PROGRAM OF STUDY

Integrated Residential Treatment Curriculum

A thirty-day curriculum for substance use disorder and co-occurring mental health conditions

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Recovering Addict and Pedagogue

FACILITATOR MANUAL

ASAM Level 3.5 · Clinically Managed High-Intensity Residential
42 sessions across 8 modality tracks and an integrative capstone

Bloom's Taxonomy learning objectives throughout

Contents

PART I

Program Framework

How the manual is organized, what the program is for, the population it serves, the taxonomy that structures every session, and the standards every facilitator delivering it works to.

How to Use This Manual

This manual is the operating document for a thirty-day residential program at ASAM Level 3.5. It is written for the clinician or trained facilitator who will deliver the sessions, not for the client. Every session is designed to be runnable from the page with roughly twenty minutes of preparation, and the elements are consistent across all forty-two sessions so that a facilitator picking up an unfamiliar session knows where to find what they need.

What each session contains

The session template

Element	What it gives you
Header block	Duration, group format, the ASAM dimensions the session addresses, and prerequisites
Purpose	The clinical rationale: why this session exists and what it is for
Objectives	Six measurable objectives, one at each level of Bloom's revised taxonomy
Materials	Everything to have in the room before you start
Facilitation sequence	A timed run-sheet from opening to close
Content	The teaching substance: what you actually convey, with tables, figures and scripts
Discussion prompts	Questions that open the material rather than testing recall
Common pitfalls	How this session fails, written by people who have watched it fail
Assessment	Formative evidence during the session; summative evidence of competence
Between-session practice	What the client does before the next group
Connections	Which other sessions this depends on and feeds

> **DOCUMENTATION**
> Every reproducible item named in a session's materials list is printed full size in the companion volume, Materials and Handouts, keyed to the same session number. That booklet holds 89 worksheets, cards, checklists and templates and is designed to be photocopied. Where a session says 'print one per client', the master is in the companion volume.

Reading the structure

Part III holds the eight modality tracks. Content is organized under the therapy it belongs to rather than repeating an explanation of each modality every time a technique appears: grief work sits inside the acceptance track because that is where its theory lives, sleep sits inside the medical track, and relapse prevention has been lifted out of the modality tracks entirely because it is not a modality. Part IV is the integrative capstone where every track's output is assembled into one document the client carries out of the building.

Read Part II before Part III. The tracks are not sequential with respect to one another: they run in parallel across the four weeks, which is what makes the program workable under rolling admission, and a facilitator who meets the sessions before understanding that shape will read the numbering as an order it does not have. Part II explains the arrival track, the four-week cycle, the departure track, and what happens when a client's admission date does not line up with the cycle. Within a track, sessions do have order, and prerequisites are stated in each session header.

> **SCOPE OF PRACTICE**
> Sessions in Track 5 are delivered by nursing or medical staff. Sessions involving trauma content, boundary-setting with unsafe relationships, and grief work require a licensed clinician. Where a session carries a specific credential requirement it is stated in the session's delivery notes and repeated in a callout. A facilitator who is uncertain whether a piece of content sits inside their scope should assume it does not and ask their supervisor: the cost of asking is a delayed answer, and the cost of guessing is on the client.

A note on the evidence

The frameworks in this manual are named where they originate, and Appendix D gives the full APA reference for each with an annotation explaining what it contributes and which sessions draw on it. This manual does not reproduce their evidence base or cite effect sizes, and facilitators should not present figures they cannot source. Where a claim in these pages is a matter of clinical convention rather than established finding, the codependency construct being the clearest example, it is flagged as such in the text.

Program Overview

What this program is

A thirty-day residential treatment program for adults with substance use disorder and co-occurring mental health conditions, delivered at ASAM Level 3.5, clinically managed high-intensity residential treatment, with medical and nursing support sufficient to hold clients through the tail of acute withdrawal and to manage medications for addiction treatment on site. The program admits on a rolling basis and operates a four-week curriculum cycle.

Thirty days is a short window and this manual is written with that constraint in front of it. The program does not attempt to resolve trauma, restore relationships, or complete anyone's recovery. It aims to stabilize the client physically, teach a set of skills to a level where they can actually be executed under load, establish the community and clinical connections that will carry the work forward, and send the person out with a written, tested plan and the means to survive a lapse. Everything in these pages is subordinate to those four aims.

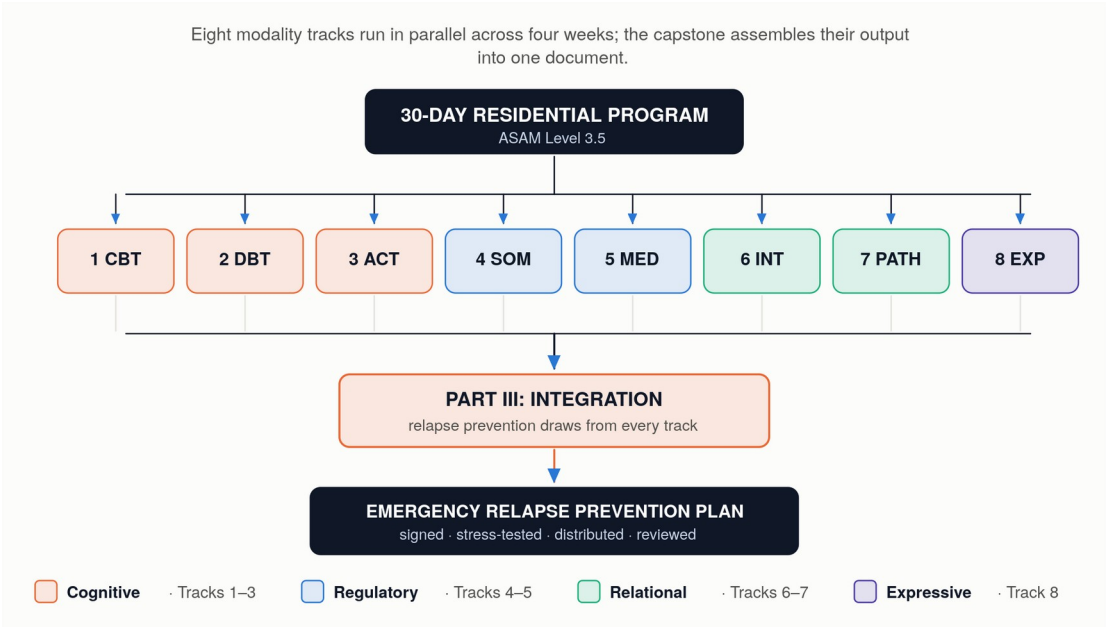
Clinical philosophy

Five commitments, and what each rules out

Commitment	What it means in practice
Skills over insight	A client who understands their pattern and cannot regulate has gained nothing durable. Sessions end with something rehearsed, not something realized.
Mechanism over slogan	Recovery language that cannot be explained gets discarded the first time it is tested. HALT is taught as physiology, not as a saying.
Pluralism over prescription	The program does not endorse a single recovery pathway. Facilitator neutrality on this is a clinical requirement, not a courtesy.
Preparation over exhortation	A lapse is a foreseeable event in this population. Every client leaves knowing how to survive one, because a survivable lapse is one a person can return from.
Specificity over intention	'Reach out' is not a plan. Every response written in this program names a person, an action, and a time.

Population

Adults admitted at Level 3.5, most with co-occurring psychiatric conditions, many with trauma histories, a substantial proportion arriving from detoxification or hospital settings, and a significant number on medication for opioid or alcohol use disorder. Literacy, cognitive capacity in early abstinence, and cultural background vary widely, and the material is written to be delivered verbally with written support rather than to be read independently. Clients in the first seventy-two hours will retain little; the schedule in Part II accounts for this.



How the eight modality tracks and the integrative capstone fit together across the thirty days

What the program is not

- It is not a detoxification unit. Clients requiring medically managed withdrawal are stabilized at the appropriate level first.
- It is not a trauma processing program. Track 4 stabilizes and prepares; reprocessing happens one-to-one with an appropriately trained clinician, on a timeline that does not fit inside thirty days.

- It is not abstinence-only in its teaching. The clinical recommendation is abstinence and the harm reduction content is delivered in full, without apology, because both are required for the client to survive.
- It is not a substitute for continuing care. Discharge without a booked appointment is a failure of the program, not of the client.

Bloom's Taxonomy in Clinical Curriculum

Every session in this manual carries six learning objectives, one at each level of the revised taxonomy. This is not academic decoration. In a thirty-day program the temptation is to deliver information and assume it converts to capability, and the taxonomy is the discipline that prevents it: a session that stops at Understand has told the client something, and a session that reaches Create has had them build something they can use.

The six levels as applied here

Level	Cognitive demand	What it looks like in a clinical group
Remember	Retrieve	Name the four skill modules; state the stages of relapse
Understand	Explain	Explain why exhale length drives parasympathetic activation
Apply	Execute in context	Complete a thought record on a real trigger; perform TIPP
Analyze	Break into parts and relate them	Run a chain analysis; sort family behaviors into enabling, supporting, abandoning
Evaluate	Judge against criteria	Assess whether a boundary is self-enforceable; weigh personal overdose risk
Create	Produce something new	Build the crisis survival kit, the action matrix, the relapse prevention plan

Why the top two levels carry the weight

Evaluate and Create are where clinical change lives, and they are the levels most often skipped. A client who can define a cognitive distortion has done Remember; a client who has assessed the evidence for a specific belief of their own and constructed a balanced alternative has done Evaluate and Create, and that is a different person leaving the room. Facilitators under time pressure will be tempted to cut the second half of a session, which is precisely the half that produces the durable outcome. Cut the lecture instead.

Verb bank

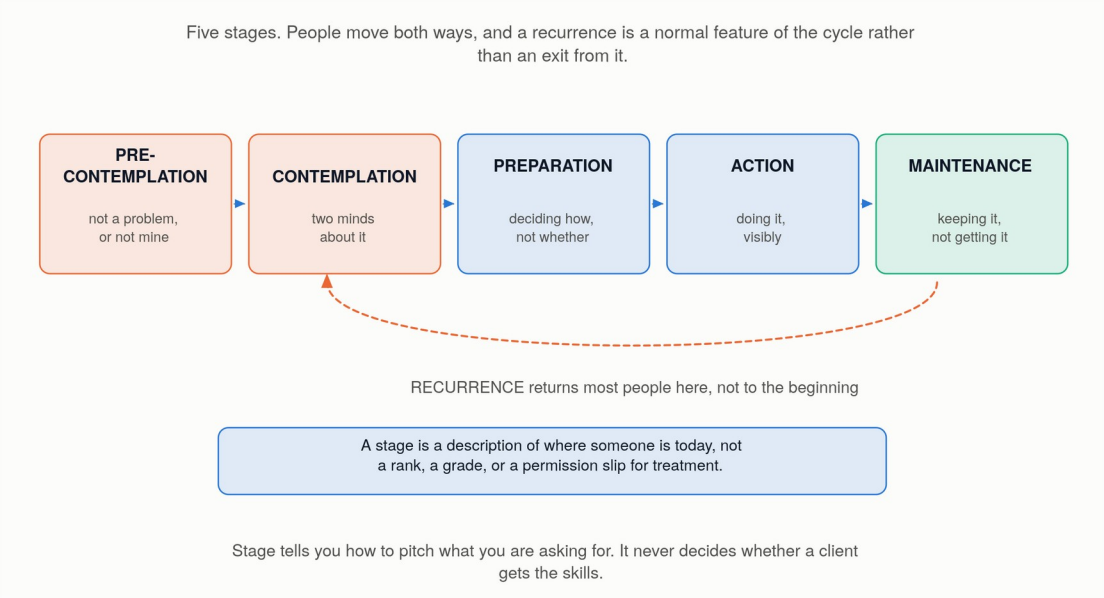
Objective verbs by level

Level	Verbs
Remember	define · list · name · state · identify · recall · recognize
Understand	explain · describe · differentiate · summarize · contrast · interpret
Apply	execute · demonstrate · complete · perform · implement · use
Analyze	break down · trace · map · categorize · distinguish · correlate
Evaluate	assess · judge · appraise · critique · defend · prioritize · determine
Create	construct · design · compose · draft · formulate · assemble · produce

> **DOCUMENTATION**
> Objectives are the basis of the competency record. Formative evidence is recorded in the group note for the session; summative evidence is recorded against the client's competency checklist in Part V. A client discharged without summative evidence on the Create-level objectives of Track 9 has not completed the program's core deliverable, and that should be visible in the record rather than inferred from attendance.

Meeting the Client Where They Are

Every session in this manual is written as though the client in front of you has already decided to change. Most have not, or have decided in a way that will not survive Thursday. The stages of change model, developed by Prochaska and DiClemente, is the framework that tells a facilitator how to pitch a session to somebody who is not where the curriculum assumes. It sits here beside Bloom's taxonomy for the same reason: Bloom's governs how the learning is structured, and this governs how it is delivered.



The five stages, with recurrence returning to contemplation rather than to the start

Recognizing the stage, and what it changes

What each stage sounds like, and what to do with it

Stage	What you actually hear	What works	What backfires
Precontemplation	'I'm only here because of the judge.' 'My use is not the problem, my wife is.'	Curiosity. Ask what other people are worried about. Give information without a verdict attached.	Persuading, arguing, evidence-stacking. Every argument you make hands them the counter-argument to rehearse.
Contemplation	'I know I should, but.' The sentence with two halves, both meant.	Explore both halves seriously. Decisional balance. Let them voice the reasons for changing.	Resolving the ambivalence for them. If you take the pro-change side, they will take the other one.
Preparation	'I'm going to, I just don't know how.' Asking logistics questions.	Concrete planning. Options, not instructions. Shrink the first step until it is certain.	Only being slow. A client who has decided and is asking how is the easiest person in the building to help, and the usual failure is making them wait for the next scheduled session.
Action	Doing it, and wanting it noticed.	Skills, structure, reinforcement. This is where most of this manual is aimed.	Assuming it is settled. Action is the least stable stage, not the finish line.
Maintenance	'It's fine, I don't really think about it.'	Relapse prevention, recovery capital, boredom management. Keeping it is a different job from getting it.	Withdrawing support because things look good. This is where programs disappear and people fall over.

Where this collides with the rest of this manual, and how it resolves

This program says in several places that action produces motivation rather than the other way round. Session 1.5 tells facilitators that motivation is the output of behavioral activation, not its precondition. Session 3.4 says readiness follows action more often than it precedes it, and instructs you not to argue about readiness but to shrink the step. Read carelessly, a stage model contradicts all of that, because it appears to say that a person in contemplation is not ready for action-stage work.

The two only conflict if stage is read as a gate. It is not a gate. Every client attends every group and is taught every skill regardless of what stage you judge them to be in. What the stage changes is narrower and more practical: what you ask them to commit to, what you count as a good outcome, and whether you read an uncompleted assignment as resistance or as a mismatch you created. A client in contemplation who comes to group, listens, and does not do the homework has not failed the session. A facilitator who then calls that resistance has.

CLINICAL CAUTION

Stage is a description, not a rank, and it must never function as a rationing decision. Do not use a stage judgment to justify reduced attention, a lower level of care, a discharge, or the withholding of medication for opioid use disorder. Precontemplation is the stage with the highest risk and the greatest need for contact, which is the opposite of what a rationing reading would produce. If you find yourself using the word precontemplative about a client you have stopped trying with, the word has become an excuse rather than an assessment.

What the evidence actually supports

Facilitators should know that this model is genuinely contested rather than settled. West argued in 2005 that it should be abandoned, on the grounds that the stages are arbitrary cut-points imposed on a continuous variable, that the boundaries between them are defined by time periods with no theoretical basis, and that stage-matched interventions have not reliably outperformed unmatched ones. DiClemente replied in the same issue. Both papers are in the reference list and the exchange is short enough to read in an afternoon.

The defensible position, and the one this program takes, is that the model earns its place as a clinical heuristic rather than as a validated mechanism. It reliably improves how a facilitator reads a room and how they phrase a request. It does not license a claim that a client must pass through stages in order, or that an intervention delivered off-stage is wasted. Teach it to staff as a lens. Do not present it to clients as a law of nature they are subject to.

Motivational interviewing: what to do once you know the stage

A stage model describes where somebody is. It does not tell you what to say. Motivational interviewing, developed by Miller and Rollnick, is the method with the strongest evidence behind it for the early stages, and this program uses its core skills throughout rather than confining them to one session. The central finding worth holding is counterintuitive: the more a clinician argues for change, the more the client argues against it, and the client's own arguments predict what they do next.

The core skills, and where this manual already uses them

Skill	In practice	Already used in
Open questions	Questions that cannot be answered with a word. 'What would have to be different?' not 'Are you ready?'	Every discussion prompt in this manual
Affirming	Naming a specific strength or effort, not praising the person generally	1.5 activity review; 8.4 unique outcomes
Reflecting	Saying back what they meant, including the half they did not finish	2.1 validation levels; 6.3 communication
Summarizing	Collecting the change talk together and handing it back	7.2 recovery definition; 9.4 plan review
Evoking change talk	Asking for their reasons rather than supplying yours	3.3 values; 7.2 definition of recovery
Rolling with discord	Treating pushback as information about the relationship, not a trait of the client	4.1 window of tolerance; 6.4 drama triangle

Two working distinctions matter more than the acronyms. The first is between sustain talk, which is the client voicing the reasons not to change, and discord, which is friction in the relationship between the two of you. Sustain talk is a normal feature of ambivalence and should be explored. Discord is a signal that you have pushed, and the response is to stop pushing rather than to push differently. The second is that a decisional balance exercise is a contemplation-stage tool. Run it with somebody already in action and you will talk them back out of a decision they had made.

SCOPE OF PRACTICE

Reading this section does not make a facilitator competent in motivational interviewing. It is a method with a substantial training and coaching literature, and proficiency requires supervised practice with feedback on recorded sessions, not a chapter. What this section supports is a house style: ask more than you tell, reflect before you advise, and stop arguing when a client starts defending. Programs that want genuine MI fidelity should budget for training and coding, and should say plainly in the meantime that they use MI-consistent practice rather than that they deliver MI.

Facilitator Standards

Who delivers what

Delivery requirements by track

Track	Minimum qualification	Notes
0.1 and the stage lens	Licensed clinician or credentialed peer specialist	Requires the Part I framework section; MI-consistent practice is a house style, not a credential
1: CBT	Licensed clinician or supervised clinical staff trained in CBT	Thought record work requires supervision until competence is demonstrated
2: DBT	Clinician with DBT skills training	Skills group only; this is not comprehensive DBT
3: ACT	Licensed clinician	3.2 and 3.5 require experience managing affect in group
4: Somatic and trauma-informed	Licensed clinician; 4.5 by a trauma-sensitive movement instructor	4.3 is psychoeducation only, never reprocessing
5: Medical and	RN, NP, PA or physician	Non-medical staff may not deliver or field questions from this

Track	Minimum qualification	Notes
nursing		track
6: Interpersonal	Licensed clinician	6.2 requires competence in intimate partner violence screening and referral
7: Recovery pathways	Licensed clinician or credentialed peer specialist	Facilitator neutrality on pathway is mandatory
8: Expressive	Trained facilitator; art therapy as intervention requires a credentialed art therapist	See the scope boundary in 8.1
9: Integration and capstone	Licensed clinician who has followed the cohort	Requires knowledge of each client's prior work

Non-negotiable practice standards

1. No hands-on physical contact in any movement or somatic session, without exception, regardless of intent or invitation.
2. No client is required to disclose trauma content in group. Participation in any experiential exercise is optional and opting out is never treated as resistance.
3. No facilitator discloses their own recovery pathway, spiritual position, or clinical opinion of another provider's treatment decisions.
4. No individual medical or medication question is answered outside Track 5. Route it to the prescriber the same day.
5. No client living with a violent or coercively controlling partner receives group-taught boundary scripts as their safety plan. That is individual work with an appropriately trained clinician.
6. Every group with activating content ends with a regulation step and an orienting close. Nobody leaves the room dysregulated.

TRAUMA-INFORMED NOTE

The six principles that govern every group in this program: physical and emotional safety; trustworthiness through transparency about what will happen; peer support; collaboration rather than instruction; voice, choice and empowerment at every point where a client can be given a decision; and explicit attention to cultural, historical and gender context. These are not a preamble. If a session as written conflicts with any of them in your room, the principle wins and the session is modified, then tell your supervisor so the manual gets fixed.

Fidelity and supervision

Facilitators observe two deliveries of a session before leading it and are observed twice before delivering it unsupervised. Fidelity monitoring uses the session's own objectives as the checklist: an observer records whether each of the six was addressed and whether the Create-level objective produced an artifact the client left with. Sessions that repeatedly fail to reach Create are redesigned rather than re-exhorted. Weekly group supervision reviews at least one recorded or observed session and one incident, and the pitfalls list in each session is the standing agenda for that review.

0.1 Where You Are Right Now

DURATION	FORMAT	ASAM DIMENSIONS	PREREQUISITES
60 minutes	Small group, arrival block	Dimension 4	None. Delivered in the first five days.

YOUR ASSIGNMENT	
DELIVERED BY	Licensed clinician or credentialed peer specialist. Delivered in the first five days, in a small group.
BEFORE THE SESSION	Print the unmarked cycle handout and the four-cell balance sheet. Decide in advance how you will answer a client who asks which stage is the right one, because somebody will.
YOU MUST LEAVE WITH	A written change sentence in the client's own words, plus a completed four-cell decisional balance with the cost-of-changing cell attempted.
DO NOT	Do not argue with anything in the reasons-to-keep-using column, and do not record a client's stated stage anywhere it will follow them through the program.

PURPOSE

Clients arrive at very different distances from a decision, and the program's schedule cannot tell them apart. This session gives every client language for their own position before any skills content lands on them, and it does one specific piece of work: it makes ambivalence sayable. A client who believes that admitting mixed feelings will be recorded as poor motivation will hide the mixed feelings, and the hidden half is the half that drives the first lapse.

LEARNING OBJECTIVES

Level	On completion, the client will be able to...
Remember	Name the five stages of change and state what each one describes.
Understand	Explain why a recurrence returns most people to contemplation rather than to the beginning.
Apply	Locate oneself on the cycle for one specific behavior, in writing.
Analyze	Separate the reasons for changing from the reasons against, without resolving either.
Evaluate	Judge which stage one occupies for two different behaviors and account for the difference.
Create	Compose one sentence naming the strongest reason for change in one's own words.

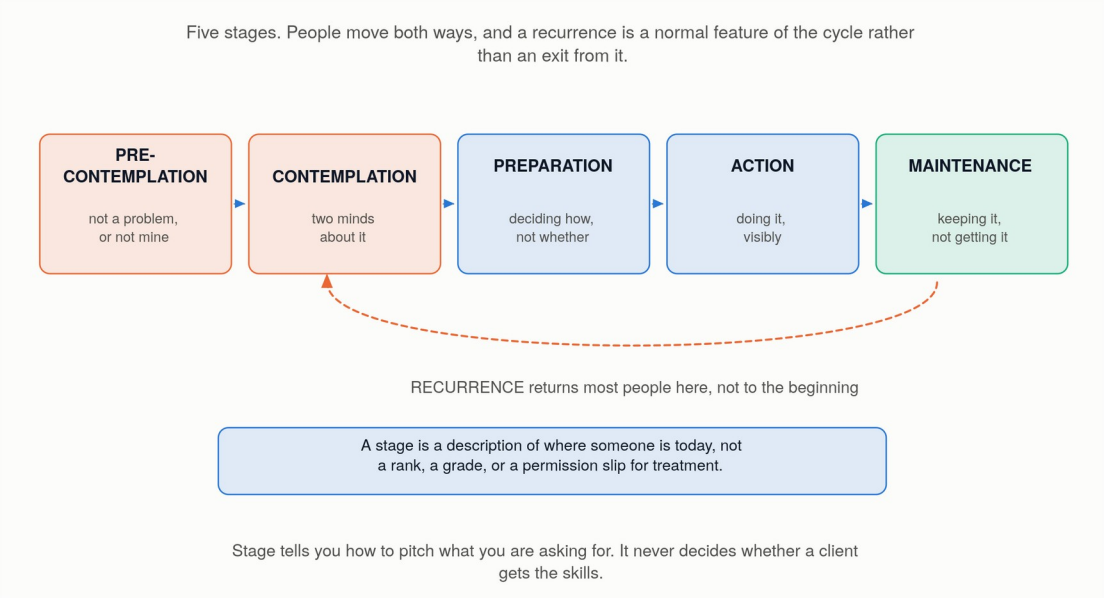
MATERIALS Stages of change handout with an unmarked cycle · Decisional balance worksheet, one per client · Index cards for the change sentence · Pens; nothing on this sheet is collected

FACILITATION SEQUENCE

Time	Phase	What happens
0-8	Frame	Say plainly that this session is not a test and that nothing written here goes in the record. Mixed feelings are the expected finding, not a red flag.
8-22	Teach	The five stages, using the figure. Keep it under fifteen minutes and use ordinary language.
22-34	Locate	Each client marks where they are for one behavior. Nobody reads out unless they choose to.
34-50	Decisional balance	Both columns, filled in properly. The facilitator does not argue with anything in the left column.
50-57	The sentence	One line, their words, on a card: the strongest reason for change they can currently believe.
57-60	Close	Cards kept by clients. Name what happens next in the program.

Why This Is the First Thing

Every other session in this program assumes a decision has been made. That assumption is wrong often enough that it is worth spending an hour on before anything else, and the cost of getting it wrong is not that a client learns less. It is that a client who is genuinely in two minds learns that this is a place where you do not say so, and then does the whole program performing a certainty they do not have. That client looks like the best outcome on the unit until the week after discharge.



The cycle as clients see it. Distribute the unmarked version and let them place themselves.

Teaching It Without Turning It Into a Grade

Clients will immediately try to work out which stage is the good one, and several will place themselves in action because that is the answer they think earns them something. Head that off explicitly. Say that people in this room are in different places, that this is expected, that nobody is graded on it, and that the stage a person names has no bearing on their treatment. Then prove it by not reacting differently to the answers.

Facilitator script: framing the exercise

"This is not a test and it does not go in your chart. I am not going to argue with anything you write."

"Most people in this room are somewhere in the middle, and the middle is not a failing grade. It is where nearly everybody actually is."

"If you are here because a court told you to, that is a real answer and you can write it down. It does not make you less welcome."

"The only thing that would be a problem is deciding what I want to hear and writing that instead. That version helps nobody, least of all you in six weeks."

Decisional Balance, Done Properly

The exercise fails when the facilitator treats the left column as an obstacle to be dismantled. The reasons a person uses are real reasons: it worked, it stopped something, it was the only thing that did. If those get argued with, the client stops writing honestly and the sheet becomes another performance. Take the left column seriously, in full, and then ask for the right column with the same seriousness. The intended outcome is not that the right column wins. It is that both columns are visible at once, which is a state most clients have been avoiding for years.

The four cells, and which two get skipped

	Reasons to keep using	Reasons to change
What I get	Usually written easily and honestly	Usually written as slogans first; push for specifics
What it costs	The cell most often left thin, because it is the one that hurts	Rarely considered at all: what changing will cost them

The bottom right cell is the one facilitators forget and clients most need. Recovery has costs: a social circle disappears, an identity has to be rebuilt, evenings become long, and a reliable method of managing feeling is removed before a replacement exists. A client who has named those costs in advance is much harder to ambush with them in month two.

TRAUMA-INFORMED NOTE

Asking a person to state what their substance did for them can surface why they needed it, and in this population the answer is frequently a trauma history. Watch the room during the left column. If a client goes quiet, flat, or leaves, that is not disengagement from the exercise, it is the exercise working faster than expected. Offer the grounding options from the arrival block, do not press for content, and pass it to their counsellor the same day.

The Sentence

The session ends with one line in the client's own words, on a card they keep: the strongest reason for change they can currently believe. Two rules make it useful. It has to be theirs, not a repeated slogan, and it has to be something they actually

believe today rather than something they hope to believe. A modest sentence that is true beats an ambitious one that is not, because the ambitious one stops working the first time it is tested.

DISCUSSION PROMPTS	COMMON PITFALLS
• Which stage did you put yourself in, and what would somebody who knows you well say? • Pick a second behavior, one that has nothing to do with substances. Are you in the same stage for it? • What is the strongest reason to keep things as they are? Say it properly, not as a joke. • What will changing cost you that nobody has mentioned yet?	• Arguing with the left column. It ends honest writing for the rest of the program, not just this session. • Letting the group turn stages into a hierarchy, or congratulating whoever claims action. • Recording a client's stated stage in the chart in a way that follows them. This sheet is not collected. • Running decisional balance with a client who is clearly in action already, which can talk them back out of a settled decision. • Treating a court-mandated client's honesty about coercion as a bad prognostic sign. It is the opposite.

ASSESSMENT

Formative: Facilitator observes each client locating themselves on the cycle and completing all four cells of the decisional balance, with the cost-of-changing cell genuinely attempted.

Summative: A written change sentence in the client's own words, plus a correct statement of what a recurrence returns a person to.

BETWEEN-SESSION PRACTICE

Carry the card. When you notice yourself arguing with your own reason for being here, read it and note what the argument was.

CONNECTIONS

Sits alongside 4.1, 4.2 and 9.1 in the arrival block. The decisional balance foreshadows the pros and cons work in 2.3 and the values clarification in 3.3. The costs-of-changing cell is revisited in 3.5, and the change sentence feeds the personal definition of recovery built in 7.2.

PART III

The Clinical Tracks

Eight modality tracks. Content sits under the therapy it belongs to rather than repeating an explanation of each modality wherever a technique appears. Tracks run in parallel across the four weeks; within a track, sessions have order, and prerequisites are stated in each session header.

Track 1: Cognitive Behavioral Therapy

Why this track is in the program

CBT is the spine of this program's psychosocial curriculum for one reason: it is the modality with the broadest and most consistent evidence base across substance use disorders and the depression and anxiety that arrive with them, and it is the one thing a client can still run on themselves at 2 a.m. in March with no clinician in the room. Other tracks do work this one does not (trauma processing, distress tolerance under acute arousal, identity reconstruction) but none of them hand a client a portable, repeatable procedure for catching the specific sentence that sits between a trigger and a decision to use. Beck's cognitive model of substance abuse and Marlatt and Gordon's relapse prevention model converge on that same target, the permission-giving thought, and the window around it is where this track works. The evidence posture should be confident and not triumphalist: CBT does not beat every alternative in every trial, its effect depends heavily on whether the client actually practices between sessions, and for opioid use disorder it is delivered alongside MOUD, never instead of it. Facilitators present this as a skill set that requires reps, not as an insight that arrives once and holds.

Delivery

Groups run 8-12 participants, twice weekly across the 30-day cycle, in a room with a whiteboard and enough table surface for every client to write; the material is written for both 3.5 Clinically Managed High-Intensity Residential and 3.7 Medically Managed Residential populations. Sessions 1.1, 1.2 and 1.5 can be facilitated by any clinical staff member (LPC, LCSW, LADC, CADC, or a trained technician under clinical supervision) working from this manual. Sessions 1.3 and 1.4 involve individualized restructuring and belief-level work; run those with a licensed or credentialed clinician in the room, and route any material that turns out to be trauma-linked into individual session rather than working it in group.

How the sessions build

1.1 installs the model (thought, emotion, behavior and physical response, all four running both ways) because nothing after it lands without a shared vocabulary for what a thought is. 1.2 fills the model with the specific errors that keep this population using, and 1.3 hands over the procedure for working one all the way through on paper. 1.4 goes underneath the automatic thoughts to the beliefs generating them, and 1.5 closes the loop back to behavior, where craving is met with action rather than argument and where the beliefs from 1.4 get tested instead of debated.

1.1 The Cognitive Model and the Cognitive Triangle

DURATION	FORMAT	ASAM DIMENSIONS	PREREQUISITES
75 minutes	Psychoeducational group	Dimensions 3, 4	None

YOUR ASSIGNMENT	
DELIVERED BY	Licensed clinician, or clinical staff trained in CBT working under supervision
BEFORE THE SESSION	Print one blank 5-column thought record per client. Draw the four-point triangle on the board before the group enters, unlabelled.
YOU MUST LEAVE WITH	Completed four-point worksheet on a personal episode, plus one caught-thought record brought to the next group and checked against the thought/feeling distinction.
DO NOT	Do not correct a client's thought as irrational. This session identifies the model; it does not restructure anything yet.

PURPOSE

Every later session in this track (and much of what happens in relapse prevention, skills groups and individual work) assumes the client can tell a thought from a feeling and can catch a thought while it is still happening. Most cannot on admission. Clients arrive able to describe what they did and how they felt, with a blank space where the cognition should be, and they will fill that space with 'I just used' unless someone teaches them there is something in it. This session installs the model and, more importantly, runs one live elicitation so the group watches a thought surface in real time from someone sitting in the room. Do not let it become a lecture about a triangle.

LEARNING OBJECTIVES

Level	On completion, the client will be able to...
Remember	Name the four points of the cognitive model and define 'automatic thought' in one sentence.
Understand	Explain why the model is drawn with arrows running both ways rather than as a one-way chain.
Apply	Apply the four-point model to one personal episode from the past week using the worksheet.

Level	On completion, the client will be able to...
Analyze	Distinguish, across ten written statements, which are automatic thoughts and which are feelings mislabeled as thoughts.
Evaluate	Judge which of the four points offered the most workable entry into your own episode, and defend the choice.
Create	Write a two-line record of one automatic thought caught within an hour of its occurring.

MATERIALS Whiteboard and markers, with the four-point model drawn large before clients enter · Four-point episode worksheets, one per client plus six spares · Thought-or-feeling sort cards: ten printed statements, cut, one set per pair · Pens, and clipboards for clients who write on their laps · One-page model summary for the client binder · A worked staff example of a four-point episode you are willing to say out loud

FACILITATION SEQUENCE

Time	Phase	What happens
0-10	Opening	Two-word check-in: one word for mood, one for what the body is doing. Frame the session as a tool clients will use in four other groups, not as theory.
10-30	Teach	The cognitive model, automatic thoughts, and bidirectionality. Use the board and the group's own examples; do not run slides.
30-42	Card sort	Pairs sort the ten statements into thought or feeling, then correct as a group. Expect disagreement on at least three and work those on the board.
42-58	Live elicitation	Take one volunteer's small, recent episode and build it on the board across all four points. This is the session; protect the time.
58-70	Individual work	Each client completes a four-point worksheet on their own episode. Circulate and read over shoulders rather than asking how it is going.
70-75	Close	Assign the catch-one-thought practice, name the staff member available on the unit tonight, and take one word from each client on the way out.

What Beck Actually Claimed

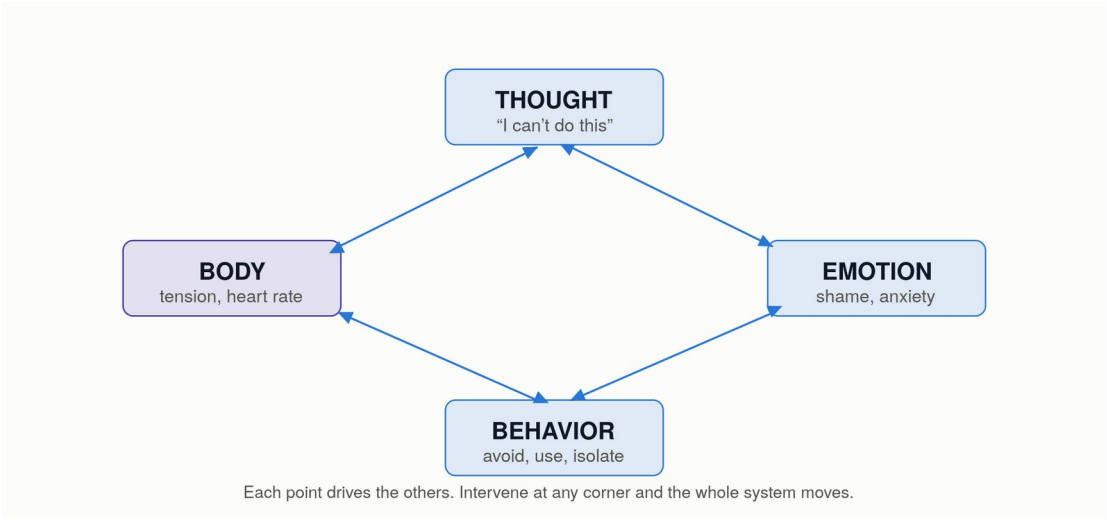
Beck's model, developed first in work with depression and later extended to substance use, makes a narrow claim that is easy to overstate. It is not that thinking causes everything, and it is not that clients feel bad because they think badly. The claim is that between an event and a response there is an interpretive step, that the step runs fast enough to go unnoticed, and that it is available for inspection if you slow it down. In addiction, that step is where the decision lives. The trigger does not produce the use; the thought about the trigger does, and that thought is short, believable, and almost never said out loud.

Automatic Thoughts

Automatic thoughts are not deliberate reasoning. They are fast, telegraphic, often not even complete sentences, and they arrive with the felt quality of fact rather than opinion, which is exactly why clients do not argue with them. They are also plausible. 'One won't hurt' is not a delusion; it is a reasonable-sounding proposition that happens to be false for this person, which is what makes it dangerous. Tell the group plainly that the goal is not to catch stupid thoughts. It is to catch the ones running unexamined, most of which sound entirely sensible when they are finally written down.

Thought or feeling? The distinction clients get wrong first

What the client says	What it actually is	How to re-elicit
'I feel like a failure.'	A thought, 'I am a failure', wearing a feeling's clothes	'What is the feeling, in one word? And the sentence under it?'
'I felt like she was judging me.'	A prediction about another person's mind	'What did you think she was thinking? Say it as a sentence.'
'I was angry.'	A feeling, one word, correctly labeled	'Good. What went through your mind right before the anger?'
'It was overwhelming.'	An appraisal of the situation, not a feeling	'Overwhelming how? What did you think was about to happen?'
'I just used.'	A behavior with the thought edited out of it	'Rewind ten minutes. What was the last thing you told yourself?'
'My chest got tight.'	Physiology: the fourth point, and often the first noticed	'What did the tightness mean to you right then?'



The cognitive model as this track actually uses it: four points (thought, emotion, behavior and physical response) with arrows running both ways between every pair. The bidirectionality is the clinical content, not decoration. It is why a client who cannot win an argument with a thought can still change the loop by moving their body, and why physical craving can manufacture a thought that was not there sixty seconds earlier.

Draw the arrows both ways and defend that choice out loud, because most clients have been taught a one-way chain (think, then feel, then act) and the one-way version fails them inside a week. Physiology drives cognition as reliably as cognition drives physiology. A client in protracted withdrawal at three in the morning is not having a thinking problem that produced a body state, and instructing them to challenge the thought first will confirm their suspicion that none of this applies to them. Behavior is usually the most accessible entry point precisely because it does not require the client to out-argue themselves. That is the whole rationale for 1.5, and it is worth saying in session one so the clients who cannot do cognitive work yet do not conclude that CBT is not for them.

One event, two clients, same unit, Friday 6 p.m.

Point	Client A	Client B
Trigger	Family session cancelled by phone	Family session cancelled by phone
Thought	'They're done with me. That was the last one.'	'She got called into work again. Annoying.'
Emotion and body	Despair, shame; heavy chest, hot face	Irritation; jaw tight for a minute, then gone
Behavior	Skips dinner, sits outside alone, texts an old contact	Complains at dinner, plays cards until lights out

TRAUMA-INFORMED NOTE

The cognitive model can be heard as a verdict. A client whose beliefs were installed by a caregiver, a war, or a decade of being accurate about a dangerous environment will hear 'your thinking is distorted' as one more person telling them their perception is the problem. Say plainly, in session one, that some thoughts are correct and that the model does not require the client to be wrong. A client who believes their family will not take them back may be right, and the work then is what they do with an accurate and painful appraisal, not disputing it. Do not run this model over trauma-related cognitions in group: 'it was my fault' after an assault is not a distortion to be corrected in a psychoeducational setting, and it belongs in individual trauma-focused treatment.

Facilitator script: the live elicitation

"I need one recent moment, from the last two days, where your mood dropped fast. Not the worst thing that ever happened to you. Something small and recent."

"Freeze it there. Where were you, what time was it, who else was in the room? Facts only: the kind a camera would have caught."

"Now: what went through your mind right at that moment? Not what you worked out afterward. The words that were actually there."

"If nothing comes, that is normal and it is not a failure. Try the picture instead: what did you see in your head?"

"Everybody watch what just happened. He did not know that sentence was in there thirty seconds ago. That is the entire skill."

- Take a small, recent episode. Big episodes recruit the rehearsed account and you will get a story instead of a thought.
- Ask 'what went through your mind,' never 'why did you feel that way.' Why-questions produce explanations; the model needs the raw sentence.

- Write the client's exact words on the board, profanity and bad grammar included. Cleaning it up removes the part carrying the charge.
- If the client hands you a feeling word, take it, put it in the emotion box, and ask the thought question again. Do not correct them in front of the group.
- Stop at one thought. Two is a lecture; one, watched by everyone, is a demonstration.
- Close the loop out loud: name which point of the model you would work first with that client, and say why you picked it.

DISCUSSION PROMPTS

- What is the last thing you told yourself before your most recent use? Not the reason: the sentence.
- Which point do you notice first: the thought, the feeling, the body, or already being halfway to the car?
- Whose voice do your automatic thoughts sound like?
- Name a thought you had this week that turned out to be accurate. What do you do with an accurate painful thought?
- What would change if a thought were just a thought and not a report on reality?
- If your body could talk before your head did, what has it been saying since you got here?

COMMON PITFALLS

- Teaching the triangle as a diagram and never running a live elicitation. Clients can draw it back to you by Wednesday and still not catch a single thought.
- Accepting 'I feel like a loser' as a feeling. Let that pass in session one and every thought record in 1.3 comes back full of feelings.
- Arguing with an automatic thought the moment it appears. Session one is elicitation only; disputing here teaches the group to stop reporting them.
- Drawing one-way arrows. Clients in protracted withdrawal will correctly conclude the model does not describe them.
- Implying the client thought their way into addiction. That reading is clinically wrong and reliably produces a walkout.
- Running the elicitation on the most distressed person in the room because their material is richest. Pick someone regulated: the demonstration is the point, not the depth.
- Dropping the physiology point to keep it simple. Physiology is where craving enters the loop, and 1.5 depends on it being there.

ASSESSMENT

Formative: Watch the card sort and the individual worksheet, not the discussion. The client who talks fluently about the model in group and then writes a feeling in the thought box has not got it, and that is the more common profile. Note who leaves the thought box empty: a blank box in session one usually means the thoughts are present and unspeakable rather than absent, and it is a better referral signal than a wrong answer.

Summative: Completed four-point worksheet on a personal episode, plus one caught-thought record brought to the next group and checked against the thought/feeling distinction.

BETWEEN-SESSION PRACTICE

Catch one automatic thought within an hour of it happening and write two lines: the situation in one sentence, the thought in your own words. One thought, not ten. A list assembled at bedtime is reconstruction, not catching.

CONNECTIONS

1.1 supplies the vocabulary every other session in this track assumes. 1.2 fills the thought box with the specific errors that precede use, and 1.5 works the behavior and physiology points for clients who cannot yet work the thought. The same four-point map is used in 4.1 to locate the window of tolerance.

1.2 Cognitive Distortions in Addiction and Recovery

DURATION	FORMAT	ASAM DIMENSIONS	PREREQUISITES
75 minutes	Psychoeducational group with structured practice	Dimensions 4, 5	1.1

YOUR ASSIGNMENT	
DELIVERED BY	Licensed clinician, or clinical staff trained in CBT working under supervision
BEFORE THE SESSION	Print the distortion reference card, one per client for the binder. Have slips of paper and a closed box for the anonymous permission-thought collection.
YOU MUST LEAVE WITH	Three of the client's own caught thoughts labeled with a distortion and a one-sentence rationale each, plus a written euphoric-recall correction that ends at the actual last scene rather than the highlight.
DO NOT	Do not let the group label each other's distortions. Labeling is a weapon in a room this raw.

PURPOSE

Clients leave 1.1 able to catch a thought and with no way to sort what they caught. This session hands them the taxonomy, but its real target is narrower: the permission-giving thought, which is the last cognitive event before use and the only one in the chain that is reliably interruptible. Everything else on the distortion list matters because it feeds that final step. Two other addiction-specific phenomena, euphoric recall and the abstinence violation effect, get equal weight here, because they are the mechanisms that convert a lapse into a return to use and clients almost never recognize either one while it is running.

LEARNING OBJECTIVES

Level	On completion, the client will be able to...
Remember	Name six cognitive distortions and give the addiction-specific example thought for each.
Understand	Explain how a permission-giving thought differs from a craving and why only one of the two can be argued with.
Apply	Label the distortion in three of your own caught thoughts from the 1.1 practice assignment.
Analyze	Trace one personal use episode backward to the permission-giving thought that closed the decision.
Evaluate	Assess whether a given negative thought is a distortion or an accurate appraisal, and justify the call.
Create	Write a euphoric-recall correction that narrates the full sequence through to the scene where the night actually ended.

MATERIALS Distortion reference card, one per client for the binder · Clients' caught-thought records from 1.1 · Slips of paper and a closed box for the anonymous permission-thought collection · Whiteboard; the play-the-tape-forward template drawn before clients enter · Blank index cards for the post-lapse sentence at the close · Pens

FACILITATION SEQUENCE

Time	Phase	What happens
0-10	Opening	Clients write their permission sentence on a slip at the door, unsigned, into the box. Read six aloud without comment. This sets the room faster than any go-round.
10-28	Teach	The distortion taxonomy against the reference card, then work three examples from the slips on the board. Card for the binder, board for their material.
28-44	Euphoric recall	Teach the edit, then run the tape forward with one regulated volunteer to the actual last scene of that night.
44-58	Abstinence violation effect	Lapse versus relapse first, then the attribution, then the shame loop. Clients write their own post-lapse sentence on a card.
58-70	Practice	In pairs, clients label the distortions in their own caught thoughts from 1.1. Circulate. Sorting only, no disputing this session.
70-75	Close	State the no-labeling-each-other rule for the rest of the week, assign practice, and check the room before releasing it.

Distortions Are Habits, Not Lies

A cognitive distortion is not a lie and not a delusion. It is a habitual processing shortcut that is partly true, arrives at speed, and gets applied to situations it does not fit. Clients need that in the first two minutes, because the word 'distortion' invites them to hear 'you are making things up,' and a client who feels accused stops reporting. The framing that works is bias rather than falsehood: the thought is one available reading of the situation that has been promoted to the only reading. Your job today is sorting, not correcting. Correcting is 1.3, and announcing that at the start stops half the room from bracing for a debate.

Distortion taxonomy with the form each takes in active addiction and early recovery

Distortion	What it does	Sounds like on this unit
All-or-nothing thinking	Collapses a continuum into two categories	'I drank Tuesday, so the whole month is blown.'
Catastrophizing	Runs to the worst outcome and stops there	'If I tell my counselor, I lose my kids.'
Emotional reasoning	Treats a feeling as evidence about the world	'I feel like I'll never get sober, so I won't.'
Mind reading	Assigns content to somebody else's mind	'Everyone in this group thinks I'm faking it.'
Discounting the positive	Deletes disconfirming evidence to protect the belief	'Eleven days is nothing. Anyone can do eleven days.'
Overgeneralization	Turns one instance into an always	'Every time I get close to someone, they leave.'
Should statements	Applies a rule and charges shame for the gap	'I should be over this by now. I should want it more.'
Labeling	Converts a behavior into an identity	'I didn't relapse. I'm a junkie. That's what we do.'

The Three That Do the Most Damage Here

Three cognitive events specific to addiction deserve more of this session than the rest of the list combined, because each sits at a decision point rather than in the background. Permission-giving thoughts close the decision to use. Euphoric recall supplies the reason. The abstinence violation effect converts a single lapse into a full return. Clients recognize all three on sight once they are named and almost none can catch them in the moment without practice, because years of use have made each one feel like clear thinking rather than craving. Work these on the board with the group's own slips, not with textbook examples.

The addiction-specific triad

Phenomenon	Mechanism	Sounds like	Counter-move
Permission-giving thought	Supplies the license the decision needs; always short	'I've earned this.' 'Just today.' 'I'll stop again Monday.'	Name it out loud as permission, then delay fifteen minutes
Euphoric recall	Replays the first twenty minutes and deletes the rest	'Friday nights on the porch. It was good back then.'	Narrate forward to the actual last scene of that night
Abstinence violation effect	Attributes the lapse to a fixed self, so the rest follows	'I already blew it. Might as well finish the bottle.'	Split the lapse from the identity; count hours, not streaks

Euphoric recall is a retrieval problem, not a motivation problem. The client is not lying about the good part; they are remembering a real twenty minutes with the following six hours edited out, and the edit is automatic rather than dishonest. The correction is therefore procedural: make them narrate forward past the good part until they reach the last actual scene of that night, which is the bathroom floor, the missed pickup, or the phone call to their mother. Marlatt and Gordon's abstinence violation effect runs the other direction. After a lapse the client attributes the slip to something fixed and internal about themselves, feels shame, and resolves the shame with the one thing that reliably ends it. The lever is the attribution, and it stays available for roughly an hour.

CLINICAL CAUTION

Two failure modes with this material and both are common. First, distortion labels become weapons: within a day of this session peers will be telling each other they are catastrophizing, usually to shut down something uncomfortable. Set the rule explicitly (you label your own thoughts, nobody else's) and enforce it in the next group rather than letting it slide. Second, not every dark thought is a distortion. A client who says their partner has left, their license is gone and their employer will not take them back may be reporting facts, and treating an accurate appraisal as a thinking error is both wrong and the fastest way to lose a room. When the evidence supports the thought, the work moves from restructuring to problem solving and grief. Say that out loud when it happens; the group is watching to see whether you will.

Facilitator script: playing the tape forward

"Give me the good part. The actual good part: where you were, what it looked like, why it worked. I am not going to argue with it."

"Now do not stop there. Keep going. What was happening at hour three?"

"Keep going. What was the last thing that happened that night? The very last scene, not the highlight."

"Say that last scene out loud, once. That is the part your memory keeps cutting."

"Next time the porch shows up in your head, your job is not to fight it. Your job is to finish the film."

Running the Practice Segment

- Collect permission sentences anonymously at the door and read them aloud. Anonymity gets you the real ones; a go-round gets you performances.
- Work board examples from the slips, never from the reference card. The card is for the binder.
- Have clients label only their own caught thoughts, in pairs, while you circulate and read.
- Expect at least one client to say all of theirs are 'all of them.' Push for the single hottest thought and one label.
- Dispute nothing today. Sorting and disputing in the same hour produces neither, and 1.3 has the procedure for the second.
- Close with the post-lapse round: everyone writes the sentence they say to themselves in the first hour after a slip. Those cards are 1.3's raw material.

DISCUSSION PROMPTS

- What is your permission sentence? Everyone has one and it is usually four words long.
- Whose voice gives you permission: yours, or somebody else's?
- Where does your euphoric recall stop? What is the scene right after the one you keep?
- What do you say to yourself in the first hour after a slip?
- Which distortion on this list would the person who knows you best

COMMON PITFALLS

- Letting clients diagnose each other. The list becomes a peer weapon inside twenty-four hours if the rule is not set and enforced.
- Treating every negative appraisal as a distortion. Some of what your clients fear has already happened, and calling that catastrophizing ends your credibility in the room.
- Running the tape-forward exercise on an already activated client. It reliably raises craving before it lowers it; use a regulated volunteer and