list

<table>
<thead>
<tr>
<th>Pleasant Activities (Things I enjoy)</th>
<th>Achievements (Things I have to do)</th>
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</table>
SECTION 4
Using the list of pleasant and achievement activities you made in Worksheet 12, plan your day. Include at least one pleasant task (P) and one achievement task (A) in each day of the week.

<table>
<thead>
<tr>
<th>Day</th>
<th>7–8am</th>
<th>8–9am</th>
<th>9–10am</th>
<th>10–11am</th>
<th>11am–12pm</th>
<th>12–1pm</th>
<th>1–2pm</th>
<th>2–3pm</th>
<th>3–4pm</th>
<th>4–5pm</th>
<th>5–6pm</th>
<th>6–7pm</th>
<th>Evening</th>
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</table>
14: Relaxation practice 1 – slow breathing

This type of breathing uses your diaphragm rather than your chest. Your diaphragm is a membrane located across the abdomen, just underneath your ribcage. It serves as a kind of plunger to move air in and out of the lungs. When you are relaxed, your diaphragm is doing most of the work in breathing, while your chest should remain relatively still and shouldn’t move much at all.

**Step 1:** Sit comfortably in a chair with your head, back and arms supported. Uncross your legs and close your eyes if that feels comfortable.

**Step 2:** Put one hand flat on your chest and the other hand over your stomach between the ribs and the navel. Remember that you want your bottom hand – the one on your stomach – to move during this exercise, but not the hand on your chest.

**Step 3:** Take a breath in and hold it as you count to 10. Don’t make this a really deep breath. Just breathe in normally, using your diaphragm, and hold it in for a count of 10.

**Step 4:** When you get to 10, breathe out and mentally say the word ‘relax’ to yourself in a calm, soothing manner.

**Step 5:** Practise breathing in and out slowly in a 6-second cycle. Breathe in for 3 seconds and out for 3 seconds (in–2–3, out–2–3). As you breathe in, use your diaphragm as opposed to your chest. Your hand on your chest should remain relatively still. Every time you breathe out, mentally say the word ‘relax’ to yourself in a calm manner.

**Step 6:** After every 10 breaths in and out, hold your breath again for 10 seconds and then continue breathing in the 6-second cycle (in–2–3, out–2–3).

Each time you breathe in, imagine you are filling your stomach with air. Picture your stomach as a balloon that you are inflating with each in-breath and deflating with each out-breath. Observe your hands as you breathe. If you are relaxed, the hand over your abdomen should be moving more than the hand over your chest. There is no need to slow down the rate of your breathing – this will happen naturally as you become relaxed. Try to breathe in through your nose and out through your mouth.

Continue this process until any symptoms of anxiety, stress, tension or anger are gone.

Monitor your slow breathing relaxation practice during the week using **Worksheet 18: Relaxation practice log**.
Step 1: Learn to relax
Close your eyes. Remember to ‘relax’ as you move your body into a relaxed position. Make sure you are in a comfortable position with your eyes closed.

Step 2: Hands and arms
Imagine that you are squeezing a lemon with your left hand. Squeeze it really hard so all the juice runs out. Hold it for five seconds really tight. Now, RELAX. Notice what it feels like as your hand relaxes. Do the same thing with your right hand.

Step 3: Arms and shoulders
Imagine that you are like a cat stretching after lying in the sun. Stretch your arms high above your head. Reach as far as you can. Hold it for a few seconds. Now RELAX. Notice what your arms feel like when they are completely relaxed.

Step 4: Shoulders and neck
Imagine you are a turtle and you see someone coming. Try to push your head back down into your shell so that you can hide. Push your head down. Hold it for five seconds. Now RELAX. Let the tightness in your neck go completely.

Step 5: Jaw
Imagine you have a nut in your mouth and you are trying to crush it with your teeth. Bite down on it and try to break it. Hold it for five seconds. Now RELAX. Notice how good it feels to let your jaw relax completely.

Step 6: Face and nose
Imagine a fly has landed right on the tip of your nose but you can’t use your hand to shoo it away. Wrinkle your nose up to try and get rid of the fly. Now RELAX. Notice how good it feels to have a relaxed face.

Now the fly has come back and it has landed on your forehead. Wrinkle your forehead up as much as you can to try and get the fly to go away. Now RELAX. Notice how good your forehead feels when it is not wrinkled and tense.

Step 7: Stomach
Imagine someone is about to jump on your stomach. Try and make your stomach as hard as you can so that someone standing on it won’t hurt. Hold it for five seconds. Now RELAX. Notice how much better your stomach feels when it is completely relaxed and floppy.

Now imagine that you have to squeeze through a narrow gap in the fence. Suck in your stomach and make it really skinny so that you can fit through. Now RELAX. Let your stomach go completely relaxed.

Step 8: Legs and feet
Imagine that you are walking at the beach down where the sand is wet and squishy. Squish your toes down as far as you can in the sand. Keep squishing for five seconds. Now RELAX. Notice how different your legs and feet feel.

Monitor your progressive muscle relaxation practice during the week using Worksheet 18: Relaxation practice log.
Mindful walking is a way of stepping out of ‘automatic pilot’ and can help you to practise paying attention to the present.

**Step 1:** Stand at one end of your walk, keeping your feet pointed forward and eyes straight ahead.

**Step 2:** Start slowly at first and, as best you can, pay attention to the way your feet and legs feel when you take each step forward.

**Step 3:** Start with the left foot and follow with the right.

**Step 4:** Slowly move from one end of your walk to the other, aware of the particular sensations in the bottoms of your feet and heels as they make contact with the floor, and the muscles in your legs as they swing forward.

**Step 5:** Continue this process up and down the length of your walk for about 10 minutes.

**Step 6:** Your mind will wander away from this activity during your 10 minutes of practice. This is normal. As best you can when you notice this has happened, gently re-focus your attention on your feet and legs and how they feel when they contact with the floor.

Once you have mastered the basic steps of mindful walking, you may like to look for books or groups that can teach you more advanced techniques. Mindfulness has been developed by Buddhist practitioners and many groups conduct courses.

Monitor your mindful walking practice during the week using **Worksheet 18: Relaxation practice log.**
Imagery/Visualisation

Here is a copy of the imagery activity completed during your session. You may like to record this on a tape and listen to it during your relaxation practice.

**Step 1:** Sit comfortably in a chair with your head, arms and back supported. Close your eyes and take a few deep breaths. When you’re ready, clear your mind of thoughts and images as if it is a blank computer screen.

**Step 2:** Think of a place where you feel relaxed and safe. It could be a place you’ve been in the past or a place you can imagine being relaxed. When you think of a place, imagine it in as much detail as you can.

**Step 3:** Ask yourself the following questions about your relaxed and safe place:
- Is it night or day?
- What can you see around you?
- Are you alone or with someone else?
- What can you hear?
- Is there any characteristic smell of this place?
- What can you feel with your fingertips and on the surface of your skin?

**Step 4:** Stay in your relaxing place and tune in to your body sensations. Ask yourself the following questions:
- What do you notice about your muscles?
- Are they tense or loose?
- What about your heart rate?
- And your breathing rate?
- Do you feel relatively warm or cool?
- Do you notice anything else about your body?

**Step 5:** Stay in this relaxed place for a few minutes, giving you time to just continue breathing and being in a state of relaxation. Remember this relaxed state so that you can enter it again later when you need to.

**Step 6:** Slowly clear your mind of images and thoughts again and bring your awareness back to the here and now. Turn your attention to the sounds in the room and perhaps outside the room. Stretch your arms and legs and yawn if you want to. When you are ready, slowly open your eyes.
<table>
<thead>
<tr>
<th>Type of relaxation</th>
<th>Minutes spent on relaxation practice</th>
<th>Tension/craving level BEFORE relaxation</th>
<th>Tension/craving level AFTER relaxation</th>
</tr>
</thead>
<tbody>
<tr>
<td>SB = slow breathing</td>
<td>SB = slow breathing</td>
<td>1 = not at all tense</td>
<td>1 = not at all tense</td>
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<tr>
<td>PMR = muscle relaxation</td>
<td>PMR = muscle relaxation</td>
<td>10 = most tense</td>
<td>10 = most tense</td>
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<tr>
<td>MW = mindful walking</td>
<td>MW = mindful walking</td>
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<tr>
<td>I = imagery</td>
<td>I = imagery</td>
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<th>Day</th>
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<td>Tension/craving level BEFORE relaxation</td>
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<td>Tension/craving level AFTER relaxation</td>
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<td>10</td>
<td>most tense</td>
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</table>
There are four main communication styles that people use. These can be described by looking at their level of directness and the degree of force or influence used.

**Passive aggressive**
A passive aggressive style is one in which a lot of force or influence is used in an indirect manner. This could be by agreeing with someone and then disagreeing behind their back or failing to comply with their request, or by using emotional manipulation to get your needs met. People notice a lot of force but your message is unclear, so they end up feeling confused and angry.

**Aggressive**
An aggressive communication style is one in which a lot of force is used and the communication is quite direct. You make your needs and opinions known in a way that disregards other people’s needs and opinions. Although the communication is direct and open, the amount of force used tends to put other people on the defensive, leading them to withdraw or fight back rather than cooperate.

**Submissive**
A submissive style is one in which you use a small amount of force and the communication is indirect. You yield to other people’s needs and opinions while discounting your own. You tend to avoid asking for what you want or to feel guilty about conveying your needs to others. As a result, you probably don’t have your needs met very often. You may become so used to suppressing your needs and opinions that you are no longer really sure what they are.

**Assertive**
An assertive style uses a small amount of force and a direct manner of communication. You ask for what you want and tell others your opinions in a way that respects their feelings and opinions. Others tend to feel comfortable when you’re assertive because they know where you stand and they have a chance to make their own needs and opinions known also.
As we saw in the **Worksheet 19: Communication styles**, there are four main communication styles that people use. These are: passive aggressive, aggressive, submissive and assertive.

Go through the examples in the communication styles and their consequences table.

Fill in the communication style that is being demonstrated in that situation and suggest what the possible consequences of using that style might be in the short and longer term.

### Communication styles and their consequences

<table>
<thead>
<tr>
<th>Situation</th>
<th>Reaction</th>
<th>Style of communication</th>
<th>Possible consequences (e.g. feelings, use of alcohol or other drugs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>You’re going through the check-out at the grocery shop and discover that one of your packages is already open.</td>
<td>‘It doesn’t really matter. I don’t want to make a fuss and hold up the people behind me.’</td>
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<tr>
<td>Your flatmate has untidy habits that have been getting on your nerves.</td>
<td>‘That’s it! I’m going to yell at him and throw his things out the window.’</td>
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<tr>
<td>You have been criticised at work a number of times and feel unfairly treated.</td>
<td>‘I’ll show them – I’ll just do the bare minimum of work if they criticise my efforts.’</td>
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<tr>
<td>You are discussing a job offer and want to know what the pay and conditions are.</td>
<td>‘I’ll let her know that I’m on good pay and conditions in my current work and ask what the job is offering.’</td>
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<td>You’re in a meeting where someone is expressing a strong opinion that you disagree with.</td>
<td>‘Well that’s his opinion but I have a different one and I think I should speak up.’</td>
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</table>
SECTION 4

Identify your own communication style

Notice that the four different communication styles can lead to particular behaviours or consequences, and that any one of them could be used in any one of the situations described in the examples.

What style do you think you use most often?

__________________________________________________________________________

__________________________________________________________________________

What would be the advantages and disadvantages of changing to a more assertive style of communication? Consider the short-term and long-term consequences of each of the communication styles described.

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Which styles are likely to get your needs met in the short term?

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Which styles are likely to cause you problems in getting along with other people in the longer term?

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21: Tips for assertive communication

Here are some simple tips to help you communicate more assertively.

1. Be aware of your own feelings, needs and opinions so that you’re able to express them clearly at the appropriate time.

2. Develop assertive non-verbal behaviour – open rather than guarded posture, eye contact, a clear voice. A guarded posture includes crossed arms, turning away from the other person; an open posture includes standing straight and front on to the other person in a relaxed stance.

3. If there is an issue to sort out with someone, make sure you focus on your feelings and preferences rather than the other person’s behaviour.

4. Ask for what you want in clear, specific terms (don’t expect others to read your mind).

5. Be prepared for your request to be turned down. Being direct and honest about your needs doesn’t mean they will automatically be met.

6. Set clear limits on other people’s requests. If you’re saying no, make sure you say the word ‘No’. Repeat yourself if necessary, but don’t escalate or get angry. You have every right to set your own limits.

7. Try again. If you think you have been too aggressive or submissive, there may be an opportunity to try to send the message again in a more assertive way.

8. Persist. If you are trying to be more assertive, you may feel guilty or anxious after the first few attempts. Don’t let this stop you.

Remember that assertive behaviour is in other people’s interests too as it helps preserve healthy relationships over the long term.
22: Tips for resolving conflict

Step 1:
- Identify your goal;
- This will usually be to express a negative feeling, with the aim of reducing it;

For example
Let your Dad know that you don’t feel trusted.

Step 2:
- Choose your moment carefully;
- Don’t raise the issue after a fight. Wait until everybody is calm and you can talk to the person alone;

Step 3:
- Raise the issue;

For example
‘Dad, I don’t feel like you trust me.’

Step 4:
- Have the conversation;
- Keep the focus on your feelings and don’t get side-tracked;
- Use the ‘When (an action) happens, I feel (a feeling)’ format;

For example
You: ‘I feel like you don’t trust me.’
Dad: ‘I do trust you.’
You: ‘When you go through my room, I feel like you don’t trust me.’

Step 5:
- Try to reach a conclusion;

For example
What do I have to do for Dad to trust me?
What does Dad have to do to let me know that he trusts me?

Remember:
- Don’t get side-tracked;

For example
If you get side-tracked, you might say something like:
‘I feel like I’m getting side-tracked. I want to talk to you about not feeling trusted.’

- Avoid questions that start with Why? They sound like you’re asking for a justification and can make the other person angry, as well as taking you off the topic;
- Avoid blaming other people. This puts them on the defensive and off your topic;
Go to sleep as soon as you feel tired. Sleep cycles cause people to feel tired approximately every 90 minutes — if you ignore the cues, you may have to wait for another 90 minutes.

Set an alarm to wake you at the same time each morning, even on weekends and holidays. This helps your body to get into a regular sleep–wake routine.

Use the bed only for sleeping and for sex. Reading, thinking and eating in bed can lead people to associate bed with activity and stress.

Get out of bed when you can’t sleep after trying for 30 minutes and go back to bed as soon as you feel tired. Do something enjoyable when you get up (e.g. watching television or reading a book). Make sure that it is a quiet and relaxing activity, not one that will stimulate your brain too much!

Do not watch the clock if you’re lying awake. Worrying that you’re not sleeping keeps your mind active and prevents you from actually getting to sleep.

Write your problems on a piece of paper before going to bed then throw the paper out or put it aside to tackle in the morning. Say to yourself: ‘There’s nothing I can do about this tonight’.

Avoid consuming caffeine (tea, coffee, cola drinks, chocolate) after mid-afternoon.

Avoid drinking alcohol at dinnertime or afterwards. Although alcohol can induce sleep, it causes you to become wakeful (rebound insomnia) several hours after drinking it. Alcohol also interferes with the energy-restoring benefits of good sleep.

Practice relaxation before going to bed. This helps to calm your body and mind and promotes entry into sleep.

Sleep with a minimum of covers so that you do not overheat. Turn off heaters and electric blankets, and keep a window open. Overheating causes restlessness and a lack of deep sleep.
This worksheet will help you to think about what's currently happening for you. Identify the most important people in your life at present, and write down their names and a description of them in the space below. You may have one or two or you may have six. Think about why these people are important or ‘key’ in your life, how you are connected, what your relationship is like with them, and what has happened with these people in the last few weeks or months.

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25: The ABCs

This worksheet will help you to understand how your thinking (beliefs – B) can have different outcomes (consequences – C), even when it starts at the same point (activating event – A). Make a note of what each brother might be thinking in their thought cloud, given the end result.

Two brothers are lying in bed, sleeping peacefully. Suddenly, they are both woken up by a sound at the window ...

One brother turns over and goes back to sleep

One brother runs into his parents’ room
26: Checking your thoughts and feelings

This sheet will help you look at your thoughts and feelings. If a situation comes up, note it down here. Write what day it is, write or draw what happened, then write or draw how you felt, what you were thinking and what you did as a result.

What day is it? ____________________

What happened? Draw a picture or write about it.

I felt

I thought

I did
This worksheet will help you record your observations of how other people think, feel and act. Remember to get their permission. Give the letter (see over page) to the person(s) you are observing this week before you start observing them, then complete this table whenever you check in with them.

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<th>Monday</th>
<th>Check in</th>
<th>Check in</th>
<th>Observe</th>
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<td></td>
<td>What are they thinking?</td>
<td>How do they feel?</td>
<td>How do they show it?</td>
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<td></td>
<td>e.g. happy, sad, angry, frustrated, anxious, calm, tired</td>
<td>e.g. frown, laugh, not talking, panic, shout, cry, smile, fold arms</td>
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To

(family member’s name)

___________________________________________________(adolescent’s name) has an experiment to complete this week.

He/she has been asked to observe you for external signs of emotion, and to ‘check in’ with you about how you are feeling inside and what you are thinking.

You can help by answering honestly when he/she checks in with you, and maybe even describe the body language that you were using to express the feeling or thought you were having at the time.

For example, if you were feeling angry inside, you might have frowned and crossed your arms, and you may have been thinking to yourself why does this never work? If you were happy, you might smile and your thought might have been what a great day I had today!
28: What’s stressing you?

This activity is designed to help you work out which things in your day are causing you the most stress. Write down four types of things that cause you stress (e.g. family, home, school, friends etc.). On each day, rate how much each of those things has stressed you. Use the stress scale on the next page to rate your stress from 0 to 10. This activity will help you to work out which areas of your life are causing you the most stress. You can then choose the stress reduction strategies that can best help you in those situations.

Write down four types of things that cause you stress

* e.g. family, home, school, friends etc.

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### My stress scale

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>I don’t think about the issues at all.</td>
</tr>
<tr>
<td>1</td>
<td>I only think about the issues when I choose to, and I feel OK when I think about them.</td>
</tr>
<tr>
<td>2</td>
<td>I only think about the issues when I choose to, and this causes mild distress.</td>
</tr>
<tr>
<td>3</td>
<td>The issues aren’t in the back of my mind.</td>
</tr>
<tr>
<td>4</td>
<td>The issues are in the back of my mind from time to time.</td>
</tr>
<tr>
<td>5</td>
<td>The issues are only in the back of my mind.</td>
</tr>
<tr>
<td>6</td>
<td>The issues sometimes jump into my thoughts but mostly are in the back of my mind.</td>
</tr>
<tr>
<td>7</td>
<td>The issues uncontrollably jump into my thoughts.</td>
</tr>
<tr>
<td>8</td>
<td>The issues are in my background thoughts all the time.</td>
</tr>
<tr>
<td>9</td>
<td>I’m continually aware of and thinking about the issues.</td>
</tr>
<tr>
<td>10</td>
<td>I think about the issues so much that I can’t think about anything else.</td>
</tr>
</tbody>
</table>
29: Distraction techniques

The following list contains some different things you can try in times of high stress and when you are feeling like you might harm yourself. Tick the things you have tried or could try at these times:

- Hold ice cubes
- Allow yourself to cry
- Take up a sport
- Deep breathing
- Relaxation techniques
- Call a friend, your therapist or a crisis line
- Try not to be alone
- Have a hot bath or shower
- Listen to music
- Go for a walk
- Write in a journal
- Wear an elastic around your wrist and snap it when you have the urge to harm yourself
- Write a letter to the person(s) that have hurt you and express how they made you feel. You can then decide what to do with it (tear it up etc.)
- Sew, cross-stitch, knit
- Write down all your positive points and why you do not deserve to be hurt
- Play a musical instrument
- Practise yoga
- Make a list of reasons why you are going to stop cutting
- Work with paint, clay, play-doh etc.
- Draw a picture of what or who is making you angry
- Massage the area you want to harm with massage oils or creams
- Break the object that you use to self-injure as a way to show that you have control over it
- Do some household chores (i.e. cleaning)
- Do some cooking
- Scribble on paper

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Source: Thompson (1996)
30: Uppers and downers

Everyone has good things and less good things in their lives. This worksheet will help you make sure there is balance in your life between the good things (uppers) and the less good things (downers). Identify things in your life that ‘lift you up’ and write these things in the ‘balloons’ provided. Then, think about the things that ‘drag you down’ and write these things in the ‘rocks’ provided. Think about how you can make sure there are more uppers than downers each day.
Adolescence is a time of change so it is normal for young people to try out different attitudes, interests, friends and activities. This may result in behaviour changes that you can notice. Some of these changes will be perfectly healthy, while others may be an indication of mental health concerns.

Unfortunately, there is no recipe for a healthy adolescent and no easy way to tell normal changes from those that indicate a serious problem. Think about the number and degree of these changes that you might be seeing in the young person or that they tell you about. Also consider the impact of the changes on the adolescent's functioning in the family and at least one other area of their life (e.g. school, work, health, friendships or other social activities). It is also a good idea to talk about any worries with the child’s teachers and health professionals.

Open communication is very important. Try to remain calm and keep the lines of communication open even when the young person does things you might not approve of, like taking drugs or drinking.

Factors to think about if you are concerned about the mental health of a young person include:

**Isolation and withdrawal**
- Some degree of withdrawal from family is healthy.
- Be more concerned about withdrawal from friends and other social activities.

**Rejection by peer group**
- Adolescence is typically a time when young people strive to be accepted by their friends. Rejection by peers at this time or the break-up of a romantic relationship can be particularly stressful and can trigger or exacerbate mental health concerns.

**Abuse**
- Young people who have experienced physical, psychological or sexual abuse or neglect are at increased risk of mental health problems.
- The onset of puberty and involvement in more intimate relationships in adolescence can be re-traumatising for young people with a history of sexual abuse.

**Drug use**
- While some degree of experimentation with alcohol and other drugs is common in adolescence, the risks associated with this behaviour should not be minimised.
- Young people may also be using alcohol or other drugs to mask or to help cope with other emotional problems.

**Current stress factors**
- Adolescents are more likely to experience mental health problems during times of stress such as the transition from primary to high school or when leaving school, during major examinations or when making important decisions.
32: When should carers worry about adolescent behaviour?

If your child has experienced mental health problems in the past, it is a good idea to talk with their doctor, case manager or counsellor about their particular warning signs of relapse. Once completed, this worksheet can help remind the whole family about signs to look out for. Ideally you will be able to complete it with your child and with the help of their health professional.

<table>
<thead>
<tr>
<th>Physical health</th>
<th>Carers expectations of ‘normal’ behaviour</th>
<th>Carers should be concerned if …</th>
<th>Treating team should be considered if …</th>
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<tbody>
<tr>
<td>Mood changes</td>
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<td>Social problems</td>
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<td>School functioning</td>
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<td>Alcohol or other drug use</td>
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Select a problem, perhaps one that you recently encountered or a current one that does not have an obvious solution. Describe it accurately. Brainstorm a list of possible solutions. Consider the possibilities and number them in the order of your preference.

**Problem-solving practice**

‘Is there a problem?’
Recognise that a problem exists. We get clues from our bodies, our thoughts and feelings, our behaviour, our reactions to other people, and the ways that other people react to us.

Note down the clues you got that there is a problem here:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

‘What is the problem?’
Identify the problem. Describe the problem as accurately as you can. Break it down into manageable parts.

Identify the actual problem here:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

‘What can I do?’
Consider various ways to solve the problem. Think of as many solutions as you can. Consider acting to change the situation and/or changing the way you think about the situation.

List brainstorming solutions here. Don’t think too much about them, just note down all the ideas you can think of, good or bad:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
‘What will happen if . . .?’
Pick the three most promising options from your brainstorm list. Consider all the positive and negative things about each one and select the one you think is most likely to solve the problem.

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Now try putting your problem-solving approach into action. After you have given it a fair trial, think about how effective it was — did it solve your problem?

‘How did it work?’
Ask yourself: does the approach I chose seem to be working out? If not, consider what you can do to beef up the plan, or give it up and try one of the other possible approaches from your list. Update your problem-solving plan here:

Adapted from Carroll (1998)
Even seemingly irrelevant decisions can take you closer to high-risk situations without you realising it. When making any decision, whether large or small, use the problem-solving approach you practiced in Worksheet 33: Problem solving to help you make safer decisions.

1. Consider all the options you have.
2. Think about all the consequences, both positive and negative, for each of the options.
3. Select one of the options. Pick a safe decision that minimises your risk of relapse.
4. Watch for ‘red flag’ thinking – thoughts like ‘I have to . . .’ or ‘I can handle . . .’ or ‘It really doesn’t matter if . . .’

Practice monitoring decisions that you face in the course of a day, both large and small, and consider ‘safe’ and ‘risky’ alternatives for each using the table below.

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<th>Decision</th>
<th>Safe alternative</th>
<th>Risky alternative</th>
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Adapted from Carroll (1998)
WORKSHEETS

35: CBT Model

- Early experiences
- Core beliefs
- Unhelpful thoughts
- Trigger
- Behaviour
- Feelings

Core beliefs

Unhelpful thoughts

Behaviour

Feelings

Early experiences

Core beliefs

Unhelpful thoughts

Behaviour

Feelings

Trigger

35: CBT Model

WORKSHEETS