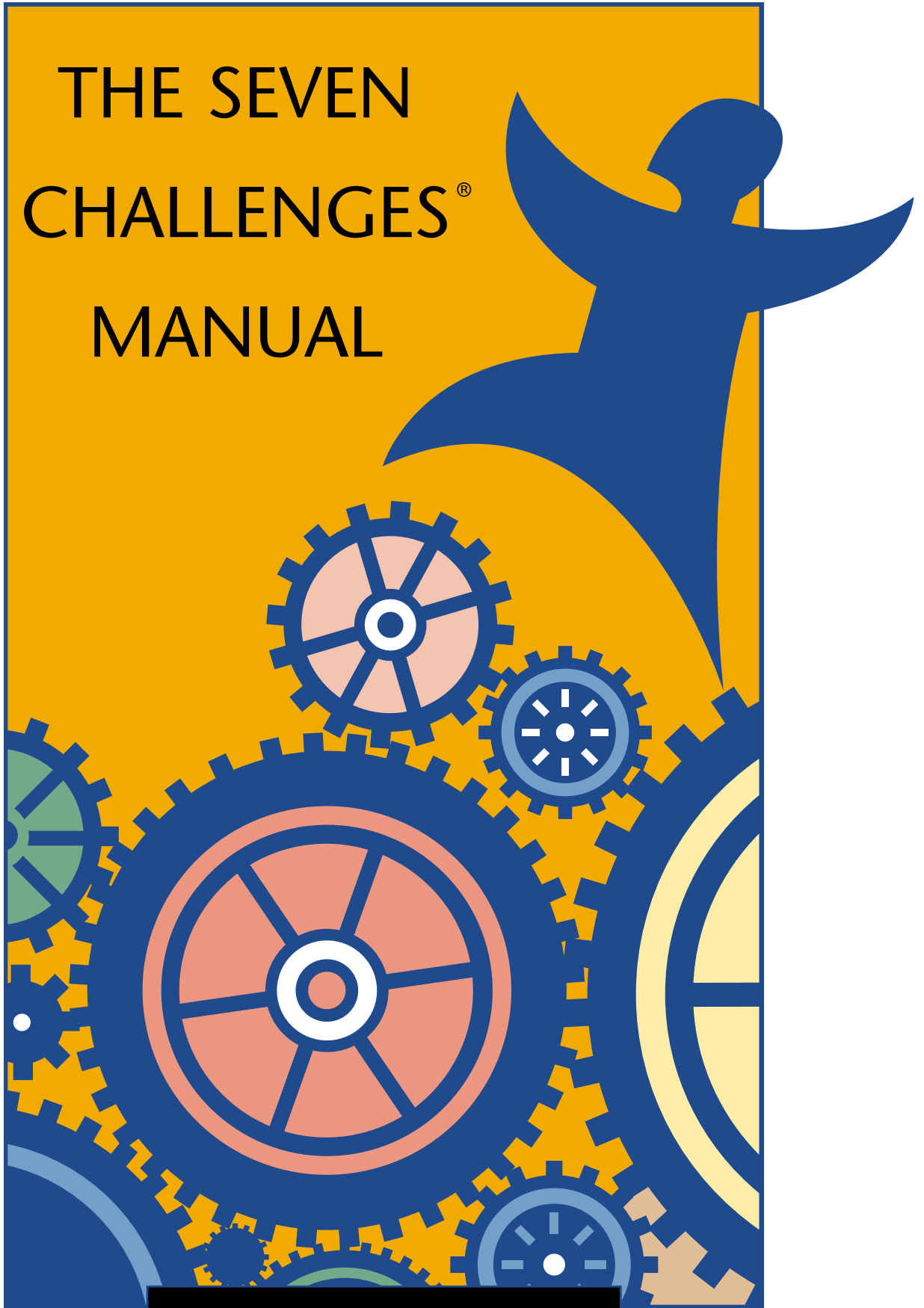
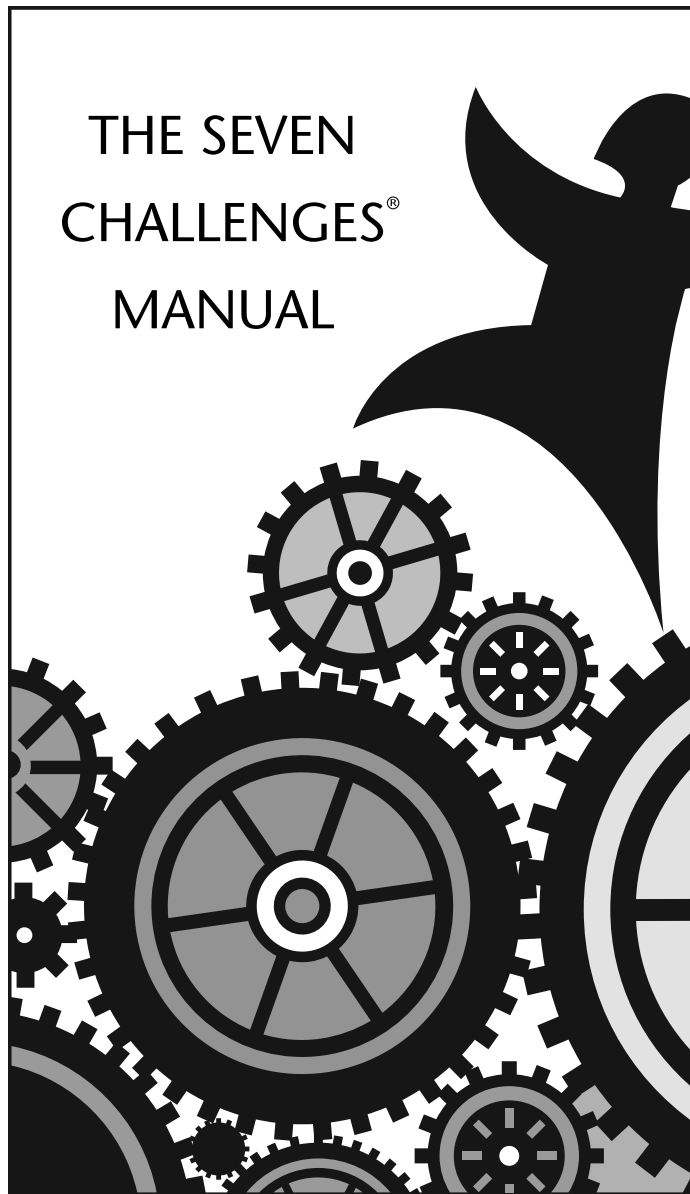


THE SEVEN  
CHALLENGES<sup>®</sup>  
MANUAL



Robert Schwebel, Ph.D.



Robert Schwebel, Ph.D.

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This manual has been written to help practitioners understand The Seven Challenges®; its clinical approaches, published materials, and implementation issues. Agencies and practitioners can purchase and use The Seven Challenges materials in their practice. However, agencies and practitioners cannot implement The Seven Challenges Program or announce that they are providing the program without training and authorization from Dr. Schwebel.

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## **ABOUT THIS MANUAL**

The idea of manualizing treatment is appealing because it helps ensure fidelity of treatment – that is, that counselors are delivering the intended approach to clients. Manuals offer a careful description of how to implement and conduct a certain approach to counseling. They serve as a good training resource. They spell out the techniques to be employed and how to implement them. Manualizing also benefits researchers who can feel confident that they are studying a unitary approach to treatment that has some degree of consistency across practitioners. The ideal outcome of research is validated technology – identifying effective programs that can be replicated. Clients, providers, and payers want to be confident that a treatment approach works.

One problem with manualizing is that the counseling process involves a specialized, interpersonal relationship that cannot be translated into simple mechanics. When counseling is manualized to the point of telling counselors what to say and do at each session, it provides standardization and consistency, but at an enormous cost. Good counseling must be responsive to clients' needs, emotions, and thought processes. Too much is compromised or lost when the whole process is rigidly guided by pre-determined protocol.

This manual has been written to help practitioners implement The Seven Challenges® Program with great confidence in the fidelity of their treatment. It is designed to supplement, but not replace Seven Challenges® Training. The manual spells out in clear detail the philosophy and strategy of the program. It explains the health decision-making process inherent in The Seven Challenges, and clarifies the meaning of each of the challenges. It presents the basic Seven Challenges Counseling Approaches. It explains how to introduce and orient youth to The Seven Challenges Program, and how to use Seven Challenges materials, including *The Seven Challenges* book, and the nine *Seven Challenges Journals*. It explains how to give feedback to help young people in journaling, one of the important elements of the program. Further, it defines “working sessions” in adolescent drug treatment, explaining how to avoid widely-played games — such as “Try to make me quit” or “Try to prove that I’ve been harmed by drugs” and other variations of these games – all of which are wasteful diversions from meaningful work.

This manual offers model statements about how to introduce and discuss various issues. It suggests ideas about content for group sessions. It discusses some of the nuts and bolts of the program such as settings in which it can be used, time requirements, types of groups, size of groups, length of group sessions, composition of groups, issues related to individual and family sessions, and more. It examines important group start-up issues, such as how to “win group consciousness.” It presents material about helping clients who are required to be drug free (perhaps by courts or schools), but may not be ready to successfully become drug free. It also provides help to supervisors in terms of issues that frequently arise in implementing the program. However, this manual does *not* micro-manage what counselors say and do on a daily basis. Rather it

## *About this Manual*

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provides the framework for implementing the Seven Challenges Program, with help and guidelines for use of the materials and for the counseling sessions. But the counseling must be personalized and individualized. Counseling is different from psycho-educational sessions that can be fully prescribed, and from the implementation of a program of rigid, mandated protocols.

With this manual and training in The Seven Challenges, counselors can get a good start on delivering The Seven Challenges Program in an effective way. Not everyone, however, will be doing the exact same thing each day. The program requires individual initiative by counselors, and draws upon their clinical skills. It also requires that counselors incorporate some distinct techniques that can add to their repertoire of skills. These skills are not mastered in one training session or by reading a manual. They are cultivated and refined over years of experience. Complemented by training, this manual will help get people started in delivering effective Seven Challenges drug counseling services to youth.

Agencies and practitioners who are not implementing the Seven Challenges Program can still purchase and use Seven Challenges materials. They should also be able to mine this manual for a wealth of information about state of the art substance abuse treatment for adolescents, including a discussion of important theoretical issues and effective clinical approaches.

Robert Schwebel, Ph.D.  
Tucson, Arizona  
April 2004

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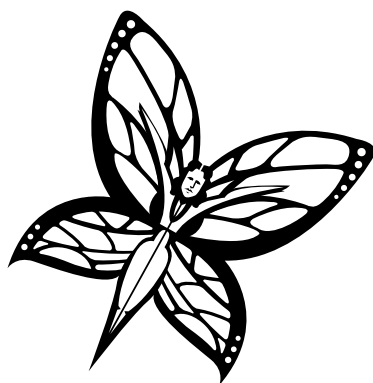
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# INTRODUCTION TO THE SEVEN CHALLENGES





## **PURPOSE OF THE PROGRAM**

The Seven Challenges® Program is designed for adolescent (and young adult) substance abusing and substance dependent individuals to motivate decisions and commitments to change. Once such decisions and commitments are made, the program guides young people toward success in implementing the desired changes.

## **START WHERE YOUTH ARE “AT”**

Although we might wish that young people would enter treatment eager and ready to quit using drugs, most come under duress, often dragged in by parents, schools, the courts, or the juvenile correctional system. We have to begin where the young people are “at” (usually resistant and reluctant to change) not where we wish they might be, or might pretend to be (fully and honestly prepared to quit using drugs).

## **TRUST AND RELATIONSHIP-BUILDING COME FIRST**

The Seven Challenges is a relationship-based program. Counselors start with an understanding that young people generally come to treatment against their will, or at best with little enthusiasm about the experience. Many youth are accustomed to lying to adults. They are also accustomed to being around adults with whom, if they told the truth, they would only get into more trouble. Most youth expect that counselors will try to control them and make them quit using drugs. Some may have had previous negative experiences in treatment. Many may be quite angry or defensive about these experiences. Unless counselors proactively address this negative expectation about counseling, most young people will remain predisposed to resisting adults or “faking it.” With The Seven Challenges, trust and relationship building come first, and remain important issues throughout the program. Our aim is to create a climate in which young people feel safe to talk openly and honestly about themselves and their drug use. Unless trust is built in a counseling relationship, there will be little likelihood of positive outcomes. Good relationships lead to retention in counseling, and retention correlates with success.<sup>1</sup> We also know that many young people in drug treatment come from high-risk environments. Forming relationships with an adult who cares is one of the key predictors of resilience. That is, youth who connect with adults who care about them are much more likely to fare well than those who do not.<sup>2</sup>

## **SUPPORT ADOLESCENT DEVELOPMENT**

Adolescents need developmentally appropriate drug treatment. During the adolescent stage of life, young people are faced with the developmental tasks of defining their own independent identities, learning systematic logical thinking, and preparing for adult roles. It makes little sense to try to dictate and control their behavior. Most youth would simply rebel. Instead, adults should help young people learn to make their own wise decisions. We need to help them develop logical abilities, and then apply these thinking skills to their lives. Because we live in a drug-filled society, when

young people forge independent identities and prepare for the future, they must determine where they stand in relationship to drugs. This is an inescapable challenge. The Seven Challenges Program gives young people an opportunity to do this – a chance to think about the impact of their drug use upon their current lives, and its potential impact upon what lies ahead in adulthood. In that way, we work with development, rather than against it.

### **COGNITIVE/EMOTIONAL DECISION-MAKING MODEL**

As trust builds in the counseling setting, the Seven Challenges Program helps young people look at their lives and consider where their drug use fits with what has happened in the past, what is happening now, and what they would like to see happen in their future. Counselors help youth through the difficult and sometimes lengthy process of thinking through drug and lifestyle decisions for themselves.

Young people consider:

- why they are using drugs
- what they like about drugs
- how they harm themselves and others by using drugs
- how their continued use might affect their future if they do not change.

Humans do not want to be controlled. Research about psychological reactance<sup>3</sup> has confirmed that no one wants to be backed into the corner and forced to behave in certain ways. People need to feel that they have choices. When backed into corners, they get defensive and attempt to assert their liberty. (“I’ll show you: No one tells me what to do.”) The urge toward self-determination is especially acute in adolescents who are developmentally charged with forming independent identities. Young clients need an opportunity to make their own informed choices.

The Seven Challenges incorporates a cognitive/emotional, decision-making process. The program does not attempt to dictate behavior or coerce young people. Rather it helps them learn to think for themselves, consider all relevant information, and then make their own wise decisions. Relevant information includes awareness of the emotional issues that influence human decision-making – the emotions we may seek and those we want to avoid or minimize.<sup>4</sup> With adolescents in particular, it is important to show confidence in their competency and to support their sense of self-efficacy, as in “You can do it.”<sup>5</sup>

### **THE HEALTH DECISION-MAKING MODEL**

In the Seven Challenges Program, young people are given an opportunity to reflect upon their drug using behavior within the framework of a health decision-making model.

Using drugs or not — and the extent of drug use by those who indulge — are health decisions. People are deciding what they choose to put in their bodies. Drug use has

important implications for physical and emotional health.

People make health decisions by weighing the “costs” versus the “benefits” of the behavior under consideration. We do this, for example, when we decide whether or not to wear seat belts: On the one hand, seatbelts are cumbersome and uncomfortable, and rarely needed. On the other hand, they are required by law and can be life-saving in an accident. (In fact, 75% of the population use their seat belts regularly.) Another example of a health decision is about eating “junk food,” which is high in calories, fat, and cholesterol, but may taste good, be readily available, and have great mouth feel. People compare the relative value of the benefits and the costs. Similarly, people make health decisions about drugs. They weigh what they like about drugs (the benefits) against the harm and potential harm (the costs).

Clear, informed thinking is required for good decision-making. This type of thinking is not likely to take place in contentious relationships in which people are arguing with one another. Too often drug treatment of adolescents can degenerate into a battle of wills with counselors trying to convince their young clients to quit, and the clients defending their drug use. That is one reason why relationship building is a crucial priority in The Seven Challenges.

## **HOLISTIC VISION**

Drug use is not a stand-alone, peripheral behavior in an adolescent’s life. People use drugs for a reason – to try to satisfy personal desires and needs. A holistic program not only must address the drug use, but also the reasons for “using.” In The Seven Challenges Program, young people identify the desires and needs they are satisfying, or attempting to satisfy, through their drug use. They may be using alcohol and other drugs to avoid or cope with stress, tension, boredom, anxiety, fear or other feelings. They may use them to moderate their anger or release it, or to “self medicate” against negative emotions. Young people sometimes use drugs to temporarily forget painful life experiences, such as child abuse or other trauma, or to silence self-doubts or self-deprecating thoughts. Sometimes drugs are used to escape from reality instead of facing it — or to quell various uncomfortable feelings. Sometimes drugs are used simply for pleasure or fun.

When self understanding increases – when young people see why they are using drugs – they have an opportunity to think about alternatives to drug use. They can learn healthy, drug-free ways to meet these same needs and satisfy desires. One way to tip the balance toward healthier decisions about using drugs is to provide healthy, drug-free options.

## **AN EMPOWERMENT MODEL: SOLVING CO-OCCURRING PROBLEMS AND TEACHING LIFE SKILLS**

The Seven Challenges Program does not narrowly focus on drug seeking and drug taking behavior. It goes further and provides young people with an opportunity to identify and solve co-occurring, underlying psychological problems that motivate

their drug use. This includes supporting them in their efforts at resolving trauma issues. Co-occurring problems are the norm with drug abuse, and these problems must be addressed in a comprehensive drug treatment program.

The Seven Challenges also places a strong emphasis on teaching social, psychological and emotional life skills, so that individuals can learn new, positive ways to cope with life, meet their needs, and satisfy their desires. In the program, young people learn problem solving skills, communication skills, anger management skills, social/relationship skills, self-control skills, thinking skills, and relaxation and stress reduction skills. Clients are given opportunities to resolve trauma issues and overcome a variety of psychological problems that may plague them.<sup>6</sup>

Solving co-occurring problems and learning life skills empowers young people to meet their needs in healthy ways, without drugs. It puts them in a position from which they could choose, of their own accord, to give up drugs, but still have other ways to attain satisfaction, pleasure, and happiness in life.

### **REDEFINING THE ROLE OF THE DRUG COUNSELOR**

Young people who believe that counselors are striving *to make them* quit using drugs will see counselors as antagonists. They will see counselors as trying to take something away from them – their drugs. Drugs may be the only way some young people can envision satisfying their own needs. *Counselors in The Seven Challenges Program must redefine their role. “We are not here to take something away. We are on your side. We are your problem-solving partners. We’re here to help you think about your options and to give you more options. When you have learned new ways to meet your needs and considered your options, you may choose – of your own accord – to give up drugs. But that will be for you to decide.”*

### **INSPIRING HOPE**

People don’t make changes in their lives if they think their lives will get worse. They make changes when they believe that their lives would improve. That is why it is so important to empower young people to feel that if they choose to give up drugs, they will have better lives. They would be giving up the benefits they derive from drug use. In exchange, however, they would stop the physical, psychological, and social harm caused by drugs, and find other ways to satisfy their personal needs.

By way of illustration:

- A person who is seriously depressed and uses drugs to self medicate is unlikely to choose to quit using unless there is some hope of overcoming the depression. Without this hope, quitting drugs would be seen as stopping the harm from the drugs, but leaving this person feeling miserable.
- A person who has a serious anger problem, uses drugs to moderate the anger, and

is frightened of being explosive when not self-medicating would be quite reluctant to choose to stop using drugs unless: (1) this person acquired skill in problem solving (to prevent angry situations from occurring); or (2) learned other ways to manage the anger; or (3) knew he or she would have an opportunity to learn anger management skills in the near future.

- Victims of physical or sexual abuse who self medicate with drugs would be reluctant to quit using drugs unless they felt they could resolve the trauma and cope with their thoughts and feelings about it.

People such as those described above, who feel pessimistic or hopeless about their future, need to believe that things could get better before they would be willing to stop coping the way they have been coping — by using drugs.

Many young people who abuse drugs have already been discouraged about life and may have a sense of powerlessness and hopelessness. The Seven Challenges promotes and teaches skills to create a better life, but also works to promote optimism and hope. This includes conveying a sense of personal power – that people can make changes and make their lives better. This sense of optimism is reinforced as young people are empowered to learn various life skills in The Seven Challenges Program.

## **THINKING ABOUT CHANGE**

After young people reflect upon their lives, including their use of drugs, The Seven Challenges Program offers them an opportunity to think about making changes:

- what it takes to change
- what they might gain and lose by changing
- which changes they might want to make
- how they would go about making such changes
- what they need to do so they feel that they could successfully make the desired changes

We know that most young people do not enter drug programs wanting to change, ready to change, or even able to change their drug use behavior. They are in the earlier stages of the change process. First they need to recognize the problem, then consider making changes, then make decisions about changing, then prepare to change, and finally, make the desired changes. Important psychological research by Prochaska, Norcross and DiClemente<sup>7</sup> has identified six stages of change in overcoming problem behaviors – and discussed the implications of their findings in terms of matching appropriate interventions to an individual's particular stage. The application of the stages of change research to work with adolescent substance abusing youth is discussed in more detail later in this manual (pages 26-28). The Seven Challenges Program is designed to match the intervention to the clients' stages of change.

### **BEHAVIORAL SUCCESS**

When young people make decisions and set goals for themselves (about their drug use or their lives), they need help and support in initiating and maintaining new behavior. The Seven Challenges Program supports them and guides them toward successful implementation of the changes they pursue.

The Seven Challenges Program provides Lifestyle Action Groups (see Seven Challenges Services, pages 83-84) for young people who are committed to making changes in their lives. These groups are focused on following through on decisions. In the groups, young people get support in making any behavior changes they have chosen to make – such as learning anger management, learning to cope with stress in positive ways, etc. For those who commit to stopping their use of alcohol and other drugs, a specialized part of the Lifestyle Action Group teaches state of the art relapse prevention skills, which is incorporated in work in Challenges Six and Seven.

When youth have decided to become drug free, individuals and agencies that implement The Seven Challenges may want to use community resources such as 12-steps programs, Smart Recovery, or other recovery groups to supplement Seven Challenges work. Appropriate support should be available to all youth who want to overcome problems of drug abuse and drug dependence. Spiritually minded youth who accept the ideas of (1) admitting powerlessness over their drug use and (2) surrendering to a higher power should be encouraged to attend 12 step groups.

Until recently, drug treatment tended to be defined as either pro 12-steps, or against it. The Seven Challenges offers a different perspective. Whereas a 12-step program is designed for people who are motivated to make significant changes in their lives, we know that most youth enter drug treatment in the very early stages of change. Most are far from ready to make informed, internally motivated, and committed decisions to quit using drugs, and are poorly prepared to succeed even if they were to make such decisions. The Seven Challenges starts working with youth in these earlier stages. It is only after considerable effort and significant progress has been made that young clients are ready to swing into the action stage. Although The Seven Challenges is not a 12-step program, it is not opposed to it. When young people are ready to stop using drugs, 12-step programs are one of a number of viable options for additional support. Youth in The Seven Challenges Program who want to take the spiritual approach to maintaining abstinence should have access to 12-step groups. Other youth should be oriented to the 12-steps, whether they accept the principles of it or not, because it is a universally available support group in their communities.

### **CULTURAL AND GENDER ISSUES**

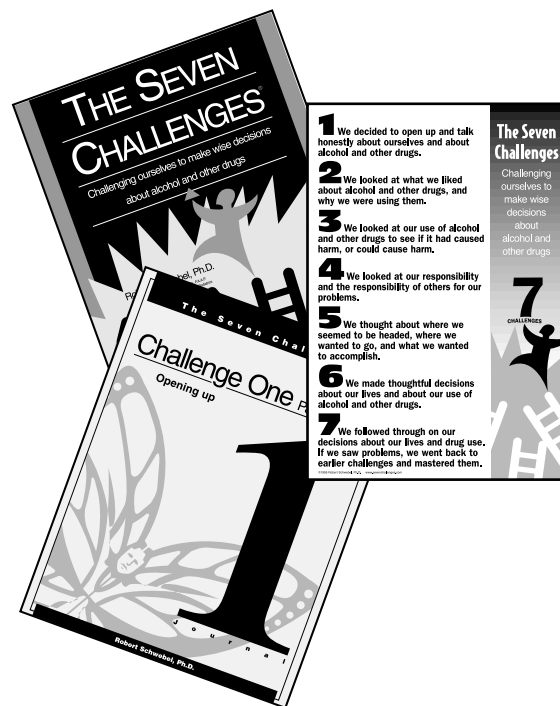
The Seven Challenges Program and materials were developed while working with – and with the input of – a culturally diverse group of youth. An effort has been made to put substance abuse in a social and cultural context. People use drugs, at least in part, in response to their circumstances and environment. The Seven Challenges

Program is designed to help young people understand and explore the context of their drug use. Often, serious environmental risk factors correlate with drug use (for example: child abuse and other trauma, poverty, and families experiencing high levels of stress). Clients need help in understanding this. By teaching life skills and encouraging positive relationships, the program builds resilience within clients to cope with these stressors, and offers an opportunity to strengthen and reinforce protective factors.

The Seven Challenges Program was developed in clinical settings with both boys and girls. As such, it could be considered gender neutral, with both sexes equally represented. However, there are special considerations when using this program with either sex. Gender responsive considerations are discussed later in this manual (pages 137-145).



# PUBLISHED MATERIALS





## **BOOKS, JOURNALS, AND OTHER PRINTED MATERIAL**

The Seven Challenges Program incorporates the use of the 120-page book, *The Seven Challenges*, which is a collection of readings for youth; the nine *Seven Challenges Journals* designed for counselor/youth interaction; The Seven Challenges Poster; and The Seven Challenges Diplomas. Resources for counselors include the books: *The Seven Challenges Activity Book* and this publication, *The Seven Challenges Manual*. A variety of other printed materials have also been developed to assist in implementation of the program, such as a sample treatment note, a list of treatment goals, and information about implementation in different settings.

The Seven Challenges and the nine *Seven Challenges Journals* are available in Spanish. They were translated by a native Spanish speaker, in collaboration with the author of the program to ensure fidelity of meaning.

Explanations about the use of this printed material are included in this manual. Seven Challenges® Training is required to maximize benefits of the published material, to fully implement the program, and for an individual or agency to announce that they are doing The Seven Challenges® Program.



# METHODS





## CORE COMPONENTS

Youth are guided through The Seven Challenges Program by a combination of:

- Readings in *The Seven Challenges*
- “Journaling” in the *Seven Challenges Journals*
- Educational/counseling sessions in one-to-one and/or group settings
- Family or multi/family sessions, when feasible and appropriate

To successfully implement the program, staff must be thoroughly familiar with The Seven Challenges published material; know how to introduce the program and the materials to youth; know how to give feedback to youth who write in the journals; know how to promote openness and talk with, or counsel, young people to empower them, without eliciting defensiveness and without getting hooked into power struggles; and be able to integrate the topics or content of counseling sessions with The Seven Challenges process. They must be prepared to work in a holistic manner with youth. On the one hand, this means being informed by a basic understanding of drug information (widely available elsewhere; not included in this manual).<sup>8</sup> On the other hand, this means being able to teach problem solving skills and various life skills, which are also essential to this program.

The extent to which the *full* power of this program is utilized will depend to a large extent on the clinical skills of those who use it. Among these are specialized Seven Challenges Counseling Approaches that maximize impact of The Seven Challenges Program. These approaches are introduced in this handbook, and taught in Seven Challenges Trainings®.

The Seven Challenges Program has been implemented in a wide array of treatment settings (outpatient, intensive outpatient, inpatient, residential, day treatment, partial care programs, and in-home). It has also been used in public and private schools, juvenile probation departments, and public and private correctional facilities.

## READINGS

*The Seven Challenges* reader is based on the experiences of young people who have been successful in overcoming alcohol and other drug problems. (This is why the text is written in the first person plural – We – format.) This book of readings expresses their point of view. What these youth had in common was that they all were willing to *challenge* themselves to think honestly about their lives and their use of drugs. That is why the book and the program are called The Seven Challenges. Readings are an important part of the program, providing ideas and inspiration to help young people look at their own lives. The book is divided into seven chapters, one for each challenge. This book and other materials are all written in very simple, easy-to-read language.

### JOURNALS

*The Seven Challenges Journals* are a valuable and powerful tool to help young people look at their lives and drug use, to support them in making important decisions about their future, and in following through with positive changes in their lives. Young people write in the nine journals, one at a time, and receive extensive feedback from counselors. When youth have answered all questions in a journal, they pass them to their counselors who read the journal and respond with their own comments. Each journal goes back and forth between the client and counselor several times before the client completes it and moves on to the next journal. Through the journaling, a special type of relationship and communication develops between youth and their counselors. Often young people will write down thoughts and feelings, and share experiences, they might be reluctant to disclose in face-to-face conversations.

There are nine journals in the program. Because of the sheer volume of material in Challenge One, this challenge has been divided into two separate publications – Challenge One: Part One and Challenge One: Part Two. Because youth are asked to make decisions about both lifestyle and drug issues in this program, Challenge Seven is divided into two parts as well. Part One concerns follow up on lifestyle decisions. Part Two concerns follow up on drug decisions.

### COUNSELING / EDUCATIONAL SESSIONS

Young people with drug problems need to “talk it out” in counseling/educational sessions as they examine their lives and consider making changes. There is no pre-set agenda for counseling/educational sessions in *The Seven Challenges Program*, nor are there scripted sessions. Good drug counseling must be responsive to the interests and needs of youth, and their current realities. Effectiveness is seriously compromised in pre-scripted, one-size-fits-all programs. Therefore, counselors must plan sessions according to the needs of individual clients at any given time. Although not pre-scripted, the content of each and every counseling session should be integrated in such a way that young people can see how their efforts relate to helping them through the decision making process using *The Seven Challenges Process*. (How to skillfully do this will be discussed later in this manual, on pages 75-76.) It is also important that counseling sessions are all “working sessions” – not a time for game playing and ceaseless argumentation (pages 127-135).

Counselors provide leadership at counseling sessions by pursuing discussions on important issues relevant to youth or initiating activities that promote thinking about relevant issues, or by teaching important life skills. This requires awareness of which issues to focus on – and when. It requires attentiveness to individual or group needs, and responsiveness to youth concerns. Co-occurring problems need to be addressed in counseling sessions. Some counselors with a background in drug counseling do not feel prepared to help with mental health issues. The program materials help with this. But these counselors may want to broaden their own training, or work on teams with other counselors with a broader background in mental health. Also, they may find

that they know more than they think about mental health issues as they work with young, drug-abusing clients.

Life skills education may be incorporated in regular Seven Challenges group work, or can be taught separately in life skills lessons or classes. Either way, connections are made to The Seven Challenges Process so that young people understand our holistic approaches and why they are being taught these various life skills.

Although planning and leading individual and group sessions require creative initiative, counselors do not have to keep re-inventing the wheel. A collection of activities for use in The Seven Challenges Program has been compiled in the book *The Seven Challenges Activities* and is provided to offer a menu of options. There are numerous other books available in bookstores about life skills education or group activities that can be integrated into work with The Seven Challenges.



# THE MAD RUSH FOR ABSTINENCE





## **PRESSURE FOR IMMEDIATE ABSTINENCE**

Aware of the harm and potential harm from drugs, most adults who work with drug abusing and drug dependent teens would like to see these young people become abstinent immediately. They want to protect them. Their well-meaning motives are reinforced by *enormous, external pressure for immediate abstinence*: Parents, schools, the courts and correctional settings want drug-free children...and they want them now! Individuals who work in the treatment field feel this pressure to deliver the desired outcome: drug-free children quickly. The result of this pressure has been *a mad rush for abstinence* in which drug treatment counselors try to convince young people to quit, or cajole them, or even coerce them into quitting. In this context, counselors tend to focus narrowly upon the harmfulness of drugs – and pound away on this topic. They cut off or dismiss discussion about drug benefits, and persist with pressure for immediate decisions to quit.

Mainstream approaches of this sort have not been proven to be effective.<sup>9</sup> Drug problems do not start overnight, nor can they be remedied overnight. Often drug problems are the culmination of a lifetime of other problems. Furthermore, counselors must consider readiness to change and the building blocks to success.

Counselors should not assume that youth, many of whom are dragged into treatment by their collars, are ready to tell the truth and make instant changes in their lives.

They should not assume that underlying and co-occurring problems associated with drug use are quickly and easily overcome.

They should not assume that youth in drug treatment possess all the life skills and abilities that would enable them to successfully care for themselves or meet their needs without drugs.

They should not assume that youth have enough self-confidence to believe that they could succeed in quitting drugs, even if they wanted to quit.

No matter how much they may want quick fixes to the drug problem, counselors have to be patient enough to find methods that are effective and start where young people are at, not where they wish they might be.

The mad rush for abstinence that has typified drug treatment for adolescence has generally elicited either of four negative response patterns, all described below, all beginning with the letter F. Youth who follow these patterns can be categorized as *Fakers*, *Flee-ers*, *Fighters* or *Followers*. These response patterns offer a likely explanation for the poor outcomes and low retention rates that have historically characterized drug counseling for adolescents.

### **FAKERS**

Fakers tell adults what they want to hear. They readily say they will quit using drugs. They will go through all the motions of pretending to learn how to be drug free. They know that this is the quickest way to get out of drug treatment. In the mad rush for

abstinence, adults teach these young people how to be drug free *before* they have even decided they want to be drug free. The youth fake it. They *say* they will quit, but clandestinely keep using. If they are in residential or correctional settings, they *say* they will quit, accept counseling as if they were serious about it, but resume using drugs quickly, as soon as an opportunity presents itself. Later they like to boast that they told the adults “what they wanted to hear.” It is easy to get these young people to say they intend to quit. The much bigger challenge is to get them to say what they really think and feel, which usually is that they have no intention whatsoever of really quitting.

### **FLEE-ERS (THOSE WHO FLEE)**

No one wants to be controlled by others. This is especially true of adolescents who, as part of a developmental process, are striving to form their own independent identities. Healthy adolescents do not want to be told what to think or do. They are likely to resist adults who they perceive as trying to dictate behavior and control them.

Many of those who flee treatment simply say, “You can’t make me” and leave — or try to leave. These are the youth who don’t return to outpatient settings or try to run away from residential placements.

Others flee from the mad rush for abstinence because of fear. They hear that they must give up drugs, but feel ill prepared to do so. They fear their life would be worse without drugs (for example, they would be in a lot of emotional pain). Some fear that they would fail if they really tried to quit, so they flee from drug counseling to avoid a failure experience.

The large numbers of individuals who flee from counseling account for the low retention rate of adolescents in drug treatment. Even among those who do not drop out, many others flee psychologically. They are physically present, but psychologically absent.

### **FIGHTERS**

The mad rush for abstinence tends to result in contentious and argumentative sessions. It generates resistance. Counselors talk about the dangers of drugs, and youth resist — either openly or passively. The tone is oppositional; the outcome of the counseling effort is predictable.

“Fighters” resist adults whom they see as trying to dictate or control their behavior. Some fighters engage in open, straightforward resistance during individual or group sessions. They say it is all “stupid” or “a waste of time.” Seeking attention and power, many others waste countless hours of counseling time with oblique resistance as they engage in the games of “Try to convince me that drugs are dangerous (or that I have a problem),” or “Try to make me quit.” These are passive-aggressive games that frustrate adults (pages 127-135).

In outpatient settings, fighters generally waste time through either passive-aggressive

or open resistance, or are asked to leave. In residential settings, they usually fight adult influence for a while with open or passive resistance, but eventually realize they cannot beat the adults who run the system. At this point, most become fakers in order to gain their release.

### **FOLLOWERS**

Followers are the adolescents who respond positively to well meaning and caring adults who are in a mad rush for abstinence. They are swayed to wanting to quit drugs, and make a sincere commitment to change. Unfortunately, when adults are in a mad rush, they pay insufficient attention to laying a solid groundwork for success — including the intensive focus needed to remediate underlying and co-occurring problems. Followers will try hard to quit, but generally fail because of insufficient preparation. For them, the outcome is another failure experience – something many of them have already experienced all too often.

It is not surprising that outcomes have been so disappointing in adolescent drug treatment, and the dropout rates have been so high. With the mad rush for abstinence, young people either “fake it” (telling adults “what they want to hear”), fight (defy or resist), or flee from adults. Or as followers, they fail because they have been inadequately prepared for success.

### **SLOWING DOWN THE CHANGE PROCESS: THE LONG ROAD TO SUCCESS**

The mad rush for abstinence runs counter to common sense and to so much of what we know about human nature, adolescent development, the change process, and the principles of good counseling. We should not attempt to teach people how to be drug free before they have *decided* they want to be drug free. This is straightforward common sense: We don't put the carriage before the horse. People should make decisions about their behavior *after* they have thought through the issues, not beforehand. The common sense idea of slowing the rush for abstinence is also supported and amplified by research findings about the stages of change in overcoming behavioral problems: There are preparatory stages that precede willingness, capability, and commitment to take successful action.

Furthermore, we know enough about human development to know that we should not try to control the behavior of adolescent clients. No one wants to be controlled, and this is especially true of adolescents who are forming their own independent identities.

The Seven Challenges Program avoids the mad rush for abstinence. It takes corrective action to ensure better outcomes in adolescent drug counseling. We initiate the change process slowly: building a relationship, starting where youth are “at,” and helping them think things through for themselves. We help them progress through

the many stages of change. With our assistance, they identify their own problems for themselves, determine it is in their own best interest to change, learn how to make changes, and begin to believe that they can be successful in making changes. Then they can make their own decisions, and we can support them as they successfully implement the desired changes.

It should be noted that this is entirely consistent with the traditional role of the counselor, as well as with research findings about positive outcomes in counseling. The traditional counseling role is not to control behavior or tell people how to behave. Doing so is condescending, takes away personal power, and is likely to increase resistance. Instead, drug counselors should perform the traditional role of the profession, which is to help clients think things through for themselves, know their options, expand their options, establish their own goals, and attain success in their own quest for wellness.<sup>10</sup>

There is considerable evidence, as well, that effective counseling with positive outcomes depends to a large extent upon a positive client/counselor relationship, in which the client feels that the counselor listens, understands, and empathizes with his or her story.<sup>11</sup> This cannot occur in the context of an argumentative, contentious relationship in which the counselor tries to control the behavior of the client. We need to engage youth in the counseling process, not antagonize them and turn them off.

### **THE STAGES OF CHANGE**

Common sense and what we know about adolescent development are two good reasons to stop the mad rush to get teens to commit to immediate abstinence. Another strong argument against the mad rush can be found in a body of research, mentioned earlier, about the way people change. Prochaska et al.<sup>12</sup> studied the change process by first looking at the way people overcome tobacco addiction. Later they studied how people overcome the abuse of other drugs, as well as how they alter a variety of health-compromising behaviors.

They found that people basically go through six stages of change: pre-contemplation, contemplation, preparation, action, maintenance, and termination. They go through these stages whether they change with the assistance of a self-help group, such as AA; in treatment, with professionals; or on their own, without assistance.

It is important to look at these stages because the researchers also recognized that the choice of intervention strategies should be keyed to the stage of change. As you will see, treatment professionals working with adolescents have tended to gloss over the early stages of change, and poorly matched the treatment methods to the stage of the individuals.

In the *pre-contemplation* stage, an individual does not recognize the existence of a problem, or is unwilling to honestly acknowledge it. In the *contemplation* stage, an individual is beginning to think that maybe there is a problem. For example, an adolescent with a drug problem may think: "Well, my grades have fallen in school.

I'm getting in trouble. I said I would never smoke marijuana on school days, but now I do. I said I would never use cocaine, and now I'm using it. I better think about this. Something does seem to be wrong." Also, a person in the contemplation stage may be quite aware of the problem, but still contemplating – trying to decide – whether or not to do something about it: "I know I have a problem, but I'm not sure I want to change, or that I could change."

People in the *preparation* stage are getting ready and making plans for a substantial change that they intend to make within a month. They acknowledge that they have a problem, and may even take certain preliminary actions. For example, a person with a drinking problem may experiment with short-term abstinence (sobriety sampling) to see how it goes. In this stage of change, people are getting ready to take strong, decisive action.

Individuals enter the *action* stage when they take the type of significant behavioral action that experts say needs to be taken in order to overcome the particular problem. For example, this occurs when someone with a tobacco addiction actually quits smoking, or begins systematically reducing his or her use until becoming tobacco-free.

After six months of success in the action stage, individuals enter the maintenance stage of change. This is when previous progress is consolidated and incorporated as part of a changed lifestyle. During this stage, individuals must exercise caution to avoid letting down their guard, which could result in relapse.

The final stage of change is *termination* when the problem has been completely overcome. People in this stage can be exposed to "high-risk situations" without reverting to the problem behavior. With alcohol and other drug (AOD) problems, a person who is abstaining would feel no temptation to drink or use drugs under any circumstance. Some people with certain problems are always at risk. For example, there are people who can never drink again and must always remain vigilant, or "in recovery." In other words, termination does not necessarily apply to all people with all problems. Nonetheless, many people have had problems in their lives that they have totally overcome.

It should be noted that people do not always move in one direction in the change process. There may be advances and setbacks from one stage to another as people find their way through the change process. For example, people may contemplate about having a problem, decide they don't, and move back to pre-contemplation. People may be in the action stage, try to make a change, suffer a setback, and move back to earlier stages – either preparation, contemplation or even pre-contemplation. Then they can resume their efforts at changing, but from an earlier stage.

For optimal outcomes in treatment, clinical interventions should be matched to the stage of change. Generally speaking, there is an especially important dividing line that distinguishes between appropriate interventions for the action stage, and those that follow, from appropriate interventions in the three earlier stages of change. In the action stage and those that follow, individuals benefit most from *behavioral interven-*

tions; that is, interventions that are designed to teach behavior. For example, people who have decided to quit smoking tobacco would be taught how to quit and maintain abstinence. They would learn a variety of behaviors such as how to systematically reduce their smoking until they quit or how to quit “cold turkey.” With this latter approach, they would learn to establish a quit day, what to do on the day they quit, and how to resist urges to smoke. With other drug problems, behavioral interventions in the action stage would be designed either to help individuals maintain abstinence and avoid relapse, or to moderate and control their use of substances. They would develop a relapse prevention plan, learn how to initiate and maintain a healthy lifestyle, and strive to overcome psychological and other problems that motivated their drug use.

In the three stages that precede the action stage (pre-contemplation, contemplation, and preparation), individuals have not yet committed to making changes. They are either unaware of problems, thinking about problems, or perhaps in the process of making decisions about future action. The type of interventions that are most appropriate with individuals in these stages could generally be classified as *consciousness-raising*. Such interventions help people gain awareness and insight, and ultimately decide to change. Individuals may need help thinking through their situation, trying to determine whether they have a problem. If they deem they do have one, then they would consider what they might be able to do about it, whether for example, they feel they are capable of making the changes, and whether the particular behavior changes would make their life better and be worth the effort.

People are not ready for the action stage until they have decided a change is needed and desirable, understood what is necessary to make the change, prepared themselves to change, and committed themselves to making the change. Then, it is time to learn the new behavior.

### **ABSTINENCE BASED? DISEASE MODEL? HARM REDUCTION?**

There are numerous theoretical and political controversies that surround the field of substance abuse treatment for adolescents. The Seven Challenges Program maintains its clinical focus, without engaging in some of the hot political battles.

The Seven Challenges has been practiced successfully by people who think in terms of the disease model, and those who do not. It has been used by people who call themselves abstinence-based, by those who say they practice harm reduction, and by others.

Whether counselors think in terms of disease or not, they still have to help young people harness all of their power and abilities to make good decisions. Whether the goal of those who run a program is stated as abstinence or harm reduction, young people still need to learn to make wise decisions. This is universally agreed upon as important. Thus, The Seven Challenges Program supports young people in making good decisions, regardless of the political or theoretical position of practitioners.

## INSISTING UPON ABSTINENCE

We all wish that young people in treatment would immediately quit using drugs. A small percentage of those who come to our attention *really* want to quit. Another small percentage will quit on our insistence. Perhaps some can be swayed by a hard line. The problem, however, is that most young people are far from ready to succeed with abstinence. It is too simplistic to dismiss this un-readiness as mere rebellion or defiance, although these can be factors. There are other psychologically significant impediments to change that must be addressed when working with youth. Youth may be in earlier stages of change because:

- They may not recognize that they have a problem, perhaps because they live in families or communities where drug use is almost universal, or because they do not understand the nature of drug abuse, or because of psychological reasons, unique to themselves.
- They may see a problem, but not be aware of any way to resolve it.
- They may see a problem and a way to resolve it, but feel overwhelmed by the thought of what their lives would be like if they did not have drugs as a crutch. (Here are a few examples: Young clients may be clinically *depressed*, perhaps even suicidal, and have so much distress that they do not feel they could cope without drugs; young clients may experience so much *anxiety* in their daily lives that they do not feel they could make it through the day without drugs; young clients may *suffer such pain* from abuse, or other trauma, that they do not feel they could cope with these feelings without drugs.) They feel hopeless about their lives getting better.
- They may want to make changes, but feel immobilized by fear of failure. They don't believe they could succeed with abstinence. Some of them have already had numerous failure experiences and want to prevent another one. They are so afraid of failing that they do not want to take the risk of trying.
- Even if youth know they have a problem, know what can be done about it, want to do something about it, and feel they would be successful in changing, they still may lack the life skills or be plagued by psychological problems that would prevent them from succeeding.

So in working with youth with substance abuse problems, we have a lot of initial groundwork to lay in order to get them to the point where they will be ready, willing, and able to stop abusing drugs.