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Project COMBINE

Combined Behavioral Intervention (CBI)

Therapist Manual

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Three training videotapes were filmed in Project COMBINE to illustrate the flow of Phases 1 and 2 of CBI.

Some material used in this manual was derived from previously published public domain treatment manuals developed for Project MATCH:

> Kadden, R., Carroll, K., Donovan, D., Cooney, N., Monti, P., Abrams, D., Litt, M., & Hester, R. (1992). *Cognitive-behavioral coping skills therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence*. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism. Project MATCH Monograph Series, Volume 3. DHHS Publication No. 92-1895.
>
> Miller, W. R., Zweben, A., DiClemente, C. C., & Rychtarik, R. G. (1992). *Motivational enhancement therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence*. (Project MATCH Monograph Series, Volume 2) Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

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A Note to Project COMBINE Therapists in Training

During the initial training period, prior to the formal start of the COMBINE trial, it is possible to clarify and improve this manual. Thus while you are in the process of trying out this new combination of treatment procedures, we welcome and encourage you to suggest ways in which the therapist manual can be strengthened to make it clearer, more helpful, and more effective. Once the trial has begun, we can make few changes in the treatment procedures - only those that prove absolutely necessary.

If the history of Project MATCH is any indication, thousands of therapists will read this manual after you. We want it to be clear not only for you, but also for those who seek to follow this approach in the years ahead. Thus these few months represent a critical period in which we can make improvements in the manual. Please help us do so: from the smallest typographical errors to the most fundamental principles, your input is welcome.

Address your suggestions to:

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Thanks for your help. We will, of course, keep you posted when significant changes are made in CBI treatment procedures. Send us your email address!

1. 0 An Integrated Cognitive-Behavioral Psychotherapy for Alcohol Problems

1.1 Overview of the COMBINE Behavioral Intervention (CBI)

The COMBINE Behavioral Intervention (CBI) integrates several elements of treatments tested in the multisite alcohol treatment study, Project MATCH: motivational enhancement therapy, cognitive-behavioral skills training, and facilitation of involvement in mutual help groups. CBI includes some standard elements that are delivered to all clients in Phase 1 and Phase 2, an individualized Phase 3 in which modules are selected from a menu of options in order to address clients' personal needs and preferences, and Phase 4 for maintenance and termination procedures. All of the elements included in CBI have been developed and tested in prior studies, with reasonable evidence of efficacy in the treatment of alcohol problems. They are combined here to create a state-of-the-art treatment approach that is both empirically sound and sufficiently flexible to be applicable in ordinary clinical practice.

Phase 1 begins with a period of open-ended motivational interviewing, to elicit and clarify the client's intrinsic motivations for change. This proceeds in the second session into more structured feedback of the client's pretreatment assessment findings (motivational enhancement therapy, as tested in Project MATCH), again to further elicit and elucidate client motivations for change. Phase 1 would normally be completed in two sessions, although the transition into Phase 2 is criterion-based rather than fixed (i.e., Phase 1 might continue over more than two sessions).

As the client evidences readiness to initiate change, Phase 2 begins. This starts with a summary of client motivations and feedback, and an invitation for the client to consider what changes are needed. A *structured functional analysis* is developed as an aid in this process, considering antecedents and consequences of drinking behavior, past perceived benefits of alcohol use, and possible alternative coping methods. A second aid is a more general evaluation of psychosocial functioning, for the purpose of identifying possible areas for skill training. These lead to the construction and discussion of an Options chart, identifying potential Phase 3 treatment foci. From this, a specific treatment plan is negotiated with the client, using the Change Plan Worksheet. This phase would normally begin in the third and continue through the fourth or fifth session, paralleling the development of a treatment plan in JCAHO-approved outpatient programs. Two brief modules also included in Phase 2 for all clients are Abstinence Emphasis counseling and Systematic Encouragement for Mutual-Help Group Involvement.

Phase 3 implements the treatment modules selected through the negotiations of Phase 2. The length of each module is negotiated rather than fixed, determined by relative needs of the client for developing coping skills in each area. Modules may also overlap in time (e.g., completing homework assignments from one module while initiating another module), but do not work on more than two modules simultaneously.

The number of sessions to be provided is guided by the achievement of goals identified in the treatment plan, again paralleling normal clinical practice. The expected duration of treatment is a minimum of 12 and maximum of 20 sessions, delivered over a period of 16 weeks from the date of the first treatment session. A final check-up visit is planned for all clients at 16 weeks after the first session, even if treatment has been terminated earlier. Sessions will normally be scheduled twice weekly at least until Phase 2 has been completed, fading to weekly or biweekly meetings as negotiated between you and your client. Therapy must end within the 16 weeks of the date of your first treatment session, or with session 20, whichever comes first. Treatment will often end earlier than this, however, by mutual agreement with your client.

The involvement of a supportive significant other (SSO) such as a spouse or parent is not only encouraged, but *expected* in CBI whenever such a person is available and has a reasonably good

relationship with the client. Evidence clearly supports the value of family involvement in the treatment of alcohol problems. Because clients are sometimes reluctant to have a SSO participate in treatment, special procedures are provided for engaging the SSO (2.6b). Although a SSO is not required in order for the client to participate, every effort should be made to identify, include, and involve a SSO in treatment, unless such involvement appears to be detrimental to treatment. The SSO may not be included in treatment, however, until after the client has completed Phase 1 (through assessment feedback).

Termination occurs in any of four ways, whichever comes first: (1) when you and your client agree that the goals of treatment have been achieved and/or that further treatment is not warranted, (2) at Session 20, (3) when a client unilaterally stops attending sessions, or (4) on the 16-week anniversary of your first treatment session (whether or not the client is still attending sessions). This anniversary is defined as the same numerical day of the month on which your first treatment session occurred. Thus if your first session occurred on March 14, the last possible day for a final session would be July 14. You may not deliver any further treatment sessions after this anniversary date. If you believe that further treatment is still needed at the point of termination, you may make an appropriate referral (see section 4.3f).

1.2 Research Basis for the COMBINE Behavioral Intervention

1.2a. Combining Effective Treatments. Project COMBINE is part of a continuing search for more effective treatments for alcohol problems. A large body of controlled trials is now available to help differentiate effective from less effective methods. This literature has been reviewed extensively, with a variety of analytic approaches (Finney & Monahan, 1996; Holder, Longabaugh, Miller, & Rubonis, 1991; Institute of Medicine, 1990, Mattick & Jarvis, 1992; Miller, Andrews, Wilbourne, & Bennett, 1998). While differing in some respects, these reviews have come to generally similar conclusions, and converge on several points including:

1. Even relatively brief intervention is more effective than no treatment (cf. Bien, Miller, & Tonigan, 1993).

2. Teaching behavioral coping skills is strongly supported as a basis for treatment of alcohol problems.

3. Family involvement in treatment is associated with more favorable outcomes.

Behavioral treatment programs increasingly combine a variety of elements with evidence of efficacy (e.g., Kadden et al., 1992; Monti et al., 1989), an approach also commonly used in the treatment of other addictive behaviors (Miller & Heather, 1998). This approach has sometimes been called *multimodal* behavior therapy, and may draw upon components from a variety of theoretical or conceptual sources. The pragmatic criterion for inclusion of components is empirical evidence that they are helpful in treatment of the disorder. This results in a modular or menu approach, wherein specific methods (treatment modules) target aspects of the problem(s) to be addressed. Some such programs have delivered a standard set of treatment modules to all clients, whereas others have sought to match components to the particular needs or desires of the individual (e.g., Kadden et al., 1992; Miller, Taylor, & West, 1980).

The bases for matching modules to clients have varied widely. Clinical judgment may be used by the therapist to select methods from the array of options, or clients may be given relatively free choice from the menu (Miller & Hester, 1986). Hope was placed in the development of actuarial criteria for assigning clients to optimal treatments, based on evidence of differential efficacy of approaches (Project

MATCH Research Group, 1993). Project MATCH, the largest clinical trial of psychotherapies ever conducted, was focused on this task, and yielded surprisingly little evidence that treatment effectiveness can be enhanced by matching clients to treatments, based on the a priori notions of what client characteristics would predict better outcomes (Project MATCH Research Group, 1997a). Instead, all three approaches that were compared (Cognitive-Behavioral Skill Training, Twelve-Step Facilitation, and Motivational Enhancement Therapy) yielded similar and quite favorable outcomes over follow-up as long as three years after treatment (Project MATCH Research Group, 1998a).

Within a classic behavioral approach, treatment methods are selected on yet another basis, a *functional analysis* of the problem behavior. The presenting concern is analyzed in the context of the person's social, cognitive, and emotional environment, with a view toward understanding what functions the problem behavior has served. Functional analysis thus searches for systematic *antecedents* and *consequences* of the problem behavior - in this case, drinking. Changes in the environment that precede drinking with some consistency known as *stimuli* can be understood in what behavioral psychologists' call, within an operant framework, discriminative stimuli, but may also be conceptualized as classically conditioned. In either event, they tend to elicit drinking. Analysis of consequences, on the other hand, searches for factors that *reinforce* drinking, that make it more likely to occur. Although the formal language of conditioning is not always used in practice, this analytic approach is implicit in language often used in treatment. Eliciting stimulus situations, for example, are often referred to as *triggers* or *slippery slopes*, and behaviors of significant others that serve to reinforce drinking are termed *enabling* in common parlance.

A comprehensive and systematic behavioral approach, then, would include a menu of empirically sound treatment components, and a process of functional analysis for determining which are most likely to be effective with each client. Treatment is thus individualized rather than standardized. The consistency is not in a particular content delivered in all cases, but rather in the underlying approach that views problem behavior as modifiable through changes in the relationship of the client to the environment. Within this perspective, it is also sensible to include in treatment at least one significant other who represents an important part of the client's social support system. The consistency of evidence of the benefit of behavioral marital therapy in treating alcohol problems (Miller et al., 1998; O'Farrell, 1993) lends further support to this perspective.

Such a comprehensive and systematic approach was pioneered in the treatment of alcohol problems by Nathan Azrin and his colleagues (Azrin, 1976; Hunt & Azrin, 1973). The *community reinforcement approach* (CRA) specifically views drinking as a behavior maintained and modifiable by positive reinforcement in the individual's real-life community context. Emphasis is not placed on insights or transactions that occur within the therapy room, but on changing environmental contingencies to provide a lifestyle that is more rewarding than drinking (Meyers & Smith, 1995). Through a series of controlled trials, the CRA has been supported as more effective than methods that were traditional at the time with inpatients (Azrin, 1976; Hunt & Azrin, 1973), outpatients (Azrin, Sisson, Meyers, & Godley, 1982), and homeless individuals (Smith, Meyers & Delaney, 1998). Other studies have supported the efficacy of the CRA in treating heroin (Abbott, Weller, Delaney, & Moore, 1998) and cocaine dependence (Higgins et al., 1991, 1993, 1994, 1995). The volume and methodology of the CRA studies have placed it on the list of most strongly supported treatment methods for alcohol problems in virtually every review of empirical studies (Finney & Monahan, 1996; Holder et al., 1991; Mattick & Jarvis, 1992; Miller et al., 1998). The CRA provides a systematic framework for integrating functional analysis, behavioral skill training, and family involvement in the treatment of alcohol problems.

1.2b. Motivational Interviewing. Other research from the past two decades points to the importance of client motivation as a determinant of treatment outcome. In Project MATCH (1997), for example, client motivation proved to be one of the strongest predictors of both short- and long-term

drinking outcomes. As reviewed below, studies have also documented the efficacy of certain interventions designed to enhance client motivation for change.

Motivation may be one key in understanding the puzzle of effective brief counseling. For three decades, studies have documented the efficacy of relatively brief interventions for problem drinking (Bien et al., 1993; Heather, 1998). In research spanning more than a dozen nations, brief counseling (1-3 sessions) has consistently been shown to be significantly more effective than no treatment (Bien et al., 1993). This has led, in the addictions field as elsewhere, to a search for critical conditions that may be necessary and/or sufficient to induce change (e.g., Orford, 1985; Rollnick, 1998). Miller and Sanchez (1994) described six elements that they found to be common components in the relatively brief interventions shown by research to induce change in problem drinkers. These are summarized by the acronym FRAMES:

FEEDBACK of personal risk or impairment
Emphasis on personal RESPONSIBILITY for change
Clear ADVICE to change
A MENU of alternative change options
Therapist EMPATHY
Facilitation of client SELF-EFFICACY or optimism

These therapeutic elements are consistent with a larger review of research on what motivates problem drinkers for change (Miller, 1985; Miller & Rollnick, 1991).

Evidence also points to the importance of the therapeutic skill of *accurate empathy*, as defined by Carl Rogers and his students (e.g., Rogers, 1957, 1959; Truax & Carkhuff, 1967). Empathic skill has been shown to be a strong predictor of therapeutic success with problem drinkers, even when treatment is guided by another (e.g., behavioral) theoretical rationale (Miller, Taylor & West, 1980; Valle, 1981). Therapist empathy has been shown to predict more favorable outcomes as long as two years after treatment (Miller & Baca, 1983). In contrast, the opposite style of direct confrontation has been associated with poorer treatment outcomes (Miller, Benefield, and Tonigan, 1993; Miller et al., 1998). Building on the work of Rogers, Miller (1983) described the clinical style of *motivational interviewing* for treating addictive behaviors. It combines the reflective, empathic style of Rogers with directive, strategic methods to enhance motivation for change (Rollnick & Miller, 1995).

The *drinker's check-up* was developed as a first application of motivational interviewing. It was initially tested with adults recruited through newspaper announcements offering a free check-up for people who would like to find out whether alcohol is harming them in any way (Miller & Sovereign, 1989). Those who responded were heavy drinkers with significant alcohol-related problems, and were randomized to receive an immediate check-up or to wait for 10 weeks before receiving the check-up (Miller, Sovereign & Krege, 1988). The intervention consisted of a 2-hour structured evaluation, followed by a 1-hour session of feedback in a motivational interviewing style. Problem drinkers given an immediate intervention showed a significant reduction in drinking at 10 weeks that was maintained a year later. Those on the waiting list were then offered the check-up, and showed a similar reduction in alcohol use. A second evaluation, again with media-recruited adults, randomized problem drinkers to receive their check-up feedback in a motivational interviewing style, or in a more directly confrontive style, with both approaches delivered by the same counselors (Miller, Benefield, & Tonigan, 1993). Relative to the waiting list group, reductions in drinking were seen in both conditions within 6 weeks of counseling, with a 69% reduction in the motivational interviewing group and a 41% reduction in the more confrontive group. Because the same counselors provided both conditions and styles thus overlapped, the actual behavior of counselors within sessions (regardless of the assigned style) was coded from tape recordings

and used to predict client outcomes. A single counselor behavior predicted client drinking as long a year later: the more the counselor confronted, the more the client drank.

Next the drinker's check-up was tested as a prelude to outpatient treatment at a U.S. Veterans Administration medical center. Clients entering treatment for alcohol abuse and dependence were randomly assigned to receive or not receive a single session of assessment feedback and motivational interviewing before beginning outpatient therapy. Those in the control condition received brief advice to make good use of their treatment. Clients receiving motivational interviewing showed substantially greater reductions in drinking at 3-month follow-up, with twice the rate of total abstinence (Bien, Miller, & Boroughs, 1993). Similar findings have been reported by Aubrey (1998) from a randomized trial with adolescents entering outpatient treatment for substance abuse. Substance-dependent adolescents given assessment feedback and motivational interviewing at intake remained significantly longer in treatment (20 vs. 8 sessions), reported greater suppression of alcohol and illicit drug use at 3-month follow-up, and showed a 63% higher rate of total abstinence from all drugs including alcohol.

This design was repeated in the substance abuse program of a private psychiatric hospital. Inpatients who received a drinker's check-up at intake were judged by their therapists (who were unaware of group assignment) to be more motivated and compliant during treatment. Three months after discharge, the motivational interviewing group again showed markedly greater suppression of drinking when compared with clients receiving the same inpatient program without a motivational session at intake. The rate of total abstinence was twice as high as in the control group who went through the same inpatient program (Brown & Miller, 1993).

Project MATCH (1993) tested a four-session motivational enhancement therapy (MET) as a stand-alone aftercare and outpatient treatment. A total of 1,726 clients (outpatients as well as clients in aftercare following intensive treatment) were randomized to MET or to one of two 12-session treatments: twelve-step facilitation therapy, or cognitive-behavioral skills training. MET clients reported somewhat more drinking during the 3 months of treatment, but the difference was no longer significant at 6, 9, 12, 15, or 39-month follow-ups (Project MATCH Research, Group, 1997, 1998).

Others have tested the efficacy of motivational interviewing and closely-related approaches with diverse populations. Significantly improved outcomes have been reported in clinical trials in the treatment of opiate (Saunders, Wilkinson, & Phillips, 1995), cocaine (Daley, Salloum, Zuckoff, Kirisci, & Thase, 1998; Daley & Zuckoff, 1998), and marijuana use disorders (Stephens, Roffman, Cleaveland, Curtin, & Wertz, 1994), with severely dependent drinkers (Allsop, Saunders, Phillips, & Carr, 1997), pregnant heavy drinkers (Handmaker, 1993), and heavy drinkers in college (Baer, Marlatt, Kivlahan, Fromme, Larimer, & Williams, 1992) or identified through health care settings (Heather, Rollnick, Bell, & Richmond, 1996; Senft, Polen, Freeborn, & Hollis, 1997; Woollard, Beilin, Lord, Puddey, MacAdam, & Rouse, 1995). Adaptations of the check-up have also been reported in positive trials with cardiovascular rehabilitation (Scales, Lueker, Atterbom, Handmaker, & Jackson, 1997) and diabetes management (Smith, Heckemeyer, Kratt, & Mason, 1997; Trigwell, Grant & House, 1997). One negative trial has been reported by Kuchipudi et al. (1990) in treating alcohol dependent patients with gastrointestinal disease who had not responded to prior counseling.

In sum, motivational enhancement methods have been found in at least 16 controlled trials to improve compliance and/or outcomes in treatment for a range of chronic problems. The two primary components of MET - structured assessment feedback and a motivational interviewing style - have been tested separately as well as in combination. Personal feedback alone, without therapist contact, was also found to suppress heavy drinking, although the effect was smaller than that commonly observed with the in-person drinker's check-up (Agostinelli, Brown, & Miller, 1995). Therapeutic empathy (Miller et al., 1980, Valle, 1981) and motivational interviewing (e.g., Handmaker, 1993; Heather et al., 1996; Saunders

et al., 1995) appear to exert beneficial effects apart from the context of assessment feedback. In combination, they enhance the outcomes of diverse treatment programs. For this reason, motivational interviewing and assessment feedback comprise the first phase of the COMBINE Behavioral Intervention (CBI). This is consistent with earlier, albeit less systematic attempts to address motivational issues at the outset of CRA treatment (e.g., Azrin et al., 1982; cf. Meyers & Smith, 1995).

1.2c. Mutual Help Group Involvement. A third element encompassed in CBI is involvement of the client in a mutual help group. Research, for example, consistently supports a modestly positive association between client involvement in Alcoholics Anonymous (AA) and more favorable treatment outcomes (Emrick, Tonigan, Montgomery, & Little, 1993), a finding upheld in Project MATCH (1997). The consistency of this finding, in the context of matching research, led Glaser (1993, p. 392) to opine that "everyone should be encouraged to *try* AA" but that "no one should be *required* to attend." Clients in Project MATCH (1997) who were assigned to the twelve-step facilitation therapy also showed a modest but enduring advantage when continuous abstinence was used as the outcome criterion.

For these reasons, encouragement to participate in a mutual help group was incorporated as a standard module in CBI. Because a range of other mutual help organizations has become available (though little is yet known of their effectiveness), the module emphasizes sampling from AA or other options available in the client's vicinity. It incorporates systematic encouragement procedures developed within the community reinforcement approach, and shown to be effective in increasing group attendance (Sisson & Mallams, 1981).

1.3 Coordination with Medical Management

This section applies specifically to COMBINE. CBI is one of two psychosocial interventions offered in COMBINE. All participants in COMBINE who are taking medication also receive Medical Management (MM). Thus your client will usually be seeing both you and an MM practitioner who will monitor trial medications and attend to medical care issues. (For clients receiving no medication, however, you will be your client's only therapist.) Here is some important information about the coordination of care between MM and CBI.

1.3a. Scheduling. Before you see a client, he or she will have been through a number of steps in the COMBINE trial including (1) screening and informed consent to participate, (2) about 3 hours of medical evaluation and initial assessment, and (3) randomization to a treatment condition that includes CBI. If the client is also receiving medication, he or she will have seen an MM practitioner first for a one-hour initial session. After this first MM session has been completed, the client is ready to start CBI with you. You may see the client for your first CBI session at any time after the first MM session, and *at the latest* one week later, coinciding with the client's second MM visit. MM visits for each client are scheduled at Weeks 2, 3, 4, 6, 8, 10, 12, and 16. It will usually be most convenient to schedule your weekly sessions to coincide with these visits. The normal procedure will be for the client to see the MM practitioner immediately before your CBI session. You may, however, schedule CBI sessions at other times as well, and there will be weeks (such as 5, 7, and 9) when there is no MM visit scheduled.

1.3b. Client Flow. You will be notified by your Project Coordinator when a new client has been assigned to you. Clients are randomly assigned to therapists in Project COMBINE, although the Project Coordinator may constrain the randomization algorithm so that therapists receive different case loads, depending on availability. As indicated in 1.3a, the client (if medication is being given) will first see the MM practitioner, and then can begin CBI. From that point onward, MM and CBI proceed independently, although it is usually best to coordinate scheduling of appointments. Both MM and CBI end by the 16 week anniversary.

1.3c. Continuation. It is a required part of CBI to encourage clients to continue on their trial medications. Follow procedures described in section 4.5 (Support of Medication Adherence pull out), and refer your client to the MM practitioner if concerns arise regarding medications and side-effects. Supporting medication compliance is part of your task in CBI (except for those clients not receiving medication). Nevertheless, clients are permitted to continue in the study, in follow-up interviews, and in CBI even if it is necessary for their medication to be discontinued (by the MM practitioner), or if for some other reason they stop taking their medication. It is also the case that clients may continue with their medication, MM, and follow-up visits even if they stop attending CBI sessions. The stopping of either CBI or medications (and MM) does not affect the client's eligibility to participate in other aspects of the study. In fact, we encourage all clients to continue in the study, whether or not they wish to continue one or both of their treatments.

1.3d. Communicating with the MM Practitioner. With the important exceptions noted below, you should not need to discuss with your client's MM practitioner what transpires in CBI. As a general rule, what clients tell you in CBI sessions is not conveyed to the MM practitioner. However, there are a number of occasions when you and the MM practitioner need to exchange information for the coordination of care. No special consent is needed for this purpose, because you are both clinical staff of the treatment program. It is acceptable to exchange information with the MM practitioner for these purposes:

1. **Scheduling the First Visit**. The first CBI session may occur any time after the client's first MM visit, and should occur no later than one week after MM and medication have been initiated. The first MM visit lasts approximately 50 minutes; others last only 10-20 minutes. It is acceptable to schedule the first CBI visit to occur immediately after the first MM visit, if the client is willing to remain for two hours. [In cases where no medication is part of the client's COMBINE treatment, CBI may begin any time after completion of baseline assessment and randomization.]

2. **Scheduling Subsequent Visits**. Coordinate with the MM practitioner so that MM and CBI sessions are scheduled for client convenience. The normal procedure will be for the client to see the MM practitioner first, and then see you for CBI. Note that from Month 1 onward MM sessions become biweekly and then monthly, whereas CBI continues on a weekly basis, so there will be CBI weeks when there is no corresponding MM session. Work closely with your client's MM practitioner to coordinate scheduling for your client's convenience.

3. **Need for Medical Information**. Contact the MM practitioner when you need information or have a question regarding trial medications (although neither you nor the MM practitioner will know which medication a client is taking) or the client's medical condition.

4. **Drinking Data**. During MM visits, the MM practitioner will be asking the client about drinking since the client's last MM visit. The MM practitioner's report (see Form B) will be passed along to you routinely by your Project Coordinator, with the client's knowledge. When you receive these reports, review them promptly, make any appropriate notations, sign them, and return them to the Project Coordinator. Alcohol use is an important consideration in medical management. If it should happen that your client, in the course of CBI sessions, divulges to you information about drinking that is discrepant with what the MM practitioner knows (e.g., the client told the MM practitioner that he or she was not drinking, but reported to you that he or she actually was; the client has been drinking much more than was admitted to the MM practitioner), you must discuss this discrepancy with the MM practitioner for safety reasons.

5. **Medication Adherence**. It may happen that a client expresses to you, during a CBI session, an intention to discontinue medication or the fact that he or she has already stopped taking medication. The MM practitioner may also indicate to you that there are problems with medication adherence via the regular report (see Form B). Here you should follow the procedures outlined in the Support of Medication Adherence (SOMA) pull out (section 4.5). Encourage your client to discuss concerns with the MM practitioner. If you have adherence information that is apparently unknown to the MM practitioner, convey this information directly and promptly to the MM practitioner yourself, either by direct conversation or in writing (on Form B). If your client discloses to you that he or she has been less than honest with the MM practitioner regarding the taking of medication, express concern, following procedures described in section 4.5, and encourage your client to discuss concerns with the MM practitioner. Also convey the information directly and promptly to the MM practitioner yourself, either by direct conversation or in writing.

6. **Side Effects and Other Medication Concerns**. During some CBI sessions, some clients may express distress about side effects, or raise other concerns related to their medication. The proper procedure for you here is: (1) encourage your client to discuss the concern with the MM practitioner; and also (2) notify the MM practitioner of your client's stated concern.

7**. Client Safety**. Finally, it is important for you to pass along to the MM practitioner any information that you believe could be important in medical management, or for the protection of your client's safety. Examples would include suicidal ideation, a marked increase in anxiety or depression, or significant physical complaints. When in doubt, convey such information to the client's MM practitioner promptly. A client's safety always has top priority. Encourage your client to talk to the MM practitioner about the concerns, *and also* convey the information directly and promptly to the MM practitioner yourself, either by direct conversation or in writing.

Whenever you convey information to the MM practitioner, document this in the client's chart.

Reference: Form B

1.4 How Does CBI Differ from Prior Cognitive-Behavioral Therapies?

The COMBINE Behavioral Intervention shares many common features with previously described comprehensive cognitive-behavioral treatment approaches (e.g., Marlatt & Gordon, 1985; Monti, Abrams, Kadden, & Cooney, 1989). In particular, we used as a starting point the cognitive-behavioral coping skills therapy that was tested in Project MATCH (Kadden et al., 1992). The CBI retains, in Phase 3, a strong emphasis on teaching clients personal coping skills to help them in their recovery. A modular approach is used to individualize treatment to clients' needs.

In other respects, CBI differs from prior cognitive-behavioral treatments that centered on the acquisition of individual coping skills. In light of more recent findings and developments in the alcohol treatment field, CBI was designed to extend and build upon basic cognitive-behavioral approaches in several respects. These include:

- use of integrated therapeutic strategies designed to move clients through the stages of change, rather than assuming initial readiness for change
- an initial focus on client motivation for change, drawing on motivational enhancement therapy as developed and tested in Project MATCH (Miller, Zweben, DiClemente, & Rychtarik, 1992)
- adoption of motivational interviewing (Miller & Rollnick, 1991) as a therapeutic style throughout treatment
- a more thorough functional analysis of drinking behavior, and a more general review of the client's psychosocial functioning, linked directly to the development of an individualized treatment plan
- explicit exploration of client strengths, resources, and prior successes
- more central emphasis on modifying the client's social environment and social support systems, consistent with a community reinforcement approach to treatment
- intentional involvement of a supportive family member or significant other throughout treatment
- specific procedures to encourage sampling of and involvement in twelve-step and other mutual-help programs
- integration of behavioral treatment with the use of therapeutic medications
- incorporation of specific counseling procedures developed from the community reinforcement approach (e.g. sobriety sampling, social and recreational counseling)
- greater flexibility in content and duration of treatment, to more closely approximate standard practice
- a Phase 4 in which treatment sessions are faded and responsibility for maintenance is shifted to the client, with an emphasis on internal attribution of change.

In general philosophy, CBI does not assume that the acquisition of individual coping skills during treatment is the primary mechanism by which recovery occurs. Rather, CBI is an integrated approach, combining several major elements, each of which has been supported as effective in alleviating alcohol problems: (1) enhancement of client motivation for change, (2) family involvement in treatment, (3) emphasis on the client's social/community context of reinforcement for drinking and abstinence, (4) an individualized treatment approach, (5) cognitive-behavioral skill training, (6) support for use of therapeutic medications, and (7) involvement in mutual-help groups. In sum, although it has similarities, CBI is quite different from and broader than cognitive-behavioral therapies that place primary emphasis on the acquisition of individual coping skills.

A Comparison of Cognitive-Behavioral Coping Skills Therapy (Project MATCH) and the COMBINE Behavioral Intervention

	Cognitive-Behavioral Coping Skills Therapy (Project MATCH)	**COMBINE Behavioral Intervention**
Number of Sessions	Fixed at 12 sessions (8 core and 4 elective)	Flexible, up to 20 sessions according to client needs
Frequency of Sessions	Weekly	Flexible; semi-weekly at first, biweekly or less during maintenance phase
Duration	3 months	up to 16 weeks
Primary Emphasis	Acquisition of individual coping skills to maintain abstinence	Enhancement of reinforcement and social support for abstinence
Client Motivation	Minimal emphasis on client motivation for change (5 minutes)	Incorporates motivational enhancement therapy at the outset
Family/SO Involvement	Limited to 2 sessions	Encouraged and expected throughout treatment
Functional Analysis	Informal (10 minutes)	Structured and detailed
Clinical Style	45 minutes of rapport building by asking questions and structuring	Motivational interviewing
Support for Medications	None	Incorporated with behavioral interventions
Mutual-help Involvement	None explicitly encouraged	Specifically encouraged and facilitated
Treatment Plan	Content fixed for 8 sessions; then 4 module sessions chosen	Fixed format for 2-3 sessions until individual treatment plan is negotiated
Content Modules	*Coping with Craving and Urges *Managing Thoughts About Alcohol *Problem-Solving *Drink Refusal *Emergencies / Coping with a Lapse *Seemingly Irrelevant Decisions Starting Conversations Nonverbal Communication Introduction to Assertiveness Receiving Criticism Awareness of Anger Anger Management Awareness of Negative Thinking Managing Negative Thinking Increasing Pleasant Events Managing Negative Moods Enhancing Social Support Networks Job-Seeking Skills Couples/Family Involvement 1+2 *core (required) sessions	Coping with Craving and Urges Drink Refusal and Social Pressure Communication Skills Assertive (Expressive) Skills Mood Management Training Social and Recreational Counseling Social Support for Sobriety Job-Finding Training [SSO involved throughout]
Module Format	One session each; one module at a time	Flexible duration; may be working on different modules simultaneously

Pull-Out Procedures (for dealing with specific problems that arise)	Two "emergency sessions" permitted, content unspecified	Procedures used as needed: Sobriety Sampling Raising Concerns Referral Resumed Drinking Support for Medication Adherence Missed Appointment Telephone Consultation Crisis Intervention Disappointed to receive CBI-only condition
Maintenance Phase	None; limited to termination session	Specific maintenance phase with fade-out of sessions, plus termination session

Phase 1

Building Motivation for Change

2. Phase 1: Building Motivation for Change

2.1. What is Motivation?

The central purpose of Phase 1 is to enhance your client's motivation for change. Some clients will come to treatment well along with readiness to change, and Phase 1 will go quickly. Others will come less ready to change, and more time will be needed to build motivation in preparation for Phases 2 and 3.

Some people have the impression that motivation is some kind of inner life force such as "will power," that clients have in varying amounts. This concept of motivation is rather vague, and can lead the clinician to give up on clients who "aren't really motivated," or to use confrontation or pep talks in an attempt to pump up the client's motivational level - strategies that are relatively ineffective in triggering behavior change.

A more helpful way of thinking about motivation is as the probability of taking steps toward change. This is, in fact, how most psychological research has defined motivation. When you ask, "What is a client motivated to do?" you are in this sense asking, "What is the client *likely* to do?" Once you understand motivation in this way, your task becomes increasing the probability that your client will take action toward change.

As it turns out, a client's *doing something* is one of the better predictors of treatment outcome. Sometimes described as "compliance" or "adherence," the common-sense general finding is that when clients take active steps toward change, they are more likely to succeed. Clients do better when they attend more treatment sessions, or take their medication faithfully (even if the medication is a placebo; see Fuller et al., 1986), or attend more AA meetings, or try out a number of different processes for change. During Phase 1, then, your job is to increase the likelihood that your client will take active steps toward change.

Motivational interviewing is a *client-centered yet directive* style of counseling designed to do just that - to help resolve ambivalence about a problem behavior and initiate change (Rollnick & Miller, 1995). It is the clinical style to be used throughout CBI. Based on principles of motivational psychology, it is designed to initiate rapid, internally-motivated change. Motivational Enhancement Therapy (MET; Miller, Zweben, DiClemente, & Rychtarik, 1992) was developed as one specific application of motivational interviewing for use in Project MATCH (1993, 1997). Derived from earlier research on "the drinker's checkup" (reviewed above), MET provides systematic feedback of the client's assessment data, offered within the supportive and empathic style of motivational interviewing. Motivational interviewing and MET constitute Phase 1 of CBI, which focuses on increasing client motivation for change. This flows naturally into Phase 2, which centers on negotiating a change plan and sets the stage for the cognitive-behavioral skill-training components of CBI in Phase 3.

An Overview of Phases 1 and 2

	PHASE 1: ENHANCING MOTIVATION FOR CHANGE
Y	Initial Period of Motivational Interviewing
Y	Supportive Significant Other Involvement
Y	Structured Assessment Feedback (Motivational Enhancement Therapy)
Y	Transitional summary
	PHASE 2: DEVELOPING COMMITMENT TO A CHANGE PLAN
Y	Functional Analysis of Drinking (New Roads)
Y	Review of Psychosocial Functioning
Y	Identifying Strengths and Resources
Y	Developing a Plan for Treatment and Change
Y	Abstinence Emphasis Counseling
Y	Mutual-help Group Involvement Counseling
Y	Consolidating Commitment
	OPTIONAL "PULL-OUT" PROCEDURES
	Case Management
	Raising Concerns
	Resumed Drinking
	Sobriety Sampling
	Support for Medication Adherence
	Missed Appointments
	Telephone Consultation
	Crisis Intervention
	Disappointed to receive CBI-only condition

2.2. Stages of Change

Motivational interviewing is consistent with research on (and is designed to facilitate) processes of natural change. Prochaska and DiClemente (1982, 1984, 1985, 1986; DiClemente & Prochaska, 1998) have described a transtheoretical model of how people change problem behaviors, with or without formal

treatment. In this perspective, individuals move through a series of stages of change in modifying addictive behaviors. This concept of stages is helpful in conceptualizing change. Each stage involves certain tasks to be accomplished and certain processes to be used in order to achieve change. Five separate stages have been identified (Prochaska & DiClemente, 1984, 1986; Prochaska, DiClemente, & Norcross, 1992).

Individuals who are not considering change in their problem behavior are described as being in **precontemplation.** The **contemplation** stage involves both the consideration that he or she has a problem and the feasibility and costs of changing that behavior. As the individual progresses, he or she moves on to the **preparation** stage which involves deciding and getting ready to take action for change. Once the individual begins to modify the problem behavior, he or she enters the **action** stage, which normally continues for 3-6 months. After successfully negotiating the action stage, the individual moves to **maintenance** or sustained change. If these efforts fail and the problem behavior recurs, the individual begins another cycle through these stages of change.

The ideal path would be to progress directly from one stage to the next until maintenance is achieved. For most people with serious problems related to drinking, however, the process involves some setbacks, recycling or spiraling toward maintenance. Several revolutions through this cycle typically occur before change is stably maintained.

From the transtheoretical perspective, motivational interviewing addresses where the client is currently in the cycle of change, and assists the person to move through the stages toward successful sustained change. It particularly addresses issues of the first three stages of change - precontemplation, contemplation, and preparation - which may not be dealt with effectively by treatment strategies that are focused exclusively on behavior change. It may be helpful in Phase 1 to consider three aspects of motivation that are reflected in the expression "ready, willing, and able." The "willing" component has to do with how *important* the client perceives change to be: how much of a problem their drinking behavior poses for them, and how their drinking is affecting them (both positively and negatively). Tipping the balance of these pros and cons of drinking toward change is part of the movement from contemplation to action. The second issue is client's perceived *ability* to change (self-efficacy). Clients consider whether they will be able to make a change, and how that change would impact their lives. It is possible, however, for a client to be willing and able, but still not ready to change. Often this has to do with the relative importance of making this change, compared with other needs and priorities in the person's life. Effectively addressing these three issues helps clients develop a firmer commitment to take action toward change.

2.3. Rationale and Principles of Motivational Interviewing

Motivational interviewing begins with the assumption that the responsibility and capability for change lie within the client. The therapist's task is to create a set of conditions that will enhance the client's own motivation for and commitment to change. The therapist seeks to mobilize the client's own inner resources, as well as those inherent in the client's natural helping relationships. The idea is to evoke and support *intrinsic* motivation for change, which will lead the client to initiate, persist in, and comply with behavior change efforts. Miller and Rollnick (1991) have described five basic principles underlying motivational interviewing:

1. Express Empathy
2. Develop Discrepancy
3. Avoid Argumentation
4. Deflect Defensiveness
5. Support Self-Efficacy

2.3a. Express Empathy. In motivational interviewing one seeks to communicate support and respect for the client. Communications that imply a superior/inferior relationship between therapist and client are avoided. The therapist's role is a blend of supportive companion and knowledgeable consultant. The client's freedom of choice and self-direction are respected. Indeed, in this view, it is *only* the client who can decide to make a change in his or her drinking, and carry out that choice. The therapist seeks ways to compliment rather than critique, to build up rather than tear down. Motivational interviewing involves careful listening. Persuasion is gentle, subtle, always with the assumption that change is up to the client. The power of such gentle, nonaggressive persuasion has been widely recognized in clinical writings, including Bill Wilson's own advice on "working with others" (Alcoholics Anonymous, 1976). *Reflective listening (accurate empathy) is a fundamental skill in motivational interviewing.* It communicates an acceptance of clients as they are, while also supporting them in the process of taking steps toward change.

2.3b. Develop Discrepancy. Motivation for change occurs when people *perceive a discrepancy between where they are or are headed and where they want to be*. Motivational interviewing seeks to enhance and focus the client's attention on such discrepancies with regard to drinking behavior. In certain cases (e.g., precontemplators in Prochaska and DiClemente's model) it may be necessary first to *develop* such discrepancy by raising the client's awareness of the personal consequences of his or her drinking. For others (e.g., contemplators) the process is one of clarifying and resolving ambivalence by strengthening motivations for change, while diminishing motivations for *status quo*. Feedback of personal information, properly presented, can enhance the perceived importance of change. As a result, the individual may be more willing to enter into a frank discussion of change options, in order to reduce the perceived discrepancy. In other cases, the client enters treatment already past the contemplation stage, and it takes less time and effort to move the client along to the point of action. Nevertheless it is good to remember that even in the action stage, clients still experience ambivalence about change, and motivational enhancement processes can be useful throughout therapy.

2.3c. Avoid Argumentation. If handled poorly, ambivalence and discrepancy can resolve into defensive coping strategies that reduce the client's discomfort but do not alter drinking and related risks. An unrealistic (from the client's perspective) attack on his or her drinking behavior tends to evoke defensiveness and opposition, and suggests that the therapist does not really understand. Motivational interviewing explicitly avoids direct argumentation, which tends to evoke defensive behavior from the client. No attempt is made to have the client accept or "admit" a diagnostic label. The therapist does not seek to prove or convince by force of argument. Direct argumentation is relatively ineffective in changing self-perception. Instead, the therapist employs other persuasive strategies to assist the client to see accurately the consequences of drinking, and to begin devaluing the perceived positive aspects of alcohol. When motivational interviewing is done properly, *it is the client and not the therapist who voices the arguments for change* (Miller & Rollnick, 1991).

2.3d. Deflect Defensiveness. How the therapist handles defensive behavior is a crucial and defining characteristic of motivational interviewing. This style does not meet client defensiveness head-on, but rather rolls with the momentum, with a goal of shifting client perceptions in the process. New ways of thinking about problems are invited but not imposed. Ambivalence is viewed as normal, not pathological, and is explored openly. *Solutions are usually evoked from the client before or instead of being provided by the therapist.* This approach for dealing with defensiveness will be described in more detail later. An important goal is to minimize client defensiveness. The greater a client's defensive behavior during the early sessions of therapy, the less the chance of enduring behavior change (Miller, Benefield, & Tonigan, 1993). This might be interpreted as evidence for the perniciousness of client “resistance” or "denial," except that the level of a client's defensive behavior is clearly influenced by the therapist, whose own responses can drive it up or down within sessions (Patterson & Forgatch, 1985).

The style of motivational interviewing is associated with significantly lower levels of client defensiveness, as compared with more directive and confrontive styles. To be sure, some clients enter treatment with a much higher level of defensive responses. Nevertheless, whether defensiveness persists, increases, or decreases during treatment is largely under the control of the therapist. In terms of enhancing long-term change, keeping client defensive behavior at a low level may even be more important than evoking overt statements of motivation and commitment (Miller, Benefield & Tonigan, 1993). In essence, defensive responses from the client represent a signal to the therapist to shift strategies.

2.3e. Support Self-efficacy. A person who is persuaded that he or she has a serious problem may still not move toward change unless there is hope for success. Bandura (1982) has described self-efficacy as a critical determinant of behavior change. Self-efficacy is, in essence the belief that one *can* perform a particular behavior or accomplish a specific task. In this case, the client must be persuaded that it is possible to change his or her own drinking and thereby reduce related problems. In everyday language, this might be called hope or optimism, though it is not an overall optimistic nature that is crucial here. Rather, it is the client's *specific belief that he or she can change the drinking problem*. Unless this element is present, a perceived discrepancy is likely to resolve into defensive cognition (e.g., rationalization, denial) to reduce discomfort instead of behavior change. This is a natural and understandable protective process. If one has little hope that things could change, there is little reason to face the problem.

2.4. Comparison with Other Approaches

2.4a. Differences from a Denial-Confronting Approach. Motivational interviewing differs dramatically from confrontational treatment strategies in which the therapist takes primary responsibility for "breaking down the client's defenses." Miller (1989) characterized these contrasts between approaches:

Denial-Confronting Approach	Motivational Interviewing Approach
Strong emphasis on acceptance of self as "alcoholic"; admitting the diagnosis is seen as essential for change	Deemphasis on labels; alcoholism label seen as unnecessary for change to occur
Emphasis on the disease of alcoholism which negates personal choice	Emphasis on personal choice regarding future drinking and consequences
Therapist presents evidence of alcoholism in an attempt to convince the client of the diagnosis	Therapist provides objective evaluation, but focuses on eliciting the client's own concerns
Defensive behavior seen as "denial," a trait characteristic of alcoholics, requiring reality confrontation by the therapist	Defensive behavior seen as an interpersonal response that is influenced by the therapist's own behavior, signaling the need for a shift in counseling strategy.
Client defensiveness is met with argumentation and correction	Client defensiveness is met with reflection and reframing

A goal in motivational interviewing is to evoke *from the client* statements of problem perception and a need for change (see "Eliciting Self-Motivational Statements"). This is the conceptual opposite of an approach in which the therapist takes responsibility for voicing these perspectives ("You're an alcoholic, and you have to quit drinking") and persuading the client of their truth. Motivational interviewing emphasizes the client's ability to change (self-efficacy) rather than the client's helplessness or powerlessness over alcohol. As discussed earlier, arguing with the client is carefully avoided, and strategies for responding to defensiveness are more reflective than exhortational. Within a motivational interviewing style, therefore, one does *not:*

argue with the client
impose a diagnostic label on the client
take responsibility for explaining why the client must change
tell the client what he or she “must” do
seek to "break down denial” by direct confrontation
emphasize a client's "powerlessness"

An adversarial interaction, in which the therapist argues for change and the client argues against it, is countertherapeutic.

2.4b. Differences from Nondirective Counseling. Motivational interviewing draws heavily on the client-centered therapist skills (e.g., accurate empathy) described so well by Carl Rogers and his students. In the classic Rogerian conception of counseling, however, the therapist does not direct treatment, but follows the client's direction wherever it may lead. There is no prescription for differential responses to clients' statements. In such nondirective counseling, whatever the client offers is met with unconditional positive regard.

In contrast, motivational interviewing is quite goal-directed, and employs systematic strategies to reach specific objectives. The therapist seeks actively to create discrepancy, and to channel it toward behavior change (Miller, 1983; Miller & Rollnick, 1991). Reflection and reframing are consciously used in a contingent manner, to strengthen the client's intrinsic motivation for change. The material is still the client's own; motivations are not provided or installed by the therapist. Instead, the client's salient attention is directed to discrepancies between the problem behavior and his or her own intrinsic interests and values. Thus motivational interviewing is a directive, client-centered, and change-oriented approach.

Nondirective Counseling Approach	Motivational Interviewing Approach
Allows the client to determine the content and direction of counseling	Systematically directs the client toward motivation for change
Avoids interjecting the counselor's own advice and feedback	Offers the counselor's own advice and feedback where appropriate
Empathic reflection is used noncontingently	Reflection and reframing are used selectively to reinforce motivation for change
Explores the client's conflicts and emotions as they are currently, without specific goals for change	Seeks to evoke and amplify the client's discrepancy in order to enhance motivation for change

2.4c. Integration with Cognitive-Behavioral Skill Training. Motivational interviewing is compatible with a wide variety of behavior change strategies. It has been found to enhance compliance and outcomes in 12-step-oriented treatment (Brown & Miller, 1993; Bien, Miller, & Boroughs, 1993), in physical rehabilitation (Scales, et al., 1997), and in cognitive-behavioral approaches (Allsop et al., 1997; Aubrey, 1998). There is a natural transition from building motivation for change (Phase 1) to the negotiation of change strategies (Phase 2). It is in Phase 2 that specific skills and strategies for change can be introduced as options. Rigid prescription of a particular change method, however, would be incompatible with the emphasis on client choice and autonomy. Providing a *menu* of change options from which the client can choose is one of the FRAMES elements described above, and quite compatible with motivational interviewing.

The transition to skills training in CBI occurs in Phase 2 of treatment, where a functional analysis of drinking is introduced as part of the development and negotiation of a change plan. The functional analysis, in turn, suggests behavior change strategies that may be particularly helpful to the client, chosen from the menu that forms the core of Phase 3 of treatment. Included in the menu of options is exposure to 12-step groups, found in Project MATCH (1997) to be associated with more favorable outcomes, particularly for clients whose social networks more strongly support continued drinking.

The empathic clinical style of motivational interviewing is meant to continue throughout the course of CBI. This style serves as a platform on which to build further interventions. Reflective

listening to the client should be found in all sessions from Phase 1 through termination. Clients are actively involved in choosing their own change strategies throughout treatment. Coping strategies are introduced with a suggesting and encouraging style, rather than in a prescriptive and imposing manner. The behavioral skill training portion of treatment (Phase 3) thus involves a balance of suggesting coping strategies while continuing to draw upon the client's own ideas and resources.

2.5. Clinical Style

Motivational interviewing has been described as encompassing two phases that correspond directly to the first two phases of CBI: (Phase 1) building motivation for change, and (Phase 2) strengthening commitment to change (Miller & Rollnick, 1991). Phase 1 focuses on developing the client's motivation to make a change in his or her drinking. Clients will vary widely in their initial readiness to change. Some may come to treatment largely decided and determined to change, but the following processes should nevertheless be pursued in order to explore the depth of such apparent motivation, and to begin consolidating commitment. Others will be reluctant or even hostile at the outset, and for them motivational enhancement is likely to be particularly important (Project MATCH Research Group, 1998b). At the extreme, some true precontemplators may be coerced into treatment by family, employer, or legal authorities. Most clients, however, are likely to enter the treatment process somewhere in the contemplation or preparation stage. They may already be dabbling with taking action, but still need consolidation of motivation for change.

Phase 1 can be thought of as the tipping of a motivational balance (Janis & Mann, 1977; Miller, 1989; Miller & Rollnick, 1991). One side of the seesaw favors *status quo* (continued drinking as before), whereas the other favors change. The former side of the decisional balance is weighed down by perceived positive benefits from drinking and unwanted consequences of change. Weights on the other side consist of perceived benefits of changing one's drinking, and anticipated negative consequences of continuing unchanged. Your task is to shift the balance of weight in favor of change.

Phase 1 of CBI involves two parts. The first is a less structured (but directive) period of motivational interviewing focused on drinking behavior, which will ordinarily occupy the first session. This is followed by a period of systematic feedback of findings from the client's pretreatment assessment, given within the style of motivational interviewing. This feedback is likely to occupy most of the second session.

This section of this manual describes how to implement the general clinical style of motivational interviewing, that is maintained throughout Phases 1-4. (Its application within the specific structure of Phase 1 will be described in the next section 2.6.) Miller and Rollnick (1991) have described several general strategies that characterize the clinical style of motivational interviewing.

2.5a. Eliciting Self-Motivational Statements. There is truth to the saying that we can "talk ourselves into" a change. Social psychology has amply demonstrated that when people are voluntarily influenced to speak or act in a new way, their beliefs and values tend to shift in that direction. This phenomenon has sometimes been described as cognitive dissonance (Festinger, 1957). Self-perception theory (1965, 1967) offers an alternative account of this phenomenon, which might be summarized thus: "As I hear myself talk, I learn what I believe." That is, the words which come out of a person's mouth are quite persuasive to that person - more so, perhaps, than words spoken by another. If I say it, and no one has forced me to say it, then I must believe it!

If this is so, then the *worst* persuasion strategy is one that evokes defensive argumentation from the person. Head-on confrontation is rarely an effective sales technique ("Your children are educationally

deprived, and you will be an irresponsible parent if you don't buy this computer"). This is a flawed approach not only because it evokes hostility, but also because it causes the client to verbalize precisely the *wrong* set of statements. An aggressive argument that "You're an alcoholic and you have to stop drinking" will usually evoke a predictable set of responses: "No I'm not, and no I don't." Unfortunately, counselors are sometimes trained to interpret such a response as further evidence of client "denial," and to push all the harder. The likely result is a higher level of client defensiveness, which in turn predicts a lack of behavior change.

The positive side of the coin here is that in motivational interviewing one seeks to elicit from the client certain kinds of statements that can be considered, within this view, to be self-motivating (Miller, 1983; Miller & Rollnick, 1991). These can be thought of as reflecting one or more of the elements, "Ready, willing, and able" (Rollnick, Mason, & Butler, in press). They include statements of four kinds:

1. *Problem Recognition*. This is a cognitive/factual acknowledging of the risk (potential) or presence of negative consequences of drinking. This should not be equated with accepting a diagnostic label. Many people can describe problems caused by their drinking, but still reject a personal label such as "problem drinker."

I guess I really am drinking too much.
I hadn't really thought much about how it is affecting my body.
I can see that if I don't change, this is going to get worse.
I didn't realize that being able to hold my liquor is a warning sign.

2. *Expressed Concern*. Problem recognition may or may not be accompanied by apparent concern from the client regarding his or her state. Expressed concern has more of an affective quality, a personal involvement and alarm.

I feel bad about what this has done to my family.
This feedback worries me; I don't like it.
I don't want to lose my job.
What am I going to do?

3. *Willingness, Desire, or Intention to Change*. A third kind of self-motivational statement directly reflects some readiness to change.

I've got to do something. I can't go on like this.
I want to get free of alcohol and drugs.
What could I do if I want to change my drinking?
I'm going to quit drinking.

4. *Optimism for Change*. Here the person expresses self-efficacy, an ability to change. Note that it may be stated hypothetically, without an expressed desire or intent to change.

I can do this. I'm going to kick it.
I could quit if I wanted to.
I've made some tough changes before. I've been through a lot.
I'm not sure about quitting, but I think I can at least cut down a lot.

There are many ways to elicit such statements from clients. The simplest is to ask for them directly, via open-ended questions. Here are some examples:

I assume, from the fact that you are here, that you have been having some concerns or difficulties related to your drinking. Tell me about those.

Tell me a little about your drinking. What do you like about drinking? What's positive about drinking for you? . .[and later] . . . . And what's the other side? What are your worries about drinking?

Tell me what you've noticed about your drinking. How has it changed over time? What things have you noticed that concern you, that you think could be trouble, or might become problems?

What have other people told you about your drinking? What are other people worried about? (If a spouse or significant other is present, this can be asked directly.)

What makes you wonder if perhaps you need to make a change in your drinking?

What makes you believe that you could quit drinking if you decided to?

2.5b. Asking Open Questions. Most counselors ask far too many questions. It is quite easy to fall into a question/answer pattern with clients, particularly in early sessions. While questions direct the client to what may be of interest to you, they tend to derail the client's own process of exploration. They can, in this sense, be roadblocks to learning about your client (Gordon, 1970). Asking a series of short-answer questions sets up an uneven distribution of power between an in-charge expert and a passive answerer. There are situations in which this may be appropriate (e.g., consultation with a family physician about an acute illness). Phase 1 of CBI is not one of them.

Within motivational interviewing, questions are used quite selectively, and with consciousness of their directive quality. A general guideline is *never ask three questions in a row*. Instead, ask a question, listen to the client's response, and reply with empathic reflection.

Questioning *is* an important component of motivational interviewing, as illustrated above in eliciting self-motivational statements. Rather than *telling* the client how he should feel, or what to do or think, *ask* the client about his/her own feelings, ideas, concerns, and plans. Then respond to elicited information with empathic reflection, affirmation, or reframing (see below).

The usual question within motivational interviewing is an *open question* that does not have a yes/no or short answer. Open questions cause one to think and reflect. In this way, they can get clients thinking along new lines. The key is not in the questions, however, but in the client's responses to them. This is why it is so important to follow an open question not with another question, but with sustained reflective listening. Questioning is no substitute for good reflection, although it is far easier. Motivational interviewing seeks to evoke intrinsic motivation from the client, and this is unlikely to be accomplished solely by firing questions. Ask an open question, then reflect.

2.5c. Listening with Empathy. The eliciting strategies just discussed are likely to evoke some initial offerings, but where therapy goes from there will depend on how you *respond* to clients' statements. The therapeutic skill of accurate empathy (sometimes also called active listening, reflection, or understanding) is the preferred response within MET, and one that helps the client to keep exploring new ground.

Empathy is sometimes thought of as "feeling with" a person, or having an immediate understanding of their situation by virtue of having experienced it (or something similar) oneself. Sometimes it is confused with sympathy. Carl Rogers, however, introduced a new technical meaning for

the term "empathy," using it to describe a particular skill and style of reflective listening (Rogers, 1957, 1959). In this style, the therapist listens carefully to what the client is saying, then reflects it back to the client, often in a slightly modified or reframed form. Acknowledgment of the client's expressed or implicit feeling state may also be included. This way of responding offers a number of advantages: (1) it is unlikely to evoke or exacerbate client defensiveness; (2) it encourages the client to keep talking and exploring the topic; (3) it communicates respect and caring, and rapidly builds a working therapeutic alliance; (4) it clarifies for the therapist exactly what the client means; and (5) it can be used selectively to reinforce ideas expressed by the client.

This latter characteristic is an important one in motivational interviewing. You can reflect quite selectively, choosing to reinforce certain components of what the client has said, while bypassing others. In this way, clients not only hear themselves saying a self-motivational statement, but also hear you saying that they said it. Further, this style of responding is likely to encourage the client to elaborate the reflected statement. Here is an example of this process.

THERAPIST: What else concerns you about your drinking?

CLIENT: Well, I'm not sure I'm *concerned* about it, really, but I do wonder sometimes if I'm drinking too much.

THERAPIST: Too much for . . .

CLIENT: For my own good, I guess. I mean it's not like it's really serious, but sometimes when I wake up in the morning I feel awful, and I can't think straight most of the morning.

THERAPIST: It messes up your thinking, your concentration.

CLIENT: Yes, and sometimes I have trouble remembering things.

THERAPIST: And you wonder if that might be because you're drinking too much.

CLIENT: Well, I know it is sometimes.

THERAPIST: You're pretty sure about that.

CLIENT: Yeah - even when I'm not drinking, sometimes I mix things up, and I wonder about that.

THERAPIST: Wonder if . . .

CLIENT: If alcohol's pickling my brain, I guess.

THERAPIST: You think that can happen to people, maybe to you.

CLIENT: Well can't it? I've heard that alcohol kills brain cells.

THERAPIST: Um hmm. I can see why that would worry you.

CLIENT: But I don't think I'm an alcoholic or anything.

THERAPIST: You don't think you're that bad off, and yet you do wonder if maybe you're overdoing it and damaging yourself in the process.

CLIENT: Yeah.

THERAPIST: Kind of a scary thought. What else concerns you?

This therapist is responding primarily with reflective listening. This is not, by any means, the *only* strategy used in motivational interviewing but it is an important one that should comprise a substantial proportion of therapist responses. Neither is this an easy skill. Readily parodied or done poorly, true reflective listening requires continuous alert tracking of the client's verbal and nonverbal responses and their possible meanings, formulation of reflections at the appropriate level of complexity, and ongoing adjustment of hypotheses. Optimal reflective listening suspends advice, agreement, disagreement, suggestions, teaching, warning, and questioning, in favor of continued exploration of the client's own processes. (For more detail, see Egan, 1982; Gordon, 1970).

Here are some contrasts between reflective listening and other therapist responses to client statements:

CLIENT: I guess I do drink too much sometimes, but I don't think I have a *problem* with alcohol.

CONFRONTATION: Yes you do! How can you sit there and tell me you don't have a problem when . . .

QUESTION: Why do you think you don't have a problem?

REFLECTION: So on the one hand you can see some reasons for concern, *and* you really don't want to be labeled as "having a problem."

CLIENT: My wife is always telling me that I'm an alcoholic.

JUDGING: What's wrong with that? She probably has some good reasons for thinking so.

QUESTION: Why does she think that?

REFLECTION: And that really annoys you.

CLIENT: If I quit drinking, what am I supposed to do for friends?

ADVICE: I guess you'll have to get some new ones.

SUGGESTION: Well, you could just tell your friends that you don't drink anymore, but you still want to see them.

REFLECTION: It's hard for you to imagine how life would be without alcohol.

Use this style of reflective listening throughout treatment. It is not used to the exclusion of other kinds of responses, but it should be your predominant style in responding to client statements. As the following sections indicate, however, motivational interviewing encompasses a variety of other strategies.

Finally, note that selective reflection may backfire occasionally. For a client who is ambivalent, reflecting only one side of the dilemma ("So you can see that drinking is causing you some problems.") may evoke the other side from the client ("Well, I don't think I have a *problem* really.") - just the opposite of what should be happening. If this occurs, try reflecting both sides of the ambivalence. This is done with a double-sided reflection that captures both sides of the client's dilemma. These are best joined in the middle by "and" rather than "but" to reinforce the simultaneous experience of both sides of the ambivalence:

> You don't think that alcohol is harming you seriously now, and at the same time you *are* concerned that it might get out of hand for you later.
>
> You really enjoy drinking and would hate to give it up, and you can also see that it is causing some serious difficulties for your family and your job.

2.5d. Affirming the Client. Affirmation involves seeking opportunities to affirm, compliment, and reinforce the client sincerely. Such affirmations can be beneficial in a number of ways, including: (1) strengthening the working relationship, (2) enhancing the attitude of self-responsibility and empowerment, (3) reinforcing effort and self-motivational statements, and (4) supporting client self-esteem. Some examples:

> I appreciate your hanging in there through this feedback, which must be pretty rough for you.
>
> I think it's great that you're strong enough to recognize the risk here, and that you want to do something before it gets more serious.
>
> You've been through a lot together as a couple, and I admire the kind of love and commitment you've had to stay together through all this.
>
> You really have some good ideas for how you might change.
>
> Thanks for listening so carefully today.
>
> You've taken a big step today, and I really respect you for it.

2.5e. Responding to Defensiveness. Client defensiveness is an important issue in treatment. Uncooperatative or "counter-change" client behaviors within treatment sessions (e.g., arguing, interrupting, denying a problem) predict poorer treatment outcome.

What is defensive behavior? Here are some specific client behaviors that have been found to be associated with a lack of long-term behavior change:

> Interrupting - cutting off or talking over the therapist
>
> Arguing - challenging the therapist, discounting the therapist's views, disagreeing, open hostility
>
> Sidetracking - changing the subject, not responding, not paying attention
>
> Defensiveness - minimizing or denying the problem, excusing one's own behavior, blaming others, rejecting the therapist's opinion, unwillingness to change, alleged impunity, pessimism

It is important to be aware that the extent of such client behavior during treatment is powerfully affected by the therapist's own style. Miller, Benefield and Tonigan (1993) found that when problem drinkers were randomly assigned to two different therapist styles (given by the same therapists), one confrontational-directive and one motivational-reflective, those in the former group showed twice as much defensive behavior, but only half as many positive, self-motivational statements. Client defensive responses were, in turn, predictive of less long-term change. Similarly, Patterson and Forgatch (1985) had family therapists switch back and forth between these two styles within the same therapy session, and demonstrated that clients' defensive and uncooperative behavior went up and down markedly in response to therapist behaviors. As in chess or martial arts, defensive behavior is the complementary response to offensive strategies. The picture that emerges is one in which the therapist dramatically influences client defensiveness, which in turn predicts the degree to which the client will change.

This is in contrast with the common view that defensive behavior arises from pernicious personality characteristics that are part of the disorder. Historically, denial was regarded to be a trait of alcoholism. In fact, extensive research has revealed few or no consistent personality characteristics among people with alcohol abuse and dependence, and studies of defense mechanisms have found no different pattern from the general population (Miller, 1985). In sum, people with alcohol problems do not, in general, walk through the therapist's door already possessing abnormally high levels of denial or other defensive styles. These important client behaviors are more a function of the interpersonal interactions that occur during treatment.

An important goal in motivational interviewing, then, is to *avoid* evoking or exacerbating defensive (counter-change) statements from the client. Said more bluntly, *defensiveness or denial is not so much a client problem, as a therapist skill issue*. How you respond to defensive behavior is one of the defining characteristics of motivational interviewing.

A first rule to go by is *never meet counter-change statements head-on*. Certain kinds of reactions are likely to exacerbate defensiveness, backing the client further into a corner, and eliciting further counter-change statements (Gordon, 1970; Miller et al., 1993). These therapist responses include:

Arguing, disagreeing, challenging
Judging, criticizing, blaming
Warning of negative consequences
Seeking to persuade with logic or evidence
Interpreting or analyzing the "reasons" for defensiveness
Confronting with authority
Sarcasm or incredulity

Even direct questions as to *why* the client is "resisting" (e.g., Why do you think that you don't have a problem?) only serve to elicit from the client further defense of the counter-change position, and leave you in the logical position of arguing for change. *If you find yourself in the position of arguing with the client to acknowledge a problem and the need for change, it's time to shift strategies*.

Remember that you want the *client* to make self-motivational statements (ready, willing, and able), and if you defend the need for change it may evoke the opposite. Here are several general strategies for deflecting defensiveness within motivational interviewing (Miller & Rollnick, 1991):

Simple reflection. One good strategy is simply to reflect what the client is saying. This tends to defuse or diffuse defensiveness, and sometimes has the effect of eliciting the opposite, balancing the picture.

Reflection with amplification. A modification is to reflect, but exaggerate or amplify what the client is saying to the point where the client is likely to disavow it. There is a subtle balance here, because overdoing an exaggeration can elicit hostility. There should be no hint of sarcasm or irony in the therapist's words or tone of voice.

> CLIENT: But I'm not an alcoholic, or anything like that.
> THERAPIST: You don't want to be labeled
> CLIENT: No. I don't think I have a drinking problem.
> THERAPIST: So as far as you can see, there really haven't been any problems or harm because of your drinking.
> CLIENT: Well, I wouldn't say that.
> THERAPIST: Oh! So you do think sometimes your drinking has caused problems, and what you don't like is the idea of being called an alcoholic.

Double-Sided Reflection. The last therapist statement in this example is a double-sided reflection, which is another way to respond to counter-change statements. If a client offers a defensive statement, reflect it back with the other side (based on previous self-motivational statements in the session). These have the quality of "On the one hand . . . . . and on the other hand . . . . ."

> CLIENT: But I can't quit drinking. I mean, all of my friends drink!
>
> THERAPIST: You can't imagine how you could not drink with your friends, and at the same time you're worried about how alcohol is affecting you.

Shifting Focus. Another strategy is to defuse defensiveness by shifting attention away from the touchy or problematic issue.

> CLIENT: But I can't quit drinking. I mean, all of my friends drink!
>
> THERAPIST: You're getting way ahead of things. I'm not making decisions for you here, and I don't think you should get stuck on that concern right now. Let's just stay with what we're doing here - going through your feedback - and later on we can think together about what, if anything, you want to change and how you might handle it.

Siding with the Negative. Defensive responses can also be met by rolling with them rather than opposing them. Taking up the negative side of the argument often will bring the client back to a balanced or opposite perspective.

> CLIENT: But I can't quit drinking. I mean, all of my friends drink!
>
> THERAPIST: And it may very well be that when we're through, you'll decide that it's worth it to keep on drinking as you have been. It may be too difficult for you to make a change. That will be up to you.

Emphasizing Personal Control. The above example also illustrates another effective strategy in responding to defensiveness: emphasizing that ultimately it is the client who decides whether or not to change. This, of course, is the truth. No one can decide for the client. That fact that there may be clear negative consequences of behavior (e.g., with a client for whom abstinence is a condition of probation) does not alter this truth. Directly acknowledging that decision and choice

are in the client's hands tends to defuse defensiveness, decreasing the need for the client to continue to assert personal control.

2.5f. Reframing. Reframing is a strategy whereby the therapist invites the client to examine his or her perceptions in a new light, or a reorganized form. New meaning is given to what has been said. When a client is receiving feedback that confirms problematic drinking, a wife's reaction of "I knew it" can be recast from "I'm right and I told you so" to "You've been so worried about him, and you care about him very much." This is an example of reframing from what could be a negative interpretation to a more positive one.

The phenomenon of tolerance provides an excellent example for reframing in the other direction, from positive to more negative (Miller & Rollnick, 1991). Clients will often admit to, even boast of being able to "hold their liquor," to drink more than other people without looking or feeling as intoxicated. This can be reframed (quite accurately) as a risk factor, the absence of a built-in warning system that tells the person when they've had enough. Given high tolerance, the person continues to drink to high levels of intoxication that can damage the body, but fails to realize it because he or she doesn't look or feel intoxicated. Thus what seemed good news ("I can hold it") becomes bad news ("I lack a warning system and am especially at risk").

Reframing can be used to encourage both client and SSO to deal with the drinking behavior. By placing current problems in a more positive and optimistic frame, you can communicate that a problem is solvable and changeable (Bergaman, 1985; Fisch, Weakland, & Segal,1982). Whenever possible, use the client's own views, words, and perceptions as you develop a reframe.

CLIENT: I just like to have a few drinks on the weekend, after a hard week.

THERAPIST: You like to reward yourself on the weekend for getting through a difficult job, and whether or not you drink it's going to be important for you to have some way of kicking back and letting go of the stress on the weekend. [This "agreement with a twist" - a reflection followed by a reframe - sets the stage for exploring other ways of making the transition to a weekend.]

CLIENT: If I didn't have a drink after I get home, I don't know what I might say to my husband or kids. It's my way of letting off steam.

THERAPIST: You've tried hard not to burden your family by telling them your feelings, and so you just carry all this around with you, and maybe alcohol helps you forget for awhile. [This depicts the client as well-intentioned, and paves the way for improving communication.]

HUSBAND (to Therapist): That makes me nervous, wondering what she's been holding back, but I'm not very happy as it is, either.

THERAPIST: So it sounds like drinking has been one way for you to avoid conflict or tension in your marriage. Your drinking kind of keeps the lid on, and in that way maybe it's been a way you've used to keep your marriage intact. Yet both of you seem uncomfortable with this now, and it doesn't seem to be doing what you want. [The implication is that the client cares about the marriage and has been trying to keep it together, but needs to find more effective ways to do this.]

The general idea in reframing is to place the behavior in a new light, and to do so in a way that causes the person to take action to *change* the problem. It invites the client to interpret experience in a new way. Remember that the general tone in reframing is to *suggest* a new way of thinking about what is

happening. If you state it too strongly, it can come across as an authoritarian interpretation, which can roadblock communication and increase defensiveness.

As illustrated above, it can be particularly effective to combine a reflection with a reframe, a strategy called "agreement with a twist" (Miller & Rollnick, 1991). Initial reflection of a counter-change statement, for example, has the effect of joining with the client's assertion, which is then melded with a shift in meaning. This is often best done as a passing comment, without great emphasis:

CLIENT: But I really *enjoy* drinking, and nobody is going to make me quit!

THERAPIST: Alcohol is very important to you [reflection], maybe so important that you will be willing to keep drinking no matter what it costs you [reframe]. What is it that you particularly enjoy about alcohol [open question]?

2.5g. Summarizing. Finally, it is useful to summarize periodically during a session, and particularly toward the end of a session. This amounts to a summary reflection that pulls together what the client has said. It is especially useful to repeat and summarize the client's self-motivational statements. Elements of reluctance or defensiveness may be included in the summary, to prevent a negating reaction from the client, but particular emphasis is given to self-motivational themes, in order to reinforce them. A summary serves the function of allowing the client to hear his or her own self-motivational statements yet a third time, after the initial statement and your reflection of it. Here is an example of how you might offer a summary to a client at the end of a first session:

Let me try to pull together what you've said today, and you can tell me if I've missed anything important. I started out by asking you what you've noticed about your drinking, and you told me several things. You said that your drinking has increased over the years, and you also notice that you have a high tolerance for alcohol - when you drink a lot, you don't feel it as much as most people do. You've also had some memory blackouts, which can be a worrisome sign. There have been some problems and fights in the family that you think are related to your drinking. On the feedback, you were surprised to learn that you are drinking more than 95% of the U.S. adult population, and that your drinking must be getting you to fairly high blood alcohol levels even though you're not feeling it. There were some signs that alcohol is starting to damage you physically, and that you are becoming rather dependent on alcohol. That fits with your concern that it might be tough for you to give up drinking. And I remember that you were worried that you might be labeled as an alcoholic, and you don't like that idea. I appreciate how open you have been to this feedback, though, and I can see you have some real concerns now about your drinking. Is that a pretty good summary? Did I miss anything?

Along the way during a session, shorter "progress" summaries can be given. A "What else?" question after a transitional summary can help to keep the process moving.

So thus far you've told me that you are concerned you may be damaging your health by drinking too much, and that sometimes you may not be as good a parent to your children as you'd like because of your drinking. What else concerns you?

2.6. Implementing Phase 1

The clinical methods just outlined are used throughout CBI, and particularly form the core of Phase 1. This first phase of treatment begins with a period of open motivational interviewing, and then proceeds into the more structured assessment feedback.

Breath Alcohol Screening. It is routine procedure in Project COMBINE to administer a breath alcohol screen prior to each and every CBI session. The client's BAC must be at or below 50 mg% (.050) in order to proceed with a session. When a client's BAC is above this level, the CBI session is rescheduled. If the client's BAC is above but near this level and descending, you have the option of waiting until the BAC level reaches .050, or of rescheduling the session. Follow your center's procedures with regard to legal liability in releasing a client with an elevated BAC (e.g., to prevent the client from driving while intoxicated). If the client has seen the MM clinician immediately prior to your CBI session and was breath tested for the MM session, it is not necessary to repeat the breath test. Procedures for coordinating this information are developed at each site.

2.6a. Getting Started with Motivational Interviewing. Begin your first meeting by greeting your client, introducing yourself, and then briefly explaining what will be happening in the first session. With the amount to be accomplished in the first session, it may take from 60-90 minutes. Here is an example of how a structuring statement might sound:

We're going to be talking for an hour or so today, maybe a little longer this first time, but usually our sessions will be an hour or less. Today I want to take some time just to understand how you see your situation, and particularly what has been happening with regard to your drinking. I'll ask you a few questions, but mostly I'm going to listen. A little later I'll explain in more detail what's available to you during the rest of treatment, and I have just a few questionnaires I will need you to complete today. Okay?

This is also the place to explain to your client the legal limits of confidentiality. With this done, proceed directly into Phase 1. If the client asks a preliminary question, answer it, but don't ask "Do you have any questions?" at this point.

The open motivational interviewing phase starts quite simply, with an open question followed by reflective listening. From your review of the client's assessment information you will already have some sense of the client's situation, which may guide you in your choice of an opening question. In essence, ask a broad question that invites the client to tell you about his or her drinking and current situation.

> Tell me what you have been thinking about your drinking recently, and maybe how that compares with what other people are telling you.
>
> Obviously there are things that you have enjoyed about drinking, or ways it has been important to you. What I'd like to ask you right now, though, is what drinking has *cost* you, what price you've had to pay not only in money, but in your life more generally.

Once this process is underway, keep it going by using reflective listening, by asking for specific examples, by asking "What else?", etc. If it bogs down, you can inquire about some general areas such as:

> *tolerance* - does the client seem to be able to drink more than other people without showing as much effect?
>
> *memory* - has the client had periods of not remembering what happened while drinking, or other memory problems?
>
> *relationships* - has drinking affected relationships with spouse, family, or friends? Who else has been concerned about the client's drinking, and what have their concerns been?
>
> *health* - is the client aware of any areas in which alcohol has or may have harmed his/her health?
>
> *legal* - have there been any arrests or other brushes with the law because of behavior while drinking?
>
> *financial* - has drinking contributed to money problems?

Information from pretreatment assessment (to be used as feedback later) may also suggest some areas to explore. Remember to ask few questions, and rely primarily on reflective listening. Keep in mind that your goal is to elicit self-motivational statements, which can then be reinforced by reflection, accumulated, and gathered together in summaries. If defensive behavior arises, use strategies outlined above to respond to and defuse it.

If you encounter difficulties in eliciting client concerns, still another possible strategy is to take up the negative side of the argument to evoke self-motivational statements. In this table-turning approach (siding with the negative), you subtly take on the voice of the client's doubts and defenses, evoking from the client the opposite side. Some examples:

> You haven't convinced me yet that you are seriously concerned. You've come down here and gone through several hours of assessment. Is that *all* you're concerned about?

I'll tell you one concern I have. This program is one that requires a fair amount of motivation from people, and frankly I'm not sure from what you've told me so far that you're concerned enough to carry through with it.

I'm not sure how much you are interested in changing, or even in taking a careful look at your drinking. It sounds like you might be happier just going on as before.

And maybe it *would* be too difficult for you to quit drinking. Maybe no matter what happens, it's worth it to you to be able to keep drinking.

If you use such statements, make them without any tone of sarcasm or irony.

Relatedly, a client may back down from a position if you state it more extremely, even in the form of a question. For example:

So drinking is really important to you. Tell me about that.

What is it about drinking that you really need to hang onto, that you can't let go of?

In general, however, the best opening strategy for eliciting self-motivational statements is to ask for them directly:

Tell me what concerns you about your drinking.
Tell me what it has cost you.
Tell me why you think you might need to make a change.

In listening to the client's perceptions and concerns, offer interim summary reflections, particularly reinforcing self-motivational statements. It can be useful to follow such interim summary reflections with "*What else*?"

I've heard three things so far that concern you some about your drinking. One is that people are starting to make comments to you about drinking too much. You also notice that you feel fairly uncomfortable when you don't have alcohol around. Then there is also this business of not remembering things that have happened when you were drinking. That scares you a little. What else?

When it seems that you have elicited most of the client's concerns, or when time is growing short (e.g., after 30-40 minutes), draw together what your client has told you in a summary reflection as described earlier. Offer a transitional summary statement such as:

Let me see if I have a good picture - at least a beginning picture - of where you are right now. And let me know if I've missed something. You ....

Proceed to pull together the self-motivational statements and themes that you have heard, perhaps also acknowledging the other side of the picture as well (the client's reluctance, what the client likes about drinking, etc.), but placing particular emphasis on the former. Then ask if your understanding is right, or if you have missed something. Respond with reflective listening to anything more that the client offers, and then provide another structuring statement:

What I want to do in the time we have left today, then, is three things. I'll tell you a little about what we'll be doing in the next few sessions. As I mentioned earlier, I have a few questionnaires for you to complete today, that will help us as we work together in the coming weeks. First, though, I want to ask you whether there is someone who might be able to help and support you as we work together . . .

2.6.b.1. Initiating Involvement of a Supportive Significant Other (SSO). One of the significant elements of CBI is the active positive involvement of a supportive significant other (SSO) in the treatment sessions. Previous research has shown that SSO involvement can help to improve treatment outcomes (reference). The SSO is invited to attend the sessions to learn more about the individual's alcohol problems, offer constructive feedback about the treatment plans, provide ongoing support for sobriety and in general, become a important motivator for change.

The SSO is not involved in sessions until phase I is completed so that the therapist has an opportunity to develop rapport and understanding about the client's current circumstances. SSO involvement is introduced in the first and second sessions but involvement does not occur until the third session, or later. The SSO selection process should be completed as early as possible in treatment if clients are not opposed to the idea. **However, in accordance with the CBI approach, SSO involvement is encouraged and supported but not imposed upon the client.** Clients need to be given the opportunity to explore underlying ambivalence and uncertainty about SSO involvement **before** a decision is made to involve the SSO. The first step is to utilize the following method for eliciting client concerns about involving an SSO. Responding to client's uncertainty and ambivalence with acceptance and respect may help to minimize client resistance to involving SSOs in treatment. Remember to utilize a motivational interviewing style when exploring SSO involvement.

Involving the SSO in treatment:

Ask open-ended questions
Employ reflective listening
Provide a definition of "support" and a clear rationale for involving an SSO
Elicit the client's thoughts, reactions, and concerns
Summarize
Decide

Begin by asking about social support in general, and support for abstinence in particular. Introduce the idea of identifying someone from the client's social network to engage in the treatment process. Pay careful attention to the client's verbal and non-verbal behavior in response to your open-ended questions because this topic may elicit resistance or discouragement from some clients. Use motivational interviewing strategies to elicit and explore your client's thinking about having the SSO involved. Emphasize the fact that the role of SSO is to build support for treatment and change. Be prepared to provide a strong rationale for SSO involvement. In addition, be prepared to respond to some concerns that clients may raise about SSO involvement. The table below may be helpful in thinking about some of the most common client objections to SSO involvement.

Category	Intervention
Limited social resources (e.g., social isolation, homelessness).	If your client has very limited social resources, inclusion of an SSO may not be feasible at this time. Let your client know that while there doesn't seem to be anybody around now, social networks can change and you would like to revisit the issue later on.
Logistic hurdles to SSO involvement (e.g., transportation or scheduling difficulties).	Problems with a potential SSO physically getting to a session because of where they live, transportation, or scheduling difficulties often signify that the involvement of that SSO will need to be limited. Their involvement may need to be as little as 1 session during the entire course of treatment. Reinforce the idea that even limited involvement by an SSO can be very helpful. Encourage your client to generate ideas about how to overcome the practical limitations and advise the client if you will be able to adjust your schedule to accommodate SSO participation (e.g., scheduling alternatives, having the SSO plan a special trip for a particular session).
The client does not feel his/her social network is emotionally supportive.	Reflect the client's view that the network is unsupportive. Review the client's Important People questionnaire to identify any people in the network that the client previously indicated were generally supportive. If all evidence points to the unsupportiveness of the network, this suggests that an SSO need not be selected at this time. Share with your client that you'll revisit this issue later in treatment. If it becomes evident that one or more members of the network have supported the client in the past, explore with your client specific ways in which these people were supportive. Then talk with your client about having these people participate in treatment.
The client believes a potential SSO will be reluctant to participate.	In order to identify if the client's negative feelings (see below) are really the concern, ask the client how he/she would feel about an SSO being there and what they think the role of an SSO is**.** If the SSO's reluctance (as perceived by the client) remains the problem, explore how the SSO has been supportive in the past. Reframe the act of asking the SSO to participate as giving the SSO an opportunity to be supportive in yet another way. It may even be an opportunity for the SSO to learn how to be supportive with regard to the client's drinking. Negotiate with the client around having either the client or the therapist ask the SSO to participate. If the client still is still reluctant, explore the risks and advantages of asking the SSO.
The client has negative feelings around SSO participation (e.g., not to burden people, embarrassment, or wants to "make it" on his/her own).	Normalize the client's feelings and appropriately praise them (e.g., for their concern about burdening others; taking responsibility for their problem by entering treatment). Discuss with your client the option of having an SSO participate as little or as much as the client wants. This can reduce burden on an SSO and increase the client's sense of control.

Do not proceed with the SSO selection process until you have the client's agreement to have the SSO participate in the sessions. If clients remain resistant to bringing an SSO after exploring in this manner, delay further discussion of SSO participation. Clients who decline to have an SSO participate at this stage **must be asked again in Phase II.** The clinician should remind themselves to query the patient again in Phase II about the possibility of SSO involvement. The clinician must use the method outlined above to query again in Phase II. If the patient declines again in Phase II, the clinician must query again in Phase III using the outline above. To summarize, the clinician should always query patients about SSO involvement in Phase I, optimally proceeding to the Important People (IP) questionnaire, which is completed at baseline to provide guidelines for the selection and clarification of the role of the SSO. If the client exhibits resistance to reviewing the IP form, the clinician will use the method outlined above (Involving the SSO in Treatment) for exploring and reflecting ambivalence. At this point, the client may resolve his or her concerns and the clinician may proceed forward to using the IP form. Alternatively, the clinician may decide to delay any further discussion of SSO participation to protect the therapeutic alliance and reduce resistance. If so, the therapist is then obligated to query about SSO involvement in Phase II and again in Phase III.

2.6.b2. Selecting a Supportive Significant Other (SSO). Use the Important People (IP) questionnaire, which is completed during the baseline assessment, to provide guidelines for the selection of a SSO. The IP is used to identify people who are important to the client, not necessarily those who can fulfill the role of an SSO. Within the present context, the IP provides a reference for the therapist to initiate the discussion of selecting a SSO from an existing pool of potential candidates. To prevent miscommunication between you and the client, a glossary of terms is included (see below). Although they are common terms, for the purpose of SSO selection, they are defined as they relate specifically to the requirements of a SSO.

Glossary of terms:

Sober:
abstinent or drinks sparingly.

Supports sobriety:

will not drink in the company of the client and
will not suggest or invite the client to drink and
will not report on their own experiences related to drinking and
will encourage the client's efforts to achieve stated drinking goals

Maintains own sobriety:

is recovering with no episodes of drinking in the last 6 months or
has never experienced an alcohol use/abuse problem

A decision tree (see Table 2.6) has been constructed to evaluate potential SSO candidates. The decision tree offers the opportunity for the therapist and client to define key requirements, potential barriers, and possible solutions for overcoming barriers, which may impact on the ability of a potential SSO to commit to this process. It also exposes the client to concrete and organized methods of decision making. It is a tool for the client to operationalize the level of support necessary for a SSO to meet the goals and objectives of the intervention.

Prior to meeting with the client, have all necessary forms ready, the Important People form, several Supportive People forms (Form ll) in the event there are a number of potential candidates for this role, the glossary of terms, and the scoring guidelines. After greeting the client, remind him or her of the purpose of this

procedure, including the importance of selecting an appropriate SSO. Take some time with the client clarifying the terminology specific to the role of the SSO.

Introduce the Supportive People form as a tool used to identify candidates for SSO, to identify potential barriers which could inhibit the ability of a selected individual to commit to this role, to identify potential solutions to those barriers, and to operationalize the level of support required by the candidate to fulfill the SSO role.

Reference: Form ll

Explore all potential candidates with the client in the event his or her first choice for SSO is unable or unavailable to participate. This will diminish the possibility that both the client and the therapist would need to dedicate part of another session to this task. Choosing an SSO should be experienced as a way for clients to include a person who is important to them and who can support them in the treatment process, not as a way to exclude people whom the client values.

Ideally, the SSO meets all of the recommended criteria. However, if the ranking falls below any of the recommended minimum percentages the therapist can request clarification from the client. There may be an area in which the obstacle can be overcome with help from Project COMBINE staff or the therapist, or a combination of all involved. For instance, if transportation is a problem (i.e. available of sessions < 50%), perhaps arrangements can be made to alleviate that concern. If you determine that there are a significant number of low ratings on the different criteria, encourage the client to identify another potential candidate for screening. Low ratings may represent obstacles for the SSO which may be insurmountable (or require more effort than is reasonable), and evaluation of another SSO candidate would be helpful. If the client is unable to identify another potential candidate it may be useful to postpone involving an SSO, or you may decide to invite this person in for no more than three sessions. This would be done with an understanding that the selected SSO may be able to fulfill the role within the three sessions or may be asked to continue to participate throughout the treatment program. For more information on the problematic SSO refer to section 2.7.h.

Decision Tree Criteria for Table 2.6:

Supportive of Treatment: Questions 1-4
1. Minimum score=75%
2. Minimum score=75%
3. Minimum score=75%
4. Minimum score=75%

Supportive of client: Questions 1-5
1. Minimum score=75%
2. Maximum score=25%
3. Minimum score=50%
4. Minimum score=75%
5. Minimum score=75%

Readily available to: Questions 1-3
1. Minimum score=75%
2. Minimum score=50%
3. Minimum score=75%

Table 2.6 Decision Tree: Selecting a Supportive Significant Other *(Shaded area denotes recommended criteria for SSO selection).*

Supportive of Treatment:					
Supports sobriety	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
Maintains sobriety	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
Available for sessions	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
Supports goals	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
***Supportive of Me*:**					
Listens	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
Blames	Always 100%	Usually 75%	Frequently 50%	Rarely 25%	Never 0%
Helps	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
Respects	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
Knows and understands	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
Readily Available to:					
Talk with me	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
See me	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
Be honest with me	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%

The following vignette demonstrates how the IP can be employed in selecting a SSO for CBI treatment.

THERAPIST: Now that we have discussed what we mean by SSO would you like to review the Important People list that you completed last week to determine if anyone on that list fits the bill for you or perhaps you have thought about someone else who you would like to consider. Let's remember that these guidelines are just that, guidelines. They help us to consider what we are asking of this person and that sometimes the people who we think will be most helpful simply won't be able to fulfill the role for a variety of reasons. For instance, perhaps they live out of the area and would be unable to attend the 3-19 sessions or their work schedules would prohibit attending sessions. In other words, they are still supportive and will be able to help you in many ways,

however, this particular role requires some things that may be difficult for them to complete. So this helps to make this important decision while recognizing there may be many helpful and supportive people but only one or two who can help in this role.

CLIENT: But I really want my spouse to do this. I know this won't be a problem.

THERAPIST: You may be right, let's take a look. As I said earlier, there are three qualities we look at in the support system. They include someone who is supportive of the treatment you are seeking, supportive of you as a person, and someone who is available to you.

CLIENT: I guess I don't understand what you mean. Why can't I just do this on my own or ask my spouse to bring me here?

THERAPIST: Well let's take a look at the guidelines. Often it really helps us to see the obstacles so we can work with them or around them. For instance, being able to get here can be a problem for the person you choose. We have identified a potential problem, transportation. Solving that problem may, in fact, help your supportive other feel better about helping. Perhaps they will feel more welcome and needed because we were able to identify a problem we knew could interfere. Of course, some problems with filling this role may be personal and something we couldn't possibly know.

CLIENT: Okay, I think that makes more sense to me.

THERAPIST: Good. So according to your Important People list there are five important people you have identified. Now, I see that you rated three of them as extremely important. Shall we start with those three?

CLIENT: Sure, my wife is on that list. Just like I said.

THERAPIST: I see that. So let's see how this guideline works. Your sister is also on the list, however, she lives in another state. Obviously, living in a different state makes it impossible for her to attend anywhere from 3-19 sessions. However, I think you would still want to ask her for support in this important decision to change your drinking.

CLIENT: Absolutely. I was thinking that I could really only have one person be there for me. This actually looks like I can ask for other people to help, but maybe one person who can do all this stuff with me.

THERAPIST: Great! So another person on this list is your brother.

CLIENT: Yeah, I think that he'd be really helpful. He's been trying to get me to stop drinking for at least three years. He finally quit but really had a hard time with it. Not that I drink like he did, but he really worries about me.

THERAPIST: Well, it looks like we are jumping ahead a little bit here, in a good way. As you can see on the guide sheet the supportive person should support your sobriety, maintain their own sobriety and your goals for treatment. How do you rate your brother on these categories?

CLIENT: I'd have to say 110%. Actually, in some ways I think he might be better at this than my spouse. Not that I haven't hurt or worried him, but my spouse has really suffered with this. Maybe I should think about asking him.

THERAPIST: Well, before you make your decision let's complete the list. Remember, you still have important people in your life, this particular person should be able to attend 3-19 sessions and you should be able to rate them pretty highly on these categories. So do you want to continue now or do you have any questions first?

CLIENT: Let's finish this now. Maybe when we are done I'll have some questions.

THERAPIST: Good enough.

If your client is reluctant to have a SSO attend, follow a motivational interviewing style to encourage SSO involvement. Particularly helpful are open-ended questions followed by reflective listening. Ask the client about specific concerns she or he has about having someone attend the sessions with him/her. Ask about what the benefits and costs are of having a SSO attend the sessions - e.g., *what is the worst and best thing that could happen if your (SSO) attends?* Reflect back the unfavorable and favorable responses about SSO attendance. For example:

> On the one hand you are concerned that your (SSO) may end up policing your drinking. On the other hand, having your (SSO) involved might enable you to stay away from alcohol. Would you be willing to give it a try at least for a session or two?

Using the aforementioned motivational techniques can help resolve the client's ambivalence with regard to SSO attendance. If the client still refuses, don't push. Acknowledge the client's autonomy ("Okay, that's how you feel for now. It's really your choice"), and indicate that you may come back to the issue (i.e., SSO involvement) later on in treatment. Then do keep trying periodically to encourage the client to involve a SSO in treatment.

If the client agrees to involve a SSO, the simplest way to initiate this is to have the client ask the SSO to come. It might be useful to rehearse how the client would approach and ask the SSO. It is also permissible for the client to telephone the SSO from the office during the session. If the client prefers, however, or if the client's own invitation does not get the SSO to come on the first try, offer to make the contact. This requires written permission from your client.

Before the client leaves the session ask him or her to give a letter to the SSO. Mention that the letter defines a role for the SSO, and provides important information on how the SSO can contribute to the therapeutic process. Show the letter to the client and ask if he or she has any specific concerns about it's contents. If the client has serious reservations, postpone handing out the letter until you have had a chance to resolve their concerns. Here is suggested language for the letter:

> Dear [SSO]:
>
> This letter is to introduce and invite you to participate in a treatment program, in support of [client], who believes you could be particularly helpful. I am currently working with [client] in our program, which is one of a number of treatment centers in the United States participating in the development of state-of-the-art treatment for alcohol problems. This treatment works best when a *supportive person* participates in the treatment sessions.
> [Client] values your help and has named you as a trusted person who could fulfill this important role. He (or she) views you as someone who is available and supportive, as well as positive about [his/her]

seeking treatment for alcohol problems. [His/her] treatment will involve up to 18 further sessions over a maximum period of 16 weeks, based on progress towards goals agreed upon at the beginning of treatment.

This letter is to ask whether you would be willing to participate in a supportive role in some of [client's] treatment. We can discuss the amount of your participation, and reach a decision that is acceptable to all involved. The treatment sessions last about an hour and are scheduled at everyone's convenience. They are held at [location].

What would be involved? As we work together, [client] will be developing specific plans for change. If you agree to participate, you could be helpful to [client] by giving encouragement, offering helpful ideas, and supporting [his/her] own efforts toward treatment goals. You would not be on your own; We will discuss in session how best you can support [client] toward positive change.

I hope that you will agree to come to at least one session, to explore how you might support [client's] efforts toward change. If you have any questions, please feel free to call me at the number listed above. Otherwise, [client] can just tell you the date and time of [his/her] next appointment so that you may attend.

Thank you for considering to help in this way. Your support could make a big difference.

2.6b.3. Summary of SSO Recruitment Process

Step One: Clinician initiates involvement of a Supportive Significant Other. If client agrees, clinician proceeds to review of Important People questionnaire (Form LL) and selection of SSO.

Step Two: If client disagrees, clinician elicits concerns and responds with motivational interviewing style as outlined in Involving the SSO in treatment, page 2:22 and in box on 2:23

Step Three: If client continues to be reluctant to discuss SSO involvement, therapist may delay further discussion of this issue, but must query again in Phase II and Phase III.

2.6c. Completing Assessment Needed for Phases 1 and 2. There are three questionnaires that all clients need to complete in preparation for the second session and for Phase 2 of treatment. Allow enough time to administer these at the end of the first session, so that you can obtain a few additional scores you will need for feedback (PFR) in session 2. Do not proceed with session 2 until these assessments have been completed (about 15-20 minutes needed). Do not send these questionnaires home with your client. They must be completed in the office, under more standard and controlled conditions. The three questionnaires are:

Desired Effects of Drinking Questionnaire	(used in 3.2b)
What I Want From Treatment	(used in 3.5b)
Client Services Request Form	(used in 4.3c)

Begin with a transitional statement such as:

As I mentioned earlier, there are some you'll need to complete in preparation for our next session together. I have three questionnaires here that I need you to complete,

Reference: Form G

and then I'll tell you briefly about what we'll be doing next time. You can fill these out right here. If you have any questions, I'll be [right outside, in the next office, etc.]*, and let me know when you're done*.

Before moving on, scan the questionnaires to make sure that all items have been completed.

Reference: Form F Client Services Request Form

Desired Effects of Drinking

Reference: Form H What I Want From Treatment

2.6d. Ending the First Session. Allow at least ten minutes to close the session. Conclude the first session with a summary statement, drawing together all that has happened in it, including self-motivational statements offered during the session.

Then explain what happens in treatment from there on. Here is an example of what you might say:

Next time I will be giving you some feedback from the interviews and questionnaires you completed, answering any questions you may have about it. Then we'll be taking a closer look together at how you have used alcohol, and how it has fit into your life thus far. That will take us a session or two. From there we'll start to think together about where you want to go from here. We have between 12 and 20 sessions to work together during the next sixteen weeks.., and you will have a lot to say about what we do here during that time. We'll work out together an individualized treatment plan that makes sense for you, that deals with things that seem important to you. Again, you are the expert on you, and no one else can decide what you are going to do. How does that sound to you?

2.6e. Scheduling the Next Session. Schedule the next session, usually within a few days of the first session. During the first four weeks of treatment it is recommended that sessions be held at least twice weekly (permissible range: 1-3 times weekly during the first four weeks in which treatment is delivered). Thereafter sessions will normally be reduced to once weekly (permissible range: 1-2 times weekly during Weeks 5-12). The maximum number of CBI sessions with a single client is 20, including any emergency sessions that may be used to deal with crises.

2.6f. Sending a hand-written note. After the first session, prepare a handwritten note to be mailed to the client. This is not to be a form letter, but rather a personalized message in your own handwriting. [If your handwriting is illegible, make other arrangements, but the note should be handwritten, not typed.]

There are several elements that can be included in this note, which are personalized to the individual:

1. A "joining message." ["I was glad to see you," etc.]

2. Affirmations of the client.

3. A reflection of the seriousness of the problem.

4. A brief summary of highlights of the first session, especially self-motivational statements that emerged.

5. A statement of optimism and hope.

6. A reminder of the next session.

Here is an example of what such a note might say:

> Dear Mr. Robertson:
>
> This is just a note to say that I'm glad you came in today. I agree with you that you have some serious concerns to work on, and I appreciate how openly you are exploring them. You are already seeing some ways in which you could make a healthy change. I think that together we will be able to find a way through these problems. I look forward to seeing you again on Tuesday the 24th at 2:00.

Place a photocopy of this note in the client's clinical file.

2.6g. Completing the Session Record Form. The Session Record Form must be completed for every client contact including regular sessions, emergency sessions, telephone contacts, canceled sessions, and no-show sessions. Begin the form by entering the client's case number and printing your own name and therapist number. [If for any reason a different therapist assumes responsibility for a case or delivers a session, a new Session Record Form must be started.] Also record the 16 week date which is the last possible session date. Staple the Session Record Form inside the front cover of the client's chart. If one form is filled and a continuation page (same form) is required, staple the new form on top of the previous form.

Log each session on this form *at the time of the session*. Do not wait until later to fill in the information needed. Enter one of the following codes in the correct column for each and every client contact (including missed sessions and telephone contacts with client or SSO):

S-___ To indicate that an actual face-to-face treatment session was completed, regardless of its length. Give each completed session a sequential number (S-1, S-2, etc.)

BA Client had positive BAC (>.05), and session was rescheduled.

CA To indicate a session that was scheduled but missed because the client canceled it (whether or not it was rescheduled) more than four hours before the time. (A time stamped answering machine message constitutes prior notice.)

NS To indicate a session that was scheduled but missed (no show) because the client failed to appear and either gave no notice or gave notice within less than 4 hours of the scheduled time.

OS Face-to-face counseling session with SSO only; client not present.

TC To indicate a telephone contact with the client, regardless of length, and regardless of whether initiated by therapist or client. This code is also used if a telephone contact included both the client and the significant other in the same call.

TH Session was canceled by the therapist (e.g., due to illness).

TS To indicate a telephone contact with the significant other but not the client, regardless of length, and regardless of whether initiated by therapist or significant other.

UC Unscheduled contact, face to face (e.g., walk-in)**.**

Reference: Form A

Record the date of the session (month/day/year) and the time that the session actually began. The latter is the time when you began talking with your client in session, not the time at which you were scheduled to begin. When the session is over, enter "time ended" as the actual time when the client left the session, not the time when the session had been scheduled to end. Then use the "time began" and "time ended" values to determine the number of minutes that the session lasted (do not round). For CA and NS codes, enter the date on which the session had been scheduled, but do not enter any values for "time began" and "time ended." Also indicate whether a significant other participated in any portion of the session by checking either "Yes" or "No". (Accompanying the client to a session does not count unless the SSO was present in the treatment room for at least part of the time.) For the TS code, this box will always be marked "Yes." Do not check Yes or No for missed sessions (CA or NS codes).

Finally, indicate the correct Phase for the session (I-IV) and which modules you delivered, at least partially, during the session by designating the two letter module codes. These codes are contained on the Therapist Checklists.

2.6h. Completing the Therapist Session 1 Checklist. In addition to the Session Record Form which you keep throughout the course of treatment, also use the appropriate Therapist Checklist during each and every session. There is a special **Therapist Session 1 Checklist** to be completed during each client's first session. The checklist helps you to remember important elements of treatment, and also allows you to document whether you have delivered each of them. (Supervisors and tape raters will use similar forms to parallel your own entries.) Use a check mark [Y] to indicate each element of treatment that you deliver, marking them *during the session* as you complete them. When the session has ended, make sure you have checked all of the boxes corresponding to procedures that you delivered. Also note that there is a procedure (hand-written note) to be completed after Session 1.

2.6i. Beginning the Second Session. Normally the second session begins with a brief status check, then proceeds with the process of assessment feedback. The transition from Phase 1 to Phase 2 may or may not occur during this session. If your client does not show readiness to discuss a change plan (Phase 2), don't insist on pressing forward during this session.

Use these two procedures at the beginning of the second and every subsequent session:

> *Status Check*. Begin this and each subsequent session with a brief check-in on how the client has been since the last session. Ask an open question (e.g., "How have you been doing since I saw you last?") and then follow with reflective listening. Except in the event of crisis, keep this check-in relatively short (< 10 minutes). Particularly if you are a good listener, it is easy to fall into a pattern of spending a significant portion of each session with recent details. While a certain amount of checking and listening is useful to develop and maintain rapport, this has the potential to impede progress in a structured treatment like CBI.
>
> *Structuring Statement*. After the status check, begin this and each subsequent session with a brief structuring statement to review what has been done thus far and explain what will be happening today. Make a gentle transition and then proceed. A common form of the opening structuring statement is:
>
> > "Last time we . . . ." or "So far we . . . . " (including checking on any homework assignments that were given to do between sessions)" and then
> >
> > "Today, we . . . .."

If it seems warranted, you may spend additional time in motivational interviewing during Session 2, before proceeding to assessment feedback.

2.6j. Providing Assessment Feedback. The style of motivational interviewing has been combined with personal feedback in a motivational "check-up" format. Personal feedback with normative comparisons can itself alter behavior, and when combined with a motivational interviewing style can substantially decrease problem behavior. The principle is that of developing discrepancy by comparing personal status with normative ranges.

After an initial period of motivational interviewing, Phase 1 proceeds in Session 2 with feedback to the client from the pretreatment assessment. This is done in a structured way, providing clients with a written report of their results (Personal Feedback Report, Appendix A). To initiate this phase, give the client the Personal Feedback Report (PFR), retaining a copy for your own reference and the client's file. Go through the PFR step by step, explaining each item of information, pointing out the client's score, and comparing it with the normative data provided. The details of this feedback process are provided in Appendix C.

A very important part of this process is your own monitoring of and responding to the client during the feedback. Observe the client as you provide the feedback. Allow time spaces for the client to respond verbally. Ask for reactions to the feedback. Use reflective listening to reinforce self-motivating statements that emerge during this period. Also respond reflectively to defensive statements, perhaps reframing them or embedding them in a double-sided reflection. Examples:

> CLIENT: Wow! I'm drinking a lot more than I realized.
> THERAPIST: It looks awfully high to you.
>
> CLIENT: I can't believe it. I don't see how my drinking can be affecting me that much.

THERAPIST: This isn't what you expected to hear.

CLIENT: No, I don't really drink that much more than other people.
THERAPIST: So this is confusing to you. It seems like you drink about the same amount as your friends, yet this says you drink a lot more than most people. You wonder how both can be true.

CLIENT: More bad news!
THERAPIST: This is pretty difficult for you to hear.

CLIENT: This gives me a lot to think about.
THERAPIST: A lot of reasons to think about making a change.

Often a client will respond *nonverbally,* and it is possible also to reflect these reactions. A sigh, a frown, a slow shaking of the head, a whistle, a snort, or tears can communicate a reaction to feedback. You can respond to these with a reflection of the apparent feeling.

If the client is not volunteering reactions, it is wise to pause periodically during the feedback process to ask:

What do you make of this?
Does this make sense to you?
Does this surprise you?
What do you think about this?
Do you understand? Am I being clear here?

Clients will have questions about their feedback and the instruments on which their results are based. For this reason, you need to be quite familiar with the assessment battery and its interpretation. Some additional interpretive information is provided on the PFR and in "Understanding Your Personal Feedback Report" (Appendix D), which the client takes home.

If not completed during the second session, return the client's PFR to the clinical file so that you are sure to have it when you resume feedback in Session 3. Then at the beginning of Session 3, retrieve the client's PFR from the file, give it to the client and resume your review by first giving a summary of feedback that has been covered thus far. Then ask, "Are you ready to go on?" and proceed.

When you have completed your review of the client's feedback, give the client a copy of the PFR as well as a copy of "Understanding Your Personal Feedback Report" (Appendix D). Explain that the latter contains information helpful in remembering what the various scores mean on the PFR, and that he or she is welcome to ask more questions about the feedback now or in future sessions.

2.6k. Completing Therapist Checklists. Therapist Checklists are to be used in all sessions throughout CBI. After Session 1 (covered in 2.6h above) there is not a separate checklist for each session. Instead, checklists document procedures that may be delivered across sessions. Start using the Therapist Checklist for Phase 1 Completion during Session 2, and continue to follow it until all Phase 1 procedures have been completed. Then proceed to the Phase 2 checklist and continue to use it until all Phase 2 procedures have been completed. In Phase 3, there is a separate checklist for each module that you and your client select allowing you to document the completion of procedures within modules. It is permissible to be working on two (but never more than two) modules at the same time during Phase 3.

2.6l. Ending Sessions. In addition to a standard opening for sessions (see 2.6i), there is also a normal procedure for bringing sessions to a close. About five to ten minutes before your scheduled time is over, signal that the session is coming to a close and offer a summary reflection, give an indication of what will happen next, and then give the client an opportunity to ask for clarification or add something. Here is an example:

> *Let me go over what we've done today, and where we will go from here. We talked a lot today about the reasons why you want to quit drinking, and also some of your concerns about quitting. I really appreciate how honest you have been with me and with yourself in exploring this. You have really enjoyed drinking, particularly up until a few years ago, and it has become a major part of your social life. You can see, though, that in another way it has taken over your life, to the point that it is compromising your health and your relationship. You started drinking in the morning, even though you had promised yourself you wouldn't ever do that, and some of the feedback we discussed worries you. We're getting to the end of the time we scheduled today, but I'd like to see you again soon because you seem really eager to take a next step. What we'll do next time, then, is to start sorting out what you want to do about your drinking. There are some things we can do together to figure out what might work best for you, and I will certainly want to hear your own ideas on what you want to do. How does that sound? Did I miss anything important? . . . . . Is there anything else you'd like to ask or tell me before next time?*

The content of the closing summary will vary, of course, depending on what happened in the session. The point is to draw together in your summary:

> what has been discussed during the session
> self-motivational themes that have emerged during the session (and before)
> honest affirmation of the client's efforts, strengths, intentions, etc.
> any tasks that the client is to do between now and the next session
> anticipation of what you will be doing in the next session
> scheduling of the next session

2.7 When the Supportive Significant Other (SSO) Attends the first CBI Treatment Session

2.7a. Overview. Typically, the first SSO-involved session occurs at the third session of CBI treatment, but only after the feedback on the baseline measures has been provided to the client. The overall purposes of the initial SSO-involved session are (1) to orient the SSO to his or her role/function in CBI treatment (2) to obtain the SSO's commitment in supporting the client's efforts to change and (3) to enhance the SSO's skill in providing clear and meaningful support to the client. Efforts are made to find opportunities for the SSO to increase his or her supportive behaviors. Other activities include helping the SSO determine when to, and when not to, offer support. For example, there are certain circumstances where it may be desirable for the SSO to "back off" rather than continuing to offer support. Such situations may involve a client's failure to adhere to treatment goals such as not taking medications, not attending job training sessions, and not willing to "sample" abstinence. Under these circumstances it may be valuable for the SSO to withdraw her/his support to allow the client the opportunity to experience the costs/consequences of his choices/actions. This process can help mobilize a client's inner resources to deal with the drinking problems.

2.7 b. Orienting the SSO to CBI. SSO selection should occur by the second CBI session. If the client agrees, the SSO is invited to the third CBI session, but only if assessment feedback has been completed. At this initial SSO-involved session, welcome and thank the SSO for coming in support of the client's treatment. Ask the SSO whether he or she received the letter inviting him or her to participate in the client's treatment (A letter inviting the SSO to participate will be given to the client to bring to the SSO prior to the initial SSO-involved session). Briefly review the contents of the letter for those who did not receive it. Ask the SSO

whether he or she has questions and concerns about the strategies and procedures covered in the letter. Respond in a straightforward manner to any questions or concerns that the SSO may have about the information.

To prevent misunderstandings between you, your client, and the SSO, which could result in compliance problems later on, review the goals and objectives of the client's treatment. Clarify what roles the SSO might play in the sessions. Remind the SSO that she or he knows much more about the client than the therapist and consequently could be helpful in a number of ways such as providing constructive feedback on the plans which have been devised by the client and therapist to maintain abstinence. Explain that the SSO is not expected in any way to be a co-therapist, and assure the SSO that you will not ask him or her to do anything that he or she is not comfortable doing. If the SSO is a family member, explain that you will not be doing marital or family therapy (in which the relationship is the focus of treatment). You may discuss issues that have to do with communication in relationships, but the primary purpose of treatment is to help the client get and stay sober. Explain also that the SSO's role does not include any policing or enforcing, but rather the main focus is to be supportive of change. Explain clearly that the SSO's role is to provide support for sobriety during treatment, both inside and outside of sessions. This will include:

offering helpful ideas and input
giving encouragement
supporting and reinforcing the client's efforts to stay sober, and
helping - in ways the client wishes- to carry out plans for staying sober.

In general, by becoming an ally for change the SSO can help to improve the effectiveness of treatment. However, you may want to remind the client that no one else can make the ultimate decision about change, or take responsibility for it.

Mention that the intention of CBI treatment is to have the SSO participate in all CBI sessions so that the client will obtain maximum benefit of treatment. Explain that the number of CBI sessions (i.e., up to 20 sessions) is usually decided collaboratively among the parties involved (i.e., client, SSO, and therapist). Typically, a client's treatment is terminated when she or he (client) has achieved treatment goals or a determination is made that she or he (client) has derived optimum benefit from such involvement. Here is an example of how this opening statement might sound in ordinary language:

THERAPIST: I appreciate your willingness to attend these sessions and to help David (client) as he makes some major changes. Your support and encouragement can be valuable in helping David overcome the drinking problem. Let me start by asking - in what way have you tried to be helpful in the past?

SSO: I found that David didn't drink at all when I kept him busy around the house, especially when I asked him to care for the children. He loves his children and would never do anything to hurt them. He never drank when he would take them out for food, ball games, and swimming.

THERAPIST: So one thing you have tried is to keep him busy, especially with the children, to help him not drink. *(Turning to the client*) Is that something that you found helpful?

CLIENT: I didn't realize what was behind it, but I know I don't drink when I'm taking care of the kids.

PIST: Good. (*To SSO)*. How else have you tried to support David in not drinking? Give me another example.

It didn't work very well, but I would kind of snoop around to see if he had a bottle - things like that.

PIST: You meant well in doing that, but it didn't really work so well. I can see, though, that you have really been looking for what you can do to support him in not drinking - whether or not it was always the right thing to do. (*Turning to client*) Let me ask you this: Do you have any concerns or anticipate any problems in having Martha (SSO) come to the sessions with you?

CLIENT: I'm concerned that if Martha comes to these sessions, she will get obsessed with my drinking. This was a problem in the past. Martha was furious with me when I was drunk, and like she said, she acted like a detective. Sometimes when I arrived home with a package I would get this suspicious look as if I was hiding booze in the bag. This stopped once I entered this program, though.

THERAPIST: (*To SSO)*. So you have been making an effort not to be too involved with his drinking since he came here. I imagine it was something of a relief for you.

SSO: It certainly is. I feel like finally I don't have to be the only one standing between him and his alcohol.

PIST: You know, that's really not so unusual. When somebody you love is in trouble, you're concerned and just want to do something, anything. It happens particularly when the level of stress and conflict is high. Sometimes people do things that don't make sense, just trying to do something, anything to bring about a change. Now it feels like the weight isn't so much on your shoulders. I think you both understand that even with Martha participating in these sessions, the real responsibility for change lies with you, David. Nobody can do it for you, even if they really want to. *(Turning to the Martha)* What I want you to do in these sessions is to provide emotional support while David is making changes related to his drinking. You could also provide constructive input and ideas along the way. But there's really nothing else right now that I need for you to do. Just your being here is helpful. What do you both think about that? Are you willing to help in that way, Martha?

Here are a few points to remember after you have given your introduction and described the SSO's role.

1. Ask whether the SSO is willing to help in this way.
2. Ask whether the client is willing to have the SSO help in this way.
3. Ask whether the SSO has any questions that you could answer.
4. Ask whether the client has any questions about how the SSO will be involved.

Ask the SSO what steps has she/he found helpful to the client in achieving sobriety. If SSO is unable to respond give her/him a few examples of what might be helpful to a client such as maintaining a sense of optimism, praising the client for his or her efforts, spending time with the client in activities incompatible with alcohol use, and celebrating the achievement of an important step - e.g., refusing to drink with a special friend. In the case illustration below, the therapist discusses with Janet (client's wife - SSO) and Bob (client) how to employ support effectively with the client:

THERAPIST: Based on my previous discussions with Bob you appear to be his strongest supporter. You seem really committed to helping him overcome the drinking problem and I really applaud your coming to the sessions with him. Maybe you can start by saying something about the steps you have taken that have been helpful to him.

JANET: Well, I am just so proud that he has been sober for the past three weeks and I told him so. I have encouraged him to open up to me about how hard it is to stop drinking.

THERAPIST: How did you do this?

JANET: I don't know. I just thought it was important for Bob to know how badly I felt about the drinking. Telling him this seemed to help him open up more to me.

THERAPIST: (To Bob) How has this helped?

BOB: Janet's support and encouragement has meant a lot to me. I find it easier to handle my urges when I know Janet is behind me.

JANET: He (Bob) appreciates my efforts. In the past, when I tried to help he would often tell me to leave him alone. This no longer happens.

THERAPIST: These are important ways to help Bob avoid drinking. I am impressed that you *both* recognize the importance of Janet's support in addressing the problem.

Comment: Here the therapist discusses the importance of the reinforcing behavior with Janet. At the same time, he (therapist) helps to build confidence of the SSO by linking Janet's change efforts to client outcomes.

Continue the discussion on the importance of these reinforcing activities. Explore other ways that the SSO could be helpful to sustain sobriety. Examine how the presence of the SSO could lead to an improvement in the drinking. Below is another case illustration demonstrating how reinforcing behavior impacts positively on the treatment process.

THERAPIST: (To Bob) What are other ways Janet can be helpful to you?

BOB: I am not sure Janet realizes this but last week when she went to the ball game with me I was tempted to order a beer from the vendor but I didn't. I knew she (Janet) would be upset if I started to drink.

THERAPIST: Janet, how did you feel?

JANET: I was glad Bob asked me along. Going to ball games and bowling can be bad for him. I was pleased that Bob had me in mind when he decided not to drink. The fact that I do not drink at these events probably helps a little bit.

THERAPIST: (To Bob) What did you learn from the situation?

BOB: Having her (Janet) there really helped. I was able to control my desire to drink because I did not want to disappoint her. Also, it helped to talk to her

beforehand about the difficulties of attending a ball game on a hot summer afternoon without having a beer.

THERAPIST: Having Janet there was really good for you. What do you suppose would have happened if she wasn't there?

BOB: I'm sure that I would have come home drunk.

THERAPIST: (To Bob) There will be times when you are in problem situations (high risk) like bowling when Janet will not be there. What do you need to do to help yourself to stay sober?

BOB: I could telephone her but this is not always possible. I probably should always keep Janet in mind if I am to get through the situation (*high risk*) without drinking.

Comment: The therapist helps Bob understand how Janet's presence enabled him to refrain from alcohol use. He helps Bob identify the coping mechanism used in this situation to forestall alcohol use. Bob learns that just "keeping Janet in mind" may be an effective coping mechanism in dealing with future alcohol use.

2.7c. When Differences Occur Between the SSO and Client. It is not uncommon to find that the SSO is more committed to changing the drinking practices than the client him/herself. As a result, discrepancies often occur between SSO and client concerning what needs to be done to overcome the drinking. Such differences need to be normalized and resolved. In the excerpt below, Janet's proposed action steps are in conflict with Bob's.

JANET: I want to raise a concern about an event occurring at our house next week. We are planning a surprise birthday party for Bob's father. I do not think we should serve alcohol at the party. Bob disagrees. He sees no problem in having alcohol available for relatives and friends. I tell him he is just looking for trouble if he serves alcohol.

THERAPIST: I am impressed that you *both* recognize this as a potential problem and are willing to talk about it. These issues are not uncommon in families where one of the partners is struggling to stay sober. What may be helpful here is to discuss what might happen if alcohol is served or not. Let's start with not serving alcohol at the party. What do you suppose would happen?

BOB: I'm afraid that it will cause trouble with my friends. I do not want to be made the *fool*.

JANET: Bob' friends may find out he has a drinking problem if no booze is served. I say, "so what". It might help if his friends know.

THERAPIST: You (Janet) feel that letting his friends know about the drinking problem would be a clear indication of Bob's commitment to change and perhaps not serving drinks would give a clear message to the friends about Bob's desire to remain sober.

JANET: Absolutely!

THERAPIST: What about the alternative, that is, serving drinks to your friends and family? What do you think would happen?

JANET: This is the situation we have faced before and it has never worked. Bob tries to have one or two drinks just to be social but after a while just loses it.

BOB: This time it will be different because you (to Janet) will be there.

JANET: I am not so sure. You still drank last time I went to the bar with you and your friends.

BOB: I get very nervous about saying 'no' to my friends and usually end up drinking too much.

JANET: You can handle your friends. You're not afraid to tell them off about other things like when they owe you money. When you feel right about something you can be really strong.

BOB: That's true.

JANET: I just want to say one thing: If you want to serve liquor I can't stop you. But I won't be there watching you 'boozing'.

BOB: You're not coming to the party?

JANET: Not if you serve drinks. I can't stand watching what you do to yourself. The arguments about trying to get you to stop. The blaming of yourself the next day followed by the apologies. This is just too much. It really upsets me (Janet begins to cry).

THERAPIST: (To Janet) You really do not want to continue hovering over Bob about the drinking, do you?

JANET: I need to let go for my own sanity. I can't stand by and watch Bob destroy himself. Maybe my not being at the party would help. Bob would finally learn that he really can't drink.

THERAPIST: Let me summarize the situation. If you serve drinks, there is a high probability that you (Bob) will resume drinking and upset your family. If you don't, then you might be pressured to drink again by your friends. Any other alternatives?

JANET: A third possibility is that the friends might actually understand and be sympathetic toward Bob about the drinking. They might even become supportive of his desire to change. This is what he should expect if they were *real friends*.

Comment: In the excerpt above the SSO demonstrates her support for and confidence in Bob's ability to handle the pressure of his friends to drink. Janet recognizes that not attending the party may not only be important for herself but for Bob as well. It might lead to Bob's understanding that he cannot drink moderately, at least when socializing with friends.

***2.7d. What Does the SSO Do If the Client Resumes Drinking*?** There may be times during the course of treatment that the client will resume drinking which in turn could pose problems for the SSO. Some SSOs

might become angry, frustrated, or disappointed with the client and leave treatment abruptly, an act which conceivably could impact negatively on the therapeutic process (e.g., undermine the self-efficacy of the client in dealing with the drinking). Alternatively, some SSOs might intervene to protect the client from the costs or consequences of the drinking. Examples of such behavior include making excuses for the client to his or her employer, friends, or family for the alcohol use, cleaning up after him/her after a drinking episode, and in general, continuing to play a supportive role despite the client's using. These activities on the part of the SSO have been termed "enabling behavior"(Meyers, Smith and Miller, 1998). Such behavior allows the client to shift responsibility for the drinking away from himself and on to the SSO. Not allowing the client the opportunity to experience the negative consequences of the drinking (i.e., enabling behavior) can undermine his or her commitment to change (Meyer, Smith, and Miller, 1998). Thus, it may be useful to have a discussion about alcohol use *while the client is still sober or before heavy drinking occurs.* At the same time, efforts should be made to have the SSO and client devise a constructive plan to deal with the drinking when or if it occurs (See #'s 1-4 below). Otherwise, there is a risk that the SSO may inadvertently diminish the effectiveness of the treatment. In short, taking a proactive stance with the SSO and client can better prepare them for dealing with the drinking episodes. Therefore, you might consider doing the following:

1. Explain that a return to alcohol use is not uncommon in alcoholism treatment especially in the early months of treatment. However, the longer the client is able to abstain, the better the chances are for continued sobriety.

2. Indicate that the client him/herself is responsible for addressing the problem.

3. Mention that procedures have been developed (see section 4.4. on Resumed Drinking) for helping the client deal with these episodes. Discuss the methods used for helping clients who have resumed drinking.

4. Examine the pros and cons of the various options the SSO might have in dealing with the drinking. One option is to withdraw support from the client while she or he is drinking. This might mean not participating in drinking-related events such as bowling, attending ball games, and parties. If the SSO is a spouse, this might mean having separate sleeping arrangements, not sharing the evening meal, and in general spending more time apart from each other while the client is still drinking. Mention that such an approach has been shown to be effective in facilitating positive change. Another option might be for the SSO to stop attending the sessions and seek help elsewhere (e.g., attendance at Al-Anon) while the client is still drinking. This may be useful for SSOs who are having a great deal of difficulty in coping with the negative feelings resulting from the client's alcohol use.

At the end of the session give the SSO a list of available phone numbers and hours in the event that he or she needs to contact the therapist. Also, give the SSO an appointment card so that he or she may feel like an integral part of the treatment process.

2.7e. Audiotaping. When a SSO arrives for the first time, before turning on the tape recorder, explain that in this program, treatment sessions are routinely audiotaped for purposes of research and supervision. Explain that what is said during sessions remains confidential, and that tapes are carefully protected and are heard only by a supervisor and project research staff. Also explain that the tape recorder can be turned off during a session, when either the client or SSO wishes, if particularly sensitive material is being discussed.

If the SSO is willing to be audiotaped, have the SSO sign the consent form for this purpose, and proceed. If the SSO prefers not to be taped during the first session attended, proceed, but explain that future sessions would have to be audiotaped if the SSO chooses to attend. If the SSO is unwilling to be audiotaped, which would prevent the taping of all future sessions, identify another SSO.

2.7f. SSO Consent. Because the SSO will be participating in treatment sessions and will be tape recorded, the SSO should review and sign a consent to be treated, acknowledging that session recordings will be reviewed by supervisors and will be used to obtain data about treatment processes. This consent form must be approved by the local IRB, and should be signed before the second session in which the SSO is involved.

2.7g. The Basic CBI Approach. While having a SSO involved in treatment can be very helpful, it does not fundamentally alter the nature of CBI. Maintain the same motivational and problem-focused style, *staying within the procedures prescribed in each module*. Some modules contain specific guidelines for how to involve a SSO. Keep your focus on the client. *Do not shift into a marital/family therapy strategy*, where you focus on changing the relationship. The primary focus is on the client.

*Examples of **appropriate** therapeutic responses involving the SSO*

Discussing how the SSO responds to client drinking
Reflecting SSO statements
Encouraging the SSO to provide positive reinforcement for sobriety
Material contained in the Communication Skills module

*Examples of **inappropriate** therapeutic responses involving the SSO*

Discussing family of origin issues
Constructing a genogram
Giving advice on parenting strategies
Sex therapy

2.7h. The Problematic SSO. If the presence of the SSO poses a temporary problem, it is permissible to gently excuse the SSO from part or all of a session. There are circumstances, however, where the SSO's involvement poses more persistent problems.

Identifying the problematic SSO. With proper screening, SSOs who interact negatively with the client will be screened out prior to their involvement in treatment. Nevertheless, there may be cases where the presence of a SSO can pose serious problems in the sessions. Therefore, it is important to detect problematic SSOs *before* they undermine the treatment process. The following circumstances are examples of SSO-related problems in sessions:

The SSO undermines the client's efforts to change the drinking behavior. The client's optimistic comments about change are met with skepticism or derision by the SSO. The client is repeatedly reminded of previous failures in implementing a change plan. Overall, the SSO displays a negative attitude toward the change process.

The SSO evidences an unwillingness or inability to participate in activities that might lead to a change in the drinking pattern such as attending alcohol-free events with the client. In developing a change plan the SSO provides few constructive remarks unless prompted by the therapist.

> The SSO demonstrates a weak commitment to the CBI treatment. She or he frequently cancels appointments without rebooking, "no-shows" at the sessions, arrives late or leaves before the session ends, and does not spontaneously participate in the sessions except to comment unfavorably.

Exploring alternatives with the SSO. To alter the disruptive pattern of interactions, begin with motivational strategies described for Phase 1. Reflective listening and reframing can be quite effective with problematic SSOs (Zweben, 1991). Understand and acknowledge the SSO's viewpoint. This can be done in a separate session or partial session with the SSO if necessary. Explain again the role that you want the SSO to play within sessions, and what things you do not want him or her to do. If these efforts fail to change the negative interaction patterns, consider the following options:

> Limit the SSO's role to information sharing and clarifying factual material. This material can be covered in one or two sessions. Inform the SSO about the client's condition with respect to drinking. Explain the importance of the study medication(s). Advise the SSO about steps the client could take to change the drinking pattern. These steps might include: attending mutual help groups, sustaining a period of abstinence (e.g. for those clients who want to control their drinking rather than abstain) and actively participating in CBI treatment. Such information can reduce a SSO's interference with treatment plans.
>
> If the SSO and client are interested and willing, offer them the opportunity to participate in the communication skills module (COMM, 5.2). Indicate that the primary objective of COMM is to reduce hurtful interactions and increase positive communication between the partners, which in turn can enable them to devote their full energies to changing the drinking problems. Once these communication issues have been addressed, the focus of the sessions can be redirected to the needs of the client. Otherwise, it may be better for the SSO to discontinue attending these conjoint sessions.
>
> If the SSO is unwilling to participate in the COMM module, then ask whether she or he might want to try something else such as Al-Anon or individual counseling (outside the Project). In Al-Anon based programs, SSOs are often asked to detach themselves from the client's drinking. Such an approach might be preferable when the SSO's active involvement in treatment seems to be detrimental.

Here is an example of how a CBI therapist might deal with a problematic SSO:

> THERAPIST: David and Martha, I know that you both agreed to attend these sessions together because of a concern for each other. However, since attending, there have been serious disagreements about what is best to do about the drinking. Each of you has your own firm solutions to the problem. As a result these sessions have become frustrating to both of you. Do you agree?
>
> CLIENT: We are getting nowhere at this point.
>
> SSO: He fights with me on every issue. Everything I say becomes a put down. If I tell him to stay home, he tells me that I am babying him. I can't take it!
>
> THERAPIST: Might I suggest some options? Are you willing to give them serious consideration? I don't want you to make a quick decision about what you ought to do. I just want you to give these alternatives serious thought.

CLIENT: You don't want us to decide right away?

THERAPIST: Right. Even if you are convinced about what you ought to do, you may change your mind after leaving the session. So let's wait until the next session for a final decision, so we can all think it over. Do you agree?

SSO: All right

THERAPIST: One suggestion is for Martha to come to the sessions mainly to learn more about drinking problems, the medications we are using, and various steps that need to be taken in order to deal with the drinking problem. Once you have sufficient understanding about these issues, you may no longer need to attend these sessions.

SSO: This means that I wouldn't be part of working out the problem.

THERAPIST: At least not in the therapy sessions, but you're always going to have an important part in what happens for the two of you. There is a another option, though. We have some communication skills training that we offer. This is for couples who are having a hard time listening to and understanding each other, especially when conflicts arise. Often disagreements arise because each person draws conclusions about what the other is saying without fully exploring or understanding the issues. Specific meanings are attached to statements that may have very little to do with what is actually being said. It gets to the place where simply mentioning certain topics such as "going out with friends" can cause a serious conflict between partners. Communication Skills can be helpful in learning how to resolve these conflict situations, which in turn can help in overcoming drinking problems.

SSO: That sounds like something we need - how to have a serious discussion without fighting. I don't know, though - it sounds scary to me. I am not sure that I have the strength to handle it.

THERAPIST: I understand that you both feel burned. It's been tough to resolve your relationship difficulties. Just keep it in mind. There is a third option, too. You might want to consider attending Al-Anon meetings or some other mutual support group while David is receiving treatment here.

SSO: This sounds even worse to me. I did go to Al-Anon meetings and they made me feel more angry at David. I don't think I want to go back. It felt like a husband-bashing session.

THERAPIST: It's too bad that you had this negative experience in a meeting. Meetings are not all alike, and many people have had good and supportive experiences in Al-Anon. There are quite a few different meetings in town. Anyhow, I don't want a decision now. Why don't you think about these options further and we can try to make a decision about them at our next session.

2.7i. Subsequent Sessions. Evaluate the effectiveness of SSO support in subsequent sessions. Review steps taken that have been successful in addressing the drinking problem. Explore alternative responses in situations that have been unsuccessful. Continue to underscore the importance of the SSO's contributions to the change process.

2.8. Making the Transition from Phase 1 to Phase 2

2.8a. Recognizing Change Readiness. The strategies outlined above are designed to build motivation, and to help tip the client's decisional balance in favor of change. A second important process is to consolidate the client's commitment to change, once sufficient motivation is present, and that is one focus of Phase 2 (Miller & Rollnick, 1991).

Timing is a key issue - knowing when to begin moving toward a commitment to action. There is a useful analogy to sales here - knowing when the customer has been convinced and one should move toward "closing the deal." Within the Prochaska/DiClemente model, this is the stage of *preparation*, when the balance of contemplation is tipping in favor of change, and the client is getting ready for action. Such a shift is not irreversible. If the transition to action is delayed too long, determination can be lost. Once the balance has tipped, then, it is time to begin consolidating the client's decision.

There are no universal signs of crossing over into the preparation stage. These are some changes you might observe (Miller & Rollnick, 1991):

Client defensiveness decreases.

The client asks fewer questions.

The client appears more settled, resolved, resigned, unburdened, or quiet.

The client makes self-motivational statements indicating a decision or openness to change.

"I guess I need to do something about my drinking."

"If I wanted to change my drinking, what could I do?"

The client begins envisioning how life might be after a change.

"How would I spend my time if I didn't go out with my friends?"

"I can see that I would be better off."

Issues of motivation and readiness may also emerge further along in Phase 2 or Phase 3. These questions may alert you to think further about your client's readiness to accept, continue in, and adhere to a change plan:

1. Is the client missing appointments or canceling sessions without rescheduling, or showing indecisiveness or hesitancy about scheduling future sessions?

2. If the client was mandated into treatment (e.g., for a drunk driving offense), have you discussed and reflected his or her reactions to this coercion?

3. Is the client taking initiative and completing homework assignments in treatment?

4. How does the treatment you are offering compare with what the client expected or has experienced in the past? If your approach differs from what the client expected, have you discussed and reflected his or her reactions to the discrepancy?

5. Does the client seem guarded during sessions, or appear to be reluctant or defensive in discussing change?

6. How does the client perceive involvement in treatment in general? Is it a shameful experience, an opportunity for a new lease on life, a sentence to be served . . .?

If the answers to these questions suggest a lack of readiness for change, it is wise to defer an attempt to obtain firm commitment to a change plan, and instead to explore further the client's ambivalence. Be sure you understand the pros and cons of drinking and of change from your client's perspective, and remember to use generous amounts of reflective listening.

For many clients, there will not be any clear moment of decision or commitment to change. People often begin tentatively to consider and try out change strategies during the contemplation and preparation stages. For some, their willingness to decide to change depends in part upon trying out various strategies until they find something that is satisfactory and effective. Thus the shift from contemplation to action often seems like a gradual, tentative transition rather than a discrete point of decision.

It is also important to remember that even when a client appears to have made a decision and is taking steps to change, ambivalence is still likely to be present. Avoid assuming that once the client has decided to change, there is no longer any need for Phase 1 strategies. Likewise you should proceed carefully with clients who make a commitment to change too quickly or too emphatically. Even when a person seems to enter treatment already committed to change, it is useful to pursue some of the above motivation-building and feedback strategies before moving into commitment consolidation.

In any event, there comes a point in treatment when you should shift your emphasis away from motivation-enhancing (Phase 1) strategies toward negotiating a change plan and consolidating commitment to it. This section addresses that transition.

2.8b. Making the Transition to Phase 2. It can be helpful to mark the transition from Phase 1 to Phase 2 (though not using those terms with the client). A useful way to close Phase 1 is with a transitional summary reflection that pulls together all of the client's self-motivational statements, as illustrated above, this time also incorporating information from the review of feedback. This is then followed by a *key question*, an open-ended question that asks, in essence, "What now?" or "What's the next step?"

What do you make of all this? What are you thinking you'll do about it?
Where do you think this leaves you in terms of your drinking?
So what's your plan?
I wonder what you're thinking about your drinking at this point.
Now that you're this far, I wonder what you might do about these concerns.

Here again the first responsibility is the client's, rather than your announcing what the client "must" do. Respond with empathic reflection. If the client appears to be at least somewhat open to discussing change, it is time to proceed with Phase 2. Before doing so, however, always complete the motivational assessment procedure (2.8c).

2.8c. Assessing Motivation. Motivation for change has various components, as suggested by the phrase "ready, willing, and able." A person needs to be *willing* to change, which involves perceiving that the change is important or beneficial. The reasons to change must outweigh the reasons to stay the same.

A person can be willing to change, but doubt his or her ability to do so. This *able* component has been described as confidence or self-efficacy. A person who feels willing but not able to change needs help in building confidence. There are also those who feel quite able to change, but not willing. "I could quit if I

wanted to," they might say, "but I don't really see why I should." For them, your task is to increase the perceived importance of change.

It is further possible to be willing and able to change, but still not ready. "I can do it, and it's important for me to change, but it's not the *most* important thing for me right now." If a person sees the importance of change and feels able to do it, what else is needed to reach readiness to do it *now*? Usually the problem is that there are higher priorities to be dealt with first. Sometimes it is an event that stands between the person and this particular change ("Not until after _____").

As you prepare to make the transition to Phase 2, complete this quick assessment of where your client stands on these three dimensions. This will be helpful in deciding not only on whether to proceed, but how. Using the Personal Rulers worksheet, obtain these three ratings:

Reference: Form I

Importance. *Now if I may I'd like to ask you three questions, and for each one I'd like you to give me a rating on a scale that goes from zero to ten.* (Show the client the Personal Rulers worksheet). *First of all, how* ***important*** *do you think it is now for you to make a change in your drinking, if zero means not important at all, and ten means extremely important. What would you say?* [Circle the one number that the client indicates. Marks between numbers are not allowed.]

> Confidence. *Now suppose that you have made up your mind to quit drinking. How* ***confident*** *are you that you could actually do it? Zero is not at all confident, and ten means you are certain you could do it. How confident would you say you are?* [Again circle the number that the client indicates, with the sheet in front of the client.]
>
> Readiness. *Now third, how* ***ready*** *would you say you are now to change your drinking? Zero is not ready at all, and ten is completely ready. How ready do you think you are?* [Circle the client's rating.]

Here is an important clinical judgment call: Should you proceed directly to Phase 2, or continue to strengthen motivation for change? As a guideline, any client rating less than a 6 bears further exploration. If there is a rating of 5 or less on any one of the scales, or if you decide for other reasons that further Phase 1 work is warranted, proceed to the optional **Exploring Motivation Ratings** procedure (2.8d). If after you have explored the client's ratings with this procedure you believe that further Phase 1 work is needed, two other optional procedures are also provided: **Constructing a Decisional Balance** (2.8e) and **Reviewing Past Successes** (2.8f). Otherwise proceed directly to Phase 2 (2.8g).

2.8d. Optional: Exploring Motivation Ratings. If the client reports low (<6) ratings or you otherwise decide that additional Phase 1 work is needed, use this procedure first. You may then decide to use either, both, or neither of the other two optional strategies that immediately follow (2.8e, 2.8f).

For each of the three ratings that a client gives, there are two open questions that can be asked. Each of these two questions tends to elicit self-motivational statements, to which you should respond with reflective listening and summarizing. The following is suggested wording, which may be rephrased in your own language to suit the clinical situation:

> 1. *Now let me ask you this: Why are you at a (*current score) *and not a zero on this scale?* [This question elicits the client's arguments *for* importance, ability, or readiness, and empathic listening is the appropriate response. Question 1 makes no sense, of course, for the rare client whose score *is* zero, in which case you should skip to Question 2.]

2. *And what would it take to get you from a* (current score*) to a* (higher score) *on this scale?* [For the latter, choose a number that is 1-5 points higher than the client's current score, but not more than 8. Question 2 evokes from the client statements about the conditions under which perceived importance, ability, or readiness could increase, offering you some clues about what is needed in Phase 2 and Phase 3. Again, reflective listening is your primary response to what the client offers. If the client's rating is already 8 or higher, skip this question.]

Ask these questions at least for each scale score that is lower than 6 (you may ask them for other scales as well). When you have completed this, offer a summary reflection that gathers together the self-motivational statements that emerged through Question 1, and the if-then statements that emerged with Question 2. Here is an example of how such a summary might sound.

Reference: Form J

So pulling all this together, you said that you are around a five on willingness to make a change in your drinking, and the main reasons why you are that far up the scale are your concern about how your drinking is affecting your family, and also the problems you have been having with the courts and your probation officer. Making a change in your drinking might get your PO off your back, and you think it would probably also help things go better with your spouse and your children. On the second ruler here, you said that you are very confident - an 8 - that you could quit drinking if you made up your mind to do it. It's just that you haven't really decided yet if you're willing to do it. And so that's reflected in your third rating, a 3, *that you are mostly not ready to make any change yet. Does that sound about right?*

2.8e. Optional: Constructing a Decisional Balance. If there is additional Phase 1 work to do in order to enhance motivation for change, a useful follow-up strategy is to ask the client (and SSO) to consider the pros and cons of change. Use the Decisional Balance Worksheet for this purpose. As an introduction, say something like this:

Sometimes it's helpful to consider the pros and cons of making a change. This is where people often get stuck. They may think about one reason why a change might be good, then they think about something they like about drinking, and after going back and forth a couple of times they just stop thinking about it altogether. Ever had an experience like that? (Listen and reflect if the client offers an example of ambivalence.)

What I'd like to do is to get a clear picture of the pros and cons as you see them. First of all, what do you see as the advantages of continuing to drink as before, the way you have been? We'll come back to this in more detail later, but in general what are the things that you've liked about drinking the way you have been? (Fill in the upper left box of the worksheet. If the client states motivations appropriate other boxes on the worksheet, print them in the appropriate spaces.)

Besides the things you enjoy about drinking, there may also be some disadvantages that come to mind when you think about changing your drinking. What are those? What might be some not-so-good things about changing your drinking? Fill in the lower left box.)

Now how about the other side. What are some of the not-so-good things about drinking for you? [This question may suffice, but you can also ask follow-up questions such as:

In what ways have you or other people been concerned about your drinking?
What have you noticed about how your drinking has changed over the years?
What hassles have you had related to your drinking?

You may also ask "in what ways . . ." questions (or ask for examples or elaborations) pertinent to problems reported by the client on the DrInC questionnaire. If a SSO is present you can ask what he or she has noticed. Spend time eliciting self-motivational statements here, and respond with reflective listening. Fill in the upper right box of the worksheet.]

Finally, what might be some advantages or benefits of making a change in your drinking? In what ways might that be a good thing? (Again, elicit and reflect self-motivational statements. Fill in the lower right box.)

Reflecting, summarizing, and reframing remain appropriate responses throughout this module. Complete the Decisional Balance procedure with a summary reflection that draws together the themes of pros and cons, placing particular emphasis on self-motivational statements.

2.8f. Optional: Reviewing Past Successes. For some clients, the primary impediment to motivation for change is shaky self-efficacy. They understand the importance of change (e.g., see the negative consequences of their drinking) but are not confident of their ability to change. They are willing to change, but question whether they are able. When low confidence is an impediment to motivation, it can be helpful to review how the client and others have changed successfully in the past. Begin by asking the client to recall times when she or he decided to make a change and did so successfully. Here is some sample language:

I know that you're not really sure at this point whether you are ready to change your drinking. Part of this seems to be that you are not sure if you could do it, if you could succeed. Maybe the best place to start is with what has worked for you in the past. Think about some times in your life where you decided to make a significant change and you did it. It might be something you made up your mind to do, or a habit you broke, or something you learned how to do. When have you made significant changes like that in your life? . . . . . What other changes have you made? When have you taken charge of your life?

Elicit several examples, and look for changes that were of the client's own initiative (rather than being imposed) and about which the client seems to feel happy or proud. Then for these explore what the client did that worked, and how similar personal skills or strengths might be applied in changing alcohol use. Respond with empathic listening, particularly reflecting client statements about personal ability to change. Rather than asking baldly, "How did you do it?" it may be helpful to have the client walk you through what changed and how it happened. How did the change process start - what triggered it? What did the client do? What difficulties were encountered? How did the client overcome them? How does the client explain his or her success? What does this imply about the client's personal strengths and skills? Avoid jargon here, and use the client's own language.

THERAPIST: I'm particularly interested in the time when you were able to get out of the abusive relationship. Tell me about that.

CLIENT: Well, I just got tired of being afraid all the time, and I decided that I wanted something better for myself. One night he beat he up really bad, and as I was lying there crying, I just promised myself that was the last time he was ever going to do that to me.

THERAPIST: You decided you had had enough of that - too much.

CLIENT: Right. I mean, I was terrified, too, and I didn't know what I would do. I didn't have a job, or any place to go, but I knew I had to get out of there.

THERAPIST: So even though you couldn't see very far ahead, and you were pretty afraid, you knew you wanted something better for yourself, and you started on your way. What did you do?

CLIENT: I waited until he went out, and then I called the women's shelter. They were really good to me. I was out of there within an hour, before he got back. He never knew what happened to me.

THERAPIST: So once you made up your mind that you wanted a better life, you took action. You knew who to call for help, and you got it! You really trusted in something. What was it?

CLIENT: I guess I just trusted in myself, and that there were people out there who would help me.

THERAPIST: You're a pretty strong person in some ways.

CLIENT: In some ways, yes.

THERAPIST: What are some of those strengths? . . . .

This short dialogue illustrates how through open questions and reflective listening you can elicit self-motivational statements to strengthen the client's sense of hope and optimism, building on past experience. It may also be helpful to describe how others have succeeded in making changes similar to that which the client is contemplating. In one form, you can describe the generally very positive outcomes for people who set out to change their drinking and related problems. In the long run, most people do succeed in escaping from alcohol dependence, even though it often takes a series of attempts. You can describe the range of different approaches that have been successful for others in the past, reflected in part in the menu of options contained in Phase 3. Be familiar with the very favorable outcomes of treatment for alcohol problems (Hester & Miller, 1995; Project MATCH Research Group, 1997a, 1998a) and more generally of efforts to change addictive behavior (Miller & Heather, 1998; Sobell & Sobell, 1992). Look for ties between approaches that have worked for others and what the client tells you about his or her own past successes. Emphasize that there is a large variety of things to try, and that the chances are excellent that the client will find something that works, even if it's not on the first try.

2.8g. Closing Phase 1.

Whether or not you have used optional modules (2.8 d,e,f) in Phase 1, bring this phase of treatment to a close with a transitional summary, followed by a structuring statement such as this:

Now that we've spent some time talking about the "why" of change, I'd like, if you're willing, for you to help me get a clearer picture of how drinking has fit into your life in the past. We can also start considering here the "how" of change - what you think you might want to do.

If the client is still reluctant, ask whether he or she is willing to move ahead to the next step, which is exploring some of the reasons for drinking (i.e., the functional analysis). Emphasize the client's personal choice and

control here, that whatever you do together, it will always be the client's decision what, if anything, to do about drinking.

Use the **Phase 1 Completion Checklist** to document your completion of the above steps. If Phase 1 continues beyond Session 2, continue to complete the checklist in Session 3. Remember also to log every session on the Session Record Form (see 2.6g).

If Phase I continues to Session 3, you should also give the Working Alliance Inventory (WAI) at the end of Session 3. Ask your client to complete it and give it to the clerk or Project Coordinator, sealed in the provided envelope. The WAI should not be returned directly to you and you should not be present when the client is completing it.

2.9. Interim Homework Assignments

Some clients will come into treatment much more ready to change than others. For these clients, Phase 1 is likely to be somewhat shorter. Even so, clients in the preparation or action stage may seem a bit restless to "get going" as you move through the processes of Phase 1 and Phase 2.

One way to address this eagerness is to provide a home task assignment at the end of the second or even first session if you are fairly sure the client is ready for it. The assignment must be consistent with one of the modules of CBI, but this still allows for considerable latitude. You could, for example, invite a client to visit a mutual-help group meeting (3.5c), or sample an enjoyable alcohol-free activity (5.8). It would be possible to start a client on mood monitoring (5.6) or completing a referral to an agency that provides a needed service (4.3). Choose an assignment that is consistent with where you anticipate treatment will be going, based on what you already know about your client. The SSO may or may not be involved in this assignment, though it is often a good place to start in initiating SSO support.

As with any home task assignment, always follow up on the assigned task at the beginning of the next session. This communicates that you place importance on your client's effort and progress in between sessions.

Phase 2

Developing a Plan for Treatment and Change

3.0 Phase 2: Developing a Plan for Treatment and Change

3.1. Beginning a Plan

Before beginning Phase 2, be sure that your client has completed the additional questionnaires that will be needed (see 2.6c) and that you have a copy of the AASE questionnaire (Temptation form) that was administered during the pretreatment assessment.

The key shift in Phase 2 is from focusing on *reasons* for change (building motivation) to negotiating a *plan* for change. Your goal during this phase is to develop with the client (and SSO) some ideas and ultimately a plan for what to do about the client's drinking. Offer a simple transitional structuring statement to mark this shift, such as:

> *Now that we've spent some time talking about the "why" of change, I'd like, if you're willing, for you to help me get a clearer picture of how drinking has fit into your life in the past. We can also start considering here the "how" of change - what you think you might want to do.*

Reflecting and summarizing continue to be good therapeutic responses as more self-motivational statements and ideas are generated.

An important and consistent message is the client's responsibility and freedom of choice. Reminders of this theme should be included during the commitment-strengthening process. Here are some examples:

> *It's up to you what you do about this.*
> *No one can decide this for you. I can't. Your* [SSO] *can't.*
> *No one can change your drinking for you. Only you can do it.*
> *You can decide to go on drinking just as you were, or to make a change.*

Before proceeding into the functional analysis, take a few minutes to understand what ideas *the client* has about how to succeed in changing. If you have used the optional RSUC procedure in Phase 1, you will already have some relevant material. It is also possible that this discussion will have begun naturally when you asked the key question as described above in 2.8b. Continue to use the style of motivational interviewing during this process. If this discussion did not flow naturally from Phase 1, start the process with a structuring statement. Here is a sample structuring statement, which connects directly with the transitional material offered in 2.8g. Note that it begins with a key question as prescribed in 2.8b.

> *So where are you now with regard to your drinking? Before we get more specific here, I'd like to know what you're thinking at this point. What ideas do you have?*

If the client is reluctant to discuss change, reframe the question as a hypothetical:

> *If you **were** to do something about your drinking, what do you think you might do?*
>
> *What encourages you that you could (quit/cut down) your drinking if you decided to?*

Respond with reflection and summarizing.

3.2. Doing a Functional Analysis

Whatever the client's current thoughts about change, complete a functional analysis in every case during Phase 2. The primary focus here is on alcohol use, and the functional analysis examines common antecedents and consequences of drinking behavior. Technical jargon like "functional analysis" and "antecedents" is not appropriate to use with most clients, of course. Introduce this part of Phase 2 with a structuring statement such as this:

> *The next thing I'd like to understand is how drinking has fit into the rest of your life. Whatever you may decide to do, this is an interesting way to get more information about how you have used alcohol.*

Reference: Form L

3.2a. Antecedents. Then proceed to inquire about common antecedents of drinking. Be careful here to use *past* tense language as illustrated below, because present and future tense verbs may alienate or alarm currently abstinent clients:

> *First, tell me about situations in which you have been most likely to drink in the past, or times when you have tended to drink more. These might be specific places, or people, or times of day, or perhaps particular ways that you are feeling. When have you been most likely to feel like having a drink, or getting drunk?*

As the client volunteers these situations, respond with reflective listening to ensure that you understand, and to reinforce responding. Record each antecedent in the "Triggers" column of the "New Roads" work sheet. (Each sheet will accommodate up to nine triggers, and you may use an additional New Roads form as a continuation sheet if necessary. Using more than two sheets is overkill.) Then ask, "*When else have you felt like drinking or getting drunk*?"and follow up with reflection, recording each response. Involve the SSO (if present) in generating ideas as well.

After you seem to have exhausted the client's spontaneous offerings of antecedents, turn to the client's pretreatment Alcohol Abstinence Self-Efficacy (AASE) questionnaire (Temptation form, *not* Confidence form). The AASE contains 20 possible triggers that the client has ranked from 1 (not tempted at all) to 5 (extremely tempted to drink). Note items rated by the client as "3" (moderately tempted) or higher. For triggers not already mentioned, say, for example:

> *I notice on this questionnaire you marked that you might be (moderately/very/extremely) tempted to drink when you _____. Tell me about that.*

Record any additional acknowledged antecedents in the Triggers column.

Reference: Form K

3.2b. Consequences. When you seem to have exhausted the common antecedents of the client's drinking, including any that emerged from discussion of the AASE, proceed to inquire about desired consequences. Remember that you are inquiring here about the client's own *perceived* or *expected* effects of alcohol, which need not correspond to veridical effects of ethanol. This is not the time to "correct" clients'

expectancies. Note that you are to fill in both the Triggers column *and* the Effects column before you begin exploring the links between the two.

> *Now I want you to tell me what you have liked about drinking in the past. We have been talking about some of the negative consequences of drinking for you, but now I need to know what were some of the attractions of drinking for you. What did alcohol do for you that you liked or enjoyed?*

As the client volunteers these desired effects of alcohol, respond with reflective listening to ensure that you understand, and to reinforce responding. Ask for elaboration. Be careful not to communicate disapproval or disagreement at this stage. Record each desired consequences in the "Effects" column of the "New Roads" sheet. Then ask, "What else have you liked about drinking or getting drunk?"and follow up with reflection, recording each response.

After you seem to have exhausted the client's spontaneous offerings of consequences, turn to the client's pretreatment Desired Effects of Drinking (DED) questionnaire. The DED contains 37 possibly desirable expected consequences that the client has ranked from 0 (never drank for this reason) to 3 (always drank for this reason). Note items rated by the client as "2" (frequently) or higher. For any desired consequences not already mentioned by the client. Say, for example:

> *I notice on this questionnaire you marked that you (frequently/always) drank to _____. Tell me about that*.

Record any additional acknowledged consequences in the Effects column.

Reference: Form G

3.2c. Client Reluctance. If the client balks at talking about positive consequences of drinking, use either (or both) of two qualifications: *normalizing* and *distancing*.

> Normalizing involves saying something like, "*Everyone who drinks has some things that they like about alcohol. There is the negative side too, of course, but it will help us to understand what for you, as an individual, was most attractive about alcohol*."

> Distancing removes the client cognitively from the drinking. For example: "*Of course you're not drinking now, and that's how you want to keep it. I'm talking about the past, back when you were drinking. Talking about this doesn't mean that it's how things are now. It may be a little uncomfortable for you to think about, but I believe you'll see shortly that this can be very helpful as we work together toward lasting change* (or *lasting sobriety* if that is the client's language)."

3.2d. Connections. Now comes the interesting step of tying antecedents to consequences. Introduce this by saying something like:

> *What I've done is to write down in these boxes the Triggers that you mentioned as situations in which you have been likely to drink, and the Effects that you mentioned as things that alcohol did for you that you liked or enjoyed.*

Show the complete New Roads form to the client. If you have used two sheets, line them up vertically so that there are continuous Trigger and Effect columns.

It won't surprise you that people often use alcohol as a way to get them from here (point to Triggers column) *to here* (point to Effects column). *Alcohol is used as a kind of vehicle to get you from one place (usually one you don't like) to somewhere else you'd rather be. Does that make sense to you?*

Pick out an item from the Trigger column and one from the Effect column that clearly seem to go together.

For example, you said that you were likely to drink, or to want a drink, when you _____, and that one thing you liked about alcohol was that it seemed to help you _____. Do they seem to go together for you? (If the client confirms, draw a line from that Trigger box to the corresponding Effect box.)

What other pairs do you see here? (Elicit pairs from the client, encouraging and reinforcing responses, so that the client gets the idea of using alcohol to get from Trigger to Effect. Let the client draw connecting lines.)

For Triggers that have not been paired, ask the client to tell you what alcohol might have done for him or her in that situation, and have him/her draw a line to the appropriate box in the Effect column. Often it will happen that there is not yet a corresponding box in the Effect column, suggesting something that needs to be added. Similarly, for any unpaired boxes in the Effect column, identify the likely antecedent, and add entries to the Trigger column as needed. Proceed until all useful pairings have been identified. It is not absolutely necessary to pair all entries.

3.2e. New Roads. Next introduce the idea of finding "new roads" - alternative paths for achieving desirable outcomes in trigger situations (Miller & Pechacek, 1987).

Some of the pairs you have drawn here are pretty common, but these patterns are different for each individual. What we are talking about here is what is sometimes called "psychological dependence." Basically, if the ***only*** *way that you have to get from here* (point to Triggers) *to here* (point to Effects) *is by using alcohol or some other drug, you are in that sense relying or depending on it. Freedom of choice has to do with having options - alternatives to chemicals - different ways of getting from here to here that don't require you to use alcohol or other drugs. Does that make sense?*

Continue to use reflective listening to respond to what your client says throughout this process. If objections or disagreements arise, continue to use the nonconfrontational methods described above to defuse rather than increase noncooperative client responses.

So let's think together about how you might be able to deal with these Trigger situations without alcohol - how you can get to a better place without relying on chemicals. That way you always have an alternative, a choice. For some of these you probably already have good alternatives. For others you may not, and we can talk about options or skills you might like to have. Having new roads to get from here to here is an important part of sobriety.

Which of these do you think have been the ways you have most often used alcohol? Which of these were most important?

Proceed to review the pairs that have been identified, starting with the ones that the client identifies as most important. For each one, ask:

What about handling (dealing with, getting from ____ to ___) without alcohol. What might you do?

Reflect and reinforce the client's own coping ideas. As you proceed through pairs, note and comment on commonalities that emerge (e.g., *"So here, too, what occurs to you is just to avoid this kind of situation. There have been several of these where avoiding is what you thought you would do*.") Where there are treatment modules that might address an area of concern, ask:

> *I wonder if you would be interested in learning _____ as an option you could have for dealing with this kind of situation? Could that be useful to you?*

3.2f. Positive Functional Analysis. Finish up your functional analysis by asking about antecedents and positive consequences of *not* drinking:

> *When are you **least** likely to drink? When are the times that you don't feel like drinking, or pass it up, or maybe don't even think about drinking?*

and

> *How do you have fun without drinking? What do you enjoy doing that doesn't involve drinking? When do you have the most fun without alcohol?* etc.

As usual, follow up by asking for elaboration, listening reflectively, and reinforcing positive statements.

3.3. Reviewing Psychosocial Functioning

Alcohol problems do not occur in isolation from the rest of a person's life. Drinking can adversely affect virtually any area of functioning, diminishing quality of life. As reflected in the New Roads functional analysis, poor functioning or a lack of coping skills in a specific life area can also increase the frequency and intensity of drinking. This two-way influence is one reason why excessive drinking is usually accompanied by a variety of other life problems. Conversely in the absence of substance abuse, effective coping and a sense of well-being tend to go hand in hand.

This relationship also makes sense of the efficacy of broad spectrum behavior therapies in treating alcohol problems (see 1.2a). CBI focuses not only on drinking, but on a range of other life problems to which it can be linked. Clients usually respond quite positively to knowing that you are concerned for their welfare more generally, and are not just interested in their drinking.

This module expands the focus of treatment for all clients by identifying areas of functioning that could, if enhanced, have a beneficial impact in the reduction of drinking and related problems. Eight broad areas are reviewed with and prioritized by the client. This is a further step toward developing a treatment plan that will address the client's unique concerns and thereby enhance motivation for change.

3.3a. Personal Happiness Form. The purpose of discussing psychosocial functioning is to identify important life areas that may be related to drinking problems. This in turn informs the process of setting goals for treatment and change.

Reference: Form M

The Personal Happiness Form identifies areas of psychosocial functioning that sometimes affect and/or are affected by excessive drinking. These are based upon but extend beyond the life problems card sort of the Comprehensive Drinker Profile (Miller & Marlatt, 1984).

Make the transition to this topic by using a structuring statement like this:

> *There is one more area to consider before we are ready to discuss a possible change plan. A lot has been learned through research over the past twenty years, and one thing that is clear now is that drinking is often linked to many other areas of one's life. If things are going well in these other areas, it's much easier to stay free from alcohol problems. On the other hand, dissatisfaction in these areas can contribute to drinking and related problems. What I'd like to do, then, is to go over with you some other areas of your life, because there may be some other things that are important as you consider possible goals for change.*

Then give the client the Personal Happiness Form with these instructions.

> *The first thing I'd like you to do is to decide how satisfied or happy you are with each of these areas of your life. The scale is the same for all of the life areas, and goes from a one (which means that you are totally unhappy or dissatisfied in this area of your life) to a ten (which means that you are completely satisfied and happy in this area of your life). There are twenty different life areas here, and I'd like you to rate them all from one to ten. If an area doesn't apply to you, though, then you can circle "doesn't apply." Any questions?*

When the SSO is present, give the SSO a copy of the form as well. The SSO does not need to fill it out, but say to the SSO that "*This is the form he/she is filling out. You may have some helpful ideas here, too*." Wait for your client to complete the Personal Happiness Form, take it back, and make sure that no items have been left blank. If items have been left blank, have the client rate them or circle "doesn't apply".

3.3b. Card Sorting. Next hand your client the card sort version of the Personal Happiness form, making sure that all of the cards are present. (First remove the title card and the YES and NO cards.) The easiest way to do this is to have the cards in numerical order (numbers in the bottom right corner) from PH-1 through PH-20 before you start. The photo-ready original text is provided with this manual. It should be copied onto card stock and cut into individual cards, forming complete decks of 20 cards each. *Always make sure you're working with a full deck!* Notice also that there is a title card that you do not give to the client, as well as two marker cards, "YES" and "NO" that you keep to use with the following instructions. You will need a small table or flat space on which to use the card sort.

Reference: Form N

> *Now here are the same areas on cards, with one area printed on each card. What I'd like you to do is to sort these cards into two pile. In one pile here* [put down the YES card on the client's left] *I'd like you to put cards that name an area of your life that you think is at least partly related to your drinking. It doesn't matter if you think the link with drinking is good, bad, or neutral. It also doesn't matter whether you think this area contributes to your drinking, or alcohol has an effect on this area of your life. All I want to know is whether you think there is at least some link between your drinking and each part of your life, and if you do, put the card here* [point to the YES pile]. *If you don't see any link between an area and your drinking, then put the card here* [put down the NO card on the client's right side].

Give the client time to complete the card sort. While the client is sorting, you may want to begin checking (Y) on the Personal Happiness Form those cards which the client places in the YES pile. Also notice on the

Personal Happiness Form those items for which the client has indicated dissatisfaction (rating of 4 or lower), because you will need to use this information shortly. When the client has finished sorting, set the NO pile aside and take up the YES pile, quickly but carefully check-marking (Y) each of the YES cards in the "Related to Drinking" column on the Personal Happiness Form (if you have not already done so). Use the card numbers to help you locate them on the Personal Happiness Form. Note that item numbers are provided for you in the "Change" column.

Now I'd like you to go through these same cards one last time. . . .

Give the *full* deck of cards (YES and NO piles recombined) back to the client.

and this time I want you to think about areas where you might like to make a change, or think it may be important for you to make a change. Sort the cards into piles once again, and this time on the YES pile put those that are areas in which you might like to make a change. For other areas where you don't think it's important for you to make a change, put the card on the NO pile. Okay?

Again, review your notes and the Personal Happiness Form rather than watching as the client sorts. When the client has finished sorting, set the NO pile aside and take up the YES pile, quickly but carefully check-marking each of the YES cards in the "Change" column of the Personal Happiness Form.

If a SSO is present in this meeting, check in with the SSO periodically during this process. Does the SSO have any thoughts or suggestions? Is there any agreement about what problem areas are and aren't related to drinking? Add a check in the "Link" column only if *the client* concurs. ("*Would it be all right to mark this one as possibly related to drinking?*")

3.3c. Reviewing the Personal Happiness Form. From here on, set aside the cards and work from the Personal Happiness Form, on which you now have three pieces of information for each area of psychosocial functioning: (a) the client's self-rating of satisfaction, (b) the client's appraisal of whether the area is related to his or her drinking, and (c) the client's current judgment as to whether or not it is important to make a change in this area.

If it's all right with you, I'd like to discuss some of these a little more, so that I understand what you're hoping for in these areas, whether or not we're going to work on them together here. First, I want to ask you about the areas where you said that making a change might be important.

For each of the areas checked (as YES) in the CHANGE column, ask one or more follow-up questions such as those listed below. Start with those CHANGE areas where the client has expressed the greatest dissatisfaction (lowest ratings). Remember that the general style is to elicit and reflect self-motivational statements that reflect the client's perception of problems, concern, desire or need for change, intention to change, optimism regarding change, etc. When you ask a question, follow up by reflecting what the client offers. Don't ask three questions in a row without reflecting in between. Continue asking about areas until all of the YES-CHANGE items have been discussed at least briefly. Here are examples of follow-up questions.

In what ways is it important for you to make a change here?

[For areas of high dissatisfaction] *You said you're pretty dissatisfied here. How would you like things to be better in this area?*

If you had things 100% the way you would like them to be, what would be different?

What might be some first steps toward a change here?

[For items marked YES in the "Related to Drinking" column:] *In what ways do you think this area is related to your drinking?*

This may leave some areas (items) in which the client indicated dissatisfaction (rating of 4 or lower) but did not pick them out as important for change. At your own discretion, you may ask about one or more of these.

I notice that you said you were fairly unhappy with how things are for you with regard to _____. That's not an area, though, where you said you want to make a change. Tell me a little about what's happening in this part of your life.

There may also be areas that the client indicated are related to drinking, but has not designated as important to change or as areas of dissatisfaction. At your own discretion, you may ask about one or more of these.

You said that you think that your _____ and your drinking are linked in some way. In what ways do you see them as related?

How does your drinking fit in here?

However the discussion goes, as always your goal is to help your client to clarify his or her own thoughts and feelings about these life areas, and to experience discrepancy. Focus on evoking self-motivational statements for change. If the client has little desire to make any changes in an area, reflect/accept and move on.

Again, when a SSO is present, get the SSO's perspectives on where change is needed. Add a check in the CHANGE column, however, only if the client concurs.

3.3d. Summarizing. Once you have reviewed the items of the Personal Happiness Form, offer a summary reflection that covers the areas discussed. Use the Form to help you remember the areas discussed. Here is a sample of how a reflection might sound:

Let me try to pull together what you've told me here, before we move on. There are several areas in which you are pretty unhappy with how things are in your life. It sounds like the biggest of those is your relationship with Fran, and especially the way you have been fighting so often and not sleeping together. Money has also been a hassle for you, and you think it might be a good idea to have a regular job. You've been feeling kind of down lately, and discouraged about things ever getting better, and you're having some trouble sleeping, especially waking up in the middle of the night and not being able to get back to sleep, so you feel exhausted a lot of the time. All of those areas where you would like to make a change, although you haven't been sure if it's possible for things to get better. You've been unhappy, too, with how much trouble you've been having in concentrating and remembering things, although that's not an area where you are thinking about making a change just now - partly because you wouldn't know what to do. In terms of your drinking, you saw all of these as linked in some way to your use of alcohol, except maybe for your money and job problems, and it seems like a chicken and egg thing to you - you're not sure which causes which. Have I missed anything important here?

3.3e. Identifying priorities. A last step in reviewing psychosocial functioning is to draw on the client's wisdom with regard to priorities for change. Here an extra focus is on areas where change will be needed in order for the client to succeed in stopping drinking or at least reducing alcohol-related problems.

Of all these areas we have discussed, which are the ones in which you think it is most important for you to see some change? Which ones are priorities for you?

Enter named areas on the Options sheet.

> *And in which areas do you think it would be most important for you to have a change, in order for you to succeed in getting free from alcohol?* [or: *if you were to decide to quit drinking;* or: *for you to start to reduce the problems you've been having in relation to your drinking,* etc.]
>
> *Which areas do you think would pose the biggest challenges for you if you didn't drink?*

Remember that an area doesn't have to be a "problem" itself, or an area of dissatisfaction, for it to be an important support for continued drinking. A client might be very happy with an intimate relationship, yet the partner is likely to support continued drinking rather than sobriety. In the area of work, in some jobs it is more difficult to avoid drinking than in others: salespeople for instance, are often expected to have meetings with clients where having a drink is a normal part of working through a sale. In other jobs, co-workers may engage in conversations about drinking escapades, or may drink at lunch or after work. Joining in such activities may be what is expected in order "to belong. "

As you explore the possibilities in each of these functional areas, be sure to maintain your empathic style. While an area may be supportive of drinking, the client may not want to make changes in this area. Your task is simply to help the client clarify these factors that may be supportive of drinking in each of these areas.

As you proceed through this review, continue to include on the Options sheet possible areas on which treatment might focus. It is likely that the client has identified more areas for change than can be worked upon within the limits of the CBI protocol, and more areas than can be worked on at any one time. Several considerations are pertinent here, including the amount of distress the client is experiencing in each area, the amount of time that would be necessary to address the need area, and the feasibility of realistic change taking place within the time and procedural confines of the CBI treatment. The next step will be to prioritize goals, but for now simply record possible areas of focus for treatment on the Options sheet.

Reference: Form O

When this review of psychosocial functioning is completed, offer one more summary reflection, and then you're ready to move on to setting change goals for treatment. If at least 15 minutes remain in the session, proceed. Otherwise, this is a good place to end the session, with the structuring statement that in the next session (ideally scheduled within a few days) you will work together to develop a change plan.

3.4. Identifying Strengths and Resources

At this point there are several good reasons to identify your client's personal strengths and resources that will be helpful in carrying out the change plan:

< A good deal of attention has been given to the client's problems and deficits, and some balancing of the picture is in order.

< Having the client describe her or his own strengths and resources serves to enhance optimism for change, and continues the process of eliciting self-motivational statements.

< Completing Phase 2 on a positive note is likely to reinforce commitment at the final step.

< Knowing your client's strengths and resources that support sobriety can be helpful in carrying out Phase 3 treatment.

Start by providing a transitional structuring statement such as this:

> *Now that we've talked about some changes you'd like to make and why you want to make them, there's one more thing I want to ask you before we wrap this up. What kind of strengths and support do you have to help you make these changes and maintain them? What is there about you as a person that will help you succeed in making changes like this?*

If the client needs further prompting, try this:

> *What I'm asking for is some of your personal strengths. What are some of your strong points that will help you to succeed with changes like this?*

Some CBI therapists like to use the prompt form, "Some Characteristics of Successful Changers," with their clients, and use it here at the very beginning of the procedure (see material on Form P below). Don't confuse this procedure with exploring changes that the client has successfully made in the past, an optional procedure used at the end of Phase 1 (see 2.8f). Though there is some overlap, here you are focusing on positive attributes of your client that can be resources during the change process. If the significant other is present, involve him or her in identifying the client's strengths as well. This is also a very good place for you to point out and affirm strengths that you see in your client. You're looking here for *stable, internal positive* attributes of your client, and when you hear them, reflect and reinforce them.

There are two kinds of recommended follow-up once you elicit a strength. First, ask the client (or SSO) to elaborate. *In what ways are you a _____ person? Give me an example.* As the client elaborates on the self-motivational statement of personal strength, continue to respond with reflection. Then ask, "*What else?*" to generate more strengths. Here is an example of how such a dialogue might go:

> THERAPIST: *So what are some of your strong points that would help you make changes like these once you've made up your mind?*
>
> CLIENT: *Well, I guess one thing is that I'm kind of a stubborn person.*
>
> THERAPIST: *Once you start something you tend to stick to it.*
>
> CLIENT: *Right. And also once I've said I'll do something, I'm not going back on my word.*
>
> THERAPIST: *That's pretty important to you, to make good on your commitments. Give me an example of how you've done that in the past.*
>
> CLIENT: *I had some gambling debts once, and I borrowed money from a friend to pay them off, and I promised to pay her back. I didn't know how I'd do it, but I made up my mind that I would, and I did pay back every penny. It took me about six months.*
>
> THERAPIST: *So you really stuck with it. Even though it wasn't easy and it took a long time, you made good on your commitment. That's what you mean by stubborn.*
>
> SSO: (to client) *You also said that when Evvy was born you'd quit smoking, and you did it. I know that wasn't easy for you*.

THERAPIST: *So one thing that you know about yourself is that you're a stubborn person, very persistent. Once you set your mind to something, you don't give up until you've done it. What else is there about you that will help you succeed?*

Continue this "what else?" pattern until a number of strengths are identified, and offer summary reflections along the way. Ask the significant other, "*What else do you see as strengths in _____ that can help him/her succeed in making changes in his/her life*?"

If you bog down, pull out the list of adjectives labeled "Some Characteristics of Changers" and invite the client and significant other to look through it for words that they would say accurately describe the client. When one of these is offered, follow up again with elaboration and then "what else on this list?"

Reference: Form P

When you have accumulated a reasonable set of strengths, offer a summary reflection and then move on to resources.

Besides these personal strengths of yours, who else is there who might support you and help you in making some of these changes? What other resources can you draw on?

As the client (and SSO) describe additional resources, follow the same procedure of asking for elaboration, reflecting, and moving on with "who else?" Clients at this point sometimes describe spiritual resources as well, such as relying on God or practicing meditation or prayer. Don't hesitate to explore these as well, asking for elaboration and examples, and following with reflection.

3.5. Developing a Plan for Treatment and Change

3.5a. Structuring Statement. As always, it is useful to provide transitional and structuring language when you shift to a new focus in treatment. Here is an example of how you might structure this section of treatment.

I really appreciate the time you've taken to fill me in, and I think I understand better some of the things that are important to you, and how they fit in with your drinking. What we will do next is decide together what goals you want to pursue as we work together here. Obviously we can't cover all of the areas we've discussed, so we need to figure out what would be most helpful for you -- how it would be best to focus our time together. I can't set goals for you, but I can talk with you now about what seems most important to you.

3.5b. Reviewing Options. As issues have been identified (during the functional analysis and the review of psychosocial functioning) that could be addressed in this treatment, you should have been printing them clearly in bubbles on the Options sheet, using the client's own language as much as possible. If you have some time for reflection before this session, review your notes to generate possible option bubbles. Examples of possible entries include:

Decrease stress
Feel better about self
Explore A.A.

Cope with urges to drink
Learn to say "No"
Comfortable conversation skills
Improve marriage communication

Be sure to leave *at least two* bubbles empty. The possible goals you have entered are a starting point for this discussion. To begin this module, show the Options sheet to your client.

> *On this sheet, which is called Options, I have been taking notes along the way. What I have been doing as we've talked is to write down possible topics that we could work on together here. As you can see,* [show your client the sheet] *I've written each idea in one of these bubbles, and I've also left some bubbles blank because you may have other good ideas. The things I have so far are: _____* (very briefly explain what you have written in each of the bubbles). *Are there other topics you can think of, that we might discuss as part of your change plan?*

Enter any additional appropriate topics into empty bubbles. Once you seem to have all of the client's spontaneous offerings of change options, consult the client's pretreatment What I Want From Treatment (WIW) questionnaire. The WIW contains 42 things that clients might want from treatment, which the client has marked YES or NO. Note items marked by the client as YES, to determine whether they suggest other desired goals of treatment not already mentioned by the client. Say, for example:

> *I notice on this questionnaire you marked that you would like to _____ in treatment. Tell me a little about that. . . . . Is that something we should include on the Options sheet?*

Reference: Form H

3.5c. Recommending Mutual Help Programs. At some point during Phase 2 for all cases (usually while completing the Options sheet), discuss with the client the possible use of mutual-help programs like A.A. Here is some sample language for raising the subject and providing a rationale:

> *One thing that many people have found helpful is to get support from other people who are also recovering from alcohol problems. People who get involved in Alcoholics Anonymous, for example, on average seem to have a better chance of staying sober. Alcoholics Anonymous or A.A. is by far the largest and oldest of these programs, but there are other kinds of support groups in this area as well including _____. I wonder if you have been to any of these groups, and if so what your experience has been.*

Listen carefully to what the client has to say about mutual help groups, and respond with reflective listening. During the discussion, encourage the client to sample several such groups. Describe the various groups that are available in your area.

> *I wonder if you would be willing to try this out as one option in your plan. Which of these groups do you think could be most helpful for you?*

For clients who have not previously attended: *I'd encourage you to try two or three different meetings, to see where you feel most at home. There are different kinds of groups and meetings, even within AA. Is that an option to consider, as a possibility?*
For clients who have previously attended and had good experience: *I'm glad you've already had some good experiences in _____. As I said, being involved in a group like this is one good source of support. If you like the group(s) you've attended, I certainly encourage you to keep going.*
For clients who have previously attended and had bad experience: *I'm sorry you didn't have a good experience in _____ when you went. There are different kinds of groups and meetings, and it can be a good idea to try several different meetings, to see where you feel most at home. Is that an option to consider, as a possibility?*

Don't pursue specifics of attendance at this point, but if the client shows at least some openness to trying mutual help groups, put this in one bubble on the Options sheet. Then return to the subject early in Phase 3, via the procedures described in module 5.7.

The availability of mutual help groups varies by geographic areas. A.A. is most widely available, and larger communities may offer a broader range of options. More detailed information about mutual help programs is provided in section 5.7. Be familiar with the different groups available in your area, and their basic principles and operational methods. Most groups welcome professionals as visitors to learn how to help their clients get involved.

3.5d. Setting Priorities. Once you have filled in bubbles on the Options sheet with possible topics to be addressed in treatment, review the sheet with the client:

When the process is complete, with the Options sheet in front of the client, ask:

Of these things we've come up with together as options for your change plan, I see several that we can work on together. Our treatment program can help with these (indicate to client which items fit within COMBINE protocol). Of those, which ones would you like for us to discuss in the weeks ahead? Which ones seem most important to you?

Mark a star or priority number inside bubbles that are mentioned by the client as priorities. Respond to the client with reflection, and after each offered option ask, "*What else*?" Try to identify *at least three* topics that can be addressed by different treatment modules. If the client does not initiate areas, raise a few that from your discussion seem to you to be good options: *What about _____. Is that something that we might work on together?*

It is important for the therapist to remember that not all items on the treatment plan will be addressed in CBI sessions. The client may feel it is important to address childhood trauma, for example, and that would not be included in the CBI sessions. Therapists should take care not to convey this to clients, so that they do not experience a sense of being promised something that is not delivered. Rather, the treatment plan should be thought of as a wellness plan which will include some items that can be addressed by the therapist and client together and some items which the client will address alone, with supportive others or through a referral.

3.5e. Preparing the Treatment Plan. The final step in Phase 2 is to develop a specific treatment plan. This draws Phase 2 to a close. The Treatment Plan form mirrors a standard problem-oriented record format consistent with clinical practice standards. The plan is developed by a process of negotiation between you and your client, based on all of your discussions thus far.

> *What we need to do now is to develop a treatment plan - what we will work on together in the time we have. Once we have filled in this plan and agree about it, we're ready to start the next phase. Now the things you've said you want to work on are . . . . .*

Each row of the Treatment Plan (Form Q) is used to specify one problem that will be addressed by treatment (or in some cases by referral). Problems are numbered sequentially, and a Treatment Plan Continuation sheet (Form R) can be used if more than five problems are identified, by starting the next sheet with Problem #6. Each and every Treatment Plan sheet must be dated and be signed by both your client and you at the time it is negotiated. Consistent with JCAHO standards, cross [Ω] through all problem boxes in unused rows. If, for example, only four problems are specified, cross through the Problem #5 box. The treatment plan may be (and often is) modified later in treatment, and this can be done with a *new* Treatment Plan Continuation sheet. A Treatment Plan sheet may not be changed once it has been signed and dated, so a new sheet must be used for all addenda and modifications. If a new problem is added, give it the next unused sequential number. If a prior problem is being modified (e.g., new goals or plans), use its original problem number and enter the new information on a new continuation sheet. Again, plan revisions are to be doubly signed and dated.

Reference: Form Q	Reference: Form R

For each problem (row) <u>you have three things to specify</u>. First of all, specify clearly the problem to be addressed by treatment or by a referral. Problem #1 will *always* be alcohol problems and/or dependence. The content for row #1 should have emerged in the transition and key question segment discussed above. If not, ask *"And what are you thinking about drinking at this point? What do you want to do?"* Reinforce the emphasis on abstinence as appropriate (see 3.5f below). Bubbles from the Options sheet identify potential problems for the Treatment Plan, but are included only by mutual agreement between you and your client. A problem may be stated on the treatment plan even if you will not directly address it in treatment. If financial problems are a serious concern for your client, you may enter these with a problem number, and the plan might be referral to consumer credit counseling.

Once a problem has been specified and numbered, the next step is to specify broad goals and specific objectives that you hope to achieve. Be specific about objectives; try to state them in observable or measurable terms. It is also wise to include goals that are *positive* (wanting to begin, increase, improve, do more of something), and not only goals that could be accomplished through general anesthesia (to stop, avoid, or decrease behaviors).

The third column in each row is for specifying how you plan to address the specified problem in order to achieve the stated goal(s). Here you can identify specific modules that will be included in Phase 3. Referrals may be specified here, as may change activities that the client is to pursue outside of treatment (such as attending AA meetings). The plan should be stated in terms that are sufficiently specific to allow a clear judgment as to whether or not the plan was carried out. At least a tentative timeline should also be stated for each problem: *when* will this be done? Progress notes that are kept throughout treatment will correspond to the problems, goals, and plans stated here.

3.5f. Emphasizing Abstinence. Every client should be given, at some point during Phase 2, a rationale for abstinence from alcohol. It is important to remember here the difference between the goal of the *treatment* program (abstinence) and the *client's* goals. It is inconsistent with a motivational interviewing style to coerce or impose a goal, nor can this realistically be done. Clients' stated pretreatment goals do predict outcomes (Miller, Leckman, Delaney, & Tinkcom, 1992). Clients who are assigned a goal of abstinence (regardless of their wishes) show no better outcomes than those who state their own goals (Graber & Miller, 1988; Sanchez-Craig & Lei, 1986). Neither is it up to you to "permit" or "let" or "allow" clients to make choices. The choice is always theirs, regardless of your recommendations. Nevertheless, in all cases you should commend the advantages of abstinence as an outcome by offering the following points:

1. Successful abstinence is a safe choice. If you don't drink, you can be sure that you won't have problems because of your drinking.

2. There are good reasons to at least *try* a period of abstinence (e.g., to find out what it's like to live without alcohol, and how you feel; to learn how you have become dependent on alcohol; to break your old habits; to experience a change and build some confidence; to please your spouse, etc.). See the Sobriety Sampling module (4.1) for more detail. Ask the client what these reasons might be for her or him.

3. No one can guarantee a "safe" level of drinking that will cause you no harm.

In certain cases, you have an additional responsibility to advise against a goal other than abstinence, if the client appears to be deciding in that direction. Again, this must be done in a persuasive but not coercive manner, consistent with the overall tone of motivational interviewing. ("It is your choice. Would it be all right, though, for me to tell you a concern I have about the option you're considering?"). Among the reasons to urge a client more to work toward complete abstinence are:

* pregnancy
* medical conditions (such as liver disease) that contraindicate any drinking
* psychological problems likely to be exacerbated by any drinking
* strong external (e.g., condition of probation) demands on the client to abstain
* use/abuse of medications that are hazardous in combination with alcohol
* a history of severe alcohol dependence.

The data in Table 3.5 may be useful in determining cases in which moderation should be more strongly discouraged. [Use the client's Alcohol Dependence Scale (ADS) score administered at intake for this comparison.] The norms in Table 3.5 are derived from long-term follow-ups (3 to 8 years) of problem drinkers attempting to moderate their drinking (Miller et al. 1992). "Abstainers" are those who had been continuously abstinent for at least 12 months at follow-up, and "asymptomatic drinkers" had been drinking moderately without problems for this same period. The "improved but impaired" group showed reduction in drinking and related problems, but continued to show some symptoms of alcohol abuse or dependence. The AB:AS column shows the ratio, within each of four client ranges, of successful abstainers to successful asymptomatic drinkers.

In addition to a general commendation of the merits of abstinence given in all cases, clients falling into ranges 3 or 4 in Table 3.5 should receive further counsel if they are entertaining a nonabstinence goal. They can be advised that in a study of problem drinkers specifically attempting to moderate their drinking, people with severity scores resembling theirs were much more likely to succeed with abstinence. Those falling in Range 4 can further be advised that in this same study, no one with scores like theirs managed to maintain problem-free drinking. Clients who are unwilling to discuss immediate and long-term abstinence as a goal might be more responsive to intermediate options, such as a short-term (e.g., 3-month) trial abstinence period,

or a tapering off of drinking toward an ultimate goal of abstention (Miller & Page, 1991). Consult Sobriety Sampling procedures.

In any event, remember that it is a goal to keep your client engaged in treatment, and also that ultimately it is the client who chooses his or her own course regardless of your advice. A disagreement about the best change goals is no reason to terminate or cause a client to leave treatment. Some clients do sustain low-level and problem-free drinking, and staying in treatment is associated with better outcomes. Even among those who initially refuse to abstain, many do ultimately choose abstinence and achieve long-term sobriety (Miller et al., 1992).

Table 3.5. Relationship of Severity Measures to Types of Treatment Outcome ALCOHOL DEPENDENCE SCALE (ADS) SCORES (LIFETIME SYMPTOMS)

Range	Scores	Total Abstainers		Asymptomatic Drinkers		Improved but Impaired		Not Improved		Ratio
		n	p	n	p	n	p	n	p	AB:AS
1	0-14	2	8%	6	24%	9	36%	8	32%	1:3
2	15-20	4	14%	4	14%	4	14%	16	57%	1:1
3	21-27	11	35%	6	19%	5	16%	9	29%	11:6
4	28+	6	75%	0	0	2	25%	0	0	6:0
	MEDIAN:	22.5		19.0		15.0		16.5		
	MEAN:	27.2		16.6		17.1		18.0		
	SD:	14.5		7.8		7.7		5.4		

Asymptomatic = Drinking moderately with no evidence of problems
Improved = Drinking less, but still showing alcohol-related problems
AB/AS Ratio = Ratio of successful abstainers to asymptomatic drinkers

3.5g. Recapitulating. Toward the end of the Phase 2 commitment process, as you sense that the client is moving toward a firm decision for change, offer a broad summary of what has transpired (Miller & Rollnick, 1991). This may include a repetition of the reasons for concern uncovered in the Phase 1 (see 2.5g on Summarizing), as well as new information developed during Phase 2. Emphasize the client's self-motivational statements, the SSO's role, the client's plans for change and goals for treatment, and the perceived consequences of changing and not changing. Use your notes, the Personal Happiness Form, and the Treatment Plan as guides. Here is an example of how a grand recapitulation might be worded:

Let me see if I understand where you are, then. Last time we reviewed the reasons why you and your husband have been concerned about your drinking. There were a number of these. You were both concerned that your drinking has contributed to problems in the family, both between you and with the children. You were worried, too, about the test results you received indicating that alcohol has been damaging your health. Your drinking seems to have been increasing slowly over the years, and with it, your dependence on alcohol. The accident that you had helped you to realize that it was time to do something about your drinking, but I think you were still surprised when I gave you your feedback, just how much in danger you were. We've talked about what you might do about this, and you and your husband had different ideas at first. He thought you should go to A.A., and you thought you'd just cut down on your drinking, and try to avoid drinking when you are alone. We talked about what the results might be if you tried different approaches. Your husband was concerned that if you didn't make a sharp break with this drinking pattern you've had for so many years, you'd probably slip back into drinking too much, and forget what we've discussed here. You agreed that that would be a risk,

and could imagine talking yourself into drinking alone, or drinking to feel high. You didn't like the idea of A.A. because you were concerned that people would see you there, even though, as we discussed, there is a strong principle of anonymity. Where you seem to be headed now is toward trying out a period of not drinking at all, for three months at least, to see how it goes and how you feel. Your husband likes this idea, too, and has agreed to spend more time with you, so you can go and do things together in the evening or on weekends. You also think that you might get involved again in some of the community activities you used to enjoy during the day, or maybe look for a job to keep you busy, and that's one of the first things that we will focus on together in treatment. You are also interested in learning some ways for managing your moods without using alcohol. Do I have it right? What have I missed?

If the client offers additions or changes, reflect these and integrate them into your recapitulation. Also note them on the Treatment Plan.

3.5h. Asking for Commitment. After you have recapitulated the client's situation, as above, and responded to any additional points and concerns raised by the client (and SSO), move toward a formal commitment to change. In essence, the client is to commit verbally to take specific, planned steps to bring about the needed change. The key question for you to ask, after the grand recapitulation, (not necessarily in these words) is:

Are you ready, then, to go ahead with this plan?
or *Is that what you want to do?*

If the client says "yes," this is a good time to sign the Treatment Plan together. Be sure to affirm your client's decision, intentions, efforts, etc.

Some clients are unwilling to commit themselves to change goals. In cases where a person remains ambivalent or hesitant about making a written or verbal commitment to deal with the alcohol problem, you may ask the person to defer the decision until a later time. Agree on a specific time to reevaluate and resolve the decision after a few more sessions. The hope in allowing clients the opportunity to postpone such decision-making is that the motivational processes will act more favorably on them over time (Goldstein, Heller, & Sechrest, 1966). Such flexibility provides clients with the opportunity to explore more fully the potential consequences of change, and prepare themselves to deal with the consequences. Otherwise, the client may feel maneuvered into making a commitment before she or he is ready to take action. In this case, a client may withdraw prematurely from treatment, rather than losing face over the failure to follow through on a commitment. It can be better, then, to say something like this:

It sounds like you're really not quite ready to make this decision yet. That's perfectly understandable. This is a tough choice for you. It might be better not to rush things here, not to try to make a decision right away. Why don't you think about it between now and our next visit, consider the benefits of making a change and of not changing. We can explore this further next time, and maybe it will become clearer to you what you want to do. Okay?

It can be helpful in this way to express explicit understanding and acceptance of the client's ambivalence, again emphasizing personal freedom of choice. You can continue with Phase 1 and Phase 2 work in sessions until the client agrees to pursue at least one Phase 3 module.

Another way to proceed is to modify the treatment plan to reflect the client's state of readiness. In such a case, the provisional goal might be "consider and decide whether or not to make a change." It is also possible to proceed with Phase 3 modules even if the client is unwilling to commit to change. This could be described as "in the meantime" working on something of value to your client, or as material that “might be

useful if you do decide later that you want to make a change in your drinking." Before beginning Phase 3, however, you should agree on and sign at least a provisional treatment plan.

Pull-Out Procedures

4.0. Pull-Out Procedures

The eight "pull-out" procedures described in this section are to be used in particular circumstances, and only as the need arises. The need may arise anywhere during treatment, and thus these procedures may be

used during Phase 3, Phase 2, or even Phase 1, as appropriate. There will also be cases in which none of these procedures will be needed. The nine pull-out procedures are:

SOBR Sobriety Sampling (4.1)
This procedure is to be used if your client is not committed to long-term abstinence, or has been drinking throughout sessions to date.

CONC Raising Concerns (4.2)
This procedure is to be used when your own goal or sense of what is best for the client differs from the client's own plan, or when for other reasons you are concerned for your client's welfare.

CASM Case Management (4.3)
This procedure is to be used when a client needs help or social services that are not available within the treatment protocol, and is referred to community resources (e.g., clergy, cooking and household management, family therapy, money management, parenting).

RESU Resumed Drinking (4.4)
This procedure is to be used when a client who has been abstaining, reports having resumed drinking since the last session.

SOMA Support for Medication Adherence (4.5)
This procedure is to be used when your client states a desire or plan to discontinue medication, or has stopped taking trial medication.

MISS Missed Appointments (4.6)
This procedure is to be used when a client misses an appointment.

TELE Telephone Consultation (4.7)
This procedure is to be used when clients or SSO's contact you by telephone between sessions.

CRIS Crisis Intervention (4.8)
This procedure is to be used when you have information from the client or the SSO that the client is in a crisis situation that warrants appropriate and immediate action.

DISS Disappointed to receive CBI-only condition (4.9)
This procedure is to be used when your client attends the first CBI session expressing disappointment at not being randomized to a medication condition.

4.1. SOBR: Sobriety Sampling

4.1a. Rationale.

Research evidence suggests that having a sustained period of abstinence may improve responsiveness to alcoholism treatment (Sanchez-Craig, 1984; Project MATCH Research Group, 1997a). In Project MATCH, aftercare clients generally fared better than outpatient clients despite having had more severe problems at intake: 35% of aftercare clients maintained continuous abstinence throughout the 15-month follow-up period whereas 20% of outpatient clients abstained for this long (Project MATCH Research Group, 1998c). These differences might be explained by the fact that nearly all aftercare clients entered treatment after sustaining at least a brief period of abstinence (i.e., 10-28 days while in residential or day treatment; Project MATCH Research Group, 1997a).

Other data indicate that clients' cognitive capacities can be improved by a period of abstinence (Sanchez-Craig, 1984). This would seem particularly important for treatments geared to developing and enhancing individuals' intellectual resources such as cognitive behavioral therapy (Sanchez-Craig, 1984; Meyers and Smith, 1995). In CBI, clients are asked to identify what goes wrong without alcohol (i.e. areas of psychological dependence; see section 3.2 on New Roads), to become aware of triggers for alcohol misuse, and to learn alternative coping responses to these problematic situations. At the same time, emphasis is placed on recognizing and enhancing a client's sense of confidence (i.e., self-efficacy) in handling these events. Emphasis is also placed on (re)building relationships with family members and friends who are interested in helping the clients change their drinking. The latter are especially important for individuals whose social relationships center mainly around drinking-related activities (Longabaugh, Beattie, Noel., Stout, & Malloy, 1993). All of these tasks can be aided by abstinence from alcohol. This pull-out module offers special procedures to help clients who continue to drink following initiation of their treatment (see section 3.5e on Abstinence Emphasis).

Before using this procedure, you may wish to review the two procedures mentioned above: Abstinence Emphasis (3.5f) and New Roads (3.2e), and your client's responses to them (if already completed). The immediate goal of SOBR is to enhance the individual's awareness of the importance of achieving an initial period of abstinence. The emphasis here should be on reasons that are important *to your client*, rather than a standard litany of reasons or only those that seem important to you. Remember that your goal is to facilitate at least a trial period of alcohol-free living. The procedures for increasing the client's commitment to this period of sobriety are similar in style to those described for Phases 1 and 2. Succeeding with a short period of abstinence increases the likelihood of sustaining a longer period of sobriety. Those who try abstinence often find they like it!

A first step, then, is to increase the client's motivation to try a period of sobriety. Rather than starting with a set of sales points, first ask your client what might be some advantages of abstaining for a while. You can employ strategies described earlier (Phase 1 and 2) for this purpose, such as:

> Asking the open question and then selectively reflecting self-motivational statements
> Asking for both sides - perhaps first the disadvantages, and then some advantages
> Making it hypothetical: *Suppose* that you were to abstain for a few weeks. What might be some good things that could come out of that?
> Emphasizing personal choice: It's up to you, of course. And if you try it and don't like it, you're always free to go back to drinking.

If needed, you can also suggest some advantages. Don't fall into the trap of selling one advantage and having the client tell you "Yes, but..." (the confrontation/denial trap). Rather, describe a series of benefits "that other people have found when they tried a period of sobriety," and ask the client to consider *which* of these might be

true for her or him. Here is a menu of points from which you can choose the ones that seem to be most appropriate for your client.

< *If it has been a long time since you've been free from alcohol and other drugs, it might be interesting just to see what life is like sober.*

< *A person's mental state - like the ability to think, remember, and learn new things - often improves quite a bit after a month or two of abstinence. How might that help you?*

< *People who start out with a period of abstinence tend to be more successful in the long run in overcoming drinking problems.*

< *A period of total abstinence could show your [wife, probation officer, children] that you are serious about making a change, that you are motivated and committed.*

< *Going without alcohol and other drugs for a while helps you get clear about ways in which you have come to depend on it. You would learn something about yourself.*

< *It's common for other difficulties to clear up somewhat even with a short period of abstinence. People often feel more energy or less depressed, relationships can improve, etc. It doesn't fix everything, of course, but often it gives you a good head start.*

Conclude this process with a summary reflection, drawing together possible advantages of a trial period of sobriety. Emphasize those reasons that the client has stated.

4.1b. Probe Willingness

Having explored possible advantages, next ask whether your client is willing to consider the possibility. Here is an example:

> *Those sound like some important benefits that could come out of a vacation from alcohol. We do ask everyone in this program to try at least a month of being alcohol-free. Of course, it's up to you, but I really do encourage you to give it a try. Are you willing to consider it?*

4.1c. Discuss Implementation

If your client is willing at least to consider the possibility, discuss how he or she might succeed. If he or she balks at a month, try agreeing on a shorter period of time (two weeks, one week, three days, etc.) - whatever the client is willing to try. If the client absolutely refuses even to discuss the possibility of abstaining for a short time, assure him or her that you will still work together, and that although you do recommend at least a trial period of abstinence, ultimately it is not your (therapist's) decision.

1. *How long?* As a first step, ask your client what would be a reasonable length of time to try being free from alcohol. For some, the one month start will be acceptable. Some will want to shoot for longer periods. Some will be reluctant to commit to a month, but will be willing to try a shorter time.

2. *Starting when?* Next discuss a clear quit date. Usually the best choice will be "starting now," - no time like the present - but others will choose a date in the near future. The point is to choose a date for

initiating abstinence. (If a future date is chosen, you should either call or schedule an appointment with the client on that day, to discuss initiation of abstinence.)

Here is an example of how this process might begin, using the overall motivational style of CBI:

CLIENT: I agree that it would be a good idea for me to quit drinking for a while, but I have a wedding coming up next week and it would be hard not to drink at that. So I guess I would like to quit drinking after the wedding.

.

THERAPIST: You're not too sure whether you could stay away from alcohol during a wedding. That might be too hard. So one thing you could do is wait until after the wedding. What do you think will happen if you did drink at the wedding?

CLIENT: I would probably get drunk, feel guilty, drink some more, and before long find myself sleeping on the couch or maybe even tossed out of the house.

THERAPIST: Sounds like you don't want that to happen.

CLIENT: Well, I don't want to break up my marriage and my home. I'm in enough trouble already.

THERAPIST: But you can't see any alternatives, even though there could be some serious consequences if you were to drink at the wedding.

CLIENT: Well, I guess I could go to the wedding and not drink, but I've never done that.

THERAPIST: That would be something new for you.

CLIENT: It sure would. I don't know what it would be like. I like to fit in with the crowd. People offer you drinks and all.

THERAPIST: And maybe you're not too sure if you could really do it.

CLIENT: I would like to go to the wedding, but I don't think if I start that I could stop drinking.

THERAPIST: So what are the possibilities you've looked at so far? You could go to the wedding and get drunk. You could go to the wedding and not drink, and see what that's like. . . And did I hear the possibility of not going to the wedding at all?

CLIENT: Maybe I could go to the wedding at the church, but then not go to the reception. That's where the drinking is. I'd hate to miss it though.

THERAPIST: So there are at least three options. Go and drink. Go and don't drink or attend the wedding but not the reception. What do you think?

Rather than getting into an argument or avoiding the issue, the therapist helps the client to explore the options and their difficulties. As a result, the client's commitment seems to be increasing, and groundwork is laid for achieving and maintaining sobriety.

3. *How to do it?* Next ask your client how she or he could be most likely to succeed. Ask *how confident* your client is that he or she can succeed in abstaining for this length of time, or break it down into shorter spans of time. The A.A. perspective of taking it one day at a time can be very helpful here. Although

the client's goal is to remain abstinent for a longer time, he or she only needs to stay sober *today*. Explore who could help the client to succeed (family and social support, sober friends, mutual help groups). Find out what methods the client has used successfully in the past. Negotiate a plan of action.

4. *What could go wrong?* Discuss possible problems and obstacles. What could do wrong with the plan? Explore specific concerns including possible withdrawal symptoms, the use of other drugs to compensate, social pressure, encountering common situations where drinking has been used to cope (see 3.2 New Roads), etc. Rather than offering solutions first, ask the client how he or she could handle each obstacle successfully. Provide accurate information, encouragement, and ideas as needed. It can be useful for you to raise "*What will you do if* . . . ?" scenarios and have the client provide solutions.

THERAPIST: So what could go wrong with your plan to stay sober for a month starting today?

CLIENT: I have to visit my Mom this week-end.

THERAPIST: What usually happens when you visit your Mom?

CLIENT: Well, everything is usually fine in the beginning, but late in the afternoon Mom and her boyfriend open up a bottle. After a couple of drinks, she starts to hassle me about living with Tom without being married. Then she *bugs* me about working as a secretary, not finishing college, things like that. She's on to me about my clothes, hair, weight, make-up, yadda yadda and the next thing I know I am having a drink, and then another, and soon I'm totally *wasted*.

THERAPIST: You get kind of angry at your mom and that's when you begin to drink.

CLIENT: Not "kind of" - I really get mad! It's hard not to drink when I feel that way, especially when booze is all around.

THERAPIST (to Tom): Is that pretty much how it looks to you during those visits?

TOM: That's about right. Whenever we drive to her Mom's I take my glasses along because I know I'm going to have to do the driving on the way back.

THERAPIST: So you don't drink on these visits.

TOM: Not really. Maybe a beer, but usually not. I'm just sick of going there on Sundays and having the same thing happen. It's totally predictable.

THERAPIST (to client): Have there been any times when you got angry at your Mom and didn't drink?

CLIENT: Yeah, when I'm not at Mom's house where there is booze around. Like I often get angry at my Mom when I'm talking to her on the phone. There is no booze around, and I can hang up and vent my frustration to Tom right after the call. That usually helps.

THERAPIST: So there are at least three things that you know often help. One is being able to get out of the situation and second, being able to vent your feelings to somebody else, especially if it's right away. The third thing is that there is no alcohol around to drink. What does that mean for your Sunday visits?

The basic steps are:

to call the client's attention to risky situations or triggers,
draw upon his or her coping resources (and those of the SSO),
and develop a specific action plan.

Successful handling of an event which in the past has led to excessive drinking can be an important boost to a client's self-efficacy and motivation for further change, especially in this early stage of treatment. Success breeds success (Meyers and Smith, 1995).

5. *Where's the fire escape?* In Step 4, you have dealt with anticipated problems that could interfere with the sobriety plan. The recurrence of drinking, however, often occurs in problem situations that were not anticipated, and for which specific coping plans were not made. In this final step, develop some general "fire escape" plans for dealing with any *unanticipated* problems. What will the client do in the case of a strong urge or craving to drink? What if he or she actually has a drink? How could he or she best stay (or get back) on track?

When a client is in the initial days or weeks of sobriety, and particularly when you know that a challenging situation (like a visit to Mom in the above case) is coming up, it is wise to schedule more than one session per week. You can also schedule sessions so that they occur immediately before (preparation) or after (debriefing) critical events.

6. Other Issues. In situations where the client evidences little control over the drinking you may need to schedule another session within the same week. At preparatory sessions, focus on developing plans for staying sober. One strategy that people use particularly in the early stages of sobriety is *avoidance* of high risk situations. In cases where even temporary avoidance is not feasible or acceptable, develop specific *coping* strategies to stay sober in high risk situations. During subsequent sessions, review how the client handled the difficult situations, reinforcing all efforts that the client (and SSO) made to change the drinking behavior, regardless of outcome.

4.1d. Reluctant Clients

Some clients are reluctant to commit themselves to even a brief period of abstinence (cf., Sanchez-Craig, 1984). In such circumstances, avoid direct confrontation or arguing with the client about his or her misgivings about an abstinence plan. Meeting reluctance head-on tends to be counterproductive, and can result in increased defensiveness or premature termination (Miller, Benefield, & Tonigan, 1993; Zweben, Bonner, Chaim, & Santon, 1988). Instead, delay decision-making about sobriety sampling, and continue to rely on motivational counseling methods such as normalization, reflective listening, reframing, and summarizing (See Phase 1 strategies). The following illustrates the use of Phase 1 strategies in proposing an abstinent plan to a reluctant client.

THERAPIST: You seem to have some doubts about whether your drinking is serious enough for you to consider trying a period of abstinence (*summary reflection*).

CLIENT: I know that I need to make a change, but I want to try to cut down first on the drinking, rather than quitting altogether.

THERAPIST: And that's your choice, absolutely. It's pretty normal at this point to have doubts about giving up alcohol entirely, even for a short-term period (*normalization*). It's a big change and can even be scary. Maybe what makes sense is to postpone any

decision here until we have had a chance to explore the pros and cons of cutting down versus stopping drinking for a period of time (*delay decision-making and resume Phase I strategies)*. Would that take some of the pressure off?

CLIENT: I guess so. I just don't want to feel rushed into something.

THERAPIST: I understand that. In fact, if I were to push you into making a decision before you're really ready, chances are it wouldn't last. The choice really is yours, and I don't want you to feel pressured. Would it be okay, though, if I asked you about one other possibility? (*asking permission*)

CLIENT: Sure.

THERAPIST: I wonder if you might be willing to keep clear of alcohol just for a few days while we continue to discuss this in the next session or so. Would that be acceptable to you?

CLIENT: (*Sighs*) Okay, that seems reasonable. How many days?

THERAPIST: Well, it's always your decision of course, and lots of people just take it a day at a time. They make a decision each morning not to drink on *that one* day. But if you want to think about a specific period for evaluation, how about one week, until our next session. That would give us enough time to do some evaluation together at the next session and then come up with a plan. Am I asking too much here?

CLIENT: No, I think that's reasonable. I know it would make my family happy.

Nonconfrontational strategies often result in gaining the cooperation of initially defensive and uncooperative clients (Miller & Rollnick, 1991). In this interview, the therapist recognized that the client is still ambivalent about abstaining. Rather than pushing hard directly, the therapist continues with basic Phase 1 methods to work toward initial sobriety sampling. In this case, a one-week abstinent period was negotiated with the client. Had that failed, a still shorter period might have been tried. The client also offers a clue that family support might be called upon to encourage a period of initial sobriety. Gaining that initial foothold on sobriety is the purpose of this sobriety sampling procedure.

4.2. CONC: Raising Concerns

4.2a. Rationale

This procedure can be used at any time during treatment when your client is expressing a goal or plan that concerns you. A few examples of such situations might be:

> Your client has a long history of alcohol dependence, but says she plans just to cut down on her drinking rather than quitting altogether. You are concerned that this is not a realistic plan, and that abstinence would be a safer initial goal.
>
> Your client has been sober for several months, and tells you that he plans to stop by his favorite bar just to see some of the old friends he misses. You are concerned that this could trigger resumed drinking.
>
> Your client reports driving home after having had six beers, and evidences no awareness that this is both dangerous and illegal. You are concerned for the safety of your client and others on the road.
>
> Your client has quit drinking and says that she has switched to marijuana, which she finds more relaxing anyhow. You are concerned that one hazardous drug is just being substituted for another, and that increased marijuana use will result in new problems (or more of the same).

How should you respond in a situation such as this? The general strategy parallels a central idea in the Assertion Skills module (5.1). It is a middle ground between passive (such as saying nothing or stating your concern indirectly or weakly) and aggressive "roadblocking" strategies (such as lecturing, warning, or shaming the client). Passive strategies are ineffective because they fail to communicate your legitimate concern. More aggressive strategies are likely to evoke defensiveness and may cause the client to "dig in" and become more committed to the risky plan or goal.

Like assertiveness, the approach to be used here is a middle road between these extremes. Its goal is to communicate effectively your concern, and to do so in a compassionate way that respects the client's judgment and autonomy, thus increasing the likelihood the client will hear and respond to your concern.

4.2b. The Basic Procedure.

When you become aware that you are concerned about some goal, plan, or intention that the client has expressed, the first step is to recognize that fact and frame it for yourself as a dilemma. Your initial impulse, with the best of intentions, might be to blurt out a disagreement, but this sets the stage for a classic confrontation/denial argument in which you wind up taking the "good" side and forcing the client to defend the wrong position. Becoming aware of your discomfort should trigger the thought, "Use the Raising Concerns procedure." Inhibit the temptation to argue and instead follow these steps.

1. *Reflect the goal, plan, or intention about which you are concerned*. It is possible that you have not fully understood what the client means, or have not heard the whole story. A first step, then, is to offer the client a clear reflection of how you understand the intention. Do this without any tone of sarcasm, alarm, or judgment in your voice. The purpose is to understand clearly. For example

> *You really don't want to quit drinking completely, but you do see some reasons to cut down.*

You're missing the friends you had when you were drinking, and you'd like to see them again. It seems like going back there ought to be okay now.

So you had a six pack of beer over at Pat's between six and eight, and then you drove home.

It seems to you that switching from alcohol to marijuana makes sense for you, and would be less risky.

Some counselors are concerned that a pure reflection of this kind "approves" or "gives permission" for the behavior, and indeed if that is all you did, the client might leave with that impression. Yet acceptance (expressed by reflection) is not the same thing as approval. The purpose in this first step is to make sure that you have it right. It is also not unusual that once you reflect the plan back, the client starts having second thoughts about it (an example of the usefulness of reflection as a way of responding to negative statements and defensiveness). In any event, the client is likely to elaborate a bit in response to your reflection, so listen to what the client has to say, using further reflection.

2. *Ask permission to express your concern*. After you have offered a clear reflection of the client's intention and listened to any elaboration, you should have a clear understanding of what the client intends. The second step in the Raising Concerns procedure is to ask your client's permission to express your concern. Here are a few ways in which you could do this:

Would it be all right if I told you a concern I have about your plan?

I think I understand what you want to do, and why. I wonder if it would be okay for me to tell you a few things that occur to me as I listen to you, which you might want to consider.

I don't know if this will matter to you, or even make sense, but I am worried for you if you do this. Would you mind if I explained why?

There are a few things that may or may not make sense to you, but I want to make sure that you know them before we go on. Maybe you already know some of these, but I'm concerned and I'd like to tell you why. Would that be all right with you?

As I'm listening here, I feel scared for you. I'm worried, I guess. [Here you leave it hanging in hope that your client will ask you why.]

Asking permission honors the client's own autonomy and judgment, and has the effect of making it easier to hear what you have to say. Clients almost always give permission for you to speak, but it's still important to ask for it.

3. *State your concern*. Clearly and concisely, say what it is that concerns you. Again, do this in a way that is not judgmental, shaming, or argumentative. The best form is probably an "I message" rather than a "You message."

Judgmental: *Do you have any idea how many human beings are killed every year by people driving around after drinking a six pack?!*

You message: *You are really putting yourself and others in danger by driving after six beers*.

I message: *I'm concerned that you are driving after drinking that much, even though it may not seem like a lot to you.*

4. Ask your client to respond to your concern. This opens the door to explore the concern further. A few examples of appropriate open questions are:

Do you understand why I'm concerned?
Does that make sense to you?
How much do you know about this already?
What are your own thoughts about this?

Respond with reflective listening to what your client offers. Listen particularly for self-motivational statements and emphasize those in reflections. Continue the dialogue until you believe the client understands (though not necessarily agrees with) your reasons for concern. Avoid falling into a disagreement where you argue for change the your client argues against it. The purpose of this procedure is for the client to hear, understand, and consider your concern. Asking permission and following up with reflective listening are effective strategies to accomplish this goal.

In simple work, the Raising Concerns procedure is: *REFLECT - ASK - STATE- ASK*

Reflect the client's intention that concerns you
Ask permission
State your concern
Ask for response.

4.3. CASM : Case Management

4.3a. Rationale

People with alcohol problems frequently have other needs and problems that are directly or indirectly related to the excessive drinking. They may need assistance with social, legal, economic or child care problems, budgeting, domestic abuse, housing assistance and medical disorders. These complex issues are often difficult to address within the confines of a specialized treatment program, and therefore it is important to draw upon a variety of health care and social service settings to address the range of difficulties confronting clients. The challenge is to implement an effective referral strategy so that ancillary problems are addressed *before* they interfere with the primary goals of alcohol (Rose, Zweben & Stoffel, in press).

A significant problem is that clients often do not follow through with referrals (Zweben & Barrett, 1997). Failure to complete a referral may stem from disparity between client and counselor views of the nature and severity of risks, or about what steps need to be taken to address problems (Zweben & Barrett, 1997). There may also be practical obstacles to obtaining needed services, such as poor transportation, language and cultural barriers, and a lack of child care.

This module is to be used when you wish to refer a client for ancillary services. It is designed to address potential obstacles to a successful referral. In this module, referral is viewed as a negotiation process between counselor and client. You will encourage your client to have input into and be actively involved in decision-making about the need, acceptability, and feasibility of referral. The process is one of counselor and client together finding solutions to obstacles that may interfere with obtaining needed ancillary services.

The therapeutic skills involved are those of a good case manager. This module represents an activist approach, recognizing that clients may need many different kinds of support. You need to put specific skills and effort into making it happen.

You can determine the need for this module in part by reviewing the Client Services Request Form (Form F) that you have all clients complete after Session 1 (see 2.8f). If there are areas marked "Yes" or "Maybe" on this form, it is worth exploring whether your client would like to know about resources where he or she could get some help in these areas.

4.3b. On-site Case Management Preparation

Each clinical site should compile a resource listing of potential referral sources. The resource list should include information on contact persons, fees, insurance coverage, restrictions on referrals, transportation information (location, bus routes, etc.), waiting lists, and other pertinent matters related to service delivery. In developing such a sourcebook it is appropriate to cast a wide net. Try the Internet. Call programs listed in the community resources section of the phone book. Ask colleagues. Call state and federal agencies and hotlines. Talk to local experts in your area. Usually there are many resources available, but no convenient way to identify them. This is where you need the information and know-how of a good case manager. Some programs and communities will already have well-developed resource lists. If your facility has an on-site computer network, this may be a convenient way to keep the resource list updated and to make it available to project staff.

For services that are frequently needed, it is useful to obtain a supply of brochures or other written information to distribute to clients. Formal linkages can be established with regularly utilized services (e.g., social welfare agency) to enhance the referral process; for example, an internal contact who can reduce the amount of time between the referral call and first appointment).

4.3c. Introducing the Module

Introduce the CASM module by explaining the following three points:

1. *"It is important for us to focus not only on drinking, but on what is happening in your life more generally*."

2. *"Our goal is not just for you to stay away from alcohol, but more importantly for you to have a good life without alcohol"*.

3. "*Earlier you filled out this questionnaire* (show the client the Client Services Request Form) *on which you indicated areas in which you may need or want some assistance. What I'd like to do in this session is to discuss how you might get some assistance with these areas, so that you have a more satisfying and happy life without alcohol. Would that be all right with you*?"

Reference: Form F

4.3d. Beginning the Case Management Process

The primary steps for implementing case management within this pull out are summarized in the acronym ARISE:

1. Identify AREAS in which your client could benefit from additional services. These are problem areas not directly addressed within the CBI program (e.g., housing, domestic violence, health issues, and financial difficulties) which your client indicates a need.

2. Identify appropriate RESOURCES to address these areas of need.

3. INITIATE referral.

4. Facilitate your client's SUCCESS in completing of the referral.

5. Follow up to ENSURE that the referral has been completed.

Clients will have completed the Client Services Request Form for you after Session 1. Review the information on this form, discussing each area in which your client indicated "Yes" or "Maybe." Focus particularly on areas where services may make a difference in achieving and sustaining abstinence. Introduce the process with a structuring statement like this:

"*I'd like to ask you, then, about the items that you marked on this questionnaire as areas where you need some help. Things may have changed since you filled this out, and also I can't promise that we'll find good resources for all of these, but let's talk about them. Okay*?"

Explore each of the identified areas by asking open questions such as these, and following up with reflective listening to evoke and reinforce self-motivational statements.

You marked _____ as an area where you could use some help. Tell me about that.

What are your concerns in this area?

What kinds of assistance would you like to have?

What would be the good things about getting some help with this?

What have you tried already? How did that work out for you?

How clear are you that you want to do something about this?

In what ways does this affect your sobriety?

4.3e. Prioritizing

Develop a sense of which goal(s) your client is *most* interested in pursuing, and focus on those (Najavits, in press). Clients can be overwhelmed by the referral process, especially if they have many areas of need. Help your client prioritize and focus. It is better to work on one referral for one problem area than to have no progress at all. Also be sure that the client's choice of goal(s) is realistic. Here is an example of prioritizing goals.

THERAPIST: Of all the problems areas we discussed which ones are you most interested in addressing first?

CLIENT: I'm having a lot of trouble with the kids, and I guess I'd like to get some ideas about parenting. I was drinking when I'd get home so I could deal with the kids, and I need to find a better way of handling them.

THERAPIST: The first thing that occurs to you, then, is that you want to learn how to be a stronger parent.

CLIENT: I don't know about stronger. Maybe more loving or patient.

THERAPIST: Ah. How to hang in there with your kids, and let them know you love them, maybe even when they're not being lovable.

CLIENT: Yeah. It's pretty tough money-wise, too.

THERAPIST: Yes, I notice that you marked that item. What do you have in mind there?

CLIENT: Well, I got food stamps once before, and I think that would help. My ex owes me a lot of back child support, too.

THERAPIST: So you'd like to qualify for food stamps, and it would also help your money situation if your ex paid up. Is that what you meant by legal assistance when you checked it?

CLIENT: Yeah. I need to go to court about it, but I just haven't had the energy.

THERAPIST: You feel pretty overwhelmed sometimes.

CLIENT: It just seems hopeless. Not always, but sometimes.

THERAPIST: And some of that may be just the number of problems you're handling all at once. You're a single parent and you're trying to do a good job there. Money is tight, and you're not getting enough child support, and it seems like such a huge effort to have to go to court to collect it. So you get discouraged sometimes. What else?

CLIENT: Isn't that enough?

THERAPIST: It's a lot. I'm just asking if there are other areas where you think you could use some assistance or support. We don't have to tackle them all at once, but I want to have a good understanding of what you're dealing with.

CLIENT: Well, I marked "support groups" there. I'd like to talk to some other parents and hear their ideas. Maybe other parents who are staying sober.

THERAPIST: That could give you some hope, to know other folks who are making it.

CLIENT: Uh huh.

THERAPIST: And some of these things that you'd like to do would involve having child care. Parenting courses, for example, are often in the evening. What about child care arrangements?

CLIENT: I think my boyfriend John would be willing to babysit if I'm taking care of myself. He knows the trouble I've been having with drinking and with the boys.

THERAPIST: Good! So child care isn't so much a barrier for you.

CLIENT: I don't think so. I just didn't realize how much the stress of taking care of the boys has been connected with my drinking.

THERAPIST: So you've mentioned several things: getting some ideas on how to be a more loving parent, applying for food stamps, getting some legal help to go to court and collect child support from your ex, and maybe going to a support group for parents. If you had to pick just one of those as a good place to start - one that might make a real difference - which would it be?

CLIENT: Seems like they're all tied together. Maybe a group where I could talk to other parents, and get some ideas about how to handle the kids better.

THERAPIST: And how might that help? What would be good about doing that?

CLIENT: I think it would be encouraging. I feel like I'm pretty alone, and if I were less stressed out about the boys, I'd probably have more energy to do some of the other things I need to do. I think it would also help me stay sober.

THERAPIST: That's a lot of good reasons! Are you ready to consider some options?

Be sure to focus primarily on your client's own reasons for pursuing referrals, rather than your own. Have your client *tell you* which areas are most important, and why.

When you identify at least one area for which your client is willing to seek further assistance, fill in a Case Management Goal Sheet. Complete a separate goal sheet for each problem area you identify. It is not necessary to complete sheets for every problem area in the same session. Referral procedures can be continued in subsequent sessions along with work on other modules. If you encounter a problem area for which you do not know of a suitable resource, tell the client you will research it and try to find an appropriate referral before your next session.

Reference: Form S

Case Management Goal Sheet (Completed example)

02-6435 ***6***

Client ID#_____ ***Goal # _____*** *(from 4.3d)*

Broader goal:	***Specific objectives:***
to receive regular health care	***1. Connect with primary care physician*** ***2. Schedule general physical exam*** ***3. Schedule dermatology consult*** ***4. Schedule dental exam*** ***5. Schedule eye exam***

Specific task to be completed	*By (person)*	*Goal Date*	*Notes*	*Completed (Date)*
Call First Care enrollment office and ask for primary care doctor assignment. 345-6789	***Client***	***2/26***	***Client called; put on hold, gave up*** ***Called from session on 2/26. Assigned to Dr. Rodriguez.***	***2/26***
Call Dr. Rodriguez's office to schedule a general physical examination. 345-7890	***Client***	***3/2***	***Client called; scheduled for 4/24***	***3/1***
Call University dental clinic to schedule dental exam. Ask for Janet. 234-5678.	***Client***	***3/9***		

Form S

4.3f. Making a Referral

After completing one or more goal sheets, discuss which problem area should be worked on first. Usually this will be the one identified by your client as highest priority. Set at least one specific case management goal, along with a specific deadline, to complete before the next session. If a client can take on more than one goal assignment, it's fine to make two or even more assignments, but be sure that each is quite specific, and that you agree to a specific deadline for each. A common deadline is "by the next session." Note that for some goals, you may also have an assignment to complete by a specified deadline (such as identifying specific resources or a contact person by the next session).

It is useful to break down complex goals into smaller steps. For example, if the client has not had any health care for years, start by connecting the client with a primary care provider for a general physical exam. Then later you might arrange a dental exam, a visual exam, and so on.

Record specific referrals that you have made (including name and phone number to call) on the goal sheet, drawing on your site's resource directory. Write down for your client on a Resource Sheet (Form T) the name of the contact person, telephone number, address, and other relevant information, along with the specific assignment and deadline.

Reference: Form T

Always troubleshoot an assignment. What might prevent the client from completing the assigned task? Discuss logistics such as transportation, costs, waiting list, amount of time required, and location (i.e., is the agency located in high crime or drug use neighborhood). Consider whether and how the client's significant others might be involved for support and other assistance (e.g., driving). Give the client the Resource Sheet to take home, perhaps with a suggestion of keeping it in a visible place (such as the dashboard of the car or the refrigerator) as a reminder.

Encourage a consumerist view with clients, indicating that they can try things out without being obligated to stay with them. Suggest that they can "shop around" until they find services they like and feel are beneficial (Najavits, in press). Explore clients' ambivalence or uncertainty about addressing a particular case management goal. Motivational interviewing can be useful with clients who are not following through on case management needs. Consider other possible obstacles. It may be helpful to role play how to make the contact, and how to deal with obstacles that could arise. Also, there's nothing wrong with making a referral call from your office during a session.

Also be careful not to pressure premature commitment to a goal. This can happen particularly if a problem seems urgent to you, but not to your client. Pushing clients to do what they are not ready to do is likely to fail, and can contribute to clients' dropping out of treatment. Instead explore the ambivalence, reflect back your understanding of the client's misgivings, clearly state your own concern (see 4.2), and accept that it is your client who ultimately decides. As long as you retain a working relationship, you can always revisit unmet case management needs at a later time after the client has experienced greater improvement (Cooney, Zweben, & Fleming, 1995).

An exception would be a situation of genuine emergency, in which you may need to take action against your client's immediate wishes. Examples include clear danger to self or others, danger to children, or coming to a session intoxicated and intending to drive. In such life-threatening situations, you would take appropriate action (such as contacting the police) in consultation with on-site clinical personnel. Except in a situation of extreme danger, however, letting the client choose, typically works best.

Be sure to follow up on your clients' progress with each goal at each session until all agreed upon case management needs have been met. In general, when you have made a task assignment, check on it at the very beginning of the next session. This emphasizes the importance that you place on the client's progress. In some cases you will need to continue addressing case management goals throughout treatment. If the client has not completed a task assignment, explore briefly what interfered with completion (motivation? logistics? unclear assignment?), problem-solve, and revise goals and tasks accordingly. Here are some options to try:

Ask whether the client still regards the goal as an important one, and ask why it is important. If the client does not regard the goal as important, change to a goal that is important to the client.

Consider involving a significant other to help the client complete the goal.

Make a call during the session.

Role-play how the client will carry out the assignment.

Arrange for a check-in call between sessions (you call the client, the client calls your voice mail, etc.)

Ask the client to talk you step by step through what needs to be done.

If the client lacks confidence, encourage him or her to "try an experiment" and specify a part of the task to be completed.

Encourage the client and/or significant other to arrange for a "celebration" reward (not drinking, of course) when the task has been completed.

4.4. RESU: Resumed Drinking Procedure

4.4a. Rationale

This section provides procedures to be used if your client resumes drinking after a period of abstinence during treatment. The goals of this procedure are to help your client:

(1) explore competing motivations to continue drinking and to resume abstinence
(2) identify specific triggers for drinking and determine whether abstinence can be aided by learning new coping skills
(3) explore her/his cognitive-affective reactions to resumed drinking, and
(4) develop a plan (as appropriate) to resume abstinence

These components correspond to some of the reasons why a client might resume drinking after an initial period of abstinence. Some of the possibilities include: (1) the client has experienced a change in motivation to remain abstinent, (2) the client is having difficulties coping with specific triggers for drinking, or (3) the client has been unable to recover from the impact of a single episode of drinking after stating that he/she had a goal of abstinence (often referred to as the Abstinence Violation Effect or AVE; Marlatt & Gordon, 1985).

If your client has not *established* abstinence but continues to drink, consult the Sobriety Sampling procedures rather than this section.

4.4b. A Word About Language

Motivations for abstinence versus drinking often fluctuate over time. As stated earlier, it is common for people with serious problems related to drinking to make several attempts before stable abstinence is maintained. In this sense, alternating periods of drinking and abstinence are not surprising as a person tries to change a longstanding pattern.

It makes a difference how you, as therapist, think and talk about resumed drinking, which is often described in dichotomous terms that have strong moralistic overtones (slipping, falling off the wagon, etc.). In preparing this manual for therapists we have specifically avoided use of the term "relapse" for this reason. This is not a matter of politically correct language, or of finding euphemistic ways to communicate the same concept. Our intent is to find a nonjudgmental way to think and talk about clients' periods of drinking on the road to recovery. Ideally, such language would: (1) forego moralistic good/bad connotations, and (2) communicate realistic expectations about the typical course of recovery. We specifically avoided absolute thinking that places the individual into one of two binary categories based on recent behavior (dirty/clean, wet/dry, drunk/sober, relapsed/not relapsed, etc.). This turns out to be challenging in a field where even professional terminology has been so interwoven with societal attitudes. Similar shifts in language and conceptualization have been achieved in other fields where moralistic terms once dominated diagnosis and treatment (e.g., sexual dysfunction, developmental disorders).

The key is to describe the *behavior* rather than an inferred state. Awareness of this difference has been emerging in the treatment of substance use disorders. Within A.A., for example, "sobriety" is recognized as being considerably more complex than mere abstinence from alcohol. A "slip" is commonly differentiated from a "relapse" (though both are dichotomous terms with moralistic overtones). Rather than judging the client's behavior, your job is to help change it.

4.4c. Motivational Issues

A first step in dealing with resumed drinking is to determine whether it resulted from (or has resulted in) a shift in your client's motivation for change. The therapeutic procedures here are those of Phase 1, for exploring and enhancing motivation to change. How does the client understand what happened? How does resumption of drinking fit in with his/her short-term and long-term goals? Here are a few examples of ways to talk with your client about resumed drinking, drawing on Phase 1 methods.

 Help your client weigh the positive and negative consequences of continued drinking against the pros and cons of resumed abstinence. (Reviewing the positives of drinking here is part of weighing them against the negatives.) Particularly elicit from the client the advantages of resumed abstinence and the risks/costs involved in continued drinking (self-motivational statements). Avoid the situation where you argue for resumed abstinence and your client argues against it.

 Review the client's originally-stated reasons for making a commitment to abstinence, and for initially quitting. Ask whether any of these reasons have changed, and whether drinking has for some reason become more important. While abstaining, did the client "miss" certain aspects of drinking?

 If you meet reluctance or defensiveness as you explore resumed drinking, use the style and procedures outlined in Phase 1.

 Have the client anticipate actual or possible adverse effects of resumed drinking. What problems have occurred in the past as a result of resumed drinking? Has the client had any problems yet as a result of resuming drinking this time (medical, emotional, financial, legal, social, relationship, etc.)? What possible negative consequences could occur with continued drinking? Remember to use open questions and reflective listening so that it is *the client* who voices adverse effects.

 Ask your client to review possible short-term and long-term benefits of resuming abstinence (e.g., improved health, relationships, emotions, school or job performance). While the client was abstinent for a period of time before resuming drinking, did he/she experience any positive changes or benefits? Were there immediate benefits that the client had hoped for, but which did not occur?

 Reassess the client's goal with regard to drinking, emphasizing his or her autonomy and responsibility for making this choice. Revisit "Abstinence Emphasis" (3.4) points if appropriate.

 Try again the Phase 1 rating scales regarding the *importance* of changing drinking behavior (how much of a problem drinking presents and how much drinking adversely affects the client and others) and the client's *perceived ability* to change (2.8c).

 Use or revisit the Decisional Balance procedure (2.8e), particularly if perceived importance of change seems to have diminished.

 Use or reuse the Revisiting Past Successes procedure (2.8f), particularly if low confidence seems to be a factor in resumption of drinking.

Here is a possible scenario in exploring motivational issues related to resumption of drinking.

CLIENT: I started drinking again this week, though not as much as when I first came in. I'm not sure if I really want to quit.

THERAPIST: There are some things about drinking that you really enjoy. [*The therapist responds with a paraphrase.*]

CLIENT: That's right. I like how I feel when I drink, and I haven't had many problems so far. Maybe I should just cut down instead of stopping.

THERAPIST: This is a hard choice for you to make. Back when we started working together, you thought that abstinence was the right choice for you, but now you're not so sure. Would it be all right if we talked about the pros and cons of drinking again? Maybe that would help. [*Asking permission.*]

CLIENT: Okay, but I think I already know them.

THERAPIST: Yes, you do. And as I've said all along, this really has to be your choice. I don't think we'll learn anything new here. I just think, since you seem to feel two ways about this, that it might help you be clearer about what you want to do. Is that all right with you? [*The therapist does not oppose the client's negative response, but instead emphasizes personal control and again asks permission.*]

CLIENT: Okay.

THERAPIST: So on the positive side, the good things about drinking, you said just now that you like how you feel when you drink, and I remember that you also said it helps you forget about troubles and maybe to feel better about yourself for a while. You also have liked drinking as a way of spending time with your friends. And you kind of like the taste of cold beer on a hot day, but that wasn't really that important to you. Did I miss anything? [*Note that the therapist here gives voice to the pros of drinking, rather than eliciting them again from the client*.]

CLIENT: Well, I just don't like being told I can't do something.

THERAPIST: I see. Drinking, in a way, represents your freedom of choice. While you've been abstaining for the past weeks, you've also felt a little trapped or controlled. [*Paraphrase and reflection of feeling.*]

CLIENT: A little, yes. I guess it's my own choice, really. I just felt kind of hemmed in.

THERAPIST: And drinking is a way of asserting that you are free to do what you want. [*Reflection, continuing the paragraph, also emphasizing personal choice.*]

CLIENT: Right. Mostly, though, it's the things you said before - blowing off worries, being with my friends, feeling better for a while.

THERAPIST: Okay. I understand that. Now what about the other side: what have been some of the not-so-good things about drinking for you? Let's start with this week, in fact. I notice that you said you haven't had *many* problems related to drinking so far. Have there been less good things about drinking this week?

CLIENT: Well, my wife doesn't seem too happy about it. I guess she's worried I'll get into trouble again with the drinking.

THERAPIST: How much does this concern you?

CLIENT: Quite a bit. I don't want things to go sour for us.

THERAPIST: She's pretty important to you. What else happened this week that might concern you about your drinking?

CLIENT: This doesn't concern me really, but I went to work with a hangover one day. No one noticed, though, so it wasn't a problem.

THERAPIST: It might have been a problem if your supervisor had noticed you were hung over, but that doesn't really worry you.

CLIENT: I don't want to lose my job or anything. I just think it wasn't a big deal.

THERAPIST: It's just that you noticed being hung over, but you don't want to make a big deal out of it. [*Double-sided reflection.*] Fair enough. So this week your wife has been worried about your drinking, which could be hard on your marriage in the long run, and you noticed that you felt hung over at work one day. What else?

CLIENT: Well, I guess I feel a little guilty. Not exactly guilty. I just feel a little bad about drinking again.

THERAPIST: In what way?

CLIENT: It's like I made up my mind, and I kind of promised myself and my wife to stay away from alcohol. Not *promised* really, but I meant it, and now I'm drinking again. I feel like I didn't keep my word.

THERAPIST: That's important to you, sticking to your commitment, and at the same time you felt kind of trapped by it, too. Anyhow, that's a third thing about this week - that you feel a little bad about yourself because you're drinking. What else have you noticed this week?

CLIENT: That's about it.

THERAPIST: Okay. Now let's look ahead a bit into the future. What are some of the risks or potential troubles that you know might happen if you go on drinking as you were before? What are some of the reasons why you stopped drinking in the first place?

CLIENT: I guess my wife could do something drastic.

THERAPIST: What are you thinking of?

CLIENT: I guess if she gets really fed up she could ask for a divorce.

THERAPIST: And you don't want that to happen.

CLIENT: Absolutely, but then my drinking may not get that bad again.

THERAPIST: That might or might not happen, then. What other problems do you think might occur if you keep drinking?

CLIENT: I guess I could have problems at work again. Sometimes when I have a hangover I can't concentrate and I mess up and my boss starts to hassle me. That was happening before I quit.

THERAPIST: How are things going at work right now?

CLIENT: They're great. When I stopped drinking things really improved, and the boss was happy. No one knows I started again. I haven't been that hung over or missed work or anything.

THERAPIST: So you're really happy with how things have changed at work, and in your marriage, too. I remember that those were two of the things you hoped for when you stopped drinking before.

CLIENT: Yeah, I guess they were. I wasn't spending as much time with my family as my wife wanted me to because I was out drinking with my friends, and the doctor told me about my liver tests being up and that I would be in trouble if I didn't quit drinking.

This motivational interview would continue as in Phase 1, leading to a summary reflection, key question, and new process of setting goals and renewing commitment. The summary might sound like this:

THERAPIST: Well, before we wrap up here, I first of all want to say that I'm *really* glad you came in today after drinking this week. I feel kind of honored, actually. And in a way, I'm glad that this happened while we're still meeting, so that we can talk through it. Not everybody comes back. Thanks for that.

Now to pull all this together, you've said that since you started drinking again you haven't really experienced any big problems. You like how drinking helps you forget things for a while, and you enjoy drinking with your friends. Drinking also gives you a feeling of being able to do whatever you want. On the other hand, your wife has expressed some concern that your drinking will get worse and you don't want to worry her, though you're not sure you agree with her. You think that if you continue drinking that you might have some health problems and that you could run into trouble again at work. If things get really bad there's a chance your wife would ask for a divorce, or your could be fired, neither of which you want. These are the same concerns you had when you decided to quit a few weeks ago. You have felt better physically, and work has been going better during this time, but things with your wife haven't improved as much as you hoped. You do think that your marriage might improve even more if you quit drinking again and gave it more time. Is there anything I missed?

CLIENT: Sounds about right.

THERAPIST: So what are you thinking you want to do about drinking at this point? [*Key question.*]

4.4d. Situational Risks and Coping Issues

A client may resume drinking not because motivation has changed, but because she or he has had difficulty coping with specific high risk situations or with an ongoing high-risk lifestyle. In this case, the client may express a *desire* to remain abstinent but difficulty in doing so. To determine whether resumed drinking has such a *functional* importance, perhaps the simplest approach is to inquire carefully about the antecedents

and consequences of resumed drinking. Often clients resume drinking in a risk situation they had *not* anticipated. It may also be helpful to repeat part or all of the Phase 2 functional analysis procedure (3.2). If specific circumstances do not seem to explain the resumption of drinking, also explore more global lifestyle issues that may make it difficult to remain abstinent. Remember that factors which contributed to the resumption of drinking may differ from those that were uncovered in your initial functional analysis (3.2), and also that drinking is often maintained by different contingencies than those which prompted initial (resumed) use. For example, clients may *continue* to drink after an initial episode in response to: (1) anticipated or unanticipated reinforcement that followed initial use; (2) the belief that once one has a drink, control is impossible; or (3) a feeling of guilt or shame about drinking, or a sense of having "blown it" in the initial episode.

In sum, there are within the category of risk and coping issues, at least three general kinds of factors to consider, which may be operating to trigger or maintain resumed drinking:

1. The client is having difficulty coping with a specific kind of situation.

2. The client is having difficulty in managing more global lifestyle issues, and this makes drinking more attractive.

3. The client is continuing to drink in response to beliefs or feelings resulting from the initial episode of resumed drinking.

On the first session following resumed drinking after at least one full week of abstinence, directly discuss the conditions that surrounded initiation of drinking. If the problem appears not to be primarily motivational, but rather related to situational or coping factors, give your client the handout, ***Understanding Resumed Drinking*** (Form U), and elicit his or her answers to the questions it contains. These questions address, in essence, the antecedents and consequences of the initial episode of resumed drinking. Exploration of the client's answers to these questions should suggest where additional attention is needed to prevent future episodes. To elaborate a bit:

(1) *What were the antecedents to drinking?* Help your client understand which elements of a specific situation might have triggered drinking. *Where* was the client? *What* happened in the situation? *Whom* was the client with at the time? What *feelings* was the client having at the time? What *thoughts* was the client having at the time? What occurred in the initial drinking situation that triggered the urge or decision to drink?

(2) *What kinds of expectations did the client have about drinking in that situation*? Often clients return to drinking in a situation where they have positive expectations about the outcome of drinking. For example, did the client expect alcohol to decrease social tension, improve a celebration, or make conflict more tolerable? If this is the case, then it may be important to work with the client to determine if there is an alternative route to obtaining these benefits, other than by drinking. The New Roads procedure (3.2e) might be revisited.

(3) *What (if anything) did the client actually enjoy about drinking in the situation*? After drinking, did the client experience the anticipated benefits of drinking or some other benefit that would make it more likely that drinking would continue in this or other situations? In some cases the anticipated benefits of drinking in a specific situation do not match the client's expectations for the benefits of drinking. Exploring this discrepancy may encourage the client to consider other alternatives for dealing with the situation.

(4) *Did the client have coping strategies available to handle the situation differently? If so, did the client attempt any coping strategies to avoid drinking in the situation*? A good predictor of whether drinking recurs in any situation is whether the client has coping strategies to handle that situation without drinking. Does the client feel able to cope with the situation without drinking? Has the client had success coping with this type of situation in the past without drinking? Would it be useful to learn new coping strategies?

(5) *What was happening in the client's life at the time drinking occurred that made drinking look attractive or increased the risk of drinking again*? Clients often think about drinking and start taking risks with sobriety before drinking actually occurs. Sometimes drinking represents a response to more global lifestyle issues or problems that a client has difficulty managing without drinking. Were there accumulating problems that the client felt ill-prepared to deal with? Was the client placing himself/herself in risky situations in which drinking was more likely to occur, without consciously acknowledging an intention to drink? If the client chose to initiate drinking as a way of dealing with an ongoing stressor this information would lend itself to a focus on coping strategies. A focus on coping would be most appropriate if the client appears to lack coping skill (rather than already having the requisite skills but not using them for motivational reasons).

(6) *How did the client react to the initial episode of drinking?* Once a client has an initial episode of drinking there is still a choice about how long the drinking will continue. Clients who resume drinking may experience a strong reaction to drinking if they had made a public commitment to abstinence. Emotional reactions that may fuel continued drinking include guilt, frustration, shame, disappointment, and anxiety. Discouraging thoughts can also fuel continued drinking (e.g., "I can't change. I can't cope.") Instead of thinking, "I just didn't handle the situation well — next time I'll stay away from those friends"), a client may make reattributions of his/her commitment to sobriety ("I guess I don't really want to change or I wouldn't be drinking."), identity as a sober person ("I guess I'll always be a drunk"), or ability to change drinking ("What's the point of trying to stay sober—once again it's clear that I have no control over my drinking and never will"). In this way, what starts out as a single drink can lead to sustained drinking.

Reference: Form U

Now here is an example of how counseling might proceed within the general style of CBI, when the problem behind resumed drinking appears to be the need for better coping strategies.

THERAPIST: I think it might be helpful if we talk a little bit about the situation in which you started drinking again. Would that be okay?

CLIENT: Sure.

THERAPIST: First of all, here are some questions that we often use to help think through what happened. Take a look at these, and we'll walk through them. We don't have to answer them all, but they might help you get clearer about what happened and what you need to do. [*Gives client the worksheet entitled "Understanding Resumed Drinking."*]

CLIENT: Okay. Well, the first time I had a drink I was at a party with some friends that I hadn't seen for awhile.

THERAPIST: Did your friends know that you had stopped drinking?

CLIENT: I'm not sure. I never really told any of them directly that I quit. I just started out the night drinking soda, and I guess I was hoping they would know that I was trying. A couple of them have seen me stop in the past and they know this is what I usually do when I'm not drinking.

THERAPIST: Okay, so you were at the party with some friends you hadn't seen in awhile and you were drinking soda. What else?

CLIENT: Well, this is a pretty heavy drinking crowd. There were a lot of people drinking quite a bit.

THERAPIST: And in the past when you got together to party with them, you would have been drinking a lot, too.

CLIENT: Absolutely!

THERAPIST: I wonder, had you ever been at a party with them before and not had any alcohol?

CLIENT: Like I said, a couple of times they saw me trying to stop. I went to the parties and drank soda, but I didn't have a very good time so I decided to stop going for awhile. I know what a wild time it usually is for everyone and how much drinking goes on. After I started drinking again I would go back.

THERAPIST: So in the past, it was *after* you had decided to drink again that you went back to parties with these friends.

CLIENT: I guess that's true, yes.

THERAPIST: Now one of the questions on the sheet there asks what you were thinking about drinking. What did you think before you went to the party? What did you expect it would be like to be there without drinking?

CLIENT: I'm not going to lie. I wondered if I would be able to get through the evening without drinking. I had been thinking about how much fun it would be if I could join in the partying. I thought about not going, not taking the risk, but I just didn't feel like staying home that night.

THERAPIST: There was something about that particular night.

CLIENT: Well, my wife and I were arguing because she didn't think I should go to the party and she didn't want to go herself. I was sick of hanging around the house so I said I was going anyway and I went by myself.

THERAPIST: How have things been going between you and your wife in general over the past few weeks?

CLIENT: Not too bad, really. It just seems like every time I want to go out and have a good time, she's worrying about me drinking again, and I get tired of it.

THERAPIST: It's annoying.

CLIENT: Yeah, it ticks me off, like she doesn't trust me, or she has to be my mother or something.

THERAPIST: Okay, so you went to the party feeling slightly aggravated about the situation because your wife didn't want you to go, didn't seem to trust you, and she wouldn't come with you.

CLIENT: Right. And to make matters worse I had to make up an excuse why she wasn't there with me to my friends. I felt lousy about lying. More than that, I just wanted her to be there with me. I wasn't having a very good time. I was upset about arguing, because things have been going pretty good, and I was still worrying about it. I just couldn't shake it off.

THERAPIST: And that was one reason you weren't having a good time.

CLIENT: Yeah, and I wasn't drinking. I kept thinking that it was boring to be drinking soda water and watching everyone else looking like they were having a good time.

THERAPIST: And it seemed to you that if you started drinking, you'd feel better and have a good time, too.

CLIENT: Right. That's right.

THERAPIST: Now how did you actually wind up taking that first drink?

CLIENT: The people having the party had hired a bartender to make drinks for the night. It was set up off to the side in the living room. I was kind of hanging around the bar area not talking to anyone and the bartender asked me if I wanted a drink. At first I said, "No thanks." I walked away and went to talk to someone, but I kept thinking about how good it would feel, and so I eventually went back and ordered a drink.

THERAPIST: What was that like?

CLIENT: I really enjoyed it. It loosened me up and I forgot all about the fight with my wife. I also talked a lot more to the other people at the party after I started drinking.

THERAPIST: And you continued to drink for the rest of the night.

CLIENT: Oh yeah, of course! Wouldn't you? I was having a great time.

THERAPIST: And then what happened?

CLIENT: I stayed until the end of the party and I guess I really tied one on. I can't remember the whole thing.

THERAPIST: And then you went home.

CLIENT: I guess I wasn't thinking too much about how my wife would react or how I would feel the next day. My wife was already asleep when I got home, but she must have known that I was drinking because when I got up the next day she seemed angry.

THERAPIST: So she could tell. How did you feel that next day?

CLIENT: I slept for a long time, and I had a terrible headache. We were supposed to go out with our kids for the day, but I didn't feel well so they went without me.

THERAPIST: So you were left alone for the day.

CLIENT: Yup. I didn't get out of bed until about 2:00 in the afternoon, nursing the hangover. And just when I began to feel better physically, I started feeling bad about drinking.

THERAPIST: In what way? [*Note that the therapist's questions are mostly open questions.*]

CLIENT: I knew my wife would be mad at me for screwing up the family day. I was also mad at myself for breaking my commitment to her and myself to stay away from drinking. I was right back in the same old situation again, and I felt lousy about it.

THERAPIST: What other feelings or thoughts did you have?

CLIENT: I felt angry at my wife for not coming with me to the party, and leaving me alone to get drunk. I felt dumb, weak kind of, for giving in. I still feel like maybe it's hopeless for me to even try to stop. It would probably just happen again, even if I go back to trying. Maybe I just don't have it in me to stop drinking.

THERAPIST: So you went rather quickly from feeling pretty good over the past few weeks, to feeling pretty down and discouraged. What happened next?

CLIENT: I did what I know best. I've been drinking every day since. See what I mean about being hopeless?

THERAPIST: That's pretty amazing. Less than a week ago you were feeling, maybe not great, but certainly much better physically, mood-wise, and in your marriage. You don't give yourself much credit for it now for some reason, but you've been doing very well, at least from my perspective. You were really making some changes. Then there was this party.

CLIENT: Well, I see what you mean. But I was feeling awfully bored - like cabin fever.

THERAPIST: That's a feeling you really don't like.

CLIENT: Well what am I supposed to do? Never enjoy myself again?

THERAPIST: You see the problem! One of the things we say here is that if you're sober but not enjoying yourself, not having fun, then you're not likely to stay that way. I think you're right. [*Agreement with a twist*]. Now there *was* something you said that made me think that you can have a good time without drinking. I guess it was that you said you had gone to parties without drinking sometimes.

CLIENT: I did, but they weren't as enjoyable.

THERAPIST: So it's been tough for you to enjoy yourself without drinking, especially if you're around other people who are drinking.

CLIENT: I guess so.

THERAPIST: And maybe another piece of this is that you have particularly felt like drinking when you're annoyed about something, when something is eating at you. Does that sound right?

CLIENT: Yeah, that's right I guess.

THERAPIST: Well let me try out an idea, then. Suppose that you were having fun in your life, enjoying yourself - not just now and then, but on a regular basis. And suppose you had a way to handle it when you feel angry - a way that doesn't involve stuffing it and feeling lousy, or blowing up, or drinking. Now if those things were true, how would you feel about sticking to your goal of not drinking?

CLIENT: I'd feel a lot better about it, that's for sure.

THERAPIST: And if both of those things were already true - you were enjoying life, and you could deal well with your angry feelings - what about that feeling of hopelessness you had?

CLIENT: I'd feel a lot more hopeful.
THERAPIST: Hopeful that . . .

CLIENT: That I could do it. That I could stay on the wagon.

THERAPIST: Okay - I think you've got something there. In fact, I notice how much brighter you look right now than when you walked in here, and we're only imagining. I wonder if you would be willing for us to talk some more about how to enjoy yourself with people without drinking, and also to work on how you can deal with strong feelings like anger without drinking. It sounds like that could make a real difference.

CLIENT: Makes some sense.

THERAPIST: I just want to ask you one more thing about this feeling of hopelessness that you've had this week. Are you thinking that because you've had a few days of drinking this week, you can't stop again?

CLIENT: What do you think?

THERAPIST: I don't think you're doomed. I think you can do it. From my perspective, you had difficulty handling a particular kind of situation, but there's plenty of evidence from other situations that you can do something - like stay sober - if you put your mind to it. You just kind of kept on rolling with the drinking this week, feeling mixed up about what you were feeling and thinking about the drinking. There is absolutely nothing in what happened this week to say how tomorrow will be. That's up to you. I also believe that you, like so many other people, can enjoy life - *really* enjoy life - without drinking. I can also teach you some ways to handle angry feelings. There's nothing wrong with feeling angry - it's just what you do with it, and in the past you've tended

to drink. You don't have to do that. If you want to be free from alcohol, you can be. Are you up to that?

CLIENT: I think so.

THERAPIST: So do I.

4.4e. Recovering from an Episode of Drinking

As illustrated in this scenario, if what seems to be needed is skill for handling a particular kind of situation, proceed to the appropriate Phase III module(s). In the above case, they would move on to the ASSN and SARC modules.

If the problem seems to be a secondary cognitive-emotional reaction to abstinence violation, however, help your client reframe what happened. There are several messages that may be helpful for a client to hear in order to decrease the negative impact of an episode of drinking, including:

(1) Achieving sobriety is a process during which "mistakes" such as an episode of unplanned drinking, can occur.

(2) If drinking occurs, it can be used as an opportunity for learning, rather than a reason to be discouraged or to beat up on yourself. Think through what happened, and figure out how to avoid such situations and/or be better prepared for them.

(3) Even if drinking occurs, it is not a reason (excuse?) to continue drinking. Each day is a new day (One day at a time).

The handout, ***Recovering from an Episode of Drinking: Eight Practical Tips*** (Form V)**,** may provide some helpful tips for your client as well. Note that this handout is to be used only after a drinking episode has occurred. It is not meant to be given to clients who are abstaining successfully.

Reference: Form V

SOMA: Support for Medication Adherence

4.5a. Rationale: The Importance of Medication Adherence

Most clients whom you treat in Project COMBINE will be taking medications prescribed as part of the trial. Alcoholism treatment studies clearly show that medication adherence is strongly associated with better outcomes. Research on the effects of naltrexone specifically shows that medication adherence subjects fare much better than compliant placebo subjects. It is also the case that important medication effects can be missed when medication adherence slips below high levels. Volpicelli, et al., (1997), for example, found that medication-adherent clients (defined as taking medication or placebo on 90% or more of the study days) were abstinent on 98% of study days with naltrexone, as compared with 89% for placebo - a significant difference replicating an earlier finding (Volpicelli et al., 1992). Among clients with lower medication adherence (<90% of study days), no significant differences were observed between naltrexone and placebo subjects on drinking measures. Thus both for clients' welfare and for the integrity of study outcomes, it is important to support high levels of adherence to study medications.

Medication monitoring and adherence are the primary responsibility of the Medical Management (MM) practitioner. Nevertheless, it is vital that you understand and fully support the use of medications in Project COMBINE, and you have something unique to offer in this regard. Both of the medications being tested in this study have a strong track record in alcohol treatment outcome research (Miller et al., 1998). The MM practitioner will keep you informed of any difficulties with client drinking, medication adherence, or participation in MM (see section 1.3).

4.5b. Why Do Clients Not Adhere to Medications?

There are many reasons why clients sometimes fail to adhere to the assigned medication regime. Here are some common ones:

Individual reasons. Some clients may believe that their drinking problem is not serious enough to require medications. Others may think that they have the problem sufficiently under control so that medication assistance is unnecessary. Some experience early side effects, or discomfort with taking pills (e.g., the large size). Some simply don't believe that medications will help them.

Interpersonal reasons. Acceptance of and adherence to medications can also be affected substantially by interpersonal interactions. A concerned spouse who closely monitors and polices a client's medication adherence may elicit reactance. Counselor style can increase or decrease a client's level of defensiveness versus cooperation. The lack of a strong therapeutic alliance may contribute to mistrust, misunderstandings, or disagreements between therapist and client concerning the importance of the drug in the management of the alcohol problems. Without resolving these differences, clients often remain uncommitted to or even defiant about medication adherence.

Contextual reasons. Clients may not have sufficient structure or control in their everyday lives to adhere to dosage requirements in a consistent manner. Abusive family relationships, residential instability, financial and legal difficulties, and mental health or other health problems are all factors that can interfere with the self-monitoring of prescribed medications. The situation is further exacerbated by social isolation and recurrence of drinking or illicit drug use. Don't overlook the obvious. Ecological issues can be of great importance in understanding nonadherence, but often receive scant attention among health care professionals (Leventhal, et al., 1997).

4.5c. Adherence Motivational Assessment

When your client is not adhering to the medication plan, your first task is to understand the reasons why. Don't criticize, and don't ask in frontal-assault fashion, *"Why haven't you been taking your medications*?" Instead, ask an open and supportive question (e.g., "In what ways has it been difficult for you to take your medications?") and follow up with reflective listening to understand the obstacles. The purpose of this assessment is to identify the sources of nonadherence, whether they involve individual, interactional and/or contextual issues. The following areas are useful to explore: (from Meichenbaum & Turk, 1987; Pettinati, Volpicelli, Pierce & O'Brien, 2000; Carroll, & O'Malley, 1996; Volpicelli, Pettinati, McLellan & O'Brien, in press):

- *Current beliefs and misperceptions about the alcohol problems*. Does the client see his or her condition as serious enough to warrant use of medications? Does the client feel "cured"? Does the client experience a sense of hopelessness about changing the drinking behavior?

- *Current attitudes toward treatment.* Has the client expressed dissatisfaction with some aspects of the treatment program, (e.g., length or content of treatment, therapist, research demands, or treatment plans)?

- *Prior history with pharmacotherapy.* Does the client have a history of repeated failure with medications?

- *Client's expectations about the medications*. How appropriate or realistic are client's expectations and beliefs about the medications? Is the client concerned that he/she is taking a placebo? Does the client have negative associations with taking medications (e.g., as a "crutch," not wanting to become addicted, etc.)?

- *Comprehension*. Does the client have difficulty understanding and following medication procedures - e.g., has difficulty completing questionnaires, understanding the blister packs, reading the pamphlets, and in general understanding the instructions given to him/her.

- *SSO involvement in supporting medication adherence*. Can the SSO be more involved in supporting adherence? Is there anything the SSO is doing that might be interfering with adherence?

- *Life circumstances*. Are there factors occurring in the client's everyday life that interfere with medication adherence such as financial difficulties, work environment or schedule, domestic abuse, family problems, and/or health and legal problems?

The overall purpose of the interview is to obtain information on reasons for the client's nonadherence. To form an alliance, start by asking general or open-ended questions. *"How are you getting along with the medications*?" Avoid confrontational remarks (e.g., "*What do you expect, a miracle*?"). Ask "*How can I be of help*?" which focuses on essentially the same issue but in a more collaborative fashion (Meichenbaum & Turk, 1987). Stay close to the general counseling style of CBI (*reflection, clarification, reframing*, etc.) to maintain rapport and to obtain more information. The following excerpt shows how an adherence interview might proceed:

THERAPIST: So you missed taking the morning dose of your medication for the last three days. Is that right?

CLIENT: I keep forgetting. I was late for work. The kids were running wild. Besides, I have been feeling down and I'm not too sure about the drugs.

THERAPIST: There's something about them that bothers you.

CLIENT: I don't know. I guess I'm just not sure they're going to do any good.

THERAPIST: You don't think they're going to help you, even if you take them faithfully.

CLIENT: Well, maybe they would. I just think I ought to do it on my own.

THERAPIST: When you succeed here, you want to know for sure that you're the one who did it. I can understand that. What else bothers you?

CLIENT: I guess I wonder if that's why I'm feeling down. Somebody told me that one of these drugs can make you depressed.

THERAPIST: So no wonder you've been careful! You're not sure you want to give credit to the drugs when you get better, and somebody also told you that they can make you feel worse! I can see why you've been skipping some doses.

CLIENT: Well is that true? Can they make you depressed?

Here, obviously, is an opportunity to set the record straight with clear information about what the medications can and can't do. It would be important for you to let the MM practitioner know these specific concerns as well, so you can both reinforce more accurate expectations. The point above, though, is to recognize how a motivational interviewing style can be used to explore in a nonthreatening manner the client's reasons for nonadherence. Each of the therapist's responses above contains reflective listening.

4.5d. Exploring Past Medication Adherence

A reasonably straightforward problem-solving strategy is to ask your client about past experience in adhering to medications. Specifically, ask about times when the client has had trouble taking medications as prescribed, and then ask about how the client has at other times succeeded in taking medications as prescribed.

THERAPIST: I'll bet this isn't the first time you've run into problems sticking with a medication plan. Can you think of other times you had a prescription and didn't quite take it as planned.

CLIENT: I had a script for tranquilizers earlier this year. I was going through a separation at the time, and my son was skipping school. I didn't take them for more than a month. I would either lose them or keep forgetting to take them.

THERAPIST: So there it was really a matter of keeping track of them, and remembering. Many people have trouble like that, particularly when there is so much going on in their daily lives. Maybe that's what's happening here, too.

CLIENT: I do have a lot of problems besides drinking, and I guess I wonder if this is the most important thing for me right now.

THERAPIST: A matter of priorities. Let me ask you, too, about times when you have been able to stick with meds that were prescribed for you.

CLIENT: Once a doctor prescribed Antabuse and I took it for three months.

THERAPIST: Really! How did you do that?

CLIENT: My mother came to live with me and helped me out at home. I wanted to show her that I could be a good parent and not drink. I actually straightened up for a while. After my mother went back home, though, I fell into the same trouble - drinking, partying, and not handling responsibility.

THERAPIST: Again, it sounds like a matter of priorities. When it was really important to you, you stuck with it. Good for you!

In the above excerpt the client offers important clues to assist her in complying with the medications. Doubts about priorities and the breakdown in her support system may account partially for the lack of medication adherence. At the same time, the client's concern for her children might be a potential motivator to continue with the medications.

4.5e. Eliciting Self-Motivational Statements for Medication Adherence

From a CBI perspective, medication adherence will be strengthened when *the client* perceives that it is important. This means that you need to discover ways in which medication adherence might support the client's own goals and interests. As in other forms of behavior change, a motivational interviewing style draws on counseling methods like reflective listening, affirming, reframing, and normalizing, and it may be particularly useful to elicit client's own self-motivational statements. This is a unique kind of support that you can provide as an adjunct to the primarily educational approach of your Medical Management colleague. Your primary emphasis is on motivational issues rather than information about the medications. Particularly address your attention to exploring the client's ambivalence or reluctance about taking the medications. Start by reflecting upon and normalizing any misgivings the client may have about the medication. Then open up consideration of the other side: What might be some advantages of giving the medication a good try? What might be the good and not-so-good consequences of not taking the medications? Whatever you do, of course, avoid the kind of interaction in which you argue for why the client *should* take the medications, and the client takes the side of resisting.

As before, it's permissible for you to express your opinion and concerns, particularly after asking the client's permission to do so (see CONC module 4.2). Focus first, though, on eliciting the client's own concerns and self-motivational statements.

In the case example below, the client is unhappy about taking the medication after experiencing a "setback" in drinking.

CLIENT: After last night's drinking and partying, I am feeling disgusted. Now my wife is on my back and complaining again about the money, me hanging out with my friends, losing my job, all that. I don't think these drugs are working any more, and I'm sick of taking them.

THERAPIST: You're really discouraged!

CLIENT: Well what's the point? It's not working.

THERAPIST: You came here, I remember, really wanting and hoping to quit drinking and to improve your family relationships. Now you see yourself as right back again where you started, with no progress at all.

CLIENT: It sure seems that way.

THERAPIST: And I know you really want to change. It must be so frustrating, when your hopes are so high. You know, temporary setbacks really aren't that unusual, even for people taking medications, especially when there have been years of heavy drinking to overcome.

CLIENT: I just thought the drugs would make everything different.

THERAPIST: And wouldn't that be great, if the medication could do it all for you!

CLIENT: I saw this story on television and read in the newspaper about this drug, acamprosate. Sure sounded like it was the answer. Maybe I'm getting the placebo.

THERAPIST: I see your dilemma. You had hoped that the medication would just do it for you. Kind of like the person who goes to the drug store for something to cure the flu, and hopes it will work without resting, drinking a lot of water, taking it easy. It's pretty common - we expect magic from drugs, but they're just part of the healing process. They can help, but may not be enough by themselves. What else might you do to get back on track here, besides giving the meds a fair try?

This example shows reflective listening, reframing, and normalizing as strategies to facilitate the client's adherence with the study medications.

4.5f. Delaying the Decision

Despite your best efforts, some clients will remain adamant about not taking medications. Don't struggle further with a client over the issue. Ask your client what his/her alternative plans are (other than medication) for maintaining sobriety. Review the pros and cons of these plans. Ask about a "back up" plan (which might include medication adherence). Then ask whether the client would be willing to delay the *final* decision about not taking medications until she or he has tried these other options. Suggest that whatever happens, the client is in a "win-win" situation. To illustrate:

THERAPIST: It sounds like you've firmly decided not to keep taking the meds. What are the things you plan to do, then, to remain sober?

CLIENT: I plan to stay home week-ends with my family and not go out with my friends.

THERAPIST: Okay. That's something you said that you had been doing before. How did it work for you?

CLIENT: Okay for a while. Then I got the cravings again and went out with the guys a few times on the weekend and got hammered. That was just before I came in here.

THERAPIST: What's different now that would change the situation?

CLIENT: I know now that I *have* to stop drinking. I don't want to lose my job and my family.

THERAPIST: They're pretty important to you, your family. And you like the job you have. Can I ask you something personal?

CLIENT: Okay

THERAPIST: What happens if it doesn't work out the way you want it to? I worry some that you did try staying home before, and it didn't work.

CLIENT: What do you suggest?

THERAPIST: Well, I was just thinking: How about giving your plan a trial run for a month. And how about a back-up plan in case you find that your cravings come back again?

CLIENT: I guess then I could try the meds again. Maybe try A.A. But I like the 30-day trial idea.

THERAPIST: All right. So you think the meds or A.A. might help if your staying-home plan doesn't work for you this time. Now, I don't know if I should say this or not, but can I suggest one more thing for you to consider?

CLIENT: Why not. I just think I should do it on my own.

THERAPIST: And you will. You are! You're the one deciding what to do here - how and whether you're going to stay sober, whether to take the medications or not. It's up to you. Anyhow, here's my idea. You were pretty discouraged this last time when you slipped back into drinking on weekends, right?

CLIENT: And my wife was more than discouraged.

THERAPIST: It hit her pretty hard. I know you feel bad about that. And I know you hope it won't happen again. I don't like to see you hit with that kind of discouragement either. It happens - no one's perfect, and I know it's been tough. This is a big change for you. Still it hurts. Anyhow, what about this: A 30-day trial of your plan *and* the medications? You don't have to decide now - just think about it. But that might be a win-win situation for you - give you the best chance of getting through that tough first month. Why not pull out all the stops, and give yourself the best chance. You can always decide later to stop the meds. It's up to you. What do you think?

The therapist accepts and reframes the client's decision not to take medications as a "temporary" one. This prevents the client from committing fully to a decision before having had a full opportunity to weigh the consequences of the action. An individual facing an initially aversive task (e.g., taking medication) may respond more favorably to the task over time (Kelman & Hovland, 1953). Emphasizing freedom to delay the decision can sometimes buy the time needed to stabilize sobriety.

4.5g. Overcoming Practical Obstacles to Medication Nonadherence

Individuals who present for treatment of alcohol dependence usually have multiple problems. They may be dealing with child care problems, housing needs, financial and legal concerns, family conflict, and medical and emotional disorders. These other concerns can interfere with medication adherence. Knowing an individual's status with regard to these factors can serve as an "early warning sign" to bolster a medication adherence plan even before major problems arise. Meichenbaum and Turk (1987, p. 105) state the problem succinctly: Such individuals typically have "difficulty fitting the treatment into their daily lives".

In these cases, explore with your client the kinds of obstacles that might interfere with taking their medications reliably, and problem-solve ways to remove them. ("*What would help you to keep taking your medication, even when the going gets tough*?") For some clients, having the active involvement of the SSO in treatment might be sufficient. When the SSO is present, ask both the client and SSO how the latter could be helpful. For example, some clients might desire the SSO to regularly remind them about the pills, while others might only want the SSO to provide encouragement in carrying out the medication plan. Before deciding on specific action steps, make sure that both the client and SSO are committed to the plan.

In the absence of a SSO, ask the client to draw upon other resources such as an AA sponsor who is supportive of pharmacotherapy to fulfill this treatment need. Other clients might need additional services to help structure or regain control of their social environment in order to adhere to the medication plan. In the latter case, the Case Management module (4.3) can be introduced, but first make sure that you have obtained the client's agreement about the need for additional services. The illustration below demonstrates how social resources can be utilized to sustain medication compliance.

THERAPIST: You have put a great deal of effort into the program, but I see that you are still struggling with whether or how to stick with your medication.

CLIENT: Coming home from a tough job, getting the meals ready, and dealing with tantrums all at once is not easy. By the time things have settled down, I have forgotten to take the evening dose. Besides they don't help me with these other problems. Right now, I feel like quitting the program altogether.

THERAPIST: You're really frustrated and discouraged because things aren't working out as well as you hoped, or as quickly. It's so bad, in fact, that you are ready not only to quit the medications, but to quit your whole program. I'm sure this feels very personal to you, but it happens all the time. It's not unusual to feel discouraged about now. What this tells me is that I haven't been as attentive to your needs as I should have been. It means that *more* needs to be done, not less. I'm wondering what kind of additional help you might need?

CLIENT: I need someone to help me with the children, especially after work. Frank leaves for work as soon as I get home. He works the evening shift in the same factory.

THERAPIST: And who else is there who cares about what happens to you?

CLIENT: My Mom and sister. I know they still care, but I kind of wiped them out of my life with the drinking. I was embarrassed about the drinking and problems we were having in our marriage. I didn't want them interfering either. Maybe it's my pride that gets in the way.

THERAPIST: You think they might still be willing to help you. It's tough asking for help, and you can do a lot on your own, but they might still be there for you.

CLIENT: Yes. I think so. I didn't realize how much I've neglected my family. Actually getting their help could be good in several ways.

THERAPIST: In what ways . . . .?

The therapist helps the client identify her need for additional support without disconfirming her own individual coping resources. Such practical support may help to broaden the client's social network, and also help sustain her commitment to treatment.

4.6. MISS: Missed Appointments

When a client misses a scheduled appointment, respond immediately. It is your job as the therapist to actively re-engage your client, rather than waiting for the client to get back in contact. First try to reach the client by telephone, and when you do, cover these basic points:

1. Clarify the reasons for the missed appointment

2. Affirm the client - reinforce for having come previously

3. Express your eagerness to see the client again

4. Briefly mention important concerns that emerged (self-motivational statements), and your appreciation (as appropriate) that the client is exploring these

5. Express your optimism about the prospects for change

6. Reschedule the appointment

It can be useful to conduct a brief functional analysis of how the appointment was missed. What led up to missing the appointment? How did the client make the decision? What happened as a result? Be careful not to make this seem like an inquisition. "*I'm curious to know what happened, if you're willing to walk me through it*," is a better tone.

If no reasonable explanation is offered for the missed appointment (e.g., illness, transportation breakdown), explore with the client whether the missed appointment might reflect any of the following:

* uncertainty about whether or not there is a need for treatment (e.g., "I don't really have that much of a problem)"

* ambivalence about making a change

* frustration or anger about having to participate in treatment (particularly with clients coerced by others into entering the program).

Handle such concerns in a motivational interviewing style (e.g., with reflective listening, reframing). Indicate that it is not surprising for a person to express their reluctance (frustration, anger, etc.) by not coming to appointments, being late, and so on. Encouraging the client to voice his or her concerns directly may help to reduce their expression in future missed appointments. Use Phase I strategies to handle any defensiveness that is encountered. Affirm the client for being willing to discuss concerns. Then summarize what you have discussed, add your own optimism about the prospects for positive change, and obtain a recommitment to treatment. Elicit some self-motivational statements from the client in this regard. Reschedule the appointment.

In all cases, unless you regard it a duplication of the telephone contact that might offend the client, *also* send a personal, individualized handwritten note with these essential points. This should be done *within two days* of the missed appointment. Research indicates that a prompt note and telephone call of this kind significantly increases the likelihood that the client will return (Nirenberg, Sobell & Sobell, 1980; Panepinto & Higgins, 1969). Place a copy of this note in the clinical file. This procedure should be used when any appointment is missed. At least *three attempts* (new appointments) should be made to reschedule a missed session. Finally, an additional handwritten note should be sent two weeks after the first. This note should 1)

acknowledge the client's decision to leave treatment and 2) encourage the client to return within the treatment window and 3) provide information about how this can be accomplished.

When clients have missed three consecutive sessions, or a period of time has passed that would have normally encompassed those sessions and you have followed the pull-out procedure to contact the client as above, the client will be considered "inactive". At this time, you will fill out an Inactive Status Form (available from the Project Coordinator) and return it to the PC. If the client returns within the treatment window and resumes CBI sessions with you, fill out the Active Status Form (available from the Project Coordinator).

NOTE: There is no Therapist Checklist for this procedure.

4.7. TELE: Telephone Consultation

Some clients and their SSOs will contact you by telephone between sessions, for additional consultation. This is acceptable, and all such contacts should be carefully documented in the client's file. An attempt should be made to keep such contacts brief (5 minutes or less), rather than providing additional sessions by telephone.

Early in a telephone contact, comment positively on the client's openness and willingness to contact you. Reflect and explore any expressions of uncertainty and ambivalence that are expressed with regard to goals or strategies discussed in a previous session. It can be helpful to normalize such ambivalence and concerns; for example:

> "*What you're feeling is not at all unusual. It's really quite common, especially this early in treatment. Of course you're feeling confused. You're still quite attached to drinking, and you're thinking about changing a pattern that has developed over many years. Give yourself some time*."

Also reflect and reinforce any self-motivational statements and indications of willingness to change. Reassurance can also be in order during these brief contacts; e.g., that people really do make changes in their drinking problems, often with a few consultations.

All telephone contacts must comply fully with and not depart from the basic procedures of CBI. Explore the concern that prompted the call, but do not deliver new treatment procedures (e.g., starting or continuing a CBI module) via telephone. Indicate that you can discuss the client's concerns in more detail at your next session.

NOTE: There is no Therapist Checklist for this procedure.

4.8. CRIS: Crisis Intervention

In certain circumstances, you may be contacted by the client or SSO in a condition of crisis. It is permissible to schedule an emergency session with the client (and SSO) within the 16 week treatment period. In many cases it will be possible to handle the situation by telephone.

If at any time, in your opinion, the immediate welfare and safety of the client or another person is in jeopardy (e.g., impeding drinking, client is acutely suicidal or violent), intervene immediately and appropriately for the protection of those involved, with consultation from your supervisor. This may include immediate crisis intervention as well as appropriate referral. If a client's urgent needs require more treatment than is provided, make a referral using procedures outlined in 4.3.

There are some standard counseling procedures used in crisis intervention. These can serve as guidelines during emergency sessions.

1. *Listen*. Rely on reflective listening to gain an understanding of what has happened and how the parties are reacting.

2. *Assess*. What is needed? Are there immediate safety issues to address? Is there danger of suicide or other violence? What additional information is needed?

3. *Help with Understanding*. Help the parties understand what is happening to them. Make the situation comprehensible. As appropriate, normalize events and reactions.

4. *Focus on Problem Solving*. After listening, assessing, and helping with understanding, focus on practical problem solving. What needs to be done first? How can the immediate crisis be abated? Develop a specific plan to address short-term and longer-term problems.

5. *Mobilize Social Support*. Who besides yourself can offer practical and emotional support for the client? What family or community resources are available to provide additional support? Link the client up with these sources of support.

Cases where there appears to be a worsening of the drinking problems or evidence of other new and serious difficulties (e.g., suicidal thoughts, psychotic behavior, violence) should be referred to the senior clinician of your team for further evaluation and consultation. Based on his/her own evaluation and the defined procedures of the study, the senior clinician will determine what action is warranted. If alternative treatments or medications are warranted, the PI will be involved in making the determination of whether the client will be continued in CBI and in the study.

4.9 DISS: Disappointed to receive CBI-only condition

This procedure is to be used when your client attends the first CBI session expressing disappointment at not being randomized to a medication condition. Although all clients have agreed to this possibility in advance when signing the informed consent, some will have forgotten or minimized this possibility, with resulting dissatisfaction upon learning that CBI-only is their randomized condition. Your response consists of four levels, and is designed to avoid the situation in which you argue for continuation while the client argues against it.

1. The first level, to be used with all clients in this situation, involves listening empathically and reflecting the client's concerns. Clients may have fantasized that the medication is a "miracle cure" or "the only thing" to help them. Convey an understanding and acceptance of the client's disappointment through your reflective responses.

2. Second, you can provide reassurance that there is good evidence that the CBI treatment is effective without added medication, as shown by previous research studies. CBI was, in fact, constructed from the treatment methods with strongest evidence of efficacy. Some clients will respond well to just this level of reflective listening and reassurance, and will indicate that they are ready to continue with the CBI intervention.

3. For clients who still seem ambivalent, consider a third level of response. Ask the client if he or she would be willing to consider listing the "pros and cons" of continuing with CBI. Make a written list of the benefits and costs that the two of you can generate about pursuing CBI, *beginning with the negatives* (such as missing out on a potentially helpful medication). When listing the costs and benefits of continuing with CBI, prompt the client, as appropriate, to consider some that might have been overlooked. These might include:

- CBI is a free treatment with good evidence of effectiveness

- The client might have received the placebo if assigned to a medication condition

- There are fewer visits and blood draws without the medication or placebo condition (the client saves 11 clinic visits)

- The client avoids any potential side effects of study medication

- There is no need to remember to take medication according to the prescribed schedule

- The client does not give up any options for later pharmacological treatment by participating in CBI. Clients can always seek pharmacological treatment after the completion of the trial if CBI is not as helpful as they hoped.

Offer a summary reflection when you have completed the list, describing both sides, and then ask what the client wants to do at this point. Clients may resolve their ambivalence about participating in the CBI-only condition once this list has been generated, perhaps hearing some perspectives from you they had not considered. If clients remain ambivalent or do not seem ready to proceed, move to the fourth level of intervention.

The fourth level involves emphasizing the client's personal choice and control. In a genuine and gentle fashion, emphasize that while you would like to proceed, it is not up to you, but it is his or her choice whether to continue in CBI. Acknowledge that the client can withdraw from the trial and obtain one of the study medications from a private physician since it is already marketed in the U.S. (naltrexone). This medication can be costly (about $2.00 per pill) but it is readily available. Your approach should be one of

accepting and honoring the client's choice, while making it clear that you are hopeful he or she will remain in the study. Above all, avoid the persuasion trap in which you attempt to convince the client he or she should remain in the study while the client responds with all the reasons they should not.

Phase 3

Assisting With Change

5.0. Phase 3: Assisting With Change

Phase 1 of CBI focuses on enhancing motivation for change, and Phase 2 has as its primary purpose the development of an appropriate individual plan for change and treatment. Both Phase 1 and Phase 2 follow a standard format, with common modules that are delivered to all clients (as well as pull-out modules that are used on an as-needed basis).

Phase 3, on the other hand, is completely individualized to your client's situation and needs. During this phase, treatment consists of procedures drawn from a menu of cognitive-behavioral skill-training modules. Through a process of discussion and negotiation with your client, select the modules that are most appropriate for his or her needs. No single module is required here. You also have discretion with regard to the number of modules that will constitute Phase 3. As treatment proceeds you and your client may discover the need for an additional module that was not planned at the outset of Phase 3, and your treatment plan can be renegotiated. Finally, you have discretion within reasonable limits regarding the length of time and number of sessions needed for each module in Phase 3.

The Phase 3 modules are designed to be practical, not just didactic. It is important not only to *tell* your client about coping skills, but also to *show* and *practice* the skills within sessions. Between-session practice assignments are appropriate in all modules, and will help your client to acquire the requisite skills for maintaining sobriety.

Although a new part of treatment begins in Phase 3, it is important to remember not to abandon what has gone before. Use the general counseling style of motivational interviewing throughout CBI. It is common in Phase 2 and Phase 3 to encounter renewed ambivalence or other motivational issues for which Phase 1 procedures can be particularly helpful. It may be appropriate to revisit parts of Phase 2, because the functional importance of drinking can shift over time, suggesting the need for a new focus of treatment. It is common to find that your treatment plan needs to be changed or amended. Continue to use the pull-out modules as you encounter the clinical situations for which they were designed. CBI is meant to be flexible, providing you with a variety of tools with which to respond to the needs of each unique client.

Phase 3 modules involve the client in learning skills that will support a positive, rewarding alcohol-free lifestyle. These are *active* modules. Never simply talk or lecture to your client about new skills. Involve your client! Practice through role-plays. Use the worksheets. Assign home tasks to try between sessions. Check on previously assigned tasks at the beginning of each session, and lavish positive reinforcement for any and all steps the client has taken to learn and apply new skills. Remember the rhythm of TELL-SHOW-TRY. First describe what to do, then model for your client how to do it, then ask your client to try it. Give plenty of positive reinforcement in the practice process - point out what your client did well, and gently coach on points for improvement, then try it again.

On the next page is a list of the modules from which you and your clients can choose in Phase 3, along with some of the more common indications for using each module. Remember that it is fine to be working on two modules at the same time, although no more than two modules should be discussed in any single treatment session. Use the Therapist Checklist provided for each module, to help you remember the procedures that are included.

Modules of Phase 3

		TOPIC	COMMON REASONS TO USE THIS MODULE
5.1	ASSN	Assertive (Expressive) Communication Skills	To learn skills for expressing feelings, opinions, requests etc. in a constructive way
5.2	COMM	Communication (Listening) Skills	To learn skills for understanding others in a way that will build positive relationships
5.3	CRAV	Coping with Craving	To learn skills for dealing with urges and craving without drinking
5.4	DREF	Drink Refusal	To learn skills for refusing drinks and resisting social pressure to drink
5.5	JOBF	Job Finding	To learn skills for finding and keeping a rewarding job that will support stable sobriety
5.6	MOOD	Mood Management	To learn skills for managing and reversing negative emotions without drinking
5.7	MUTU	Mutual Help Group Facilitation	To find and become actively involved in a mutual help group that will support stable sobriety
5.8	SARC	Social and Recreational Counseling	To find and become actively involved in pleasant social and recreational activities that do not involve drinking
5.9	SSSO	Social Support for Sobriety	To increase positive social support for maintaining stable sobriety

5.1. ASSN: Assertion and Anger Management Training

5.1a. Overview

Assertion training has come to be used in treating alcohol problems because of evidence that interpersonal conflicts and anger can be antecedents of a return to drinking. Social skills training has been found to improve treatment outcomes for clients with a broad range of alcohol problems (Miller et al., 1998). In one study, mood management training was contrasted with active communication skills training (Monti et al., 1990). Clients who received active communication skills training, with or without a partner present, drank significantly less in the six months following treatment than did clients receiving the mood management program. A modification of this skills package was included in Project MATCH. Assertiveness training has been used to help reduce multiple problem behaviors including drinking, smoking, gambling, and overeating.

This is a structured module designed to help clients whose inability to address others in an assertive manner may leave them vulnerable to heavy drinking. This training module helps clients use assertive communication skills to increase their personal power in conflicted interpersonal situations. When clients become more assertive, they may be able to avoid the maladaptive pattern of using alcohol to cope with interpersonal conflict. This module focuses on the *expressive* aspect of communication. The *receptive* (listening) aspect of communication is covered in the COMM module (5.2). These two modules work well together.

First, teach clients to identify situations in which they may need to communicate their feelings, particularly in stressful situations. Next, define assertive behavior and differentiate assertive communication, passive communication, and aggressive communication. Then teach appropriate assertive communication skills. Present clients with various hypothetical high-risk scenarios and have them practice assertive responses in role-play with you.

It is important in this module, as in other Phase 3 modules, to make the material concrete and personally applicable to your client. For example, in reviewing situations where assertive communication is needed (see 5.1c), don't simply recite the list to your client, but make it personally relevant by asking, "When was the last time you . . . . (criticized someone, were criticized, etc.)." Exploring each situation will give you further information about where skill development is particularly needed.

It is also important to note that what constitutes assertive communication (as distinct from aggressive or passive communication) varies widely across cultures and subcultures. What is regarded as normal assertive behavior in New York City may be extremely aggressive and inappropriate behavior in a Scandinavian or Native American social context. The basic principle of finding a socially appropriate middle ground (between aggression and passivity) crosses cultures reasonably well, but cultural sensitivity is needed in determining what constitutes appropriate assertive behavior in the client's social contexts.

5.1b. Rationale and Basic Principles

People drink for a variety of reasons. One common reason that people drink, especially in situations where they feel negative emotions (e.g., angry, nervous, shy, or depressed), is that they believe drinking will help them relax, speak their mind, express their feelings, or stand up for their rights. Drinking can also be used to cover up the emotions that correspond with not asserting oneself in a difficult or intimidating situation. Even in situations that do not directly involve alcohol, nonassertive ways of relating to other people may eventually lead to drinking. For example, one reinforcing consequence of drinking alcohol is quick relief from negative emotions. Unexpressed emotions, however, tend to build up over time. This can lead to "blowup" eruptions of aggressive communication style, and again to drinking. The result can be a confusing alternating pattern of

suppressing emotions (passive communication) and erupting with strong emotions (aggressive communication). Drinking alcohol does sometimes provide quick relief in these situations and may, for awhile, make the client forget or feel "on top of the world." Yet alcohol doesn't get to the source of this problem, and so the same problem comes up again and again -- often growing worse over time.

Assertiveness skills are directed at the source of the problem, making it less likely that clients will rely on passive or aggressive communication styles and want to drink for "relief." This module, focuses on general skills for expressing feelings in a constructive manner.

5.1.c. Step 1 – Identifying Situations that Call for Assertive Communication

The first step in teaching clients to become more assertive is to help them identify situations that call for assertive behavior. Do this by asking your client to identify times or experiences that typically elicit strong emotional states such as anger, resentment, embarrassment or frustration. Frequently, clients are very adept at naming particular situations that produce strong emotions, but it helps sometimes to have a list of such situations available. A few examples are shown in Form W, which should be photocopied for use with each client. Drinking situations frequently call for assertive behavior as well, but drink refusal and assertive communication about maintaining abstinence from alcohol are covered in a separate module (see Drink Refusal.)

Reference: Form W

The following clinical dialogue illustrates how you might introduce this module and explore situations in which the client needs greater skill in assertive communication.

THERAPIST: *So as we discussed last time, today we're going to work on assertive communication skills. Okay?*

CLIENT*: Yeah, I guess so. I'm not really sure what you mean.*

THERAPIST: *Well, that's a great place to start. Most people can benefit from some practice in assertiveness. What that means is skill for good communication, expressing your feelings or getting your point across in a way that is respectful of both yourself and the other person. I plan to explain this in more detail to you today, and I hope we can also spend some time practicing. How does that sound?*

CLIENT: *Sounds all right to me.*

THERAPIST: *Good – well the first thing we need to do is to make a list of some situations where more assertive communication might be helpful to you. One good indicator of this is situations in* which you feel emotional red flags around other people - negative emotions, like when you feel nervous, or resentful, or irritated by someone, or when you feel put down. Those are good times to have some assertive communication skills handy.

CLIENT: Yeah – I can see that.

THERAPIST: Here's a list, for example, that shows a few situations where people might need good communication skills. Do any of these sound like situations that you encounter sometimes?

CLIENT: Well, sure – like just before I came into treatment, I had to deal with the cops. And I really am having a hard time dealing with my roommate. He does little things that drive me crazy.

THERAPIST: Great – now that first example would fall under this category – of dealing with an authority figure, so I'll circle that one. The second would focus on giving negative feedback or constructive criticism, so I'll circle number two. Can you think of any other real situations that might be coming up where it could be helpful for you to have good assertive communication skills?

CLIENT: I'm due to go to court in a couple of weeks.

THERAPIST: All right - that's a good example. I'm going to write that down here on these extra lines.

CLIENT: Also, it may be silly, but I really hate asking people for directions. It's like I have this idea that I should always know where I am and where I'm going. It's embarrassing.

THERAPIST: That's a great example! (Writes it on worksheet.) What else might be coming up?

CLIENT: I have to ask my parents for some money to cover me for a few days, and I know they'll think that I'm going to use it for partying. They'll think I'm conning them, and that makes me nervous, and it makes me mad.

THERAPIST: Very good! What else occurs to you?

CLIENT: That's about it, I guess.

THERAPIST: Okay. We may think of some more later, but that's a great start. Now that we've got these situations identified, I'd like to explain a little more about how assertive communication works, and then we'll have some time to try some practice with these skills. With these situations, we can use examples that will be really meaningful to you.

CLIENT: Okay. I guess it can't hurt.

After you complete the worksheet, move on to describe assertive communication and how it differs from passive and aggressive styles. Throughout this process, engage your client actively in the discussion. Avoid any long spans of time where you are talking and the client is just listening passively. Ask for and encourage feedback, examples, questions, disagreement, concerns, etc.

5.1d. Step 2. Defining Assertive Communication

Assertiveness means expressing oneself effectively in a way that does not violate the rights of others. In short, assertive communication occurs when a person expresses opinions, feelings, or requests without alienating or hurting others. As shown on the worksheet, sometimes assertive communication just involves the statement of opinion; other times it involves a request for a behavioral change in another person. Still other times, assertive communication can involve taking responsibility for one's own actions and trying to make amends.

Basic Beliefs. For assertive communication to be effective, there are two general beliefs that the person should believe or at least agree with:

1. That I have a right to express my feelings, make requests for a change in behavior that affects me, and agree or disagree with what other people say.

2. That (all) other people have a right to express their feelings to me, make requests for a change in my behavior that affects them, and agree or disagree with what I say.

It can be useful to discuss these basic beliefs with your client, and ask whether he or she agrees with each of them. In the process, you may uncover some basic assumptions that need to be addressed for the client to accept assertive communication. (For basic cognitive therapy procedures, see the Mood Management module.)

Contrasting Passive, Aggressive, and Assertive Communications. The next step is to explain assertive communication as a middle road between two extremes. Some people lean to one extreme, some to the other, and some vacillate back and forth between them. It can be helpful to explain the two extremes and ask your client to tell you the disadvantages of each approach.

Passive communication is when the speaker gives up his or her rights whenever it appears there might be a conflict between what they want and what someone else wants. Passive communication includes keeping silent, downplaying how one feels about something, or trying to get a message across though indirect means such as withdrawing, pouting, or isolating from others. Thoughts or feelings that might create conflict are not expressed directly, and so the other person may not know about them. This can result in a bottling up of feelings out of habit, even when the situation doesn't require it, and a consequence can be anxiety or resentment. Alternatively, passive communication sometimes results in depressive symptoms, as the person may engage in a great deal of self-blame.

Furthermore, passive communication is often misinterpreted. A client might state, for example, "I wasn't speaking to her – she knew what I wanted, because I was so quiet, and that's just how I am." The person believes that not communicating is correctly understood by others (mind reading), and may resent that his or her rights and feelings are not respected. The person who relies on passive communication seldom gets what he or she wants. In addition, other people may come to resent the passive style of communication, and by association, the person, for not communicating in a direct and assertive manner.

Aggressive communication, on the other hand, occurs when people press their rights while disregarding
the rights and feelings of others. An aggressive, coercive style often satisfies immediate short-term goals (get it "off my chest," get what I want) but the long-term consequences of this type of communication are often quite negative. The aggressive communicator earns the ill will of other people, who in the long run may not want to be involved with the person anymore, or thwart his or her long-term goals. Examples of aggressive communication extend, but are by no means limited, to violence and threatened violence. Shouting, blaming, name-calling, insulting, shaming, demanding, derisive humor, and ordering are direct verbal forms of aggressive communication.

Assertive communication occurs when people express themselves directly, and in a manner that also honors the rights and feelings of others. There is a planful element in assertiveness: being clear about one's own material (feelings, needs, goals), thinking through the most appropriate way to express these to the people involved, and then acting on the plan. Usually, the most effective plan of action is to openly and directly state feelings and opinions, or make specific requests for the changes desired. In different situations, however, people may decide that a more passive response is the safest approach (e.g., not responding verbally to a threat from a stranger), or that a more aggressive response is called for (e.g., when appropriately assertive requests have been ignored). Assertive communication is flexible in that it takes into account the unique aspects of

each communication challenge and tailors responses accordingly. The middle way is not the *only* way, but it is usually the one that yields the best long-term results. People who reliably use assertive communication techniques usually feel good about their own actions *and* are well thought of by others.

The following vignette demonstrates how these definitions can be communicated to a client.

THERAPIST: So, now that I've explained the basics, I want to be sure that you're clear on the differences between these three styles of communication: Passive Communication, Aggressive Communication, and Assertive Communication.

CLIENT: Okay – let's see. I know that if I shout at someone, or tell them off, that's aggressive

.

THERAPIST: Very true- that is indeed aggressive communication. Aggressive communication occurs whenever someone acts on their own thoughts or feelings while running directly over the listener's rights. Yelling, name calling, shouting someone down – those are all types of aggressive communication. Why do you think people sometimes use aggressive communication?

CLIENT: Well – it usually makes you feel better. At least when you really say it like it is, you get some of the steam out.

THERAPIST: At least in the short term, you feel as though they are accomplishing something, getting it out.

CLIENT: Right. It works. It gets through. I told my boss just a few weeks back to get off my case, or I would lose it. He stayed away from me the whole rest of the day.

THERAPIST: And did he continue to leave you alone the next weeks?

CLIENT: Not really. He didn't talk to me for a few days, but then he was back at it. He stuck me with some real scut work. He didn't harass me anymore though.

THERAPIST: Sounds like you got what you wanted in the short run, but it cost you something in the long term.

CLIENT: I hadn't really thought of it that way, but I really haven't been enjoying my job much, and I'm really not very hopeful that it's going to get any better.
THERAPIST: Let's step back from this example for a minute. You've told me some of the reasons why people use an aggressive style sometimes. What do you see as some of the less good things about an aggressive style?

CLIENT: Well, I guess it doesn't last. I mean, you get an immediate jump, but then you're right back where you started or worse.

THERAPIST: In what ways?

CLIENT: It's like, even if you win, then the person has it in for you and you have to watch out all the more.

THERAPIST: It's more like a competitive game than a relationship.

CLIENT: Well – yeah. Me against them.

THERAPIST: I think you're really getting the idea here. In talking about your communication, you correctly labeled telling your boss off as an example of aggressive communication. You also recognize that it felt good in the moment, and even got you what you wanted in the short run, but that in the long run things look pretty discouraging. You also described very well the opposite extreme of communication – the one that your boss uses.

CLIENT: I don't get what you mean.

THERAPIST: Your boss communicated with you after you told him off - by not communicating. He used a passive communication style. First he gave you the silent treatment, and then he assigned you tasks that weren't pleasant, without saying why he was doing it.

CLIENT: I knew what he was doing, though.

THERAPIST: Well, that's the point. He was communicating with you, but not very clearly. He may have been angry, or you may have scared him, or maybe he just had to get the scut work done! The problem with passive communication is that it is so open to interpretation, that you have no way of knowing if our interpretation is correct, unless another type of communication is used. He wasn't communicating with you in a very direct or helpful way. He's not likely to get a better employee out of it.

CLIENT: That's for sure.

THERAPIST: Any more than you're likely to get a better boss by communicating with him in an aggressive way.

CLIENT: Okay Okay! I understand aggressive, and I see what you mean about passive. So what's this other way of talking?

THERAPIST: Good question! Let's use this same example. Either you or your boss could have communicated assertively, and it might have helped the situation go better. Instead of basically threatening him, you could have expressed your feeling of frustration and asked if he would be willing to treat you in a little different way. He could have asked you not to raise your voice when asking for a change, and told you directly that he didn't like it rather than just assigning you scut work. If both of you had communicated assertively, it would have gone even better, but you can make a real difference just by how you communicate yourself.

CLIENT: Easier said than done.

THERAPIST: You're right - it's not easy at first. Like anything else, it takes time to get the hang of it, but in the long run it's worth it. But it sounds like you get the basic idea now.

CLIENT: I think so. Usually, the most effective way is to be direct, but not in a way that sets the other person back.

THERAPIST: Exactly! Now that you have the "why," the next step is to get some basic "how to." There are a few simple rules you can remember, that are really helpful. And then we'll still have some time to start some practice today, and I'll give you some things to try this week before we get together again.

5.1e. Step 3. How to Communicate Assertively

Assertive Communication involves skills that take practice and persistence. Don't just discuss skills. *Practicing* is an effective method for learning assertive communication skills.

Begin by reviewing the four basic tips on Form X: Some Basic Tips for Assertive Communication (which you should photocopy for your client). Then proceed with role-play practice of assertive communication skills.

Reference: Form X

A fundamental skill to teach here, which is applicable across many forms of assertive communication, is the "I message" (Gordon, 1970). The basic idea is that when expressing a feeling or opinion, the sentence should begin with "I" rather than "You." This makes it clear that the person is expressing a personal feeling or opinion, and is less likely to elicit defensiveness from the listener.

There are various levels of complexity to "I" messages. The most basic is "I feel . . . ." Even here, people mix up feelings with opinions. The expression "I feel that . . . . ." is not a feeling, but an opinion. If the word "that" can be logically inserted, what the person is expressing is not a feeling. In a true feeling statement, the word "that" doesn't fit.

I feel this conversation is going nowhere. (not a feeling)
I feel frustrated. (feeling)

Another component of a clear "I" message can tie it to a particular situation or action of the other person. "I feel _____ when you _____" is a clearer communication, less likely to be perceived as blame, than a "You" message.

You never talk to me! ("you" message)
I feel lonely when you keep quiet like this and don't talk to me. ("I" message)

Again, this is likely to be only an idea, quickly lost, unless you help the client apply and practice it in personally meaningful contexts. Tell-Show-Try. Ask about recent situations in which the person had a strong feeling, and things didn't turn out as well as the client would have liked. Explore how (if) the client expressed his or her own feelings, opinions, or preferences in this situation. Practice different ways in which the client might have communicated assertively. Consider how others might have responded differently.

5.1f. Asking for a Change

After you have reviewed the general guidelines in SOME BASIC TIPS FOR ASSERTIVE COMMUNICATION, discuss in more specific detail how assertive people express themselves. A good place to start is in rehearsing how to ask someone for a change in their behavior. The *assertive* person decides what he or she wants, plans an appropriate way to involve other people, and then acts on this plan. Usually, the most effective plan is to clearly state one's own feelings or opinions in a respectful way, and directly request the changes that one would like from others. Assertive people do this without using threats, demands, blaming, or negative statements directed at others. When communicating assertively, a person is more likely

to say what he or she means, and is less likely to get sidetracked into other issues. As a result, the person is more likely to have his or her needs met.

Use explanations like this:

> *Instead of focusing on what the other person is doing to you, assertive communication focuses on your own reactions to that behavior. You can do this by beginning the sentence with the word "I," rather than "You." This is the "I" message we talked about earlier, a way of taking responsibility for your own behavior. When we begin a statement with the word "You", it often places blame on the other person. Notice the difference in these two ways of communicating a frustration:*
>
> *"You never listen to what I have to say."*
>
> *vs.*
>
> *"I feel frustrated when I think you're not listening to me."*

Explain that assertive change messages have three parts (Huszti, 1996):

Describe the behavior: Describe (but don't criticize) what the other person is doing. Be sure you are describing behaviors and not calling the other person names or making accusations.

Describe your feeling or reactions: This is a brief description of how you feel about the behavior, or how it affects you. For example: "I feel mad when…" A good common form of this expression is "*I feel* _____ *when you* _____ *because I* _____." It contains an "I" message of feeling, describes the other's behavior, and takes partial responsibility.

Describing what you want to see happen: This is what you would like the other person to do differently. Again, remember to use specific descriptions that focus on the behavior rather than putting the other person down! General criticism does not bring about change. A specific request is more likely to succeed.

Assertive communication is a skill that takes practice and becomes more comfortable with time. It is important in this module that you actually *practice* assertive expression. Specific home assignments are also important, for your client to practice between sessions. Then at the next session, review this assignment as a first priority, to communicate the importance you place on practice. When you are ready to begin in-session practice, return to the scenarios identified in 5.1c. Here is a clinical example:

> THERAPIST: Okay, let's apply these basic rules to real life situations. You mentioned earlier two particular situations where you might be able to use stronger assertive communication skills. You said that you recently had a run-in with the police and have a court date coming up, and that you were struggling with a roommate who annoys you.
>
> CLIENT: Yeah – My roommate is a real drag.
>
> THERAPIST: Okay. Can you tell me more about the roommate – what his name is, and how it is that he annoys you.
>
> CLIENT: His name is Chris, and he's about my age. We used to get along pretty well – until we moved into this apartment together. Then he started to get on my nerves, and now I can't stand the guy. He's a selfish, lazy slob who thinks only about where his next beer is coming from. It's been really hard to handle since I'm trying to stay sober.

THERAPIST: So there are things you have liked about Chris, but now that you live together there are things he does that really bother you, and his drinking is one of them.

CLIENT: You got it.

THERAPIST: Now in terms of these three styles of communication that we have been discussing, what would you say is the typical style of communication between you two? Passive, Aggressive, or Assertive?

CLIENT: Well – its definitely not assertive. Like last week, I was in the kitchen, and the sink was full of empty cans and glasses that Chris had just dumped in there when he staggered off and fell asleep on the couch. When I went to make coffee, I couldn't even get into the sink. I just lost it. I threw it all in a bag, and I woke him up to scream at him about being such an inconsiderate jerk!

THERAPIST: And that communication style was . . . .

CLIENT: (smiles) Aggressive, I'd say.

THERAPIST: You were pretty upset. How did Chris respond?

CLIENT: Typical – he just ignored me, and went back to sleep. He hardly even speaks to me these days, and I could care less. He did the same damn thing later that night when he came home - just went straight to his room. That's pretty passive, I guess.

THERAPIST: So in this situation, at least, you responded aggressively, and he responded passively. It sounds like the communication style isn't making either of you happy in your living situation. It's not getting either one of you a better roommate.

CLIENT: No – that's true. I guess I'm pretty aggressive when I rant and rave like that. I even talk to the walls about him.

THERAPIST: So you can accept some partial responsibility here. I appreciate that. You know, it sounds like at other times you're passive, not communicating with Chris directly – you talk to the walls.

CLIENT: Yeah – I hadn't thought about it that way, but you're right. Chris is even more passive though – he acts like I'm not even there.

THERAPIST: Okay – let's try something here. Let's see if we can re-write that scene from last week. I'll be Chris, and you be you. All right?

CLIENT: I don't know. That always makes me a little embarrassed.

THERAPIST: Good for you! You told me how you feel! And you did it in a way that lets me keep talking to you about it. Sure – role-playing can be a bit uncomfortable at times – but you did a great job of acting out your part earlier when I asked you to show me what you said. If you're willing to give it a try - here I am, Chris, snoring away on the couch in your apartment. (Makes snoring sounds.)

CLIENT: Yeah – and I go into the kitchen and the place is a mess, and I start chucking stuff in the garbage.

THERAPIST: “Hey – what’s all the noise about?”

CLIENT: “You left all this crap for me to clean up after you!”

THERAPIST: “Chill out! I’m going to clean it up later. I’m going out.” (Gets out of chair and stomps off, then returns to chair in therapist role.) Well – how was that?

CLIENT: Not bad. That’s about how it goes at our place these days.

THERAPIST: Okay, so let’s try again using a more assertive, less aggressive style – again, you play yourself, and I’ll be Chris. Okay?

CLIENT: Alright – I walk into the kitchen, and I’m steamed. Instead of throwing things, I come out, and I say “Hey – Chris – wake up. I’m sick and tired of doing the damned dishes all the time. Can’t you pick up after yourself for a change?”

THERAPIST: “Hey – you don’t always pick up either.”

CLIENT: “Well, that’s true, I don’t always. What I’d really appreciate is if you could at least take care of the bottles and cans. I’m really trying to stay sober, and it bums me out to be confronted with this stuff first thing in the morning. Could you do that for me?”

THERAPIST: “Hhmm – I guess I can do that. I’ve smoked outside and kept the ashtrays empty since you quit smoking.”

CLIENT: “Yeah - like that. And I really appreciate it!”

THERAPIST: “Okay. I’ll try.” (Shifts back to therapist role.) Now – how do you think that went?

CLIENT: Well – it was a little better – at least you responded somewhat better.

THERAPIST: And so did you! You used “I” statements for the most part – Rule 1. You expressed your feelings directly instead of throwing things - Rule 3. Instead of attacking my personality, you addressed the specific behavior that bothers you – Rule 2 - and you also requested a specific behavior change. You also showed respect for me, too - you acknowledged my efforts, and you responded well to my indirect communication about your mess, by taking partial responsibility. You even used appropriate eye contact that time, although I did see you roll your eyes once or twice. That was a huge improvement! Anything else you could do to make the interaction more assertive?

CLIENT: I think I still sounded a little aggressive at the beginning, and I don’t think he would have responded as nicely as you did. What else did you notice?

THERAPIST: Just that you did a very nice job of balancing your negative feelings with some positive feedback and respect. He could have gotten defensive when you mentioned trying to stay sober, but you balanced that by staying focused on your own feelings about yourself - “I” messages - without attacking his own drinking. Shall we try it one more time, for a better beginning? Give it a try.

CLIENT: Sure. “Hey – Chris – wake up, pal. I’m doing your dishes a lot of the time! Could you give me a hand cleaning up here?”

THERAPIST: "Alright, alright. I don't know why you get so bent out of shape about it! You don't always pick up your own stuff."

CLIENT: "That's true - I don't, and I'll try to do better. I'd really appreciate it, though, if you could take care of the bottles and cans. I'm trying to stay sober, and it bums me out to have to deal with this stuff first thing in the morning."

THERAPIST: "Okay, sure – I guess I can get that – it's like your having to deal with the ashtrays when you don't smoke."

CLIENT: "Exactly."

THERAPIST: "Okay. I'll try to keep the booze out of your way." (Shifts back to therapist role.) Hey – that seemed really great. What did you think?

CLIENT: It felt pretty good. Now I just have to learn how to do it in real life.

THERAPIST: Yes – that's the challenge. It's easier in the heat of the moment just to snap back. Let's see if there are some more scenes we can practice to give you a little more flexibility when you take these skills and use them out there. How about the court situation . . .

Spend a substantial part of the remaining time doing role-plays of scenarios personally relevant to the client. If the client gets stuck, or is having a hard time responding assertively, try switching roles. It is often easier for the client to role-play the offending other than to come up with a new way of responding. After you have modeled assertive behavior, reverse roles and have the client practice his or her own side of the conversation. It can be useful for you to model appropriate communication, but always have the client take his or her own role to practice the new skills.

5.1g. Using Assertive Communication to Deal With Interpersonal Conflicts

Interpersonal conflicts, and the resulting anger and negative feelings, are high-risk situations for drinking. Assertive communication skills can help clients deal effectively with differences or conflicts with other people. Since criticism is often viewed as a negative or unpleasant event, it is useful subject matter with which to practice assertive communication in conflict situations. These points are summarized on the handout Form Y.

Reference: Form Y

Receiving Criticism. Regardless of how we live our lives, we all face situations where people make critical statements or give us feedback about ourselves that we perceive to be critical. Justifiable or not, criticism an leave one with upset feelings of anger, anxiety, sadness, or shaken self-confidence, especially if the criticism was expressed in anger or hostility. One of the most difficult things to do in our interactions with people is to receive criticism gracefully. Criticism can actually provide us with a valuable chance to learn things about ourselves and how we affect others. This gives us an opportunity to make positive changes in ourselves.

Suggested questions for discussion:

Can you remember times when someone criticized or confronted you? How did it come out? Can you remember a time when it seemed to clear the air? Have there been other occasions when relationships were damaged by criticism? Were there differences in the way communication happened in these different cases?

The strategies listed below can help the client to work toward a positive outcome when someone *confronts* him or her about a situation, regardless of whether the criticism is delivered in a *constructive* or *destructive* manner. Discuss the various strategies, using your own words to elaborate the details. Having available an effective response (not a "come-back") to criticism can reduce conflicts and the probability of drinking. When a client finds himself or herself being criticized or in a confrontation, these are four helpful approaches:

1. **Keep cool; avoid escalation.** --*It is often easier to say "keep cool" than to actually do it. However, keeping cool in the face of criticism is important for all concerned. When you feel criticized or confronted, try to be aware both of your own feelings and of those of the other person. Make a conscious effort to calm down. Sometimes the old custom of "counting to ten" will help. Other times you should stop the conversation in favor of continuing it at a more appropriate time or place. Ask yourself if you are in the appropriate surroundings to continue the interaction, or if a "cooling off" period would help. If so, try to postpone the interaction in order to take the heat out of the situation. If you do try to obtain a cooling-off period, or want to move the conversation to a more suitable location, be careful not to appear to be dismissive of the person or of their grievance. Explain that you are taking the complaint seriously, but that you could give it more careful consideration if you could talk about it in a quieter place or at a time when you could give it your full attention. Be specific about arranging a time and place which would suit you both.*

2. **Listen: show you understand.** --*Let the other person have their say without interrupting; hear them out. (See Module 5.2.) Let them know that you understand the substance of their criticism. It can be helpful to reflect back what they say to you. This helps to clarify their complaint and shows them that you are treating them with respect. This is also a way of checking that you really do understand, because if you have misunderstood they will almost certainly put you right.*

3. **Correct misunderstandings.** --*Try to figure out if there has been a misunderstanding in your communication and talk it through in order to set the record straight.*

4. **Apologize when it is appropriate**. -- *If you are at least partially in the wrong, apologize. Everyone makes mistakes, it is just part of everyday life. It could be that you have misunderstood or forgotten something; or perhaps you had not realized how your actions would affect another person. In these circumstances the most realistic and respectful way forward is to acknowledge your own (at least partial) responsibility, and that the other person has cause for complaint. Say that you are sorry and, if necessary, explain the steps you are going to take to put things right.*

Giving constructive criticism. Many problem drinkers report that they drink when they feel frustrated or angry with other people. They believe that they cannot speak up and confront another person or deliver criticism without having a drink first. Learning to give constructive criticism while sober will reduce the likelihood that the client will feel the need to drink when he or she wishes to comment on someone's behavior (Monti et al., 1989).

Discuss with the client situations in which it is necessary to confront another person, to tell that person directly whatever is troubling him or her, in order to solve a problem. Help the client to see that there are effective ways of doing this and still maintaining a positive relationship with the other person. In fact, if done constructively, confronting another person can help strengthen the relationship.

Suggested questions for therapist/client discussion:

Can you remember a situation where you had to confront another person about their behavior? How did that interaction end?

Can you think of any situation that has deteriorated because you have put off confronting another person about their behavior?

In your experience, are there occasions when it is better not to confront another person about behavior that is causing you problems?

These are some tips for giving constructive criticism:

Stay calm. -- Try not to criticize or confront someone while you are feeling very angry. Just as when you are on the receiving end of criticism, you need to be sufficiently cool and in control to be constructive and to choose your words carefully. If your feelings are too hot you may say things that you regret later. Remember a display of anger or annoyance can arouse feelings in the other person which interfere with how they hear your message.

Choose the right time and place. --*Decide when it is the right time and place for talking to someone about their behavior. For example, in the heat of the moment, when one or both of you are feeling angry or hurt about something, you may not be able to solve a problem so that it has a good outcome.*

Check out misunderstandings. -- *Once you have decided to confront someone, the first step is to check, politely and sincerely, that there is no misunderstanding on your part or that of the other person. This gives you the opportunity to back down gracefully if the mistake is your own, and the other person the chance to apologize if the mistake is theirs.*

Don't blame. --*If there are no misunderstandings between you, but the other person does not understand your problem, help them to see things from your point of view. It will be difficult to achieve their cooperation, however, if you antagonize them. In talking about the problem, describe behavior but do not blame, moralize, or comment on character. Doing so shows disrespect for the other person, and gets in the way of problem-solving. It stops people from listening to you and, therefore, stops them from seeing your point of view.*

Use "I" language. --*Use your assertive communication skills and deliver "I" messages. If you need to confront another person, tell them how their actions affect you. The emphasis is on "me", my responsibilities and needs, and the problems that arise for "me" as a result of the other person's actions.*

Offer to help. – *Offer to do what you can to help or thank the person for making the change you are requesting . Ask what you can do to help it happen*.

One way to give your client practice in providing constructive criticism is to provide a real-life opportunity within the session itself. (This can also be a good opportunity to show how to respond appropriately when receiving criticism.) Ask the client:

Tell me something that you haven't liked about how I have worked with you so far. What do you wish I had done differently?

5.1h. Giving Encouragement and Making Positive Comments

Assertive communication also involves the expression of positive feelings and comments. Positive reinforcement is something that strengthens communication and relationships. It is also something that sometimes decays in the close relationships of problem drinkers. A final emphasis in this module is to increase the level of positivity in communications. Form MM provides some examples of ways in which positive statements can be made.

Reference: Form MM

The client (and SSO) can keep track of the number of positive statements made to other people each day, and the people to whom they were said. These are like little deposits into the relationship piggy bank. It might even sound a little hollow at first, but bit by bit it gets more solid.

The other side of this, of course, is to decrease the "withdrawals" - not to give in to opportunities to criticize, judge, blame, or hurt others. Discussions about your client's communication pattern may point to aversive communications that need to be interrupted. Within a primary relationship, each partner can keep track of positive and negative communications to and from the partner each day. This raises awareness, and discrepancies in the two records can be revealing.

When both client and SSO are present in sessions (whether or not this module is used), keep their communications on a positive tone. Don't allow them to "play back tapes"of argument, blame, criticism, etc. Actively intervene if this begins, pointing out that rehearsing the negatives is more hurtful than helpful. Focus on how communication can be better in the future, not on how badly it was done in the past.

5.1i. Closing a Session

Don't try to cover all of this in one session! Pick out manageable chunks of new information to cover, and spend a substantial part of your time practicing within sessions. Before you close a session, double-check and review your client's understanding of what you covered. Provide a handout as appropriate. The sections below can serve as reminder handouts, for example. Negotiate a homework assignment for your client to practice between sessions, and review how it went as a first priority in the next session.

5.2. COMM: Positive Communication Skills Training

This module is for those clients you determine would benefit from learning more effective social communication skills. It is also a good module to use with clients whose partner is attending as a SSO, to improve positive communication in their relationship. It focuses particularly on *receptive* communication skills - good listening - and on intentional planning of positive reinforcement in relationships. In this way it is a good companion module for Assertion Training (5.1) which focuses on *expressive* communication skills. For clients with alcohol problems, lack of good communication skills can hinder progress in a number of ways. Some clients may have never developed good communication skills, while others' skills may have diminished as a result of isolation related to their drinking. Clients' communication skills may also have become distorted as their social interactions have become increasingly defensive and argumentative as a result of their drinking. Important relationships are often damaged or lost in relation to problem drinking. Learning to listen and communicate well can often help clients take steps to rebuild important relationships or establish new ones. Having rewarding interpersonal relationships is an important aspect of stable sobriety, and clear communication (and stronger relationships) can be helpful in changing drinking behavior in the first place. Effective communication skills can enhance clients' ability to cope with high-risk situations, and can strengthen the social support network that is important to the maintenance of sobriety.

This module can be delivered on an individual basis, and can be particularly useful when a spouse or significant other is attending treatment with the client. In the latter case, this module can be used to strengthen communication within the client's primary relationship.

The overall aims of this module are to help the client:

Become more aware of the *process* of interpersonal communication,

Understand that effective interpersonal communication depends on skills that can be acquired,

Learn how to understand more clearly what other people mean when they speak, and

Thereby to avoid misunderstandings and build stronger relationships.

As throughout the rest of CBI, maintain the client-centered, empathic style described in Phase 1. Through this motivational interviewing style you are already modeling good non-verbal communication and reflective listening as well as a number of other important communication strategies. Good modeling in itself is a powerful way to teach effective communication.

5.2a. The Process of Interpersonal Communication

As a beginning, point out that interpersonal communication takes place every time people interact (and indeed is happening at this very moment). We talk, listen, observe and react to each other, exchanging all kinds of information, in many different ways. While communicating effectively can be one of the most satisfying and interesting of human activities, it can also be hard work to do it well. Good communication doesn't come *naturally* to most people. The good news is that good communication involves skills that *can be learned* and improved.

Start by asking your client to recall some communication situations.

Think of someone you know who you think is really a good listener. Someone who makes you feel good, feel understood when you talk. What does that person *do* to be a good listener?

Think of a recent situation in which you had something important to say to someone, and that person really put some effort into understanding your point of view. How did you feel after that? (Most likely he or she left the situation feeling good.)

Recall a different situation when you tried to say something important to someone, but it didn't go well and you left the situation feeling frustrated or discouraged. Why did that communication not go as well? (Chances are, in the latter situation, the client felt that the person to whom he or she was talking did not listen well and did not really understand what the client had to say.)

Everyone likes to be understood. Much of our communication is aimed at getting others to see the world as we see it. But for each person who is understood, there needs to be someone who understands. It is a gift we need to give each other. It is a skill.

Give your client a copy of the "How Communication Happens" handout (Form Z) and discuss in detail what is actually happening when two people are trying to communicate. Clients generally find this diagram interesting and helpful in understanding how communication problems can develop. Say something like this:

One useful way to think about interpersonal communication is as a series of messages --information that goes back and forth between people. You send a message, you receive a message.

Now, when you, the sender, want to let someone know something, you start out with an intention, your own private thought - which is what you MEAN to communicate. This is the "message meant" box down here (point out box marked "message meant"). *To get across what you mean, however, you have to put it into words. You know that people don't always say exactly what they mean, right? As you put your meaning into words, there are a lot of things that influence the words you choose: your previous experiences in life, with that person, with this particular topic, any feelings you might be having, and your expectations of how the other person might react. All of these things influence the message you send. It's like what you mean to say passes through a kind of filter. This means that the message you send in words* (point out box marked "message sent") *doesn't always match what you meant to communicate. Does that make sense so far?*

This "message sent" includes not only your words, but your tone of voice, body language and facial expression. After the words are spoken and the message is sent, the receiver or listener gets involved. First of all, the listener has to hear the words, and it's possible that he or she doesn't even receive the words accurately. [Again, indicate the ellipse.] *Why might it be that the listener doesn't get your words right?* [Discuss factors like attention, culture, accent, distance, expectations, hearing problems, etc.].

Once the words you send are received, then the message is interpreted by the listener, much the same way it was filtered by you before you sent it. What the listener hears might be influenced by culture, past experiences, expectations, feelings and many other things. By the time the listener interprets your message, it may look quite different from the one you were intending to send.

Reference: Form Z

Ask your client whether this makes sense, and if it reminds him or her of any experiences like this. Discuss the steps along the way in an example: the message that was intended, the words that were said, the words that were received, and the message that was heard. If an example is not available from the client's own experience, provide an example that is appropriate to the client's situation. The overall point here is motivational: Given that there are so many ways that communication can go wrong, it is really important to learn how to send and receive messages accurately. Communication can go very wrong in just one round, unless you do something to keep it straight.

5.2b. Communicating Effectively

Discussing the *process* of communication leads naturally to skills for clear communication. The following practice exercises are meant to be done first in session, with subsequent home assignments to provide practice in the client's own world.

5.2b1. Attending

Draw on the earlier discussion (5.2a) of what a good listener *does* to discuss the nonverbal aspects of listening. Good listening, first of all, involves some silence. One must give the person time to talk, and don't interrupt. There is a lot that one can do to be a good listener even without saying a word.

> *A good way to illustrate this is to try something that is kind of hard. I'll do it first, and you can tell me how I did. My job is to be a good listener - to let you know that I am hearing and understanding what you are saying - without saying a word. I will allow myself some little noises like "hmm" and "mm hmm," but I'll try to say no words at all, yet have you know that I'm listening and caring about what you are saying.*
>
> *Now, to do that, you need something you can talk about for a while without much help from me, because you are going to do all of the talking for a few minutes while I just listen. Here's one that most people can talk about for a while: What it was like in my home when I was growing up. That lets you choose what to talk about - where you grew up, what your parents were like, what your home looked like, other family members, school, whatever. So if you will talk about that for a while, I'll do my best to let you know without words that I'm listening. Okay?*

Allow the client to talk for a few minutes until you reach what seems a natural stopping point. Illustrate the nonverbal aspects of listening described below. Then ask the client to tell you how you did as a listener, and what in particular he or she noticed that indicated you were listening. This leads to a brief discussion of nonverbal attending:

Devote your whole attention to what the other person is saying. Don't do anything else (looking at watch, looking around, reading, etc.). Even if you "can do two things at once," don't.

Keep your body and head turned towards the other person.

Maintain good eye contact. A speaker naturally looks at you and then looks away. A good listener keeps fairly constant eye contact without the feeling of "staring." Don't let your gaze wander about as though you are thinking about other things or looking for someone more interesting.

Use nods and facial expression appropriately to reflect feeling and understanding.

Use some non-word sounds that encourage the person to keep talking (Hmm, Ah, Mmhmm).

Assure the client that often this sort of listening is as valuable as having a discussion about a problem. In fact, often what people want from us is not problem-solving, but just to listen and understand. We

show by our encouragement that we are interested, that the speaker is not boring us, and that we are putting their needs first. Just being listened to can encourage people to communicate what is on their minds and can sometimes help them to sort out problems for themselves. It also builds friendships. For clients who need to establish new relationships, point out that good listening is one of the most effective conversational skills, and it helps to build friendly relationships quickly.

Next, as appropriate, have the client be the listener, using the same rules. Choose an appropriate topic about which you can talk for a few minutes while the client listens. If a significant other has accompanied the client, have the SSO be the speaker and the client the listener. Then debrief first by asking what it was like to be the listener - what your client was experiencing. (For example, many people say that they thought of all the things they *would* have said ordinarily.) Be sure to comment positively on what the client did well to communicate listening and understanding. If there is something specific that the client could do to be a still better listener, comment on it, but be sure to begin and end with positive reinforcement. If an SSO is present, you could reverse roles and have the client be the speaker and the SSO the listener.

5.2b2. Avoiding Roadblocks

A next step is to explain that there are many things that people do, often with the best of intentions, that are not really listening. Most of these have to do with putting in the listener's own "stuff" - advice, opinions, suggestions, and so forth. This is okay to do sometimes, but it really isn't good listening because it tends to put up a roadblock (Gordon, 1970). Instead of going along naturally, the speaker now has to deal with your stuff - and basically go around it to get back on the same track (detour). Most often the conversation winds up going off in a whole different direction, and never gets back to the original road.

A good conversation, of course, involves you talking about yourself as well as listening - some give and take. What we are focusing on here, though, is good listening, which is harder for most people than talking about themselves. Here are the main kinds of roadblocks that stop people from talking to you about themselves:

Giving advice, making suggestions, or telling the person what to do
Agreeing or disagreeing with what the person says
Criticizing, blaming**,** or shaming
Interpreting, analyzing, or being logical
Reassuring or sympathizing
Asking questions
Ignoring, withdrawing, or humoring

Again, it's okay to do these things at times. Asking questions, for example, gives you information that is of interest to you. But in good listening, you let the other person talk. In that way, good listening is a sacrifice. You give up your own "stuff" for a while and give your whole attention to listening. It is a real gift.

5.2b3. Guessing About Meaning

If staying quiet isn't enough, and many of the things that people say aren't really listening, then what can you say to be a good listener? That is the third piece of this module.

Go back to the "How Communication Happens" diagram and point out that when communication is going well, the lower right box (what the listener thinks the person means) closely matches the lower left box (what the speaker really means). Most people react to their *interpretation* as if it were what the speaker really

meant. Good listening involved checking out whether what's in your lower right box (what you think it means) is what the person really means (lower left box).

One way to do this is just to ask if what you think the person meant is what they really meant. This works, but it does tend to get in the way of a smooth conversation. Nevertheless, it's worth demonstrating. Again, it may be useful for you to be the listener first while the client is the speaker, then reverse roles. Here are the roles:

Speaker: Finish this sentence: One thing that I like about myself is that I _____.

Listener: Ask a series of questions about what the speaker might mean. Always use the form: "Do you mean that you _____?"

Rule: The speaker may answer only "Yes" or "No" and say nothing more.

The exercise makes it obvious that one is "guessing" what a speaker means, and often is not right in the guess. It also becomes clear that a speaker often means more than one thing - there are levels of meaning.

In debriefing when the client has been the listener (question asker), find out what the client was feeling and experiencing in that role. Besides the insights above, there is often a feeling of frustration that "I wanted to hear more than Yes or No." Similarly, the speaker almost always in this exercises feels the frustration that "I wanted to say more than Yes or No." It illustrates that good listening naturally keeps a conversation going, making the speaker eager to say more and the listener eager to hear more.

If the client brought an SSO to the session, have the client practice this with the SSO rather than with you as a speaker. Their roles may then be reversed for a third round of practice. It can be good practice for *both* people who are not the speaker to generate "Do you mean" questions.

5.2b4. Understanding Statements

Asking questions is not the best way to listen. The last step for present purposes is to teach your client how to form understanding statements. The point is simply to say, as a statement, what you believe the other person means. It's a short step from the "Do you mean..." exercise. All one has to do, really, is drop off the words, "Do you mean that" and inflect the sentence down (for a statement) rather than up (for a question) at the end.

Speaker: I feel really low on energy this week.

Question: Do you mean that you're feeling pretty tired?
Understanding statement: You're feeling pretty tired.

Speaker: I don't like the way you handled that.

Question: Are you saying that how I handled it didn't seem fair to you?

Understanding statement: How I handled it didn't seem fair to you.

It is worth discussing how the speaker might feel and respond to each of these. In general, questions pull subtly for more defensiveness, argument, and negative response. A simple statement just tends to keep the

conversation going, and it doesn't really matter if the guess was right or wrong. Either way the person tells you more about what he or she meant.

To consolidate this next step, have the client practice making understanding statements. As before, you can go first to show how it's done, then reverse roles with the client. Here are the roles:

Speaker: Complete this sentence: One thing about myself that I would like to change is that I _____.

Listener: Make an understanding statement (not a question).

Rule: The speaker should then respond with "Yes" or "No" *and also say some more* about what he or she means. In response to this, the Listener makes *another* understanding statement, taking in the new information.

Note that some speaker statements don't go anywhere. "One thing about myself I'd like to change is my hair color." Or "One thing about myself that I'd like to change is that I smoke." Even these sometimes lead in surprising directions, but in general the speaker should offer something that has some feeling, importance, and ambiguity attached to it.

Example:

One thing about myself that I'd like to change is that I'm scatter-brained.

You have a hard time concentrating on one thing at a time.

No, it's not really that. But I'm losing things all the time, even in my small apartment.

And that doesn't seem normal to you.

Yeah, well I guess everybody loses things, but I just feel like I can't keep track of anything - where my life is going, what day it is, birthdays, anything.

It's like you're out of touch with what's going on around you.

Yes, and even with what's going on inside me.

And that's pretty upsetting. You feel a little out of control.

I feel *a lot* out of control. . . .

If an SSO is present, start with yourself as the speaker and both the client and SSO as listeners. Coach them along the way in forming understanding statements, with lots of positive reinforcement. Then have one of them become the speaker, and coach the other on making understanding statements, offering a few yourself (but be careful not to usurp the listener role).

Don't try to cover this whole module in one session. Cover an appropriate amount of material, and then craft a home assignment to allow the client some practice in his or her own social environment. Listening skills can be tried out with a partner who knows that it's practice, or with someone else when only the client is

aware of trying to practice new skills. A reflection sheet (Form aa), filled out by the client after one or more practices, can be a helpful aid for discussion at the next session.

Reference: Form aa

5.2c. Increasing Positive Interactions

There is one more component to address within this module. This pertains particularly to clients who have a primary relationship, whether or not the SSO is participating in treatment. Decreasing negative communications and replacing them with more positive patterns of communication is only one piece of the puzzle. Cognitive-behavioral relationship therapy also typically includes increasing the level of shared positive activities - another way of making deposits in the relationship piggy bank.

Begin this section by explaining that good relationships are fostered by doing positive things together. During dating and courtship, most of the time that people spend together is focused on fun and positive activities: sharing meals, dancing, physical intimacy, etc. Over the course of a relationship this can decay, and less time is shared in pleasant activities, more in routine or even aversive activities. Sharing positive experiences strengthens a relationship (including friendships) and deepens positive feelings for each other. Make sure that this rationale makes sense to the client (and SSO) before proceeding.

The key here is to find fun, pleasant, positive activities that can be shared and that do not involve drinking (see SARC module 5.8). One avenue, in a relationship with some history, is to ask what attracted the couple (or friends) to each other in the first place - what things they did together that were fun early on in the relationship, etc. When both partners are present, keep this discussion free of implicit criticism ("Well, *back then* he was fun to be with.") Use reflective listening to emphasize positive aspects that are offered (a relationship-building form of self-motivational statements). Brainstorm what things the client and SSO enjoy, that they could do together as experiences that would be positive for both.

Negotiate specific shared positive activities as assignments between sessions. Be careful not to make too big a jump at first. If it has been a long time since they shared fun activities, start small and simple. The goal is just to have a good time together (without drinking). Positive communication practice can be integrated into these assignments. For example, a "sofa session" can be assigned in which each partner takes turns talking about his or her day, feelings, hopes, etc. - perhaps 5 minutes each at first - while the other gives full attention to listening without roadblocks. If both partners are participating in treatment, it is wise to try this in the office first to make sure that the needed skills are in place or can be coached. As with all assignments, give priority to asking about and discussing the assignment at the beginning of the next session. Assignments of having fun can continue while other modules are in progress.

5.3. Coping with Craving and Urges

5.3a. Rationale

Craving and urges to drink are most often experienced early in treatment, but may persist for weeks or even months after a person stops drinking. These experiences may be uncomfortable, but they are very common and do not mean something is wrong. Expect craving to occur from time to time in your clients, and be prepared to cope with it.

The words "urge" and "craving" refer to quite a broad range of subjective experiences that include thoughts ("Wouldn't it be nice to have a drink now"), positive expectancies ("I'd feel better if I just had a couple of drinks"), physical sensations (such as tremulousness), emotions (like feeling anxious), and behaviors (such as pausing as one passes the beer display in a store). The fundamental phenomenon is a subjective experience of increased risk (probability) of drinking despite at least some desire not to do so. This can be experienced as an actual or potential loss of control, in the sense that Jellinek (1960) called "inability to abstain" (to distinguish it from an experienced inability to stop drinking once started).

In this regard, perhaps the most important and central message of this module is that experiences of urges and craving are *predictable* and *controllable*. The following are particularly important messages to give to a client:

1. Urges to drink are *common and normal* in the course of recovery. They are not reason for alarm or a sign of failure. Instead, learn from them.

2. Urges to drink or craving tend to occur in certain *predictable* situations; they are triggered by things in the *environment.* The drinker may not initially be aware of the environmental triggers for these experiences, but they can be identified. Typically they are sensory experiences - seeing, hearing, smelling something that has been associated with drinking (or withdrawal).

3. Sometimes the triggering event is *internal* - such as a thought or physical sensation. Physical sensations may include tightness in the stomach, mouth dryness, or a vaguely nervous feeling. Triggering thoughts can include imagining how good it would feel to use alcohol or drugs, remembering drinking times past, planning how to go about getting a drink or drugs, or thinking "I *need* a drink."

4. Craving and urges are *time-limited*, that is, they usually last only a few minutes and at most a few hours. Rather than increasing steadily until they become unbearable, they usually peak after a few minutes and then die down, like a wave. You can "surf" over them. (For skiers, the image of skiing over or around moguls without falling might be better.)

5. You win every time you surf (ski) over an urge without drinking. Indulging an urge only feeds and strengthens it. On the other hand, when you learn how to cope with them, urges become weaker and less frequent over time.

6. This raises the last important point: you are not helpless in the face of craving or urges to drink: rather *there is something you can do about them.* It's like learning to ski the moguls or surf the waves.

5.3b. Discovering and Coping with Trigger Situations A first step is to identify the particular cues or situations in which the client experiences urges or craving. Ask your client to describe ***a few recent situations in which he or she experienced craving or an urge to drink. (Note: Some clients do not identify with the term "craving" but will talk about weaker and stronger urges to drink. For others, "craving" is a meaningful term that describes their experience. Use the terminology that is comfortable for your client.) Ask:***

> What *specifically* was the experience like? How did the client *know* that she or he was having an urge to drink, or was craving? Was it a thought, a physical sensation, an emotion ....?
>
> What was happening just *before and during* the experience? Where was the client - with whom - doing what? What was going on; what did the client see, hear, smell, taste, feel?
>
> What happened *after* the experience or urge or craving? Did the client drink? If not, how did the client succeed in staying sober? What did the client think, feel, etc. afterward?

Be aware that talking in detail about a craving experience can *itself* trigger sensations of urge or craving. This is not something to fear - in fact it can be a good opportunity. It is wise, however, not to start this process at the end of a session, before you have time to discuss and debrief it. Check in with your client periodically during the sessions of this module to find out whether he or she is experiencing urges or craving right there and then.

The point of this step is to identify urge triggers so that you can plan coping strategies for them. Most likely there will be multiple cues that can trigger urges, so make a list of higher-risk situations. The *New Roads* exercise from Phase 2 (Triggers column) may give you some good material here. The best initial source is likely to be the client's own recollections of situations in which craving or urges occurred, even though the client may not know initially what it was about the situation that triggered a desire to drink. Some common external triggers include:

> Exposure to alcohol itself
>
> Seeing other people drinking
>
> Contact with people, places, and things previously associated with drinking (such as drinking companions, parties and bars, watching football on TV)
>
> Particular days or times of day when drinking tended to occur (getting home from work, weekends, payday, sunset)
>
> Stimuli previously associated with withdrawal (hospital, aspirin, morning).

Other triggering stimuli are internal rather than external (though none of them are *eternal*). These can be puzzling to the person because they do not seem to occur in predictable situations, but "just pop up." Some examples are:

Particular types of emotions (such as frustration, fatigue, feeling stressed out). Even positive emotions (elation, excitement, feelings of accomplishment) can be triggers.

Physical feelings (feeling sick, shaky, tense, having a headache). These are often misattributed; they occur for a reason that is not immediately apparent to the person (e.g., normal anxiety, high or low blood sugar, caffeine intake), and are misinterpreted as craving, withdrawal, or a "dry drunk."

5.3c. Monitoring Urges

Some triggers are hard to recognize through in-session discussion, and for this and other reasons self-monitoring of urges can be a useful procedure. Blank urge monitoring cards are shown on the next page, along with an example of a partially completed monitoring card below.

As with any home assignment, first provide a rationale for urge monitoring. Describe benefits that are likely to be meaningful to your individual client (better self-awareness, greater self-control, feedback of improvement, etc.). Better still, *ask your client* how keeping these records for a while might be beneficial (elicit self-motivational statements). Set a time limit on the monitoring (usually 2-3 weeks), at the end of which you will reevaluate together what has been learned and whether it is useful to continue.

Make it easy. Give your client self-monitoring cards. Form bb can be photocopied onto card stock, from which cards can be trimmed out for clients.

Reference: Form bb

A Sample Completed Urge Monitoring Card

Date / Time	Situation	0 - 100	How I Responded
5/16 3:30 pm	Feeling stressed out. Had an argument with my boss.	**75**	Shut the door to my office, closed my eyes and relaxed. Felt better after 20 minutes.
5/17 11:00 pm	Feeling antsy at bedtime. Had trouble getting to sleep. Drink would help.	**60**	Took a hot bath, listened to music.
5/19 Noon	Went to Andy's Diner for lunch. Angry that I can't have a drink like before.	**80**	Ordered tonic with lime. Felt like a close call - dumb to go back there.
5/20 5:30 pm	Payday. Bob wanted me to party after work.	**50**	Suggested we go for coffee instead. He said okay!! Surprised.

These are the instructions to give along with a supply of blank urge monitoring cards.

1. Keep a couple of cards and a pen or pencil with you all the time. (Discuss how your client can do this - where to carry the cards, etc. Elicit your client's own ideas.)

2. Any time you feel an urge to drink, write it down right away, or as soon as possible. Records are much less accurate and useful if they are made later. Do not, for example, wait until the end of the day and then try to reconstruct your day. (Still - better late than never, though.)

3. There are four things to write down each time:

The date and time of day

The situation: Where you were, whom you were with, what you were doing or thinking

Rate how strong the urge was, from 0 (no urge at all) to 100 (strongest you've ever felt)

What you did - how you responded to the urge. If you do have a drink, write that down. If you don't, write down what you did instead.

Work through an example of what to write down, perhaps using a recent experience the client has described. Troubleshoot - what could go wrong that might prevent him or her from keeping good records? What can the client do to keep good records? Any problems foreseen? Never get in a power struggle over this; just understand the client's perspective and see whether he or she is willing to try at least one more week of recording.

Again, as with all home assignments, give priority to reviewing these cards at the beginning of the next session. Reinforce - comment positively on any amount of record-keeping. If there were problems, troubleshoot briefly what happened but don't spend a lot of time discussing failure to adhere. Ask for the client's own ideas about how to keep more complete records in the week ahead. This discussion may also unearth client doubts about the importance of monitoring.

5.3d. Coping with External Triggers

There are four basic strategies for coping with external triggers: Avoid, Escape, Distract, or Endure.

Avoid. Perhaps the easiest way to deal with high-risk situations is to avoid them in the first place. How could the client reduce exposure to people, places, and situations that trigger urges to drink? Some common examples are:

Getting rid of alcohol at home

Avoiding parties or bars where drinking occurs

Reducing contact with friends who drink, meeting them only in non-drinking contexts

It is noteworthy that people who successfully quit drinking, smoking, or using other drugs typically avoid such situations altogether, particularly *early* in the quitting process. It just seems to be easier not to deal with unnecessary high-risk situations during the early months of abstinence.

Escape. Of course it isn't possible to avoid all high-risk situations. The unexpected occurs, and in fact recurrence of drinking often happens not in the situations for which the person was prepared, but in unanticipated risk situations. What happens, then, when the client finds herself or himself in a high-risk situation - either because it was not anticipated, or because avoidance failed?

A second line of defense is to escape - to get out of the situation as quickly as possible. Have your client identify how this might happen - suddenly being in a high-risk situation such as:

> You go over to a friend's house for dinner, and didn't realize (or hoped against it) that there would be a lot of drinking.
>
> You are in a new social situation, and someone who doesn't know that you're sober hands you a drink.
>
> At home you find a bottle that you had forgotten about.

Ask the client to brainstorm ideas for how to get out of the situation quickly and gracefully. Practice the dialogue that would be involved in a social situation.

One alternative to drinking - either to avoid or to escape - is to go to a mutual help group meeting. In most areas they are available throughout the day, and particularly at higher-risk times like evenings, weekends, and holidays.

Distract. Urges pass relatively quickly as long as you don't indulge them. If you can't avoid or physically escape from a situation, find a distracting activity that you enjoy. Read something, make something, go to a movie, exercise (walk, run, bicycle), call someone. Urges tend to pass more quickly when you get interested in something else. Have your client brainstorm things to do for distraction from an urge.

Endure. Then there are those situations that cannot readily be avoided or escaped from, and where distraction isn't enough. These are riskier earlier in sobriety, but as sober time passes, people often find it less necessary to restrict their contact with previously risky people, places, and things. Sometimes it's no problem to be on previously "slippery slopes" - the ice has melted. At other times, one needs tools to hang on. Some possibilities are:

> *Talk it through*. Talk to a friend, family member, or sponsor about craving when it occurs. Talking about cravings and urges can be very helpful in pinpointing the source. Often talking about craving helps in itself to relieve the feeling.
>
> *Ask for help*. In the midst of a risky situation, take someone with you or ask someone to help you get through it without drinking.
>
> *Wait it out*. Everything passes with time, especially something as temporary as an urge. Don't try to *make it stop*, just wait it out and *don't drink*.
>
> *Take protection*. Other than a helpful friend, what could you take into a high-risk situation with you that would help you to endure through an urge. Brainstorm. A reminder card? A treasured object? A photo? A cell phone? No money?

5.3e. Coping with Internal Triggers

With a few modifications, the same strategies can be applied to internal triggers. One exception is that avoidance is a particularly poor strategy for coping with subjective experiences like thoughts and feelings. Trying *not* to experience something often backfires. Trying to avoid one's internal world is a futile effort. That leaves basically two strategies: *let go* (a parallel to escape or distract), and *endure*.

Letting Go. Letting go means moving on, not dwelling on the experience. Having a thought does not mean that one needs to pursue it, to keep thinking about it. Certain feelings, like anger, can persist only if one keeps fueling them through thoughts of resentment, revenge, rejection, etc. Experiencing thoughts as they pass through, without following them, is a key aspect of transcendental meditation.

Another way of letting go is to refute the thought that drives the urge. The essential methods of the Mood Management module can be applied here - recognize the thought, stop it, analyze the error in it, and replace it. Here is an example of such an internal process.

It sure would be nice to have a drink right now. It couldn't hurt just to have one little drink ...

Wait a minute! Hold on here! What am I thinking?

It really COULD hurt. How much pain have I been through because of drinking? I know the "just one" stinking thinking routine. Who am I kidding? What good is one drink going to do me? I think I'm just feeling sorry for myself that I can't drink.

But the truth is that I could drink - nobody is stopping me. The truth is that I CHOOSE not to drink today, because that's how I want my life to be. Why play with fire?

When experiencing a craving, many people have a tendency to remember only the positive effects of alcohol and minimize the negative consequences of drinking. Therefore, when experiencing craving, some people find it helpful to remind themselves of the benefits of not drinking and the negative consequences of drinking - what one stands to lose by drinking. Sometimes it is helpful to carry these benefits of sobriety and consequences of drinking on a small reminder card.

Distraction activities (5.3d) are yet another way to let go of an internal trigger experience - moving on to something interesting, and not dwelling on it.

Enduring. These approaches might be said to go *through* the experience rather than around it. The endurance strategies from 5.3d can be useful here - talking it through, asking for help, waiting it out, using protection.

Another enduring approach is to *go with it*. Don't try to make the thought or feeling go away - just accept it as a normal and temporary event that will pass, and experience it, focus on it. Pay attention to exactly what the experience is like - what physical feelings, emotions, thoughts, etc. Trying to *make it stop* usually has the opposite effect, like trying not to think about raccoons. Going with it is the most common meaning of the term "urge surfing." Urges are a lot like ocean waves. They start small, grow in size, and then break up and dissipate. The idea behind urge surfing is similar to the idea behind many martial arts. In judo, one overpowers by first *going with* the force of the attack. By joining with the opponent's force, one can take control of it and redirect it to one's advantage. It's a lot easier to swim with a wave than to stand up against it. One can initially join with an urge (as opposed to meeting it with a strong *opposing* force) as a way of keeping balance. What one is "going with" here, of course, is not drinking but the experience of the urge itself.

If a client experiences an urge or craving within a treatment session, it can be useful to practice such coping *in vivo*. With the client sitting in a comfortable chair, feet flat on the floor and hands in a comfortable position, try these instructions like these:

> Take a few deep breaths and focus your attention inward. Allow your attention to wander through your body. Notice where in your body you experience the craving and what the sensations are like. Notice each area where you experience the urge, and say what you are experiencing. For example, "I have a dry feeling in my mouth and nose, and a kind of cold sensation in my stomach."
>
> Focus on one area where you are experiencing the urge. Notice the exact sensations in that area. For example, do you feel hot, cold, tingly, numb .. what? Are your muscles tense or relaxed? How large an area is involved? Notice the sensations and describe them to yourself. Notice the changes that occur in the sensation. "Well, my mouth feels dry and parched. There is tension in my lips and tongue. I keep swallowing. As I inhale or swallow, I can imagine the smell and tingle of booze."
>
> Repeat the focusing with each part of your body where you experience craving. Pay attention to and describe the changes that occur in the sensations. Notice how the urge comes and goes. Many people find that after a few minutes the urge is gone, or very weak. The purpose of this exercise, however, is not to make the urge go away but to experience it in a new way - as an *experience* in itself.

5.3f. Developing an Individual Coping Plan

Develop with your client a specific plan to cope with future urges or craving. After reviewing the general strategies that can be used, ask your client to select two or three that seem to fit best, that seem most realistic to use in her or his own daily life. Then develop these in detail. For example, if getting involved in a distracting activity seems helpful, which activities would be best? Are these reliably available? Which of these might take some preparation? For strategies amenable to practice (as most of these are), use in-session role-play or home assignments. Develop any practical aids (like reminder cards) that might be helpful. When home assignments are made, always make it a priority to check on them at the beginning of the next session. What seemed to work, and what did not? Adjust the client's individual coping plan accordingly.

5.4. DREF: Drink Refusal and Social Pressure Skill Training

5.4a. Social Pressure and Drink Refusal

Social pressure plays a significant role in resumed drinking for many clients. There are two distinct types of social pressure exerted by contact with other drinkers; *indirect* and *direct* social pressure. Learning to cope with both types of social pressure can help prevent a client from returning to drinking but it takes good decision making and practice to develop the skills to cope with both types of social pressure.

It is important to remember that this module can be useful even if a client does not anticipate direct social pressure to drink. A client may experience *indirect social pressure* when he/she feels tempted to drink as a result of being around other people who are drinking. Situations in which other people are drinking can create pressure or temptation for the client to drink, even if the client is not offered a drink. For example, a client may go to a friend's house for a party or to a family wedding where most of the people in attendance are drinking. Although the client may not be offered a drink, he/she may experience an increase in temptation or craving to drink simply as a result of watching his friends or family members having a good time while drinking. Alternatively, a client may feel "left out" of the party if he/she is not drinking along with other people, and be tempted to return to drinking in an effort to feel more comfortable in a social situation. As a result of the client's experience with drinking in social situations, he/she may be more likely to feel the temptation to return to drinking in situations where: (1) there is an expectation built into the situation that everyone will be drinking (e.g., at a wedding), (2) the client is with people who have been drinking companions in the past, (3) the client is in an environment that encourages drinking (e.g., at a bar), or (4) the client is in a situation in which he/she lacks confidence in hihe/sher ability to cope without using alcohol (e.g., when socially anxious).

One way of coping with indirect social pressure is to *avoid* certain situations in which the client knows he/she will be around other people who are drinking. This requires advance planning and *good decision-making* about the types of situations that should be avoided. Since alcohol plays a role in many social occasions the client is likely to find it difficult to avoid all situations in which other people are drinking. In some cases the client may choose not to avoid situations in which other people are drinking because the situations are significant events, such as an anniversary or holiday party. In these situations, *coping strategies may be necessary* to avoid a return to drinking, such as: (1) leaving open the possibility of escape from the situation if the temptation is too strong, (2) relying on sober support to cope with temptation during the event, or (3) planning alternative activities during the event, like drinking soda, to minimize the urge to drink.

A client may experience *direct social pressure* when he/she is *offered an alcohol beverage or a drinking opportunity*, and as a result feel an increased temptation to return to drinking. The person who offers the client a drink may or may not know that the client is trying to stop drinking, may make the offer with varied levels of insistence, and may respond to a refusal with varied levels of assertiveness. For example, a client may be faced one day with an innocent request from a waitress in a restaurant who asks *"What would you like to drink this evening?"* or a coworker who asks *"How about joining me for a few beers after work?"* However, the client may also be faced with a relative at a wedding who says, *"Oh come on, it's a party. You've got to join us in the toast!" o*r an old drinking companion who responds to a refusal by saying *"I thought we were good friends, and now you're saying you can't drink with me? You've tried to stop drinking lots of time and never made it, so do us both a favor and give up."*

In direct social pressure situations the client needs good *drink refusal skills* in order to avoid returning to drinking. It may take practice for the client to develop good refusal skills, and to learn how to cope with offers from different people and a variety of responses to a refusal. There are some general

guidelines that a client can learn for a skillful "drink refusal," although the response may need to vary with the person offering the client a drink, the intensity of the offer, the person's response to the refusal, and other aspects of the situation. For example, a friendly and casual offer from a waitress or coworker to have a drink may require a different response from the client than persistent, aggressive offers from a close friend or family member.

5.4b. Using Cognitive-Behavioral Therapy to Develop Drink Refusal Skills

Drink refusal is often much more difficult than the client anticipates it will be. *Practicing* various refusal responses ahead of time can be quite valuable, especially if a client has difficulties with assertiveness or responding effectively when he/she is feeling anxious. Practicing a refusal in the context of treatment via behavioral role-play provides your client with an opportunity to receive feedback about the effectiveness of his/her drink refusal response, to acquire some mastery over his/her refusal skills, and to increase confidence in facing direct social pressure.

A client's response to social pressure is likely to be influenced by his/her relationship with people in the environment who are drinking or making him/her an offer to drink. Therefore, it is important to examine a client's ability to cope with social pressure in response to specific people. For example, it may be more difficult for the client to make a decision to avoid family gatherings than the local bar, or it may be more difficult for the client to refuse an offer to drink from a close friend who is insulted by the client's refusal than a casual acquaintance who is polite. For this reason it is useful to practice refusal skills for a variety of personal relationship contexts.

Thoughts as well as behavior are involved here. How a client thinks about his/her decision to either avoid a social situation involving drinking or to refuse a drink in order to stay abstinent can influence how successfully he/she copes with social pressure. Some common concerns that clients have are:

that other people will see them as "weak" or a "goody goody" for deciding that they will no longer drink,

that they are "boring" or will be rejected if they do not drink,

that it will be impossible for them to make new friends or maintain old friendships if they are not drinking,

that it is not "right" to refuse a drink when everyone else is sharing an occasion involving drinking,

that they do not want to give up a relationship with a heavy drinker simply because they (the client) have stopped drinking, and/or

that they are imposing on or offending other people if they are assertive about not drinking.

It is also important to explore how the client thinks about sobriety itself. A common perception early in sobriety is that "I *can't* drink" or "I am not *allowed* to drink." It is as if some external authority were imposing rules and limits on them, and this can set the stage for a kind of "cognitive claustrophobia" against which the client ultimately rebels. This makes it easier to cave in to indirect or direct social pressure to drink.

5.4c. Assessing Social Pressure

Begin this module by explaining the two types of social pressure (direct and indirect) that can increase the temptation to drink. Indirect social pressure is related to observing other people drinking, even if no one is directly encouraging you to drink or offering you a drink. Direct social pressure is when other people directly offer you a drink, encourage you to drink, or give you a hard time for not drinking.

Determine what types of social pressure the client believes could increase his/her temptation to resume drinking. Explore both indirect and direct social pressure situations. Throughout this module, use the worksheet "Identifying Social Pressure Situations and Coping Responses" (Form cc) to record specific risk situations (and then possible coping responses). For some clients, only one type (direct or indirect) of social pressure may seem important. It is not necessary in every case to prepare for both direct and indirect social pressure coping if your client sees no need for one or the other. (We recommend printing this worksheet on carbonless 2-page forms, so that you can give a copy to your client and also retain one for your file. Photocopying the completed form is another option.)

Reference: Form cc

First help your client generate a list of potential *indirect social pressure situations* that he/she may face in the future. These are situations in which the client will feel tempted to return to drinking as a result of being around other people who are drinking or intoxicated. Examples of situations that may involve indirect social pressure include weddings, anniversaries, or holiday parties, hanging out with friends who drink, working with people who drink on the job, family members who show up at the client's house intoxicated, or going to a drinking establishment with coworkers. To generate this list, ask your client to think about *situations* from the past in which he/she has felt tempted to drink primarily as a result of just being around other people who were drinking. Also, ask the client to think about new situations in which he might encounter other drinkers and would be likely to feel a temptation to drink (e.g., an airline flight on which free alcohol is served). Record these situations in the left-hand column of Form cc.

Next ask your client to think about *specific people* who might offer a drink or pressure him/her to drink, and the situations in which this might occur. Remember that the focus here is not only on the actual offer of a drink, but also more generally on direct invitations, encouragement, cajoling, shaming, and other forms of direct social pressure. Again ask for experiences from the past and also anticipate situations in the future when this might occur. Examples of people who might offer the client a drink would include friends, neighbors, relatives, coworkers, an employer, and a former drinking companion. Some of the people who may offer the client a drink may have already been mentioned in indirect social pressure situations described above. Examples of situations in which this might be more likely to occur include those in which alcohol is served (e.g. in a bar or restaurant that serves liquor), drinking is encouraged (e.g. at a party where alcohol is served), or other people with drinking problems are present. Again, record these on the worksheet in the left-hand column.

You may also have your client complete the optional "Checklist of Social Pressure Situations" (Form dd) to suggest potentially problematic situations, and learn your client's perception of how much of a problem each is likely to be. This can provide a basis for further discussion.

Reference: Form dd

5.4d. Developing Skills for Coping with Social Pressure to Drink

As you make the transition from assessment to focus on coping skills, emphasize how helpful it can be to have thought through and practiced how to cope with the situations just discussed. Being prepared can make the difference between not drinking and drinking. Of course there will always be situations for which you have not prepared specifically, but the more you can prepare, the better. Also, when you have rehearsed a variety of different coping strategies, you are better prepared for the unexpected. Therefore, the purpose of the next section is to develop a number of different skills for coping with social pressure. (Remember to *practice* and not just *talk about* coping strategies.)

Explain that in general there are two ways of coping with social pressure:

1. *Avoid* situations in which social pressure is likely to occur, and

2. When you cannot or choose not to avoid such situations, have *specific coping strategies* ready before you enter the situation. It is wise to include an *escape plan* for leaving the situation if temptation feels too high.

The first of these involves conscious decision making. It is a strategy that is used earlier in the course of recovery, by people who successfully abstain. Which situations involving drinking can be avoided? Ask your client to identify which *situations* on the worksheet he/she thinks it would be best to avoid altogether in order to reduce the temptation to drink. On the worksheet, write "avoid" as one coping response in the right-hand column for each situation the client plans to avoid. Anticipate and explore thoughts, feelings , and problems that could occur in relation to avoiding these situations. Look for specific thoughts or feelings that could interfere with the appropriate use of avoidance as a coping strategy for these situations. Are there negative consequences that could be anticipated as a result of avoidance? For example, does the client feel guilty about avoiding friends or family or worry about how it will appear to other people if he/she avoids a situation? Does the client feel he/she is weak for needing to avoid a situation in which there will be a temptation to drink?

Of course, people cannot avoid all situations in which other people are drinking, or where they will experience direct pressure to drink. Even if the client's intent has been to avoid certain situations, they may still be exposed to them by accident or choice. This raises the issue of what other coping responses the client will have and use to avoid drinking. Emphasize the need to develop several possible strategies for situations that he/she can or will not be able to avoid. (It is both acceptable and a good idea to record two or more possible strategies in the right-hand column for risk situations.)

Consistent with the motivational style described in Phase 1, your primary approach for developing coping strategies should be one of *asking* more than *telling*. There in nothing wrong with giving your client good ideas for possible coping strategies, and direct rehearsal is part of this module, but *always first ask your client to suggest ways in which he or she could cope with the social pressure situations*. This includes exploring successful drink refusals in the past. Clients usually have very good

ideas about what would work for them, often better and more appropriate than the ideas a therapist might prescribe for them. There's nothing wrong with suggesting strategies, but it is important for the client to "own" and accept the strategies you develop together. To avoid "yes .. but" scenarios (a variation of the denial-confrontation trap described in 2.4), it is a good idea when making suggestions to present a range of different ideas and ask your client to tell you which of them might work best. If you have serious concerns about a coping method your client is proposing for a particular situation, use the approach described in pull-out module, "Raising Concerns" (4.2).

For situations in which the client believes he/she could be tempted to return to drinking as a result of direct or indirect social pressure, ask your client what strategies might help him/her to avoid drinking. How could he/she cope in these situations? Some general ideas are:

Bring along a sober friend.

Plan an escape if the temptation gets too great.

Ask others to help him/her not drink by refraining from pressuring or drinking in his/her presence.
Practice effective "I don't drink" responses.

Remember not only to draw on your client's expertise, but also to use plenty of reflective listening and positive reinforcement. Here's an example of a discussion of social pressure and how to cope with it. The situation involves both indirect and direct social pressure, but the initial focus of the discussion is on how it will feel to be around other people drinking.

THERAPIST: Now that we've talked about the two types of social pressure that can lead to temptation, and some of the general strategies that you might use to decrease the risk of drinking in these situations, I'd like to get a better idea of how you are affected by social pressure. I think you mentioned that you feel particularly tempted to drink when you are around other people who are drinking. Is that right?

CLIENT: Yes.

THERAPIST: Tell me more about that - describe some of the situations in which you might find yourself around other people who are drinking.

CLIENT: I've been drinking for a long time. There are a lot of them.

THERAPIST: Yes, I'm sure there are, so lets start with a situation that you are likely to be in sometime soon – for example, do you have any current plans to socialize with family or friends who drink?

CLIENT: Actually I'm supposed to go to a friend's house for a barbecue next Saturday. It's a yearly event. I know there will be plenty of drinking at the party. It's kind of a heavy drinking crowd.

THERAPIST: Good example! Do you have some concerns about going to the party?

CLIENT: Definitely! I've never been to one of these parties without drinking. You know how it is— it's hot and everyone's drinking beer. The party starts in the afternoon and by dinnertime everyone is feeling pretty happy.

THERAPIST: This is the first time you would be attending the party without drinking.

CLIENT: Right. I've tried to cut down on my drinking a few times when I've been to the party because it can get pretty crazy, but you know how it is once you get started….

THERAPIST: So your experience has been that trying to cut down won't work for you in this situation. What would your goal be if you were to attend the party now?

CLIENT: Well I haven't had anything to drink since I started the study and I don't want to start up again. I'd want to stay sober but I don't know if that's possible at this party.

THERAPIST: You're not sure whether or not you should go. I can understand that. If you had to guess right now, what do you think it would feel like to be at this party without drinking?

CLIENT: Very strange. All I can picture is everyone laughing and talking and me standing around feeling stupid. I would probably be miserable watching them, feeling like I was missing out on something.

THERAPIST: And that would tempt you to drink.

CLIENT: Absolutely. And it would definitely create some attention I don't want.

THERAPIST: So it's hard to imagine having as good a time at the party without drinking, and you also think people would pay attention to your not drinking.

CLIENT: I don't really know, but I think I'd feel like the oddball who can't even handle a few beers.

THERAPIST: They would judge you, you think, for not drinking.

CLIENT: Well, I don't know. I've never been in this situation before. I just think I'd stick out if I'm not drinking.

THERAPIST: Is anyone likely to offer you a drink?

CLIENT: The people who are having the party, I'm sure. Someone would probably fill a glass from the keg and bring it over when I get there. No one really asks—they just assume you're drinking.

THERAPIST: So you'd have to be ready from the moment you walked in to refuse drinks gracefully. How comfortable would you be in turning down a beer or asking for something else instead?

CLIENT: Really uncomfortable. I'm sure the other people would probably feel uncomfortable, too. I guess I'm the first one in our crowd to stop drinking. I'm not the only one who has a problem with alcohol.

THERAPIST: I see. So you're also worried that other people might feel judged or criticized personally, maybe threatened by the fact that you're not drinking. That's very considerate of you! I wonder if there would be anyone else at the party who's not drinking.

CLIENT: Maybe. I've never really noticed. Everyone I hang with seems to drink.

THERAPIST: So it's possible that there have been other people there not drinking; and you've just never noticed.

CLIENT: No, I don't pay much attention to what other people are drinking. No one makes a big deal out of the drinking, really, but it seems like they all drink. It's just part of the deal—hot dogs, hamburgers, and beer.

THERAPIST: So it's not like everyone is *required* to drink. It's more like it's just *assumed*, or at least pretty available. Would you say that there will be people at the party who are pretty good friends?

CLIENT: Sure. I grew up with most of the people there. We've known each other a long time.

THERAPIST: Anyone at the party who already knows that you've stopped drinking?

CLIENT: No. It's not really something I've been ready to tell people. I suppose they'll find out eventually but I'm not ready to let anyone know. I guess a couple of them would think it's a good idea because in the past they've told me they thought I needed to slow down my drinking.

THERAPIST: So at least some of your good friends at the party might think it's a good idea you stopped drinking, and might even support your effort to do this.

CLIENT: Well, I don't know what they would say if I showed up and told them I totally stopped drinking. They might have thought I just needed to cut down a little.

THERAPIST: You're not sure how they might react.

CLIENT: They might think it was a total drag to be around me, especially when they're drinking.

THERAPIST: So I wonder how you're going to handle this situation.

CLIENT: I guess I may have to avoid the party. I know if I go there's a good chance I'll drink and I don't want to blow things.

THERAPIST: Would that be okay? How would you feel about having to avoid the party?

CLIENT: Not good. It really ticks me off that I can't go to a party, but I just know I'm not ready to go there without drinking.

THERAPIST: Okay. I'm writing down on this worksheet the situations that we talk about that create some social pressure. I'll give you the list when we're done. I'm also going to write down your ideas for how you're going to handle these situations to avoid drinking. So for this one I'll write down "Don't go" under this situation. Is that okay?

CLIENT: If I have to avoid everyone who drinks I'll never be able to socialize again.

THERAPIST: That must seem pretty discouraging, even lonely.

CLIENT: Well, gee - alcohol is everywhere. You can't avoid it forever.

THERAPIST: You're right about that. In fact, as we were discussing this situation I was already thinking about how you might in the future be able to be in a situation like this and not drink - how it will get easier for you. But right now I respect your decision that avoiding the party is the best choice. In fact, people who successfully stay sober often avoid temptation situations at first, and then gradually ease themselves into some of the situations when they are more confident of their coping skills. So I don't think you're talking about "forever" here. In fact, part of our work together here is to help you prepare for dealing with situations like this in the future, when you choose not to avoid them. Are there any others coming up soon?

CLIENT: My family is throwing a 50th wedding anniversary for my parents in a month. There's going to be a lot of drinking at the party.

THERAPIST: That sounds like a really special occasion - one you wouldn't want to miss.

CLIENT: Yeah. My parents are pretty old, and it's incredible that they've been together for fifty years these days. I want to be there.

THERAPIST: That's a celebration you want to be part of. Are you worried at all about how you'll handle not drinking if you go?

CLIENT: Definitely. I think I'll probably feel tempted to drink, but I have to go or my family will never forgive me.

THERAPIST: You know, one thing I hear in your words is that you feel a little trapped - hemmed in. A while ago you said that it makes you angry that you "can't" go to a party, and now that you "have to" go to this party. It sounds like you feel like your choices are really limited here.

CLIENT: Well, aren't they?

THERAPIST: No, I don't think so. At least not quite in the way I'm hearing. You *can* go to a party if you choose. You *can* decide not to go. What you're really talking about here is consequences - what you want, how you'd like things to be. Does that make sense?

CLIENT: Well, I guess so. But still I'm someone who can't drink.

THERAPIST: And you're angry about that. But what does that mean, really?

CLIENT: I can't drink without losing it, without screwing up.
THERAPIST: Exactly. You know that if you do drink, the consequences are likely to be bad - not how you want your life to be. You always *can* choose to drink and have those consequences - there's no one else stopping you. That choice is yours. What you're saying, in a way, when you say that you "can't" drink is that you *choose* not to drink.

CLIENT: Because of what happens when I do.

THERAPIST: Right. I'm sure it doesn't seem fair to you that that's how it is - that when you drink sooner or later it's a nightmare - but you do seem to be recognizing, even accepting that that's how it is, even if it's not fair. I really admire that - it's not an easy thing to do.

CLIENT: No.

THERAPIST: So if you do choose to go to the anniversary, what do you think could create the most temptation for you at this party?

CLIENT: Just seeing other people laughing and talking and having a good time. I'll be able to tell they're feeling pretty good from drinking.

THERAPIST: And it's not possible, really, to have a good time without drinking.

CLIENT: I wouldn't know. I've always been drinking when I've had a good time, though.

THERAPIST: So what you'd like is to go to this family celebration, not drink, *and* have a good time. That's a new idea for you. Any ideas about how you could do that?

CLIENT: Not really.

THERAPIST: Will there be anyone else at the party who is not drinking?

CLIENT: I have one brother who is also in recovery and doesn't drink. I don't really hang out with him too much because he's so serious. Not my type.

THERAPIST: I wonder how it would feel to talk to him during the party if you were feeling tempted to drink, maybe even ask him for some advice about how he does it.

CLIENT: I suppose it's possible. He has asked me to go to meetings with him, although I've never taken him up on it. At least he would understand what it's like not to be able to drink when everyone else is having a party.

THERAPIST: So, that's one possibility. Talk to your brother - find out how he chooses not to drink. I'm going to write this down as something that might be helpful to you to get through the party without drinking. Are you planning to bring anyone to the party with you?

CLIENT: No. Should I?

THERAPIST: Sometimes people find it helpful to bring along a sober friend so they have someone to talk to if they're having a difficult time.

CLIENT: I hadn't thought about it, but I could bring someone. I don't know who would want to go to something like this, though.

THERAPIST: Sometimes people have friends who are in recovery or who don't drink, who are willing to offer some support. It does mean asking somebody for help, though.

CLIENT: I guess I could think about that.

THERAPIST: You're not too sure about this, but lets write that down as another possible coping response for this situation. Anything else you could do in this situation that would help with the temptation to drink?

CLIENT: I need to make sure I always have a soda so someone doesn't shove something alcoholic in my hand.

THERAPIST: That sounds like a good idea! I'll write that down too. And I wonder what you think about this: Some people are more comfortable if they have something in their hand that *looks* like an alcohol beverage - maybe ginger ale - while other people choose to make it clear that they are not drinking alcohol. What do you think?

CLIENT: Seems dishonest to be pretending to drink when I'm not. I think I'd just have a soda.

THERAPIST: Okay. Now how about a fire escape. How about a way to leave the party if the temptation gets too great? Will you have your own car?

CLIENT: Yeah. I guess I can stay as long as I can handle it and then if I need to I'll leave. I guess that's all I can do.

THERAPIST: So you have several good ideas here. You might take someone with you for support. You could talk to your brother about what's happening. You would keep a soda in your hand. And you would leave the party if you felt like it was getting to be too much for you, rather than taking the chance of drinking. What about the possibility that someone at this party might offer you a drink?

CLIENT: Sure. Most everyone there will be drinking. I'm sure someone will ask me if I want a drink.

THERAPIST: How could you turn down the offer and feel okay about it?

CLIENT: I don't know. I've never tried.

THERAPIST: This is really something new for you! Okay, we'll come back to that situation a bit later. Are there any other situations that you think you might be in that involve drinking?

CLIENT: There's Friday night poker game once a month at my friend's house.

THERAPIST: And there's a lot of drinking there.

CLIENT: You could say that.

THERAPIST: Anyone stay sober during the game?

CLIENT: Nope.

THERAPIST: I wonder what it would feel like for you to play without drinking.

CLIENT: I've never done it. Who knows, maybe I'd clean up. (Laughs)

THERAPIST: How do you think your friends would react?

CLIENT: I have no idea. It might make them uncomfortable.

THERAPIST: This is so new that you just don't know what would happen. Might be interesting to see. Do you think they would try to get you to drink if you said you weren't drinking.

CLIENT: I think they would have a hard time believing I didn't want to drink. They might think it was a practical joke or a way to beat them at cards or something.

THERAPIST: And if they did feel uncomfortable, it would be harder for you to stay sober. You don't want them to feel uncomfortable.

CLIENT: Probably.

THERAPIST: So what do you think is the best approach for you to take for now, in order to stay sober? Is this a situation that you think you might want to avoid for awhile or do you think that you want to try facing it without drinking.

CLIENT: I think the anniversary is enough challenge. I think I'll avoid the poker game this month.

THERAPIST: Is that a problem for you in any way?

CLIENT: It's my one night out with the guys. It stinks.

THERAPIST: Being out with the guys is fun for you. Is there anything other than playing poker that you guys do together?

CLIENT: We used to go fishing occasionally. We haven't done that in a long time.

THERAPIST: Was there a lot of drinking involved in that?

CLIENT: Some, but nothing like when we play poker. When we went it was early in the morning. I think only a couple of the guys were drinking, and I was one of them.

THERAPIST: So, avoiding poker night seems like a good idea right now, but maybe you could suggest to your friends that you'd like to go fishing with them instead. OK, I'll write that down.

This illustrates the process of eliciting ideas from the client and adding in suggestions here and there. For each of the risk situations on the worksheet, particularly for those likely to occur in the near future, develop at least one coping strategy, and preferably more. Distinguish situations that the client chooses to avoid from those for which active coping strategies are needed. This sets the stage for the next step.

5.4e. Coping Behavior Rehearsal

It is not enough to *talk about* possible coping behaviors. Be sure that you actually *rehearse* social situations to make sure that the client can voice the appropriate responses. The following section illustrates this important component through the scenario of refusing an offered drink.

Introduce the idea of having an escalating *sequence* of responses for handling a social situation. For some situations, a single simple refusal will suffice. For others, a more assertive reply may be needed if the person persists. For example:

First offer: *No, thank you*.

Second offer: *No, thanks. I really don't want a drink*.

Third offer: *Look, I'm not drinking now, and this is very important to me. I would really appreciate it if you would help me out here as a friend, and stop trying to convince me to drink.*

Engage your client in coming up with escalating refusals, for situations where a person persists. The goal is to find a refusal that is clear and firm, yet friendly and respectful (e.g., assertive; see 5.1).

Here are some points for coaching an assertive, effective refusal response.

Look directly at the person, with eye contact, and state your response.

Vague excuses are not necessary, and can be dangerous *(" I don't want a drink right now because I have a headache, but maybe later," or "Not right now, it's too early in the day")* because they leave the door open to another invitation.

Keep it short, clear, and simple. Long explanations are not necessary, and tend to prolong the discussion about whether you should have a drink.

If the situation warrants an alternative suggestion, the client should recommend an activity that does not involve drinking. A clear response would be: *"Let's go out to dinner or the movies instead of a bar."* This shuts the door on drinking but leaves it open to social activity.

A useful strategy here is the "broken record" technique. In this approach the client has a single, clear message that is repeated in response to each pressuring statement. It can be accompanied by an acknowledgment of some part of the other person's statement, followed by the simple broken record assertion.

Introduce behavior rehearsal by emphasizing the importance of being prepared and *practicing "drink refusal" ahead of time* to enhance skills and confidence. Present the idea of participating in a *practice situation* with you in which you take one role and the client takes the other. (Clients often find "practice" a more comfortable concept than "role-play.") If yourclient already has reasonably good social skills, you can begin with the client taking the refusal role, while you try to persuade him or her to have a drink. If the client's assertiveness is more shaky, start with reversed roles, with the client pressuring you to have a drink while you model good assertive refusal.

To construct a role-play situation, ask your client to provide details about the person(s) who might make the offer, where the offer might occur, who else might be in the situation, and anything else that might influence his/her drinking at the time the offer is made. Let the client know that this type of specific information helps you to construct a more realistic role play so that he/she can get the most out of the practice.

Then try it out. When the client is in the assertive refusal role, take it easy at first, then build up to more difficult scenarios. Following each practice, review with the client whether the role play created an urge to drink, how he/she felt refusing the offer, and whether he/she felt the refusal was effective or could be improved. Provide lots of honest feedback about his/her responses. Look for specific things that your client did *well*, and point them out. Let the client know what was skillful about his/her response and also how he/she might improve the response. Coach gently. Practice the same situation several times, as needed to improve confidence and performance..

If the experience of refusing an offer feels particularly stressful to your client, even though he/she is able to do it skillfully, then it may be appropriate for the client to practice seeking support after he/she has refused an offer. Whom would the client call, and what would they say to this person to obtain support?

Here is an example of discussing direct social pressure, including behavior rehearsal.

THERAPIST: You've said that you also have had some difficulty avoiding the temptation to drink when you are in situations where other people are pressuring you to drink. Let's talk about some of those situations and see if we can come up with a plan to help you avoid drinking. Okay?

CLIENT: Sure.

THERAPIST: You mentioned earlier that you thought someone at your parents' anniversary party might offer you a drink. Is that right?

CLIENT: Yeah - it could happen. Probably will.

THERAPIST: Who do you think might be the one to offer you a drink?

CLIENT: Could be lots of people. Maybe one of my brothers. They all drink except the one I mentioned to you is sober. Probably not my parents—they've been trying to get me to stop drinking.

THERAPIST: Let's pick one of your brothers who might be likely to offer you a drink. Which one would it be?

CLIENT: I'd say Al.

THERAPIST: Okay, tell me a little bit about Al. What is he like when he's asking you if you want something to drink?

CLIENT: Well, he's always got a drink in his hand. He'll probably be drinking when I get there. He might walk over and say, "Hey guy! You're hand is empty. What are you having to drink?"

THERAPIST: So he would take it for granted that you would want something to drink.

CLIENT: Yes.

THERAPIST: How hard would he push you to have a drink? How loud would his voice be when he asked you?

CLIENT: He's kind of a big guy and he talks pretty loud, especially if he's been drinking.

THERAPIST: So he would be sort of forceful in offering you a drink?

CLIENT: Yes, I guess you could say that.

THERAPIST: Can you show me again what his offering you a drink might be like? Give me his voice.

CLIENT: "Hey guy! How's it going? What are you drinking?"

THERAPIST: Okay, I have an idea what that would be like. Now, what might you say to him to avoid drinking?

CLIENT: I guess I could say, "Nothing right now, I just got here."

THERAPIST: How do you think he would take that?

CLIENT: I don't know. He might be insulted, like I was blowing him off. After all he was offering to get me a drink.

THERAPIST: So he doesn't know you've stopped drinking?

CLIENT: He knows. He just doesn't believe it.

THERAPIST: I see. Well, it sounds like you plan to refuse the offer to drink, so I'm going to write down this situation and put "drink refusal" as the coping response under this situation. Does that seem right?

CLIENT: Yeah.

THERAPIST: Lets talk a little bit more about how to refuse that offer in a way that you'll feel comfortable with and also will give your brother a clear message. Do you feel comfortable that your brother would leave you alone if you said "Nothing right now, I just got here."

CLIENT: I don't know. I've never said that before. Seems okay to me.

THERAPIST: I like the directness of it. You're saying no clearly. There is one concern I have about the way you said it, though. Can I tell you?

CLIENT: Sure.

THERAPIST: I wonder if it leaves the door open to the possibility that you might want something to drink later. You say, "I just got here," which kind of implies that you'll have something later.

CLIENT: I see what you mean.

THERAPIST: How about a response that is short, simple, and polite. And you might have to give it more than once. There's a technique called "broken record" that can be handy. In this approach, no matter what the other person says, you come back with the same clear, simple message. You can acknowledge what the person said, but your message is always the same, like a broken record that repeats the same thing over and over again. What would your clear, simple message be?

CLIENT: How about, "I'm not drinking any more."

THERAPIST: Great! That's simple and clear. Now let's try this situation again. This time I'll be Al and you be yourself. Respond as you would if your brother were offering you a drink.

Let's say we're at the party. You just walked in. You see your brother headed toward you with a drink in his hand. You can tell he's had a couple and is feeling pretty good. He says (in a loud and booming voice) "Hey, what's happening, guy?"

CLIENT: Not much.

THERAPIST: Where have you been? The party got started hours ago.

CLIENT: Well, I just didn't want to get here too early tonight.

THERAPIST: Don't want to hang with your brothers, huh? So, your hand's empty there. What are you drinking? We've got a great bar here.

CLIENT: Nothing, thanks. I'm not drinking.

THERAPIST: What do you mean you're not drinking? It's a party!

CLIENT: Really, I'm not drinking anymore. That's it.

THERAPIST: Man, you always do this at the worst times. What's with you? You know you're not going to stick with this.

CLIENT: What's with me is that I decided not to drink, and I'd really appreciate it if you'd support me on this as your brother. I've decided to stop drinking and let's leave it at that. Now I'm going to go find Mom and Dad to say hello. I'll talk to you later.

THERAPIST: Whatever.

THERAPIST: (Out of role.) So, how did that feel to you?

CLIENT: I felt kind of tense, but actually I think it went pretty well. I felt like I really got my point across and didn't hang around too long to get into an argument.

THERAPIST: I agree. I felt like you were clear with your brother without being defensive. Sounds like you might need to talk to him at a later time if he continues to bug you. What do you think?

CLIENT: Probably, he would.

THERAPIST: What do you think you might say?

CLIENT: Same thing. I've decided to stop drinking and I don't want you to keep asking me about it. If you don't back off I'm not talking to you anymore.

THERAPIST: Sounds pretty clear. You know, I liked even better what you said before - asking him to be your brother and help you out. But you're right - you might have to set a hard line if he doesn't support you.

CLIENT: I just hope I can say that when the time comes.

THERAPIST: Why don't we practice it one more time……

The role play would be repeated with some variations, so that the client gets practice in handling different twists, and gets comfortable responding with a consistent message. It is also important to try different situations.

THERAPIST: Is there another situation in which someone might offer you a drink?

CLIENT: Another one that comes to mind is Friday nights after work. A group of us go out after work on Fridays to the same restaurant - mostly the same guys who play poker once a month. They have cheap pitchers of beer on Fridays so every time we go that's what we order.

THERAPIST: Tell me a little bit more about what happens after you sit down at the table.

CLIENT: Well, a lot of the waitresses know us pretty well. If we get someone we know waiting on us they usually come over and say "Hello. Are you guys having the usual tonight?"

THERAPIST: And that means a few pitchers of beer?

CLIENT: Right. Two to start, anyway.

THERAPIST: Who usually does the ordering when the waitress asks you this?

CLIENT: Any one of us. It doesn't really matter. The answer is always "yes."

THERAPIST: Does anyone ever order anything else?

CLIENT: Once in awhile someone from work who doesn't usually come with us will order a mixed drink or someone's spouse will come along and order something else. Once one guy's wife who was pregnant came, and she ordered a soda.

THERAPIST: So it's possible. How do people react when someone orders something different?

CLIENT: Well, no one said anything about the guy's wife who was pregnant drinking a soda. They understood. One guy even complimented her for not drinking.

THERAPIST: How about the other people who have ordered something else?

CLIENT: I think one of the guys gave someone a hard time once. It's no big deal.

THERAPIST: What do you think it would be like for *you* to ask the waitress for soda after the guys ordered their beer?

CLIENT: I think it would be really awkward. Everyone would be wondering what was wrong with me. I don't really want them asking me a lot of questions and I definitely don't want the waitresses to know I don't drink anymore.

THERAPIST: What would that mean to you if they knew you had stopped drinking?

CLIENT: That I was a wimp. That I couldn't hold my liquor. They might think I was sick. I don't know.

THERAPIST: I can see why it would be uncomfortable if you think that's how they would think about you. Is that how you thought about other people who didn't drink?

CLIENT: To tell you the truth, I really never thought much about what other people ordered. I didn't really care.

THERAPIST: So, you're feeling like it would be pretty awkward for you to order something non-alcoholic in this situation. Remember, one option you always have is to avoid the situation altogether, at least for a while. Have you thought about whether you want to continue going out with people to this restaurant given the way you feel?

CLIENT: I do want to stay sober. It's important to me.
THERAPIST: How important is it?

CLIENT: Very. I want to do it.

THERAPIST: This really does matter to you! Okay - so you could avoid the situation, but if you're willing, let's just try out how you might respond to the waitress if you did go. Would that be okay?

CLIENT: Sure.

THERAPIST: I'll be the waitress now, and lets assume that when I ask "The usual?" someone immediately says "Yeah - bring the pitchers." I start to turn to go to the bar, and that's when you need to catch my attention. What's my name?

CLIENT: Sally.

THERAPIST: Okay. Here we go. (Therapist stands up.) "Hi guys! You're looking good tonight! The usual?" . . . . . Okay, I'll be right back with those pitchers." (Turns to walk away.)

CLIENT: Hey, Sally, could I have a club soda please?"

THERAPIST: Sure - no problem. Feeling a little under the weather?

CLIENT: No, I'm fine. Just a club soda.

THERAPIST: Okay. (Breaks role.) How did that feel?

CLIENT: Fine. I think that would be okay. It's what the guys say to me next that I worry about.

THERAPIST: Okay, let's try that. By the way, I thought what you said was great. It was clear, assertive, comfortable. Very nice.

CLIENT: Thanks.

THERAPIST. So Sally just left the table . . . . .

Because a significant other can be included in treatment sessions, one possibility here is to bring in a real friend who might pressure your client to drink. This can have a double benefit. First of all, the client is practicing drink refusal skills with a real-life SSO who can offer highly realistic social pressure.

Second, by engaging the SSO in this session for the purpose of helping the client learn how to refuse drinks, you may create yet another SSO ally to support the client in efforts toward sobriety.

At the end of each session, summarize what you have learned about the types of situations in which your client feels at risk for resuming drinking as a result of social pressure. This summary might include both situations in which the client is exposed to other people drinking (indirect) and specific people who may offer the client a drink (direct), if the client has raised both of these as potential triggers for resuming drinking. Also, review the types of coping strategies that the client has chosen to rely on to remain abstinent. Emphasize the different possibilities for coping with social pressure, including avoidance, escape, using social support, and "drink refusal." Discuss with the client where he/she feels that additional practice is needed to sharpen or gain confidence in drink refusal skills before moving on, or whether he/she feels ready to move on to another topic. Continue to record risk situations and coping strategies on the worksheet throughout this module. If you need to use more than one worksheet, giving your client a copy at the end of a session, that's fine. Keep copies of worksheets in the client's file.

5.5. JOBF: Job-Finding Training

5.5a. Background

Employment is one of the more consistent correlates of sobriety. People who are gainfully employed are more likely to stay sober, and of course those who stay sober are more likely to remain employed. From the social-reinforcement perspective of CBI, this makes sense. Work is one of the primary settings in which people can receive positive reinforcement for prosocial, non-drinking activities. Financial independence and security through employment provide many reinforcers to a client. Steady and rewarding employment can assist in long-term life-stabilizing goals such as owning a home, a car, and having money to spend on pleasurable activities. In addition, a job introduces structure into the day and enables clients to schedule their time in an active manner. Based on Azrin and Besalel's *Job Club Counselor's Manual (1980),* the CBI module for job counseling is a step-by-step approach to teach clients skills in obtaining and keeping a job.

This module should only be used if the client expresses some desire to have a job or find a new job more supportive of sobriety. Remember, though, that you have counseling procedures to build motivation for change (Phase 1), and these can be used to enhance a client's willingness to seek employment.

This module is designed to provide some initial skills and systematic encouragement in job finding. If your client needs more thorough vocational assistance and training, use procedures described in the Referral module (4.3).

5.5b. Introducing the Module

It is appropriate at the outset to clarify the advantages of having a good job. Although you can certainly describe these to the client, and explain how employment supports stable sobriety, it may be better to *elicit from the client* the good things (and perhaps not-so-good things) about having a job. You can follow the basic procedures outlined in Section 2 of this manual.

Example Dialogue

THERAPIST: One thing we haven't discussed so far is employment. I know that you've been unemployed for a while, and I wonder what your thoughts are about working, and how that might fit in with being sober.

CLIENT: Well, I kind of like not getting up in the morning and just sleeping in.

THERAPIST: So one good thing about not having a job is that your schedule is your own - you can do what you want when you want.

CLIENT: Yeah, well not really. I mean, I can sleep if I want to, but I don't have any money to do the things I'd like to do.

THERAPIST: So on the other side, it would be nice to have a steady income.

CLIENT: Yeah. I can always sell dope, but that's not such a good idea. I have enough legal problems already.

THERAPIST: What you would like is to have a source of income that doesn't get you in trouble, and helps you stay sober.

CLIENT: Welfare is going out the window, I know that.

THERAPIST: Which means that you wouldn't have even that small amount of income. So having a job might be good for that reason. What else might be good about having a regular job?

CLIENT: I'd probably feel better about myself.

THERAPIST: Uh huh.

CLIENT: I like sleeping in, but where is it getting me? And if I don't get blasted at night, I won't need to sleep in so much anyhow.

THERAPIST: That would be a real change for you. So it would be nice to have a regular income that would let you do things you'd like to do, to enjoy yourself more. And you might feel better about yourself if you were working. And it sounds like having a job to go to might get you out of the cycle of getting drunk at night and sleeping in through the morning. What else?

CLIENT: Well, I just think it's time for me to do something different - to have a different life.

THERAPIST: A better life than you've had for the past few years.

CLIENT: Yeah. It's like I've wasted these years, lost them.

THERAPIST: And you don't want to lose any more of your life.

CLIENT: Right. That's right. Enough.

THERAPIST: What do you think about getting a job, then? Is that something you want to do?

CLIENT: Yeah, I guess so. I think it would help.

5.5c. Resume Development

In the job-finding process, a strong resume is a first step to success. Many clients have never had one. The main goal of a resume is to obtain an interview; thus, the resume should describe the client in the most favorable light possible. One tell-tale problem on a resume is large periods of time in between jobs. There are at least two ways to address this problem. One is to prepare a *functional resume* that describes the person's skills and experience without detailing a chronology of jobs. If a chronological resume is required, as is often the case, you can display periods of temporary unemployment as periods of self-employment, or as times when the client was rethinking career goals. Once an interview is granted, the client can give a more thorough and personal explanation of the problems and how they were resolved.

During the initial JOBF session, be sure to discuss in considerable detail your client's employment history including prior jobs and training. This will allow you to determine what information should be included in the resume. Often, clients will fail to bring up many skills, duties, or jobs they have had that are valuable. Strongly urge your client to describe former job duties in great detail, and develop a list of all the skills involved. Positive personal characteristics such as attention to detail, patience, thoroughness, good communication skills, etc., should also be included on a resume. Even when a chronological resume is required, it is helpful to include a list of skills and positive attributes as well. Ask your client about positive feedback that past employers or co-workers have given them. This will assist in generating their personal characteristic list.

Finally, a resume should be neatly typed, including a cover letter to accompany it. There are excellent computer programs to assist in developing quality resumes. Use one of these as a resource, in addition to the *Job Club Counselor's Manual (Azrin & Besalel, 1980)* which contains forms to help in the development of a resume. If the client does not have access to a word processor, prepare the resume and cover letter for the client through your office staff.

Example Dialogue:

THERAPIST: John, you expressed some interest in finding a job last session. I think this could really benefit you by helping you meet some of your other treatment goals like getting a place of your own, having money to take your kids out to the movies and purchasing a car. How about if we work on a plan to achieve this goal?

CLIENT: Sounds good. I really do want to become more independent and I always feel better about myself when I am supporting myself and my kids.

THERAPIST: I gave you a task to do at home. Did you write down the jobs you have held and the dates that you held them?

CLIENT: Yeah.

THERAPIST: Fantastic! Well, a first step in finding a job is putting together a resume. The role of the resume is to get you in the door, to get interviews with potential employers. It looks like here, there were some gaps of time in between jobs.

CLIENT: Those were times when I was drinking a lot.

THERAPIST: Could we say on the resume that those were times when you were self-employed or re-thinking your career path? When you get an interview, you can explain what was going on more fully if the employer asks about those periods. More importantly, this will give you the opportunity to explain that you've been sober and what positive steps you have taken already in your recovery.

CLIENT: O.K., that sounds like a good idea. I'm going to focus on the positive.

THERAPIST: That's exactly right. Next, can you describe what your duties and responsibilities were with each job and the necessary skills you had or learned for each job?

(Client describes the above items while therapist writes the descriptions down under each job)

THERAPIST: Another good thing to include on your resume is a list of favorable, positive characteristics you have that make you a good employee. What kinds of qualities make you a good employee?

CLIENT: I'm always on time when I have a job and I take pride in my work, so I always try to do the best job possible.

THERAPIST: Great. You're prompt, dependable, and you take pride in doing your work well. (Therapist writes down good qualities). What other things can you think of? What nice things have your employers or co-workers said about your work?

CLIENT: A few co-workers always were commenting that I could get along with the rudest people and make them happy.

THERAPIST: Wonderful! That can be a real asset in plenty of jobs. You are friendly, patient and have good communication skills that are especially valuable in working with difficult customers. (Notes additions to quality list) Great! We can make a solid resume with all these positive things.

Some Steps:

1. Clearly explain how the task of finding a good job is a full-time job in itself, and will require a lot of attention and time on the part of the client.

2. As homework, have the client list all previous jobs in the last 5-10 years and dates held, or have them bring in an old resume if they have one.

3. Look for employment gaps and explain to the client how these can be described as times of self-employment, or thinking about changing career path. Make sure the client understands why this would be done, and practice how to talk about these times in the interview (focusing on the positives accomplished with relation to alcohol use, etc.).

4. Have the client describe all prior jobs in full detail, including duties, responsibilities, training acquired, and skills for each job. Write these next to each job.

5. Have the client describe personal characteristics they possess that make them valuable in the workforce. Prompt by asking about feedback employers or co-workers have given to them in the past. Reword feedback to emphasize positive qualities of the client (persistent, honest, hard-working, dedicated, etc.)

6. Have client neatly type resume and cover letter. Help in finding a typewriter or word processor, formatting the resume, wording resume, etc. If it is not realistic for the client to prepare the resume, provide support through office staff.

5.5d. Identifying and Avoiding Jobs with High Relapse Potential

You will now be familiar with the types of jobs your client has held in the past. Discuss for each position the potential for drinking that may be associated with each job. The aim is to direct the client

away from jobs that have a high potential for encouraging drinking. Some higher paying employment opportunities may be coupled with environments that in the past have led to drinking. Even though the client may be confident in maintaining their sobriety and expresses interest in returning to these jobs, problem-solve with your client in an attempt to find better alternatives.

Example Dialogue:

THERAPIST: I now have a good idea of the types of jobs you have had in the past or may be qualified for. Were there any jobs that made it difficult for you to stay sober? What was there about these jobs that may have encouraged drinking, or were associated with drinking for you?

CLIENT: When I worked construction, the guys would always have beer on the job, and if we didn't drink during the day, we definitely would have a few after work.

THERAPIST: What do you think about looking for construction jobs then?

CLIENT: Well, I do make good money working construction. I could probably handle it.

THERAPIST: Would it be all right if I told you a concern I have about that?

CLIENT: Sure. I think I know what you're going to say.

THERAPIST: Maybe you do. I guess I'm just worried about you walking back into a tempting environment. Sometimes old habits are surprisingly powerful when you get back in the same situation. When people are being treated in a hospital program, for example, they often think that urges to drink or use drugs just won't be a problem for them - that they've licked it. Then they get back into old familiar situations and suddenly they feel very tempted. It surprises them. Do you know what I mean?

CLIENT: Sure. I haven't been back there for a while.

THERAPIST: Exactly! What about looking for jobs that might actually *help* you be sober and meet your goals, instead of providing a constant reminder or temptation to drink?

CLIENT: It's probably a good idea, at least until I get more comfortable with not drinking.

THERAPIST: Good. Let's look at other jobs that you have had that weren't so involved with drinking, maybe jobs you had when you didn't drink for a period of time. . . . .

Some Steps:

1. Troubleshoot with your client about jobs that may increase the risk of drinking. Are there any jobs in which alcohol is present? Do co-workers routinely bring alcohol to work, or go out to drink afterwards? Were any of the jobs so stressful that often drinking would occur to cope with the stress? These are all examples of questions that may help identify jobs that have high risk potential.

2. If jobs are identified that could increase risk of drinking, discuss with your client the pros and cons of the job. Build motivation to try out other jobs that may better enhance and support sobriety.

5.5e. Completing Job Applications

Teach clients the necessary skills for completing a job application properly. This includes reviewing basics like using a typewriter or printing legibly and neatly. Emphasize the need for a clean job application and how this is an opportunity to make a favorable first impression with a potential employer.

You can ask your client to bring in job application forms for actual employment opportunities. It's a good idea also to have available various job application forms from the community so your client can practice answering a variety of types of questions and can receive your feedback. Coaching on particularly difficult questions may be helpful. For example, if an application asks about drug or alcohol problems, you might advise the client to leave the question blank. Without being dishonest, this enables the client to discuss in person with the employer the difficulties in this area, and it provides an opportunity to focus on how the problem is being resolved. An initial interview may not be granted if the client simply states an alcohol problem, thus depriving the client of an opportunity to discuss in person their skills for the job and their recent success at dealing with this issue.

Example Dialogue:

THERAPIST: I have many different job applications from the community, including some from big employers like the city and the county. I thought we could practice filling the applications out today. That way, I can give you feedback and help out with any difficulties you may encounter. What do you think?

CLIENT: That sounds okay. Sometimes I don't always know what the application is asking for. (Client completes a sample application)

THERAPIST: Wow! You have great handwriting! It is always a good idea to complete the applications neatly as you have done. This is the first impression an employer will get of you. I see you wrote down here that you have had three previous DWI convictions. I admire your honesty, and you certainly should not give inaccurate information on a job application. I might suggest leaving this question blank and any other questions that directly ask about alcohol or drug problems. In doing this, you may get an interview that initially you may be passed up for. It gives you the opportunity to explain in person why you would be a good employee, and the positive actions you are taking in recovery. Always focus on the positive, because you have accomplished a great deal in treatment already!

CLIENT: That makes sense. I can do that.

Some Steps:

* Collect different job applications from the community, particularly focusing on employers who have many jobs and hire regularly. Practice completing applications with your client. Praise any positive efforts no matter how small. Help clients with any problems that arise. Ask if they have a typewriter or word processor available, if they can type, or if they have problems reading or writing. Address the concerns and problem solve until a solution is agreed upon.

* Talk with your client about leaving questions that directly ask about an alcohol problem blank. Explain the rationale for this. Role play how to address such questions in an interview.

5.5f. Generating Job Leads

After completing an acceptable resume, and becoming proficient in completing application forms, the client is now ready to generate job leads. Some clients randomly look for employment opportunities that are presently open by walking or driving around town. This is not a good strategy for several reasons. It is not a particularly effective method for finding a good job. It does not allow time for the client to prepare for and become comfortable with the interview process. It leaves little room for discussing how the job might benefit or impact the client's goals in treatment (including the risk potential of the position). Instead, recommend that your clients adhere to a step-by-step procedure that entails listing a series of job leads, and then documenting all relevant information pertaining to contacts.

There are many ways to generate job leads. Because most jobs are obtained through word of mouth, one possibility for acquiring leads is to ask friends or family members if they know of any job openings or possibilities. Former employers or co-workers may also prove helpful in obtaining leads. The yellow pages are a helpful list of potential employers in specific interest areas. Job postings at large firms or at employment agencies, and newspaper want ads may all be useful. If your client is attracted to using the yellow pages, make sure their search for potential employers is broad. For example, if the client is interested in a job working with shoes, encourage the client to also look under shoe retailers, manufacturers, distributors, repairs, etc. This will broaden their possibilities within their specific area of interest.

At least ten job leads should be generated before the client starts to make phone calls to prospective employers. Have the client keep a record of the names of possible jobs, contacts, and calls. The job log should also contain the date the company was called, the name of the person in charge of hiring, the telephone number, the address and the outcome of the call. This directly institutes a call back list for agencies that are currently not hiring, but may be in the future.

Example Dialogue:

THERAPIST: It looks like you're ready to start looking for job leads. There are many ways that people do this including asking friends or family members if they know of any employment opportunities, looking through the yellow pages, newspaper, or employment agencies. Which one sounds like something you would like to try?

CLIENT: Usually I start by keeping my ears open at family gatherings. I have a big family. Then I just get out there and stop into places that have "help wanted" signs posted.

THERAPIST: Starting with your family is a good idea. In fact, most people who have jobs heard about them through word of mouth. Instead of just keeping your ears open, do you think that you would be able to ask your family if they have heard of any jobs opening up?

CLIENT: Sure, I've done it before.

THERAPIST: Great. And besides your family members, who else might be able to tell you about job openings?

CLIENT: Just about anybody, I guess. I can just ask around.

THERAPIST: Good! Ask everyone you know if they have heard about job openings, and tell them you'd like their help if they do hear of one. Now you also mentioned stopping in at places that have help wanted signs posted. This is a good idea, but maybe something to work up to.

That way we'll be able to discuss what to say to potential employers and also discuss if the job seems to match your treatment goals. What do you think?

CLIENT: I guess that would be O.K.. Where do I start then?

THERAPIST: What about employment agencies, newspapers or yellow pages?

CLIENT: I think I could make phone calls.

THERAPIST: Good. But before you start calling, make a good list of possibilities. Ten at least. I remember you're interested in shoes and have some experience there. Why don't you begin by looking up shoe stores, but also look up shoe manufacturers, distributors, and repair places as well. That will broaden your opportunities but still keep you in your interest area.

CLIENT: I can do that. I'm interested in other things, too.

Therapist. Great! So you will talk with your family about openings, and will start identifying places from the phone book. Why don't you come up with at least 10 job leads and bring that list to our next session. Does that sound like something you can do?

CLIENT: Easy.

THERAPIST: That sounds like a good plan. When coming up with job leads I like people to use a "job leads log" (show Form ee to your client). This helps keep track of the employers you have called, their phone numbers and the time and date that you called. Let's do one now for practice.

Reference: Form ee

Job Leads Log (Sample)

Job Title or Type:	Retail Sales Clerk	Retail Sales Clerk	Shoe Repair
Source of Job Lead:	Yellow pages	Judy Turner	Yellow pages
Name of Company:	Shoe Emporium	Dillards	Marco's Fine Shoe Repair
Address:	178 American Mall	196 American Mall	254 Central
Telephone:	555-1234	555-4321	555-3214
Hiring Contact:	Judy Turner	Bob Riemer (?)	Marco Polo
Call Date(s)	2/10 3:00	2/10 3:15	2/10 3:45
Notes	No jobs currently open. Interview scheduled for 2/12 at 10:00 Okay to use Judy's name as referral to Dillards	Two sales jobs open. Interview set for 2/12 at 1:00 No other leads	No job open. Interview declined. Says Central Shoe Repair may be hiring: Erik Erikson Okay to use Marco's name as referral

Some Steps:

1. Familiarize your client with the Job Leads Log (Form ee). With your client, search for at least one job lead together, using the phone book, newspaper, or calling an agency that posts job listings over the phone. Complete the log for this lead.

2. Have your client generate at least 10 job leads through friends, yellow pages, or newspaper. Look over the list to ensure the leads are appropriate before you encourage them to begin calling.

5.5g. Telephone Skills Training

Next, clients use the telephone to make contacts and arrange interviews. Before encouraging your client to proceed with using the telephone in this way, train them to be *brief, clear, and positive* when communicating over the phone. Here are some concrete steps in making a "cold call" about a job possibility:

1. Introduce yourself by giving your name and then asking for the person who does the hiring.

2. If the person in charge of hiring is reached, address the person by name and introduce yourself.

3. Briefly state your qualifications and request an interview.

4. If an interview is not granted for a current position, inquire about an interview in the event that an opening occurs later.

5. If an interview is still not granted for future openings, ask if they know of any other job openings.

6. Ask permission to use this individual's name for job leads.

7. Inquire about a reasonable time to call back about future job openings.

Role-play with your client until they have mastered the steps. It can be helpful to sit back to back when practicing telephone calling. Practice different scenarios that may come up; for example, what to do if the supervisor is not available (have client get their name so they can directly ask for them on the next call). If appropriate, have the client make one or more calls from your office. If an extension phone is available, you may (with the client's permission) listen in and then give helpful feedback, emphasizing things that the client did well and making specific suggestions for change.

Example Dialogue:

THERAPIST: Thank you for working so hard on generating job leads. Now we can practice what to say on the phone when you call these places. (Therapist explains the recommended procedures) OK why don't we practice. Do you want to be the caller?

CLIENT: O.K., I'll pretend I'm calling you. Hello, my name is John. I'm interested in getting a job at your company. Can I speak with the person in charge of hiring?

THERAPIST: Good, that was brief, you stated your name and requested to speak with the hiring staff. Why don't you try first just asking for the supervisor in hiring.

CLIENT: Hi, my name is John. May I please speak with the person who does the hiring.

THERAPIST: Yes, her name is Judy Turner. Let me connect you.

CLIENT: Hello Judy. My name is John and I heard the Shoe Emporium is hiring new salespeople. I have 10 years of experience in shoe sales and I was hoping I could set up a time to meet with you to discuss the possibility of joining your sales team.

THERAPIST: We actually don't have any openings at the moment.

CLIENT: Well, thank you for your time.

THERAPIST: Great!!! You addressed her by name, introduced yourself, briefly stated your qualifications and requested an interview!!! That was perfect! Now, thanking her for her time was a good way to end the conversation, but I wonder if you could have asked her anything else?

CLIENT: Oh yeah, I forgot to ask when she expected they would be hiring again.

THERAPIST: Exactly. Or you could ask for an interview anyhow, in case there are future openings. Or you could ask for an interview for a later date, and if she knew of any other stores hiring.

CLIENT: O.K., let me try that. Could we set up an interview time in the event that an opening does come up?

THERAPIST: That would be fine. I have time this Friday at 10am.

CLIENT: Thank you! Do you know of any other stores hiring currently?

THERAPIST: I believe Dillards is looking for salespeople.

CLIENT: Thank you, would it be all right if I say you suggested I call them?

THERAPIST: Sure. I'll see you on Friday at 10am. (Out of role) Now that was just perfect, John!! Can we try something a little different now, for other situations that may come up?

Some Steps:

1. Emphasize being brief, clear, and positive on these phone calls.

2. Role-play the phone procedures with your client until they have mastered them. If needed, model being the caller, to show how you would handle an ordinary or difficult situation.

3. Introduce different scenarios that may come up and practice how the client could respond effectively. The goal here is to enhance the client's flexibility in making cold calls.

5.5h. Interview Skill Training

Job finding is also easier with good interviewing skills. As needed, review the basics with your client about cleanliness, proper attire, being prompt, and arranging reliable transportation to the interview. Then through in-session practice strengthen your client's interviewing skills. The *Job Club Counselor's Manual* (Azrin & Besalel, 1980) is one good source that has many examples of commonly asked interview questions and appropriate responses. Graduate the difficulty of the interview questions as you rehearse interview behavior, exposing your client to a variety of questions ranging from less to more challenging. Give positive feedback generously. The idea here is to allow the client to gain confidence in interviewing.

Also discuss with your client for the possibility of rejection. Rejection is part of the job finding process. The "yes" usually follows a long series of "no" responses. Again focus on the positive, viewing "unsuccessful" interviews as successful practice, and good learning experiences. Carefully monitor motivation for job finding, and return to motivational enhancement as needed. Praise your client for any and all efforts toward finding a job.

5.6. MOOD: Mood Management Training

5.6a. Background

The word *mood,* in psychology and in everyday life, is a broad term describing temporary emotional states. The content of a mood might be sad, worried, angry, or merry. A key aspect, however, is that a mood state is relatively temporary or transitory in nature. It is expected to pass in a relatively short period of time: minutes, hours, or at most a few days. Mood, in essence, is normal human emotional change. Mood normally shifts in response to events in the person's world.

Mood Management Training is a structured program designed to help clients whose efforts to stop heavy drinking may be compromised by the normal occurrence of negative moods in day-to-day life. This training module instructs clients in the use of cognitive behavioral techniques to manage negative feelings. Clients learn to replace destructive and avoidant ways of responding to negative moods (such as drinking) with more positive responses.

First you will teach clients a model of emotion to help them understand negative moods. Next you will help them identify automatic thoughts that lead to negative emotions. Your clients will monitor their subjective mood states, and together you will use this self-monitoring information to assess and address cognitive themes. Finally, you and your clients will plan ways to counter automatic thoughts and related negative moods with cognitive and behavioral challenges.

5.6b. Research Basis for a MOOD Module

The use of mood modification programs in substance abuse treatment grew out of theoretical and empirical work suggesting that negative mood is linked to a return to addictive behaviors. Marlatt and Gordon (1985) reported that situations which pose high risk for return to drinking are frequently accompanied by negative mood states. Negative affectivity is associated with abuse of and dependence upon a variety of substances (Cannon et al., 1992; Cunningham et al., 1995; Shiffman, 1980). Retrospective accounts of return to drinking episodes often indicate that clients had been experiencing unpleasant affect at the time of the first drink. Prospective ratings of mood at the close of treatment have sometimes shown that patients with more negative mood fare less well following treatment (e.g., Brown et al., 1997). Thus, interventions targeting negative mood are supported by retrospective, predictive and correlational data. On this basis, it is plausible that addressing negative mood states may improve treatment outcome.

The literature on treatment for negative moods in alcohol dependent populations is still growing. There is some indication from recent research that optimal programs go beyond teaching clients how to cope with negative mood itself, and move into coping with both the antecedents and sequelae of negative mood. That is the approach taken in this module.

5.6c. Rationale and Basic Principles

Negative moods do not occur or continue in a vacuum. Indeed, emotions can be thought of as a sequence of events occurring within a particular context. The acronym STORC is useful in explaining this sequence to your client. Emotions occur in a particular SITUATION, which is interpreted through the client's THOUGHTS. ORGANIC responses, such as physical bodily sensations, are usually involved,

and the person's behavioral RESPONSES to this chain of events lead to certain CONSEQUENCES, which in turn become part of the client's SITUATION, thus repeating the cycle.

The MOOD module is a relatively straightforward application of cognitive-behavioral principles. First, teach the client to identify the five factors that make up human experience, and discuss the connections between them, drawing on examples from the client's own life. Then start your client with self-monitoring to identify the particular STORC components of moods that are experienced in different situations. Automatic thoughts that support or exacerbate negative mood will be a particular focus, along with the idea that changing one's thoughts and one's style of thinking can improve mood. Automatic, maladaptive behaviors are also explored. Then cognitive and behavior change is planned. In essence, you will be teaching your client how to have greater self-control over the frequency and intensity of negative moods, by restructuring automatic thoughts and changing maladaptive behaviors. It is important to make the STORC model directly relevant and applicable to the client's life, using real-life examples and assignments.

5.6d. Explaining the STORC Model

Refer to Form ff, which outlines the basic model that underlies this module. Give your client a copy of this handout, and explain that it describes how moods occur. The steps it describes are useful both in understanding negative moods, and in finding ways to change them.

The background material provided in the following sections is intended to help you in explaining the importance of each step in the STORC model. *Do not* present this level of detail to your client. Rather use the material to tailor an explanation appropriate to your client's cognitive style and level of conceptual understanding. Each section describes how one component affects mood, and suggests therapeutic interventions that can be directed at that component. An optimistic aspect here is that change can start almost anywhere in the STORC cycle. The amount of emphasis placed on each component is a matter of decision for you and your client.

An optimistic aspect of the STORC model is that there are things one can *do* about negative moods at every point in the cycle. These are highlighted in the following review of the five components of STORC.

Reference: Form ff

5.6e. Situational Factors

The ***Situation (S)*** refers to the persons, places and things that surround the person at a particular point in time. Clients often attribute their moods to these external sources. It is important to explain that the situation is only one part of how moods occur. Not even the most severe of situations has the power in itself to control one's moods. Viktor Frankl (1963), describing conditions within the Nazi death camps of World War II, recalled individuals who spent their time encouraging and comforting others. Rather than being defeated by the seeming hopelessness of their situation, they held on to hope and shared it with others. A recent follow-up study of people treated for alcohol dependence found that it was not the number of stressful situations to which they were exposed, but rather how they *coped* with stressful situations that influenced whether or not they returned to drinking (Miller, Westerberg, Harris, & Tonigan, 1996).

Nevertheless, certain kinds of situational factors do seem to increase the probability that negative moods will occur. To be sure, individuals differ in their susceptibility to such situational influence, and the other elements of the model (T, O, R, and C) play a role in determining what impact the situation will have. All else being equal, however, there are conditions that promote negative mood and depression. These include prolonged exposure to stressors such as significant loss, crowding, noise, etc. Another important area to explore is the amount of positive reinforcement (versus criticism, punishment, and other aversive conditions) that the person experiences in daily life. Positive reinforcement and pleasant events appear to be important in maintaining a positive mood and outlook, much as vitamins are important in promoting physical health. Some people have lifestyles or occupations which provide them with very little regular positive input, combined with a rich diet of criticism and negative evaluation. Sometimes (as when a relationship or job is new) reinforcement starts out at a high level but then drops off gradually over time. When such a drop in positive reinforcement occurs, it is described in everyday language as "being taken for granted," or not being appreciated. Continual exposure to conditions of low reinforcement can lead toward negative moods and depression.

As you explore situational aspects of mood with your client, focus particularly on what seem to be the most mood-relevant aspects of the client's environment. The following brief example illustrates how to engage a client in identifying mood-important aspects of the environment.

> THERAPIST: Okay, so if the Situation refers to people, places and things around you, suppose you were sitting in your living room at home, alone in the house. Is that an okay example for starters?
>
> CLIENT: Yes, I guess that's one situation.
>
> THERAPIST: But that only gives me a general idea of the situation. Tell me more about it, things that might relate to your mood. Picture it - you're sitting in your living room at home - and tell me about it. How are you feeling there?
>
> CLIENT: Bad. My mood is negative.
>
> THERAPIST: Okay, that's a start. What's going on in the living room that might contribute to your negative mood? How's the temperature?
>
> CLIENT: Our air conditioner is broken and the temperature is going higher every day, which may make me more irritable than usual.
>
> THERAPIST: Good. What else might be going on that would affect your mood?
>
> CLIENT: The noise from the neighbors is ridiculous. We ask them to keep it down, but they never listen.

THERAPIST: Great – what else?

CLIENT: Well, one other thing really gets me. Fran was supposed to be cleaning the house earlier this week, but it's still a mess. There's dust and piles of stuff everywhere.

THERAPIST: Okay, so you've given me some really good examples of aspects of one situation that seem to contribute to your negative moods. Now let's talk about some other situations, especially those where you might have some bad feelings. . . .

Exploring the client's environment can provide clues for where to intervene cognitively and behaviorally.

What can be done at the level of *situational* factors in order to prevent or reduce negative mood states? The main emphasis here is on planning and arranging for oneself a "balanced diet" in daily life. One strategy is to plan intentionally for each day to include some pleasant events, large or small, that function like "psychological vitamins" to help keep the rest of the day in balance. Self-monitoring can be useful here to increase awareness of the daily balance, by keeping a daily record of pleasant and unpleasant events that occur. If the unpleasant or stressful events seem to dominate and overbalance pleasant events, it is important to plan time for additional positive experiences. Regular social support can be an important source of such positive and balancing experiences.

If a client's daily diet is heavy with negative and stressful experiences, it is important to seek ways to decrease these. Which of them are unnecessary and avoidable? For those that are unavoidable, plan for additional pleasant events and social support when especially negative experiences are anticipated.

In planning a balanced psychological diet, it is important to avoid a common pattern: to have all of the negative or stressful events packed together into the daytime, followed by a sudden shift to positive time (represented symbolically by the "happy hour"). Marlatt and Gordon (1985) have associated this lifestyle with a risk for alcohol and drug abuse, and propose that instead it is healthier to distribute positive events throughout the day.

5.6f. Thought Patterns

Although situational factors do play a role in mood, there is another sense in which *nothing* in the external situation is really *responsible* for one's mood. Positive and negative emotions are not direct reactions to the "real" world, but rather are responses to how the person *perceives* that world. Encountering a rattlesnake along a wilderness trail might evoke considerable arousal for a person who recognizes it for what it is, but could result in little more than curiosity for a person who had no idea of the danger it poses. A toy can be a source of fun, fear, jealousy, anger, worry, or sadness, depending upon how it is perceived and used. Similarly, "depressing" events are not inherently depressing, and one's reaction depends upon how one perceives them. In the classic film, "It's a Wonderful Life," George Bailey (played by Jimmy Stewart) experiences a sudden series of major setbacks on Christmas eve. Perceiving his situation as hopeless and his life as worthless, he falls into a suicidal mood and wishes he had never been born. In a transforming vision, he gets his wish, seeing life in his town as it would have been had he never existed. Afterwards, the same life looks entirely different to him (hence the film's title). All that has changed is his perspective. Within the context of a positive or optimistic attitude, events which might otherwise be considered stressful or depressing can have a diminished or different impact.

Attributions are particularly important cognitions when it comes to mood. Attributions are explanations of why things happened (or did not happen), or the causes of life events. One dimension on which attributions vary is *internal* versus *external*. An internal attribution is a perception that a particular event was caused by one's own actions. An external attribution, by contrast, is a perception that a specific event was caused by factors beyond one's own influence. Another important dimension on which attributions may vary is *stable* versus *unstable*. Stable attributions explain an occurrence as being due to something that is not likely to change. An unstable attribution, on the other hand, is a cause that is highly changeable.

As a general rule, people do not expect things to change when they attribute a situation to a stable cause, but do expect change when they attribute a situation to an unstable cause. People normally show a somewhat optimistic style in which they tend to attribute successes to internal causes, but failures to external and/or unstable causes. "My successes are because of my abilities and efforts, but my failures are due to insufficient effort, interference of others, or just plain bad luck." Even psychotherapists may see the world this way: "My successes are because I am a good therapist; my failures occur when the case is just impossibly difficult, or the client isn't motivated enough." Though perhaps a bit self-deluding, this normal attributional style is one that encourages a positive outlook and continued personal effort.

Negative mood and depression, on the other hand, are associated with a rather different attributional pattern. In the midst of depression, negative outcomes tend to be attributed to stable, general negative characteristics of oneself: "That's how it always goes; I mess up everything I touch." "I'm a loser in every relationship; who could care for somebody like me?" Positive outcomes, on the other hand, tend to be attributed to external causes: "I just got lucky." "They let me win because they feel sorry for me." "She's nice to everybody."

Changing self-statements has rather consistently been found to have an impact on mood. Cognitive therapies, which focus on altering thought processes, have been found to be quite beneficial in treating anxiety and affective disorders. Cognitive intervention typically begins by identifying the individual's thought patterns that may be fostering negative moods (Beck, 1976; Burns, 1980). Some common examples are: unrealistically high expectations of oneself or others, hopelessness, pessimism, and excessive self-criticism. These cognitive patterns are then challenged and changed, seeking new beliefs and self-talk that promote healthier functioning.

5.6g. Organismic Experience

Some think of moods as purely *physical sensations*. Certainly there are neurobiological processes involved, many of which operate below conscious awareness. There is a diffuse autonomic arousal associated with many emotions, and individuals may experience this in physical changes such as dry mouth, cold hands, a hot face, stomach contractions, etc. What physical sensations does your client experience as being upset, angry, sad, afraid, etc.? Often physical sensations are quite similar across subjectively different emotions. In fact, research has shown that given autonomic arousal, the emotion that a person experiences is influenced by how the person *interprets* the arousal and the situation. Sometimes emotions are aroused or amplified in direct response to an internal physical sensation, as in fear of fear.

The “organismic” component is the person’s experience, both physical sensations and the emotional name that is given to it. It is often helpful to clarify exactly what your client experiences, physically, as a negative emotion or mood. Emphasize that these physical (organismic) responses are a part, but only a part, of the chain of events experienced as emotion.

There are various strategies to directly alter physical states (e.g., medication, relaxation training, physical exercise). None of these is included in CBI, in part because they have a rather disappointing track record as components of treatment for alcohol problems (Miller et al., 1995). In fact, substance abuse may be an attempt by the client to modify directly the O component in negative emotionality. Primary emphasis is placed here on modifying cognitive (T), behavioral (R), and environmental (S, C) elements in the chain.

5.6h. Response Patterns

When your client experiences mood-relevant physical changes, what happens? What does the client *do* in response to emotional arousal? Once a person begins to experience a negative mood, how he or she responds to this feeling can make a big difference. There are two generally maladaptive response patterns to watch for in particular: *avoidance* and *aggression*.

A common and often unhealthy response is avoidance or withdrawal. The reaction may seem quite understandable, even natural. Being down, experiencing low self-esteem, the person feels like poor company. He or she may not feel up to usual social contacts, or may not want others to see him or her in this dejected state. Feelings of fatigue may contribute to the tendency to avoid and withdraw. Yet avoidance tends to strengthen negative emotions. The person who, once thrown from a horse, continues to avoid horses will experience intensified fear of them. The depressed individual who withdraws from his or her social support network is thereby cut off from important sources of feedback and reinforcement, which in turn amplifies the depression. The general remedy here is to do the opposite of the seemingly natural tendency to withdraw. For the depressed person, it is important to continue seeing friends and engaging in

previously pleasurable activities, even though it requires an effort and may not immediately feel pleasant. The same applies to feeling down and low moods more generally.

Another maladaptive way in which people respond to negative moods is to strike out, to react aggressively. This pattern, like avoidance, is often exacerbated by substance use. Aggression can be reinforced by having the desired *immediate* effect. In the long run, however, aggression rather consistently changes the person's social environment in ways that make negative emotionality worse rather than better.

In part, the problem here can be the lack of an important coping skill. Deficient social skills, for example, can impede an individual from developing a reinforcing and supportive network of friends, which in turn decreases resistance to depression. Social skill deficits can also perpetuate depression in adults. In these cases it is important for the person to learn a new coping style, a new way of responding that promotes healthier moods and adjustment. If this appears to be the case, it may be useful to include other CBI skill-building modules in treatment.

5.6i. Consequences

Finally, mood and depression are influenced by how the social environment responds to one's behavior. An environment that provides very little positive reinforcement can foster negative mood and depression. In such situations, no matter what the person does, very little reinforcement is forthcoming. A prolonged period of this may result in an attitude of helplessness and pessimism, which itself feeds negative emotionality.

Ironically, some social settings strongly reward an individual for negative mood. Consider a woman with poor social skills, who consequently has no close friends. Her everyday life is rather uneventful and empty. In time, she becomes depressed and confides to several people that she is feeling suicidal and very down. Suddenly the church community, of which she is a member, comes alive for her and rallies around her. The pastor calls regularly. Friends begin telephoning and dropping in, often bringing food, helping with chores, or even sitting with her through the night. What had been a largely inattentive group of people becomes, almost overnight, a warm and supportive community. Amazed, she begins feeling better, and as she does, her friends go back to their previous business, leaving her alone again. The "sensible" response to these contingencies is to become depressed again.

Change at this level involves rearranging the social environment, as much as possible, to reinforce healthy behavior instead of unhealthy, disabled behavior. It is not enough just to stop reinforcing depression. Consider again the woman just described. Suppose her friends had decided to abandon her in sickness *and* in health! Likely her depression would not be lessened. Instead she needs to learn better social skills for forming personal and lasting relationships with others. A key is to establish a social support network that provides ongoing reinforcement for healthy and adaptive functioning.

Still another possibility is to try new activities, new sources of potential enjoyment and reinforcement. There is a tendency for adults to fall into predictable patterns of social and leisure activities. Substance dependence also commonly involves a steady withdrawal from previously enjoyed people and activities. Some people are reluctant to try new skills because they might not excel at them; consequently they do only what they are sure they can do well. Such limitations unnecessarily restrict a person's possibilities. Exploring new activities, just for the fun of it, can lead to new and rewarding relationships and involvements.

5.6j. Exploring Negative Mood States

Sometimes people have a difficult time naming or describing their own moods directly. They may describe their thoughts rather than their feelings. For such clients, reflective listening may be fruitful, and you may be able to infer a mood from the client's more general description of STORC elements of a particular event. This is often done by exploring a recent specific situation in which the person felt a negative emotion or mood.

THERAPIST: So – give me an example. When was the last time you felt a strong negative feeling?

CLIENT: Well, yesterday, when I was stuck in traffic, I thought all those people were jerks.

THERAPIST: You were in a traffic jam and you were feeling a strong mood. What name would you give that mood?

CLIENT: I didn't feel anything in particular; I just thought about what jerks people are, and how I wished I was anywhere but there. I kind of wanted a drink.

THERAPIST: Interesting! So you're not sure what to call your feeling, but it was pretty negative. It sounds, even in your tone of voice right now, like you were a little irritated.

CLIENT: I guess you could call it irritated. And it was more than a little.

THERAPIST: We agree, then, that you got kind of angry in traffic yesterday. And that's when you felt this urge to drink.

CLIENT: I suppose so. It's strange to think about it that way. I just blamed it on the traffic. At least I didn't drink!

THERAPIST: What a good example! That's not unusual, to think that your feeling is the direct result of what's happening *out there*. One of the things we are focusing on here, with this STORC approach, is how the situation is only one small part of how negative moods happen.

CLIENT: I guess I was more irritated than I realized.

THERAPIST: And now you see it. Good for you! It's pretty common for people to feel like drinking when they get into a negative mood like that, and it sounds like for you, feeling angry is a particularly strong one. The point, though, is that you have a lot to say about your own mood. You can, to a large extent, decide how you feel about something. And as this experience shows, even if you do get into a negative mood, you don't have to give in to the urge to drink that goes with it. . . .

Another option is to use Form gg, which provides a broad list of feeling names. Show your client the list, and ask which words might best describe how he or she felt in the situation being discussed.

Reference: Form gg

5.6k. Self-monitoring

After you have explained the STORC model, the next step is to have your client begin self-monitoring mood states. Start by having your client complete one column of the mood monitoring sheet (Form hh), based on the most recent time he or she experienced a negative feeling. In the top (Mood) box, begin with a general mood rating from -10 (very negative feeling) to +10 (very positive feeling), for the client's experienced mood level at that time.

The Situation box is fairly easy to complete. First ask the client to describe the situation to you, and then have the client make a brief note in the S box to indicate the external circumstances.

Sometimes people have initial difficulty with the Thoughts component, because they are unaware of any specific thoughts that occurred in between the situation and the emotion. If this happens, go on to the O box, and then come back to T and ask, "What *might* (or *must*) you have thought to get from here (S) to here (O)?" Emphasize again that feelings are not automatic results of the situation, but rather result from thoughts that occur, often so quickly and automatically that we are unaware of them.

In the O box, have the client fill in specific physical sensations as well as a name for the emotional state. How did the person *feel* in this situation? Help the client to distinguish between thoughts and feelings. For example, when a person says "I felt *that* ..." it is almost always a thought rather than an emotion (for example, "I felt that I was being treated unfairly"). Listen for an implicit "that" in the statement: ("I felt I was being treated unfairly" is still the same statement, and conveys a cognition, a mental interpretation rather than an emotion.) If there is a "that" in there, it's not an emotion.

For the R box, ask what the client *said or did* in response to the situation, thought, and feeling. How did the client react? Have the client make a brief note about it.

Finally, in the C box, what happened as a result? How did others react, or what changed?

Reference: Form hh

THERAPIST: Okay, now let's try out keeping a mood diary on these sheets. What will be most helpful is if you keep a record of times when you have a particularly positive or negative feeling. You don't have to put every feeling in the diary, or you could be at it all day, but when there is what seems like a significant feeling - something especially positive or negative, write it down. As an example, think back to the last time this week when you experienced a particularly negative feeling. When was that?

CLIENT: (Laughs). Just before I came in here. I had a big fight with one of my kids.

THERAPIST: Okay, fine. Now in this first box, I want just a rating of how good or bad you were feeling. It's a rating scale from minus ten (which is feeling about as bad as you can feel) to plus ten (which is feeling on top of the world, about as good as you can feel). Where would you rate your mood in that situation?

CLIENT: During it? I was so mad I could hardly talk. Minus 8 or 9, maybe.

THERAPIST: So, a very negative feeling - almost as mad as you ever get.

CLIENT: Well, minus seven, maybe.

THERAPIST: Okay, write that down. Now what was going on just before this feeling happened? What was the situation?
CLIENT: Toni, my 18 year-old, showed up with her navel pierced and bleeding. She decided to have one of her friends pierce it to put in one of those rings. I was so mad.

THERAPIST: So she hadn't discussed it with you, and just went ahead and did it.

CLIENT: We had discussed it all right, and I had told her "No way."

THERAPIST: All right. Just make a note in the Situation box there - maybe, "Toni came home with navel ring." Now what were you thinking to yourself when you saw her with the ring?

CLIENT: I thought, "How stupid can you be? That's going to get infected. What were you thinking?"

THERAPIST: What else?

CLIENT: "You did this just to spite me. I told you 'No,' and you defied me."

THERAPIST: Great! Write that in there. . . . . So then come the feelings. Really mad, you said.

CLIENT: Yup. Fried. I felt that I was about at the end of my rope with this kid.

THERAPIST: Put that in there: Really mad. Fried. That's good! The last thing you said, though, goes up in the Thoughts box.

CLIENT: Why is that?

THERAPIST: What you said, I think, is that you felt that you were at the end of your rope. That's not a feeling really, though it certainly leads to a feeling. It's a thought flashing through your mind: "I've had it. I can't do this much longer." Something like that, right?

CLIENT: Right, I see what you mean. That's what I was thinking to myself, but I didn't say it to her, thank goodness.

THERAPIST: Okay – you're thinking, "I'm at the end of my rope. This kid intentionally disobeyed me, and did something stupid." And then you feel fried, angry. So what did you do?

CLIENT: I said something like, "How could you be so stupid? You're grounded for a month." I wasn't thinking. I couldn't even see straight, I was so mad.

THERAPIST: Actually you *were* thinking - says so right there. And what you were thinking got you pretty hot.

CLIENT: Yeah, I see what you mean. Anyhow, I told her she was grounded, and she called me a name and ran out of the house.

THERAPIST: All right. So in the R box there, just make a little note about what you said. There's not a lot of room, so just make it enough to remember what you did. . . . And then in the C box, make a note that Toni yelled at you and ran out of the house.
CLIENT: Right then - I almost had a drink. I really felt like it.

THERAPIST: That sounds important. Let's explore that a little, and keep going with this. The consequences - what happened - become part of a new situation for you, and the process continues. So let's do the next column. The situation is that Toni just yelled at you and ran out of the house. That goes up there in the next S box. . . . And you think to yourself, "I'd really love to have a drink." What were you actually *feeling* at that point?

An important quality of discussion like this is that you and your client are standing back and reflecting on the flow of events involved in feelings. Some of this discussion can even be fairly light-hearted, gaining some distance from what was a significant emotional event.

Once your client seems comfortable with how to fill in the mood monitoring sheets, give the assignment of keeping them as a diary between this session and the next, and to bring them back at the next session. ("Would you be willing this week to keep these as a kind of diary . . . ?") Give your client a supply of the forms, asking him or her to complete at least three of them (that is, nine specific events). Make sure that is agreeable, and that the client understands what you are asking him or her to do. Emphasize that you want the client to record situations in which either *positive or negative* emotions occurred. Both are useful.

If time permits, you can continue with the next section, or postpone this until your client returns with completed mood monitoring forms.

5.6l. Automatic Thoughts

Start this section with a discussion of how certain types of thoughts lead to negative emotions. Ask your client for examples, to determine the extent to which he or she grasps the idea. Those with experience in AA may link this to the concept of "Stinking thinking." Use examples from the mood monitoring sheets to explore how thoughts are linked to emotions. As your client begins to break his or her negative mood sequences down according to the STORC model, a *pattern* of automatic thoughts that are *mood magnifiers* should emerge. You're looking for patterns, for themes or consistencies. These thoughts might be likened to weeds in the garden, with the analogy of plucking them out, one by one, to allow room for what you want to grow.

Emphasize that emotions are transient - they tend to come and go. For an emotion like anger to persist, it has to be fueled by thoughts. Going over and over certain thoughts is like putting logs in the fireplace. If you stop feeding the fire, or pull out the wood, it eventually goes out.

Another important point, strange to some clients, is that we *choose* how we think about things. This is a crucial point, because mood management involves *changing* thought patterns, pulling weeds, pulling fuel out of the fire.

The thought-changing process is a two-step process. First, learn to recognize the automatic thoughts, to catch them as they go by. Second, learn to replace them with more balancing thoughts. Again, for clients with AA background this will be familiar territory, though they may not have explored it in quite this way. "Resentment" is a common theme in AA meetings, and serves as a very good example of how thoughts fuel negative feelings, which in turn can lead toward drinking.

As with all task assignments, when you have asked your client to keep mood monitoring records, give this priority at the beginning of the next session. Ask for the records, lavishly praise the client for keeping them, and take time to go over them together. Look particularly for consistencies in thought patterns that lead to negative emotions. Consider both consistencies of *content* as well as distorted thought *processes*. Here are some common erroneous thought processes described by David Burns (1990):

> **Filtering** involves selective attention, looking only at certain elements of a situation while ignoring others.
>
> **Black and white thinking** classifies reality into either/or categories without recognizing the many degrees of difference.
>
> **Overgeneralization** involves broad conclusions based on limited evidence, such as "making a mountain out of a mole hill."
>
> **Mind reading** makes assumptions about what others are thinking and feeling, what motivated their actions, etc.

Catastrophizing assumes that the worst will happen.

Personalization is the error of seeing every experience as related to your own personal worth.

Blaming is holding other people responsible for your own pain.

Shoulds or **Oughts** can be rules that are rigid, not flexible enough to take into account human frailties.

Emotional reasoning is when feelings overrun reality-checking: if you feel it, it must be true.

Fallacy of external control is the perception that one has no power or responsibility for what happens in his or her life.

Fallacy of omnipotent control is the opposite pattern: believing that you control (or are responsible for) everything. This is another common theme discussed in AA meetings (see Kurtz, 1979).

Don't bore clients by reciting this list. Rather, the list is meant to help you think clearly about what systematic, automatic distortions may be occurring. With your client's collaboration, identify the content or process errors in thinking that lead to negative emotionality (Burns, 1990).

It would be inconsistent with the overall style of CBI to argue with your client about whether or not the client's thoughts and beliefs are correct. Instead, invite your client to consider *how else* it would be possible to view or interpret the same situation. The point is not to say "you're wrong," but to show how different ways of thinking about things actually lead to different realities (O, R, and C). No matter the situation, human beings always have the freedom to choose how to think about and understand them. This, in turn, is the freedom to choose how one *feels* about life as well. (For clients with AA experience, explore this in relation to the idea of serenity.)

5.6m. Challenging Toxic Thoughts

This leads naturally to the next step of challenging and finding antidotes to toxic thoughts - trying out new ways of thinking and being. Once you have identified thought patterns that lead to negative emotions, work together to find ways to challenge and replace those thoughts. Again, emphasize that this is a matter of choice. The client does not *have* to think differently. (In fact, to say so would be to practice a distortion.) Rather your client can *choose* how to think (T) about situations (S), and thus have some choice about how to feel (O) and act (R) as well, which in turn influences what happens (C) in the client's external world. It is also not your job to prescribe for your client the "correct" or "rational" thoughts that he or she *ought* to have. It's fine to suggest different possible interpretations if your client gets stuck, but always first invite your client to suggest different ways of looking at things. Again, think of it as developing a menu of options from which the client chooses.

There are at least two basic ways to intentionally challenge toxic thoughts. One is to *think* (T) differently - in essence, talking to yourself. Another is to *act* (R) differently, to live *as if* different assumptions are already true. (In AA this is sometimes described as "fake it till you make it."). Just as negative moods can be magnified by either thoughts or actions, they can also be counteracted in the same two ways.

This is where you can use Form ii - the Thought Replacement Worksheet. Often it is best introduced by working through a specific example or two.

Reference: Form ii

THERAPIST: Okay – you have completed several of these sheets. What we're going to focus on today is how your thoughts affect your moods, and what you can do about that. Sound okay?

CLIENT: Sure.

THERAPIST: Well – let's see what you have here. (Looks over sheet.) I see that you had some pretty strong negative moods on this sheet, with some urges to drink.

CLIENT: Yeah – that one night was especially tough.

THERAPIST: And I see some real mood magnifiers here.

CLIENT: I don't know what you mean.

THERAPIST: Well – close your eyes for a minute, and imagine its Friday night again. You're sitting in the chair at home alone, channel surfing. What are you saying to yourself?

CLIENT: Here I am on a Friday night, watching television by myself. What a loser I am!

THERAPIST: A loser - and that kind of says, "It's just how I am. It will never get better." Does that sound right?

CLIENT: Uh huh.

THERAPIST: So how are you feeling? Can you feel it now?

CLIENT: Lonely. Depressed . . . discouraged.

THERAPIST: Exactly. If the problem is *who you are* - if this is something hopeless that can never change, then *of course* you feel demoralized. It follows! The thought is a mood magnifier.

CLIENT: I can see that.

THERAPIST: Are you willing to try to pick some weeds here, clean out the garden a little?

CLIENT: How do I get rid of thinking that way?

THERAPIST: Well – let's look at that thought that things will never get better. How accurate do you think that is? Are you 100% sure that things will never get better?

CLIENT: Not really – but I do think that there's a good chance things won't improve.

THERAPIST: What are the odds you would give yourself, in your head? 50/50? There's a 50% chance that things will get better?

CLIENT: No, I'd say there's a 10% chance that things will improve.

THERAPIST: Now there *is* a bad mood magnifier! The doctor only gives you a 10% chance of having a life. You gonna take the doctor's word for it?

CLIENT: Maybe I should get a second opinion (laughs).

THERAPIST: Yes! A second opinion. That's good! Choose yourself a better doctor.

CLIENT: It would be nice.

THERAPIST: Your tone of voice sounds a little hesitant.

CLIENT: Yeah – I don't know about this.

THERAPIST: You're not too sure you can do this - maybe a 10% chance?

CLIENT: (smiles).

THERAPIST: I agree. It's not easy. Here - let's take a look at that thought about things never getting any better. I'm going to use this new sheet here. (Takes out the Thought Replacement work sheet.)
CLIENT: Okay. How do you want to look at it?

THERAPIST: Well, you said that your mood was really negative on Friday night. How did you feel on Saturday morning?

CLIENT: Okay, I guess. Yeah – I had some stuff to do, and I hadn't had anything to drink, so I was feeling a little better.

THERAPIST: So – you were improved the next day?

CLIENT: Well, yeah – somewhat – but I wasn't totally happy or anything.

THERAPIST: Not perfect – and that's a point well taken. We're not looking for total perfection here – we're just looking for what moves your mood one way or the other. What if you had drunk on Friday night?

CLIENT: Would have been much worse. Okay – I see where you're headed with this. I have some choice about what happens.

THERAPIST: So let's try a little mind experiment here. This is your initial thought on Friday night - hopeless - I'm writing it in the Automatic Thought box. And we know where that one leads - you felt lonely, depressed, discouraged. I'm writing that in here.

CLIENT: Right.

THERAPIST: Now, just use your imagination. *What else* could you have said to yourself, sitting there at the television, besides, "I'm a loser, and I'm always going to be a loser."

CLIENT: Something like, "I may feel miserable right now, as if I was never going to feel better, but chances are I will feel better tomorrow."

THERAPIST: All right! That's a much more balanced thought. Good work! I'm writing that in here, in the Thought Replacement box. And what do you suppose your feeling would have been if you had said that to yourself instead?

CLIENT: A little more peaceful, maybe.

THERAPIST: Peaceful. Okay. I'll put that in here. You get the idea?

CLIENT: Uh huh. I think so.

THERAPIST: Okay. Now you try one. Here's the sheet. Let's look back at your mood diary for this week and find another place where you had negative feelings. How about this one. "Upset," it says. And under Thoughts you have "Unfair." What's the mood magnifier there? . . . .

Thought Replacement Worksheet (Example)

Toxic Thought	Resulting Feeling	Replacement Thought (Antidote)	Resulting feeling
I'm a real loser. It's never going to change. I'm always going to be this way.	**Discouraged** **Lonely** **Depressed**	**I'm feeling lonely right now, but I'll probably feel better in the morning. What else could I be doing besides sitting here watching TV?**	**More peaceful** **More hopeful**
I'd really like to have a drink. I'd feel better. If I don't have a drink this feeling is just going to get stronger and stronger.	**Panic** **Thirsty** **Helpless**	**Wait a minute. I've already tried that. If I drink now I'll feel a whole lot worse. Who am I kidding?**	**Relieved** **Stronger**

In the same way, examine what the client *does* in negative mood situations (R), and how this may be a mood magnifier. Similarly, explore what else the client *could have done instead*. As with thought substitution, the idea is to emphasize choice. Some common examples of behaviors that may serve to reinforce negative moods are: withdrawing, arguing, sulking, drinking, driving aggressively, smoking, overeating, and criticizing or blaming.

As before, it is not your job to confront, criticize, or correct your client's behavior. Instead, invite the client to consider with you, as a mental experiment, *what else* she or he could have done, and what different consequences might have followed. A problem-solving approach works well in this context, with therapist and the client working together to generate a list of different response options that could have different effects on moods.

> THERAPIST: Now a piece we haven't talked about yet is how what you *do* can also be a mood magnifier. Looking back at your Friday night, you say you were watching TV alone and eating chips. And doing that, you felt lonely, discouraged, depressed. Now what are some other possibilities. What else could you have done when you were feeling that way?

CLIENT: I could have had a drink or twenty.

THERAPIST: Right - and you chose not to. What if that's what you had done? What would have happened?

CLIENT: Like I said, I would have felt a lot worse on Saturday. I would probably have stayed home on Saturday and drank all day, instead of going out and getting things done.

THERAPIST: All right. There's one thing you could have done differently, that would have led to much *worse* feelings and consequences. It would have magnified your negative mood. Now the opposite is true, too. What else could you have done differently on Friday night, besides staying home alone, that might have had better results?

CLIENT: What else am I supposed to do? I'm not supposed to go to bars, and there's not much else to do out there on a Friday night.

THERAPIST: It's a real challenge sometimes to figure out what to do instead of a mood magnifying behavior. First identify the behavior that's magnifying your mood, and then try some healthier options.

CLIENT: I don't know – maybe it's best just to be alone.

THERAPIST: I hear some mood magnifying thoughts right there!

CLIENT: Well, the being alone thing really bugs me. I know I don't want to be alone, which is a more balanced thought, I guess, but at the same time, I'm nervous about meeting people. I guess that's what AA meetings are for.

THERAPIST: You can meet people at meetings. You can also meet them at a ton of other places. The Thursday night newspaper every week has pages of things that are happening in the community, most of which don't involve drinking. And going out and doing something around other people is just one set of possibilities. What else could you do?

CLIENT: You mean like call somebody on the phone?

THERAPIST: There's a good idea! What if you had done that instead on Friday night? . . . .

Thought substitution and response substitution lend themselves well to task assignments between sessions. The spirit here is one of experimentation - of trying out different thoughts and different behaviors, to see what happens. It's the same idea expressed in the module on Social and Recreational Counseling (SARC, 5.8) - sampling different possibilities to find what is more rewarding. Negotiate specific assignments, drawing heavily on your client's own ideas whenever possible. It can be useful to continue keeping the mood monitoring sheets during this period when new thoughts and responses are being tried.

5.6n. Applying STORC with Urges to Drink

If your client experiences urges to drink, the procedures of this module may be particularly helpful. Urges can be analyzed with the same STORC model, and positive changes may occur at any link in the chain. Urges often involve a good deal of self-talk, which can have a magnifying effect. Similarly, thought and response substitution can counteract and weaken urges to drink.

Hidden automatic self-statements about urges can make them harder to handle ("Now I want a drink. I won't be able to stand this. The urge is going to keep getting stronger and stronger until I blow up or drink.") Other types of self-statements can make the urge easier to handle ("Even though my mind is made up to stay sober, my body will take a while to figure this out. This feeling is uncomfortable, but in a few minutes it will pass. I'll surf over it.")

The two basic steps are the same:

1. Identify the STORC components that make up an urge to drink. What is the situation? What self-talk is involved? What are the automatic thoughts that make it harder to cope with an urge? How does the client respond when experiencing (and labeling) an "urge"?

2. Find ways to challenge the toxic self-talk (stinking thinking) with replacement thoughts and responses. Here are some examples of replacement thoughts that people have used successfully in sobriety:

> *Where is the evidence?* What is the evidence that if you don't have a drink in the next 10 minutes, I will die? Has anyone who has been detoxed ever died from not drinking? Who says that successfully sober people don't have these feelings from time to time? What is the evidence that there is something uniquely wrong with me, that means I can't stay sober? Who do I think I am?
>
> *What is so awful about that?* What's so awful about feeling bad? Of course I can survive it. Who said that sobriety would be easy? What's so terrible or unusual about experiencing an urge to drink? If I hang in there, I will feel fine. These urges are *not* like being hungry or thirsty or needing to relieve yourself – they are more like craving a particular food when you see it, or an urge to talk to a particular person – they pass in short order.
>
> *I don't have to be perfect. I'm not God.* So I make mistakes. I can be irritable, preoccupied, or hard to get along with sometimes. Other times I'm more centered, loving, and lovable. Human beings make mistakes. It's part of being alive and human.

Similarly, there are many possible responses to try instead of drinking. Call someone. Go to a movie. Take a hot bath. Go to a meeting. As always in CBI, it is best to elicit the client's own ideas. It can sound terribly trite to list things a person can do instead of drinking, and clients generally have better ideas anyhow.

5.7. MUTU: Mutual-Support Group Facilitation

5.7a. Rationale

Support for sobriety makes a big difference. Studies rather consistently find that involvement in mutual-support groups is associated with less drinking and more abstinence after treatment. Particularly for clients whose current social systems support drinking rather than abstinence, involvement in a mutual-support group can provide a new support system for sobriety, and may significantly improve treatment outcome (Project MATCH Research Group, 1998a).

For this reason, all clients in CBI are encouraged to at least sample mutual-support groups. This module is a much shortened version of Twelve-Step Facilitation therapy (Nowinski, Baker & Carroll, 1995), an important change: encouragement is broadened to mutual-support groups more generally, and is not restricted to twelve-step groups; consequently, no emphasis is given to helping clients work the early steps of the twelve-step program. Instead, the module focuses on facilitating the client's sampling of available mutual support groups as an aid for sobriety. Specific objectives of this module are:

To give clients a rationale for using social supports as a primary mechanism for stabilizing and maintaining treatment gains.

To identify clients who have a particular need for mutual-support group participation because of inadequate social support for sobriety.

To educate clients about the anticipated benefits of different mutual-support programs, and what to expect (procedurally) from different support groups.

To minimize faulty beliefs about different mutual-support programs by providing pertinent support group information including (when available) "approved" literature, or source materials.

To offer temporary support and a resource for clients to address questions about, or discuss negative experiences with mutual-support group involvement.

To assist the client in finding an appropriate and acceptable mutual-support group.

5.7b. Definition and Background of Mutual Support

People with problems in their lives seek many routes to alleviate their distress. One common response is to seek the help of others with similar problems. The process of turning to a group of peers with similar problems has been described as *self-help or mutual aid* (McCrady & Delaney, 1995), terms synonymous with the one that is used in this manual: *mutual support***.** Self-help or mutual-support groups have proliferated for persons with substance abuse problems. Many of the mutual-support groups had their beginnings in the fertile climate for alcohol treatment services in the United States after the post-war era. However, mutual-support groups are not simply an artifact of the U.S. treatment system, but are becoming more common in other countries as well, where they are seen increasingly as an important adjunct to alcoholism treatment (Mäkelä, 1993; McCrady & Delaney, 1995).

5.7c. Overview of Mutual-Support Programs

The earliest of the contemporary mutual-support groups is Alcoholics Anonymous (AA). Founded in Akron, Ohio in 1935, AA claims to have 2 million members, and more than 90,000 registered groups in over 140 countries (Alcoholics Anonymous World Services, 1994). AA is a fellowship of men and women who help each other to stay sober by living without alcohol through following the 12 steps of recovery (see Appendix E). The core beliefs reflected in the 12 steps include the "powerlessness" of the alcoholic to control his/her drinking; and the existence of a "higher power" (i.e. "God as we understand him") who can restore a life, if allowed *(paraphrased from steps 1, 2, and 3)*. A number of other groups established on the steps and traditions of AA have developed to help individuals addicted to other psychoactive substances such as narcotics (Narcotics Anonymous - NA) and cocaine (Cocaine Anonymous - CA). AA groups are peer led, and the organization of AA is non-professional, relying on the volunteer activities of its members to chair meetings, coordinate activities, and represent the interests of its members at the state and national levels.

Other groups exist that either complement AA or provide an alternative. Overcomers Outreach (OO), is a program for evangelical Christians that applies biblical teachings to the 12 steps. OO emphasizes abstinence and the disease concept, and is open to persons with any kind of addiction, as well as others who consider themselves "co-dependent." The Calix Society, a program for Catholics who are recovering from alcoholism, was founded in 1947 and is present at least in the United States, Canada, Scotland and England. Both of these programs focus on spirituality and religious study in the context of recovery from alcoholism through AA.

Several other mutual-support groups have developed from a different view of alcoholism, one that emphasizes rationality and personal responsibility rather than spirituality. They are intended to be alternatives to AA and the other more spiritual or faith-based recovery programs.

Women for Sobriety (WFS) was founded in 1967 by Jean Kirkpatrick (1978) as a mutual-support program designed specifically to meet the needs of women in recovery. The program is based on the belief that many of the underlying principles of AA such as powerlessness and surrender are counter-therapeutic to the needs of women. WFS believes that many woman develop drinking problems as a way of coping with negative emotional states. While emphasizing abstinence as a necessary goal, WFS emphasizes personal control, and a positive self-identity as the appropriate mechanisms of recovery. WFS asserts that once a woman can cope without drinking, she is no longer in need of support services. WFS meetings are led by a moderator (often a mental health professional and/or a former WFS member), and in that regard are not strictly mutual-support groups.

Secular Organizations for Sobriety - Save Our Selves (SOS) began in 1985 as a self-help program promoting a scientific (as opposed to the spiritual or religious) method of achieving sobriety. SOS promotes the importance of supportive others in achieving and maintaining sobriety, and promotes abstinence as the only rational approach to living. SOS meetings are peer-led, and are structured around a set of suggested guidelines for sobriety.

Rational Recovery (RR) was founded by Jack Trimpey in 1986 and is based on the principles of rational-emotive-therapy (Ellis & Velten, 1992). RR proposes 13 rational ideas as an alternative to the 12 steps of AA (Trimpey, 1989). RR emphasizes abstinence as the safest route to overcoming an alcohol or drug problem, but also stresses personal decision-making. RR groups are peer-led, but all groups have a professional therapist who functions as an advisor.

The newest American addition to mutual-support programs is Moderation Management (MM), founded by Audrey Kishline (1994). It was designed for people who are "problem drinkers" rather than

chronically alcohol-dependent people, and MM specifically departs from a disease model of alcoholism. Its purpose is "to provide a supportive environment in which people who have made the healthy decision to reduce their drinking can come together to help each other change." Meetings are free of charge, and are peer-led by volunteers. Specific guidelines and limits are prescribed, drawn from research on behavioral self-control training. It is the only U.S. mutual-support group that focuses specifically on a goal of moderate and problem-free drinking. (MM's goal conflicts with the abstinence emphasis within COMBINE, which is restricted to alcohol-dependent clients. Nevertheless, it is important to be knowledgeable about MM as a mutual-help program.)

Other groups that fit the general definition of a mutual-support group may exist in certain communities. Many urban churches have special outreach ministries established to help in recovery from substance use disorders. These are generally peer-led, often by a church member who is in recovery. In addition, communities with large ethnic populations often establish organizations to promote cultural identification and affiliation within the community. These organizations may sponsor groups organized to offer positive role-models and social or recreational outlets for constituents. These natural support systems represent indigenous resources that can be used to support clients who are in need of enhanced social resources and supports. Delgado (1996) suggests that these groups can provide a culturally acceptable alternative to the more conventional mutual-support groups described in this section. These resources "can be used to address expressive, informational, and instrumental needs within individuals, families and communities... and present opportunities for members of a community to take on help-giving roles" (page 5). In other words, faith groups and community-based organizations may provide effective alternatives as mutual-support experiences and should be incorporated into the menu of mutual-support options suggested to augment CBI treatment.

Basic Aspects of Mutual-Help Groups

GROUP	LEADERS	INTENDED FOR	APPROACH	ABSTINENCE EMPHASIS
Alcoholics Anonymous	**Peers**	**Anyone with a sincere desire to stop drinking**	**Spiritual, 12-step Disease model**	**High**
Calix Society	**Professional Affiliate**	**Catholics in recovery**	**Catholic faith and 12 steps**	**Low**
Moderation Management	**Professional Moderator**	**People who want to reduce their drinking**	**Behavioral self-control**	**Low**
Overcomers Outreach	**Peers**	**Christians seeking to overcome an addiction**	**Christian faith and 12 steps**	**Moderate**
Rational Recovery	**Internet**	**Anyone with an alcohol or other drug problem**	**Rational-emotive therapy**	**High**
Secular Organization for Sobriety	**Peers**	**Anyone sincerely seeking sobriety**	**Secular and scientific approach to recovery**	**Moderate**
SMART Recovery	**Trained Coordinator**	**Anyone wanting to change addictive behavior**	**Rational-emotive behavior therapy**	**High**
Women for Sobriety	**Professional Moderator**	**Women who desire to stop drinking**	**Empowerment, cognitive therapy**	**Low**

adapted from McCrady & Delaney (1995)

5.7d. Matching Considerations in Mutual-Support Referrals

The recommended method for utilizing mutual-support groups is to integrate them into your treatment approach (Ouimette, Moos, & Finney, 1998). A number of researchers have indicated that a referral to AA or another support program should be routinely offered to clients with an abstinence goal (Edwards, 1980; McCrady & Delaney, 1995). Glaser (1993) specifically recommended that *all* clients should be encouraged to *try* mutual-support groups, and also that *no one* should be required to do so. This is the approach taken in CBI: to encourage (but not require) all clients to sample mutual-support options as potential aids to recovery.

There are many possible considerations in matching clients with optimal mutual-help programs. Here are several:

Availability. One obvious limitation is the range of mutual-support programs available in the community. AA is most likely to be accessible. In some areas it will be the only mutual-support resource. A broader range of alternatives is often available in more populous areas.

Program Philosophy. There are substantial differences in the philosophy, structure, orientation and leadership of the various mutual-support groups. Even within large organizations like AA, there can be wide variety in the group environment of meetings (Tonigan, Ashcroft, & Miller, 1995). If you know both your client and the available programs and groups, you may be able to provide helpful guidance in the selection of initial meetings to try.

Spirituality. A major distinction between 12-step and the more secular organizations (RR, SOS, WFS) is the emphasis placed on spirituality - a central and consistent component of AA. It is not the case that clients need to be "religious" in order to be comfortable in or respond to AA. Nevertheless, the God language, open prayer, and spiritual steps of AA meetings may be alien or offensive to some clients.

Similarity. An important determinant of social affiliation is perceived similarity. Consider who the client is likely to encounter at various programs and groups. If the client might be the only woman, Hispanic, or person under 30, it is not likely to be a comfortable social network.

5.7e. Social Support for Sobriety

A recent clinical trial investigating client-treatment matching showed that AA (and by extension, other mutual-support group) involvement may be less important for individuals who already have a high level of social support for abstinence (Project MATCH Research Group, 1998a). This does not mean that AA or other group attendance will be unhelpful. Indeed, mutual-support group members will reinforce the client's decision to abstain, and may provide useful role-models for long-term drug-free coping. For individuals with good social support for abstinence, encourage mutual-support group attendance as you would other possible strategies for maintaining behavior changes (Snow, Prochaska, & Rossi,1994).

Clients with networks supportive of continued drinking, however, do substantially better in treatment that specifically and concretely attempts to facilitate their affiliation with AA (Longabaugh, Wirtz, Zweben, & Stout, 1998). The MATCH study cited above revealed that attending AA groups during the first year following treatment served to immunize the individual, increasing the resiliency of abstinence (Project MATCH Research Group, 1998a). This finding is very consistent with the folk

advice in AA suggesting that sobriety is promoted by "going to meetings, reading the 'Big Book' and talking to your sponsor."

5.7f. Initiating Mutual-Support Group Involvement

Provide a Rationale. Begin by providing a clear rationale for mutual-support group involvement. As always, start by asking your client for reasons why having additional support could be helpful (self-motivational statements). It may be useful to provide information from research or from personal experience about mutual-support group participation, emphasizing its value in maintaining long-term, stable abstinence. The purpose here is to provide a rationale for participation that is both factual and congruent with the client's beliefs or circumstances.

Explore Attitudes about Mutual-Support. Next ask about your client's prior experience with mutual-support groups. Most clients will have had some exposure, which may have been positive or negative. What did the client like or appreciate about the groups he or she attended? What did he or she dislike, or what were the barriers to participating? For clients with no prior mutual-support experience, ask what they could imagine would be helpful about participating in such groups. Consistent with the motivational style of CBI, be careful not to get into a disagreement with your client in which you argue for mutual-support participation and the client argues against it.

Give Information about Available Groups. Offer information that is pertinent to this particular client, in language she or he will appreciate. Draw on your knowledge of the available groups. Regarding AA, for example, you might say to a male client who is unfamiliar with 12-step programs:

> *AA was started in 1935 by an New York stockbroker and an Ohio surgeon who had been "hopeless" alcoholics. They had both tried and failed at many attempts to quit on their own, and finally discovered that what helped them was to help other alcoholics who were still drinking. For these men, forming a group with other alcoholics, for mutual encouragement and support was the key to their staying free from alcohol. Millions of others have tried this approach.*

Besides general information, also give practical information about exactly what a client is likely to experience in attending a meeting.

> *AA meetings tend to follow a routine. When you go to this particular meeting, you will probably find that it starts with a time of silence followed by the serenity prayer. Then the secretary (that's the voluntary leader of the group) will have someone read a description of AA from 'How it Works' in the Big Book of AA. Then they'll ask if there are any newcomers or visitors to the group. If you are willing, you introduce yourself by your first name only, so that the rest of the group can welcome you. It's okay to pass, though. You don't have to say anything at all if you don't want to. You will probably feel more a part of the meeting, though, if you say something about why you are there, and what has been happening. This meeting then discusses one of the twelve steps. It's over in an hour, and at the end everyone holds hands and recites the Lord's prayer. How does that sound to you?"*

A good way to know these specifics is to sample meetings yourself. If you are not a person in recovery, most programs nevertheless allow visitors to attend, or may have specific "open" meetings (as in AA). Give a fair and accurate description of the various groups available in your area.

Encourage Sampling. Particularly for newcomers, it is useful to encourage your client to "try it out" or "shop around" without making an initial commitment. Emphasize that groups vary widely, and

each person should find the group(s) most comfortable and appropriate for his or her own situation. Give your specific endorsement to participating,

> *I would really like you to give serious thought to trying out AA or another kind of group, in addition to the work we are doing together here. Treatment and mutual support* ***together*** *seem to lead to the best outcomes. Which of these groups that I've described do you think might be the best place for you to start - the one you might check out first?*

Provide Referral Information. Once you have arrived at a specific plan for sampling groups, give your client the needed contact information. This will usually include some introductory literature and a list of local meeting times and places. Written material is available for most groups. Use officially approved literature when you are referring clients to 12-step meetings. Give local or toll-free numbers through which your client can contact the group of interest.

Make a Specific Plan. Finally, arrive at a specific plan. Which meeting will the client attend? When and where? How will the client get there? Trouble-shoot any obstacles to attendance that may be encountered. For many clients, it is not enough just to give the information. Consider specific steps to help your client get to meetings. For example, pre-arrange with a group member to receive a call from you (from the session, with your client's permission), and give the phone to your client so that the member can offer to meet the client at the group, perhaps provide transportation, etc. Practical steps like these can make a big difference in whether clients actually get to meetings (Sisson & Mallams, 1981).

5.7g. Emphasizing Action

Contrary to some aphorisms, it is not simply attending mutual-support groups that results in positive change. A number of studies investigating the level of participation have found that it is active involvement and personal investment that predict abstinence. For instance, Sheeren (1988) reported that "reaching out to other members of AA for help and the use of a sponsor" were the most important activities predicting whether an AA member would relapse or not. Similarly, Montgomery, Miller, and Tonigan (1995) reported that the extent of involvement or active participation in AA processes (i.e. working the steps, using a sponsor, etc.), rather than mere attendance at meetings, was associated with more favorable outcomes on both consumption and meaning-in-life measures.

The implication of these findings is straightforward. Clients benefit more if they become more actively involved in the program. Thus, as your client finds a group that is acceptable, continue to ask about and encourage active involvement.

> *So you heard some people at meetings who have several years on a program. What is it, do you think, that keeps them coming back? . . .*
>
> *In general, the research on mutual-support groups shows that people who invest more, get more out the group. It's not just going to more meetings, but also things like showing up early, sticking around afterward to talk to people, exchanging phone numbers, reading the materials.*
> *Some people volunteer to make the coffee, clean up after the group, or offer some other kind of help. Different things appeal to different people. What have you thought about, as ways you might get a little more involved?*

As with other home task assignments, always ask about your client's ongoing experience with AA or other support groups, once you have negotiated participation. Explore potential obstacles, particularly clients' beliefs and attitudes that impact whether or not they are likely to follow through

(Meichenbaum & Turk, 1987). Remember to provide information and advice within the larger clinical style of motivational interviewing.

5.7h. Handling Negativity about Mutual-Support Group Attendance

Clients may express directly (e.g., complaints), or indirectly (e.g., non-attendance) their dissatisfaction with or disinterest in mutual-support groups. Explore the roots of negativity in a supportive, nonjudgmental manner. Value the client's own perceptions and experience, offering accurate reflection. Add your own encouragement, but never insist that a client attends. If the client is not ready to consider attending now, put the topic on hold and come back to it later in treatment when he or she may be more receptive.

> *I understand you felt self-conscious at the meeting, and also you're wondering whether you really need this kind of support. It really is up to you, of course. I just encourage you not to close the door. There are many different meetings, and getting involved really does help many people to establish and maintain their sobriety. Let's just leave it at that for now, but would it be okay if we talked about it again in a few weeks?*

5.8. SARC: Social and Recreational Counseling

Often when clients present for treatment, they have few outside interests and activities. As alcohol dependence develops, drinking occupies more and more of the person's time, and drinking companions displace prior associates. Conversely, an important part of the process of recovery is rebuilding a life without drinking. This may include finding a nondrinking peer group, sampling and pursuing positive social-recreational activities that do not involve drinking, and establishing or re-establishing stable employment (see 5.5).

The central goal in this module is to help your client connect with reliable sources of positive reinforcement that do not involve or depend on drinking. The SARC module is one that is easily done in combination with another module. You may not need to devote the entire session to SARC procedures, but rather can work on two modules during the same sessions.

5.8a. Explaining the Rationale

Start by discussing with your client the importance of healthy, supportive relationships and rewarding recreational activities. As much as possible, elicit from the client reasons why it is important to have rewarding activities and companions not associated with drinking. Avoid lecturing clients about matters of which they are likely at least somewhat aware. You might say, "Drinking has occupied a lot of your time and energy in the past, and it sounds like many of your regular contacts were drinking companions. One of the important challenges is to develop new interests, friends, and rewarding ways to spend your time that don't involve alcohol. What might be the advantages, do you think, of having fun, finding some new interests, or being with friendly people without drinking?" As self-motivational statements emerge, reinforce them with reflection.

Here are a few of the points that often arise in discussions of this kind. If your client does not come up with advantages, offer a series of these and ask which of them seem like the best reasons. Present the basic ideas in language appropriate for your client, not necessarily as phrased below.

> Drinking friends, even if they don't pressure you, can be powerful triggers for drinking, especially early in sobriety.
>
> Empty time (including time spent in relatively mindless activities) is not rewarding, tends to promote low moods, and does not support self-esteem.
>
> If you're sober but not enjoying it, you're not likely to stay that way.
>
> Positive reinforcement is like vitamins. It helps to be sure you have some every day.

Finish up with a summary reflection that draws together the important reasons for developing alcohol-free sources of positive reinforcement.

5.8b. Assessing Sources of Reinforcement

Have your client describe people, places and activities that were often associated with drinking. This will give you a sense of how drinking was linked to particular peers, places, or events. Similarly,

ask your client to describe recreational events, people, and places that they have enjoyed in the past that are not associated with drinking. Compare the two lists, discussing how they are different in order to clarify patterns that support drinking versus sobriety.

Sometimes it has been so long since the client had a sober lifestyle (if they ever did as an adult) that he or she cannot list alcohol-free activities, people, or places that have been enjoyable. Here it can be helpful to have a menu of options to examine. This menu should be tailored for your specific area, but a generic head start is found in Form jj. Local newspapers sometimes carry, once a week, lists of clubs, free activities, support groups, volunteer opportunities, and/or entertainment options. Have clients review the menu and identify things that they *might* enjoy, or really don't know whether they would enjoy. Another good option is asking your client to think of activities, hobbies, and interests of friends or acquaintances who do not drink (or at least of activities that do not involve drinking).

Reference: Form jj

If possible, move smoothly from discussion of enjoyable non-drinking activities to a specific plan for increasing or at least trying them. This is easier when your client already knows of activities, people, and places that are fun and don't involve or emphasize drinking.

Example:

> THERAPIST: One life area that has been shown to have an effect on treatment success is social and recreational activities. When people have strong social supports for staying sober, they are more likely to succeed. Social support for not drinking can come in a variety of ways including nondrinking friends or family, clubs or associations that don't emphasize drinking, and activities that are fun to do but don't involve drinking.
>
> CLIENT: I can see how that might help. I never drink with my boyfriend because he's been so encouraging throughout treatment and feels it has helped our relationship a lot.
>
> THERAPIST: That is exactly what I'm talking about. Gabe wants to see you succeed in treatment and you've told me that he's helped by planning weekend hiking trips for the two of you because you never drink when you go hiking. Can you think of other fun activities, places or friends that aren't associated with drinking? How does Gabe spend his time?
>
> CLIENT: He's pretty involved in his church. I never drink when I go to church with him. I don't drink when I'm with Gabe anywhere, or when I'm around my family. My family has been worried about my drinking too.
>
> THERAPIST: Good! What else?
>
> CLIENT: I do love to work out, and of course I don't drink when I'm exercising. In fact, when I'm finished exercising, I don't feel like drinking either.
> THERAPIST: So the exercising has a triple benefit. It's a good way to be healthy and feel good, you don't drink while you're doing it, and you don't feel like drinking after you've been exercising. What else?
>
> CLIENT: I enjoy swimming. I don't drink underwater - at least I've never tried it
>
> THERAPIST: O.K., that's a good list to start! Now, for the other side of the picture, I'd like you to tell me about people, places or activities that have been associated with drinking for you in the past.

CLIENT: My best friend Jenny and I always drink together because we usually go out dancing or to bars. The people from work seem to go out to happy hour a lot after work and it's hard for me to resist the drink specials. In fact, I don't think I ever do anything outside of work with my co-workers that doesn't involve drinking. We have a softball league that I'm involved in and everyone drinks beer during and after the game.

THERAPIST: Okay. It sounds like bars and the softball league from work may be smart things to stay away from. Also, you mentioned that you tend to drink with Jenny and your co-workers. On the other hand, you have a lot of activities that you enjoy when you're not drinking. Hiking, working out, swimming, going to church, and being with Gabe and your family are all positive social supports for not drinking.

CLIENT: Yeah, it does seem like certain activities make me drink. I really like the softball league though, and wish I could continue with that.

THERAPIST: I wonder if there is a softball league you could join that doesn't emphasize drinking? That may be a good way for you to continue doing something you enjoy, but with peers who aren't drinking.

CLIENT: I think maybe Gabe's church belongs to a softball league! I'll check into it this week. Maybe Gabe would even join with me.

THERAPIST: Perfect!!! I'm writing down that you will get the information about your church's softball league and ask Gabe to join with you as an assignment for this week! Is that Okay? You really have the hang of this!!

Help your client to identify nondrinking activities that will (or may) be enjoyable. It's also a good idea to find activities that occur during times when the client previously was most likely to be drinking. Have your client pick five to ten activities that sound the most pleasant or exciting to them.

5.8c. Developing a Nondrinking Support System

Another purpose here is to create and maintain friendships with those who will support the client in their sobriety. If possible, start with an activity that involves someone who is already supportive of the client's abstinence. It is useful for the client to discuss with friends and family how they might be helpful in supporting sobriety.

A more general point is to focus on pleasant activities that will bring the client into contact with nondrinking people. Do things that are fun, and do them around people who are not drinking. Discuss local activities such as concerts, outdoor events, sport organizations, and social clubs. This means that you need to be familiar with local activities, groups and events that are accessible to the client. These activities should be alcohol-free or ones that place little emphasis on alcohol use so that your client has the opportunity to cultivate new relationships with nondrinkers. Make *informed* recommendations so that it does not end in a bad experience for your client.

Other suggestions for building social support for sobriety can be found in the adjacent sections (5.7 and 5.9) of this manual.

5.8d. Reinforcer Sampling

After identifying a menu of options, have your client pick one activity that supports sobriety and try it out before your next session. Ask which of the options that you have discussed sound interesting to try out, whether there are other activities that caught their eye on television or in the newspaper, etc..

Reinforcer sampling is the process by which clients try out or experiment with new social activities. The idea here is that trying a variety of new activities will likely result in finding at least one that is rewarding. Sometimes clients are reluctant to sample new activities sober. Explain that trying an activity once does not mean they have to commit to it for the rest of their life, but that they will be "sampling" activities to find one or more that they enjoy and can support them in staying sober. Find a suitable analogy, like tasting different kinds of ice cream. Take some time to discuss any apprehension or fears about trying something new. Problem-solve factors that might interfere with the client trying or enjoying a designated activity. This may mean reviewing communication skills training for interacting with strangers, asking a nondrinking friend to go along, or generating a plan for transportation. The point is to *try* activities that could be enjoyable, particularly activities that bring the client into contact with other people outside of drinking contexts. Assign between-session tasks that involve sampling at least one new activity. The more specific the plan, the more likely it is to be carried out. "I'll go to the softball practice on Saturday afternoon" is better than "I'll look for something fun to do."

5.8e. Systematic Encouragement

It's a common problem. Many clients have good intentions of sampling a new activity, yet do not follow through, perhaps because they don't have the skills, are embarrassed, or are not well prepared to begin something new. Systematic Encouragement is a three-step process for motivating your client to plan and complete the process of reinforcer sampling.

First, once your client has agreed on an activity, don't assume they will make the first contact. Instead, practice how they will go about contacting the organization and what they will say on the phone. Role-play the phone interaction and if possible, have the client make the phone call during the session. This will allow you to encourage your client in the things they do well, while gaining valuable behavioral information about how the client interacts with others.

Second, whenever possible, call a contact person from your resource list to meet the client at the door or introduce themselves to the client. Knowing that someone will be there to meet them can set a client more at ease socially, and increase the likelihood of following through. If possible, arrange for a contact person to provide transportation to and from the activity.

Finally, review with your client the reinforcement value of the activity. Was the activity something they enjoyed and would like to do again? Problem-solve any barriers to re-attending such as transportation to the activity or childcare. If the client did not attend, problem solve to create a plan that will assist them in attending the following week.

Example:

> THERAPIST: Alley, you talked last time about the church's softball league as a new activity you could try. That sounds like a good idea to me, too. How about if we give the church a call now to see what we can find out.
>
> CLIENT: I don't have their phone number with me.

THERAPIST: We have a phone book right here in the drawer. We can look up the number and call together.

CLIENT: The name is First Baptist Church.

THERAPIST: Here's the number. Ready to call?

CLIENT: From the office? I wouldn't know what to say.

THERAPIST: Well, how about starting by asking if the church still has a softball league and the name and number of the person to call if you're interested in signing up?

CLIENT: Okay. I think I can do that.

THERAPIST: All right then, how about if we practice it once before making the actual call. I'll start you out. Hi, my name is Alley and I'm interested . . . .

CLIENT: I'm interested to know if there is still a softball league and how I could sign up for it.

THERAPIST: Great!! Sounds like you're ready!

Client (dials the number): Hello? My name is Alley. I want to know if there is still a softball team at the church. . . . . A-L-L-E-Y. . . . Saturday afternoons? . . . . Well, I don't know. . . . . Phillips? . . . . Okay, thank you.

THERAPIST: Wonderful! They meet on Saturdays? Is that a good time for you?

CLIENT: Yeah. I've gone to that aerobics class a few times, but I'd be getting exercise at softball. I'll ask Gabe to go with me to sign up. He likes to play softball and told me that he enjoys spending time with me when I'm not drinking. The lady on the phone said they were looking for men and women to play.

THERAPIST: That's great! I'll look forward to hearing how the first practice went at our next session!

Help your client to keep sampling new nondrinking activities until he or she finds several that are enjoyable and are likely to "stick." Assigning the sampling of a new activity each week can continue while you work on other modules.

5.9 Social Support for Sobriety

5.9a. Rationale

This module helps clients to get important people in their life to support their recovery, provides a letter to give to those people, and is consistent with the option of inviting a family member or friend to the session (see Phase 1 procedures for involving an SSO in treatment). Clients are surrounded by people who can impact their recovery for better or worse. Those people may be family members, friends, treaters, and self-help group members. For example, clients may say…

"My cousin keeps offering me marijuana and won't stop."

"My AA sponsor told me that I shouldn't be on any psychiatric medications, that those are just as bad as drugs like heroin or cocaine."

"My counselor told me that I need to drink so that I can get into a detox because my PCP use is out of control but they won't let me in for that."

"I get into abusive fighting with my parents. Before I know it, I'm yelling."

This module teaches clients to assess whether people in their lives are supportive or unhelpful to their sobriety. Clients are encouraged to educate others about how to be most helpful during the difficult process of change. A letter is provided to give to people in their life to promote this process of education.

5.9b. Three Types of Social Support Problems

It may be helpful here to differentiate three different groups of clients with problematic social support: those who have no support in general, those with low support for abstinence, and those with high support for continued drinking. These may seem like fine distinctions, but each connotes a slightly different need in regard to the emphasis of social support enhancement.

Clients with few or no general support resources are likely to be depressed, isolated, and perhaps undersocialized. These clients may experience difficulties attending mutual-help meetings because the level of interaction may be too stressful, and therefore aversive. Despite their reservations, this group needs social support enhancement, and mutual-support groups are one source of easily accessible help (see module 5.7). Connecting clients who are isolated and depressed can be facilitated through case-management activities such as arranging a 12-step contact, or connecting the client with groups and activities that will bring them into contact with others (see module 5.8). Once such social connections are made, monitor the client's attendance for second thoughts, adverse events and other problems that may interrupt the client's ongoing social involvement.

The second group, clients with low support for abstinence, are less likely to be anxious and depressed, but also need social support enhancement. These individuals are likely to have close relationships that are relatively undamaged by drinking, and therefore members of the social network may be unaware of or indifferent to the client's treatment status. It isn't that the client lacks support, but the

available support is non-contingently accepting of the client. In other words, it won't make any difference (in terms of social consequences) if the client drinks or not. Explore the client's network to identify individuals who might be educated about the client's circumstances and thereby *converted* into a resource supporting abstinence. With some encouragement and planning, your client may decide the best way in which to approach these individuals to ask for their support for abstinence. This is a similar strategy that someone might use to garner support for beginning an exercise program, or saving money. *"I'm trying to cut down on my expenses, so I am not going out for lunch for a while. If you want to get together, we can pack a lunch and meet at the park for a walk."* Consider inviting the person to participate as an SSO in one or more treatment sessions. A joint session provides you an opportunity to educate the person about alcohol disorders, and explore his/her attitudes and feelings toward the client in general (and his/her drinking in particular). This gives you an indication of the level of support the client can expect, and allows you to proceed with additional joint sessions if appropriate. The person may also be a problem drinker, so be prepared to provide screening, advice and referral if the need arises. Mutual-support groups (see module 5.7) can be used to augment the social network, providing drug-free friends and an orientation toward long-term sobriety and recovery. This is likely to increase the resiliency of the client's decision to abstain, particularly in light of environmental triggers or developmental pressures that come to bear after treatment has ended.

The final group, individuals with high network support for drinking, is in the most need for an intervention designed to enhance their social supports. These individuals are likely to have drinking peers, and perhaps a drinking spouse/partner who represents an active threat to the client's commitment to abstinence during or after treatment. Addressing this set of problems will require tact, skill and patience, in that these drinkers are likely to experience the greatest loss on a personal and social level when they stop drinking. Be prepared to blend the concept of social support into other change activities that are part of other CBI Phase 3 modules. Long-term sobriety usually requires the balanced use of multiple coping strategies. Clients who rely on one or two change strategies have lower rates of successful change (Prochaska & DiClemente, 1986). Encourage your client to sample mutual support groups (even within a single program like AA), looking for a good fit, because involvement in such groups is particularly helpful to people with high network support for drinking. This can be accomplished by attending one group several times, or a number of groups one time. Discuss these experiences during therapy sessions, as you would any other home task assignment (see module 5.7).

5.9c. Educating Significant Others

A principal goal here is to help your client articulate what he or she needs from others in the way of social support for sobriety. A good start is the handout, "A Letter to People in Your Life" (Form kk). It may be helpful to ask discussion questions to help the client process the material. For example:

Is there anything you'd like to add or delete from the letter?
Would it be helpful to give it to someone in your life? If so, who?
What do you most want people in your life to understand about your recovery?
What help can people in your life give to you? Can you ask for this help?

Also, you may want to keep in mind the following points as you work with the client:

The *Letter* is designed for clients to hand to important people in their life who want to help the client recover (e.g., friends, spouse or significant other, AA sponsor, etc.).

It is up to the client to decide whether and whom to give the *Letter* to. The only exception: *If the client is being domestically abused, do not give the letter to the abuser; it is risky to intervene in any way with an abuser, even with something as simple as this letter.*

5.9d. Rehearsing How to Ask for Support

Encourage the client to rehearse aloud what support he or she would want from others. This can be useful even if in real life there are reasons it can't be expressed (e.g., the client is too afraid to say it). Among the many ways a client might directly ask a significant other for support are:

Please don't ever offer me drugs or alcohol
Please do not give me feedback on your opinions about me or my drinking
Please do not ask me to take on new demands right now
Please do not criticize me right now: At this point, only supportive statements are helpful to me
Please accept that sometimes I need to cry and get upset
Please do not use drugs or alcohol when you are around me
I need you to just respect where I am right now in the process of change
Please do not ask me about my drinking
Please do not get "on my case" about going to AA—I'll go if I want to [or: Please remind me to go to AA—I find that helpful]
This is a difficult time-- you can be helpful by:…picking up the kids from school…coming with me to my appointment….checking in by phone…
You can help me by going to Al-Anon so that you get more support for yourself.

If the client has only people who support continued drinking, or is totally isolated with no family or friends, focus the client on seeking more help from other sources. Trying to help the client to start new relationships with healthier people is an important goal but this can take awhile. Look for more immediate sources of support from mutual-help groups, professionals or agencies, churches or other supportive communities (see modules 5.7 and 5.8).

Reference: Form kk

Phase 4

Maintenance Check-Ups

6.0. Phase 4: Maintenance Check-ups

Phase 4 is the maintenance phase of treatment. It consists of periodic check-up sessions that extend from the end of Phase 3 until the 16 week treatment period ends.

6.1. Initiating Phase 4

Phase 3 can end in one of three ways:

1. You and your client reach a mutual agreement that regular treatment sessions will end (normal termination). This could occur for any of a variety of reasons including (a) you agree that the goals of treatment have been achieved; (b) there are no further Phase 3 modules that address your client's needs; (c) you and your client agree for other practical reasons to stop having regular treatment sessions. In this case, initiate Phase 4 of treatment by scheduling a session 2-4 weeks after the final Phase 3 session.

2. Your client unilaterally decides to terminate treatment. This could occur in any of several ways including (a) your client announces that he/she is terminating; (b) your client refuses to schedule another session; (c) your client stops attending sessions, missing three or more sessions in a row, without formally announcing that she/he is terminating. In this case, contact your client by telephone or letter, suggest that you meet less frequently, and schedule the next (Phase 4) session at the earliest agreeable date. When clients have missed three consecutive sessions, they are designated as "inactive" regardless of the reasons for missing the session. If this happens, you will complete an Inactive Status Form (available from the Project Coordinator) in addition to initiating the notes and phone calls mentioned above. If the client resumes CBI sessions, you will complete an Active Status Form (also available from the PC).

3. You end the sixteenth week after the first session. No further CBI treatment sessions may be delivered after this date. If Phase 3 treatment has extended to within 2 week deadline, do not initiate Phase 4. Simply terminate treatment (see section 7.0) when Phase 3 is finished, or you reach the end of the sixteenth week, whichever comes first.

6.2. Presenting the Rationale for Phase 4.

At the conclusion of Phase 3 (for reasons 1 or 2 above), explain that the normal procedure now is to meet every few weeks for a check-up, until you reach the 16 week anniversary date. Even for people who are doing very well, it can be useful to check in periodically through the first the 16 weeks. Ask whether your client is willing to come back periodically for the next ___ weeks (until the 16 week anniversary date), and schedule the first check-up session. If your client declines, explain that you will be able to see him or her for further sessions up until the 16 week anniversary date, after which treatment is over. Invite your client to call you back if it seems that a session might be useful.

Do not use "relapse" language. The rationale for Phase 4 sessions is *not* to "keep from relapsing." Rather present these sessions as a free option that can be useful in maintaining health, like routine health check-ups with a doctor or dentist.

6.3. The Basic Structure of Check-up Sessions

Think of Phase 4 as "booster" sessions to reinforce the motivational processes and cognitive-behavioral skills developed in Phases 1-3. As before, the significant other should be involved in these sessions. There are three essential components of a check-up session:

1. Review progress
2. Renew motivation
3. Redo commitment

Because several weeks normally pass between Phase 4 sessions, routinely send your client a handwritten note, or telephone your client a day or two before the scheduled appointment. This serves as a reminder, and also expresses your continued active interest.

Review Progress. Begin each session with a discussion of what has transpired since the last visit, and a reflection on what your client has accomplished thus far. Emphasize the positive; reinforce all forms of progress. If drinking has occurred, review what happened in a nonjudgmental way, with a goal of gaining an accurate understanding.

Renew Motivation. Your primary therapeutic style in Phase 4, as throughout treatment, should be the motivational approach described in Phase 1. Be careful not to assume in Phase 4 that ambivalence has been resolved, and that commitment to sobriety is now solid. It is safer to assume that your client is still at least somewhat ambivalent, and to continue using the motivational approach. Elicit self-motivational statements. What are your client's goals now? Why are these goals important? What aspects of "how it was" does your client particularly want to avoid?

Complete each check-up session with a summary reflection of where your client is at present, eliciting the client's perceptions of what steps should be taken next. The prior plan for change can be reviewed, revised, and (if appropriate) rewritten. There should be a clear sense of continuity of care. Think of (and present) these sessions as progressive consultations, and as continuous with the subsequent (research) follow-up sessions. Phase 1 builds motivation and strengthens commitment, Phase 2 develops a specific change plan, Phase 3 develops cognitive-behavioral skills for sobriety, and subsequent sessions (including Phase 4 and the research follow-ups) serve as periodic check-ups of progress in continuing and maintaining change.

It can be helpful during Phase 4 sessions to discuss specific situations that have occurred since the last session. Two kinds of situations can be explored: (1) Situations in which the client drank, and (2) Situations in which the client didn't drink.

Drinking Situations. If the client drank since the last session, discuss how it occurred. Remember to remain empathic, avoiding any judgmental tone or stance. Renew motivation, eliciting from the client further self-motivational statements by asking for the client's thoughts, feelings, reactions, and realizations. Key questions can be used to renew commitment (e.g., "So what does this mean for the future?" "I wonder what you will need to do differently next time?"). It is also appropriate to review coping skills discussed during Phase 3. Remember that motivational problems can be a lack of *confidence* as well as a lack of perceived *importance* or readiness. You and your client can decide to resume more regular sessions as new problems and challenges arise, up until the 16 week anniversary date when CBI ends.

Nondrinking Situations. Clients may also find it helpful and rewarding to review situations in which they might have consumed alcohol previously, or in which they were tempted to drink, but did not do so. Reinforce self-efficacy by asking the client to clarify what he/she did to cope successfully in these situations. Encourage the client for all small steps, little successes, even minor progress.

Resuming Phase 3. As indicated above, it is permissible to resume Phase 3 intervention through regular (weekly) sessions if you and your client agree that it could be useful. Avoid communicating to your client, of course, that "*you won't make it without my additional help*." Rather, offer additional sessions or modules and discuss whether the client might find these helpful. Weekly sessions can continue throughout the 16 week treatment period if needed.

7.0 Termination

The last session of CBI should be a formal termination session. In most cases, termination will be the primary focus of this session, although it is acceptable to combine this with finishing up or reviewing a prior module.

7.1. Preparing Your Client

Never surprise your client that "*this is our last session*." From the beginning it should be clear that treatment ends within the 16 weeks and it is wise to remind clients from time to time of the approximate ending date toward which you are working. Three sessions before the last (termination) session, let your client know that "*We have three more sessions together after this one, so I want to be sure we have time to talk about anything we may have missed along the way*." Renew this reminder at the next-to-last session, that "*Next time will be our last session together, and your follow-ups will begin after that*."

7.2. Preparing Yourself

Discuss termination with your supervisor while you still have at least three sessions left. Go back over all your case notes, paying particular attention to positive changes and progress that your client has made during this time. Consider also whether the client may need to seek additional treatment or services. Confirm the date when the client will be due for the next follow-up interview by COMBINE assessment staff.

7.3. Timing

Normally the termination session will occur within the last two weeks of the 16 week treatment period. If you have been in Phase 4 and meeting less frequently, be sure to schedule in advance the termination session for the appropriate time period. No treatment sessions may be held after the 16 week anniversary.

If you are still in Phase 3 during the 16 weeks of treatment, schedule the termination session for the appropriate week and let your client know that it will be your last session together.

In some cases, a client will insist on terminating treatment earlier, and will be unwilling or unable to return for a final session at the end of the 16 weeks. In this case, seek to persuade your client to return for one more wrap-up session at some scheduled time before the end of the 16 weeks, "just to review together what we have done, and what you want to do after we've finished."

In rare cases where a client refuses to return even for one more session, complete the termination session procedures (below) during the current (and last) session.

7.4. Essential Elements of the Termination Session

1. Express your appreciation for the client and the work you have done together. This should not be "canned," but genuine, and individualized to this client.

2. Ask your client what important changes he or she has made during treatment. Start by eliciting the client's own perceptions of positive changes. Use reflective listening to reinforce positive elements of what the client offers. Emphasize personal choice and autonomy.

3. Review the positive changes and progress that the client has made. Give your own perspective on changes the client has made. As appropriate, remind the client of where he or she started prior to treatment, and comment positively on steps taken toward change. Keep this positive and relatively free of qualifiers (such as, "Even though you . . ." or "except for . . ."). This is generally accomplished by a final recapitulation of the client's situation and progress through the sessions.

4. Attribute positive changes to the client. Explicitly give the client credit for positive changes that have been made. For example, "*I'm glad if I have been helpful, but really it is you who have done the work and made the changes. I certainly didn't do it. Nobody else could do it for you. I appreciate how much you've accomplished in this relatively short time*."

5. Explore termination feelings. Ask an open question such as, "*How are you feeling now that treatment is coming to an end*?" Reflect what the client offers. If negative feelings emerge, normalize them ("That's pretty common") and express understanding. If the client is terminating early, leave the door open to come back within the 16 week window ("*Sometimes after awhile people have second thoughts, or think it might be useful to check in. If that happens, it would be okay to call during the next _____ weeks*."). If applicable, encourage continued sessions with the MM practitioner.

6. Ask what's next. Ask your client to reflect on what is likely to happen in the months ahead. Are there additional changes that he or she would like to make? What new goals does he or she want to pursue? Elicit self-motivational statements for the maintenance of changes that have occurred, and for any additional changes the client would like to make.

7. *Support self-efficacy*. Emphasize the client's ability to choose and change. Express hope and optimism for the future, based on your knowledge of the client.

8. Consider additional treatment. If appropriate, discuss whether additional treatment might be helpful. If you have a specific concern, describe it and encourage the client to consider seeking further treatment. Provide specific referral information (see Case Management module).

9. Follow-up reminder. Remind the client that his or her COMBINE experience is not over. There are very important follow-up interviews ahead. "*We want you to complete these, because they help us know how you're doing after treatment. Whatever is happening in your life, we want to know how you are doing. It's very important for you to give us honest and accurate information, which will help us learn how to help others*." Emphasize that people often find these sessions personally helpful as well. Let the client know when the next follow-up interview will be (it can even be scheduled at this point), and remind the client that he/she will be paid for the time and inconvenience involved in helping us with the study.

10. Closing. Express again your genuine appreciation/admiration. Express optimism for the future, based on your knowledge of the client. Offer your best wishes, and say good-bye.

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Appendix A

Personal Feedback Report

PERSONAL FEEDBACK REPORT

1. Alcohol Use

YOUR DRINKING

Number of standard "drinks" per week: _____ **drinks**

Your drinking relative to American adults (same sex): _____ **percentile**

LEVEL OF INTOXICATION

Estimated blood alcohol concentration (BAC) level on the day you drank the largest amount of alcohol: _____ **mg%**

ALCOHOL TOLERANCE LEVEL

Low (0-60)	Medium (61-120)	High (121-180)	Very High (181+)

ALCOHOL DEPENDENCE LEVEL

0	1	2	3	4	5	6	7

2. Other Drug Use

Percentiles (US Adults)					
	Tobacco/ Nicotine	Marijuana/ Cannabis	Stimulants/ Amphetamines	Cocaine	Opiates

3. Consequences

Men								Women					
17-24	23-30	23-24	17-36	16-21	86-135	10		17-24	22-30	23-24	15-36	14-21	81-135
15-16	20-22	21-22	14-16	14-15	75-85	9		14-16	18-21	22	12-14	12-13	68-80
13-14	18-19	19-20	12-13	12-13	68-74	8		13	15-17	20-21	11	10-11	61-67
12	15-17	18	10-11	10-11	60-67	7	High	11-12	13-14	18-19	9-10	9	53-60
10-11	13-14	16-17	9	9	53-59	6		10	11-12	15-17	8	8	48-52
9	11-12	14-15	8	8	46-52	5	Medium	9	9-10	14	6-7	6-7	41-47
7-8	9-10	12-13	7	6-7	39-45	4		7-8	8	12-13	5	5	36-40
6	7-8	10-11	6	5	32-38	3	Low	6	6-7	10-11	4	3-4	29-35
4-5	5-6	7-9	4-5	3-4	24-31	2		4-5	3-5	7-9	3	2	22-28
0-3	0-4	0-6	0-3	0-2	0-23	1		0-3	0-2	0-6	0-2	1	0-21
Ph	**Re**	**Pe**	**Im**	**Sr**	**Tot**			**Ph**	**Re**	**Pe**	**Im**	**Sr**	**Tot**

Ph **Physical consequences**
Re **Relationship (interpersonal) consequences**
Pe **Intrapersonal (emotional, self-esteem, etc.) consequences**
Im **Impulsive actions**
Sr **Social responsibilities**
Tot **Total negative consequences**

4. Desired Effects of Drinking

12	12	12	12	12	12	12	12	12	**Always**
11	11	11	11	11	11	11	11	11	
10	10	10	10	10	10	10	10	10	
9	9	9	9	9	9	9	9	9	
8	8	8	8	8	8	8	8	8	**Frequently**
7	7	7	7	7	7	7	7	7	
6	6	6	6	6	6	6	6	6	
5	5	5	5	5	5	5	5	5	
4	4	4	4	4	4	4	4	4	**Sometimes**
3	3	3	3	3	3	3	3	3	
2	2	2	2	2	2	2	2	2	
1	1	1	1	1	1	1	1	1	
0	0	0	0	0	0	0	0	0	**Never**
Mental	**Positive Feelings**	**Relief**	**Social Effects**	**Drug**	**Assertion**	**Sexual**	**Negative Feelings**	**Self Concept**	

5. Preparation for Change in Drinking

Very Ready for Change	Support for Abstinence	High Confidence	Low Temptation
10	1	10	1
9	2	9	2
8	3	8	3
7	4	7	4
6	5	6	5
5	6	5	6
4	7	4	7
3	8	3	8
2	9	2	9
1	10	1	10
Not Ready For Change	**Support for Drinking**	**Low Confidence**	**High Temptation**

6. Mood States

Tension	Depression	Anger	Vigor	Fatigue	Confusion
16-20	14-20	13-20	18-20	16-20	13-20
13-15	12-13	11-12	16-17	13-15	11-12
10-12	9-11	9-10	14-15	10-12	9-10
6-9	6-8	6-8	11-13	7-9	7-8
5	4-5	4-5	8-10	5-6	5-6
4	3	3	7	4	4
3	2	2	5-6	3	3
2			3-4	2	2
1	1	1	1-2	1	1
0	0	0	0	0	0

7. Blood Tests

	Your Score		**Your Score**		**Your Score**		
M: 10-45 F: 10-36	**Normal Range**	M: 6-48 F: 6-37	**Normal Range**	M: 7-74 F: 5-49	**Normal Range**	M: 79-97 F: 79-98	
AST (SGOT)		**ALT (SGPT)**		**GGT (GGTP)**		**MCV**	

Appendix B

Instructions for Preparing the Personal Feedback Report

Prior to your second session with a CBI client, complete the Personal Feedback Report (PFR) by obtaining the pertinent data from the client's research file. We recommend that this be done by the CBI therapist, although at some sites it may be preferable to have the PFR prepared by a research assistant. Consult your Project Coordinator for proper procedures at your site, to ensure that the PFR is completed correctly and in time for your second CBI session.

In order to complete the PFR you will need access to the following information from the client's file:

Form 90-AIR (which incorporates Hours of Drinking)
Number of alcohol dependence symptoms (of 7) met
DrInC questionnaire (scored)
Desired Effects of Drinking questionnaire (Form G, completed during the first CBI session)
URICA scale (scored)
Profile of Mood States (POMS, scored)
Serum chemistry profile

You will also need to be familiar with BACCuS, the IBM-PC software program for converting alcohol consumption data into standardized measures (Markham, Miller, & Arciniega, 1993).

Procedures for Completing the PFR

Section 1. Alcohol Use

The first piece of information to be presented to the client is the average number of standard drinks consumed during a week of drinking. This figure is computed from Form 90-AIR, the interview protocol for quantifying alcohol consumption. The calculation is based on the 90 days preceding the most recent drink (*not* on the entire period covered by the Form 90-AIR, which may include a period of abstinence prior to the interview.) Use figures computed by the Form 90-AIR software provided by the Coordinating Center. (Until software is provided by the CC, these computations from Form 90 will need to be done by hand.) Two figures are considered, of which *the higher of the two* is the number entered on the first line of Section 1 of the PFR. The two numbers are:

The number of standard drinks per week as reported on the Steady Pattern chart and
The average number of standard drinks per week during the 90-day period.

In some cases the Steady Pattern chart will not have been completed, and in this case the 90-day average will be the figure to use. Once you have determined the client's number of standard drinks per week, use the following chart to obtain the client's percentile among American adults. Note that there are separate norms for men and women. Enter the percentile figure *for the client's gender* on the percentile line of Section 1 of the PFR.

The third figure for Section 1 is an estimate of the client's peak blood alcohol concentration (BAC) during the 90-day baseline prior to last drink. This is estimated from the Hours of Drinking section of Form 90-AIR. Using the BAC calculation program, enter the number of standard drinks consumed and the number of hours of drinking to estimate peak BAC. For two or more calculations, use the highest BAC estimate. If the estimate is higher than 700 mg%, however, doublecheck your figures, and if correct, enter 700 (never higher) as the estimated value in Section 1.

ALCOHOL CONSUMPTION NORMS FOR U.S. ADULTS

DRINKS PER WEEK	Men	Women
0 (Abstainers)	28%	43%
1	54%	77%
2	61%	83%
3	68%	88%
4	71%	90%
5	73%	92%
6	76%	93%
7	77%	94%
8	79%	95%
9	80%	96%
10	82%	97%
11	84%	97%
12	85%	98%
13	86%	98%
14	87%	98%
15	88%	98%
16-17	89%	98%
18-19	90%	99%
20-21	91%	99%
22-23	92%	99%
24-26	93%	99%
27-30	94%	99%
31-36	95%	99%
37-42	96%	99%
43-49	97%	99%
50-59	98%	99%
60+	99%	99%

Source: 1995 National Alcohol Survey of 4,925 households. Alcohol Research Group, Berkeley, California. Courtesy of Dr. Thomas K. Greenfield.

One standard drink = 0.5 oz (15 ml) of absolute ethanol (Miller, Heather, & Hall, 1991)

To complete Section 1, mark the Tolerance Level box according to the level of intoxication above. For example, if BAC was 145 mg%, you would circle "High." Then enter the number of DSM-IV symptoms of alcohol dependence that the client met during intake assessment. The maximum possible score is 7.

Section 2. Other Drug Use

This information is also obtained from the Form 90-AIR. The critical information is the *number of days of use* during the 90-day baseline window for each of the five drug classes shown. Use the following table to determine the percentile for U.S. adults for each of the drug classes.

Tobacco

	Men	Women
No use	0	0
Any use	69	72
Pack (20 cigarettes) or more/day	85	89

Marijuana

Use the total days of use in this 90-day period

Days Use	Men	Women
0	0	0
1-2	93	96
3-11	94	97
12-50	96	99
51 or more	99	99.5

Stimulants/Uppers

	Men	Women
No illicit use	0	0
Any illicit use	99.1	99.5

Cocaine

Days Use	Men	Women
No use	0	0
Any use	99.1	99.7

If Crack:

	Men	Women
No use	0	0
Any use	99.5	99.8

Opiates

	Men	Women
No illicit use	0	0
Any illicit use	99.5	99.8

Source: NIDA National Household Survey on Drug Abuse 1997.
For adults 18 and over.

Section 3. Consequences

Score the DrInC-2R and record the client's raw scores in the boxes at the bottom of the chart on page 2 of the PFR. Use the norms shown on the PFR to determine the client's decile for each of the five subscales and the total score. Within each scale, circle the range in which the client's score falls. Be sure to use the correct side (men or women) of the profile.

Section 4. Desired Effects of Drinking

Score the Desired Effects of Drinking questionnaire using the key below. Each item can contribute up to three points to the subscale score, and each subscale contains four items, for a maximum possible score of 12 on each subscale. Then on the PFR circle the total score for each of the nine subscales.

Desired Effects of Drinking Key

	Scale	**Items**				**Totals**
A	Assertion	7	16	25	34	
D	Drug Effects	6	15	24	33	
M	Mental	2	11	20	29	
N	Negative Feelings	9	18	27	36	
P	Positive Feelings	3	12	21	30	
R	Relief	4	13	22	31	
S	Self Esteem	10	19	28	37	
SE	Sexual Enhancement	8	17	26	35	
SF	Social Facilitation	5	14	23	32	
Total Score						

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Section 5. Preparation for Change in Drinking

The Readiness score is obtained from the URICA scale. Use the norms below to determine the client's decile, and circle it.

The Support score reflects the degree of Support for Drinking, and is obtained from the Important People interview. Use the norms below to determine the client's decile, and circle it.

The Confidence score is obtained from the Alcohol Abstinence Self-Efficacy (Confidence) scale. Use the norms below to determine the client's decile, and circle it.

The Temptation score is obtained from the Alcohol Abstinence Self-Efficacy (Temptation) scale. Use the norms below to determine the client's decile, and circle it.

Decile	URICA Readiness	IP Support for Drinking	AASE Confidence	AASE Temptation	Decile
10	12.9 or higher	66.8 - 100%	4.4 or higher	4.0 or higher	**10**
9	12.3 - 12.8	58.4 - 66.7 %	3.9 - 4.3	3.7 - 3.9	**9**
8	11.7 - 12.2	50.1 - 58.3%	3.5 - 3.8	3.5 - 3.6	**8**
7	11.3 - 11.6	41.8 - 50.0%	3.3 - 3.4	3.2 - 3.4	**7**
6	10.7 - 11.2	37.6% - 41.7%	3.0 - 3.2	3.0 - 3.1	**6**
5	10.3 - 10.6	33.4 - 37.5%	2.8 - 2.9	2.8 - 2.9	**5**
4	9.9 - 10.2	25.1 - 33.3%	2.6 - 2.7	2.4 - 2.7	**4**
3	9.4 - 9.8	16.8% - 25.0%	2.3 - 2.5	2.0 - 2.3	**3**
2	8.9 - 9.3	8.4% - 16.7%	1.9 - 2.2	1.6 - 1.9	**2**
1	8.8 or lower	0 - 8.3%	1.8 or lower	1.5 or lower	**1**

Section 6. Mood States

Score the Profile of Mood States (Short Form - 30 items) using the publisher's profile form. Enter the client's ***raw*** score for each of the six subscales, entering the score in the appropriate box.

Section 7. Blood Tests

Obtain the client's serum chemistry scores on AST (SGOT), ALT (SGPT), GGTP, and MCV from the lab report. Record these lab scores in the corresponding boxes of the PFR. Interpretive ranges shown in the lower boxes should be the lab normal values for the laboratory performing the assays (to be filled in at local site).

Appendix C

CBI Therapist Guidelines for Presenting the Personal Feedback Report

This information is to help you in interpreting the Personal Feedback Report to your clients. Following the general motivational counseling style described in this manual, your task is to provide a clear explanation of the client's feedback in understandable language.

Give the original copy of the PFR to your client (and significant other), and retain a copy for your file. The PFR consists of three pages of data from interviews and questionnaires. When you have finished presenting the feedback, the client may take home the PFR plus a copy of "Understanding Your Personal Feedback Report." If you end a session partway through the feedback process, however, you should retain the original PFR, sending it home with the client only after you have completed your review of feedback at the next session.

Be thoroughly familiar with each of the scales included on the PFR. "Understanding Your Personal Feedback Report" provides basic information for your client. Here are some additional points that may be helpful to you in reviewing the PFR with clients.

1. Alcohol Consumption

Standard Drinks per Week. The idea of a "standard drink" is an important concept here. Explain that all alcohol beverages - beer, wine, spirits - contain the same kind of alcohol, ethyl alcohol. They just contain different amounts of this drug. We are using, as a "standard drink," any beverage which contains half an ounce of ethyl alcohol. Thus, the following beverages are each equal to one standard drink:

Beverage	Usual %		X	Ounces	=	Alcohol Content
Beer	.05		X	10 oz	=	0.5 oz
Table Wine	.12		X	4 oz	=	0.5 oz
Fortified Wine	.20		X	2.5 oz	=	0.5 oz
Spirits						
80 proof	.40		X	1.25 oz	=	0.5 oz
100 proof	.50	X	1 oz		=	0.5 oz

Explain that the average number of standard drinks per week was calculated from the client's own report of drinking in the pretreatment interviews, and was converted into standard units. The normative table (in Appendix A) provides an estimate of the client's standing among American adults of the same sex, with regard to alcohol consumption. The conversion table provides percentile levels for various numbers of standard drinks per week, based on U.S. household survey data. A good explanation of this percentile figure is that, "This means you drink more than _____% percent of American [men/women] do, or that (100-X)% of American [men/women] drink as much or more than you do."

Estimated BAC Peak. Explain that the number of drinks consumed is only part of the picture. A certain number of drinks will have different effects on people, depending on factors like their weight and gender. The pattern of drinking also makes a difference: Having 21 drinks within 4 hours on a Saturday is different from having 21 drinks over the course of a week (3 a day). Another way to look at a person's drinking, then, is to estimate how intoxicated he or she becomes during periods of drinking. Be clear here that you are discussing "intoxicated" in terms of the level of alcohol (a toxin) in the body, and *not* the person's subjective sense of being drunk. It is common for alcohol dependent people to be quite intoxicated (high BAC) but not look or feel impaired. The peak intoxication level is one reflection of the person’s tolerance for alcohol.

The unit used here is milligrams of alcohol per 100 ml of blood, abbreviated "mg%." This is the unit commonly used by pharmacologists, and has the additional convenience of being a whole number rather than a decimal (less confusing for some clients). If you or your client wish to compare this with the usual decimal expressions of BAC, simply move the decimal point three places to the left. Thus:

80 mg% = .08
100 mg% = .10
256 mg% = .256 and so on

Note that the "normal social drinking" range is defined as from 20-60 mg% in peak intoxication. In fact, the vast majority of American drinkers do not exceed 60 mg% when drinking. Although 500 mg% is a lethal dose of alcohol for most adults, some alcohol dependent clients have been known to survive much higher levels, with some even continuing to drink and drive at 700 mg%. We have used 700 mg% as a cut-off for estimates, even though somewhat higher levels can be survived.

The behavioral effects as shown in "Understanding Your Personal Feedback Form" can be understood as the ordinary effects of various BAC levels. Because of tolerance, people may reach these BAC levels without feeling or showing the specific effects listed. The presence of a high BAC level, especially if accompanied by a reported absence of apparent or subjective intoxication signs, is an indication of alcohol tolerance.

Tolerance. Discuss tolerance with your client as a *risk factor*. This is counterintuitive for many clients, who believe that an apparent absence of subjective impairment means that the person is in *less* rather than more danger. In fact, people with a high tolerance for alcohol have a *greater* risk of being harmed and developing serious problems from drinking. Tolerance level here is estimated from the maximum BAC level reached by the client during the pre-treatment assessment period. A few points to cover (in language appropriate for your client) are:

1. Tolerance is partly inherited, partly learned.

2. For the most part, tolerance does *not* mean being able to get rid of alcohol at a faster rate (although this occurs to a small extent). Rather it means reaching high levels of alcohol in the body without feeling or showing the normal effects.

3. Normal drinkers are sensitive to low doses of alcohol. They feel the effects of 1-2 drinks, and this tells them they have had enough. Other people seem to lack this warning system.

4. One result of tolerance is that the person tends to take in large quantities of alcohol - enough to damage the brain and other organs of the body over time - without realizing it. Thus the drinker is harmed but does not "feel" it, creating a false sense of safety or impunity. An analogy would be a person who loses all pain sensation. While at first this might seem a blessing, in fact it is a curse, because such a person can be severely injured without feeling it. The first sign that your hand is on a hot stove is the smell of the smoke. Similarly, for tolerant drinkers, the first signs of intoxication are not felt until rather high BAC levels are reached.

Alcohol Dependence Level. Explain the concept of alcohol dependence to your client. Many will be familiar with physical withdrawal signs, and may equate these with dependence. In fact, dependence is much broader than physical withdrawal, and involves alcohol progressively dominating more and more of the person's life. A few points to cover (in language appropriate for your client) are:

1. Dependence is not limited to physical withdrawal, but is a behavioral pattern in which drinking becomes increasingly central and important in one's life.

2. Dependence occurs gradually, and many people do not realize it is happening.

3. It is not an all-or-none thing; dependence varies in severity.

4. There are seven signs of dependence on any drug. The current standard, to make a diagnosis of alcohol dependence, is meeting at least three of these. You had _____ out of 7 signs. [If appropriate, it is okay to review the symptoms, which briefly stated are:

1. Tolerance
2. Withdrawal (physiological dependence)
3. Using (drinking) more or longer than intended
4. Persistent desire or failed efforts to cut down or quit
5. Much time spent in obtaining, using, and recovering from the drug
6. Giving up important social, occupational, or recreational activities
7. Continued use despite persistent problems

5. Your assessment report will contain the specific symptoms of dependence which are positive for your client, although the format varies across sites. You should not give this information to your client; it is provided for your information only.

2. Other Drug Use

Here the client's personal use of drugs in several categories is being compared with national norms, as established by the household survey of the National Institute on Drug Abuse. The survey is conducted quite carefully, with full confidentiality, and proper measures are taken to sample households representatively (e.g., not only those with telephones).

Explain what the percentile (%) scores mean that have been written on this first sheet. A **95** in this column, for example, means that the client's use of this drug is greater than 95 out of 100 American adults (over the age of 12). Said another way, fewer than 5% of adults use this drug as much as the client does.

These numbers will often seem quite high to a client. The reason is that the vast majority of U.S. adults do not use these drugs at all, a fact that is often surprising to clients whose social circle is comprised primarily of users.

3. Consequences

The client's recent negative consequences of drinking (as scored from the DrInC-2R) are shown on page 2 of the PFR. The client's raw scores for the total scale and for five specific subscales are printed in the boxes at the bottom of the profile form (note that there are separate norms for men and women). These same raw scores are circled in the column corresponding to each scale, to show the client's elevation relative to *individuals currently seeking treatment for alcohol dependence*. Be sure to point out that the normative reference group has changed from page 1, where drinking and drug use were being compared with the general population. Here a "low" score is low relative to people entering treatment for alcohol dependence, which may still be a rather high score in the general population. (This is the only normative base currently available, and comes from Project MATCH.)

Explain that this shows the extent to which the client has experienced negative consequences (problems) related to his or her drug use, in comparison with people who are being treated for such problems.

Here is some basic information to help you interpret the subscales. This information is also on the client's form, *Understanding Your Personal Feedback Report*.

Physical This score reflects unpleasant physical effects of alcohol use such as hangovers, sleeping problems, and sickness; harm to health, appearance, eating habits, and sexuality; and injury while drinking

Interpersonal These are personal, private negative effects such as feeling bad, unhappy or guilty because of drinking; experiencing a personality change for the worse; interfering with personal growth, spiritual/moral life, interests and activities, or having the kind of life that you want.

Social Responsibility These are negative consequences more easily seen by others. They include work/school problems (missing days, poor quality of work, being fired or suspended), spending too much money, getting into trouble, and failing to meet others' expectations.

Interpersonal These are negative effects of drinking on important relationships. Examples are damage to or the loss of a friendship or love relationship; harm to family or parenting abilities; concern about drinking expressed by family or friends; damage to reputation; and cruel or embarrassing actions while drinking.

Impulse Control This is a group of other negative consequences of drinking that have to do with self-control. These include: overeating, increased use of other drugs, impulsive actions and risk-taking, physical fights, driving and accidents after drinking, arrests and trouble with the law, and causing injury to others or damage to property.

4. Reasons for Drinking

A fourth general domain of interest is your client's stated reasons (motivations) for drinking. These are derived from the Desired Effects of Drinking questionnaire, which you administered in Session 1. Simply circle the client's total score for each of the subscales. Feedback here is not normed, but reflects the absolute level of each reported reason for drinking. The nine scales are:

Mental to feel more creative or mentally alert; to think, work or concentrate better
Positive Feelings to change mood or feel good, to relax or celebrate
Relief to relieve tension, forget problems, avoid painful memories
Social Facilitation to be sociable and comfortable in social situations, to meet and enjoy people
Drug Effects to get drunk, get over a hangover, to sleep, or stop shakes or tremors
Assertion to feel more powerful or courageous, to express anger
Sexual Enhancement to feel more romantic and sexually excited, enjoy sex more, be a better lover
Negative Feelings to feel less depressed, angry, ashamed, or fearful
Self-Esteem to feel better about oneself, less guilty, disappointed, or angry with oneself

5. Preparation for Change in Drinking

This section contains four different variables that may be important indicators of how prepared your client is for change in drinking. Low scores on these four scales reflect potential obstacles to change.

Readiness. The first of these is the client's self-reported level of readiness for change, a summary index scored from the URICA by adding together the contemplation, preparation, and action items and subtracting the precontemplation items. The decile norms here are from Project MATCH, and compare your client's readiness score with those from clients entering treatment for alcohol dependence. High scores indicate high self-reported readiness for change.

Support. What is being measured here (from the IP interview) is the degree to which your client's social network supports continued drinking. Note that the deciles are inverted here, with 10 at the bottom. Vertically low scores (higher deciles) suggest a potential obstacle to change: namely, that the client's social network favors continued drinking. Vertically high scores (lower deciles) reflect low social support for continued drinking.

Confidence. High scores here reflect a high degree of confidence (self-efficacy) to abstain from drinking. Clients with low scores are not reporting much confidence in their ability to abstain.

Temptation. This scale, like Support, is also inverted, with high deciles at the bottom. Clients with vertically low scores (higher deciles) are reporting a lot of temptation to drink in their social environment. Clients with vertically high scores (lower deciles) report low levels of temptation to drink.

Remember that vertically low scores on all these scales represent potential obstacles to change. Vertically high scores on all these scales represent preparation for change.

6. Mood States

This section reflects your client's mood state during the week before pretreatment evaluation. These mood states fluctuate widely, and thus the scores may or may not represent the client's mood at the time of your feedback session. The scale names are fairly good descriptors of the adjectives contained in each factor. Norms here are based on U.S. adults.

7. Blood Tests

These four serum assays can be elevated by excessive drinking, and thereby reflect in part the physical impact of alcohol on the body. It is noteworthy that many heavy and problematic drinkers have normal scores on these assays. The physical damage reflected by elevations on these scales may emerge much later than other types of problems. Also, normal scores on these tests *cannot* be interpreted as the absence of physical damage from drinking. The destruction of liver cells near the portal vein where blood enters, for example, can occur well before liver enzymes reflect a warning. When these scales *are* elevated, then, it is information to be taken seriously.

Be sure to clarify that, as a nonmedical professional, you are not qualified to interpret these findings in detail. The medical staff will review elevations with your client, if they have not already done so. Clients who are concerned and want more information should be advised to discuss their results with medical staff (such as the MM practitioner).

The following information will help you explain to clients the basic processes underlying these assays, and what they may mean:

AST and ALT. AST (aspartate animotransferase, previously called SGOT) and ALT (alanine transferase; previously called SGPT) are enzymes that reflect the overall health of the liver. The liver is important in metabolism of food and energy, and also filters and neutralizes poisons and impurities from the blood. (The analogy to an oil filer is helpful for some.) When the liver is damaged, as happens from heavy drinking, it becomes

less efficient in these tasks, and begins to leak enzymes into the bloodstream. Elevated levels of these enzymes are general indicators of compromised liver function.

GGT. Serum gamma glutamyl transpeptidase (GGT or GGTP) is an enzyme found in liver, blood, and brain, which is more specifically sensitive to alcohol's effects. If drinking continues, elevations of this enzyme predict later serious medical problems related to drinking, including injuries, illnesses, hospitalizations, and deaths. This enzyme is often elevated first, with AST and ALT rising into the abnormal range as heavy drinking continues. GGT is also sensitive to *recent* drinking, and an elevation may reflect a recent heavy drinking episode.

MCV. This is not a liver function measure, but rather is *mean corpuscular volume*, the average size of red blood cells. Heavy drinking causes blood cells not to have enough hemoglobin which is necessary to carry oxygen around the body and brain. Trying to make up for less hemoglobin, the blood cells grow larger. While there are no serious immediate consequences of this enlargement, it reflects harmful effects of drinking that in the long run can damage circulation and brain cells.

Elevations on serum test scores can occur for reasons other than heavy drinking. GGT, for example, can be elevated by cancer or hormonal changes. In this population, however, the most likely cause of an elevation is heavy drinking. These test values tend to return toward normal if the person stops drinking. Reductions in GGT (by changed drinking) have been shown to be associated with substantially reduced risk of serious health problems.

Appendix D

Understanding Your Personal Feedback Report

The Personal Feedback Report summarizes results from your pretreatment evaluation. Your counselor has explained these to you. This information is to help you understand the written report you have received, and to remember what your counselor told you about it.

Your report consists of three sheets. They summarize information from interviews, questionnaires, and blood tests completed as part of your pretreatment evaluation.

Section 1: Alcohol Use

The first line in this section shows the **average number of drinks** per week that you reported having during the months before entering this program. Because different alcohol beverages vary in their strength, we have converted your regular drinking pattern into standard "one drink" units. In this system, "one drink" is equal to:

10 ounces of beer	(5% alcohol)	or
4 ounces of table wine	(12% alcohol)	or
2.5 ounces of fortified wine (sherry, port, etc.)	(20% alcohol)	or
1.25 ounces of 80 proof liquor	(40% alcohol)	or
1 ounce of 100 proof liquor	(50% alcohol)	

All of these drinks contain the same amount of the same kind of alcohol: one-half ounce of pure ethyl alcohol.

This first piece of information, then, tells you how many of these standard "drinks" you were consuming per week of drinking, according to what you reported in your interview. (If you have not been drinking for a period of time recently, this refers to your pattern of drinking before you stopped.)

To give you an idea of how this compares with the drinking of American adults in general, the second number in Section 1 is a **percentile** figure. This tells you what percentage of U.S. men (if you are a man) or women (if you are a woman) drink *less* than you reported drinking on average. If this number were 60, for example, it would mean that your drinking is higher than 60% of Americans of your sex (or that 40% drink as much as you reported, or more).

Your total number of drinks per week tells only part of the story. It is *not* healthy, for example, to have ten drinks per week by saving them all up for Saturday. Neither is it safe to have even a few drinks and then drive. This raises the important question of level of intoxication.

A second way of looking at your past drinking is to ask what level of intoxication you were reaching. It is possible to estimate the amount of alcohol that would be circulating in your bloodstream, based on the pattern of drinking your reported. Blood Alcohol Concentration (BAC) is an important indication of the extent to which alcohol would be affecting your body and behavior. It is used by police and the courts, for example, to determine whether a driver is too impaired to operate a motor vehicle.

To understand better what BAC means, consider this list of common effects of different levels of intoxication:

COMMON EFFECTS OF DIFFERENT LEVELS OF INTOXICATION

20-60 mg% This is the "normal" social drinking range.
NOTE: Driving, even at these levels, is unsafe.

80 mg% Memory, judgment, and perception are impaired.
Legally intoxicated in some states.

100 mg% Reaction time and coordination of movement are affected.
Legally intoxicated in all states.

150 mg% Vomiting may occur in normal drinkers; balance is often impaired.

200 mg% A "blackout" may occur, loss of memory for events occurring while intoxicated.

300 mg% Unconsciousness in a normal person, though some remain conscious at levels in excess of 600-700mg% if tolerance is very high.

450 mg% Fatal dose for a normal adult, though some survive much higher levels if alcohol tolerance is substantial.

The number shown as **level of intoxication** is a computer-calculated estimate of your highest (peak) BAC level during the months preceding your entry to this program.

It is important to realize that there is *no known* "safe" level of intoxication when driving or engaging in other potentially hazardous activities (such as swimming, boating, hunting, and operating tools or machinery). Blood alcohol levels as low as 40-60 mg% can decrease crucial abilities. More dangerously, the drinker typically does not *realize* that he or she is impaired. The only safe BAC when driving is *zero*. If you must drive after drinking, plan to allow enough time for *all* of the alcohol to be eliminated from your body before driving.

Section 1 also shows a **level of alcohol tolerance** based on your BAC peak. Tolerance refers to the ability to "hold your liquor," to have alcohol in your bloodstream without showing or feeling the normal signs of impairment for that level of intoxication. Some have the impression that a high level of tolerance means that a person can drink more safely than others, but in fact the opposite is true. A person with a high tolerance for alcohol simply does not feel or show the level of intoxication, and as a result may expose his or her body to high and damaging doses of alcohol without realizing it.

Finally, in Section 1, is your score for level of **alcohol dependence**. Although many people think of dependence as having physical withdrawal from alcohol, alcohol dependence is actually much broader. In fact, one can be alcohol dependent without experiencing withdrawal symptoms when drinking is stopped. Alcohol dependence is a pattern of one's life becoming more centered on drinking. In essence, drinking (and recovering from its effects) gradually dominates more and more of one's time and life. There are seven signs of alcohol dependence, and the score that is circled here shows how many of these signs you reported. Three signs are required for a diagnosis of alcohol dependence.

Section 2. Other Drug Use

A person who uses other drugs besides alcohol runs several additional risks. Decreased use of one drug may simply result in the increased use of another. The effects of different drugs can multiply when they are taken together, with dangerous results. A tolerance to one drug can increase tolerance to another, and it is common for multiple drug users to become dependent on several drugs. The use of other drugs, then, increases your risk for serious problems. This section focuses on your recent use of five other kinds of drugs, as reported during your pretreatment evaluation.

The numbers printed in each box are **percentiles**, again showing where you stand in relation to U.S. adults in general. Because most American adults do not use these drugs, there may be some high numbers here. A 90, for example, would mean that 90% of Americans use less (or none) of this drug than you reported. Said another way, a 90 would mean that only 10% of Americans use as much of this drug as you reported.

Section 3. Consequences

This section summarizes negative consequences of drinking as you reported them - the harmful effects alcohol has had in your life. Here your own personal scores are being compared *with other people who are already in treatment for alcohol dependence*. Thus a "medium" score on these scales means that your score is typical for people who have already had enough trouble with alcohol to seek treatment. A "medium" score here would be a very high score for Americans in general.

There are five specific scales that show the level of problems you reported in five areas:

Physical This score reflects unpleasant physical effects of drinking such as hangovers, sleeping problems, and sickness; harm to your health, appearance, eating habits, and sexuality; and injury while drinking.

Interpersonal These are personal, private negative effects such as feeling bad, unhappy or guilty because of drinking; experiencing a personality change for the worse; interfering with your personal growth, spiritual/moral life, interests and activities, or having the kind of life that you want.

Social Responsibility These are negative consequences more easily seen by others. They include work or school problems (missing days, poor quality of work, being fired or suspended), spending too much money, getting into trouble, and failing to meet others' expectations of you because of drinking.

Interpersonal These are negative effects of alcohol on your important relationships. Examples are damage to or the loss of a friendship or love relationship; harm to family or your parenting abilities; concern about drinking expressed by your family or friends; damage to your reputation; and cruel or embarrassing actions while drinking.

Impulse Control This is a group of other negative consequences of drinking that have to do with self-control. These include: overeating, increased use of other drugs, impulsive actions and risk-taking, physical fights, driving and accidents after drinking, arrests and trouble with the law, and causing injury to others or damage to property.

The last score in this table shows the total level of negative consequences of drinking that you reported for the months immediately preceding your entering this program.

Section 4. Desired Effects of Drinking

People drink for various reasons, wanting or hoping for different effects from alcohol. This section shows how you answered a questionnaire about the effects you have wanted from alcohol. There are nine different groups of reasons:

Assertion	to feel more powerful or courageous, to express anger
Drug Effects	to get drunk, get over a hangover, to sleep, or stop shakes or tremors
Mental	to feel more creative or mentally alert; to think, work or concentrate better
Negative Feelings	to feel less depressed, angry, ashamed, or fearful
Positive Feelings	to change mood or feel good, to relax or celebrate
Relief	to relieve tension, forget problems, avoid painful memories
Self-Esteem	to feel better about oneself, less guilty, disappointed, or angry with oneself
Sexual Enhancement	to feel more romantic and sexually excited, enjoy sex more, be a better lover
Social Facilitation	to be sociable and comfortable in social situations, to meet and enjoy people

Section 5. Preparation for Change in Drinking

How prepared are you to make a change in your drinking? This section reviews four different factors that can help (or stand in the way of) your changing. Scores toward the *top* of these four bars show things that should make it easier for you to change. Scores toward the *bottom* of these four bars reflect things that might be obstacles for you in changing your drinking.

Readiness. The first of these is how willing, motivated, or ready you feel to make a change. There is some truth to the idea that people change when they are ready to do so. This score summarizes the extent to which you have been thinking about, getting ready for, and already doing something about making a change in your drinking.

Support. People you care about and spend time with can have a significant influence on change. To what extent do you have support for change from your friends and family? A score at the top indicates good social support for abstinence. A score at the bottom suggests that most people close to you would support your continued drinking, and this can be an obstacle to change.

Confidence. How confident are you that you will be *able* to abstain from alcohol? A high score indicates that think you could do it. A low score reflects some doubt about your ability to quit.

Temptation. Finally, how much temptation to drink do you encounter in your daily life? Scores at the top here reflect a good degree of *freedom* from temptation. Scores toward the bottom reflect significant levels of ongoing temptation to drink.

Section 6. Mood States

Moods can be important in the process of recovery. In particular, a high level of negative mood can be a signal of increased risk of drinking. Moods change quickly. These scores show how you were feeling during the week before your pretreatment evaluation. Thus they may or may not reflect how you are feeling now. There are six different mood groups shown here: (1) tension and anxiety, (2) sadness and depression, (3) anger and frustration, (4) vigor and energy, and (5) confusion. Your scores here are compared to a general population of U.S. adults.

Section 7. Blood Tests

Your pretreatment evaluation also included a blood sample. These particular blood tests were chosen because they have been shown in previous research to be negatively affected by heavy drinking. You should realize that normal results on these tests do not guarantee that you are in good health (for example, that your liver is functioning completely normally). An abnormal score on one or more of these tests, however, probably reflects unhealthy changes in your body resulting from excessive use of alcohol and/or other drugs.

Research indicates that elevated scores on the blood tests reported here will often show improvement and even a return to normal range when the person stops drinking. The longer one continues drinking, however, the more difficult it is to reverse the physical damage that is done.

Three of these tests are directly related to how the liver is working. Your liver is extremely important to your health. It is involved in producing energy, and it filters and neutralizes impurities and poisons in your bloodstream. Alcohol damages the liver, and after a long period of heavy drinking, parts of the liver begin to die. This is the process of scarring or cirrhosis, but physical changes in the liver can be caused by drinking long before cirrhosis appears. As the liver becomes damaged, it begins to leak enzymes into the bloodstream, and is less efficient in doing its work. This can be reflected in abnormally elevated values on the first three tests reported in this section.

Elevations on the fourth blood test, MCV, indicate an enlargement of the blood cells that carry oxygen throughout the body. Heavy drinking decreases the ability of blood cells to carry the necessary oxygen, and in an attempt to make up for the problem, the blood cells grow larger. Although not dangerous in itself, this enlargement is a danger sign for future problems with the blood, and of damage to parts of the body (like the brain) that are particularly sensitive to oxygen supply.

Elevated values on any of these tests should be taken seriously. They do not happen by chance, and are very likely related to physical changes in the body caused by excessive drinking. You may discuss your tests results with our medical staff.

Summary

Your Personal Feedback Report summarizes a large amount of information that you provided during your pretreatment interviews. Sometimes this information can seem surprising or even discouraging. The best use of feedback like this is to consider it as you decide what you want to do about your drinking. Many of the kinds of problems covered in your Personal Feedback Report do improve when heavy drinking is stopped. What you do with this information is up to you. Your Report is designed to give you a clear picture of where you are at present, so that you can make good decisions about where you want to go from here.

Appendix E

Mutual Support Groups: Representative Readings and National Contacts

National Contact Numbers

Alcoholics Anonymous http://www.alcoholics-anonymous.org
A.A. General Service Office, 475 Riverside Drive
New York, NY 10015 Phone: 212-870-3400 Fax: 212-870-3003

Al-Anon (1-800-344-2666). For relatives and friends of alcoholics.
http://www.al-anon-alateen.org

Alateen (1-800-344-2666). For younger relatives and friends of alcoholics.
http://www.al-anon-alateen.org

Families Anonymous (1-800-736-9805). Follows 12-step model, for friends and relatives of children with drug and alcohol problems.

National Clearinghouse for Alcohol and Drug Information (1-301-468-2600).
http://www.health.org

National Council on Alcoholism Information Line (1-800-NCA-CALL).

Moderation Management http://www.moderation.org

Rational Recovery 800-303-2873
Main office: 530-621-4374, or 530-621-2667, weekdays, 8 AM - 4 PM, PST.

Secular Organizations for Sobriety http://www.secularhumanism.org/sos
SOS National Clearinghouse, The Center for Inquiry - West
5521 Grosvenor Boulevard, Los Angeles, CA 90066
VOICE: (310) 821-8430 FAX: (310) 821-2610

SMART Recovery http://www.smartrecovery.org
24000 Mercantile Road, Suite 11
Beachwood, OH 44122
(216) 292-0220 FAX: (216) 831-3776 EMAIL: srmail1@aol.com

Women for Sobriety 800-333-1606 http://www.womenforsobriety.org
AOL chat room: WOMEN4SOBRIETY CHAT

Appendix F
Forms Used in the Combined Behavioral Intervention (CBI)

	FORM	TO BE USED IN:	BY/FOR:
A	Session Record Form	Every Session	CBI Therapist
B	MM Treatment Coordination Checklist	Every Session	MM Clinicians
C	Support for Sobriety Card	2.6b	Client
D	Sample Permission Form	2.6b	Signed by Client
E	Hours of Drinking Form	2.6c & PFR	Research Staff
F	Client Services Request Form	2.6c & 4.3c	Client
G	Desired Effects of Drinking Questionnaire	2.6c & 3.2b	Client
H	What I Want From Treatment	2.6c & 3.5b	Client
I	Personal Rulers Worksheet	2.8c	CBI Therapist
J	Decisional Balance Worksheet	2.8e	CBI Therapist
K	Alcohol Abstinence Self-Efficacy (T)	3.2a	Client (at intake)
L	New Roads Worksheet	3.2b & 3.2e	CBI Therapist
M	Personal Happiness Form	3.3a	Client
N	Personal Happiness Card Sort	3.3b	CBI Therapist
O	Options Sheet	3.3e & 3.5b	CBI Therapist
P	Some Characteristics of Successful Changers	3.4	Client
Q	Treatment Plan	3.5e	CBI Therapist
R	Treatment Plan (Continuation)	3.5e	CBI Therapist
S	Case Management Goal Sheet	4.3e	CBI Therapist
T	Resource Sheet	4.3f	Client
U	Understanding Resumed Drinking	4.4d	Client
V	Recovering from an Episode of Drinking	4.4e	Client
W	Examples of Situations Where Assertive Communication is Needed	5.1c	Client
X	Some Basic Tips for Assertive Communication	5.1c	Client
Y	Tips on Assertive Communication in Conflict Situations	5.1g	Client
Z	How Communication Happens	5.2a	CBI Therapist
AA	Reflection Sheet	5.2b4.	Client
BB	Urge Monitoring Card	5.3c	Client
CC	Identifying Social Pressure Situations & Coping Responses	5.4c	Client
DD	Checklist of Social Pressure Situations	5.4c	Client
EE	Job Leads Log	5.5f	Client
FF	STORC: Understanding Emotions and Moods	5.6d	CBI Therapist

GG	**Feelings from A to Z**	**5.6j**	**Client**
HH	**Mood Self-Monitoring Record**	**5.6k**	**Client**
II	**Thought Replacement Worksheet**	**5.6m**	**Client**
JJ	**Menu of Possibly Pleasurable Activities**	**5.8b**	**Client**
KK	**A Letter to People in Your Life**	**5.9**	**Client/SSO**
LL	**Supportive People**	***2.6.b2.***	**CBI Therapist**
MM	**Communicating Positive Feelings and Comments**	**5.1h.**	**Client**

Session Record Form

(to be stapled inside chart)

Use the Session Record Form provided by the COMBINE Coordinating Center.

Form A

Project COMBINE

MM Treatment Coordination Checklist

MM practitioner: Complete immediately after every MM appointment

Patient Code: _____ Date of MM visit: _____/_____/_____

Did the patient keep this appointment? ____Yes ____No
Comments (If No):

Did the patient report drinking since the last MM session? ____Yes ____No
Comments (If Yes):

Did the patient report illicit drug use since the last MM session? ____Yes ____No
Comments (If Yes):

Is the patient taking medications as prescribed? ____Yes ____No
Comments (If No; significant side effects or other reasons for not taking medication):

MM Practitioner signature:_____

Return form promptly to your Project Coordinator

Coordinator: When patient is also in CBI, route this form to the CBI therapist. Otherwise route directly to the PC.

Reviewed by CBI therapist (date):_____/_____/_____

___No significant discrepancies noted; or ___Discussed with MM Practitioner on ____/____/_____
Notes:

CBI Therapist signature:_____

Return form promptly to the Project Coordinator

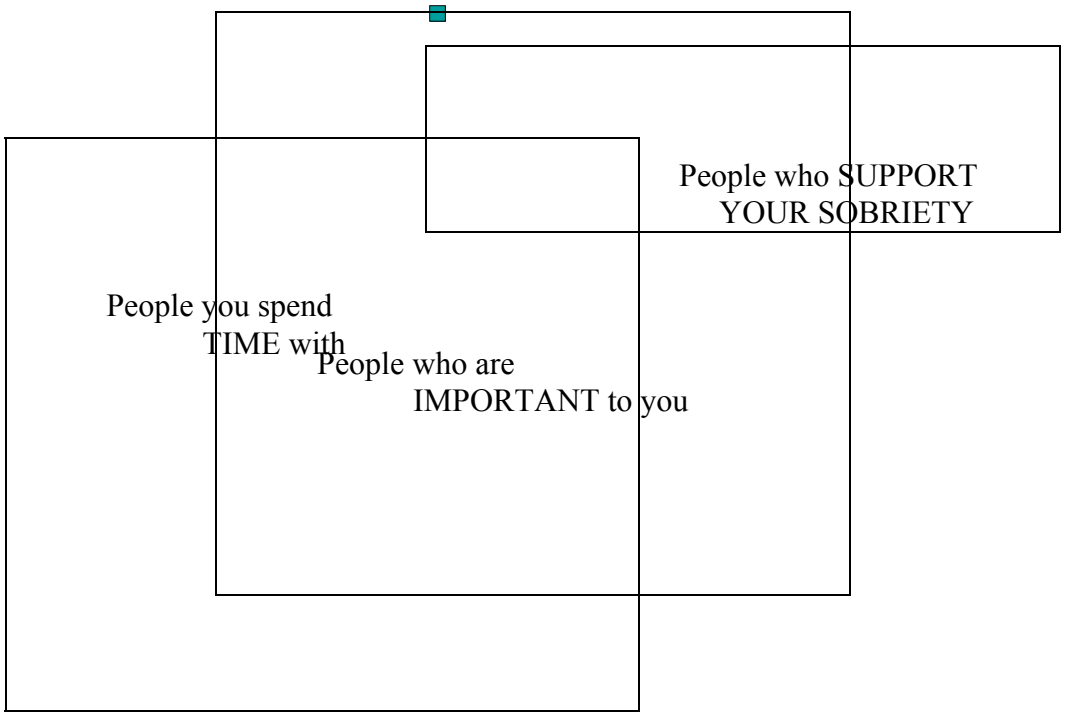
Form B

Support for Sobriety

Please choose someone whose support you would like to have during treatment. The ideal kind of person would be someone:

who is important to you
whom you see and spend time with regularly
who cares about you, understands and listens to you
who has been helpful to you in the past
who would help support your sobriety, and
who would be willing to come with you to sessions

Form C-1


People who SUPPORT
YOUR SOBRIETY
People you spend
TIME with
People who are
IMPORTANT to you

Form C-2

Project COMBINE
Getting Support in Treatment

In this program, we ask each client to bring along a special person to each treatment session. The purpose of involving this special person is to understand and to offer you support during treatment. The best person is someone who knows you well, cares about you, and would be willing to help you become free from alcohol during the months ahead. Some people bring a spouse or partner; others bring a parent or grandparent, brother or sister, son or daughter, uncle or aunt. Some bring a close friend; others bring their rabbi, priest, or minister. The important thing is that it is a person who cares about you, who has been helpful to you in the past, and would be willing and able to give you support during the months of treatment. They would not need to come to every session, although it is most helpful if they can.

Who might be the best person? You can invite the person yourself, or your therapist can ask the person to come to sessions with you. If you want your therapist to make the contact, complete the permission form below.

Statement of Permission

I give permission for my therapist to contact, by mail or telephone, my _____, whose name is _____, to ask and encourage him/her to come with me to my treatment sessions. I understand that the purpose is for him/her to understand and offer support in my treatment. The best way to reach this person is:

Telephone number(s):_____

Address:_____

_____

_____

Client's name (printed):_____

Client's signature:_____

Date of signature:_____

Witness:_____

Form D Sample Permission Form

Hours of Drinking Form

Client's body weight: _____ pounds

Date of Most Drinking (from Form 90-AIR)	*Total Alcohol Consumed (from Form 90-AIR)*	*# of Standard Drinks*	*Hours of Drinking*	*BAC (BACCuS)*

Note: This form is now incorporated into Form 90-AIR

Form E

Client # _____ **Therapist:_____**

Client Services Request Form

Would you like assistance in any of the following areas? (Please circle Yes, Maybe, or No for each one)

1. Housing (place to live, landlord, etc.)	**Yes**	**Maybe**	**No**
2. Employment	**Yes**	**Maybe**	**No**
3. Legal assistance	**Yes**	**Maybe**	**No**
4. Self-help or support groups	**Yes**	**Maybe**	**No**
5. Parenting and family issues	**Yes**	**Maybe**	**No**
6. Health care or medical problems	**Yes**	**Maybe**	**No**
7. Financial assistance (food stamps, Medicaid, debt, welfare, budgeting, etc.)	**Yes**	**Maybe**	**No**
8. School, education or training	**Yes**	**Maybe**	**No**
9. How to spend my free time	**Yes**	**Maybe**	**No**
10. Violence or abuse at home	**Yes**	**Maybe**	**No**
11. Child care	**Yes**	**Maybe**	**No**
12. Transportation	**Yes**	**Maybe**	**No**
13. Utilities (telephone, heat, water, etc.)	**Yes**	**Maybe**	**No**
14. Clothing and household needs	**Yes**	**Maybe**	**No**
15. Mental health, psychological problems	**Yes**	**Maybe**	**No**
Any other areas in which you need assistance? (If so, please write them below)	**Yes**	**Maybe**	**No**
16.			
17.			
18.			

Form F

Client # :_____ **Therapist:**_____

Desired Effects of Drinking

Drinking alcohol can have many different effects. What results or effects have you wanted from drinking alcohol ***during the past 3 months***? Read each effect/result of drinking on the left and indicate how much this was an effect of drinking you ***wanted*** during the past three months.

During the past 3 months, how often did you want this effect from drinking alcohol?		**Never 0**	**Sometimes 1**	**Frequently 2**	**Always 3**
1.	to enjoy the taste	**0**	**1**	**2**	**3**
2.	to feel more creative	**0**	**1**	**2**	**3**
3.	to change my mood	**0**	**1**	**2**	**3**
4.	to relieve pressure or tension	**0**	**1**	**2**	**3**
5.	to be sociable	**0**	**1**	**2**	**3**
6.	to get drunk or intoxicated	**0**	**1**	**2**	**3**
7.	to feel more powerful	**0**	**1**	**2**	**3**
8.	to feel more romantic	**0**	**1**	**2**	**3**
9.	to feel less depressed	**0**	**1**	**2**	**3**
10.	to feel less disappointed in myself	**0**	**1**	**2**	**3**
11.	to be more mentally alert	**0**	**1**	**2**	**3**
12.	to feel good	**0**	**1**	**2**	**3**
13.	to be able to avoid thoughts or feelings associated with a bad experience	**0**	**1**	**2**	**3**
14.	to feel more comfortable in social situations	**0**	**1**	**2**	**3**
15.	to get over a hangover	**0**	**1**	**2**	**3**
16.	to feel brave and capable of fighting	**0**	**1**	**2**	**3**
17.	to be a better lover	**0**	**1**	**2**	**3**
18.	to control my anger	**0**	**1**	**2**	**3**
19.	to feel less angry with myself	**0**	**1**	**2**	**3**
20.	to be able to think better	**0**	**1**	**2**	**3**
21.	to celebrate	**0**	**1**	**2**	**3**
22.	to control painful memories of a bad experience	**0**	**1**	**2**	**3**
23.	to be able to meet people	**0**	**1**	**2**	**3**

24.	to sleep	**0**	**1**	**2**	**3**
25.	to be able to express anger	**0**	**1**	**2**	**3**
26.	to feel more sexually excited	**0**	**1**	**2**	**3**
27.	to feel less shame	**0**	**1**	**2**	**3**
28.	to feel more satisfied with myself	**0**	**1**	**2**	**3**
29.	to be able to work or concentrate better	**0**	**1**	**2**	**3**
30.	to relax	**0**	**1**	**2**	**3**
31.	to forget about problems	**0**	**1**	**2**	**3**
32.	to have a good time	**0**	**1**	**2**	**3**
33.	to stop the shakes or tremors	**0**	**1**	**2**	**3**
34.	to be able to find the courage to do things that are risky	**0**	**1**	**2**	**3**
35.	to enjoy sex more	**0**	**1**	**2**	**3**
36.	to reduce fears	**0**	**1**	**2**	**3**
37.	to feel less guilty	**0**	**1**	**2**	**3**

Tracy L. Simpson, Ph.D., Judith A. Arroyo, Ph.D., William R. Miller, Ph.D., and Laura M. Little, Ph.D.

Client # :_____ **Therapist:**_____

WHAT I WANT FROM TREATMENT

(4.0 COMBINE)

People have different ideas about what they want, need, and expect from treatment. This questionnaire is designed to help you explain what you would like to have happen in your treatment.

Is this something that you would like from treatment? (Circle YES or NO for each item below)	**YES**	**NO**
1. I would like to receive detoxification, to ease my withdrawal from alcohol or other drugs.	**YES**	**NO**
2. I would like to find out for sure whether I have a problem with alcohol or other drugs.	**YES**	**NO**
3. I would like to stop drinking alcohol completely.	**YES**	**NO**
4. I would like to decrease my drinking.	**YES**	**NO**
5. I would like to take medication that would help me avoid drinking.	**YES**	**NO**
6. I would like to learn more about alcohol problems.	**YES**	**NO**
7. I would like to stop or decrease my use of drugs other than alcohol.	**YES**	**NO**
8. I would like to learn some skills to keep from returning to alcohol or other drugs.	**YES**	**NO**
9. I would like to know more about 12-step programs like Alcoholics Anonymous (AA).	**YES**	**NO**
10. I would like to know more about mutual support groups other than AA.	**YES**	**NO**
11. I would like to learn how to deal with craving or urges to drink.	**YES**	**NO**
12. I need to fulfill a requirement of the courts.	**YES**	**NO**
13. I would like to learn how to resist social pressure to drink.	**YES**	**NO**
14. I would like to find enjoyable ways to spend my free time.	**YES**	**NO**
15. I would like to deal with some problems in my marriage or close relationship.	**YES**	**NO**
16. I would like help with some health problems.	**YES**	**NO**
17. I would like to decrease my stress and tension.	**YES**	**NO**

18. I would like to improve my physical health and fitness.	YES	NO
19. I would like to overcome depression or moodiness.	YES	NO
Is this something that you would like from treatment?	**YES**	**NO**
20. I would like to deal with anger problems.	YES	NO
21. I would like to have healthier relationships.	YES	NO
22. I would like to discuss sexual problems.	YES	NO
23. I would like to learn how to express my feelings in a more healthy way.	YES	NO
24. I would like to decrease my stress and anxiety level.	YES	NO
25. I would like to decrease my feelings of boredom.	YES	NO
26. I want to find a way to deal with loneliness.	YES	NO
27. I would like to decrease or prevent violence at home.	YES	NO
28. I would like to feel better about myself, to have more self-esteem.	YES	NO
29. I would like help with legal problems.	YES	NO
30. I would like to find a better place to live.	YES	NO
31. I would like to find a job.	YES	NO
32. I have thoughts about suicide and would like to discuss this.	YES	NO
33. I would like information about or testing for HIV/AIDS.	YES	NO
34. I would like someone to listen to me.	YES	NO
35. I would like to learn to have fun without drugs or alcohol.	YES	NO
36. I would like someone to tell me what to do.	YES	NO
37. I would like help in setting goals and priorities in my life.	YES	NO
38. I would like to learn how to use my time better.	YES	NO

39. I would like to talk about my past.	**YES**	**NO**
40. I would like help in getting motivated to change.	**YES**	**NO**
41. I would like for my spouse (or someone close to me) to come to treatment with me.	**YES**	**NO**
42. I would like for my treatment to be short.	**YES**	**NO**

Form H William R. Miller & Janice M. Brown (1998)

Client # :_____ **Therapist:_____**

Personal Rulers Worksheet

Importance Ruler

0	1	2	3	4	5	6	7	8	9	10
Not at all important		Somewhat important		Fairly important		Important		Very important		Extremely important

Confidence Ruler

0	1	2	3	4	5	6	7	8	9	10
Not at all confident		Somewhat confident		Fairly confident		Confident		Very confident		Certain

Readiness Ruler

0	1	2	3	4	5	6	7	8	9	10
Not at all ready		Somewhat ready		Fairly ready		Ready		Very ready		Completely ready

Form I

Client # :_____ **Therapist:**_____

Decisional Balance Worksheet

Cons (Reasons Not to Change)	Pros (Reasons to Change)
Good things about continuing to drink as before	Not-so-good things about drinking
Not-so-good things about changing my drinking	Good things about changing my drinking

Form J

Client # :_____ **Therapist:_____**

AASE-T

Listed below are a number of situations that lead some people to drink. How tempted may you be to drink in each situation? Circle the number that best describes your feelings of *temptation* in each situation *at the present time*.

Situation	Not at all tempted	Not very tempted	Moderately tempted	Very tempted	Extremely tempted
1. When I am in agony because of stopping or withdrawing from alcohol use	1	2	3	4	5
2. When I have a headache	1	2	3	4	5
3. When I am feeling depressed	1	2	3	4	5
4. When I am on vacation and want to relax	1	2	3	4	5
5. When I am concerned about someone	1	2	3	4	5
6. When I am very worried	1	2	3	4	5
7. When I have the urge to try just one drink and see what happens	1	2	3	4	5
8. When I am being offered a drink in a social situation	1	2	3	4	5
9. When I dream about taking a drink	1	2	3	4	5
10. When I want to test my willpower over drinking	1	2	3	4	5
11. When I am feeling a physical need or craving for alcohol	1	2	3	4	5
12. When I am physically tired	1	2	3	4	5
13. When I am experiencing some physical pain or injury	1	2	3	4	5
14. When I feel like blowing up because of frustration	1	2	3	4	5
15. When I see others drinking at a bar or a party	1	2	3	4	5
16. When I sense everything is going wrong for me	1	2	3	4	5
17. When people I used to drink with encourage me to drink	1	2	3	4	5
18. When I am feeling angry inside	1	2	3	4	5
19. When I experience an urge or impulse to take a drink that catches me unprepared	1	2	3	4	5
20. When I am excited or celebrating with others	1	2	3	4	5

Carlo C. DiClemente, Department of Psychology, University of Maryland Baltimore County

Client # :_____ **Therapist:**_____

New Roads Work Sheet

Triggers		Effects

Form L

Client #: _____ **Therapist:_____**

Personal Happiness Form

Life Areas	How happy or satisfied are you with each of these areas of your life? (Circle only one number for each item) Completely Dissatisfied / Somewhat Dissatisfied / Somewhat Satisfied / Mostly Satisfied / Completely Satisfied / Doesn't Apply	Link Y	Change Y
Friends and social life	1 2 3 4 5 6 7 8 9 10 NA		1
Job/work	1 2 3 4 5 6 7 8 9 10 NA		2
Where I live	1 2 3 4 5 6 7 8 9 10 NA		3
Money, financial security	1 2 3 4 5 6 7 8 9 10 NA		4
Education and Learning	1 2 3 4 5 6 7 8 9 10 NA		5
Leisure time and fun	1 2 3 4 5 6 7 8 9 10 NA		6
Mood and self-esteem	1 2 3 4 5 6 7 8 9 10 NA		7
Anger and arguments	1 2 3 4 5 6 7 8 9 10 NA		8
Stress and anxiety	1 2 3 4 5 6 7 8 9 10 NA	0	9
Physical health	1 2 3 4 5 6 7 8 9 10 NA		10
Spirituality	1 2 3 4 5 6 7 8 9 10 NA		11
Love and affection	1 2 3 4 5 6 7 8 9 10 NA		12
Family relationships	1 2 3 4 5 6 7 8 9 10 NA		13
Relationship with spouse/partner	1 2 3 4 5 6 7 8 9 10 NA		14
Sexuality	1 2 3 4 5 6 7 8 9 10 NA		15
Eating, weight	1 2 3 4 5 6 7 8 9 10 NA		16
Physical activity, exercise	1 2 3 4 5 6 7 8 9 10 NA		17
Giving/caring for others	1 2 3 4 5 6 7 8 9 10 NA		18
Mental ability, memory	1 2 3 4 5 6 7 8 9 10 NA		19

Personal safety, security	1	2	3	4	5	6	7	8	9	10	NA		20
	Completely Dissatisfied		Somewhat Dissatisfied		Somewhat Satisfied		Mostly Satisfied		Completely Satisfied		Doesn't Apply		

Form M

Personal Happiness Card Sort

Personal Happiness Card Sort	**Friends and Social Life** **1** PH-01 11	**Job/Work** 2 PH-02
Where I Live 3 PH-03	**Money and Financial Security** 4 PH-04	**Education and Learning** 5 PH-05
Leisure Time and Fun 6 PH-06	**Mood and Self-Esteem** 7 PH-07	**Anger and Arguments** 8 PH-08
Stress and Anxiety 9 PH-09	**Physical Health** 10 PH-10	**Spirituality** 11 PH-11

Love and Affection 12	**Family Relationships** 13	**Relationship with Spouse/Partner** 14
Sexuality **15** PH-15 15	**Eating and Weight** 16 PH-16	**Physical Activity and Exercise** 17 PH-17
Giving/Caring for Others **18** PH-18	**Mental Ability and Memory** 19 PH-19	**Personal Safety and Security** 20 PH-20
YES	**NO**	

Form N **Copy onto card stock and cut into cards**

Client #:

Options

Form O

Some Characteristics of Successful Changers

Accepting	Committed	Flexible	Persevering	Stubborn
Active	Competent	Focused	Persistent	Thankful
Adaptable	Concerned	Forgiving	Positive	Thorough
Adventuresome	Confident	Forward-looking	Powerful	Thoughtful
Affectionate	Considerate	Free	Prayerful	Tough
Affirmative	Courageous	Happy	Quick	Trusting
Alert	Creative	Healthy	Reasonable	Trustworthy
Alive	Decisive	Hopeful	Receptive	Truthful
Ambitious	Dedicated	Imaginative	Relaxed	Understanding
Anchored	Determined	Ingenious	Reliable	Unique
Assertive	Die-hard	Intelligent	Resourceful	Unstoppable
Assured	Diligent	Knowledgeable	Responsible	Vigorous
Attentive	Doer	Loving	Sensible	Visionary
Bold	Eager	Mature	Skillful	Whole
Brave	Earnest	Open	Solid	Willing
Bright	Effective	Optimistic	Spiritual	Winning
Capable	Energetic	Orderly	Stable	Wise
Careful	Experienced	Organized	Steady	Worthy
Cheerful	Faithful	Patient	Straight	Zealous
Clever	Fearless	Perceptive	Strong	Zestful

Shelby Steen (1999)

Form P
Client #: _____

TREATMENT PLAN

Problems to be addressed by treatment or referral	Broad goals and specific objectives to be achieved	Treatment plan (how) and anticipated timeline (when)
# 1 Alcohol		
# 2		
# 3		
# 4		

# 5		
Therapist signature:	Client signature:	Date: _____

Form Q

TREATMENT PLAN (Continuation)

Problems to be addressed by treatment or referral	Broad goals and specific objectives to be achieved	Treatment plan (how) and anticipated timeline (when)
# _____		
#_____		
#_____		

#_____		
Therapist signature:	Client signature:	Date: _____

Form R

Case Management Goal Sheet

Client ID#:_____ ***Goal #: _____***

(from Treatment Plan)

Broader goal:	***Specific objectives:***

Specific task to be completed	***By (person)***	***Goal Date***	***Notes***	***Completed (Date)***

Form S

Resource Sheet

Prepare small sheets like this to be used for giving case management referral contacts to clients. They may be printed on a colored paper for emphasis. An example of a completed sheet is shown below.

Resource Sheet

Contact:

at:

Address:

Telephone:

Ask for:

To be completed by:

Example:

Resource Sheet

Contact: Ima Helper

at: University Dental Clinic

Address: 1234 University Avenue

Telephone: 456-7890

Ask for: an appointment to have your teeth cleaned and examined

To be completed by: Monday, March 3

Form T

Understanding Resumed Drinking

At the time I had my first drink or drinks:

1. *Where* was I ?

2. *What was happening* in the situation just before I drank, that may have increased my desire to drink?

3. *Who* was with me?

4. *What was I feeling* before I drank?

5. *What was I thinking* before I drank? Was I thinking about drinking?

6. What did I *expect* to happen from drinking? How did I think I might *benefit* from drinking in this situation?

7. What *actually happened during and after* I drank? Did this match what I expected would happen?

8. What was it about this situation (if anything) that made it *particularly risky?*

9. *How else might I have coped* with this situation without drinking? What things did I try (if any) to avoid drinking in this situation?

10. Were there bigger *problems or concerns in my life at the time* that may have influenced my decision to resume drinking?

Recovering from an Episode of Drinking

Eight Practical Tips

1. Get right back on track! Stop drinking – the sooner, the better!

2. Give yourself some breathing room. Get rid of any alcohol and remove yourself, if possible, from the situation where you drank.

3. Each day is a new day. Even though having had one drink (or several) can be unsettling, you don't have to continue drinking. You are responsible for your choices.

4. Call in some help! Call your counselor or a sober and supportive friend right away to talk about what's happening, or go to an AA or other mutual help meeting.

5. Make a break. Do things that are incompatible with drinking, to interrupt the behavior pattern.

6. Think it through. With a little distance, discuss what happened with your counselor or friend at a meeting, to get a better understanding of what contributed to your drinking at that particular time, in that specific situation.

7. Don't beat up on yourself! It doesn't help to run yourself down. If feeling bad cured drinking problems, there wouldn't be any. Don't let feelings of discouragement, anger or guilt stop you from asking for help and getting back on track.

8. Learn from the experience. Use what happened to strengthen your commitment and plans to stay sober. Figure out what you need to do to prevent it from happening again!

4.When dealing with people in authority (as in asking for a raise, talking to a police officer about a ticket, discussing your treatment with your doctor).

4.When receiving criticism from someone, especially from individuals who are important to you.

Examples of Situations Where Assertive Communication is Needed

2. When expressing anger or criticism, especially to individuals who are important to you.

4.When refusing a direct request from someone.

When dealing with people in authority (as in asking for a raise, talking to a police

3. When receiving criticism from someone, especially from individuals who are

4.When making a request, asking for help, a favor or support from someone.

tant to you (as in explaining yourself, taking responsibility for your actions, izing to someone or making amends).

4.When expressing an opinion.

When expressing positive feelings or giving compliments to someone.

4.When .....

4.When .....

4.When .....

4.**When .....**

Form W

SOME BASIC TIPS FOR ASSERTIVE COMMUNICATION

1. Use an "I" Message

When you are expressing yourself - your thoughts, feelings, opinions, requests - begin with the word "I" rather than "You." By starting with "I" you take responsibility for what you say. Statements that start with "You" tend to come out as more aggressive - blaming, threatening, etc.

2. Be Specific

Address a specific behavior or situation, and not general "personality" traits or "character." A specific request, for example, is more likely to result in a change, whereas general criticism is unlikely to improve things.

3. Be Clear

Say what you mean. Don't expect the other person to read your mind, to just "know" what you want or mean. When you make a request, make it clear and specific. When you respond to a request, be direct and definite. "No, I don't want to do that" is clearer than, "Well, maybe .. I don't know." Your facial expression and body language should support your message. Speak loudly enough to be easily heard, and use a firm (but not threatening) tone. Look the person in the eye (not at the floor). Don't leave long silences.

4. Be Respectful

Don't seek to intimidate, win, or control the other person. Speak to the person at least as respectfully as you would like to be spoken to. If you have something negative or critical to say, balance it with a positive statement before and after. Also recognize that people have different needs, and hear in different ways. In conflict situations, take partial responsibility for what has happened and is happening.

Form X

Tips on Assertive Communication in Conflict Situations

Three Parts of an Assertive Message

Describe the behavior.

Describe your own feelings or reactions.

Describe what you want to see happen.

When Receiving Criticism

Keep cool; avoid escalation.

Listen carefully; show that you understand the other
rspective.

Correct any misunderstandings.

Take partial responsibility and apologize when
.

When Giving Negative Feedback (Constructive Criticism)

Keep calm; don't speak in anger or hostility.

Choose the right time and place.

Be specific; describe behavior and don't blame.

Check out misunderstandings.

Use "I" language.

Take partial responsibility or offer to help, as appropriate.

Form Y

When Asking for a Change

Describe what the person is doing - the specific behavior in which you would like a change.

Describe your own feeling or reactions, using an I message.

Describe what you want to see happen.

Take partial responsibility or offer to help, as appropriate.

How Communication Happens

Message Sent (Words)

Message Received (Words)

Message Meant (Intention)

Message Heard (Interpretation)

Form Z

Reflection Sheet

I practiced listening with (person):_____

On (date and time):_____

The other person knew that I was practicing my listening skills: 9 Yes 9 No

Here's how I think I did as a listener:

	Not Good		OK		Really Good
Paying complete attention and letting the person see that I was listening.	1	2	3	4	5
Keeping my own "stuff" out of it (advice, opinion, interpreting, etc.).	1	2	3	4	5
Keeping good eye contact.	1	2	3	4	5
Making understanding statements.	1	2	3	4	5

Notes: (What we talked about, how I felt, what happened afterward, etc.)

Urge Monitoring Card

Client ID:			
Date / Time	**Situation**	**0 - 100**	**How I Responded**

Form bb

Identifying Social Pressure Situations and Coping Responses

Client ID:	**Date:**
Situation (Person, Place, etc.)	**Coping Strategies**

Form cc

Client #: _____ **Therapist:_____**

A CHECKLIST OF SOCIAL PRESSURE SITUATIONS

To what extent do you expect that these situations could pose a problem for you in staying sober?

	Y No Problem	Y Some Problem	Y Big Problem
1. I am around other people who are drinking.	_____	_____	_____
2. Someone who is important to me is still drinking.	_____	_____	_____
3. Family members disapprove of my not drinking.	_____	_____	_____
4. Friends disapprove of my not drinking.	_____	_____	_____
5. Other people feel uncomfortable because I am not drinking.	_____	_____	_____
6. People offer me a drink.	_____	_____	_____
7. I am embarrassed to tell other people that I am not drinking.	_____	_____	_____
8. Someone I live with is a drinker.	_____	_____	_____
9. Most of my close friends drink.	_____	_____	_____
10. I go to parties and celebrations where there is drinking.	_____	_____	_____
11. I try to help someone who drinks too much.	_____	_____	_____
12. I am around drinking at work or school.	_____	_____	_____
13. Someone I love drinks too much.	_____	_____	_____
14. People pressure me to have a drink.	_____	_____	_____
15. People give me a hard time for not drinking.	_____	_____	_____
	No	**Some**	**Big**

Problem **Problem** **Problem**

Form dd

Job Leads Log

Job Title or Type:			
Source of Job Lead:			
Address:			
Telephone:			
Hiring Contact:			
Call Date(s):			
Notes:			

Form ee

STORC: Understanding Emotions and Moods

S Your Situation

These are the people, places, and things around you. People often think that they feel certain moods or emotions *because* of what is happening around them, but this is only one part of the complete picture.

T Your Thoughts

No situation affects you until you *interpret* it. How you think about what is happening has a powerful influence on how you feel about it. Different thoughts or interpretations lead to different feelings.

O Your Organismic (Physical or Bodily) Experiences

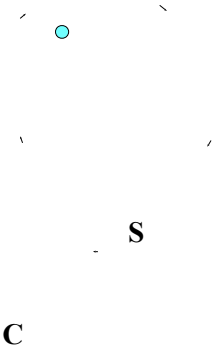
What is happening inside your body is also an important part of the moods or emotions that you experience. Many emotional experiences involve a particular kind of physical arousal that can be experienced as being agitated, angry, upset, afraid, etc. Which particular emotion you feel depends in part on how you *interpret* or name what is going on inside your body.

R Your Response or Reaction

Interestingly, how you *react*, what you *do* in response to S, T, and O also has a large effect on how you feel. Different behavioral reactions lead to different moods and emotions.

C Consequences of Your Response

How you respond, what you do, in turn has certain effects or consequences. This is how your environment (especially other people) reacts to what you do. These consequences also influence your mood and feelings, and become part of your Situation, repeating the cycle.



R O

Form ff

Feelings from A to Z

Afraid
Agitated
Alive
Angry
Annoyed
Anxious
Awful
Awkward
Bashful
Betrayed
Bored
Carefree
Confused
Cozy
Cranky
Crazy
Crushed
Depressed
Distressed
Down
Elated
Embarrassed
Empty
Excited
Free
Frenetic
Funny
Giddy
Guilty
Happy
Hurt
Impish
Irritated
Joyful
Jumpy
Kaput
Kind
Lonely
Loving
Mad
Mean
Naughty
Open
Overjoyed
Passionate
Peaceful
Relaxed
Relieved
Resentful
Reserved
Sad
Safe
Satisfied
Scared
Shy
Silly
Sympathetic
Terrible
Terrific
Tired
Trusting
Uneasy
Upset
Vicious
Violated
Vivacious
Wild
Wonderful
Yucky
Zany
Zonked

Form gg

Client #: _____ **Therapist:**_____

Mood Self-Monitoring Sheet

Mood Level: rating: _____ **-10 •••••••• 0 ••••••••• +10** **very neutral very** **negative positive**	**Mood Level: rating: _____** **-10 •••••••• 0 ••••••••• +10** **very neutral very** **negative positive**	**Mood Level: rating: _____** **-10 •••••••• 0 ••••••••• +10** **very neutral very** **negative positive**
S Situation:	**S Situation:**	**S Situation:**
T Thoughts:	**T Thoughts:**	**T Thoughts:**
O Feelings:	**O Feelings:**	**O Feelings:**
R What I did:	**R What I did:**	**R What I did:**

C **What happened:**	C **What happened:**	C **What happened:**

Form hh

Client #: _____ **Therapist:_____**

Thought Replacement Worksheet

Toxic Thought	Resulting Feeling	Replacement Thought (Antidote)	Resulting feeling

Form ii

A Menu of Possibly Pleasurable Activities

Here are many different ways in which people enjoy themselves. Some of these you would find fun or enjoyable; others will not seem pleasant to you.

Take a drive to see something new
Relax and read the newspaper
Help your child with homework
Plant something to watch it grow
Go for a walk
Take a nap
Build something from wood
Feed the birds or ducks
Hang a hummingbird feeder
Enjoy a special dessert
Go for a run
Get up early to watch the sun rise
Walk a dog
Play frisbee
Sew something
Have a relaxed breakfast
Spend an hour in a favorite store
Have a makeup demonstration
Visit a shopping mall
Add one new item to your wardrobe
Pamper your feet in a basin of warm water
Massage your feet with a cooling lotion
Write a letter to someone who helped you
Work on a quilt
Pray
Visit an old friend
Cook a favorite meal
Lie on the grass
Go out for a special meal
Rent a funny movie
Play tennis
Try a new recipe
Go to a yard sale or garage sale
Have your own yard sale
Go skateboarding or rollerblading
Go roller skating or ice skating
Have coffee with a friend
Visit a museum
Walk along the water
Visit someone who is homebound
Walk or ride a bicycle path
Buy a small gift for a friend or child
Find a place for a moment of solitude
Make a pizza
Visit the library
Play a card or board game
Buy thick fluffy new bath towels
Put fresh sheets on the bed
Hunt for bargains at a thrift store
Trade backrubs for 20 minutes
Take a relaxing hot bath
Indulge in your favorite childhood treat
Enjoy one perfect flower in a vase
Compliment someone
Babysit for someone who needs relief
Send a care package to a student
Call someone special in your family
Write to an old friend

Go to a movie, perhaps with a child
Make a big bowl of popcorn
Have or give an oil massage
Listen to your favorite music
Read a book you've heard about
Bake a batch of cookies
Make some food for a friend
Add an item to your collection
Hum or sing
Write in a diary or journal
Ride a motorcycle
Play golf or miniature golf
Clean out your purse
Read old letters you have kept
Read poetry
Write poetry
Start a memory box
Read your favorite children's book
Rearrange the furniture
Call a friend who makes you laugh
Bake biscuits or tortillas
Daydream a little
Enjoy the quiet of an early morning
Have lunch with a friend
Roll down a hill
Polish your nails a new color
Grow (or shave off) a beard or mustache
Try a new hairstyle
Enter a contest
Search your family history
Volunteer to be a coach
Paint a room
Wash and wax your car
Lie under a tree and watch the sky
Do some gardening
Take a class
Play a musical instrument (or learn to)
Visit a wild life refuge
Visit (or volunteer at) the zoo
Go horseback riding
Look at maps for places to visit
Cover a bulletin board with family pictures
Meditate
Go camping
Search the Web
Take a creek walk- the stream is your path
Pick fresh fruit or berries
Make homemade ice cream
Read a favorite magazine
Go to a demonstration in a store
Play tennis
Join a gym and work out
Go to a sporting event with someone
Spend an hour alone with your child
Be creative - try out a new kind of art
Make a family scrapbook
Build a swing in a tree
Refinish old furniture
Call someone you'd like to talk to

A Letter to People in Your Life

Wash your windows
Have a picnic in the park
Find a good spot and watch the night sky
Go fly a kite
Go dancing
Sing in a chorus
Go downtown
Go to an open house
Have dinner at a romantic restaurant
Give and receive a foot massage
Visit an aquarium
Ski or play in the snow
Build a fire
Work on a car or truck
Plan a holiday or trip
Smile
Find shapes in the clouds
Draw a cartoon
Roast hotdogs and marshmallows
Cut, chop, or carve wood
Go for a swim
Listen to a favorite radio station or program
Frame a picture
Put your feet up
Skip stones across water
Go to the mountains
Ride a train
Go to a talk or concert

Shelby Steen, 1999

Form jj

Helping Someone Overcome Alcohol Problems

Your genuine support can make all the difference. The more support people have for making an important change in their lives, the more likely it is to happen.

Alcohol problems are serious. Although heavy drinking sometimes seems to be encouraged in society and in the media, it is one of our nation's most serious health problems. More than 100,000 deaths each year are linked to heavy and risky drinking. People who drink heavily can become truly dependent on alcohol.

Overcoming alcohol dependence can be difficult. The person you care about may have "roller-coaster" mood swings, and problems (such as isolation, difficulties sleeping, anger at small events). In early months of abstinence, it is common to experience such changes as the person readjusts to sober living.

Be patient. It can be tempting to say, "just get over it!" If it were that simple, though, change would have happened long ago. The process of recovery can be slow at times, up-and-down, and even painful to watch someone go through. Mistakes and setbacks are common when people undertake a major change. It's progress in the long run that counts. It is natural to become impatient or frustrated at times, but to the extent that you can focus on the person's needs, listen without judgment, and give the person time and space to change, you will be making a valuable contribution.

You can help the person you care about in specific ways if the person wants your help. It is entirely up to that person to decide whether and how you could help, however; don't impose help where it is not wanted.

Ask the person you care about how you might be supportive. You may or may not be willing to do everything the person would like, but make sure you at least understand what he or she would find helpful.

Never offer the person alcohol or drugs of any kind. Don't buy alcohol or drugs for him or her, or promote drinking or drug use in any way.

Don't protect the person from the natural consequences of drinking. Never lie to protect the person, pretend that alcohol use is not a problem, or "clean up after" the consequences of drinking.

Read about alcohol problems.

Support the treatment process. Ask the person about how treatment is going, and what seems to be helpful. There may be new skills that you can help the person to practice. If the person asks you to come along to a treatment session, consider doing so.

Encourage the person you care about to stick with treatment even if he or she doesn't feel like it or is discouraged. It is normal for the person to have mixed feelings about treatment, but the only way to move forward is to show up and talk about those feelings.

Listen without judgment. Often is it very helpful to have a trusted person who just listens. Earning trust means listening without judgment, without "solving" the problem, and without being shocked or offended by what is said. Also, respect what the person does and does not want to tell you. For example, if he or she does not want to talk to you about drinking, don't insist on it. Encourage honesty, but also honor privacy.

Support self-control. People with alcohol problems have often lost control over their lives, and may feel powerless. The more you allow the person to take healthy control, the better. Avoid power struggles (arguments, coercion), as they rarely help and often harm.

Don't blame, attack, or judge the person. Deciding "who's to blame" is not helpful. For people who are dependent on alcohol, drinking has often been a way to cope with life; it may take awhile to learn other ways to cope. *Remember that it is up to the person to change*. You can be supportive and encouraging, but no one can make the choice or force someone else to give up alcohol. Punishment, guilt and threats are not likely to make any positive difference.

If you find yourself frequently having intense negative feelings toward the person, consider getting yourself some support. A list of resources *for you* is provided below. For example, Al-Anon provides self-help to family and friends of people with alcohol problems. You may want to consider brief therapy to help you manage the stress of the relationship.

Some Organizations That Can Be Helpful

If you feel you cannot be helpful during recovery, it is best to do nothing rather than to do harm. Respect the person's feedback about how helpful or hindering you are being to their change process. If the person asks you to back off, back off.

Treat the person you care about with great kindness and respect. "A loving heart is the truest wisdom" (Charles Dickens).

All of the resources below are free.

Alcohol/substance abuse resources
Al-Anon (1-800-344-2666). For relatives and friends of alcoholics.
Alateen (1-800-344-2666). For younger relatives and friends of alcoholics.
American Council for Drug Education (1-800-488-DRUG).
Cocaine Helpline (1-800-COCAINE).
Families Anonymous (1-800-736-9805). 12-step program for friends and relatives of children with alcohol or other drug problems.
National Clearinghouse for Alcohol and Drug Information (1-301-468-2600).
National Council on Alcoholism Information Line (1-800-NCA-CALL).
National Clearinghouse for Alcohol and Drug Information (1-800-729-6686)
Center for Substance Abuse Treatment Clearinghouse (1-800-662-HELP [4357])
National Institute on Drug Abuse Info-Fax Service (1-888-NIH-NIDA [644-6432] (free, faxed information on treatment, substance abuse trends, statistics, and drug effects).

AIDS
AIDS Hotline (English: 1-800-235-2331); (Spanish: 1-800-637-3776).

Parenting
Parents Anonymous (1-800-421-0353).

Mental Health
National Alliance for the Mentally Ill (1-703-524-7600).
National Mental Health Association (1-703-684-7722).
The National Mental Health Consumers' Association (1-215-735-2465).

Supportive People

Client #: _____ **Therapist:_____**

SSO:

Supportive of Treatment:					
Supports my sobriety	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
Maintains own sobriety	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
Available for sessions	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
Supports my goals	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
***Supportive of Me*:**					
Listens	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
Blames	Always 100%	Usually 75%	Frequently 50%	Rarely 25%	Never 0%
Helps	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
Respects	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
Knows and understands	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
Readily Available to:					
Talk with me	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
See me	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%
Be honest with me	Never 0%	Rarely 25%	Frequently 50%	Usually 75%	Always 100%

Form ll

Communicating Positive Feelings and Comments

Expressing a positive feeling and attachment

I feel very close to you when we talk like this.
I love you, I care.
I like being your friend.
I admire how loving you are with your children.
I feel good when we're together.
I like spending time with you.

Making a positive general comment about the person

I think you're a really good person.
You're so kind and thoughtful.
I like how honest you are with me.
You look good today.
You're a strong person; you've been through a lot.
I appreciate how you hang in there with me, even when I mess up.

Making a positive specific comment about the person

That was a really thoughtful thing to do.
When you give me a little hug like that, it means a lot.
That's a really good color for you - you look good in it.
Thanks for calling me - I really appreciate it.
You're so good about letting people know how you feel.
You wrote that really well - it's clear and straight.

Taking partial responsibility

I know I haven't been as patient and kind with you as I'd like to be.
If you misunderstood, maybe I didn't say it clearly.
I'm sorry you felt criticized, and maybe I was unfair in what I said..
It really takes two people to make it work, and I need to do my part too.

Offering to help

It's asking a lot for you to quit drinking. How can I support you?
I'd be glad to do my part too. What can I do to help?
How would you like me to say what I feel, so that it's not as scary for you?
I know I've hurt you a lot in the past, and I'm sorry. What can I do to help you feel safer and closer to me again? (Partial responsibility + asking to help.)

Form mm

Appendix G

Therapist Checklists

No.	Content	Manual Section
1a	Session 1	2.6a - 2.6g
1b	Phase 1 Completion	2.6i - 2.9
2	Phase 2	3.0
S	When an SSO Attends for the First Time	
P1	Sobriety Sampling	4.1
P2	Raising Concerns	4.2
P3	Case Management	4.3
P4	Resumed Drinking	4.4
P5	Support of Medication Adherence	4.5
P8	Crisis Intervention	4.8
P9	Disappointed to Receive CBI-only Condition	4.9
3a	Assertive Communication Skills	5.1
3b	Communication Skills	5.2
3c	Coping with Cravings and Urges	5.3
3d	Drink Refusal and Social Pressure Skills Training	5.4
3e	Job-Finding Training	5.5
3f	Mood Management Training	5.6
3g	Mutual Help Group Facilitation	5.7
3h	Social and Recreational Counseling	5.8
3i	Social Support for Sobriety	5.9
4a	Maintenance Check-ups	6.0
4b	Termination Procedures	7.0

Client #: _____ Therapist: _____

Therapist Checklist: Session 1	
	Materials Needed Alcohol breath tester — *Completed IPI form* *Support for Sobriety* card — *Supportive People Form (LL)* Permission form to contact SSO *What I Want from Treatment* form (blank) *Client Services Request Form* (blank) *Desired Effects of Drinking* questionnaire (blank)
	Administer alcohol breath test.
	Turn on tape recorder.
	Beginning Phase 1
	Provide an opening structuring statement.
	Explain legal limits of confidentiality.
	Ask open question and follow by reflective listening.
	Explore (by open question and reflection) the client's areas of concern (eliciting self-motivational statements).
	Offer interim summary reflections.
	Affirm the client (as appropriate and sincere).
	Respond to client concerns and statements with reflection.
	End with a summary reflection and transitional structuring statement.
	Engaging a SSO in Treatment
	Initiate discussion of inviting SSO into treatment (use ***Support for Sobriety*** card).
	Clarify possible roles of SSO, client, and therapist.
	Make a plan to invite SSO to session (client vs. therapist; rehearse following feedback).
	If necessary, obtain written permission for therapist to make contact.
	Completing Assessment
	Have client complete 3 questionnaires.
	Scan questionnaires for any items not completed.
	Wrapping up
	Offer a structuring statement for the next steps in treatment.
	Schedule next session (preferably within a few days).
	After Session 1
	Write and send hand-written note to client (include photocopy in client file).

	Fill in ***Session Record Form*** and write client contact note.

Client #: _____ Therapist: _____

Therapist Checklist: Phase 1 Completion	
	Materials Needed Alcohol breath tester Client's completed PFR packet including "Understanding Your PFR" information Personal Rulers Worksheet (blank) Decisional Balance Worksheet (blank) Letter to SSO *Working Alliance Inventory*
	Getting Started
	Administer alcohol breath test.
	Turn on tape recorder.
	Status check: Ask open question of client and follow by reflective listening.
	Offer structuring statement (review of last session and direction of this session).
	Providing Assessment Feedback (PFR)
	Provide transition and structuring statement to introduce assessment feedback.
	Provide ***Personal Feedback Report*** (PFR) to the client.
	Review PFR with client.
	Elicit and attend to client reactions to feedback.
	Respond to client's concerns and statements with reflection.
	Give the client the PFR copy and ***Understanding Your Personal Feedback Report***.
	Offer transitional summary, incorporating SMS and feedback information.
	Ask a key question and respond with reflection.
	Closing Phase 1 (2.8b)
	Provide transitional summary and ask key question. Reflect.
	Assessing Motivation (2.8c)
	Obtain 3 motivation ratings using the Personal Rulers Worksheet (if any rating is less than 6, explore using optional module 2.8d; otherwise, begin Phase 2).
Optional	**Exploring Motivation Ratings (2.8d)**
	Discuss Personal Ruler scores ("*Why x and not 0? What would it take for you to go from x to higher score*?") andreflect.
	End with a summary reflection.
Optional	**Constructing a Decisional Balance (2.8e)**
	Introduce ***Decisional Balance*** worksheet to discuss pros and cons.
	Have client list advantages of continuing to drink (fill in upper left box).

	Have client list disadvantages of changing drinking (fill in lower left box).
	Have client list disadvantages of drinking (fill in upper right box).
	Have client list advantages of changing drinking (fill in lower right box).
	Conclude with a summary reflection.
Optional	**Reviewing Past Successes (2.8f)**
	Elicit from client times in past where he/she decided to make a change and did.
	Explore what client did that worked (personal skills/strengths).
	If appropriate, walk through experience with client.
	If appropriate, use examples of how others have succeeded in making changes similar to those desired by client.
	Listen empathically and reflect client statements about personal ability.
	End with summary reflection.
	After Session
	Give client the *Working Alliance Inventory* if Phase I extends to Session 3. Fill in ***Session Record Form and local site client contact note.***

Client #: _____ Therapist: _____

Therapist Checklist: Phase 2	
	Materials Needed Alcohol breath tester Client's completed *What I Want From Treatment* form *Personal Happiness card sort* (deck arranged in order) Client's completed *Client Services Request* form Client's completed *Desired Effects of Drinking* form Copy of Client's completed *AASE-T* form Mutual help group contact and schedule information (local) *New Roads* work sheet (blank) *Personal Happiness Form* (blank) *Options* sheet (blank) *Some Characteristics of Changers* sheet *Treatment Plan* form *Working Alliance Inventory*
	Administer alcohol breath test.
	Turn on tape recorder.
	Beginning Phase 2
	Introduce Phase 2 with a structuring statement and open question.
	Explore client's *own* ideas about what and how to change. Respond with reflection.
	Functional Analysis (3.2)
	Provide introductory structuring statement.
	Ask for triggers and record on ***New Roads*** work sheet (use past tense).
	Review ***AASE-T*** items: record any additional triggers.
	Ask for past effects (positive consequences) and record on ***New Roads*** work sheet.
	Review ***DED*** for additional consequences: record any additional effects.
	Review ***New Roads*** worksheet with client, introduce "vehicle" or "path" idea.
	Have client connect triggers with effects on worksheet (add items as needed).
	Link to idea of "psychological dependence" and explain "new roads" concept.
	Elicit new roads, ideas or areas, and record on ***Options*** work sheet.
	Reviewing Psychosocial Functioning (3.3)
	Present and have client complete ***Personal Happiness Form*** (PHF).
	Have client complete ***PH card sort*** - Which are at least partly related to drinking?
	Check off in "Link" column of ***PHF.***
	Have client re-sort ***PH cards*** - In what areas would client like to make a change?
	Check off in "Change" column of ***PHF***.
	Discuss each Change item on ***PHF*** with client (begin with most dissatisfied areas).
	Follow up on other items, as needed.
	Offer a summary reflection.

	Identify client's priorities for change. Record on ***Options*** sheet.

	Identifying Strengths and Resources (3.4)
	Provide transitional structuring statement.
	Identify personal strengths. Ask for elaboration. "What else?" ***Characteristics*** list?
	Offer summary reflections.
	Identify additional sources of support.
	Developing a Plan for Treatment and Change (3.5)
	Provide structuring statement.
	Introduce ***Options*** and review options already recorded.
	Review any additional YES areas from "***What I Want***" as possible ***Options***.
	Recommend use of mutual-help programs and encourage client to sample (3.5c).
	If client shows openness to programs, add to bubble on ***Options*** sheet.
	Prioritize options with client.
	Offer structuring statement: developing a treatment plan together.
	Develop ***Treatment Plan*** with client (complete all columns, cross out unused rows).
	Specify the client's goal with regard to drinking (Goal #1) and other goals.
	Elicit or present advantages of abstinence (3.5f) State concerns as needed.
	Consolidating Commitment
	Recapitulation: summarizing SMS and change plan.
	Ask for client's commitment to the plan. Affirm.
	Client and Therapist sign and date completed ***Treatment Plan***.
Optional	**SOBR - Sobriety Sampling (4.1)**
Optional	**CONC - Raising Concerns (4.2)**
Optional	**CASM - Case Management (including referral) (4.3)**
Optional	**RESU -Resumed Drinking (4.4)**
Optional	**SOMA - Support for Medication Adherence (4.5)**
Optional	***MISS - Missed Appointments (4.6)***
Optional	***TELE - Telephone Consultation (4.7)***
Optional	***CRIS - Crisis Intervention (4.8)***
Optional	***DISS- Disappointed to receive CBI-only condition (4.9)***
	After Session

	Give client the Working Alliance Inventory at end of Session 3, if not completed in Phase I. Fill in ***Session Record Form and local site client contact note***.

Use this checklist whenever a SSO attends a session for the first time

Client #: _____ Therapist: _____

Date:	SSO's name:
	When SSO is present for the first time
	Welcome and thank SSO for participating.
	Introduce audiotape and have SSO sign consent to be part of treatment sessions and audiotaped.
	Explore how SSO has tried to be supportive in the past.
	Reflect.
	Clarify SSO's role and ask whether the SSO is willing to help in this way.
	Ask whether the client is willing to have the SSO help in this way.
	Ask whether the SSO has any questions that you could answer.
	Ask whether the client has any questions or concerns about SSO's participation.

Client #: _____ Therapist: _____

Therapist Checklist: Sobriety Sampling	
	Materials Needed May want to review client's responses to completed Treatment Plan and New Roads
	Assessing Motivation for a Period of Sobriety
	Elicit SMS (e.g., ask open-ended questions about benefits to abstaining).
	Reflect SMS.
	Summarize with emphasis on reasons for a trial period of sobriety that client has stated..
	Probe Willingness (4.1b)
	Ask whether client is willing to consider possibility of abstinence.
	Respond with reflection.
	Discuss Implementation (4.1c)
	How long? (begin by suggesting one month).
	Starting when?
	How to do it?
	Discuss obstacles and problems and problem-solve (fire escape, avoiding).
	Reluctant Clients (4.1d)
	Delay decisions.
	Emphasize personal choice.

Client #: _____ **Therapist:** _____

Therapist Checklist: Raising Concerns	
	Basic Procedure (4.2.b)
	Reflect the goal, plan, or intention about which you are concerned.
	Ask permission to express your concern.
	State your concern.
	Ask client to respond to concern.

Client #: _____ **Therapist:** _____

	Therapist Checklist: Case Mangement
	Materials Needed Completed Client Services Request Form (F) Access to resource listing of potential referral sources Forms S & T
	Beginning the Case Management Process (4.3d)
	After introducing the module, implement steps summarized in acronym ARISE.
	Prioritize (4.3e)
	Fill in Case Management Goal Sheet (Form S).
	Making a Referral (4.3f)
	Follow up on client's progress (Form T).

Client #: _____ **Therapist:** _____

Therapist Checklist: Resumed Drinking	
	Materials Needed May want to use Form J (Decisional Balance Worksheet) Forms U & V
	Assessing Motivation
	Employ Phase 1 strategies for assessing motivation.
	May revisit Abstinence Emphasis (3.4), Decisional Balance Worksheet (Form J), or Past Successes (2.8f).
	Summary reflection, key question, setting new goals.
	When Drinking Resumed due to Situational Risks and Coping Issues (4.4d)
	Elicit responses to Understanding Resumed Drinking (Form U).
	Recovering from an Episode of Drinking (4.4e)
	Use handout on 8 practical tips (Form V).

Client #: _____ **Therapist:** _____

Therapist Checklist: Support for Medication Adherence	
	Assessing Motivation
	Identify sources of nonadherence (4.5c).
	Explore past medication adherence.
	Elicit Self Motivational Statement for Adherence (4.54e)
	Employ Phase 1 strategies to increase motivation for adherence.
	Delaying the Decision (4.5f)
	Review pros and cons of nonadherence.
	Elicit "back-up" plan (which may include adherence).
	Ask permission to delay decision.
	Overcoming Practical Obstacles to Nonadherence (4.5g)

Client #: _____ **Therapist:** _____

Therapist Checklist: Crisis Intervention	
	Counseling Procedures
	Listen.
	Assess urgency.
	Focus on problem-solving.
	Mobilize support.
	Follow up.

Client #: _____ **Therapist:** _____

	Therapist Checklist: Disappointed to receive CBI-only condition
	Level I: Listening Empathically
	Listen empathically.
	Convey an understanding and acceptance of the client's disappointment through reflective responses.
	Level II: Provide Reassurance
	Inform the client that previous research has indicated that CBI is effective even without medication.
	Inform the client that CBI was constructed from the treatment methods with strongest evidence of efficacy.
	Level III: Pros and Cons
	Ask the client if he or she would be willing to consider listing the "pros and cons" of continuing with CBI.
	Beginning with the negatives, make a written list of the benefits and costs that the two of you can generate about pursuing CBI.
	Prompt the client, as appropriate, to consider some that might have been overlooked.
	Offer a summary reflection when you have completed the list, describing both sides.
	Ask what the client wants to do at this point.
	Level IV: Emphasize Personal Choice and Control
	In a genuine and gentle fashion, emphasize that while you would like to proceed, it is ultimately up to the client.
	Acknowledge that the client can withdraw from the trial.
	Avoid persuasion.

Client #: _____ **Therapist:** _____

	Therapist Checklist: ASSN
	Materials Needed Forms MM & W & X & Y
	Identifying Situations that call for Assertive Communication
	Ask clients to identify experiences that elicit strong emotional states.
	Use Form W.
	Defining Assertive Communication
	Discuss basic beliefs.
	Contrast passive, aggressive, and assertive communication.
	Discuss pros and cons of each.
	How to Communicate Assertively
	Review four basic TIPS on Form X (give copy to client).
	Tell-Show-Try the "I" message and how to ask for a change in behavior.
	Using Assertive Communication to Deal with Interpersonal Conflicts
	Review TIPS on how to receive and give constructive criticism.
	Giving encouragement and making positive statements.
	Closing a Session
	Review and negotiate a home assignment.

TCL 3a

Client #: _____ **Therapist:** _____

	Therapist Checklist: COMM
	Materials Needed Forms Z & aa; Involve SSO in exercises
	Introducing the Process of Interpersonal Communication
	Ask client about communication situations.
	Give client a copy of "How Communication Happens" (Form Z) & discuss.
	Communicating Effectively
	Complete Attending exercise.
	Discuss Communication Roadblocks.
	Guessing about Meaning exercise using Form Z.
	Forming understanding statements exercise (home assignment of Form aa).
	Assign homework of keeping track of positive statements.
	Increasing Positive Interaction
	Discuss how good relationships are fostered by doing positive things together.
	Negotiate shared positive non-drinking activities to do during the week.

Client #: _____ **Therapist:** _____

	Therapist Checklist: CRAV
	Materials Needed Form bb
	Rationale
	Discuss reality of cravings and urges.
	Discuss predictability/triggers for cravings (internal and external).
	Discuss course of cravings.
	Discovering and Coping with Trigger Situations
	Identify recent "craving" situations client encountered.
	Have client describe experience (be specific).
	Check in with client regarding potential triggering of craving experience session.
	Monitoring Urges
	Discuss rationale for urge monitoring (try to elicit self-motivational statements).
	Give client self-monitoring cards (Form bb) and discuss using them.
	Troubleshoot any obstacles.
	Practice with example.
	Homework Assignment: 2-3 weeks of urge monitoring.
	Coping with External Triggers
	Discuss each of the four identified strategies for coping with external triggers (Avoid, Escape, Distract, Endure).
	Coping with Internal Triggers
	Discuss two strategies for coping with internal triggers (Let Go and Endure).
	Developing an Individual Coping Plan
	Have client select 2-3 strategies that fit him or her best.
	Develop selected strategies in detail.

Client #: _____ **Therapist:** _____

	Therapist Checklist: DREF
	Materials Needed Forms cc & dd; optional is to have a SSO/friend participate in practice
	Social Pressure and Drink Refusal
	Explain direct and indirect social pressure.
	Identify social pressure situations and coping responses (Forms cc & dd, "Checklist of Social Pressure Situations" optional).
	Identify specific examples of social pressure as well as specific individuals.
	Developing Skills for coping with Social Pressure to Drink
	Discuss rationale for thinking through and rehearsing drink refusal.
	Explain two ways of coping: Avoid or Escape.
	Elicit and problem solve strategies for coping with social pressure.
	Reflect and affirm.
	Coping Behavior Rehearsal
	Introduce importance of being prepared to react in pressure situation.
	Discuss idea of having a sequence of responses.
	Introduce importance of behavior rehearsal.
	Rehearse pre-determined drink refusal strategies with gentle coaching, variations on scenarios, and increasing difficulty.
	Closing Session
	Summarize and review coping strategies.
	Discuss where client thinks that additional practice is needed.
	Continue to record on worksheet throughout module.
	Give client copy of worksheet to take home and keep copy in file.

Client #: _____ **Therapist:** _____

	Therapist Checklist: JOBF
	Materials Needed Form ee; sample job applications from community
	Introducing the Module
	Clarify the advantages of having a job by eliciting the good things about having a job.
	Reflect and summarize.
	Resume Development
	Teach difference between a functional resume and a chronological resume.
	Explain how job-finding is a full-time job.
	After reviewing in session, have client list all the jobs that he/she has had in last 5-10 years. (include dates) as homework and then fill in gaps
	Have client describe duties, responsibilities and necessary skills for each.
	Have client list positive personal characteristics.
	Have client type resume and cover letter.
	Identifying and Avoiding Jobs with High Relapse Potential
	Completing Job Applications
	Teach skills for completing an application.
	Practice completing sample applications.
	Problem solve any problems or concerns (e.g., alcohol questions).
	Generating Job Leads
	Familiarize client with Form ee, *Job Leads Log*.
	Generate list of 10 job leads to create a job log.
	Telephone Skills Training
	Train client to be brief, clear and positive.
	Employ steps in making "cold calls."
	Role play "cold call" phone conversation.
	Have client make one or more phone calls from office.
	Interview Skill Training
	Review basics of interviewing.

	Rehearse interview questions and respond with positive reinforcement.
	Discuss possibility of rejection.
	Assess motivation and return to resolving ambivalence as appropriate.

TCL-3e

Client #: _____ **Therapist:** _____

	Therapist Checklist: MOOD
	Materials Needed Forms ff, gg, hh, & ii
	Rationale for MOOD Module
	Introduce and explain STORC acronym (give out Form ff).
	Explore situational factors, thoughts, organismic experiences, responses, and consequences.
	Explore negative mood states (optional Form gg).
	Begin self-monitoring (Form hh).
	Practice with one identified event, completing each column and discuss.
	As home assignment, suggest client monitor mood over the next week.
	Automatic Thoughts
	Teach connection of thoughts and emotions and rationale behind thought changing.
	Review mood monitoring sheets, looking for consistent patterns that lead to negative moods (content and process).
	Explore other ways to view or interpret situation.
	Challenging Toxic Thoughts
	Review rationale for challenging and replacing negative patterns.
	Emphasize choice.
	Introduce 2 ways of changing thoughts: Think or Act differently.
	Present *Thought Replacement* worksheet, Form ii.
	Practice completing worksheet using situations from mood sheets.
	Explore situations and ask client what he/she could have done instead.
	Negotiate home assignment.
	Applying STORC with Urges to Drink
	Identify STORC components that make up an urge to drink.
	Find ways to challenge the toxic self-talk with replacement thoughts and responses (elicit client's own ideas).

Client #: _____ **Therapist:** _____

	Therapist Checklist: MUTU
	Definition and Background of Mutual Support
	Discuss rationale/importance of support groups.
	Initiating Mutual-Support Group Involvement
	Explore attitudes about mutual support.
	Give information about available groups.
	Encourage sampling.
	Provide referral information.
	Make a specific plan.
	Emphasizing Action
	Once client finds a group that is acceptable, ask about and encourage active involvement.
	Explore potential obstacles (client beliefs and attitudes).
	Handling Negativity about Mutual-Support Group Attendance
	Explore roots of negativity.
	If client is not ready to attend, put on hold and return to topic later.

Client #: _____ **Therapist:** _____

	Therapist Checklist: SARC
	Materials Needed Form jj
	Explaining the Rationale
	Discuss importance of healthy relationships and rewarding recreational activities.
	Elicit client's feelings and thoughts.
	Reinforce self-motivational statements.
	Provide summary reflection-important reasons for developing alcohol-free sources of positive reinforcement.
	Assessing Sources of Reinforcement
	Have client describe people, places, and activities associated with drinking.
	Compare two lists - clarify patterns that support drinking vs. sobriety.
	Move to plan for increasing/sampling non-drinking activities that client approves.
	Assign homework assignment.
	Developing a Non-Drinking Support System
	Identify supportive people either from non-drinking activity discussion or from client's discussion with family and friends.
	Reinforcer Sampling
	Have client pick one activity from menu of options.
	Assign client to try out reinforcing activity before next session.
	Discuss apprehension/fears about trying something new.
	Problem-solve factors that might interfere with trying or enjoying new activity.
	Systematic Encouragement
	Practice contacting organizations.
	Call contact person to meet client at meeting.
	Review reinforcing value of activity.

Client #: _____ **Therapist:** _____

	Therapist Checklist: SSSO
	Materials Needed Form kk
	Explain the purpose of the module
	Elicit from client ways in which he/she would like support from significant others.
	Give client a copy of Form kk.
	Have the client read the letter and discuss it.
	Decide whether the client wishes to give the letter to anyone.
	Rehearse ways in which the client could ask others for support.

Client #: _____ **Therapist:** _____

	Therapist Checklist: Maintenance
	Presenting the Rationale for Phase 4
	Explain that meetings will continue (every few weeks) until the 16 week date.
	Present as free option, without using relapse language.
	Basic Structure of Check-up Sessions
	Review progress.
	Renew motivation.
	Discuss (if it occurred) drinking situations with possible decision to resume regular sessions as new challenges arise until the 16 week date.
	Review non-drinking situations.
	Resume Phase 3 if you and client agree that it could be helpful.

Client #: _____ **Therapist:** _____

	Therapist Checklist: Termination
	Preparing Your Client
	Three sessions before the last session, remind your client that you have 3 more sessions.
	Prepare Yourself
	Review progress.
	Discuss termination with your supervisor 3 sessions before ending treatment.
	Consider whether the client may need additional services elsewhere (beyond available 20).
	Confirm the date for the follow-up interview.
	Essential Elements
	Express your appreciation.
	Ask what important changes were made.
	Review the progress made.
	Attribute positive changes to client.
	Explore termination feelings.
	Ask what's next.
	Support self-efficacy.
	Consider additional treatment.
	Give a follow-up reminder.
	Closing.

TCL-4b

Appendix H

Clinical Care Guidelines

Guidelines for Discontinuation of Subjects from Study Treatment

For reasons of ecological validity, guidelines for discontinuation of subjects from study treatment will be somewhat flexible. Given the duration of the treatment period (sixteen weeks), there will be greater opportunity to resolve clinical problems that might otherwise be more difficult to address in a briefer intervention period (i.e., less than three months). Consequently, drinking and drug use that might require detoxification, or inpatient/ partial hospitalization during the 16-week study period should not routinely constitute grounds for removal of subjects from the protocol. However, subjects who are incarcerated for criminal activity will be discontinued from the study during their incarceration. Thus, decisions concerning the withdrawal of hospitalized clients from study treatment will be made on a case-by-case basis and in general, every effort will be made to safely manage subjects in the protocol..

Since this is an intention-to-treat study, individuals will not be required to complete a finite number of sessions or adhere to the medication regime (after random assignment) to be considered a participant in the protocol. Within this context, individuals failing to appear for scheduled appointments, those refusing medication, or evidencing other compliance problems (e.g., failing to return blister pack) will be allowed to remain in the clinical protocol. *Subjects who have been absent from the protocol for four or more weeks will need to be rescreened prior to going back on study medication. Full laboratory tests will be performed including a urine drug screen and a pregnancy test*. These matters will be addressed by therapists/counselors utilizing procedures and strategies developed in the MM and CBI manuals and clinical supervision.

However, it is anticipated that there will be some cases that cannot be safely managed in the clinical protocol. These cases include, but are not limited to, the following categories:

IV. Acute psychosis (hallucinations, impaired reality testing, paranoid ideation, etc.) requiring medication and/or hospitalization or intensive outpatient intervention;
IV. Suicidal or homicidal ideation that results in a credible threat of violence directed at oneself or others.
V. Hospitalization for psychiatric symptoms

Subjects requiring more intensive treatment resulting from acute psychosis or suicidal/homicidal behavior will be referred to local treatment centers, but will not be provided with medication or psychotherapy by study staff. It should be noted that these guidelines are meant for non-emergency situations. It is expected that the local clinical staff will deal with emergency situations. In cases where it is unclear whether the subject should be discontinued from study treatment, e.g. transient suicidal ideation in the context of acute intoxication, sites are encouraged to contact a Clinical Care Committee representative for consultation. Subjects will be permitted one medical detoxification and still be allowed to continue in the study. Subjects who are started on antidepressants or other psychotropics will be discontinued from study medication but will be allowed to continue in the protocol. The PI and the Coordinating Center must be notified in all cases involving the removal of subjects from the protocol or from taking medication.

- ***Pregnancy.*** *Subjects who become pregnant during the course of the treatment will be discontinued from the study medication.*

- ***Elevated liver enzymes.*** *Individuals whose ALT/AST is greater than 5X normal will need to have ALT/AST repeated within 1-2 weeks and if still greater than 5X normal the subject's medication will be stopped. If the repeat values are less than 5X normal but still elevated the subject should be monitored using clinical judgement. Individuals whose total bilirubin is above 50% baseline level but within the normal range will be evaluated by a study physician to*

determine whether study medication should be discontinued. Individuals whose total bilirubin is greater than 10% above ULN will be taken off the study medication immediately.

- ***Renal insufficiency.*** *Individuals whose serum creatinine level is 1.3 or 1.4 will be evaluated by study physician to ascertain whether study medication should be discontinued. However, a creatinine cut-off of 1.5 should be cause for removal from the study medication.*

- ***Opioid medication.*** *The study medication will be stopped if an individual needs opioid medication while participating in the study. There will be a 10-day delay after the last dose of opioid medication before the study medication is restarted (There will be an exception if the individual has been on methadone). Before the study medication is reintroduced the individual will need to produce a negative urine. The study medication may need to be retitrated when it is restarted. Retitration will occur according to the instructions provided in the Medical Management Treatment Manual. Also, the individual will need to be warned about not resuming opioid medication while on the study medication and the risks of having a severe withdrawal if they were to take naltrexone while taking opiates.*

- ***Physical illness.*** *Subjects will need to be removed from medication if they have a disabling condition that precludes them from taking the study medication. The MM clinician is responsible for referring the individual to a physician if a previously untreated or new medical problem is identified during the MM sessions.*

- ***Psychotropic Medications.*** *Subjects who require psychotropic medication will be discontinued from study medication. Subjects may receive one medical detoxification and remain on study medication. Subjects may receive hydroxyzine (Vistaril®) for anxiety, nausea, dizziness, nervousness or insomnia, as outlined in the MM Treatment Manual, and remain on study medication.*

The decision about whether to discontinue a subject temporarily or permanently from the study medications will be made by local medical management staff. Subjects who improve to the degree that their illness or other reason for withdrawing from the medication resolves, and who have no medical contraindication for being rechallenged with study medication, will be encouraged to resume the medication by study staff. Study medication may be retitrated in subjects at the discretion of the treating physician according to the MM Treatment Manual recommendations, but it is suggested that subjects who have been off medication for less than four weeks not be retitrated.

All subjects must be managed clinically. This means that individuals who suffer adverse experiences related to the study medication will be referred to the local medical management staff. The medical staff will utilize guidelines included in the MM manual related to handling adverse effects of study medications and concomitant medications (see Appendices A1, A2 and B for list of procedures to be employed in managing side effects.) The medical staff may reduce study drug dose and/or provide prescriptions or over-the-counter medications to reduce symptoms as outlined in the MM Treatment Manual. If this is not successful, study drug medication may be held completely until the physician believes study medication can be restarted.

Clinical Care Subcommittee

For purposes of quality assurance and monitoring of clinical care, a Clinical Care Committee will be formed and two members of the Committee, to include one M.D. and one Ph.D., will be assigned to each site. In most cases, staff will draw upon procedures in the MM and CBI manuals along with clinical supervision for managing clients in the clinical protocol. Consultation may be requested from the Clinical Care Committee if further assistance is necessary. A site will need to contact the Coordinating Center to initiate a consultation. The Committee will review cases of clinical deterioration and provide guidance when it is unclear whether clients could be managed within the COMBINE protocol or should be withdrawn from the clinical arm of the study and referred for more intensive intervention. This is expected to promote the consistency of application of trial-wide criteria for retention (or removal) of subjects in the clinical arm of the trial. However, the final decision to remove deteriorated subjects from the treatment arm will be made at each site by

a joint decision of the project coordinator, therapist and principal investigator. Reports of withdrawals due to clinical deterioration will be forwarded to the Coordinating Center for review of consistency and frequency of, and reason for, removal across sites and treatments. These data will be compiled and forwarded regularly to the data monitoring board for ongoing review of safety of the trial and study treatments. Clients who are removed from the clinical protocol will remain in the research sample and will be followed up and included in the analyses.

Implementation

Goals. *The overall goal of the Committee is to safely manage subjects in the clinical protocol. Another purpose is to attend to issues involving subject removal and possible reintroduction to the study medications. In addition, the Committee will provide consultation dealing with the removal of deteriorated subjects. This will entail (1) further defining and operationalizing adverse consequences occurring during the course of treatment that would constitute cause for removal of subjects from the treatment protocol (2) providing consultation in determining whether or not a client can be managed within the assigned COMBINE treatment (3) assisting the CRUs in safely managing subjects in the clinical protocol and (4) assisting in dealing with the withdrawal of subjects from the protocol if deemed necessary.*

Procedures. *In most instances the decision about whether or not to retain an individual in the protocol treatment can, and will be made by the PIs/PC and therapist based upon case material. In "gray areas", the Clinical Care Committee will be consulted. The first task is to evaluate the behaviors that constitute cause for removal from the treatment protocol (e.g., impairment of mental health) and the potential risks of maintaining the subject in a COMBINE treatment. The second is to assist PIs/ PCs and therapists in developing a plan for stabilizing the client so that he or she can remain in the study treatments. The third is to assist in the handling of the removal of subjects from the study and providing recommendations for appropriate levels of treatment.*

Two members of the Clinical Care Committee will be assigned to a CRU(s) to act as consultants in decisions involving the retention of subjects. The PC will contact the Coordinating Center to determine the appropriate representative to review a case and to make recommendations about whether an individual should be maintained in the clinical protocol. If there appears to be a consensus about the appropriateness of the client, a plan will be developed for stabilizing the condition of the client so that he or she can remain in the protocol. Committee members will determine whether the issue can be resolved with the parties involved or whether the case warrants a conference call with the full Committee, a representative of the Operations Committee, the PI/Co-PI/PC and therapist of the local CRU. The final decision about retention will be made jointly by the local PI/Co-PI/PC and therapist after consultation.

Clinical Care Committee site assignments:

Boston University:	*Estee Sharon, Psy.D.; Ismene Petrakis, M.D.*
Brown University:	*Suzy Gulliver, Ph.D.; J.C. Garbutt, M.D.*
Harvard University:	*Suzy Gulliver, Ph.D.; Ismene Petrakis, M.D.*
Medical University of South Carolina:	*Estee Sharon, Psy.D.; J.C. Garbutt, M.D.*
University of Miami:	*Estee Sharon, Psy.D.; J.C. Garbutt, M.D.*
University of New Mexico:	*Estee Sharon, Psy.D.; Lance Longo, M.D.*
University of Pennsylvania:	*Judy Arroyo, Ph.D.; Ismene Petrakis, M.D.*
University of Texas, San Antonio:	*Judy Arroyo, Ph.D; Lance Longo, M.D.*
University of Washington:	*Judy Arroyo, Ph.D.; Lance Longo, M.D.*
University of Wisconsin:	*Suzy Gulliver, Ph.D.; Ismene Petrakis, M.D.*
Yale University:	*Suzy Gulliver, Ph.D.; Lance Longo, M.D.*

Bob Swift, M.D. will be available to the Committee to provide consultation as needed.