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This manual was developed as part of NIDA Grant DA06162,  
*Improving Drug Abuse Treatment for AIDS-Risk Reduction (DATAR)*.

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Institute of Behavioral Research  
Texas Christian University  
P.O. Box 298740  
Fort Worth, TX 76129  
(817) 921-7226  
(817) 921-7290 (FAX)  
Email: [ibr@tcu.edu](mailto:ibr@tcu.edu)

August, 1993

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## “Growing” Maps in Group Settings

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In this chapter you will find examples of actual maps drawn during group counseling sessions in an outpatient methadone treatment center. All of the clients involved had previously been shown maps and the link system; none were seeing the system for the first time (see Chapter 4 for basic “map training” for clients).

Since these maps were drawn in two sessions (each taking about 60 minutes), much of what was said is necessarily omitted from the following brief protocols. We have reconstructed key elements of the sessions to give a general idea of how maps “grow” in sequential stages during the course of group interaction. In addition, after each map is presented in its final form, we will add some comments about the mapping process.

### Mapping can be used in group counseling to

- ❖ show—visually—that group members’ own ideas can be organized and combined to help them deal with common problems,
- ❖ provide a springboard for further discussion and elaboration,
- ❖ help maintain the focus of discussion,
- ❖ produce an on-going record of the group’s interaction that can be used in later thinking and discussion about this topic, and
- ❖ provide a basis for **“shared ownership.”** That is, seeing one’s own ideas integrated with those of others can create or intensify
  - group cohesion,
  - motivation to participate, and
  - acceptance or internalization of ideas (contributing to a set of ideas can lead to a feeling of “owning” the whole set).

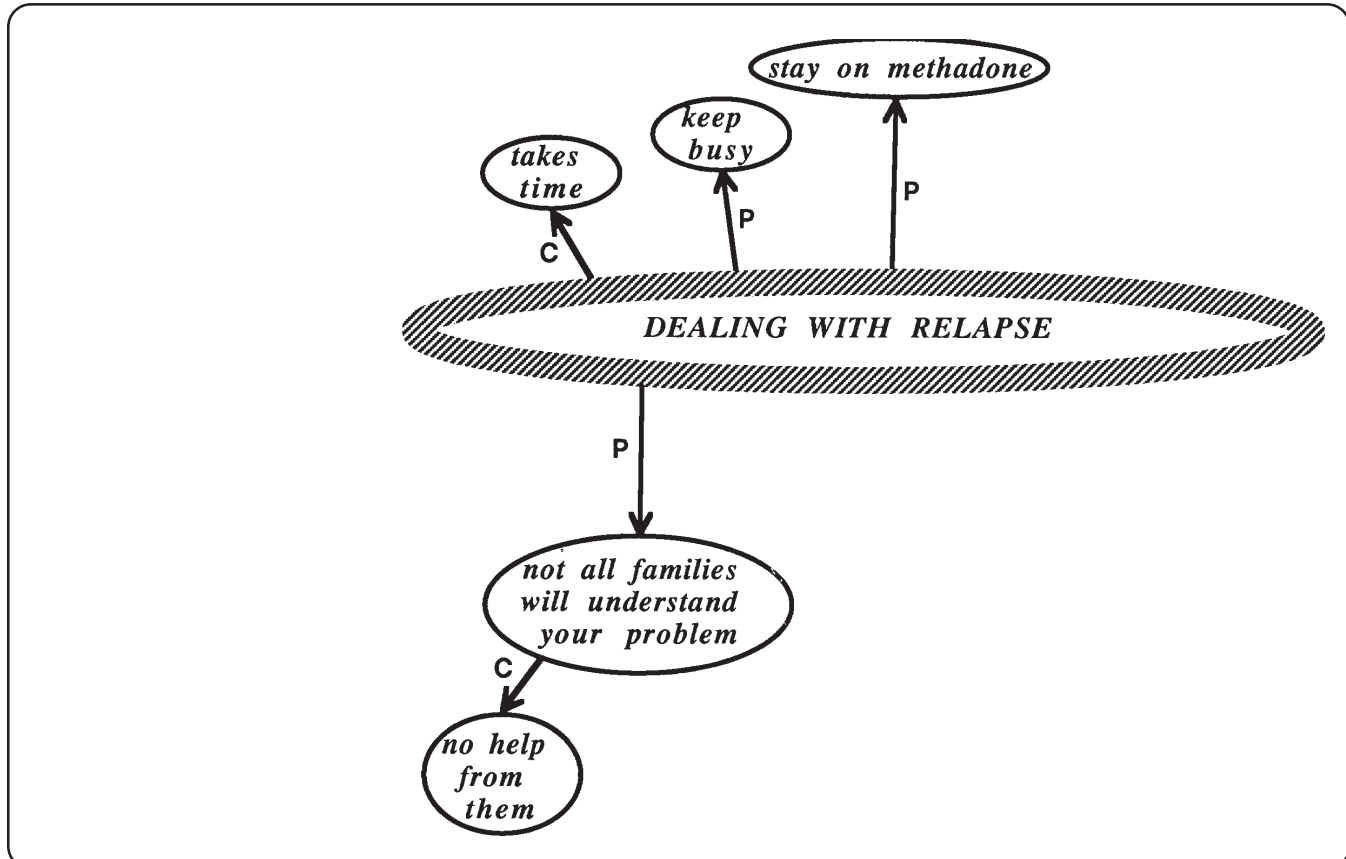
## Group Session Example #1

Seven clients are participating in this discussion; all have histories of drug addiction but are currently drug-free. Each has had approximately 3 minutes to share immediate concerns with the group. From what has been said, the counselor realizes that in the past week each client has experienced some fears about relapsing.

**Counselor:** **It looks like relapse is a pretty hot topic right now. So let's talk about how you would deal with a relapse.**

[The counselor begins by asking Jim how he would deal with a relapse. The discussion goes on for several minutes before the counselor walks to the chalkboard and draws the central node of a map labeled, "Dealing with Relapse."]

**Counselor:** **Let's map what we've discussed so far. You've said that dealing with a relapse takes time, you have to stay busy, you have to stay on methadone, and family members may not understand your problem and may not help you.**



Group Session 1 — Map 1.

**Counselor: What else is important here?**

Joe: You got to accept that you need help.

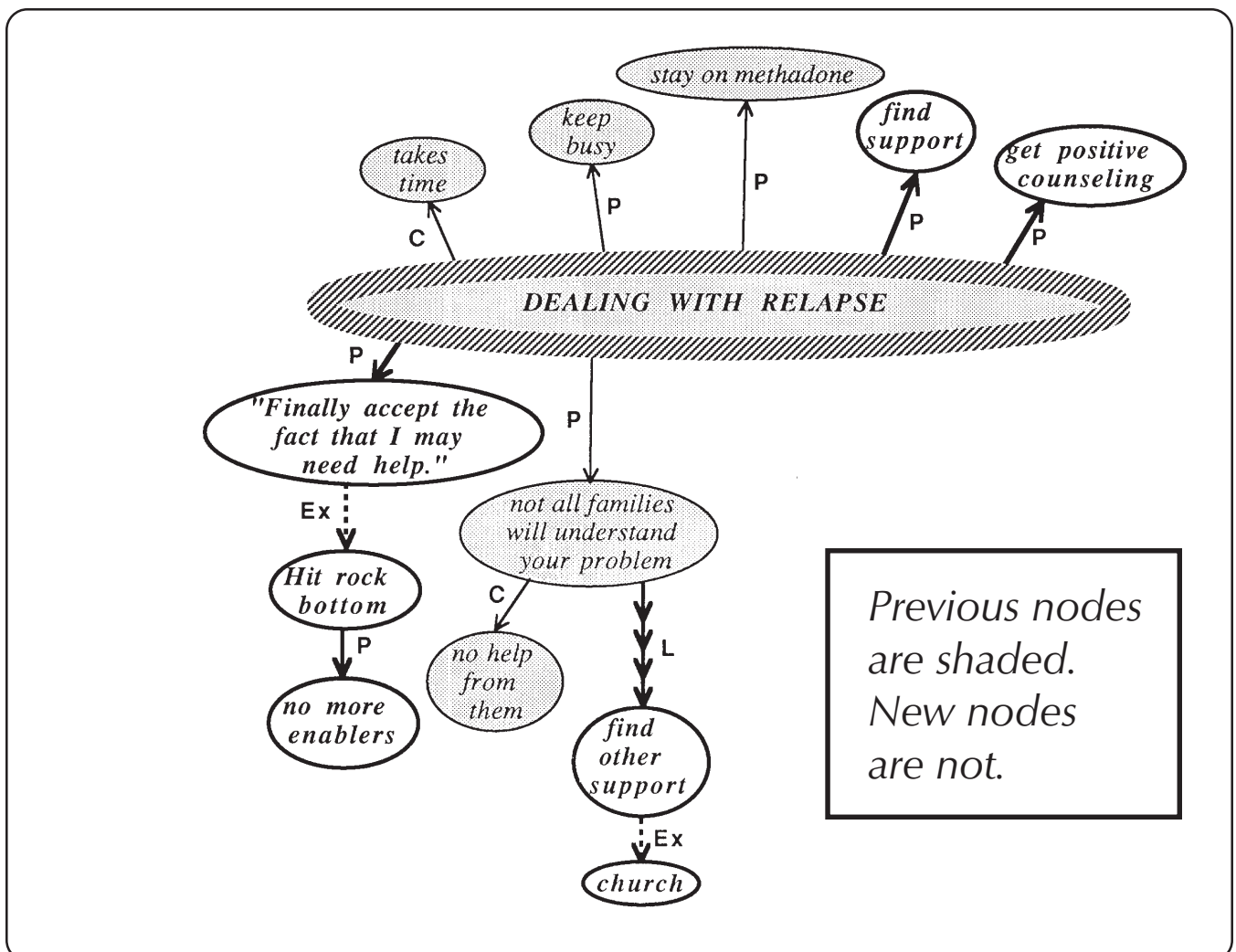
Gina: Yeah, When you hit bottom and can't con anybody into helping you up, you figure out that you need help. Maybe not till then.

Sam: Go to your counselor and talk it over.

Jim: When your family kicks you out, find somebody who's been through it to talk to and support you.

Kayce: When my father told me to hit the road, a person in our church helped me . . . got me a place to stay.

[For the next 15 minutes there is talk about potential support systems. The counselor adds to the map, occasionally asking "Have I got this right? Is this what you mean?"]



Group Session 1 – Map 2.

[The discussion shifts . . . ]

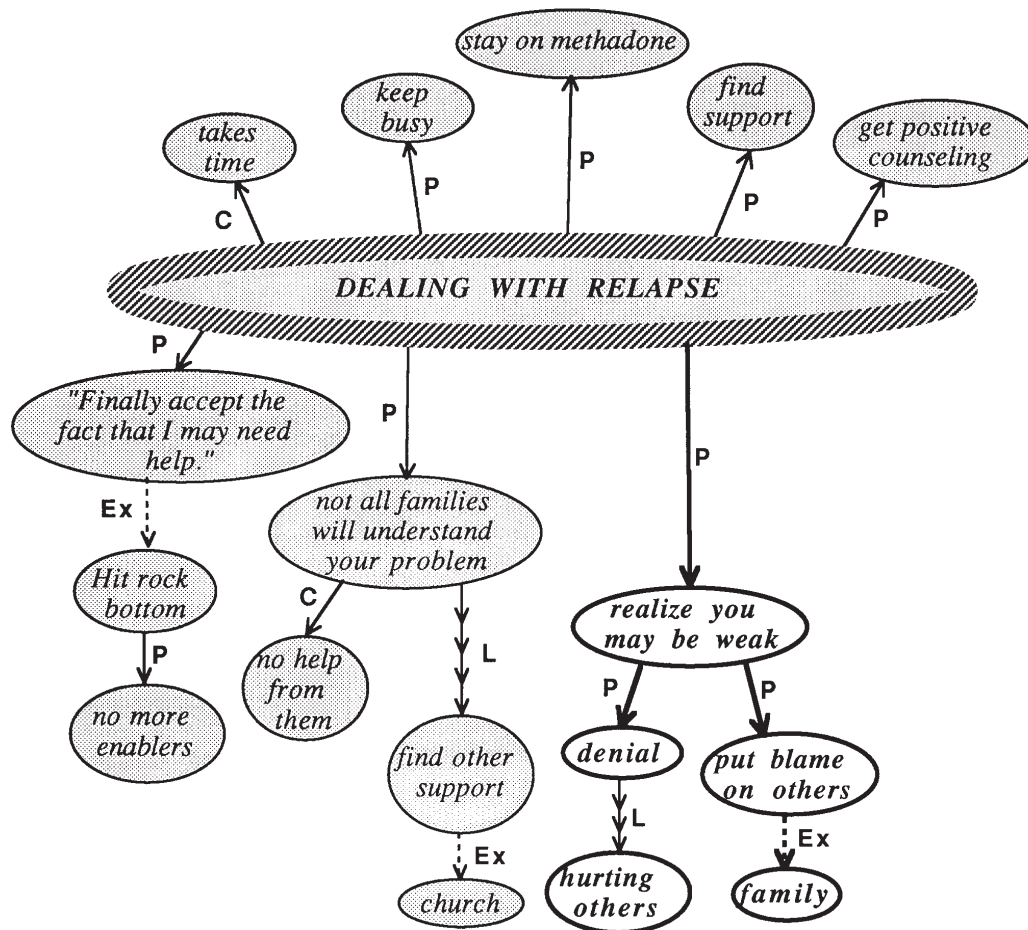
**Counselor:** What feelings come up when you think about a relapse?

*Jim:* I'm weak. I have to know that I'm weak. I'll say I don't have a problem and blame everybody else, like my family. I know I hurt people.

*Stella:* That's right. The first thing I do is say it don't mean anything—that I slipped a little. Then I tell my kid that he made his momma do more dope because he screwed up at school.

*Hank:* That's DENIAL, man. That's denial. You just don't want to admit you're doing it again. But even while you're not admitting it, it hurts.

**Counselor:** It hurts you and it hurts others. [Referring to the chalk-board . . . ] Is this what you're saying here?

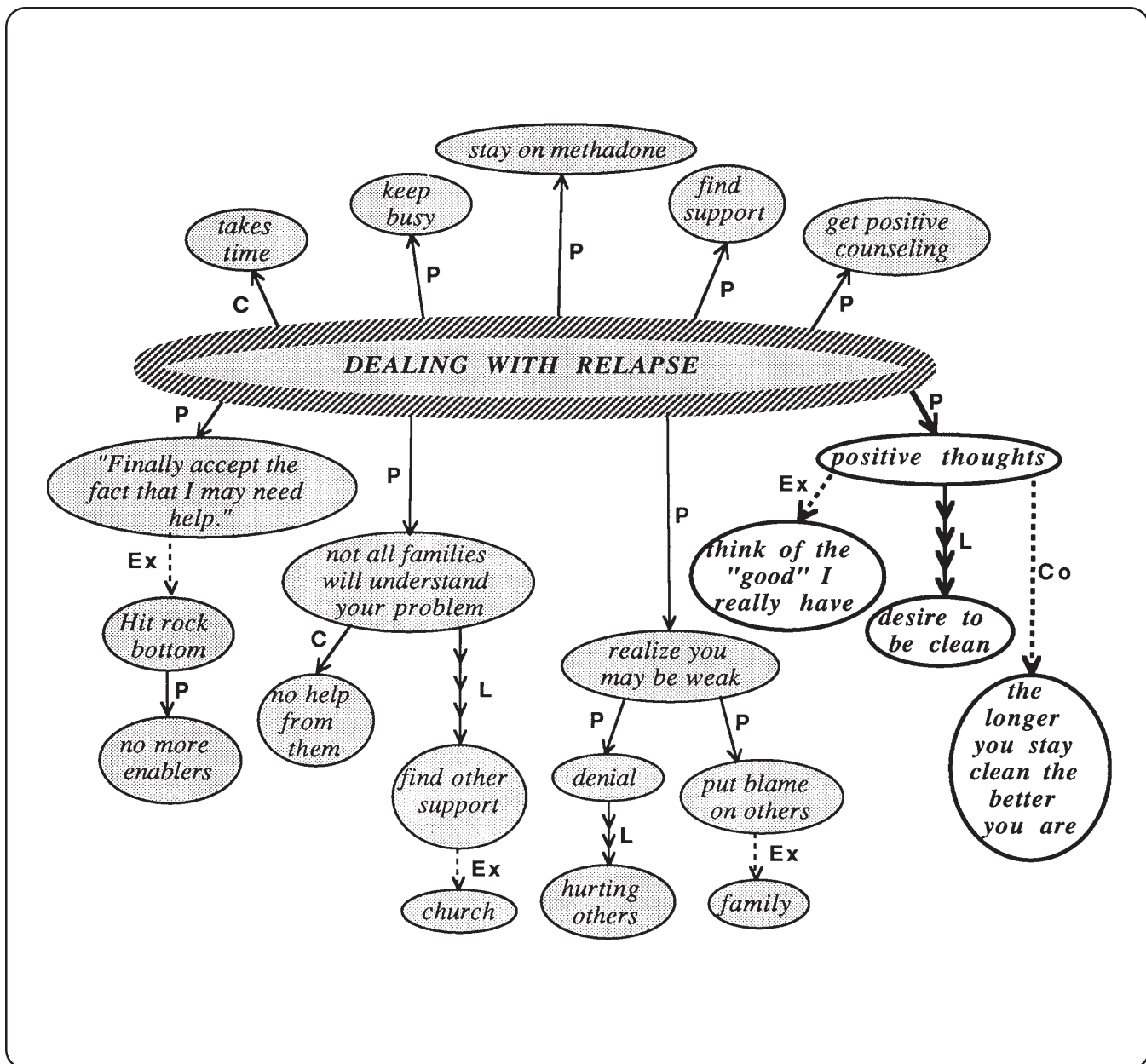


Group Session 1 – Map 3.

**Counselor:** Are there any positive things that can come from a relapse?

*Hank:* What goes on in my own head is really important. If you think negative all the time you won't make it. You got to have positive thoughts . . . got to think about the good things you've got going for yourself. That's what makes you want to stay clean.

*Jim:* Yeah . . . like I stayed clean longer this last time. I ain't Mr. Wonderful yet, but I'm better than I was.



Group Session 1 – Map 4.

**Counselor:** Let's look at this map and see what we have.

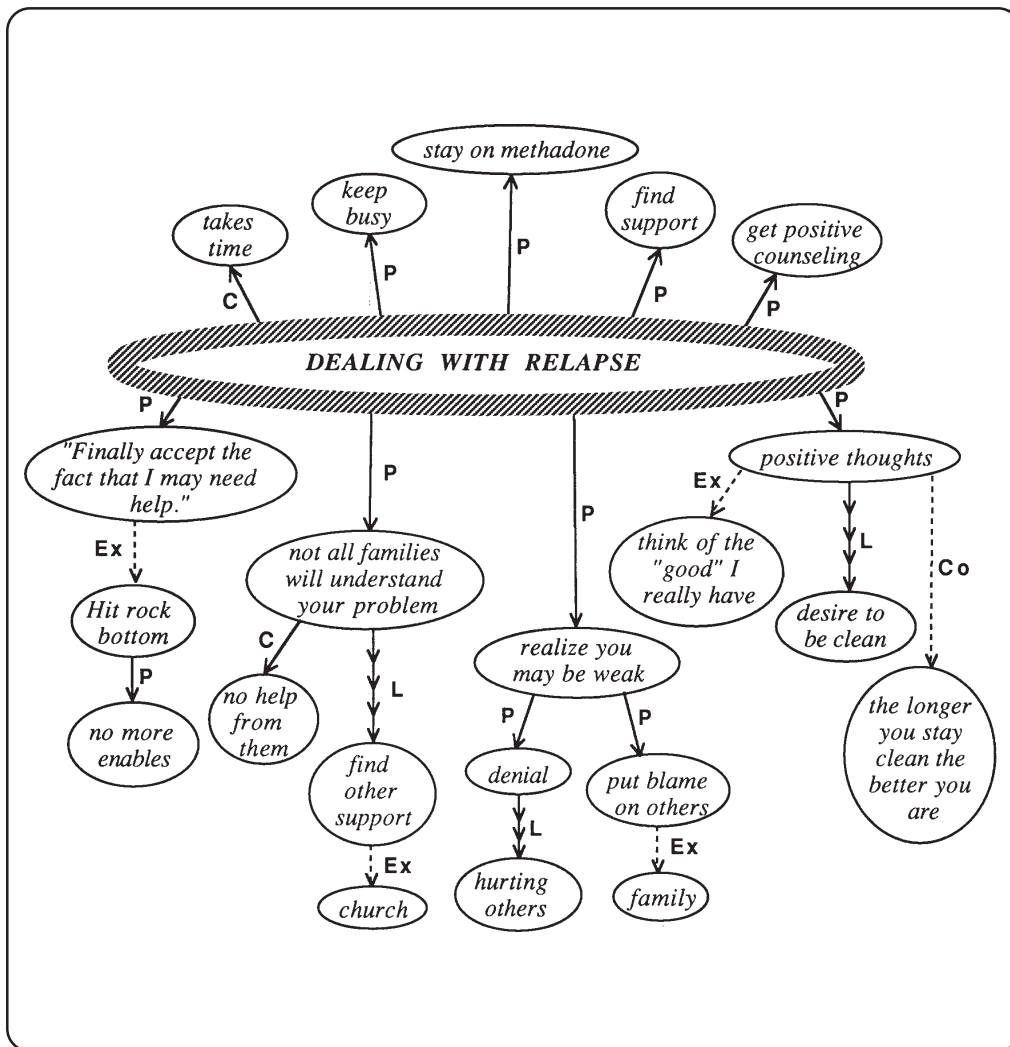
[Some members of this group have been copying on paper the map the counselor is drawing on the board. Copies will be made for those who prefer not to draw their own.]

When we started this session, several of you were really concerned about relapsing. From this map of our discussion, it looks like you have some pretty clear ideas about things that need to happen if you do relapse. You know [pointing to nodes on the map for emphasis] that you can't expect to come out of a relapse overnight, that you've got to get some dependable help, and that through it all, you must stay on your methadone.

Another big part of the relapse process is what you've got going on in your own head—what you're telling yourself. Here [on the map] you have indicated that you have to

mentally accept at least two things: that you need help, and that you may be weak. But, having said that, we have over here the beginnings of your ideas about what positive thinking can do for you. Maybe we should have made the "positive thoughts" node a lot larger—that's one we really need to spend some time on. Generally, we're pretty rough on ourselves; looking for the good things is not something we do automatically.

Our talk today has been fairly general. I hope that we can deal with some of these ideas in more detail when we meet next week.

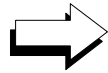


Group Session 1 – Whole Map.

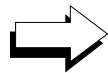
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## Comments on the process: group example #1

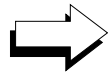
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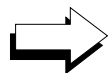
Mapping was started only after the counselor sensed strong concern about a particular issue and decided to focus the remainder of the discussion on this topic. The map was driven both by the interest and input from group members and by questions and conclusions from the counselor, increasing the opportunity for members to feel a “shared ownership” of what went into this map.



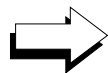
The counselor asked for verification of what was being created in the map. These kinds of questions (“Do I have this right?” “Is this what you’re saying?”) can indicate that the counselor values members’ input and wants to understand clearly what is meant.



As the map grew, group members had the opportunity to see that, as a group, they could produce valid strategies for dealing with relapse.



This map reflects a variety of personal experiences. An idea contributed by one member may allow another to consider a whole new range of possibilities. It may not have occurred to several group members, for example, that time would be an important aspect of dealing with a relapse.



Each group member, as well as the counselor, came away from this general discussion of relapse issues with a map that could serve as the basis for later sessions dealing with more detailed solutions and plans. Some clients will want to copy the map as it is being drawn. Others will find this distracting and will be better served by a xeroxed copy.



## Group Session Example #2

Nine clients are participating in this group session. It is near Christmas, and several are struggling with feelings of sadness; all are trying to remain drug-free while coping with the extra demands and temptations of the holiday season. The first 15 minutes of the session have centered on what their families expect of them. There is some joking about “robbing a bank” and “knocking over a toy store.” But Jesse, who has five children, is more serious; he has not laughed.

**Counselor:** **Jesse, you look like you’re thinking hard about this.**

*Jesse: Yeah. You know, I feel real low right now. I’m broke. I got nothing. And those kids of mine . . . I really have thought about going in with a guy who works where I do—he always has a load of stuff to sell—radios, cameras. He says he’ll cut me in if I’ll just help him sell it—no questions asked. I’ve always said “no,” but now . . . I don’t know . . . It makes me feel real bad not to have anything for my kids. [Several group members protest . . . ]*

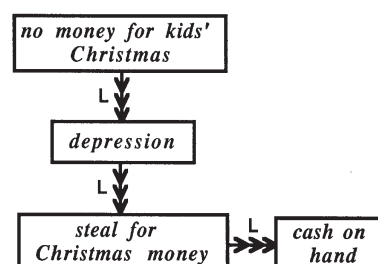
*Carl: C’mon, man. You’ll get your tail busted and spend Christmas in jail. Will your kids like that?*

*Linda: Jesse, I know a guy at the Salvation Army who can help you with Christmas—gifts, food—all of that stuff. Forget this other stuff.*

*Nancy: Hey, I don’t have money either, but I’m not gonna steal. I might as well do dope again if I’m gonna do that. If I got my hands on enough money for presents, I’d blow it on dope. So I’d be using again and be a thief, too. No way. [Several members nod agreement.]*

*Jesse: Yeah. I hadn’t thought about having money around—since I never have any.*

**Counselor:** **Let’s see if I understand what all of you are saying here.**  
[Goes to the board and begins to draw a map.]



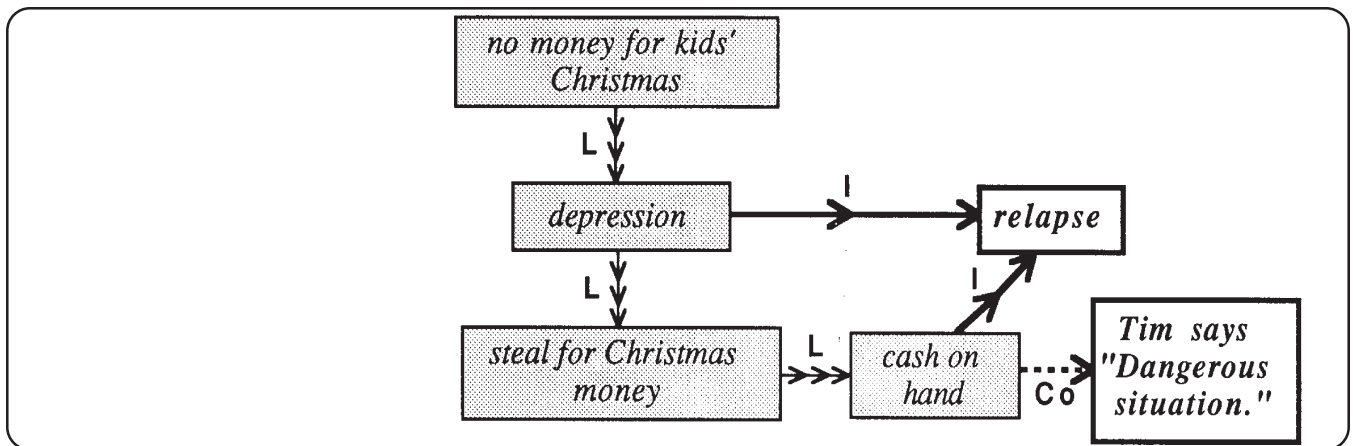
Group Session 2 — Map 1.

**Counselor:** Is this what we're talking about? [Heads nod.] Where does going back to using again—a relapse—fit into this picture?

*Jesse:* The last time I felt this bad I got back on drugs.

**Counselor:** So [drawing]—your feeling of depression can influence a relapse, right? [Group response indicates agreement.] How about cash on hand if you steal . . . same thing?

*Tim:* Yeah—that can get you to relapse, too. That's a dangerous situation.

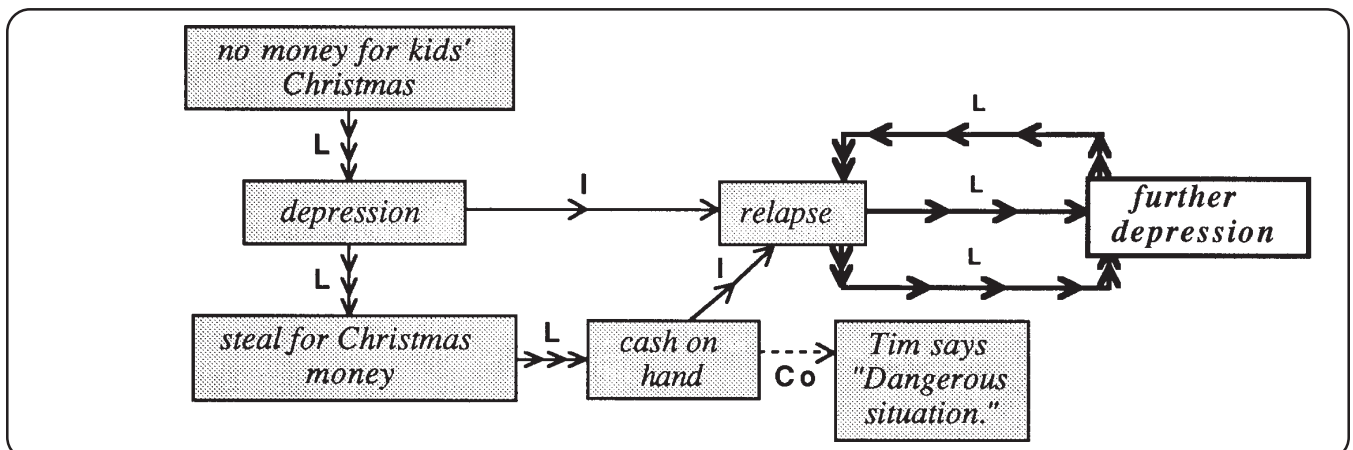


Group Session 2 — Map 2.

**Counselor:** And if you relapse, how are you going to feel?

*Jesse:* Rotten. Worse than I do now.

**Counselor:** Relapse can lead to depression and it can make that depression even worse. And the depression can keep you in relapse. It's a loop you get into and have to break out of, isn't it? Let's draw it.



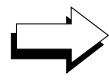
Group Session 2 — Map 3.



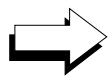
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## Comments on the process: group example #2

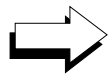
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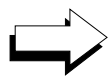
During this session, group members explored the relationship of depression to relapse, getting into the discussion by looking at a poor strategy for dealing with a painful situation (no money for Christmas gifts). The counselor summarized group comments under the term “depression” (then checked it out with the group) and gave “going back to drugs” the label “relapse.” Using labels can work well if the counselor knows that these terms are familiar to group members (are related to past discussions or instructional activities).



Drawing the map allowed group members to see the potential interdependence of depression and relapse, and then talk about effective strategies for avoiding both.



In contrast to the breadth of the map in Example #1, this map focuses more narrowly on a dynamic relationship, and makes more extensive use of “leads to” and “influence” links. Maps will and should be different, reflecting the varied nature of counseling sessions.



Just the physical act of drawing a map may be beneficial to some clients (in both group and individual sessions). This can work to focus the attention of clients whose thoughts seem to ramble from one topic to another. Individuals who appear to have an overabundance of nervous physical energy may benefit from having their hands involved in copying or drawing parts of the map. Clients who are shy or especially embarrassed may feel relieved if they can perceive that a map—and not they—are the focus of discussion.