Oxytocin-Enhanced Motivational Interviewing Group Therapy (OE-MIGT) for Stimulant Use Disorder

Facilitator's Manual

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Adapted using:
Christopher C. Wagner & Karen S. Ingersoll, With Contributors. (2013). *Motivational Interviewing in Groups*. New York, NY: Guilford, 416 pp.

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I. Group Specifications

A. Group Objectives

1. Foster motivation to engage with treatment and group cohesion with group facilitators and other group members.
2. Stop or reduce stimulant use (or other positive behavior change).
3. Reduce physiological stress responsivity and, thus, psychological defensiveness.

B. Group Format

Structure	Semi-structured
Admission	Closed
Group Duration	Time-limited (6 sessions)
Session Length	90-minutes
# of Facilitators	2
# of Participants	4-6

C. Target Population(s)

Each group cohort will be composed of 4-6 homogenous members with stimulant use disorder. Suggested variables for grouping are 1) primary stimulant type (*either* meth *or* cocaine) and 2) subpopulations (e.g., men who have sex with men, military veterans, etc).

To avoid issues with scapegoating, group facilitators may also want to consider demographic variables such as race/ethnicity, age, education, housing status, and chronicity of stimulant use and ensure balance of these variables (e.g., having a group of five men in their 20's and one man in his 60's is less preferable than four men in their 20's and two men in their 60's or a diverse age range).

II. Motivational Interviewing

Miller & Rollnick (2013) cite three different definitions of **Motivational Interviewing** (MI). 1) a collaborative conversation style for strengthening a person's own motivation and commitment to change. 2) a person-centered counseling style for addressing the common problem of ambivalence about change. 3) a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.

Motivation is interpreted as an internal process rather than a personality trait (Miller, 1983). There are typically two sides of balance with **ambivalence**: one side wants to change the problem, while the other side wants to maintain the status quo or avoid the problem altogether.

A. Broad Spirit

- **Collaborative:** Facilitator's do not take on an expert role, but a partnership.
- **Compassion:** Promote the best interests of others, want them to succeed and prioritize their needs.
- **Acceptance**: Recognize the absolute worth of clients as human beings. Perceive clients' inner worlds—experiences, perspectives, emotions, meaning—and use those perceptions to better understand their lived experience (accurate empathy). Accept clients where they are.
    - **Absolute worth:** Having unconditional positive regard by accepting and respecting individuals as they are.
    - **Empathy:** Understanding the internal processes of another person and what their experiences are like.
    - **Autonomy**: Support clients' ability and authority to make choices, consider options, and take actions. Recognize that we cannot *make* clients do anything.
    - **Affirmation**: Momentum is better achieved by building upon what is working well than by fixing what is not. MI should never be used against clients' own best interests.
- **Evocation**: Elicit clients' perspectives on defining which behaviors might be problems, explore their own concerns, and elicit their intention to change and optimism about change. Client should discover perspectives on their own. Motivation, options, and change talk do not come from the therapist.
    - *What makes you think you need to make a change?*
    - *What is the next step?*
    - *What would be good about changing [insert behavior]?*
    - *If you did decide to make a change, what would you have to do in order for it to happen?*

B. Techniques: Open-Ended Questions, Affirmations, Reflections, Summarize (OARS)

1. **Open-Ended Questions:** Ask open-ended questions to understand clients' views. Allows clients to think deeply about issues and explore reasons to change.
   - *What brought you here today?*
   - *What do you enjoy about [insert behavior]?*
   - *What would you like to focus on today?*

2. **Affirmations:** Helps build rapport by focusing on clients' strengths. Therapist affirmations should be *genuine* and *congruent*. This is especially useful when discussing clients' past failures.
   - *Your commitment really shows by [insert actions].*
   - *It is very clear you are trying to change [insert behavior].*
   - *I appreciate you coming in despite how hard it must have been.*

3. **Reflections:** Mirrors what the client says in a non-judgmental manner that allows client to feel understood. Reflections are phrased as statements, not questions (voice does not go up at the end). This is important, if reflections are phrased as a question the therapist risks sounding sarcastic or aggressive. Therapists may repeat, rephrase, and paraphrase while implementing reflective listening.
      - *You really feel stuck.*
      - *Your drug use has been a major way of coping with life's stresses.*
      - *You want [insert behavior] to change, and you are not sure you can do it because of difficulties you've had in the past.*
   - **Simplified Reflection***:* Mirrors what the person said without adding any additional content. Simplified reflections are best used initially to build rapport or to reflect change talk.
      - Participant: *I need to stop using.*
      - Facilitator: *You really want to stop using stimulants.*
   - **Amplified Reflection:** Maximizes or minimizes what the participant said (both sides of ambivalence) to evoke disagreement toward change talk. Amplified reflections are best used in response to sustain talk. They are always executed with empathy and sincerity, not hostility or sarcasm. Coming alongside is the strategy of using an amplified reflection to assume the client's argument that he or she should not change and names it, often freeing up the client to think and feel the other side.
      - Participant: *But my entire friend group does them.*
      - Facilitator: *You don't know one person who does not use stimulants, I can see how you'd feel like you have no other option but to use.*
   - **Double Sided Reflection***:* Simple reflection of sustain talk, then amplified reflection toward change talk. Mirrors what the participant said, then reveals more than one perspective—often by bringing in previously stated values or goals.

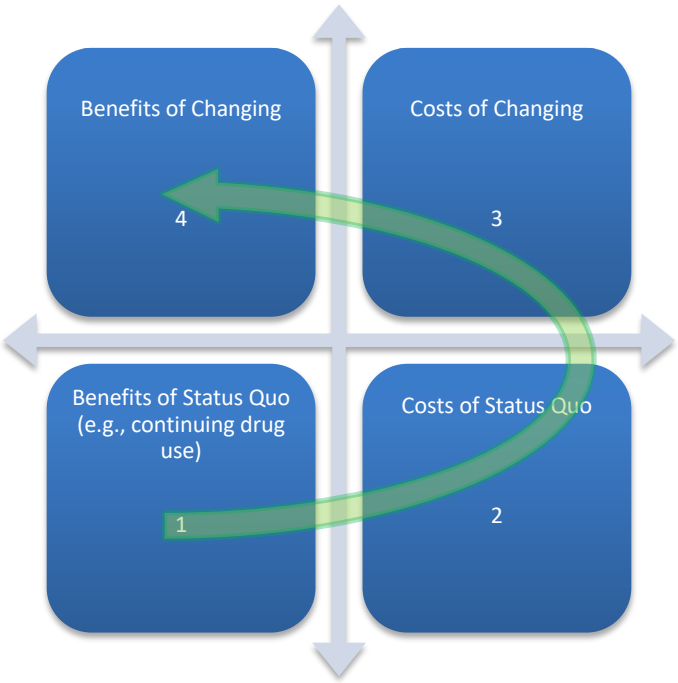
- Participant: *I can't stand being lonely.*
- Facilitator: *You really don't want to face loneliness after you stop using; you've mentioned before that you're really wanting to reconnect with your sister.*
- Participant: *It's hard to be with my sister, I feel like she's judging me for my past.*
- Facilitator: *Being with your sister brings up some of the conflicts you've had over your drug use, you mentioned earlier that you two used to be really close.*

- **Shifted Focus Reflection:** Mirrors what the participant said but directs attention away from resistance or stuck point.
  - Participant: *I don't think my sister will ever trust me again.*
  - Facilitator: *You worry that you'll never get that same closeness back. You mentioned earlier that you felt really good about discussing your use history with your primary care doctor the other day. She didn't know before you decided to let her in on the bigger picture.*
- **Continuing the Paragraph Reflection:** Facilitator states what he or she thinks might be next in the participant's statement.
  - Participant: *She still doesn't know how much I use.*
  - Facilitator: *It's not a bad idea to feel things out before you divulge everything to someone, and you've been working on cutting down your use.*
- **Reframe/Agree with a Twist:** Acknowledges the validity of the person's raw observations but offers a new meaning or interpretation for them. It often validates the uses or benefits of the problematic behavior in the short-term and then offers a perspective on the long-term disadvantages by offering information. Reframes are best kept brief. Let the client decide if she or he wants to accept the reframe.
  - Participant: *I really can use a lot, it doesn't affect me the same as if affects other people.*
  - Facilitator: *You've mentioned before that you can use more than other people. This might be due to tolerance. People with high tolerance truly don't notice as many negative effects, and it can actually put them more at risk.*

4. **Summarize:** Therapist conveys understanding and interest. This is an opportunity to state both sides of a client's ambivalence and stress information that will promote change. Can be used after a client has been speaking for a while or as a transition. At the end of the summary facilitator may ask:
   - *Am I correct?*
   - *What else?*

C. Exercises

1. **Decisional Balance Chart**: – Start with exploring the benefits of maintaining the status quo (bottom left) and move through the chart, ending with exploring the benefits of change. This allows early focus on sustain talk to decrease resistance to the change talk that follows.



2. **Importance and Confidence Rulers**: Ask participants to say how *important* changing a specific behavior is to them or how *confident* they are that they can change by using a 10-point scale.
   - *On a scale of 1 -10, 1 being not confident at all that you'll be able to make this change and 10 being extremely confident that you will make this change, what number best reflects how confident you feel at the present moment?*
     - *Why is it not a [#] (always ask why it wasn't lower, this forces them to argue for change instead of resist against it)?*
     - *What would you need in order to make your number higher?*
     - *How would your life be different if you moved from [#] to [#]?*

3. **Develop Discrepancy/Columbo Approach:** Facilitators should amplify discrepancies between clients' past/current behaviors and their hopes/goals. This allows for the patient to begin understanding the conflicts between where they are versus where they want to be. Behavior change may happen when patients realize their own discrepancies. Always use "and", not "but".
   - *On one hand you want to [insert hope], <u>and</u> on the other hand you [insert behavior].*
   - *Help me understand. You want [insert hope] <u>and</u> are [insert behavior]. What do you think is preventing [insert hope]?*

III. Motivational Interviewing Group Therapy (MIGT)

MIGT: 1) uses MI spirit, techniques, and exercises to increase motivation for change, 2) fosters healthy interactions among members and leaders to promote change, and 3) involves group members and facilitators meeting in a shared physical space. MI groups can improve recognition of ambivalence, support autonomy, increase commitment to change, and improve treatment engagement and participation.

A. Guiding Principles

1. **Focus on Positives and Growth**: Groups do not do well with catharsis of negative emotions. Eliciting hopes, focusing on progress, and exploring solutions can be more productive than resolving problems. Focus on building members' energy and confidence around change.
2. **Bring Members to the Moment**: Don't discuss "out there" (past events, current relationship issues), instead discuss "in here" (processes occurring in the room, interactions between group members).
3. ***Explore* Perspectives and Focus on the *Present***: Lower defenses through affirmations and experiences of group bonding during earlier phases of the group. Reflect members' statements, then ask open-ended questions to the group that build toward shared themes. You can also use process summaries to highlight how members worked together, supported each other, or built off of each other's comments.
4. ***Broaden* Perspectives and Focus on the *Future***: During later phases of the group, continue to limit focus on specific details of members' pasts and maintain focus on the future to build momentum around change talk.
5. **Hear Complaints, but do NOT Elicit Grievances**: "Roll with" defensiveness, but do not elicit shared negative emotions. Find something positive in negative comments to focus on. Harness the nervous energy, then shift in a more positive direction. Never get defensive yourself**.**
6. **Reflect and Explore a Positive Focus on Desires, Needs, and Plans**: Shift members' agreement, judgment, rescuing, or advice giving to preparatory change talk, desires, needs, reasons, ability, and overall positive aspects. Okay to acknowledge harsh realities, then pivot. Don't directly challenge self-judgment, instead focus on conscientiousness, honesty, autonomy, grit, self-preservation (i.e., even if certain behavior has become maladaptive, perhaps it initially developed for survival in reaction to abuse or trauma during critical developmental periods and requires compassion and a realized sense of current safety in order to change).
7. **Support Self-Efficacy**: Remind members frequently that goals and improvement will be different for each of them. Leaders can reflect common experiences and themes to enhance group cohesion, and members can brainstorm, practice, and share tips, but ultimately change comes from each member's specific narrative.
8. **Counteract Negative Reactions Before Sessions End**:
    i. **Advice Giving**: Redirect using the following techniques. Acknowledge altruistic intentions and affirm that specific advice may work for the advice giver. Then share concerns that specific advice may not always fit for everyone. *I know that I'm less likely to take information in when it comes in the form of advice and more likely to be affected by hearing*

others' personal experiences. Offer an opportunity to reframe or ask for consent to give advice. You can also ask to defer advice giving until after a specific member of focus can come up with their own tentative plan. Remind participants that ambivalence is one of the normal stages of change and that fully experiencing or "sitting in" ambivalence and having others be curious about their unique experience will be much more helpful than receiving advice from others.

ii. **Criticism**: Normalize conflict and the fact that group members may be at different places along their journeys. Remind them that a primary goal of the group is to ensure that everyone feels safe to share their individual thoughts and feelings, especially when they differ from others. Diversity is the spice of life. Provide the criticizer an opportunity to speak to how they're feeling without oppressing other group members. Often projection happens when the criticizer doesn't feel safe enough to acknowledge certain traits about themselves; ensure that they feel safe and not attacked for criticizing while encouraging empathy and reflection. Balance focus between individual members and the entire group (e.g., reflect ongoing ambivalence of all members). Avoid disintegration of the group into subgroups, highlight that all group members are somewhere along a continuum related to specific issues.

iii. **Not Talking**: All group members should contribute by the end of each group session. If a particular client is silent, invite (rather than expect) in a stepwise fashion. You may initially say "What else?" or "Who else?", while making low-key, easy eye contact weighted toward the silent member (do not say "Anything else?" or "Anyone else?"). You can direct more verbal members to speak to the silent member(s) (especially if conversation is exclusively being directed at group leaders). Use processes, such as "rounds", that communicate an expectation that each person will briefly participate in turn, or invite the silent member to comment on a topic or respond to another client's question. If he or she hesitates, simply acknowledge that you wanted to make sure they knew there was space for them, but they don't need to feel pressured to speak. Shape interactions over time so that talkative members listen more and quiet members talk more. Generally, it becomes harder to speak if a person remains silent for too long.

If *multiple* members are silent, you will need to consider what might be happening (or not happening) to inhibit conversation. Be aware that you may have not provided sufficient guidance, you may have prematurely attempted to explore topics that members feel vulnerable about or have not thought about before, or another member may have explicitly or implicitly violated a group norm and there may be some general sense that the group is unsafe. A good place to start is to consider the group's focus in the session and attempt to counter it (see "Shaping Group Conversations"). If the topic has gotten too narrow, broaden the focus. If the discussion remains at the surface, deepen the conversation. If the focus has become too deep and members have become uncomfortable, lighten the mood. If a specific group is particularly quiet, you may comment directly on group process. Normalize that it may take some time for a group to synch up. Let them know that they don't have to worry about being off-topic or repetitive,

that you will make sure the group stays productive so they can remain relaxed and join in naturally.

B. Group Processes/Phases

1. **Engaging**: Enlist the group in the process of opening up by involving them in meaningful relationships based in understanding and acceptance.

   When: Typically important during the early stages of therapy (primarily the first session), at the beginnings of sessions, or when you or the client(s) become defensive.

   Techniques/Exercises:

   i. Direct open-ended questions, affirmations, and reflections to the group as a whole.
   ii. Summarize similarities.
   iii. Reflect simple ideas/themes that link members.
      - *Even though you're focusing on different issues, you both are working to be more assertive with others about your needs.*
   iv. Avoid the expert stance.
   v. Avoid premature focus on deep exploration.
   vi. Roll with resistance (avoid argument or persuasion).
   vii. Avoid the creation of subgroups by linking issues among members on a continuum rather than black and white.
   viii. Make early efforts to engage isolated members.
   ix. Address problematic styles early in an MI-consistent manner by affirming their associated strengths (Appendix C and D) and reflecting positive interactions.

2. **Exploring Perspectives/Focusing**: Collaboratively, and strategically, narrow the focus from cohesion-building to members' perspectives about their current situations. Members' social identities emerge at this phase. Develop the group into a positive social network where members experience a sense of group identity, participate, attach, influence, and are influenced. Members can learn how to build trust, share vulnerabilities, understand how others perceive them, recognize interpersonal sensitivities that trigger often automatic suboptimal reactions, and recognize behavior that negatively affects others.

   When: Once client(s) are Engaged. When Evoking (next phase) gets too off topic or too broad.

   Techniques/Exercises:

   i. Start with focus on goals of greater happiness and life satisfaction.

ii. Foster strengths, hope, support, and determination to improve things.
iii. Foster universality through linking reflections and interweaving focus between individuals and the group. Raise awareness of the universality of challenges/struggles/setbacks. Isolated problems become "our problems". Sharing a common bond increases motivation.
iv. Help increase members' sense of acceptance by the group.
v. Redirect advice-giving to safely focus on members' own issues.
vi. Keep emotions, especially negative emotions, at a relatively low level until more group safety and trust has been established.
vii. Instill hope and acknowledge small successes.
viii. Bring the group into the moment.
    - *What would you like to accomplish this afternoon?* (versus *How have things been since our last meeting?*)
ix. Focus on the present.
    - *Even though everyone has a long history that has contributed to who you are today, we generally try to focus on the present and moving forward.*
x. Ask about obstacles to making improvements.
xi. Foster members' awareness of how they can reframe complaints, concerns, and problems into workable therapeutic tasks.
xii. Acknowledge suffering, but don't elicit grievances. Reflect feelings and acknowledge the member's determination to move forward despite negative experiences.
xiii. Help members perceive and begin to change maladaptive social patterns if barriers to change.
xiv. Maintain boundaries around attendance.

3. Broadening Perspectives/Evoking: Elicit client perspectives and ideas about change, motivation to change, and hopes for success. Help broaden their field of vision to include new ideas/interests and a greater range of options moving forward. Elicit and respond to change talk and build momentum toward positive change. Accept and respond to sustain talk in order to prevent defensiveness, but do not elicit sustain talk. Pivot sustain talk toward positive change. Definitely avoid the pitfall of trying to convince group members to see and do things differently. Group identity develops in this phase. The group becomes "us".

When: When clients are focused on change and/or offering change talk. When Planning (next phase) elicits defensiveness (i.e., may be too soon or becomes too overwhelming).

Techniques/Exercises:

i. Increase members' sense of autonomy and freedom to choose.

ii. Create an atmosphere that naturally evokes positive emotions: calmness, curiosity, joy, acceptance, creativity, cohesion (negative emotions tend to evoke fight-or-flight responses).
iii. Build on positive change momentum.
iv. Reflect group processes, such as when members boost each other up, put their trust in the group to share vulnerabilities, or how the group makes it safe for members to share.
v. Guide members to maintain focus on the future and develop new goals for themselves.
vi. Develop discrepancies between current actions and future goals.
    - *It seems like you want [insert goal]* ***<u>and</u>*** *you like [insert behavior] the way it is. What do you think about that?*
vii. Accept defensiveness (which can return when developing discrepancies), be comfortable with members' negative emotions and tension at this point while also pivoting to positive focus.
viii. Use Importance and Confidence Rulers.
ix. Affirm positive efforts and new strategies.
x. Review past successes in order to boost confidence.
xi. Reframe failures as necessary steps toward eventual change.
xii. Can begin revealing your thoughts about group dynamics and observations about the group at a meta level.
xiii. Create a vision and options for fulfilling goals together as a group.
xiv. Link members around what they find useful in the group at a process level and what they'd like more of.
xv. Shift toward greater member-member interactions.
    - *What does the group think about that?* or even better *You might consider asking what the group thinks about that.*
    - *There are many ways to approach one issue. What are some ideas?*
    - *Would you like to tell the group what might be helpful for you at this point?*
xvi. Continue to attend to members slower to engage.
    - *Some of you have a pretty clear focus, and others are still unsure. We've spent most of our time talking about concerns, pressures you face, and a little bit about how you got here. Now let's spend some time looking toward the future, not to get ahead of ourselves, but to pick a star to steer by, like sailors used to out on the ocean, to avoid getting lost. In the group, we might explore each of your guiding stars, where you're heading. What are some examples of those?* (Wagner and Ingersoll, 2012, p.200).
xvii. Gradually increase the group's comfort with expressions of emotion as part of Exploring/Broadening Perspectives, while keeping anxiety across members at a manageable level.

4. **Moving Into Action/Planning**: Develop specific plans for *how to* implement change.

   When: Once ambivalence is explored and/or resolved.

   Techniques/Exercises:
   i. Saying "*What now?*" or "*Where does this leave you?*".
   ii. Summarize (e.g., change talk + Importance and Confidence reports).
   iii. Guide members to ask for what they need.
   iv. Encourage members to pay attention to group process.
   v. Clarify the goals of change.
   vi. Explore options for change (remember: options always come from clients, not therapists).
   vii. Ask members to discuss which options are most likely.
   viii. Focus on actions.
   ix. Help monitor progress.
   x. Monitor for subgrouping around different rates and amounts of change among members, normalize different paces and paths, bring members together by acknowledging that they have all learned from each other and will continue to benefit from the group even after it's over.
   xi. Prepare for and process termination. Remind participants about the Attachment Psychoeducation session (see below) as a way to begin discussing how termination may affect them.

C. Shaping Group Conversations

1. Establish and maintain focus: MI groups are client-centered, in that the focus is on the members developing greater ownership of life choices and behavioral patterns; but groups are not client-led. It is your responsibility to manage group process and conversational focus so that members proceed through the group phases. Depending on the phase of the group, you may need to broaden or narrow focus, change focus when on unproductive details/stories/complaining (using transitional summaries, reflective strategies such as agreement with a twist, or making an overt statement that you are shifting focus), or maintain focus when conversations are productive (simple reflections, specific affirmations). If the group insists on diverging, try to relate the topic to an aspect of change (e.g., importance, confidence, readiness, envisioning, resolve, planning, or ambivalence) or to group development (e.g., openness, cohesiveness, support, universality, or altruism).

2. Elicit discussion: Invite rather than expect. Reflect themes, then ask an open-ended question to the group. Direct members to talk to each other rather than the leaders. Eye contact with targeted members.

3. Link members: Link concerns, themes, feelings, attitudes, goals, motivation, and *any* change talk. Use "we", "us", "the group" whenever possible.

4. Guide member communication: At times, you may need to emphasize the idea of supporting one another without pressuring, remind members that they each must decide for themselves what and how to change, or guide them to use OARS techniques with each other (most importantly, model them yourself).

5. Consider the depth, breadth, and momentum of conversation:
    i. Depth: level of meaning, ranging from surface level (superficial events, factual matters, general interests) into deeper level (personal matters, values, identity issues, underlying emotions or perspective).
    - *Deepening*: When the group is ready to share more vulnerable issues and becomes too focused on surface issues, starts intellectualizing, or is stuck on ambivalence:
        - Reflect emotions, values, higher purpose, or commitment.
        - Link members together by their deeper levels of purpose and commitment.
        - Affirmations that highlight a core value, especially when the value takes place in a group action (e.g., altruism).
    - *Lightening*: When things go too deep too quickly, when major conflict arises, or when time is running out for the session:
        - Use lighthearted humor to elevate the mood.
        - Affirm the intention and redirect explicitly (give reason).
        - Link deeper aspect to an everyday surface element.
        - Provide closing summary.

    ii. Breadth: how narrowly the conversation focuses on a single event, issue, or idea versus how much it broadens into general themes.
    - *Broadening*: When members are too focused on specific details or become overwhelmed by numerous, seemingly unrelated, problems:
        - Link behaviors or situations to establish a theme that extends across them and toward a broader goal.
            - *How do all these things fit together in the bigger picture?*
            - *What connections might there be between feeling isolated and using meth more often than you'd like?*

- Linking summary: link current themes to previous theme(s) or link an individual member's issue(s) with other members' issue(s).
- Ask open-ended questions to the group.
- Develop discrepancy.
- Elicit-Provide-Elicit.
- Use imagery reflections to stimulate creativity.
    - *Dealing with changing [insert behavior] is kind of like pulling weeds, if you don't get it out by the roots it just comes back.*

- *Narrowing*: When members are vague about what they'd like to change:
    - Selective reflections or, rarely, closed questions to focus on specific issues.
    - Ask them to define vague or broad terms or statements.
    - Ask them how they'd like to start the process of change.

iii. Momentum: the pace of forward movement—the degree to which new ideas emerge or how the conversation proceeds toward some conclusion or commitment to action.

- *Acceleration*: When members focus on the past or current details to the point of becoming unproductive:
    - Consider accelerating the conversation toward change.
        - *How might things be better?*
        - *What options do you have in moving past [fill in the blank]?*
        - *What would help get rid of this obstacle?*
    - Use **continuing the paragraph reflection** to guess the next things members might say if they were moving toward change (being careful not to confuse this with giving advice).
    - Use affirmations to underscore members' strengths to change the things that bother them.
    - Ask a stuck member if they'd like to use the group to brainstorm some options for moving toward change. After a few possibilities are generated, check in with the member and see which option he or she resonates with the most or would like to build upon (do not focus on options they dislike).
- *Deceleration*: When groups move too quickly toward strategies for change, before members have developed enough cohesion and trust to offer more vulnerable experiences or perceptions, or if they race past considering issues, experiences, or possibilities that may have value in exploring further:
    - Suggest slowing down.
    - Explore a related or secondary theme that may be easier for the group to digest.
    - Use linking reflection back to previous topics that were not fully explored.

- Explore potential obstacles to change and backup plans before proceeding to planning if members seem overconfident.

D. Co-Facilitator Roles

Overall the role of the group facilitators is to move the group members toward and into the Moving Into Action/Planning Phase using the various techniques outlined above. As co-facilitators, you also have the benefit of modeling: mutual respect, genuine interest in each other's viewpoints, collaboration, support for each other's autonomy, and being empathetic in a goal-oriented manner.

It may be helpful to split responsibilities. This can be planned beforehand, but is more likely to emerge naturally as the group progresses. For instance, different co-facilitators may be responsible for presenting specific psychoeducation components based on prior experience and expertise. You may also take on different roles in the group, such as *content facilitator* or *process facilitator*. For example, in the Moving Into Action/Planning Phase, the *content facilitator* focuses on eliciting change talk and commitment talk during change planning discussions by using key questions like, "*What do you hope to gain from making this change?*", "*How will you do it?*", "*How will you know it's working?*", "*How can the group help?*", while the *process facilitator* summarizes, creates links between members' feelings about change, affirms positive interpersonal moments, and ensures all group members are engaged in the discussion.

If possible, group co-facilitators should meet immediately prior to each group session to review objectives for that session. Group co-facilitators should definitely meet after each group session for discussion and/or supervision. Discussion should focus on techniques or processes that facilitators found particularly helpful during the preceding session, identifying which phase(s) the group is in, methods to progress this specific group into the next phase, and any issues preventing the group from progressing to the next phase. If sessions are video or audio recorded, specific interactions may be reviewed and alternative techniques discussed.

IV. Psychoeducation Components

The inclusion of a semi-structured psychoeducation framework to this group provides several potential benefits. It may help newly forming groups, which can initially be unfocused or unsure, become involved and productive and perceive the group as safe to participate. It will provide personalized information and new skills specific to a population of clients with stimulant use disorder receiving oxytocin as an adjunct to MIGT. It may help integrate concepts and practice specific skills.

A. Topics

The topics we have chosen for this group are designed to maximize the effects of intranasal oxytocin and match the specific objectives of this manual (and accompanying research study). The psychoeducation components will be presented and discussed early on in the course of the group in order to help *engage* and *focus* the clients. Later sessions of the group will be left unstructured in order to allow more time for *evoking* and *planning*. For example, in a six-session course, the following four topics should be presented during sessions 1, 2, 3, and 4, respectively, leaving sessions 5 and 6 relatively unstructured.

1. **Stages of Change**
2. **Ambivalence & Decisional Balance Chart**
3. **Attachment and Trauma**
4. **Reframing Stress: Threat versus Challenge**

B. Guidelines

To maintain the spirit of MI (e.g., client autonomy, evocation), don't see this as a "curriculum", rather as tools to help move the group through the phases of Engagement, Exploring Perspectives, and Broadening Perspectives. While these psychoeducation components may help advance the group into deeper phases, being with the group in the moment and having a relaxed and confident attitude about whatever comes up is more important. Each psychoeducation component should take *no longer than 10 minutes* for you to explain, leaving the rest of the time for group discussion. In general, it may be helpful to illustrate concepts on a white board, but avoid handouts. Use the following guidelines:

1. Make attempts to link each topic to conversations and themes spontaneously brought up by clients earlier in the session or in previous sessions.
2. Be explicit about shifting into the "expert"—or educator—role.
    - *I'd like to put on my therapist hat for a few minutes and provide you with some specific information that I think may be helpful.*
3. Ask for permission.

- *In order to move forward, I think it'd be good for us to all be on the same page about [topic]. Do you mind if I give you a little bit of information about it before we continue the discussion?*

4. Elicit–Provide–Elicit
    - Elicit current awareness/knowledge/perspectives on each topic.
        - *Have you heard about [topic]?*
        - *What do you already know about [topic]?*
    - Fill in the knowledge gaps by providing relevant information, simplify your presentation to two or three basic concepts, and do not give advice or instruction (only information).
    - Elicit clients' reactions to the information you shared and how they may use it.
        - *How does that sit with you?*
        - *How do you think this information might fit with your goals?*

V. Session 1

Establishing a safe and supportive atmosphere that engages members in the group process is more important than establishing therapeutic focus during the first session.

A. Introductions

1. Be sure to start *on time*.

2. Introduce yourselves.
    a. Give some brief information about your prior experience with group therapy, etc. Try to instill a sense of confidence in your skills and ability to lead the group while being careful not to establish yourself as "the expert" or set any guidelines just yet.
    b. It is okay to disclose a thing or two about yourself that you think may help the participants feel more comfortable (e.g., for an MSM group, you may disclose up front that you are part of the LGBT community or have a specific reason for working with this population).
    c. You can let the participants know that you'll eventually discuss the group and the work you'll be doing together after you all get to know each other a little. Begin the group by emphasizing social aspects over business aspects.

3. Invite each group member to introduce themselves.
    a. Ask them to share something positive (e.g., if they were a superhero, what would their special power be).
    b. Elicit experiences in previous groups and expectations for this group. Discuss how MIGT may or may not be similar to previous experiences or meet participants' expectations.
    c. Elicit individual members' goals for the group. Use their language to talk about addiction, "recovery", etc. Focus on *initiation goals* (what they hope or seek to achieve, gain, or develop), not *cessation goals* (what they are attempting to stop, lose, or diminish). For example, if a participant reports a goal of "cutting down on meth use", focus on what they will do to replace the habit or on skills they will develop to overcome barriers to achieving their goal.
    d. Normalize that members may be at different stages. A deeper discussion of this topic will happen later in today's session.
    e. During participant introductions: make links, summarize similarities, and affirm.

B. Orientation to MI

The following should be conveyed casually, using eye contact, not read from a script. It is okay to paraphrase.

I should explain right up front that we're not going to be changing you. I hope that we can help you think about your present situation and consider what, if anything, you might want to do, but if there is any changing it will all come from you. Our main goal for the group is to create a safe environment in which each of you will feel heard and understood and that, together, we develop a sense of group cohesiveness and community. We'll try to keep focus on the future and positive aspects of change, but change is certainly associated with some growing pains. We'll work through any growing pains together as they arise. We'll also be giving you some information and maybe education around certain issues. We might assist you in thinking through your current situation and discuss the possibility of making some changes, but what you do with all of that during and after our six sessions together is completely up to you. I couldn't change you if I wanted to. The only person who can decide whether and how you change is you*. Any questions about anything we reviewed before we start? We want to make sure that this group format makes sense and everyone is comfortable with participation.* [Wagner & Ingersoll, 2013, p.168]

C. Setting Guidelines

1. *It's easier to create a safe and comfortable atmosphere together if there are some group guidelines. Does anyone have any suggestions for guidelines that may lead to a better experience for everyone?*
2. Use the word "guidelines" as opposed to "rules".
3. It may be helpful to first elicit the purpose of the group, then ask what guidelines for the group will help serve that purpose.
4. Using an elicit-provide-elicit template to come up with a set of group guidelines. Use input from all group members to hone ideas into a list of concrete guidelines. Broader guidelines may be better. When possible, combine and simplify broader overarching themes.
5. Each group may have a different set of guidelines, so it is important to keep track of these as co-facilitators and review them before each group.
6. If the group is having a difficult time getting started, you may offer up examples and have the group discuss and decide whether setting a guideline around this would be helpful for the group. Examples:
    a. Have everyone turn off their cellphones during the group to avoid disruption from the outside world.
    b. Abstain from talking about politics.
    c. Group leaders will make sure to start and end promptly on time.
    d. Avoid conversations about the group outside of the group.

e. Don't talk over one another (turn-taking).
f. Respect one another.

7. Make sure that ***attendance*** and ***punctuality*** are thoroughly discussed.
    a. If not brought up spontaneously by group members, and you are unable to elicit any further suggestions, you may bring the topic up yourself. Example: "*Would it be okay if we contribute something to our group guidelines? The only request we have for this group is that each member makes it a priority to attend all six sessions and arrive on time. This helps maintain trust in each other and creates a safe and containing group environment without undue disruptions.*"
    b. You should have already discussed guidelines around notifying group leaders of any planned absences and grounds for termination from the group. You can restate these at this time and emphasize that participating in each group session will take some amount of *planning*.
    c. Elicit reasons why members may not want to attend a group session (e.g., group participation may lead to anxiety, peer pressure to engage in an alternate activity occurring at the same time, may be high or withdrawing during group time). Emphasize your request for "sticking with" the group, even if it seems uncomfortable at first.

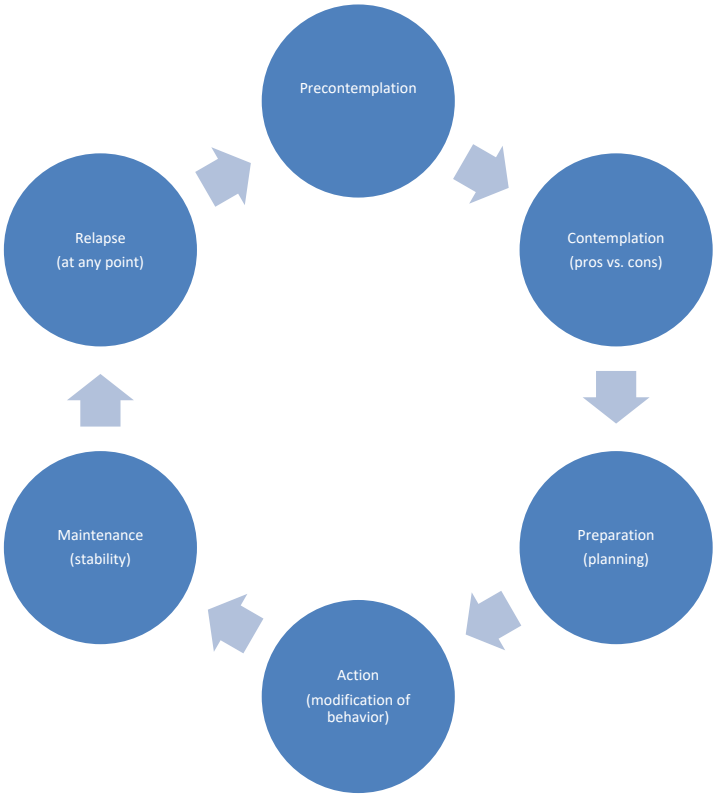
    Being uncomfortable opening up in a group of strangers is normal. Exercise is a good comparison; it can cause soreness at first, but if you're able to tolerate this discomfort and keep training, your body adjusts and can eventually tackle even higher intensity exercise with ease. However, let us monitor the safety of the group for you so you can focus more on what changes you'd like to make in your life. In fact, the most important changes you make can come from addressing and getting support around feelings of discomfort, boredom, or resistance to group process. Each group of people is unique and is expected to unfold differently over the six sessions because its creation is collaborative and depends on your participation. We are creating something together in order to have the experience of and practice with group cohesion, which is a healing process in and of itself. If you notice obstacles within yourself that keep you from engaging in group collaboration, bring voice to these. It is very likely that you will not be alone in your experience.
8. Review final guidelines.
9. Elicit reactions to the process of setting group guidelines together and ensure that everyone is content with the guidelines as they stand.

D. Psychoeducation – Stages of Change

1. *We expected that not everyone here is in the same stage of recovery and that everyone has their own unique path. Please remember that the goals and experiences of recovery are not the same for everyone. We ask that everyone accept and respect, even try to understand, each other's differences.*

2. ***Elicit*** previous major life changes that group members have made successfully (not related to substance use). Ask how much time elapsed between first becoming aware of the desire or need to change and beginning to try to change? Next, ask how long it was between beginning to try to change and completing the change.
    a. *The field of psychology knows a lot about the process of change. Change is not typically immediate. Rather it is a process with multiple steps. We also know that people usually make several attempts to change before they are able to make permanent changes, and that each attempt is a learning opportunity making it easier and easier to maintain changes in the future.*
    b. Ask if members are interested in hearing more about the stages of change in general.

3. Have one of the co-facilitators draw a Stages of Change diagram on a white board.



4. *Remember that the stages are* NOT *linear, which is why we draw them in a circle. Change is not a continuous process, meaning that it does not move in a straight line and may jump between stages throughout treatment.*

5. Precontemplation: The individual is unaware that he or she has a problem. Individuals are not considering changing nor do they intend to change in the future. They may not believe that their behavior is problematic or have not endured all the negative consequences. Participants in this stage may be argumentative, hopeless, and discouraged. The selection process for this group will likely screen out participations in the Precontemplation stage; however, participants may move into a Precontemplation stage sometime after being selected for group participation.
    a. Facilitator strategies for Precontemplation
        - Validate participant's choice not to change.
        - Facilitators should resist the urge to convince the participant that he or she should make a change.
        - Reflect that the decision is theirs and the group is not here to persuade them.
        - Encourage self-exploration.
    b. Guiding participant into the next stage:
        - *What would have to happen for you to think that you may need to make a change?*
        - *Have you previously tried to make a change in the past?*

6. Contemplation: During this stage the individual's awareness of problematic behavior surfaces. They are still engaging in the problematic behavior but are starting to think about changing it. They may weigh the positives and negatives about making a change. They may feel stuck or completely ambivalent.
    a. Facilitator strategies for Contemplation
        - Validate participant's stuckness or ambivalence about changing.
        - Reflect that the decision is their own decision.
        - Encourage participant to think about pros and cons of changing their behavior or maintaining the status quo.
    b. Guiding participant into the next stage:
        - Use decisional balance chart
        - *What are the reasons for not changing?*
        - *What are the barriers preventing you from change?*
        - *What would help you in this moment?*

7. Preparation: The individual makes specific plans for changing. They may still be engaging in problematic behavior but have the intent to change in the near future. During this stage, they set up goals and may involve family or friends.

a. Facilitator strategies for Preparation
    - Encourage small steps.
    - Reflect hope and skills for behavior change.
    - Prioritize opportunities for change.
b. Guiding participant to the next stage:
    - Use Confidence Rulers.
    - Develop Discrepancies.
    - Praise them for having the desire to make a change.
    - Focus on behavioral changes.

8. Action: The individual begins to initiate their plans developed during the Preparation stage.
    a. Facilitator strategies for Preparation
        - Reemphasize importance of small steps.
        - Discuss any potential obstacles.
    b. Guiding participant to the next stage:
        - Pinpoint resources and social support.
        - Contingency management.
        - Discuss what the person is **gaining** instead of losing.

9. Maintenance: The behavioral change has been made. The challenge becomes sustaining the behavior over time.
    a. Facilitator strategies for Maintenance
        - Summarize internal rewards.
        - Reflect coping strategies.
        - Discuss new skills and behaviors for maintaining changes.

10. Relapse:
    a. Facilitator strategies for Relapse
        - Normalize relapse as a part of recovery that can happen at any stage.
        - Explore different ways to prevent additional relapses from occurring.
        - After relapse a person may be in a previous stage (i.e. precontemplation or contemplation). It's important to meet the individual where they are and use techniques that will explore their ambivalence and elicit behavioral change, even if you feel you have already moved past this with a specific individual.

11. Summarize the group's experience with the topic of Stages of Change.
    a. Highlight that it is normal for group members to be at different stages and for members to move around between stages.

12. Continue to elicit responses and facilitate discussion around topic until it is time to end the group.

E. Post-Session

The co-facilitators should leave time to discuss the preceding group session and plans for Session 2.

- What did or did not go as expected?
- What are each member's goals and/or values?
- How is each member engaging? Any signs of problematic styles? [Appendix C and D]
- What roles are each of you taking on as co-facilitators?
- What phase is the group in? (should be the "Engaging" Phase for the first session)
- What techniques can you use to move the group into the Exploring Perspectives Phase during the next session?

VI. Session 2

A. Check-in

- Using a client-centered approach, ask the group what *they* would like to accomplish or discuss during today's session.
    - *What would you like to accomplish this afternoon?*
    - *What topics would you like to dive into today?*

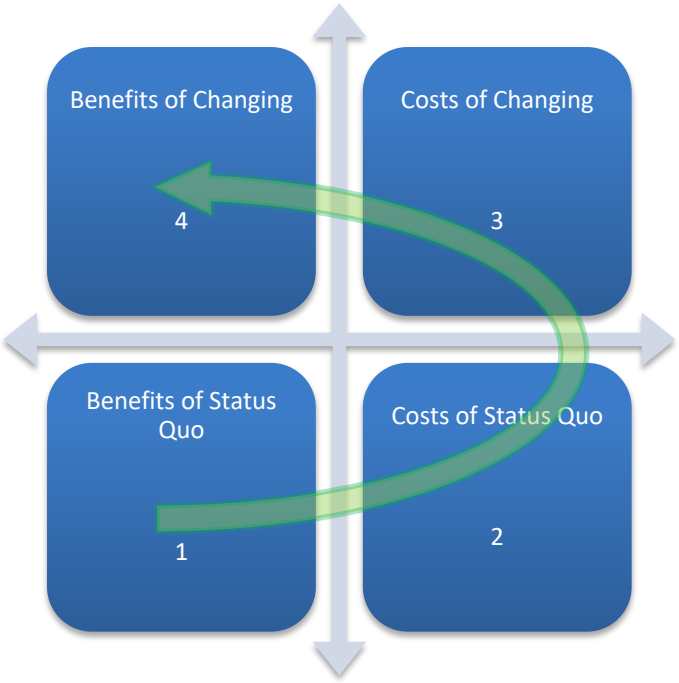
B. Elicit

- Elicit reactions to the previous session and explore any issues that may come up.
- Ensure that everyone has a basic understanding of the Stages of Change.
- Elicit the group's understanding of ambivalence as a concept.

C. Psychoeducation – Ambivalence

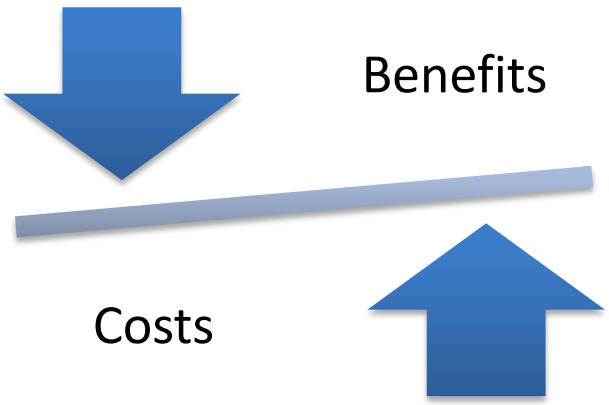
1. Explicitly introduce the concept of ambivalence
    a. Define and normalize.
    b. Ask permission to engage in an exercise that helps identify and work through ambivalence.
    c. Openly state that change is challenging and that it's normal to have mixed feelings about change.
    d. Facilitators should explain that they are not there to force change, but rather to discuss members' feelings and what they believe is causing them to be stuck.

2. Decisional Balance Chart
    a. Exhaust each box (starting with 1 and moving through 4), asking "what else?" even when it seems like they have nothing more to say. Keep participants on topic (for example, when starting with benefits of maintaining things as they are, make sure they don't start to list costs of status quo or benefits of changing).



b. Rounds (optional): Ask each member to identify one thing on the chart that resonates the most with their situation. If they say something in the pro-change side—ask how they can use that to support making a change. If on the status quo side—ask how they can overcome that barrier or compensate for losing it by replacing it with something else.

3. Weigh and balance pros and cons of stimulant use.
   a. Summarize the benefits of maintaining the status quo (box 1).
   b. Summarize the consequences of maintaining the status quo (box 2).
   c. *How do these pros and cons relate to each other?*



4. Weigh and balance the pros and cons of changing.
    a. Summarize the costs of changing (box 3).
    b. Summarize the benefits of changing (box 4).
    c. How do these costs and benefits relate to each other?

5. Identify and address ***ambivalence***.
    a. Use reflective listening.
    b. Explore members' values and elicit how they may use these to make positive change.
    c. Elicit self-motivational statements.
    d. Reflect and summarize hopes and plans for improvement.
    e. Reflect and summarize common themes.

D. Wrap-up

- *We only have about 10 minutes left. What has been your experience with this topic today?*
- *Are there any questions or anything we have not addressed that you want to discuss?*
- *Any goals for the next group?*

E. Post-Session

The co-facilitators should leave time to discuss the preceding group session and plans for Session 3.

- What did or did not go as expected?
- Discuss the non-verbal process.
- What are each member's goals and/or values?
- How is each member engaging? Any signs of problematic styles? [Appendix C] If so, what techniques can you use to correct this? [Appendix D]
- What roles have you taken on as co-facilitators?
- What phase is the group in? (should aim for "Exploring Perspectives/Focusing" Phase)
- What themes of ambivalence generalize to the whole group?
- What techniques can you use to move the group into exploring attachment during the next session? What has already come up in the group that may be a good linking reflection for attachment?

VII. Sessions 3

A. Check-in

- Using a client-centered approach ask the group what *they* would like to accomplish or discuss during today's session.
    - *What would you like to accomplish this afternoon?*
    - *What topics would you like to dive into today?*

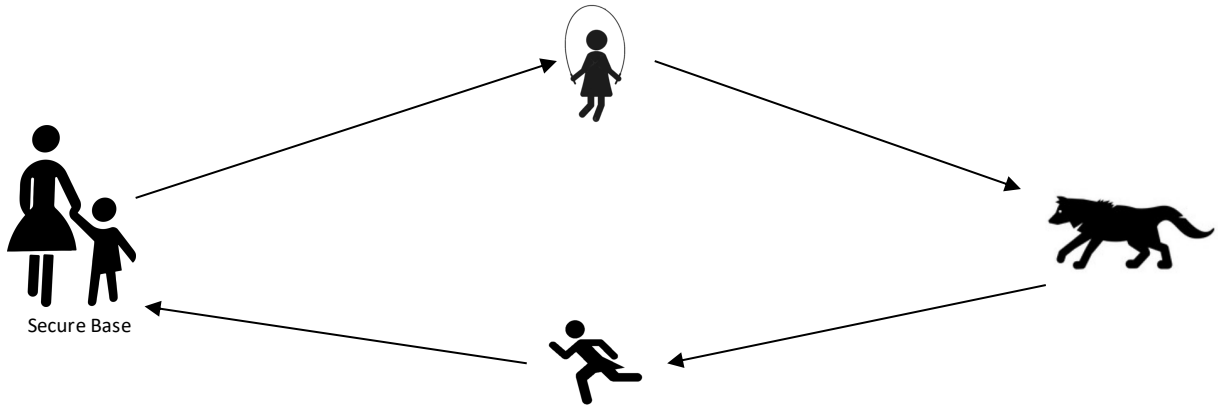
B. Elicit

- Elicit reactions to the previous session and explore any issues that may come up.
- May finish the Decisional Balance Chart exercise if you did not have time to complete it during Session 2.
- Ensure that everyone has a basic understanding of ambivalence and its role in the Stages of Change.
- Elicit the group's understanding of attachment.

C. Psychoeducation – Attachment and Trauma

1. Introduction to Attachment Theory

- Acknowledge that this topic can be triggering. Invite curiosity and group discussion throughout and monitor for signs of individual disengagement from group process. Conversation may need to be slowed or broadened in this instance.



- Draw a simplified attachment theory "cycle" on white board to demonstrate a secure attachment pattern: secure base (from which to explore) → exploration/mastery (*challenge*) → stress/fear/pain (*threat*) → attachment seeking → secure base (reduction in stress).

- **Secure Attachment**:
- *Development*: Requires an attachment figure who is available and responsive when the child is distressed, while also giving them freedom to explore.
- *Adulthood*: Individuals with secure attachment tend to have high self-esteem, good social support, thrive in intimate relationships, and are able to balance intimacy and dependence. Secure attachment is also protective against developing substance use disorders.

2. Insecure Attachment

- *People have developed different attachment "styles" based on genetics and various stressors, such as abuse or neglect by a caretaker, that may have occurred while their attachment system was developing (from around ages 6mos to 2yrs). Interestingly, once our attachment system develops with our primary caregivers, we tend to* repeat *these relationships over and over into our adult relationships. These are variants of normal* [secure, avoidant, and anxious attachment are roughly 50%, 30%, and 20% of the population, respectively]*, everyone has an attachment style. We hope that this can be a safe space to openly explore your patterns, and to accept and respect, even try to understand, each others' differences.*
- Briefly demonstrate the insecure attachment styles using the secure attachment cycle as a foundation. You may represent attachment insecurity as a survival tactic that helped the child function in reaction to abuse and/or neglect by their caretaker. These survival tactics may no longer be as functional in adult relationships and may, in fact, be keeping an individual from having meaningful relationships.
  - **Avoidant** (or Anxious/Fearful-Avoidant) **Attachment**
    - *Development*: Parents tend to be emotionally neglectful. When the child becomes distressed, the caregiver may ignore, or even ridicule, the child. Thus, the child has no secure base to help them deal with stress, and exploration quickly becomes dangerous and feared—leaving the child stuck. The child learns to be overly self-sufficient, yet they never learn healthy ways of coping with stressors and tend to be fearful of exploration and novelty.
    - *Adulthood*: Avoidantly attached individuals tend to socially isolate and avoid intimacy, which they find highly aversive. They tend to neglect important relationships themselves, modeling the behavior of their caregivers. They have difficulty tolerating novel or uncertain situations.
    - *Coping*: They learn to suppress painful thoughts and negative emotions (too overwhelming), deny fears and vulnerabilities (which suggest threat to one's only source of protection, themselves), and they tend to notice negative self-traits in others (projection) and reject those individuals as a way to reject those traits in themselves. They are at risk for using substances to avoid social interactions and negative emotions and to instill a sense of confidence.
  - **Anxious** (or Anxious-Resistant/Ambivalent) **Attachment**
    - *Development*: Parents tend to be intrusive or inconsistently available. Prevent independent exploration, and often punish the child for such behavior. Overly nurturing and sensitive when

the infant is ill, rewarding helplessness and weakness; although can be insensitive and rejecting when the child is angry or upset.

- *Adulthood*: Anxiously attached individuals seek constant care and support from their partners through clinging and/or controlling. They can be overly dependent on relationship partners as a source of protection. They expect abandonment and rejection from close others (also known as attachment anxiety). Inhibitions in independent exploratory behavior.
- *Coping*: They are hypervigilant to threat (especially interpersonal threat or abandonment), can detect threat in neutral social interactions or bodily sensations, and they often take on a "sick role" as a way of eliciting care from others. They are at risk of using substances to deal with attachment anxiety or the pain of rejection or loneliness.

3. Disorganized Attachment

- While secure, avoidant, and anxious attachment are "organized" styles, disorganized attachment is another form of attachment insecurity in which there is no typical strategy for managing stress and intimate relationships.
- *Development*: Caregiver is often child's only source of safety from outside danger, yet also a main source of fear. The caregiver's behavior is unpredictable and abusive, alternating between intrusion and withdrawal. No strategy (avoidant or anxious) allows the child to feel consistently safe without fear. Parents are typically fearful themselves and have unresolved trauma, such as from a history of childhood sexual abuse. Disorganized attachment can also occur if a child loses or frequently changes their primary caregiver during a critical developmental period.
- *Adulthood*: Individuals with a disorganized attachment style cannot form a coherent narrative or make sense of their childhood trauma and often have difficulty distinguishing reality from fantasy. It's difficult for them to trust others, yet they long for intimacy. They tend to struggle with interpersonal relationships.
- *Coping*: They often have major trouble regulating emotions, have high rates of substance use disorders and other psychiatric illnesses, and frequently become both victims and perpetrators of domestic violence.

4. Attachment, Addiction, & Oxytocin:

- Substances can replace social reward from close relationships in the brain and provide:
    - A sense of intimacy
    - Consistency
    - Stress relief, acutely (although withdrawal effects and chronic use can heighten feelings of stress)
    - Eventually substances can take control over social and other aspects of a person's life and mimic patterns seen in insecure or disorganized attachment

- Oxytocin is a naturally-occurring social molecule in the brain and:

  - Natural levels have been shown to diminish with chronic drug use
  - In animal research, oxytocin reduces addiction behavior
  - Theoretically, it may help shift relationship focus from drugs to positive social relationships
  - It may enhance the experience of social connectedness with supportive individuals
  - It may reduce feelings of stress and facilitate the reduction of stress from social support
- The biggest *resilience* factor, which helps transcend intergenerational transmission of insecure attachment styles, is *self-reflection/mentalization*.

D. Wrap-up

- *We only have about 10 minutes left. What has been your experience with this topic today?*
- *Are there any questions or anything we have not addressed that you want to discuss?*
- *Any goals for the next group?*

E. Post-Session

The co-facilitators should leave time to discuss the preceding group session and plans for Session 3.

- What did or did not go as expected?
- Discuss the non-verbal process.
- What did you learn about individual members during the attachment discussion that may be pertinent to group process?
- What common themes of attachment generalize to the whole group?
- How is each member engaging? Any signs of problematic styles? [Appendix C] If so, what techniques can you use to correct this? [Appendix D]
- What roles are you taking on as co-facilitators?
- What phase is the group in? (Should aim for "Exploring Perspectives/Focusing" Phase or possibly beginning of "Broadening Perspectives/Evoking" Phase)
- What techniques can you use to move the group into exploring reframing stress during the next session?

VIII. Session 4

A. Check-in

- Using a client-centered approach ask the group what *they* would like to accomplish or discuss during today's session.
    - *What would you like to accomplish this afternoon?*
    - *What topics would you like to dive into today?*

B. Elicit

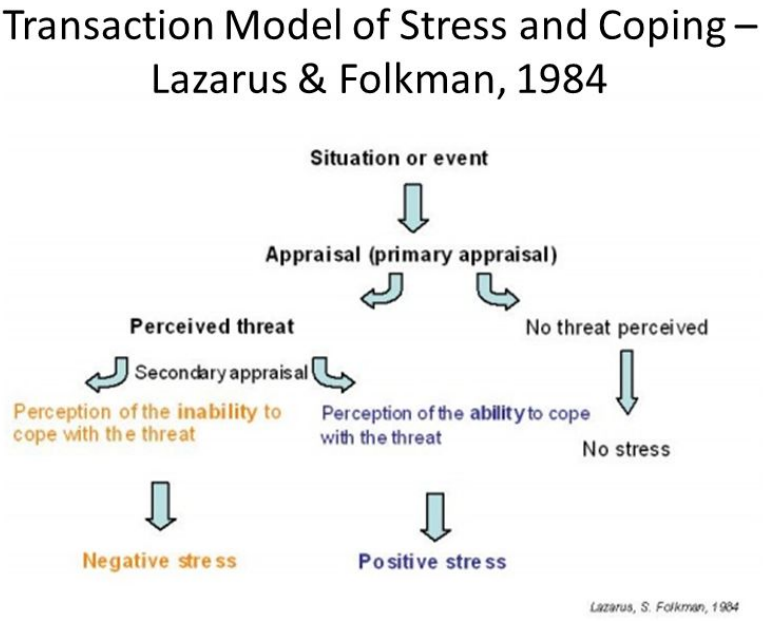
- Elicit reactions to the previous session and explore any issues that may come up.
- Elicit the group's understanding of stress.

C. Psychoeducation – Reframing Stress, Threat vs. Challenge

1. Stress and Stressors
    a. Stressful experiences are comprised of an interaction between a stimulus and a response.
    b. *Stressors* (stimuli) are events that cause stress.
    c. *Stress* (response) can be defined as "a particular relationship between the person and the environment [which includes the stressor] that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (Lazarus & Folkman, 1984, p. 19).
        i. A person's *perception* of the situation is key. Stress is an individual's subjective reaction to a stressor. What one person perceives as stressful may not be perceived as stressful to another person.
2. Appraisals
    a. **Primary** appraisals occur when an individual decides if a relevant situation or event is threatening to them, and should thus become a stressor.
    b. **Secondary** appraisals occur when individuals decide whether or not they can cope with the stressor. The stressor then becomes threat or challenge:
        i. "Negative stress", or *threat*: when individuals don't believe they can manage the stressor. Threat draws attention to our flaws, weaknesses, vulnerabilities, and inadequacies.
        ii. "Positive stress", or *challenge*: when individuals believe they can manage the stressor and achieve a positive outcome in which stress is reduced. Challenge draws attention to our capabilities, strengths, and potential.
    c. **Reappraisals** can happen when new information is conveyed.

d. **Stereotype Threat** occurs when a member of a marginalized group is reminded (even subconsciously) that they are a member of a group with weaknesses in a certain domain (e.g., an "addict"). Stereotype threat activates physiological stress responses (fight-or-flight), performance monitoring (self-criticism), and the mental suppression of negative thoughts and emotions (dissociation, avoidance). [Alter, *et. al.*, 2010]

3. Facilitator draws diagram on white board:



4. Use the group to come up with obvious examples of threatening versus challenging stressors.
5. Coping
    a. *Coping* does not occur automatically but rather is a learned response.
    b. Everyone experiences stressors, and everyone has different coping strategies for stress.
    c. **Problem focused coping:** Used more in "challenge" situations when individuals feel they have control of the situation. This involves noticing the stressor and then gathering more information, searching for and discovering alternative strategies, and implementing strategies to decrease stress. Focuses on changing the problem or stressor.
    d. **Emotion focused coping:** Used more in "threat" situations when individuals believe they do not have control of the stressful situation. They may use avoidance, substances, or forms of self-harm to cope and maintain a sense of control.
    a. An alternative way of dealing with stressors when we may feel helpless or have little control involves meditation, or mindfulness. *Mindfulness* is a mental state achieved by

focusing one's awareness on the present moment, while calmly acknowledging and accepting one's feelings, thoughts, and bodily sensations without judgment, even if they are negative and/or threatening. Mindfulness may allow us to i) accept, or be at peace with, our helplessness over a specific stressor while remembering that we maintain control over other stressors and aspects of our lives (i.e., to not generalize a sense of helplessness) or ii) *reappraise* and *reframe* the threat into a challenge, by viewing the stressor from a different perspective (e.g., seeing participating in group therapy as a "learning experience" that will improve your life in the future, rather than just a venue that will highlight shameful topics and cause discomfort that you'd like to avoid). This, obviously, takes a lot of practice. The most fruitful practice of mindfulness requires a safe space and trust (remember attachment theory); otherwise, in survival mode it's hard to face thoughts and emotions that may be overwhelming. Remind the group members that group participation in and of itself could have been perceived as a threat, but the ones who remain in Session 4 are likely to have framed group participation as a challenge, a learning experience, an opportunity for growth (despite the possibility of growing pains).

6. **Mindfulness Exercise**: One of the co-facilitators, depending on prior experience, may lead the group in a brief mindful exercise (e.g., 5-minute body scan in **Appendix E**) and, afterward, elicit group members' experiences of the exercise.

D. Wrap-up

- *We only have about 10 minutes left. What has been your experience with this topic today?*
- *Are there any questions or anything we have not addressed that you want to discuss?*
- *Any goals for the next group?*

E. Post-Session

The co-facilitators should leave time to discuss the preceding group session and plans for Session 5.

- What did or did not go as expected?
- Discuss the non-verbal process.
- How may your co-facilitator roles shift now that there will be no more psychoeducation sessions?
- What phase is the group in?
- How can you help them move toward/stay in the "Moving Into Action/Planning" Phase?

IX. Session 5

A. Check-in

- Using a client-centered approach ask the group what *they* would like to accomplish or discuss during today's session.
    - *What would you like to accomplish this afternoon?*
    - *What topics would you like to dive into today?*

B. Elicit

- Elicit reactions to the previous session and explore any issues that may come up.
- Ensure everyone has a basic understanding of mindfulness and reframing threat.

C. Discussion

a. Focus on any positive change participants may have made (e.g., situations where members were in high risk situations or were tempted over the past month but did not engage), even if successes are small.
b. What did you change? What did you do? What were the barriers?
c. If no one has offered any successes, continue to focus on change talk.
d. Facilitators should either broaden perspectives or help participants move into action.
e. If changes have been made, discuss how these changes can be maintained or explore additional areas of change that may be accomplished in the future.
f. Explicitly discuss upcoming termination if it hasn't already come up organically.

D. Wrap-up

- *We only have about 10 minutes left. What has been your experience with this topic today?*
- *Are there any questions or anything we have not addressed that you want to discuss?*
- *Any goals for the next group?*

E. Post-Session

The co-facilitators should leave time to discuss the preceding group session and plans for Session 6.

- How did the group do in a more unstructured session?
- Do you foresee any issues with termination?
- What phase is the group in? (should be moving into "Moving Into Action/Planning")
- Any barriers to the progression of the group?

X. Sessions 6

A. Check-in

- Using a client-centered approach ask the group what *they* would like to accomplish or discuss during today's session.
    - *What would you like to accomplish this afternoon?*
    - *What topics would you like to dive into today?*

B. Elicit

- Elicit reactions to the previous session and explore any issues that may come up.
- Review the most important factors that motivate clients to change.
- Thoughts about it being our last group.

C. Discussion

- Focus on actions.
- Help monitor progress.
- Process termination. Remind participants about the attachment psychoeducation session as a way to discuss how termination may be affecting them.
- Monitor for subgroups around different rates and amounts of change among members, normalize different paces and paths, bring members together by acknowledging that they have all learned from each other and will continue to benefit from the group even after it's over.

D. Wrap-up

- We only have about 10 minutes left. Is there anything we have not addressed that you want to discuss?

E. Post-Session

The co-facilitators should leave time to discuss the preceding group session as well as:

- Group processes as a whole.
- Have the goals of the group been met?
- What could have been done differently?
- Are you planning to co-facilitate another group?

XI. Appendix

A. Stimulant Use Disorder

Diagnostic and Statistical Manual of mental Disorders (DSM-5)

Diagnostic Criteria

A. A pattern of amphetamine-type substance, cocaine, or other stimulant use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. The stimulant is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control stimulant use.
3. A great deal of time is spent in activities necessary to obtain the stimulant, use the stimulant, or recover from its effects.
4. Craving, or a strong desire or urge to use the stimulant.
5. Recurrent stimulant use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued stimulant use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the stimulant.
7. Important social, occupational, or recreational activities are given up or reduced because of stimulant use.
8. Recurrent stimulant use in situations in which it is physically hazardous.
9. Stimulant use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the stimulant.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of the stimulant to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of the stimulant.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for the stimulant.
    b. The stimulant (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

- **Note:** This criterion is not considered to be met for those taking stimulant medications solely under appropriate medical supervision, such as medications for attention-deficit/hyperactivity disorder or narcolepsy.

- **Mild**: Presence of 2-3 symptoms
- **Moderate**: Presence of 4-5 symptoms
- **Severe**: Presence of 6 or more symptoms

B. Evidence for Motivational Interviewing with Stimulant Users

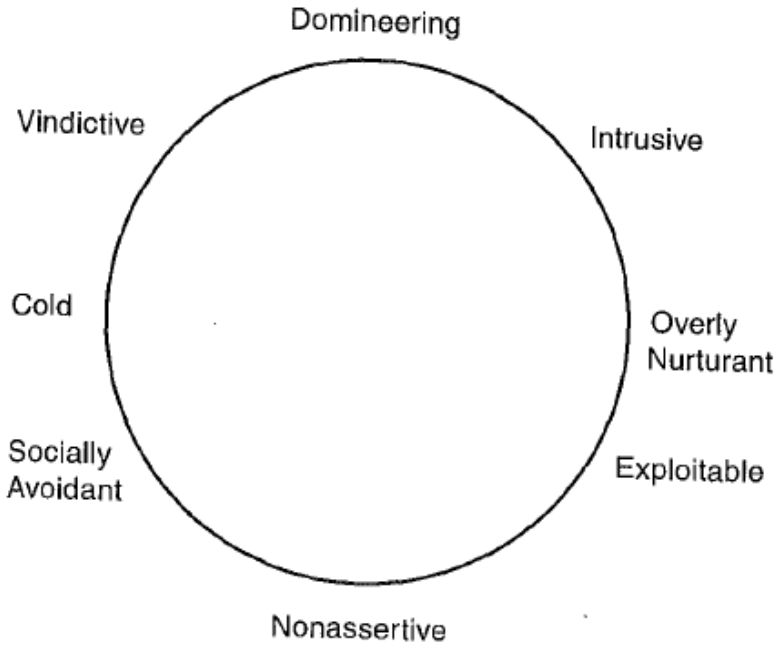
1. Stein, Herman, Anderson (2009)
    a. Sample: 198 adults who used cocaine at least weekly for the last 6 months
    b. Intervention: Four individuals interventions for motivational intervention or an assessment control group scheduled between baseline and 6 months
    c. Results: participants in randomized to MI intervention reported 13.1 days reduction in frequency of cocaine use. Controls reported a mean reduction of 8.2 days. More reported a cocaine reduction (71.3% vs. 59.1%), a 50% or greater relative reduction in frequency of cocaine use (61.2% vs. 43.9%), and cocaine abstinence (30.6% vs. 21.1%).
2. Galloway, Polcin, Kielstein, Brown, & Mendelson (2007)
    a. Sample: 30 treatment seeking Methamphetamine-dependent adults
    b. Intervention: 9 weeks of Motivational Enhancement Therapy
    c. Results: Participants used methamphetamine on a smaller proportion during treatment (31% vs. 47%); p = 0.011). Participants had a smaller proportion of MA-positive urine samples when compared to the screening period (44% vs. 64%; p = 0.015).
3. Huang, Tang, Lin, and Yen (2011)
    a. Sample: 94 adolescents who used MDMA and MAMP were recruited from a juvenile abstinence center
    b. Intervention: 46 received 3 MET session and 48 received educational materials only (no MET)
    c. Results: The MET group had higher posttest scores of readiness to change.
4. Zule, Poulton, Coomes, Et.al. (2012)
    a. Sample: 39 MSM who used MAMP were recruited in North Carolina.
    b. Intervention: one 55 minute MET session. This was a pretest-posttest with no comparison group.
    c. Results: Men reported reductions in MAMP use. At baseline the average was 9.4 days and use reduced to 3.3 days at follow up ($p<0.05$). Unprotected anal intercourse at baseline was an average of 4.8 sex partners and decreased to 2.9 at follow up ($p<0.05$).
    d. Self-reported unprotected anal intercourse at last sex with a nonprimary partner decreased significantly (from 81% at baseline to 25% at follow-up; $p = 0.001$).
5. Mausbach, Semple, Strathdee, Zians, Patterson (2007)
    a. Sample: 451 participants from San Diego, California that were HIV-negative, heterosexual methamphetamine users.
    b. Intervention: Three treatment conditions: 1: a safer sex behavioral intervention (Fast-Lane [FL]), 2: the FL intervention with boosters (FL+B), or 3: a time-equivalent diet-and exercise attention-control (D&E) condition.
    c. Results: Compared to the D&E control group:
        i. The FL+B condition (p=.019) & FL condition (p=.020) significantly increased their engagement in protected sex acts over the active intervention phase.
        ii. FL condition demonstrated a significant decrease in unprotected sex (p =.005) and an increase in percent protected sex (p=.001) during the active intervention.

iii. FL participants had significant improvements in self-efficacy for negotiating safer sex (p= .011), and change in self-efficacy mediated the efficacy of the FL condition for increasing safer sex behaviors (p=.033).

6. Martino, Carroll, O'Malley, Rounsaville (2000)
    a. Sample: 23 adults with DSM-IV substance related disorders with comorbid mood/psychotic disorders
    b. Intervention: 45-60 minute motivational interview or standard preadmission interview.
    c. Results: Standard interview subjects reported more psychiatric symptoms. MI participants had overall better treatment outcomes than the standard interview participants

C. Interpersonal Problems Circumplex

- Alden, Wiggins, & Pincus, 1990; Hopwood et al, 2011; Locke, 2000
- Typically these problematic styles are due to rigidity and extremity. People with interpersonal problems typically have difficulty reading social cues, adjusting their style to the different needs of different individuals or situations, and moderating the intensity of their interactions (Kiesler, 1996).



D. Interpersonal Problems, Corresponding Strengths, and MI Group Strategies

Style	*Description*	*Strengths*	*Strategy*
Domineering	Has problems with controlling, dominating, and trying not change others	Ambitious, determined, decisive, persuasive, assertive	1. Elicit/reflect member's intention to be helpful. 2. Guide member to focus on his or her own experiences, interests, and concerns. 3. Ask member to invite others to share reactions in order to explore discrepancy between the member's intent (to help) and its actual impact upon others (often, to make others resistant to suggestions the member offers). 4. Affirm member's determination.
Vindictive	Is distrustful and suspicious of others and is unable to care about others' needs when they conflict with one's own	Clever, skeptical, watchful, witty	1. Emphasize personal choice and control. 2. Elicit that member's intent is to protect self from perceived attacks or criticisms, rather than to attack others. 3. Affirm member for "keeping it real" (when appropriate).
Cold	Is unable to express affection and feel love for others; is unable to be generous to, get along with, and forgive others	Thick-skinned, straightforward, focused, tough minded	1. Emphasize pragmatic solution finding. 2. Invite sharing of "hard truths" learned along the way. 3. Affirm member's ability to "go it alone" when needed.
Socially Avoidant	Is anxious an embarrassed around others; has difficulty initiating social interactions, expressing feelings, and socializing with others.	Private, soft spoken, solitary, sparing	1. Invite participation during discussion of strengths. 2. In rounds, arrange for person to speak second or third to prevent too much anxiety buildup (but also so the person does not have to go first). 3. Give permission to observe silently until comfortable, then invite participation later in session. 4. Affirm individual virtues and strengths.
Nonassertive	Has difficulty-making needs known to others; experiences discomfort in authoritative roles; is unable to be firm with and assertive towards others.	Content, a contributor, avoids getting in others' way, able to avoid arguments	1. Encourage person to share understanding and reactions to others' dilemmas. 2. Ask person to observe and comment on group dynamics or processes. 3. Emphasize personal choice/control. 4. Affirm member for being a "team player" (when appropriate).
Exploitable	Has difficulty feeling and expressing anger for fear of offending	Modest, humble, forgiving, gentle	1. Evoke perception during periods of low stress.

	others; is gullible and readily taken advantage of by others.		2. Invite to share perspective when another member describes feeling taken advantage of or being unable to express anger. 3. Emphasize personal choice/control. 4. Affirm gentle, forgiving nature.
Overly Nurturant	Tries too hard to please and is too generous, trusting, caring, and permissive in dealing with others.	Considerate, warm, welcoming, likeable, helpful, soothing, understanding	1. Gently guide back to focus on own needs, desires. 2. Ask the person to help other members better intact with significant others. 3. Emphasize personal choice/control. 4. Affirm attempts to understand and help others.
Intrusive	I inappropriately self-disclosing, attention seeking; has difficulty spending time alone.	Sociable, approachable, energetic, expressive	1. Reflect themes or emotions to guide away from storytelling. 2. If in rounds, put this person at beginning, emphasizing need to hear everyone (or at end). 3. Ask the person to observe others quietly during activity, then summarize. 4. Affirm energy, exuberance.

E. 5-min Body Scan Script

Begin by making yourself comfortable. Sit in a chair and allow your back to be straight, but not stiff, with your feet on the ground. You could also do this practice standing or if you prefer, you can lie down and have your head supported. Your hands could be resting gently in your lap or at your side. Allow your eyes to close, or to remain open with a soft gaze.

Take several long, slow, deep breaths. Breathing in fully and exhaling slowly. Breathe in through your nose and out through your nose or mouth. Feel your stomach expand on an inhale and relax and let go as you exhale.

Begin to let go of noises around you. Begin to shift your attention from outside to inside yourself. If you are distracted by sounds in the room, simply notice this and bring your focus back to your breathing.

Now slowly bring your attention down to your feet. Begin observing sensations in your feet. You might want to wiggle your toes a little, feeling your toes against your socks or shoes. Just notice, without judgment. You might imagine sending your breath down to your feet, as if the breath is traveling through the nose to the lungs and through the abdomen all the way down to your feet. And then back up again out through your nose and lungs. Perhaps you don't feel anything at all. That is fine, too. Just allow yourself to feel the sensation of not feeling anything.

When you are ready, allow your feet to dissolve in your mind's eye and move your attention up to your ankles, calves, knees and thighs. Observe the sensations you are experiencing throughout your legs. Breathe into and breathe out of the legs. If your mind begins to wander during this exercise, gently notice this without judgment and bring your mind back to noticing the sensations in your legs. If you notice any discomfort, pain or stiffness, don't judge this. Just simply notice it. Observe how all sensations rise and fall, shift and change moment to moment. Notice how no sensation is permanent. Just observe and allow the sensations to be in the moment, just as they are. Breathe into and out from the legs.

Then on the next out breath, allow the legs to dissolve in your mind. And move to the sensations in your lower back and pelvis. Softening and releasing as you breathe in and out. Slowly move your attention up to your mid back and upper back. Become curious about the sensations here. You may become aware of sensations in the muscle, temperature or points of contact with furniture or the bed. With each outbreath, you may let go of tension you are carrying. And then very gently shift your focus to your stomach and all the internal organs here. Perhaps you notice the feeling of clothing, the process of digestion or the belly rising or falling with each breath. If you notice opinions arising about these areas, gently let these go and return to noticing sensations. As you continue to breathe, bring your awareness to the chest and heart region and just notice your heartbeat. Observe how the chest rises during the inhale and how the chest falls during the exhale. Let go of any judgments that may arise. On the next outbreath, shift the focus to your hands and fingertips. See if you can channel your breathing into and out of this area as if you are breathing into and out from your hands. If your mind wanders, gently bring it back to the sensations in your hands.

And then, on the next outbreath, shift the focus and bring your awareness up into your arms. Observe the sensations or lack of sensations that may be occurring there. You might notice some difference between the left arm and the right arm – no need to judge this. As you exhale, you may experience the arm soften and release tensions. Continue to breathe and shift focus to the neck, shoulder and throat region. This is an area where we often have tension. Be with the sensations here. It could be tightness, rigidity or holding. You may notice the shoulders moving along with the breath. Let go of any thoughts or stories you are telling about this area. As you breathe, you may feel tension rolling off your shoulders.

On the next outbreath, shift your focus and direct your attention to the scalp, head and face. Observe all of the sensations occurring there. Notice the movement of the air as you breathe into or out of the nostrils or mouth. As you exhale, you might notice the softening of any tension you may be holding.

And now, let your attention to expand out to include the entire body as a whole. Bring into your awareness the top of your head down to the bottom of your toes. Feel the gentle rhythm of the breath as it moves through the body.

As you come to the end of this practice, take a full, deep breath, taking in all the energy of this practice. Exhale fully. And when you are ready, open your eyes and return your attention to the present moment. As you become fully alert and awake, consider setting the intention that this practice of building awareness will benefit everyone you come in contact with today.

Script written by Shilagh Mirgain, PhD, for UW Cultivating Well-Being: A Neuroscientific Approach