When Talking Won't Work: Implementing Experiential Group Activities With Addicted Clients

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Traditional talk therapy, particularly cognitive behavioral techniques, are often ineffective when working with addicted clients for many reasons. By tapping into the power of the group modality, experiential activities can serve as a powerful facilitator of insight and behavior change. The authors provide a brief review of the literature followed by the presentation of three effective exercises for groups of addicted clients.

Keywords: addicted clients; experiential activities; group process; group work; psychodrama

Experience is not what happens to a man, but what a man does with what happens to him.

—Chuck Knox
As quoted by Brown (2001)

Like many novice counselors, when I finished my initial graduate degree, I was excited to work with the myriad of struggling individuals that filled my case load. Trained in the generic application of cognitive-behavioral therapeutic (CBT) interventions, I found myself processing clients' experiences and trying to help them generalize their insights into effective lifestyle changes. It was not too far into my years as a clinician before I realized that traditional CBT-based talk therapy was not working for the majority of my addicted clients. With additional research, consultation, and supervision, I surmised

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that this was due to my inability to work with clients' ineffective cognitions and maladaptive behaviors when these in themselves served ulterior motives: namely to keep the addict "safe" from having to make any changes that would threaten the need for continued use of alcohol, drugs, or addictive behaviors.

Seeking more effective approaches to aid in my work with addicted clients, I was introduced to the applications of Prochaska, DiClemente, and Norcross' (1992) Transtheoretical Model of Change. Due to the defense mechanisms and faulty thinking (e.g., minimization, rationalization, and denial) common among addicted individuals (Miller & Rollnick, 2002), this Stages of Change Model proposes that up to 80 percent of clients are either unaware of their need for change (i.e., those in the Precontemplation stage) or when confronted with the need for change, are not ready to take the necessary steps to make it happen (i.e., those in the Contemplation stage). The model further proposes that insight and experiential therapies are most effective with clients in the Precontemplation and Contemplation stages, whereas CBT is useful for clients who are planning for, or making overt changes in their behaviors (i.e., those in the Determination/ Planning and Action Stages).

We have concluded that there is a lack of effective and ready-to-implement exercises designed specifically to use with this population: hence the purpose of this article. Before moving into the exercises themselves, it is first important to (a) explore some of the foundation upon which the exercises are based, (b) discuss the client populations for which experiential activities have proven useful, and (c) focus on the specific utility of these exercises with addicted clients. Following this brief literature review, we present three "tried and true" exercises that have been developed by experienced addiction professionals. Following each exercise, a list of process questions are offered, for as Mr. Knox noted in the quote above, it is not enough to simply facilitate an experience for clients: clinicians must effectively translate clients' insights into life-enhancing changes.

FOUNDATIONS OF EXPERIENTIAL EXERCISES

In a time of cognitive behavioral approaches and traditional talk therapy, experiential exercises are slowly coming into the forefront as an alternative way to engage clients in the therapeutic process. Whereas the authors note the long history behind the development of experiential exercises, it is our intent to cover but a few of the more prominent theories and techniques to help set the stage for the exercises we offer herein.

Experiential exercises have evolved from a variety of treatment and personality theories, to include psychodrama, Gestalt, play, and adventure therapies (Gerstein, 1999; Leveton, 2005; Rohnke, Tait, & Wall, 1997). Many of the concepts that formed the foundation for experiential activities stemmed from the early work of Jacob L. Moreno (1946), often noted as the founder of psychodrama. Moreno examined sociometry, the study of social relationships in groups, through such methods as psychodrama, social atom theory, and role theory, each of which shared a foundation in role plays. His expressions of creativity, spontaneity, and dramatic dialog opened new doors for the establishment of experiential learning (Moreno, 1969).

Stemming from Moreno's work, experiential learning has roots in many theoretical methods, each of which notes the importance of increasing clients' awareness of thoughts, feelings, and behaviors in the here-and-now context of therapy (Crocker, 1999). Drawing from Experiential Learning Theory (ELT), activities are used for the primary reason that experience plays the central role in the learning process (Kolb, Boyatzis, & Mainemelis, 2001).

Experiential learning has applications for the use of psychodrama, Gestalt, adventure, and play therapies. For example, psychodrama provides many opportunities for clients to develop self-awareness and personal empowerment through a variety of role-reversal techniques (Bannister, 2003; Casson, 2004; Dayton, 2005; Kellermann, 2007). Similarly, Gestalt therapy employs experiential activities to move clients toward an awareness of internal conflicts, a greater sense of self, and increased emotional expressions (Glickauf-Hughes, Wells, & Chance, 1996; Oaklander, 2001; Woldt & Toman, 2005).

Adventure therapy and adventure education provide many opportunities to use experiential activities to help clients develop interpersonal skills. According to Rohnke, Tait, and Wall (1997), the factors that most impact the learning processes in these therapies are those that result from the dynamics of group work. Adventure education is an integration of action and learning, with the goals of using group work to increase self-esteem, build trust, and facilitate problem-solving through outdoor experiences (Clements & Wagner, 1995). The experiential activities most often used in adventure education are those known as the "ropes course" (Carns, A., Carns, M., & Holland, 2001). A wide variety of high and low rope initiatives provide opportunities for groups to develop effective problem-solving skills, while at the same time learning how to cooperate and commit themselves to one another. Experiential counseling techniques, such as adventure education, can increase self-efficacy skills and build interpersonal skills (Moote & Wodarski, 1997), both of which are common goals of therapy.

Play therapy is another form of treatment that utilizes experiential exercises. Whether this takes the form of traditional play therapy for children, play therapy for adults, or play therapy used by adults for their children (known as filial therapy), experiential activities provide a safe avenue for clients to express and explore their thoughts, feelings, and behaviors (Garza, Watts, & Kinsworthy, 2007; Watts & Broaddus, 2002). In reviewing the concept of play as it relates to an expression of the imagination, the literature suggests that play therapy can be an influential treatment modality that encourages imagination, creativity, and spontaneity in clients through the experience of playful activities (Oaklander, 2001).

Having explored some of the origins of experiential activities and the therapies with which they are typically utilized, we now turn to a brief exploration of the client populations that have benefitted from their use.

APPLICATIONS OF EXPERIENTIAL EXERCISES

Experiential education has been defined as "learning by doing" (Lewis & Williams, 1994, p. 5). When applied to clinical settings, theorists and researchers have found experiential exercises to be beneficial when working with a variety of client concerns and in all therapeutic modalities, ranging from individual (Blatner, 2006; Daniel, 2007; Garcia & Buchanan, 2000; Gershoni, 2003; Malchiodi, 2008), couples (Casado-Kehoe, Vanderbleek, & Thanasiu, 2007; Leveton, 2005), families (Blatner, 2005; Gladding, 2005; Oxford & Wiener, 2003; Wiener & Pels-Roulier, 2005), and group therapy (Dayton, 2005; Ferris & Stein, 2002; Glass, 2006; Pica, Engel, & Welches, 2003; Carlson-Sabelli, 1998).

Perhaps the most often cited use of experiential activities has been in the group modality. For example, studies have pointed to the utility of experiential exercises with trauma survivors (e.g., Carey, 2006; Carlson-Sabelli, 1998; Ciotola, 2006; Glass, 2006; Hudgins & Drucker, 1998; Marvasti & Florentine, 2004; Toscani, 1998), with groups of clients struggling with various illnesses (Ferris & Stein, 2002; Greenstein & Breitbart, 2000), and with clients struggling to manage their anger (Pica, Engel, & Welches, 2003). Having briefly discussed the application of experiential activities with a variety of client issues and modalities, let us now focus on their specific use with groups of addicted clients.

Experiential Exercises with Addicted Clients

Among the variety of theoretical approaches to working with addicted clients, many note the value of using experiential activities

with this population (Dayton, 2005; Edwards, 1993; Gillis & Simpson, 1994; Koehn, 2007; Woodward, 2004). From cognitive-behavioral techniques, to systems approaches, to existential exercises, experiential components are an important part of many treatment paradigms (Litt, Kadden, Kabela-Cormier, & Petry, 2008; Longo, 2004; Miller & Guidry, 2001). One reason that experiential exercises are so powerful is because they provide a form of self-expression that goes beyond that found in traditional talk-therapy practices (Moreno, 2005). This is especially important given the internal struggle that is common among addicted clients: the struggle between the "addict" (which is characterized by resistance, denial, and other defenses that oppose change) and the "self" (which longs for liberation from the chains of addiction) (Nakken, 1996; White, 2007). Experiential activities allow the "self" to have an outlet for expression in a safe and supportive environment, while circumventing some of the "addict's" defense mechanisms (Longo, 2004). This is because experiential activities engage the affective and behavioral realms while bypassing the cognitive domain [from which irrational (i.e., defensive) thought processes emanate] (Dayton, 2005).

In addition to the self-expression allotted by experiential activities, another benefit is that these exercises provide opportunities for members of addiction recovery groups to interact in new and important ways. This is especially important given the noted impact of group therapy on the recovery process (Humphreys, 2004; Margolis & Zweben, 1998; Nerenberg, 2000; Plasse, 1995; Roth, 2004). According to Margolis and Zweben, group therapy provides addicted clients with the opportunity for personal growth through the receiving of direct feedback, the building of interpersonal skills, and the learning (or re-learning) of appropriate emotional expressions. These goals allow addicted clients to build upon strengths and develop the necessary skills that serve as powerful forces of change.

There are several additional benefits of group-based experiential exercises for addicted clients. For example, addicted clients can practice self-regulation in a non-hostile environment. Newly recovering clients struggle with many challenges, ranging from interpersonal-related problems to more global problems (Islam, 2005); they therefore need assistance with understanding the range of possible reactions to such challenges. Adams (2008) noted another benefit of experiential exercises when he described the addiction as the most important relationship in an individual's life. This relationship results in the addict losing a full range of emotional expression, an inability to self-regulate their reactions to events, and ultimately a loss of one's identity separate from that of being an "addict." Utilizing experiential exercises in a therapeutic setting has helped clients to self-regulate

their feelings and emotions by practicing hands-on techniques with other group members. This results in clients discovering who they are both separate from the addiction and in relation to other people. Similarly, in Klontz, Garos, and Klontz's (2005) study of the effectiveness of experiential therapy with sexual addicts, the researchers found that using psychodrama and other Gestalt modalities gave addicted clients the freedom to express themselves through the re-experiencing of significant life events in a safe setting, thus teaching them necessary self-regulatory skills.

Experiential exercises also provide addicted clients an avenue to build trust in a safe and supportive environment (Longo, 2004). Without such trust, addicted individuals tend to employ denial and defensiveness as they relate to others (James, Lonczak, & Moore, 1996). To move beyond these, Longo asserted that experiential exercises helped addicted individuals to develop empathy, practice interpersonal skills, and focus on trust building. Similarly, adventure therapy has provided adolescents struggling with substance abuse and other addictions the opportunity to learn how to trust themselves and other group members, thus aiding in the recovery process (Carns, Carns, & Holland, 2001).

Having noted the aforementioned benefits of using experiential activities in group for addicted clients, it is also important to note the *kinds* of activities that have proven useful. For example, Klontz, Garos, and Klontz (2005) used mindfulness meditation and art therapy exercises to help sexual addicts both reveal their unfinished business and reduce their experience of anxiety. Others have demonstrated the efficacy of using music therapy with substance abusing clients as a means to expressing emotions that had previously been suppressed with drugs and alcohol (Baker, Gleadhill, & Dingle, 2007; Jones, 2005). Similarly, Dayton (2005) studied the use of experiential exercises with addiction-related losses, finding that psychodrama was very effective at helping clients cope more effectively with their grief.

Finally, it is important to recognize the many reasons the group modality itself has such a mediating impact in the treatment of addictions. Several authors have noted these influences. For example, Hook, Hook, and Hines (2008) cited member benefits such as learning the necessary skills to avoid addictive disorders, recognizing the complexities of the addictive cycle, and forming strong relationships with others. Group-specific dynamics of mutual support, direct confrontation, and vicarious insight have also been noted (Kim, 2007). Additional benefits of the group modality noted by Bratter (2002) include structure, safety to try new behaviors, the implementation of positive peer pressure, and the creation of an environment where addicted clients can experience stressful life events and learn how to avoid

addictive drugs and behaviors as a means to cope. Finally, we have witnessed several impacts of the group modality on our addicted clients, to include the improvement of group member self-efficacy when viewing the successes of others; the reality testing provided by senior members to the junior members with overzealous expectations; and the development of authentic, congruent, and intimate relationships with people as a means to replace relationships with drugs, alcohol, or behaviors.

Whereas utilizing experiential group-based activities has become increasingly prevalent, there is little literature that outlines the specific techniques used, along with how and why these specific activities are meaningful and powerful with addicted clients. Novice and experienced clinicians alike are often looking for ready-to-implement activities with their addicted clients, something that will breathe life into a group that has become stagnant or reached an impasse. Recognizing this need, the authors dedicate the rest of this article to the description of such activities with the hope that they will offer readers exactly what they desire.

CROSSING THE SWAMP AND OTHER EXPERIENTIAL ACTIVITIES FOR ADDICTED CLIENTS

At the 2008 American Counseling Association national conference in Honolulu, Hawaii the International Association of Addiction and Offender Counselors hosted a panel discussion of clinicians and educators. These individuals were chosen due to their expertise in the practice and teaching in the area of addiction counseling. "Expert" status was established by (a) the highest degree earned (minimum of a master's), (b) the number of years as a clinician and/or counselor educator (minimum of 10 years), and (c) proficiency in topics related to addictions counseling (as demonstrated by a proven record of practice, research, service, and/or national presentations). Each panel member was challenged to bring his/her most prized group activity or exercise that had been successfully implemented in the practice of addiction group counseling.

The authors recognize that each activity offered herein may warrant its own manuscript that would provide a research-based rationale with empirical support; we respectfully submit that this was not the intention of the current article. Rather, given the aforementioned challenges to working with the addicted client population, we intentionally assembled some of the best and well-known clinicians and essentially asked them, "How do you do what you do?" The exercises found herein were their answers. Each expert agreed to share

their work with the broader audience of *Journal for Specialists in Group Work*.

In an effort to disseminate this information, the authors synthesized and adapted the work of these experts into a "ready to implement" format. As noted below, this format includes (a) the contributing individual and his/her professional affiliation; (b) the purposes, appropriate cautions, necessary materials, and set-up instructions; (c) a detailed description of the activity/exercise, and; (d) a set of questions that can be used to process the activity. The authors and contributing clinicians note the importance of readers practicing these activities with appropriate supervision and feedback before implementing them for the first time. This is especially important given that the intent of any experiential activity is to elicit a range of client emotional responses and behaviors—both of which need to be accurately processed and generalized to behaviors used outside of the group experience.

Crossing the Swamp: The First Year of Recovery

The following is an activity used by the lead author who currently works at the University of Central Florida. Adapted from a team-building exercise suggested by Butler and Rohnke (1995), it has been successfully used as an experiential exercise for clients (ages 12 and older) who struggle with addictive disorders, regardless of the stage of recovery. The goal of the *Crossing the Swamp* activity is twofold. First, it is designed to reinforce the 12-Step principles used in many treatment programs. Second, the activity facilitates an awareness of the importance of including other people as an integral part of one's recovery process.

Crossing the Swamp involves movement and balance: clients who are older, physically challenged, or unstable (e.g., in the early stages of detoxification) may choose to observe rather than participate. Even in observing, participants will have much to contribute to the exercise. The activity also involves touch, so if clients have concerns with being touched or touching others, they may choose to observe. Finally, appropriate shoes should be worn (i.e., heels and flip-flops may pose a challenge).

Materials and set-up. This is a two-part activity that can easily take between 90 minutes and 2 hours to complete and process. Groups of 8–12 work best, though it can be adapted for smaller or larger groups. For smaller groups, clients will have to double-up on some of the elements of the activity, whereas for larger groups, many can serve in observation and processing roles. For the sake of the description

provided herein, a group of 12 members will be used. In terms of the materials and set-up, group leaders will need to provide 12 legal-sized ($8\frac{1}{2} \times 14$ inches) pieces of paper (cardstock works best), markers of various colors, and a large room or outdoor space approximately 20–30 yards in length. In designating the space where the activity will occur, be sure to clearly mark the beginning and ending points. Finally, group facilitators should provide access (visual and/or auditory) to the 12-Steps, especially for those unfamiliar with them. This typically involves having clients gather around a wall-mounted poster of the 12-Steps for the first part of the activity.

Activity: Part One. Part one of this two-part activity begins with the group leader facilitating a discussion in which clients are encouraged to recognize how the 12-Steps, as well as other people in treatment, can aid them in their recovery. This can take anywhere from 30 minutes to an hour. Begin by asking for/designating 12 participants: each participant should be supplied with one piece of paper and two colored markers of their choosing. Assign one of the 12 steps to each of the participants (hopefully these steps will be hanging somewhere within sight). Each participant is to write their assigned step word-for-word on the piece of paper using one colored marker. Instruct them to write large enough so that the text takes up the entire page. Given that members of the group are likely recovering from various substances or behaviors, instruct the individual that is assigned Step 1 to insert the word "our addiction" for the word "alcohol" (if you're using AA's 12-steps as a guide). Each participant is then instructed to use the other colored marker to circle, underline, and/or highlight whatever words or phrases found in the step they feel will be important to their recovery process. For example, in Step 1 ("We admitted we were powerless over our addiction—that our lives had become unmanageable") the participant might underline "admitted," "powerless," and "unmanageable."

Once everyone has finished writing and highlighting their step, each participant does a mini-presentation for the group. This presentation involves reading the step out loud and sharing why he/she chose to highlight the words that he/she did. Others are encouraged to provide feedback about the importance of the concepts discussed. The facilitator can provide additional information as to the history behind the step, the purpose of each step, the intentional sequencing of the steps, the challenges found in each step, and the average amount of time that each step might take. For those unfamiliar with these topics, the reader is encouraged to read *Twelve Steps and Twelve Traditions* (AA Services, 2002) and/or Parker and Guest's (1999) *The Clinician's Guide to 12-Step Programs: How, When, and Why to Refer*

a Client. Following this discussion, participants are taken to the starting point of the experiential component of the activity.

Activity: Part Two. The second part of the activity is where participants will use the 12-Steps to cross the first year of recovery. This can take anywhere from 30 minutes to an hour. If there are time constraints or more time is needed, additional processing can occur in another group on another day.

Setting up this part of the activity includes several steps. First, have the group assemble along the start of the 20–30 yard expanse. A rope boundary, or something similar, can be used to designate the beginning and end of the "swamp." Next, share this with the group: "You are about to enter your first year of recovery. The only obstacle that lies between you and your one year anniversary is a large, alligator-infested, swamp. In order to cross the swamp, you will have to use each of the 12-Steps as lily pads and leap-frog across it as a group."

After setting the tone, continue with the following processes. Begin with stating, "The swamp will represent the challenges associated with the first year of recovery." Ask the group about what they believe some of those challenges might be. Responses might include old "using" friends, the neighborhood, challenging family members, difficult supervisors, bad moods, and unforeseeable negative circumstances. Next, tell the group: "Each of these challenges will likely be found in the first year of recovery and will be represented today by the alligators. The object is to make it to the end of your first year in one piece, and to do so with the help of your group members." The final piece of the set-up involves sharing with the group: "The pieces of paper that you hold in your hands are the lily pads that you'll need to leapfrog across the swamp. To successfully navigate the swamp, you'll need to use all 12-Steps and each other. Here are the rules."

Rules. There are several important rules that need to be shared with the group. The first rule is that everyone should participate safely. As the "director" of the activity, the facilitator will have the opportunity to shout "freeze" and at that point participants must freeze in whatever position they find themselves. If freezing will involve participants being placed in a precarious position, that would be an indication of a lack of safety. Other rules include (a) all participants must start and finish the activity together—no one gets left behind; (b) no part of the body may come in contact with anything other than the lily pad (e.g., if anyone's foot lands in the swamp, the group must start over); (c) participants can never lose

contact with a lily pad (i.e., each piece of paper has to have someone touching it at all times)—if contact is lost, the group must surrender it. At this point, the facilitator should give the group a few minutes to discuss how they plan to cross the swamp (i.e., don't tell them how to do it). Watch for how the various personality types emerge and how these affect the group's decision-making process. Store this information away for processing later.

After allotting sufficient time for planning (i.e., 5–10 minutes), tell and ask the group, "Your preparation time is up. How do you plan to cross the swamp?" Participants should demonstrate their plan (without entering the swamp). If the group is stuck or needs some re-direction, the facilitator can demonstrate how to lay one piece of paper down and have someone step on it: don't offer this solution too quickly. Finally, remind the group: "Be safe, don't leave anyone behind, and don't lose contact with your 12-Steps. You may begin."

Processing during the activity. At the beginning of the activity, be sure to pay close attention. Inevitably, someone quickly loses contact with one of the steps, be it because they simply throw it down on the ground and then step on it, or because the person behind does not place their foot on it quickly enough. The facilitator should take the piece of paper away from the group (be prepared to catch some grief) and ask the group: "What just happened at the start of your recovery?" Participants will likely blame the facilitator for taking away their step or blame someone else for not paying attention. Ask the group, "How does this relate to your first time entering recovery?" Look for responses such as "We blame others for our mistakes," "We think that we know what we're doing," "We want to speed through to the end and ignore the here-and-now experiences," or "We want to cut corners and do it our way." This can easily lead into a brief discussion (or this can be saved until the end of the exercise) about what occurs to many people around the 30 day mark of their recovery. Insightful comments might include, "People want to do it the easy way," "People think that they know the best way to recovery without looking around themselves for evidence to the contrary," or "After 30 days people think they've 'got it beat': then they end up drinking/drugging/behaving again to prove to themselves that they're cured and then realize that they aren't."

After getting the group to resume the activity, the facilitator should be watchful for several things. First, participants will inevitably lose contact with one (if not several) of the steps throughout the activity: add each one to the steps that have been collected. Next, the facilitator is encouraged to allow one of the group's losses, and/or

allow for someone's foot to step into the swamp, to "slip" past his/her attention (i.e., pretend to not see it). Then, at some point, stop the group and ask: "Have we talked before about how honesty is the foundation of recovery?...If we're going to work an honest first year of recovery, what has to happen if we quote 'break the rules'?...Does anyone want to share something that they've noticed about how honestly we've been in crossing the swamp?" At some point (and admittedly this may result from the author's need to play the devil's advocate), the facilitator should stand close to those that are participating and offer to pass one of the steps forward. As soon as someone hands you a step, announce to the group that they have lost another step and halt their progress (expect to catch some major grief at this point). Ask the group, "How does this relate to what might happen during your first year of recovery?" Typical responses might include "People may try and sabotage your progress, even those you trusted," "Your sponsor, or someone you depend on, may start 'using' again," or "You cannot place the total success of your recovery on only one person—it takes a group of supportive people."

At several points along the route through the swamp, the facilitator should stop the group (by announcing "freeze") and process their experiences. The first point to process is at the beginning (the first month of recovery). The next break should occur approximately one-third of the way through the swamp. Ask the group (and/or the observers) about the progress that is being made. Follow up by having them discuss what might help the group to move forward more effectively. Note such things as the communication that is occurring (or not), the physical touch that is occurring (or not), and process these at the end. The third place to halt progress is at thee mid-way point. The facilitator should encourage the group with noting the good progress that is being made and then ask how they are feeling individually and/or collectively (and relate these to those feelings of someone at the 6 month mark of recovery). Typical responses include: "I'm feeling pretty confident," "We're gonna win," "This is getting easier," or "I wish that we could go faster/slower." The final place to interrupt the group's progress is after the first couple of people reach the end of the swamp. Participants will typically start celebrating early, will lose contact with the steps, and/or not serve as an encouragement to those still in the swamp. The participant can ask the group, "What might happen if you're not careful at the one year mark of recovery?" Responses such as "I want to celebrate my accomplishments: maybe I should try 'just one beer' to see if it still affects me," "I want to believe that I have this thing under control and might stop paying such close attention to my recovery," and "I get focused on my own successes and forget about those that have been important to my recovery" are

common. Once everyone has crossed the swamp, encourage them to give themselves a round of applause.

Process questions. In addition to the questions that were offered above to process the participant's actions and reactions as they occurred during the activity, the following are a list of questions that can be used to generalize the learning that occurred.

(a) "What happened (exactly)?" Get everyone to share something specific about what happened during the course of the exercise. Be very concrete and specific (e.g., "Eric started out with all the lily pads and lost the first one. Then Sharnee . . .").

(b) "What did you/the group do in order to successfully traverse the first year of recovery?"

(c) "What did you/the group do that interfered with your success?"

(d) "Which of the 12-Steps were you able to keep?" Have each person read one of the steps that the group held onto and explore why that step would be important to retain. This can move into a discussion about what might happen if they avoided or forgot to "work" that specific step.

(e) "Which of the 12-Steps did you lose?" Read each of the 12-Steps that you were able to secure. After each one, explore why that step might be a challenge and why someone might want to forgo it. Ask about consequences to avoiding or loosing that step.

Additional questions to process what occurred during the activity include:

(a) "What happened to the level of communication as you traversed the swamp?"

(b) "What happened to the amount of touch that occurred in the group? What is touch all about? Why are some people reluctant to touch (this can be physical or emotional touching)?" This can lead to a discussion about the difficulty people have with asking for/reaching out for help.

(c) "At the beginning and throughout, various people took on various roles of responsibility whereas others stayed in the background. How does the role that you took today compare to the role you assume in your life? Will this help or hinder your recovery process?"

(d) "What happened when I (the facilitator) took away one of your steps? What does this say about placing total reliance for your recovery onto one person (be it your therapist, sponsor, family member, friend, etc.)? What is a better approach?"

(e) "What happened at those points that I stopped you (the beginning, 1/3 of the way, mid-way, and the end)? What might be some things that you'll need to be aware of at these points in your recovery?"

(f) "What does all this information mean to your recovery?" This can be asked as a follow-up question after any of the above questions or can saved until the end.

(g) "What can you take from this experience to make your first year of recovery a successful one?"

The contributing author notes that this activity has never failed to (a) strengthen the cohesiveness of the group that engaged in the activity and (b) engender insight with accompanying behavior changes among his addicted clients.

Roadblocks to Recovery

The following sand-tray based activity was contributed by Joseph "Chip" Cooper from Marymount University. Adapted from an activity by Matto, Corcoran, and Fassler (2003), this activity is appropriate for adolescents and adults who become "blocked" in their recovery (e.g., for clients who struggle to stay clean and sober, who have experienced a relapse, who have difficulty setting boundaries with drug-using friends, etc.). The goal of this exercise is to help participants make their "roadblocks" more tangible so they can experience them, share them, experiment with them, change them, and learn from them. Facilitators are cautioned to be aware of how the activity may impact clients who can easily decompensate (e.g., those suffering with schizophrenia). Some of the miniatures used with the sand tray (death symbols, dragons, and witches) may trigger emotionally labile clients. If these clients are a part of the group experience, the threatening figures may be removed. As with all activities offered in this article, specialized training (in this case in such areas as play and/or fililial therapy) is suggested if one plans on using these activities as a permanent part of the therapeutic services offered.

Materials and set-up. Given the nature of this activity, several materials are needed that can become a permanent part of the tools utilized in the reader's setting. Obviously, a sand tray is important. These wooden structures are usually 20 inches wide × 24 inches long × 4 inches deep, but any similar sized container (e.g., the long plastic storage containers that can be purchased in many locations) works well. Next, enough play sand is needed to fill the tray two inches deep. Finally, a wide assortment of miniature objects is needed. These objects should represent all aspects of life, to include people, animals, plant life, natural objects, mythological figures, machines, various symbols, and others. If it is not feasible to purchase/store a sand tray and accompanying materials, an alternative would be to provide paper and crayons/pencils/markers of various colors: clients can use this medium to participate in the activity.

Not much set-up is needed for this activity. Other than placing the sand tray in the middle of the room prior to the group members entering, the miniatures should be set to one side of the tray. If clients

will be drawing for the exercise, then the drawing materials (paper, crayons, erasers, pencils, etc.) should be easily accessible.

The activity. Before moving into the activity, the facilitator should begin a discussion of the possible roadblocks to recovery. This would likely occur by asking group members to briefly share some of their own experiences and examples of the roadblocks they have encountered at various points of their recovery. Next, group members would be invited to participate in an experiential exercise that will help them to find creative solutions to better manage their roadblocks. The facilitator should share, "We are going to use the sand-tray and the miniatures to create a 'picture' or 'story' that best represents the roadblock that you are struggling with at this time."

The activity begins when the first participant volunteers to create a "picture" in the sand of his/her roadblock (agreeing to process this experience with the group). The facilitator should keep the member focused on a roadblock with which he/she is *currently* struggling. (Note that all members do not have to create a scene: it should be their choice to participate or not. It is just as powerful an experience for those who choose to observe). If several group members want to volunteer, the group can decide the order that they will go.

The first participant to create the scene of his/her *Roadblock to Recovery* in the sand is instructed to use the miniatures in whatever way they choose. Individuals can use the figures in literal (e.g., a male miniature to represent a father figure) or abstract (e.g., a lion to represent a force with which to be reckoned) ways. The time allotted to the creation of the scene should be dependent on the group member; if external time constraints are a factor, these should be explained before the person begins. Once the participant has created the scene, ask him/her to describe the scene to the group and what it means in regards to his/her recovery. Many interesting details about the group member and his/her recovery process will emerge; the facilitator should be inquisitive and ask questions about the scene (e.g., "Who is this figure, what does it represent?", "Why is this figure placed so far away?", and "What does this figure need right now?"). Allow the other group members to ask questions and/or to give feedback about what they see. It is important to stress that no interpretations should occur, neither from the facilitator nor from the other group members.

Once the group has processed the initial scene, the participant is encouraged to change the scene in such a way that would depict a solution or resolution to the roadblock. Prompts such as "What needs to happen to create a positive change?", "Do you need to introduce new figures to the scene?," "Do you need to take something out of the

scene?" and "Do you need to change the positions of any of the figures?" can help someone who is unsure of how to proceed. After the participant has made his/her desired changes, he/she is asked to describe what has changed and how this change will facilitate his/her progress through the roadblock. Often many implicit strengths and resources will emerge, so it is important to "ground" the learning by inquiring how the participant might transfer these insights into the real "here and now" world of recovery.

Finally, to further ground the awareness of the participant's strengths and resources (as well as to improve the group's cohesion), encourage each observing member to choose one miniature that they feel would provide some additional strength or resource (e.g., a healing symbol) to help the participant to overcome the roadblock that was portrayed in the original scene. Once the other members have chosen the miniature and explained why they feel it would be a helpful image, they should place that miniature in the sand along with the initial participant's "scene." Out of respect for the participant, members should not alter the original scene in any way; rather, they should place their miniature unobtrusively in the sand tray. Process this part of the exercise with the participant by asking "How will you carry and use these additional strengths offered to you?" Repeat the entire process over again with each group member who desires to participate until all members have completed the activity.

Process questions. Given that the goal of this exercise is to help participants experience, share, experiment with, change, and learn from their roadblocks, each of these should be processed. One method is to use the "what," "so what," "now what" series of questions. "What" questions ask participants to explain concretely what occurred during the sand-tray experiences. "So what" questions address meaning: "How does what happened during the exercise relate to your recovery?" Finally, the "Now what" questions are directed toward application: "With what you've just learned, what do you need to do to avoid/circumvent/address the roadblock when it appears in your life?"

The facilitator can close the activity by taking a photograph of the sand tray and giving the picture to the client to take with away with him/her, thus "grounding" the experience. Finally, if drawings were used instead of the sand tray, members can draw a picture of a strength or support for those clients who presented their roadblocks. These pictures (either those from the camera or those drawn by clients) can then be taken home and placed on the refrigerator or mirror to serve as a reminder of clients' strengths and commitment to the recovery process.

Navigating the Blind Maze of Recovery

Ed Brand, from Florida State University, created an activity to help adolescents and adults to apply well-known recovery slogans to the realities of their lives. This exercise has worked well for a variety of clinical concerns and is appropriate for the different developmental levels of recovery. Given that the activity involves clients being blind-folded, facilitators should be cognizant of the possible impacts of this on those clients who have experienced such things as rape or other traumatic losses of control.

Materials and set-up. The Blind Maze requires little in the way of materials: blindfolds, chairs, several lengths of masking tape, and a large room are all that are necessary. Scarves or cut pieces of fabric can serve as the blindfolds. Folding or stackable chairs work best as they can be easily moved and manipulated; approximately 25–50 chairs are needed. Tear off nine pieces of tape approximately 3 to 4 feet in length and set them aside. Finally, whereas a 50 by 50 foot room would be ideal for this activity, tighter mazes for smaller rooms may be constructed. (Note: it is possible to use masking tape or lengths of rope to set up the maze along the floor if chairs are not available).

Now that the materials have been gathered, it is time to create the maze. This is done by placing the chairs next to one another with their backs toward the area in which the group members will be walking. Leave approximately three feet between the chair backs (chairs are represented by the letter "h" in Figure 1). Lay out a maze-like struc-ture using the chairs, providing enough twists and turns (and even some dead-ends) to make it challenging (see Figure 1). At three spots along the maze, lay a length of tape across an area that members must cross. Label these areas as "crisis points." Finally, clearly mark the beginning and end of the maze. You are ready to begin the activity.

The activity. Ideally the group (12–15 members works best) will meet somewhere (e.g., the "prep" room) other than the room where the maze has been created so that they cannot anticipate the challenge set before them. Before moving into the maze room, the facilitator should open with a psycho-educational discussion about how the task before them will be similar to what it is like to begin a new life of recov-ery. This new life can be exciting (ask the group members what would make it exciting for them) as well as scary (again, prompt discussion). The pre-activity discussion would finish with the facilitator impress-ing upon the group the need for an intentional plan for their trip through recovery, one that includes both a guide (i.e., a sponsor) and a connection with fellow travelers (i.e., a support group).
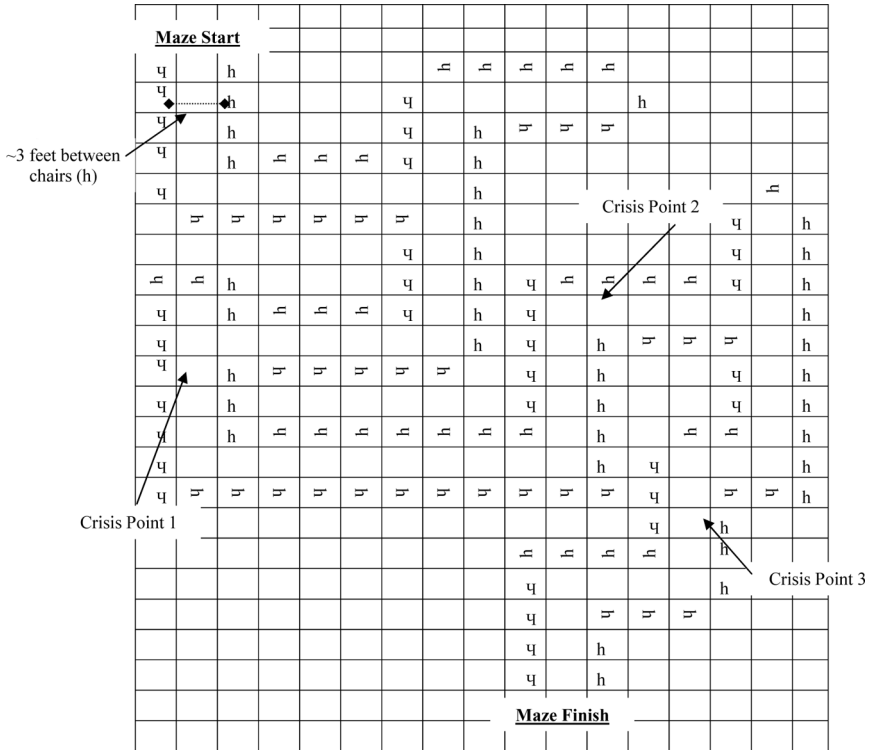
Figure 1   Setting up the Maze.

The rules are next shared with the group members. First, the group should be split into three smaller groups of equal size—be mindful of the subgroups that may have already formed in the group and use/split these as needed. Designate who will be blindfolded first, who will serve as the guide, and who will observe. Given time and at the facilitator's discretion, members can experience each of the various roles. Each sub-group should enter the maze on their own while the other sub-groups wait in the "prep" room.

Members are told that the blindfolded individual will need to traverse the entire maze solely with the vocal help of the guide. Another rule to share is that when the blindfolded member reaches any of the three taped off points in the maze (designated as a "crisis point"), he/she must correctly answer a question posed by the facilitator before breaking the tape and moving forward. Whereas members are given the instruction that only the guide can assist them through the maze, they are not informed that they may utilize their other group members to answer the questions that are posed at the crisis points.

In order to add a little competitive spirit to the activity, the next set of rules involves the number of points that can be accrued. The only time a team loses points is when the blindfolded member touches the maze (i.e., a chair). Teams gain (a) one point each time the blindfolded member stops and asks the guide for assistance, (b) one point for each "crisis point" question answered correctly by the blindfolded member (but five points if he/she asks for help from the observers on team), and (c) one point if the blindfolded member receives help from an observer without asking for such assistance. (Note: whereas the blindfolded member may receive help from the observers, he/she must be the one who actually gives the answer to receive the allotted points). The group at the end with the most points "wins" (the facilitator should designate some sort of reward beforehand).

The three designated "crisis points" are created to represent those times in recovering addicts' lives when they are faced with a dilemma that causes them to slip into addictive thinking, the result of which will lead to a relapse if they do not rely on newly learned coping mechanisms. It is at these taped-off areas of the maze where the blindfolded member must stop and answer a question, the aim of which is to focus them on imbedded recovery slogans. The following is a short list of possible questions that can be posed by the facilitator:

(a) What does the acronym H.A.L.T. mean? How does it apply to your recovery?
(b) What does the phrase, "No major changes for one year" mean?
(c) What does the phrase, "Every relapse is planned" mean?
(d) What does the phrase, "Our sickness is between our ears" mean?
(e) What does the phrase, "There's no one too dumb for this program, but it's possible to be too smart" mean?
(f) What does the phrase, "Your mind is out to get you" mean?

Additional questions can be generated as they evolve out of whatever has been addressed up to that point in the members' treatment program. Remember that the blindfolded member may receive help from the observers to answer these questions, but this fact is not shared at the outset. Once the question has been answered correctly, the member is instructed to break the tape and proceed through to the rest of the maze.

Process questions. Whereas most everyone has a fun time traversing the maze, the real learning occurs during the post-activity follow-up discussion. To begin, each member that participated would be encouraged to share what his/her experience was like. Be sure to explore each role (blindfolded, guide, observer) and how they felt in each role. If they had been in a different role, what would they have

done differently? Next, be sure to note those who became upset at their guides/team and relate this to an individual's tendency to (a) "assume one knows the best answer" and/or (b) "blame others when life does not turn out like I expect." Finally, process the experience for those who got so frustrated that they moved chairs (and/or quit). Ask what prompted these behaviors and relate it to how they may approach their recovery. These questions can easily move into a discussion of the coping skills that need further development for each group member.

Finally, process the various elements of the activity. Such questions might include:

(a) "What did touching the chair symbolize?" Possible answers might include coming in contact with old "using" friends, driving past locations where one used to drink/drug, falling to a temptation, or the actual use of an addictive drug or behavior.
(b) "What were the 'crisis points' about, to include the tape and the time where you had to answer a recovery question?" The "crisis points" were explained above, but hopefully members will recognize that the tape was nothing but a superficial barrier that could easily be broken through with enough forward momentum. This might symbolize clients' tendencies to "catatrophize" their experiences, when in reality all that is required is an honest evaluation of what is occurring in their lives. Members should also discuss what the posed questions caused them to do (i.e., focus on their coping mechanisms, reach out for help, etc.).
(c) "Why did the blindfolded member have to provide the answer to the questions that were posed?" Possible answers might include the need to own one's answers, avoid codependent relationships, and to accept responsibility for one's recovery.

The facilitator should allot at least 45 minutes to process this activity, focusing on the generalization of one's experiences to a life in recovery.

To conclude, one might use this activity as a pre- and post-evaluation of the skills learned in a treatment program. That is, if clients all start a treatment program at the same time, they might participate in the Blind Maze at the beginning of the program, see how much time it takes and the feelings/behaviors that evolve, and then traverse the maze toward the end of their program and compare the results. Newly developed skills (e.g., communication, relationship, anger management, coping) should be evident and solidified.

CONCLUSIONS AND FUTURE DIRECTIONS

The authors would like to reiterate several points. First, we assert that experiential group activities are the "gold standard" for working

with addicted clients. These activities (a) increase group cohesion, (b) by-pass the defense mechanisms and ineffective thought processes common to addicted individuals, (c) meet clients "where they are 'at'" in terms of their stage of change, and (d) offer creative right-brained opportunities for clients to explore their feelings, motivations, and insights as they relate to their past experiences, current ineffective coping mechanisms, and the development of more adaptive problem-solving strategies.

Another important point is that whereas these activities are outlined in such a fashion that they are ready to use with groups of addicted clients, clinicians should take all the necessary pre-cautions in order to implement them in a competent fashion. Given the active nature of these activities, as well as the affective nature inherent to experiential exercises, counselors should be ready to (a) facilitate clients' strong emotional expressions, (b) set appropriate rules and boundaries for group members' beha-viors, (c) intercede when it is deemed necessary (e.g., should a client's personality disorder become a concern), and (d) examine one's own emotional and/or cognitive reactions to what occurs during an activity.

The authors also note that future research should be directed at providing empirical support for how well these (and other) activities facilitate client growth and/or goal attainment. For example, whereas the first author has used the *Crossing the Swamp* activity for several years as a means to demonstrate the utility of the 12-steps as an important part of the recovery process, it might be important to assess how effective this activity is in attaining this goal over another method, say a purely psycho-educational approach. Data gathered through such an endeavor may lead to improved treatment protocols, thus resulting in enhanced client outcomes.

Finally, the last piece that warrants restating is that readers are highly encouraged to practice any new exercise/activity before using it with clients. This would include requesting supervision and/or feedback from other colleagues. It may also include seeking addi-tional training in some of the techniques and therapies that we reviewed in the literature review (e.g., psychodrama, play therapy, art therapy, etc.). This will help guarantee that counselors are ade-quately prepared to (a) facilitate an activity for a group, (b) accu-rately process the events that occur, and (c) generalize what happens in group to the real world of clients. For it is in this way that addicted clients will be motivated to move from a lack of aware-ness (Precontemplation) to awareness without change (Contempla-tion) to active involvement in the changes necessary to improve their lives.

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