

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

**COMBINE**  
MONOGRAPH  
S E R I E S

**Volume 1**

# **Combined Behavioral Intervention Manual**

**A Clinical Research Guide for Therapists Treating  
People With Alcohol Abuse and Dependence**



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health



National Institute on Alcohol Abuse and Alcoholism  
COMBINE Monograph Series  
Volume 1

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# Combined Behavioral Intervention Manual

## A Clinical Research Guide for Therapists Treating People With Alcohol Abuse and Dependence

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# Contents

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<b>Acknowledgments</b> .....	.xi
<b>Foreword</b> .....	.xv
<b>Overview of COMBINE</b> .....	.xvii
<b>1. An Integrated Cognitive-Behavioral Psychotherapy for Alcohol Problems</b> .....	1
1.1 Overview of the Combined Behavioral Intervention .....	1
1.2 Research Basis for the Combined Behavioral Intervention .....	2
1.2a Combining Effective Treatments .....	2
1.2b Motivational Interviewing .....	4
1.2c Mutual-Help Group Involvement .....	6
1.3 Coordination With Medication Management .....	7
1.3a Scheduling .....	7
1.3b Client Flow .....	7
1.3c Continuation .....	7
1.3d Communicating With the MM Practitioner .....	8
1.4 How Does CBI Differ From Prior Cognitive-Behavioral Therapies? .....	9
<b>2. Phase 1: Building Motivation for Change</b> .....	13
2.1 What Is Motivation? .....	13
2.2 Stages of Change .....	14
2.3 Rationale and Principles of Motivational Interviewing .....	15
2.3a Express Empathy .....	15
2.3b Develop Discrepancy .....	16
2.3c Avoid Argumentation .....	16
2.3d Deflect Defensiveness .....	16
2.3e Support Self-Efficacy .....	17
2.4 Comparison With Other Approaches .....	17
2.4a Differences From a Denial-Confronting Approach .....	17
2.4b Differences From Nondirective Counseling .....	18
2.4c Integration With Cognitive-Behavioral Skill Training .....	19
2.5 Clinical Style .....	19
2.5a Eliciting Self-Motivational Statements .....	20
2.5b Asking Open Questions .....	22
2.5c Listening With Empathy .....	22
2.5d Affirming the Client .....	24

2.5e	Responding to Defensiveness .....	25
2.5f	Reframing .....	27
2.5g	Summarizing .....	28
2.6	Implementing Phase 1 .....	29
2.6a	Getting Started With Motivational Interviewing .....	30
2.6b	Initiating Involvement of an SSO .....	32
2.6c	Completing Assessment Needed for Phases 1 and 2 .....	39
2.6d	Ending the First Session .....	39
2.6e	Scheduling the Next Session .....	40
2.6f	Sending a Handwritten Note .....	40
2.6g	Completing the Session Record Form .....	40
2.6h	Completing the Therapist Session 1 Checklist .....	42
2.6i	Beginning the Second Session .....	42
2.6j	Providing Assessment Feedback .....	42
2.6k	Completing Therapist Checklists .....	44
2.6l	Ending Sessions .....	44
2.7	Involving the SSO in CBI Treatment .....	45
2.7a	Overview .....	45
2.7b	Orienting the SSO to CBI .....	45
2.7c	When Differences Occur Between the SSO and Client .....	49
2.7d	What Does the SSO Do If the Client Resumes Drinking? .....	50
2.7e	Audiotaping .....	51
2.7f	SSO Consent .....	51
2.7g	The Basic CBI Approach .....	52
2.7h	The Problematic SSO .....	52
2.7i	Subsequent Sessions .....	54
2.8	Making the Transition From Phase 1 to Phase 2 .....	54
2.8a	Recognizing Change Readiness .....	54
2.8b	Making the Transition to Phase 2 .....	56
2.8c	Assessing Motivation .....	56
2.8d	Optional: Exploring Motivation Ratings .....	57
2.8e	Optional: Constructing a Decisional Balance .....	58
2.8f	Optional: Reviewing Past Successes .....	59
2.8g	Closing Phase 1 .....	61
2.9	Interim Homework Assignments .....	61
<b>3.</b>	<b>Phase 2: Developing a Plan for Treatment and Change .....</b>	<b>63</b>
3.1	Beginning a Plan .....	63
3.2	Doing a Functional Analysis .....	64
3.2a	Antecedents .....	64
3.2b	Consequences .....	65
3.2c	Client Reluctance .....	65
3.2d	Connections .....	66
3.2e	New Roads .....	67
3.2f	Positive Functional Analysis .....	67



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3.3	Reviewing Psychosocial Functioning	68
3.3a	Personal Happiness Form	68
3.3b	Card Sorting	69
3.3c	Reviewing the Personal Happiness Form	70
3.3d	Summarizing	71
3.3e	Identifying Priorities	72
3.4	Identifying Strengths and Resources	72
3.5	Developing a Plan for Treatment and Change	74
3.5a	Structuring Statement	74
3.5b	Reviewing Options	75
3.5c	Recommending Mutual-Help Programs	75
3.5d	Setting Priorities	76
3.5e	Preparing the Treatment Plan	77
3.5f	Emphasizing Abstinence	78
3.5g	Recapitulating	80
3.5h	Asking for Commitment	81
<b>4.</b>	<b>Pull-Out Procedures</b>	<b>83</b>
4.1	Sobriety Sampling (SOBR)	84
4.1a	Rationale	84
4.1b	Probe Willingness	85
4.1c	Discuss Implementation	85
4.1d	Reluctant Clients	88
4.2	Raising Concerns (CONC)	90
4.2a	Rationale	90
4.2b	Basic Procedure	90
4.3	Case Management (CASM)	92
4.3a	Rationale	92
4.3b	On-Site Case Management Preparation	93
4.3c	Introducing the Module	93
4.3d	Beginning the Case Management Process	93
4.3e	Prioritizing	94
4.3f	Making a Referral	96
4.4	Resumed Drinking (RESU)	98
4.4a	Rationale	98
4.4b	A Few Words About Language	99
4.4c	Motivational Issues	99
4.4d	Situational Risks and Coping Issues	103
4.4e	Recovering From an Episode of Drinking	109
4.5	Support for Medication Adherence (SOMA)	109
4.5a	Rationale: The Importance of Medication Adherence	109
4.5b	Why Do Clients Not Adhere to Medications?	110
4.5c	Adherence Motivational Assessment	110
4.5d	Exploring Past Medication Adherence	112
4.5e	Eliciting Self-Motivational Statements for Medication Adherence	112

4.5f	Delaying the Decision .....	114
4.5g	Overcoming Practical Obstacles .....	115
4.6	Missed Appointment (MISS) .....	116
4.7	Telephone Consultation (TELE) .....	117
4.8	Crisis Intervention (CRIS) .....	118
4.9	Disappointed to Receive CBI-Only Condition (DISS) .....	119
<b>5.</b>	<b>Phase 3: Assisting With Change .....</b>	<b>121</b>
5.1	Assertive (Expressive) Communication Skills (ASSN) .....	121
5.1a	Overview .....	121
5.1b	Rationale and Basic Principles .....	123
5.1c	Step 1: Identifying Situations That Call for Assertive Communication ..	123
5.1d	Step 2: Defining Assertive Communication .....	125
5.1e	Step 3: How to Communicate Assertively .....	128
5.1f	Asking for a Change .....	129
5.1g	Using Assertive Communication to Deal With Interpersonal Conflicts ...	133
5.1h	Giving Encouragement and Making Positive Comments .....	135
5.1i	Closing a Session .....	136
5.2	Communication (Listening) Skills (COMM) .....	136
5.2a	The Process of Interpersonal Communication .....	137
5.2b	Communicating Effectively .....	138
5.2c	Increasing Positive Interactions .....	142
5.3	Coping With Craving and Urges (CRAV) .....	143
5.3a	Rationale .....	143
5.3b	Discovering and Coping With Trigger Situations .....	144
5.3c	Monitoring Urges .....	145
5.3d	Coping With External Triggers .....	146
5.3e	Coping With Internal Triggers .....	147
5.3f	Developing an Individual Coping Plan .....	149
5.4	Drink Refusal and Social Pressure Skills Training (DREF) .....	149
5.4a	Social Pressure and Drink Refusal .....	149
5.4b	Using Cognitive-Behavioral Therapy to Develop Drink Refusal Skills ...	150
5.4c	Assessing Social Pressure .....	151
5.4d	Developing Skills for Coping With Social Pressure to Drink .....	152
5.4e	Coping Behavior Rehearsal .....	159
5.5	Job-Finding Training (JOBF) .....	165
5.5a	Background .....	165
5.5b	Introducing the Module .....	166
5.5c	Résumé Development .....	167
5.5d	Identifying and Avoiding Jobs With High Relapse Potential .....	169
5.5e	Completing Job Applications .....	170
5.5f	Generating Job Leads .....	170
5.5g	Telephone Skills Training .....	172
5.5h	Interview Skills Training .....	175
5.6	Mood Management Training (MOOD) .....	175

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5.6a	Background	175
5.6b	Research Basis for a MOOD Module	176
5.6c	Rationale and Basic Principles	176
5.6d	Explaining the STORC Model	176
5.6e	Situational Factors	177
5.6f	Thought Patterns	179
5.6g	Organismic Experience	180
5.6h	Response Patterns	180
5.6i	Consequences	181
5.6j	Exploring Negative Mood States	182
5.6k	Self-Monitoring	182
5.6l	Automatic Thoughts	185
5.6m	Challenging Toxic Thoughts	186
5.6n	Applying STORC With Urges to Drink	190
5.7	Mutual-Support Group Facilitation (MUTU)	191
5.7a	Rationale	191
5.7b	Definition and Background of Mutual Support	192
5.7c	Overview of Mutual-Support Programs	192
5.7d	Matching Considerations in Mutual-Support Referrals	194
5.7e	Social Support for Sobriety	195
5.7f	Initiating Mutual-Support Group Involvement	195
5.7g	Emphasizing Action	197
5.7h	Handling Negativity About Mutual-Support Group Attendance	198
5.8	Social and Recreational Counseling (SARC)	198
5.8a	Explaining the Rationale	198
5.8b	Assessing Sources of Reinforcement	199
5.8c	Developing a Nondrinking Support System	200
5.8d	Reinforcer Sampling	201
5.8e	Systematic Encouragement	201
5.9	Social Support for Sobriety (SSSO)	203
5.9a	Rationale	203
5.9b	Three Types of Social Support Problems	203
5.9c	Educating Significant Others	204
5.9d	Rehearsing How to Ask for Support	205
<b>6.</b>	<b>Phase 4: Maintenance Checkups</b>	<b>207</b>
6.1	Initiating Phase 4	207
6.2	Presenting the Rationale for Phase 4	207
6.3	The Basic Structure of Checkup Sessions	208
<b>7.</b>	<b>Termination</b>	<b>211</b>
7.1	Preparing Your Client	211
7.2	Preparing Yourself	211
7.3	Timing	211
7.4	Essential Elements of the Termination Session	212

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**8. References** .....215

**Appendix A** Personal Feedback Report .....A-1

**Appendix B** Instructions for Preparing the Personal Feedback Report .....B-1

**Appendix C** CBI Therapist Guidelines for Presenting the Personal Feedback Report ..C-1

**Appendix D** Understanding Your Personal Feedback Report (for Clients) .....D-1

**Appendix E** Mutual-Support Groups: Representative Readings  
and National Contacts .....E-1

**Appendix F** Forms Used in the Combined Behavioral Intervention (CBI) .....F-1

**Appendix G** Therapist Checklists .....G-1

**Appendix H** Clinical Care Guidelines From COMBINE Protocol .....H-1

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# Foreword

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A major focus of the efforts of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in treatment research is to develop and test promising medications and behavioral therapies for treating alcohol disorders. This commitment is particularly reflected in NIAAA's multisite clinical trial, COMBINE, which tests two promising medications, naltrexone and acamprosate, alone and combined, in conjunction with two behavioral therapies, Medical Management and Combined Behavioral Intervention. The project involves 11 geographically diverse clinical sites representing both public and private treatment facilities as well as hospital and university outpatient facilities, and a data coordinating center. The cooperative agreement under which this project was established allowed direct collaboration between NIAAA and the researchers, who are among

the most senior and experienced treatment scientists in the field.

The two treatment manuals in this series are the result of the collaborative efforts of the COMBINE investigators and are used as guides by therapists in the trial. As used in COMBINE, these manuals summarize the consensus of the investigators on reasonable intervention approaches based on present knowledge and are presented to the alcohol research community as standardized, well-documented intervention tools for alcoholism treatment research. Forthcoming publications from COMBINE will address the relative efficacy of the combinations of interventions. We look forward to offering further refinements of these approaches as COMBINE data are analyzed and published and as further advances are made in alcoholism treatment through ongoing research.

Ting-Kai Li, M.D.  
Director  
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and Alcoholism



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# Overview of COMBINE

## Clinical Trial Combining Medication and Behavioral Therapies for the Treatment of Alcoholism

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### Introduction

This treatment manual and a companion manual in this series are provided to the public to permit replication of the behavioral therapies employed in COMBINE, a multisite clinical trial started in 1997 and funded as a cooperative agreement by the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

The goal of COMBINE is to determine if improvements in treatment outcome for alcohol dependence can be achieved by combining pharmacotherapy and behavioral interventions. COMBINE seeks to evaluate the efficacy of the two most promising medications (naltrexone and acamprosate), both singly and together, when used in conjunction with two behavioral treatments of differing intensities.

One behavioral intervention, Medical Management (MM), employs a series of brief counseling sessions to enhance medication adherence and abstinence from alcohol. The other, Combined Behavioral Intervention (CBI), is a more intensive treatment that combines several successful features from previously evaluated interventions. The brief session therapy (MM) is a type of treatment that might be suitable for delivery in primary care settings. The more intensive therapy (CBI) is suitable for delivery by trained psychotherapists working in specialized alcoholism treatment facilities.

The following sections summarize the nature of the treatments tested in COMBINE, the study design, and considerations for those contemplating use of the manuals. This information has been previously published in greater detail by the COMBINE Research Group. For further information, consult the publications on the study's methods and rationale (COMBINE Research Group 2003*a*); the safety and tolerability of the combined medications (Johnson et al. 2003); and the results of a protocol feasibility study (COMBINE Research Group 2003*b*). The first page of the COMBINE Web site (<http://www.csc.unc.edu/COMBINE>) lists topics on the Web site that are accessible to the public.

### The COMBINE Interventions

#### Medication Treatments

Each of the COMBINE medications, naltrexone and acamprosate, has shown efficacy in the treatment of alcohol dependence in placebo-controlled clinical trials conducted in the United States and Europe (Kranzler and Van Kirk 2001; Streeton and Whelan 2001; Mann et al. 2004). In most of these studies, patients received a behavioral treatment to which the active medication or placebo was added. Outcomes typically reported included the amount of drinking or the proportions of

patients remaining abstinent. Naltrexone has been approved as a treatment for alcohol dependence by the U.S. Food and Drug Administration (FDA) since 1994 and is approved in over 30 countries around the world (Litten and Allen 1998). Acamprosate currently is approved for treating alcohol dependence throughout most of Europe and South America, Australia, and parts of Asia and Africa and is now under FDA review in the United States (Mason and Ownby 2000).

A body of laboratory and clinical data suggests that naltrexone and acamprosate act on different neurochemical systems involved in the addictive response and presumably target different aspects of the alcohol dependence syndrome.

Naltrexone acts to block the opioid receptors, causing a reduction in the dopamine levels in the nucleus accumbens and leading to an attenuation in the positive reinforcement effects of alcohol (O'Malley and Froehlich 2003). Naltrexone appears to decrease craving for alcohol as well as decrease the rate of alcohol consumption (O'Malley et al. 2002). Most studies have also observed a decrease in the number of days of heavy drinking (Anton and Swift 2003). Acamprosate interacts with the glutamate receptor in a manner that is still unclear (Harris et al. 2002; Koob et al. 2002). This interaction appears to diminish the negative reinforcement of conditioned craving that follows cessation of drinking by reducing the protracted alcohol withdrawal symptoms (Spanagel and Zieglgansberger 1997; Koob et al. 2002). It is therefore reasonable to hypothesize that the combination of naltrexone and acamprosate might make it easier both to abstain from alcohol and to prevent a slip from turning into a relapse to drinking. Acamprosate may be particularly useful in avoiding initial alcohol consumption and enhancing treatment retention by attenuating symptoms of protracted alcohol withdrawal. Naltrexone may be particularly

efficacious in reducing the likelihood of heavy drinking following a slip.

## Behavioral Treatments

Modern pharmacotherapy efficacy studies in alcohol dependence generally have employed intensive psychotherapies delivered by trained therapists. However, treatment has increasingly moved toward treating alcoholics within a managed care setting in which the number of sessions is limited, and the sessions usually are provided by staff without specialized training in addiction treatment. It is therefore important to determine if the effects of pharmacotherapy depend on the type of counseling or psychotherapy with which it is combined. The two behavioral approaches tested in COMBINE contrast a treatment feasible for the primary care environment (MM) and one more suitable for use in an alcohol dependence specialty treatment facility (CBI).

Pharmacological and behavioral treatments are not mutually exclusive and indeed may enhance each other. Thus, pharmacotherapies may reduce craving for alcohol and/or the reinforcement experienced from drinking alcohol. Behavioral therapies can teach skills needed to maintain sobriety for extended periods. Several studies have demonstrated that the type of psychosocial intervention can influence the outcome with naltrexone (Anton and Swift 2003).

**Medical Management (MM)** is a manualized treatment (Pettinati et al. 2000) designed to approximate a primary care approach to alcohol dependence. The treatment, delivered by a medical professional (e.g., nurse or physician), provides strategies to increase medication adherence and supports abstinence through education and referral to support groups (Emrick et al. 1993; Barrett and Morse 1998; Carty et al. 1998). The initial session (40–60 minutes) involves discussion of the alcohol dependence diagnosis and negative conse-

quences from drinking, a recommendation to abstain, medication information, strategies to enhance medication adherence, and referral to support groups such as Alcoholics Anonymous. In the eight subsequent 15- to 25-minute visits, the clinician assesses the client's drinking, overall functioning, medication adherence, and any medication side effects.

Session structure varies according to the client's drinking status and treatment compliance. When the client does not adhere to the medication regime, the clinician evaluates the reasons and helps the client devise plans to address the problem(s). Clinicians urge clients who drink to attend support groups and offer commonsense recommendations, such as avoiding bars. If the client suffers from medical side effects, the clinician specifies procedures for using concomitant medication to ameliorate them or reduces the dosage of either one or both study agents, resuming the study agents if side effects remit. If a client discontinues medication because he or she cannot tolerate it, the clinician schedules a monthly 15- to 25-minute "medical attention" meeting, during which the clinician employs a similar approach that focuses on the client's drinking and overall health, omitting the medication adherence component.

***Combined Behavioral Intervention (CBI)*** was designed to be a state-of-the-art individual outpatient psychotherapy for alcohol dependence. It merges a variety of well-supported treatment methods into an integrated approach. A manual-guided therapy, CBI nevertheless allows for normal clinical flexibility and individualization of treatment. CBI builds upon features in the manualized therapies of Project MATCH (Kadden et al. 1995; Miller et al. 1992; Nowinski et al. 1995; Project MATCH Research Group 1993) and provides skills training and support-system involvement modeled on a community reinforcement approach to treatment (Azrin et al. 1982; Meyers and

Smith 1995). A maximum of 20 sessions is permitted, with the treatment course organized in four phases:

- *Phase 1* emphasizes building motivation for change. It begins with a single session of motivational interviewing (Miller and Rollnick 1991), which is the general clinical style used throughout CBI. This is followed by client assessment feedback in the style of motivational enhancement therapy (Miller et al. 1992).
- *Phase 2* includes a functional analysis of the client's drinking, a review of the client's psychosocial functioning, and a survey of the client's strengths and resources, the results of which will be used in developing an individual plan for treatment and change. The therapist emphasizes the merits of an abstinence goal, and each client is encouraged to become involved in a 12-step or other mutual-help group. Whenever possible, a supportive significant other is identified to participate in the client's treatment sessions as frequently as seems appropriate, ranging from a few to all sessions. The supportive significant other's role is to facilitate the client's compliance and abstinence and to reinforce as many of the CBI modules as the nature of the relationship appears to warrant.
- *Phase 3* draws upon a menu of nine cognitive-behavioral skill-training modules chosen on the basis of the client's needs identified during Phase 2 (cf. Kadden et al. 1995). The modules include (1) assertiveness skills, (2) communication skills, (3) coping with craving and urges, (4) drink refusal and social pressure, (5) job finding, (6) mood management, (7)

mutual-help group facilitation, (8) social and recreational counseling, and (9) social support for sobriety. All modules involve specific behavioral coaching and skill practice.

- *Phase 4* involves maintenance checkups in which the therapist and client review progress to date, renew motivation for change, and reaffirm commitment to an original or revised change plan.

CBI also includes a set of eight optional “pull-out” procedures that can be used at any appropriate point during treatment: (1) sobriety sampling, (2) raising therapist’s concerns, (3) implementing case management, (4) handling resumed drinking, (5) supporting medication adherence, (6) responding to a missed appointment, (7) telephone consultation, and (8) crisis intervention.

The number, frequency, and duration of CBI treatment sessions are negotiated between the therapist and client within the bounds of 20 sessions and 16 weeks. Weekly 50-minute outpatient visits are typical but not absolute. All therapy sessions are audiotaped, and random samples are reviewed and rated for quality control purposes.

## Study Design

### Study Population

The goal recruitment for the trial was 1,375 subjects drawn from 11 clinical research units. Patients met the criteria for alcohol dependence specified in the American Psychiatric Association’s *Diagnostic and Statistical Manual, Fourth Edition* (DSM–IV) (American Psychiatric Association 1994).

To be eligible, subjects had to acknowledge a

desire to stop drinking and a history of alcohol consumption at or above a certain threshold. Prior to randomization and initiation of study pharmacotherapy, all subjects were required to complete any needed detoxification and abstain from alcohol for 4 days. Subjects had to have been drinking a minimum of 14 drinks (females) or 21 drinks (males) on average per week over a consecutive 30-day period in the 90-day period prior to initiation of abstinence. They also had to have had 2 or more days of heavy drinking (defined as four drinks for females and five drinks for males) in the previous 90 days, with the last drink being within 21 days of randomization to treatment.

Subjects were excluded if they reported recent opiate use, past 6-month opiate abuse or dependence disorder, or active dependence disorder with any substance other than cannabis or nicotine; serious psychiatric disorders requiring specific pharmacological intervention; unstable medical conditions for which either of the study medications was contraindicated (including liver function tests that were more than three times normal); and having received either study medication within the past 30 days.

Participants were recruited from in- and outpatient referrals within the study sites and from community and media sources. Subjects had to have had a breath alcohol level of zero to complete the informed consent and baseline measures. A certificate of confidentiality was obtained by all clinical sites.

### Treatment Conditions

After assessment, subjects were randomly assigned to one of nine treatment conditions, as shown in Figure 1, using a permuted block randomization procedure with varying block sizes, which resulted in approximately 153 subjects per cell. Subjects in one cell (termed “cell 9”) were to receive no study medication (active or

placebo) or MM intervention but only CBI therapy. This cell was included to contrast the effects of pill-taking (Barlow et al. 2000) on the outcome achievable with CBI alone and was considered a control condition for placebo

**Figure 1. COMBINE Treatment Combinations**

**Medical Management**

	Placebo	Acamprosate
Placebo	1	2
Naltrexone	3	4

**Medical Management + Psychotherapy**

	Placebo	Acamprosate	No Pills
Placebo	5	6	
Naltrexone	7	8	
No Pills			9

effects that might result from the pill-taking regimen of 8 pills per day for 16 weeks.

The medications were dispensed to subjects in blister packs with sections divided into morning, noon, and evening doses. Naltrexone was supplied in two tablets to be taken each morning, as 25 milligrams (mg) for the first 3 days, 50 mg for the next 4 days, and 100 mg per day thereafter. Acamprosate was provided in 500-mg pills, as two pills to be taken three times per day, for a total of 3 grams. The two drugs look different, and each has a matched (i.e., identical) placebo. Subjects were given no information about the identity of the medications they received.

All participants randomized into the eight cells, involving either active or placebo medication, were assigned to nine Medical Management appointments at weeks 0, 1, 2, 4, 6, 8, 10, 12, and

16. The subset of participants who also received CBI had a maximum of 20 sessions over a total of 16 weeks of study participation. They also were evaluated for drinking history and craving by research assistants on the days they attended their MM sessions, with longer assessments at weeks 8 and 16. After week 16, all treatments were stopped, but subjects were followed for the next 52 weeks and seen in person on weeks 26, 52, and 68 (following randomization) for drinking history and other assessments.

If necessary, subjects were terminated from the treatment portion of the protocol, primarily for adverse events, serious clinical deterioration, or lack of interest. All subjects who left prematurely underwent an end-of-treatment evaluation and were encouraged to attend research followups.

**Assessment**

The assessment battery measured the following broad domains: (1) screening and inclusion/exclusion criteria; (2) history/physical, physiological, and laboratory assessments; (3) treatment-related expectancies; (4) drinking-related, psychological, and behavioral outcomes, predictors, mediators, and generalizability measures; and (5) therapy and medication adherence and therapy process measures. Subject compliance was tracked by several methods: attendance records to monitor behavioral intervention participation, counting pills from returned medication cards, and a timeline followback procedure to assess self-reported medication compliance.

Most measures were administered at baseline and again at one or more followup points. Measures considered to be particularly sensitive to subject reactivity (e.g., drinking self-report measures) were placed earlier in the battery. The primary followup assessments occurred at postrandomization weeks 8, 16, 26,

52, and 68. Within-treatment measures of drinking and craving were administered at weekly intervals or at each of the MM visits.

## Caveats and Considerations

It is important to understand the conditions under which Medical Management and Combined Behavioral Intervention were delivered in the COMBINE trial. Therapy was conducted in the context of a structured research situation. Both of the manual-guided COMBINE treatments were administered by experienced therapists who had received specialized training in one of the two project interventions. Therapists closely followed the procedures outlined in the manuals. With few exceptions, all sessions were audiotaped to allow both local and project-wide clinical supervisors to observe therapists in action and provide session quality control. Therapists who deviated from protocol or demonstrated weakness in generic counseling skills were “red-lined” for further training and monitoring. This manual was written for therapists who had similar training and supervision and may not affect participants the same way if it is given under different quality-control conditions.

Likewise, the manual was designed to standardize the delivery of the therapy within the particular context of the COMBINE project design. For example, all clients received their behavioral treatment(s) after undergoing an extensive baseline assessment battery. Before each therapy session, the client had a breath alcohol test to ensure sobriety. If the client tested positive for alcohol, the session was rescheduled, and arrangements were made to help the client get home safely. Therapists were prohibited from mixing other treatment approaches with the experimental intervention. All therapy was completed within 16 weeks of randomization.

Other standardized features of clinical trials that may also influence the effect of the therapy

include inclusion/exclusion criteria, randomized assignment to treatment, and guidelines for dealing with clients who are late for treatment, fail to attend, or deteriorate clinically during the 16-week treatment period. Guidelines regulated and documented the type and amount of therapy the client could receive from sources other than COMBINE. The research and therapy components were kept separate, and all data collection was performed by trained research assistants who did not deliver treatment (although there is anecdotal evidence that some clients may not have grasped the distinctions among the different types of personnel with whom they came into contact).

Although the procedures and principles of the intervention are the result of careful development and are based on models validated in other studies, the COMBINE study and NIAAA staff make no claims or guarantees regarding the effectiveness of the treatments described herein. All manuals of this kind should be regarded as being under development and subject to ongoing improvement based on subsequent research and clinical experience. Information on the efficacy of this approach relative to other approaches and on the types of clients for whom it may be most useful will be available when study results are published, a process expected to begin in 2005. In the interim, it is our hope that the COMBINE treatment manuals will be useful tools for the community, as the Project MATCH therapy manuals have been. (The Project MATCH manuals, previously published by NIAAA, continue to be widely requested by researchers and clinicians from all sectors of the community.) The authors of the COMBINE manuals and NIAAA welcome feedback from users on their experiences with these newest treatment manuals.

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

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## 1.1. Overview of the Combined Behavioral Intervention

The Combined Behavioral Intervention (CBI) integrates several elements of treatments tested in the multisite alcoholism 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 to address clients' personal needs and preferences; and Phase 4, maintenance, followed by 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 is usually completed in two sessions. The first session begins with 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.

As the client evidences readiness to initiate change, Phase 2 begins. This phase normally begins in the third session and continues through the fourth or fifth session, paralleling the development of a treatment plan in outpatient programs. Phase 2 starts with you providing a summary of client motivations and feedback and an invitation for the client to consider what changes are needed. Two aids are developed to assist in this process. The first is a *structured functional analysis* that considers antecedents and consequences of drinking behavior, past perceived benefits of alcohol use, and possible alternative coping methods. The second is a more general evaluation of psychosocial functioning that identifies possible areas for skill training. These lead to the construction and discussion of an **Options** chart that identifies potential Phase 3 treatment foci. From this chart, you negotiate a specific treatment plan with the client using the Treatment Plan Worksheet. Included for all clients are two brief sections: "Emphasizing Abstinence" and "Recommending Mutual-Help Programs."

Phase 3 implements the treatment modules selected through the negotiations of Phase 2. The length of each module is determined by relative needs of the client for developing coping skills in each area. Modules may also overlap in time (e.g., the client can be completing homework assignments from one module while you initiate another module in the following session), but you should not be working on more than two modules simultaneously.

The number of sessions is guided by whether the client achieves the 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. All clients have a final checkup visit 16 weeks after the first session, even if their treatment has been terminated earlier. Sessions will normally be scheduled twice weekly at least until Phase 2 has been completed, reduced to weekly or biweekly meetings as negotiated between you and your client. Therapy must end within 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 an SSO participate in treatment, special procedures are provided for engaging the SSO (section 2.6b, “Initiating Involvement of an SSO”). A client does not need an SSO to be able to participate in treatment, but you should make every effort to identify, include, and involve an SSO, unless such involvement appears to be detrimental to the client’s treatment. The SSO is not included 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 (e.g., 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 the client needs further treatment at the point of termination, you may make an appropriate referral (see section 4.3f, “Making a Referral”).

## 1.2. Research Basis for the Combined Behavioral Intervention

**1.2a. Combining Effective Treatments.** 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 and Monahan 1996; Holder et al. 1991; Institute of Medicine 1990; Mattick and Jarvis 1992; Miller et al. 1998). Although differing in some respects, these reviews have come to generally similar conclusions and converge on several points, including the following three:

1. Even relatively brief intervention is more effective than no treatment (cf. Bien et al. 1993b).
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 and Heather 1998). This approach has 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 et al. 1980).

The bases for matching modules to clients have varied widely. Therapists may use their clinical judgment to select methods from the array of options, or clients may be given relatively free choice from the menu (Miller and Hester 1986). Based on evidence of differential efficacy of approaches, there was some hope that actuarial criteria could be developed for assigning clients to optimal treatments (Project MATCH Research Group 1993). Project MATCH, the largest clinical trial of psychotherapies ever conducted, was focused on this task. Surprisingly, it yielded little evidence that treatment effectiveness can be enhanced by matching clients to treatments that were based on the *a priori* notions of what client characteristics would predict better outcomes (Project MATCH Research Group 1997a). Instead, the three approaches that were compared—cognitive-behavioral skill training, 12-step facilitation, and motivational enhancement therapy—yielded similar and favorable outcomes over followup as long as 3 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 client'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, called *stimuli*, are also what behavioral psychologists call, within an operant framework, discriminative stimuli, but these changes may also be conceptualized as classically conditioned. In either event, these changes tend to elicit drinking. Analysis of consequences, however, 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. 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 by Nathan Azrin and his colleagues (Azrin 1976; Hunt and Azrin 1973).

The *community reinforcement approach* (CRA) specifically views drinking as a behavior maintained and modifiable by positive reinforcement in the person'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 and Smith 1995). Through a series of controlled trials, the CRA has been supported as more effective than methods that were traditionally used with inpatients (Azrin 1976; Hunt and Azrin 1973), outpatients (Azrin et al. 1982), and homeless people (Smith et al. 1998). Other studies have supported the efficacy of the CRA in treating heroin (Abbott et al. 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 and Monahan 1996; Holder et al. 1991; Mattick and 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 (Meyers and Miller 2001).

**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 (1997a), 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. 1993b; Heather 1998). In research spanning more than a dozen nations, brief counseling (one to three sessions) has consistently been shown to be significantly more effective than no treatment (Bien et al. 1993b). 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, as follows:

- 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 and 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 and 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 et al. 1980; Valle 1981). Therapist empathy has been shown to predict more favorable outcomes as long as 2 years after treatment (Miller and Baca 1983). In contrast, the opposite style of direct confrontation has been associated with poorer treatment outcomes (Miller et al. 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 and Miller 1995).

The *drinker's checkup* was developed as a first application of motivational interviewing. It was initially tested with adults recruited through newspaper announcements offering respondents a free checkup to determine if alcohol was harming them in any way (Miller and Sovereign 1989). Those who responded were heavy drinkers with significant alcohol-related problems; they were randomized either to receive an immediate checkup or to wait for 10 weeks before receiving the checkup (Miller et al. 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 also offered the checkup and showed a similar reduction in alcohol use. A second evaluation, again with media-recruited adults, randomized problem drinkers to receive their checkup feedback either in a motivational interviewing style or in a more directly confrontational style, with both approaches delivered by the same counselors (Miller et al. 1993). Relative to the waiting list

group, reductions in drinking were seen in those who received both types of intervention within 6 weeks of counseling, with a 69-percent reduction in the motivational interviewing group and a 41-percent reduction in the confrontational group. Because the same counselors provided both conditions, and their 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 was identified as predicting client drinking as long as a year later: the more the counselor confronted, the more the client drank.

Next, the drinker's checkup was tested as a prelude to outpatient treatment at a U.S. Department of Veterans Affairs 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 followup, with twice the rate of total abstinence (Bien et al. 1993a). Similar findings have been reported by Aubrey (1998) from a randomized trial with adolescents entering outpatient treatment for substance abuse. Substance-dependent adolescents who received assessment feedback and motivational interviewing at intake remained significantly longer in treatment (20 sessions compared with 8 sessions), reported greater suppression of alcohol and illicit drug use at 3-month followup, and showed a 63-percent 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 checkup 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 and Miller 1993).

The Project MATCH Research Group (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 1 of 2 12-session treatments: 12-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 followups (Project MATCH Research Group 1997*a*, 1998*a*).

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 et al. 1995), cocaine (Daley et al. 1998; Daley and Zuckoff 1998), and marijuana use disorders (Stephens et al. 1994); with severely dependent drinkers (Allsop et al. 1997); pregnant heavy drinkers (Handmaker 1993); and heavy drinkers in college (Baer et al. 1992) or identified through health care settings (Heather et al. 1996; Senft et al. 1997; Woollard et al. 1995). Adaptations of the checkup have also been reported in positive trials with cardiovascular rehabilitation (Scales et al. 1997) and diabetes management (Smith et al. 1997; Trigwell et al. 1997). One negative trial has been reported by Kuchipudi and colleagues

(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 checkup (Agostinelli et al. 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 constitute the first phase of 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 and 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 consistently supports a modestly positive association between client involvement in Alcoholics Anonymous (AA) and more favorable treatment outcomes (Emrick et al. 1993), a finding upheld in Project MATCH (1997*a*). 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*a*, 1998*a*) who were assigned to the 12-step facilitation therapy also showed a modest but enduring



advantage when continuous abstinence was used as the outcome criterion.

For these reasons, encouraging clients to participate in a mutual-help group was incorporated as a standard module in CBI. Because there are now a range of other mutual-help organizations (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 and Mallams 1981).

### 1.3. Coordination With Medical Management

This section applies specifically to COMBINE. CBI is one of two psychosocial interventions COMBINE offers. All COMBINE participants 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, you will be your client's only therapist.) This section discusses important information about the coordination of care between MM and CBI.

**1.3a. Scheduling.** Before you see a client, he/she will have been through several 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/she will have seen an MM practitioner first for a 1-hour initial session. After completing this first MM session, 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 1 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. As indicated in section 1.3a ("Scheduling"), the client (if receiving medication) will first see the MM practitioner and then will 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 for Medication Adherence"), 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 followup 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 sessions, and followup visits even if they stop attending CBI sessions. If the client stops either CBI or medications (and MM), it does not affect his/her 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, at times, you and the MM practitioner will need to exchange information to coordinate the client's care; seven such occasions are listed below. You do not need to obtain special consent from the client for this purpose because you are both clinical staff of the treatment program.

1. *When 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 1 week after the initiation of MM and medication. The first MM visit lasts approximately 50 minutes; others last only 10 to 20 minutes. You can schedule the first CBI visit immediately after the first MM visit if the client is willing to remain for 2 hours. (In cases where the client does not receive medication as part of his/her COMBINE treatment, CBI may begin any time after completion of baseline assessment and randomization.)
2. *When 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 after the first month, MM sessions become biweekly and then monthly, whereas CBI continues on a weekly basis, so

there will be CBI weeks when the client has no corresponding MM session.

3. *When You Need 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. *When You Are Sharing 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 the **COMBINE MM Treatment Coordination Checklist** [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 in the course of CBI sessions your client divulges to you information about drinking that is different from what the MM practitioner knows (e.g., the client told the MM practitioner that he/she was not drinking but reported to you that he/she actually was; the client has been drinking much more than he/she admitted to the MM practitioner), you must discuss this discrepancy with the MM practitioner for safety reasons.
5. *When You Are Sharing Information About Client Medication Adherence.* It may happen that a client expresses to you during a CBI session that he/she

intends to stop taking medication or the fact that he/she has already stopped taking medication. The MM practitioner may also indicate to you via the regular report that the client has problems with medication adherence (see Form B). In this case, you should follow the procedures outlined in the “Support for Medication Adherence (SOMA)” pull-out (section 4.5). Encourage your client to discuss concerns with the MM practitioner. If you have adherence information that the MM practitioner appears not to know, 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/she has been less than honest with the MM practitioner about taking medication, express concern by following procedures described in section 4.5, and encourage your client to discuss his/her issues with the MM practitioner. Also convey the information directly and promptly to the MM practitioner yourself, either by direct conversation or in writing (on Form B).

6. *When Your Client Is Worried About Side Effects and Other Medication Concerns.* During CBI sessions, your client may express distress about side effects or raise other concerns related to his/her medication. In these cases, you should encourage your client to discuss the concern with the MM practitioner and notify the MM practitioner of your client’s stated concern, either by direct conversation or in writing (on Form B).

7. *When You Are Sharing Information Pertaining to Client Safety.* Pass along to the MM practitioner promptly any information that you believe could be important in medical management or for the protection of your client’s safety. Examples include suicidal ideation, a marked increase in anxiety or depression, or significant physical complaints. 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 (on Form B).

#### REFERENCE

#### ***Form B: COMBINE MM Treatment Coordination Checklist***

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

### **1.4. How Does CBI Differ From Prior Cognitive-Behavioral Therapies?**

The Combined Behavioral Intervention shares many common features with previously described comprehensive cognitive-behavioral treatment approaches (e.g., Marlatt and Gordon 1985; Monti et al. 1989). In particular, the cognitive-behavioral coping skills therapy tested in Project MATCH (Kadden et al. 1992) was used as a starting point. In Phase 3 CBI retains 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 helping the client acquire individual coping skills. In light of more recent findings and developments in the alcoholism treatment field, CBI was designed to extend and build upon basic cognitive-behavioral approaches in several respects. These include the following:

- 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 et al. 1992*b*)
- Adoption of motivational interviewing (Miller and Rollnick 2002) 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
- 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 12-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 client's acquisition of individual coping skills during treatment is the primary mechanism of his/her recovery. Rather, CBI is an integrated approach that combines several major elements, each of which has been supported as effective in alleviating alcohol problems, listed below:

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. Individualized treatment approach
5. Cognitive-behavioral skill training
6. Support for use of therapeutic medications
7. Involvement in mutual-help groups.

**Table 1.1 A Comparison of Cognitive-Behavioral Coping Skills Therapy (Project MATCH) and the Combined Behavioral Intervention**

	<b>Cognitive-Behavioral Coping Skills Therapy (Project MATCH)</b>	<b>Combined Behavioral Intervention</b>
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; semiweekly 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/ Significant Other Involvement	Limited to two 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 eight sessions; then four module sessions chosen	Fixed format for two to three sessions until individual treatment plan is negotiated, then flexible

**Table 1.1 Continued**

	<b>Cognitive-Behavioral Coping Skills Therapy (Project MATCH)</b>	<b>Combined Behavioral Intervention</b>
Content Modules	<ul style="list-style-type: none"> <li>• Coping With Craving and Urges</li> <li>• Managing Thoughts About Alcohol</li> <li>• Problem-Solving</li> <li>• Drink Refusal</li> <li>• Emergencies/Coping With a Lapse</li> <li>• Seemingly Irrelevant Decisions</li> <li>• Starting Conversations</li> <li>• Nonverbal Communication</li> <li>• Introduction to Assertiveness</li> <li>• Receiving Criticism</li> <li>• Awareness of Anger</li> <li>• Anger Management</li> <li>• Awareness of Negative Thinking</li> <li>• Managing Negative Thinking</li> <li>• Increasing Pleasant Events</li> <li>• Managing Negative Moods</li> <li>• Enhancing Social Support Networks</li> <li>• Job-Seeking Skills</li> <li>• Couples/Family Involvement (1–2 core [required] sessions)</li> </ul>	<p>Coping With Craving and Urges</p> <p>Drink Refusal and Social Pressure</p> <p>Communication Skills</p> <p>Assertive (Expressive) Skills</p> <p>Mood Management Training Social and Recreational Counseling</p> <p>Social Support for Sobriety Job-Finding Training [SSO involved throughout] Mutual-Support Group Facilitation</p>
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	<p>Procedures used as needed:</p> <ul style="list-style-type: none"> <li>Sobriety Sampling</li> <li>Raising Concerns</li> <li>Case Management</li> <li>Resumed Drinking</li> <li>Support for Medication Adherence</li> <li>Missed Appointment</li> <li>Telephone Consultation</li> <li>Crisis Intervention</li> <li>Disappointed to Receive CBI-Only Condition</li> </ul>
Maintenance Phase	None; limited to termination session	Specific maintenance phase with fade-out of sessions, plus termination session

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## 2. Phase 1

# Building Motivation for Change

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### 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 prepared for change, and Phase 1 will go quickly. Others will come less ready to change, and you will need more time to build their motivation in preparation for Phases 2 and 3.

If you hold the view that motivation is a kind of inner life force, such as willpower, that clients possess in varying amounts, you may give up on clients who “aren't really motivated” or may use confrontation or pep talks in an attempt to pump up the client's motivational level. These strategies are relatively ineffective in triggering behavior change.

The view that motivation is the *probability* of taking steps toward change is a more helpful perception and is the way most psychological research has defined it. 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 that of increasing the probability that your client will take action toward change.

As it turns out, a client's *doing something*—sometimes described as “compliance” or “adherence”—is one of the better predictors of positive treatment outcome. Common sense suggests 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 several different processes for change. During Phase 1, 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 the client resolve ambivalence about a problem behavior and initiate change (Rollnick and Miller 1995). It is the clinical style you will use throughout CBI. Based on principles of motivational psychology, it is designed to initiate rapid, internally motivated change. Motivational enhancement therapy (MET) (Miller et al. 1992b) was developed as one specific application of motivational interviewing for use in Project MATCH (1993, 1997a). Derived from earlier research on “the drinker's checkup” (see section 1.2b, “Motivational Interviewing”), 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.

## 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 and Prochaska 1998) have described a trans-theoretical model of how people change problem behaviors, with or without formal treatment. In this perspective, people move through a series of stages of change in modifying addictive behaviors, and in each stage, people accomplish certain tasks and use certain processes. The five separate stages are described below (Prochaska and DiClemente 1984, 1986; Prochaska et al. 1992):

**Stage 1: Precontemplation.** People in the first stage are not considering change in their problem behavior.

**Stage 2: Contemplation.** People in this stage are considering that they have a problem and are contemplating the feasibility and costs of changing that behavior.

**Stage 3: Preparation.** As people progress, they move on to the third stage, which involves deciding and getting ready to take action for change.

**Stage 4: Action.** Once people begin to modify the problem behavior, they enter this stage, which normally continues for 3 to 6 months.

**Stage 5: Maintenance.** After successfully negotiating the action stage, people move to *maintenance*, or sustained change. If these efforts fail and the problem behavior recurs, people begin another cycle through these stages of change.

**Table 2.1 An Overview of Phases 1 and 2**

**PHASE 1: ENHANCING MOTIVATION FOR CHANGE**

- ✓ Initial Period of Motivational Interviewing
- ✓ Supportive Significant Other Involvement
- ✓ Structured Assessment Feedback (Motivational Enhancement Therapy)
- ✓ Transitional Summary

**PHASE 2: DEVELOPING COMMITMENT TO A CHANGE PLAN**

- ✓ Functional Analysis of Drinking (New Roads)
- ✓ Review of Psychosocial Functioning
- ✓ Identifying Strengths and Resources
- ✓ Developing a Plan for Treatment and Change
- ✓ Abstinence Emphasis Counseling
- ✓ Mutual-Help Group Involvement Counseling
- ✓ 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



The ideal path would be for a person to progress directly from one stage to the next until he/she achieves maintenance. For most people with serious problems related to drinking, however, the process involves some setbacks, and they recycle or spiral through the stages toward maintenance. Most people typically undergo several revolutions through this cycle before they maintain a stable change.

From the transtheoretical perspective, motivational interviewing addresses the stage the client is in and assists him/her in moving through the stages toward successful sustained change. Motivational interviewing particularly addresses issues of the first three stages of change—precontemplation, contemplation, and preparation.

You may find it helpful in Phase 1 to consider three aspects of motivation reflected in the expression “ready, willing, and able.” The “willing” component has to do with how *important* clients perceive 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.

Next is the client’s perceived *ability* to change (self-efficacy). The client considers whether he/she will be able to make a change and how that change would affect his/her life. It is possible, however, for a client to be willing and able but still not be 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 areas 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. Your task is to create a set of conditions that will enhance the client’s own motivation for and commitment to change. You will seek 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 *internal* 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, listed below and described in detail in the following sections:

1. Express empathy.
2. Develop discrepancy.
3. Avoid argumentation.
4. Deflect defensiveness.
5. Support self-efficacy.

**2.3a. Express Empathy.** In motivational interviewing, the therapist 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/her drinking and to 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. Researchers have widely recognized the power of such gentle, nonaggressive persuasion, as did Bill Wilson in his advice on working with others (AA 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 [1984, 1986]), the therapist may first need to *develop* such discrepancy by raising the client's awareness of the personal consequences of his/her drinking. In other cases (e.g., contemplators), the process is one of clarifying and resolving client ambivalence by strengthening his/her motivations for change while diminishing his/her motivations for keeping with the status quo. The therapist's feedback of personal information, properly presented, can enhance the client's perceived importance of change. As a result, the client may be more willing to enter into a frank discussion of change options to reduce the perceived discrepancy. In still other cases, the client enters treatment already past the contemplation stage, and it takes less time and effort to move him/her 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/her drinking behavior tends to make the client defensive and to evoke client opposition and suggests that the therapist does not really understand. Motivational interviewing explicitly avoids direct argumentation, which tends to make the client defensive. The therapist does not attempt to have the client accept or "admit" a diagnostic label and 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 his/her 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 and Rollnick 2002).

**2.3d. Deflect Defensiveness.** Minimizing client defensiveness is an important goal. 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. The therapist invites new ways of thinking about problems but does not impose them. The therapist views the client's ambivalence as normal, not pathological, and it is explored openly. *The client usually invokes solutions instead of the therapist providing them.*

The more defensive a client is during the early sessions of therapy, the less the chance he/she has of achieving enduring behavior change (Miller et al. 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 and Forgatch 1985). Motivational interviewing is

associated with significantly lower levels of client defensiveness, compared with more directive and confrontational styles. To be sure, some clients enter treatment with a much higher level of defensive responses. Nevertheless, whether the client's defensiveness persists, increases, or decreases during treatment is largely under the therapist's control. 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 et al. 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/she has a serious problem may still not move toward change unless he/she has 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 for him/her to change his/her own

drinking and thereby reduce related problems. This could also be called hope or optimism, though it is not crucial that the client have an overall optimistic nature. What is crucial is the client's *specific belief that he/she can change the drinking problem*. Unless the client has this belief, he/she is likely to resolve a perceived discrepancy into defensive cognition (e.g., rationalization, denial) to reduce discomfort instead of changing his/her behavior. 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 (1999) characterized the following contrasts between approaches,

**Table 2.2 Contrasts Between Denial-Confronting Approach and Motivational Interviewing Approach**

Denial-Confronting Approach	Motivational Interviewing Approach
Strong emphasis on acceptance of self as "alcoholic"; admitting the diagnosis is seen as essential for change	De-emphasis 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.

outlined in table 2.2 below:

It is a goal in motivational interviewing for the therapist to evoke *from the client* statements of problem perception and a need for change (see section 2.5a, “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 in section 2.3c, the therapist carefully avoids arguing with the client, and strategies for responding to defensiveness are more reflective than exhortational. Within a motivational interviewing style, therefore, the therapist does *not* do the following:

- 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/she “must” do

- Seek to “break down denial” by direct confrontation
- Emphasize a client’s “powerlessness”
- Create an adversarial interaction, in which the therapist argues for change and the client argues against it.

**2.4b. Differences From Nondirective Counseling.**

Motivational interviewing draws heavily on the client-centered therapist skills (e.g., accurate empathy) described by Carl Rogers and his students (e.g., Rogers 1957, 1959; Truax and Carkhuff 1967). 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 the client’s statements. In such nondirective counseling, the therapist meets whatever the client offers with unconditional positive regard.

In contrast, motivational interviewing is goal-directed and employs systematic strategies to reach specific objectives (see table 2.3). The therapist seeks actively to create discrepancy and to channel it toward behavior change (Miller 1983; Miller and Rollnick 2002). The

**Table 2.3 Comparisons Between Nondirective Counseling Approach and Motivational Interviewing 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
Uses empathic reflection noncontingently	Uses reflection and reframing 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 to enhance motivation for change

therapist consciously uses reflection and reframing in a contingent manner to strengthen the client's intrinsic motivation for change. The material is still the client's own; the therapist does not provide or install motivations. Instead, the therapist directs the client's salient attention to discrepancies between the problem behavior and his/her own intrinsic interests and values. Thus, motivational interviewing is a directive, client-centered, and change-oriented approach.

**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 and Miller 1993; Bien et al. 1993b), 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 the therapist can introduce specific skills and strategies for change 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 in section 1.2b ("Motivational Interviewing") and is compatible with motivational interviewing.

The transition to skills training in CBI occurs in Phase 2 of treatment, where the therapist introduces a functional analysis of drinking as part of the development and negotiation of a change plan. The functional analysis, in turn, suggests particularly helpful behavior change strategies that the client chooses 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 (1997a) to be associated with more

favorable outcomes, particularly for clients whose social networks more strongly support continued drinking.

The therapist is meant to continue the empathic clinical style of motivational interviewing throughout the course of CBI. This style serves as a platform on which to build further interventions. The therapist should employ reflective listening to the client in all sessions from Phase 1 through termination. Clients are actively involved in choosing their own change strategies throughout treatment. The therapist introduces coping strategies with a suggesting and encouraging style, rather than in a prescriptive and imposing manner. Thus, during the behavioral skill training portion of treatment (Phase 3), the therapist balances suggesting coping strategies with drawing upon the client's own ideas and resources.

## 2.5. Clinical Style

Motivational interviewing encompasses 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 and Rollnick 1991). As mentioned at the outset of this chapter, Phase 1 focuses on developing the client's motivation to make a change in his/her drinking. Clients will vary widely in their initial readiness to change. Although some may come to treatment largely decided and determined to change, the following processes should be pursued to explore the depth of such apparent motivation and to begin consolidating commitment. Other clients will be reluctant or even hostile at the outset; 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 members, an employer, or legal authorities. Most clients, however, are likely to enter the treat-

ment process somewhere in the contemplation or preparation stage. They may already be dabbling with taking action but still need consolidation of motivation for change.

A good way to think of Phase 1 is that it has techniques for tipping the motivational balance toward change (Janis and Mann 1977; Miller 1995; Miller and Rollnick 1991). One side of the seesaw favors status quo (continued drinking as before); the second side favors change. On the first side, the decisional balance is weighed down by perceived positive benefits from drinking and unwanted consequences of change. The other side is weighed down by the perceived benefits of changing one's drinking and the anticipated negative consequences of continuing unchanged. The therapist's task is to shift the seesaw's balance to the side favoring change.

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

The second part shows how to implement the general clinical style of motivational interviewing that is maintained throughout Phase 1 to Phase 4. (Applying it within the specific structure of Phase 1 will be detailed in section 2.6, "Implementing Phase 1.") Miller and Rollnick (1991) have described the following general strategies that characterize the clinical style of motivational interviewing, outlined below:

### **2.5a. Eliciting Self-Motivational Statements.**

It is true that one can "talk oneself into" a change. Social psychology has amply demon-

strated that when people voluntarily speak or act in a new way, their beliefs and values tend to shift in that direction as well. This phenomenon has been described as cognitive dissonance (Festinger 1957). Self-perception theory (Bem 1967) offers an alternative account, summarized thus: "As I hear myself talk, I learn what I believe." That is, the words that come out of a person's mouth are 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 to evoke defensive argumentation from the person one is attempting to persuade. Head-on confrontation is rarely an effective sales technique (e.g., "Your children are educationally deprived, and you will be an irresponsible parent if you don't buy this computer"). This is a flawed therapeutic approach for another reason: not only does it evoke hostility but it causes the client to verbalize precisely the *wrong* set of statements. An aggressive argument in which the therapist claims, "You're an alcoholic, and you have to stop drinking" will usually evoke a predictable set of client 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 this aspect of human behavior is that in motivational interviewing, the therapist's goal is to elicit from the client self-motivating statements (Miller 1983; Miller and Rollnick 1991) that reflect one or more of the elements in the phrase "ready, willing, and able" (Rollnick et al. 1999). They include four kinds of statements, described below:

1. *Problem Recognition.* This is a cognitive/factual acknowledgment by the client of the risk (potential) or presence of negative consequences of drinking. This should not be equated with the client accepting a diagnostic label. Many people can describe problems caused by their drinking, as listed below, 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.* The client’s recognition of his/her problem may or may not be accompanied by the client’s apparent concern regarding his/her state. Expressed concern has more of an affective quality, a personal involvement and alarm; examples are listed below:

- 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.* This statement directly reflects some readiness to change; examples are listed below:

- I’ve got to do something. I can’t go on like this.
- I want to get free of alcohol and other drugs.

- What could I do if I want to change my drinking?

- I’m going to quit drinking.

4. *Optimism for Change.* Here the client expresses self-efficacy, an ability to change. Note that it may be stated hypothetically, without an expressed desire or intent to change; examples are listed below:

- 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 one of these four types of statements from clients. The simplest is to ask for them directly, via open-ended questions such as these listed below:

- 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 that might become problems?

- What have other people told you about your drinking? What are other people worried about? (If an SSO is present, you can ask this to him/her 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 easy to fall into a question/answer pattern with clients, particularly in early sessions, but you should avoid this pattern for several reasons. For one, although questions direct the client to what interests you, they tend to derail the client's own process of exploration and become roadblocks to learning about your client (Gordon 1970). For another, asking a series of short-answer questions sets up an uneven distribution of power between an in-charge expert and a passive responder. There are situations in which this may be appropriate, such as a physician discussing an acute illness with a patient. Phase 1 of CBI is not one of them.

Within motivational interviewing, therapists use questions 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/she 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 section 2.5f, page 27).

The usual question within motivational interviewing is an *open question* that does not have a yes/no or short answer. Open questions cause respondents to reflect and think, often along new lines. The key is not in the questions, however, but in the client's responses to them. Therefore, it is important to follow an open question not with another question but with sustained reflective lis-

tening. Questioning is no substitute for good reflection, although it is far easier. Motivational interviewing seeks to evoke internal motivation from the client, and therapists are unlikely to accomplish this solely by firing questions. Ask an open question, then reflect on the answer.

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

Empathy is sometimes thought of as "feeling with" a person or having an immediate understanding of the person's situation by virtue of having experienced it (or something similar) oneself. Sometimes it is confused with sympathy. 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. The therapist may also acknowledge the client's expressed or implicit feeling state. This way of responding offers several advantages, listed below:

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.



5. It can be used selectively to reinforce ideas expressed by the client.

This fifth characteristic is an important one in motivational interviewing. You can reflect 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. Furthermore, this style of responding is likely to encourage the client to elaborate upon the reflected statement process, as shown in the example below.

**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 make up a substantial proportion of therapist responses. Nor 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.)

The example below contrasts reflective listening with other types of 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 as your predominant style throughout treatment, although not to the exclusion of other kinds of responses. As the following sections indicate, motivational interviewing encompasses a variety of other strategies.

It is important to 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 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, as shown in the following examples:

- 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 several ways. They can (1) strengthen the working relationship, (2) enhance the client's attitude of self-responsibility and empowerment, (3) reinforce the client's effort and self-motivational statements, and (4) support the client's self-esteem. Some examples of affirmations are provided below:

- 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, and the way the therapist responds to defensive behavior is one of the defining characteristics of motivational interviewing. Uncooperative, or “counterchange” client behaviors within treatment sessions (e.g., arguing, interrupting, denying a problem) predict poorer treatment outcome.

What is defensive behavior? Below is a list of specific client behaviors 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, showing 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, being unwilling to change, alleging impunity, showing pessimism.

As discussed above in section 2.3d (“Deflect Defensiveness”), 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 and colleagues (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 and made only half as many positive, self-motivational statements as those in the latter group. 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, predicting in turn 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. Expressed more bluntly, *defensiveness or denial is not so much a client problem as it is a therapist skill issue.*

Remember this rule: *never meet counter-change statements head on.* If you make certain responses, the client is likely to become

more defensive, backing him/herself further into a corner and causing him/her to make further counter-change statements (Gordon 1970; Miller et al. 1993). Types of therapist responses to be avoided include the following:

- 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
- Using 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?) will make the client defend the counter-change position more strongly 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, you may evoke the opposite. Below are several general strategies for deflecting defensiveness within motivational interviewing (Miller and Rollnick 1991):

- *Simple reflection.* 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 your words or tone of voice. An example of this strategy is shown in the dialogue below:

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 the example above 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 . . .” statements. Below is an example:

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.* Defuse defensiveness by shifting attention away from the touchy or problematic issue, as shown in the example below:

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.* Roll with defensive responses rather than oppose them. Taking up the negative side of the argument often will bring the client back to a balanced or opposite perspective. The example below shows this strategy:

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 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. The 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/her perceptions in a new light or a reorganized form, which gives new meaning to what has been said. For example, when a client is receiving feedback that confirms problematic drinking, you can recast a wife's reaction of "I knew it" from "I'm right and I told you so" to "You've been so worried about him, and you care about him very much." The therapist reframes 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 and 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. You can reframe this (quite accurately) as a risk factor, the absence of a built-in warning system that tells the person when he/she has 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/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").

You can use reframing to encourage both your client and his/her 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 et al. 1982). Whenever possible, use the client's own views, words, and perceptions as you develop a reframe, as shown in the example below.

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 a while. (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 client 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 cause a roadblock to communication and increase defensiveness.

As illustrated in the dialogue above, it can be particularly effective to combine a reflection with a reframe, referred to there as an "agreement with a twist" (Miller and 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, as shown below:

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.** 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. Include elements of reluctance or defensiveness in the summary to prevent a negating reaction from the client, but give particular emphasis to self-motivational themes to reinforce them. A summary serves the function of allowing the client to hear his/her own self-

motivational statements yet a third time, after the initial statement and your reflection of it. In the example below, the therapist gives a first-session summary:

**THERAPIST:** 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 Personal Feedback Report, you were surprised to learn that you are drinking more than 95 percent 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, you can give shorter “progress” summaries. A “What else?” question after a transitional summary can help to keep the process moving, as shown in the example below:

**THERAPIST:** 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 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 COMBINE to administer a breath alcohol concentration (BAC) screen prior to each and every CBI session. The client's BAC must be at or below 50 mg% (.050) to proceed with a session. When a client's BAC is above this level, reschedule the CBI session. If the client's BAC is above but near this level and descending, you have the option of waiting until his/her 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 received a breath test for the MM session, it is not necessary to repeat it. 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. Because you need to accomplish a lot in this first session, it may last from 60 to 90 minutes. Below is an example of a structuring statement:

**THERAPIST: 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.* After this, proceed directly into Phase 1. If the client asks a preliminary question, answer it, but don't ask if he/she has any questions at this point.

The open motivational interviewing phase starts 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 his/her 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/her drinking and current situation, such as the examples below.

- 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?" or other eliciting questions. If the interview bogs down, inquire about some general areas listed below:

- *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, or other memory problems, while drinking?
- *Relationships.* Has drinking affected relationships with spouse, family, or friends? What other people have 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.* Has the client had any arrests or other brushes with the law because of his/her 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 the client becomes defensive, use strategies outlined



above in section 2.5e (“Responding to Defensiveness”) to respond to and defuse it. If you encounter difficulties in eliciting from the client self-motivational statements, take up the negative side of the argument. In this table-turning approach (siding with the negative), you subtly take on the voice of the client’s doubts and defenses, causing him/her to take the opposite side. Examples of negative-siding statements are listed below:

- 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 follow 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 as though 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.

A client may back down from a position if you state it more extremely, even in the form of a question, as in the examples below:

- So drinking is really important to you. Tell me about that.
- What is it about drinking that you really need to hang on to, 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, as in these examples:

- 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 by saying, “What else?” as in the example below:

**THERAPIST: 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 you think that you have elicited most of the client’s concerns, or when time is growing short (e.g., after 30 to 40 minutes), draw together what your client has told you in a summary reflection as described earlier. Offer a transitional summary statement such as the one below:

**THERAPIST: 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 (e.g., the client's reluctance, what the client likes about drinking), 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, such as the one below:

**THERAPIST: What I want to do in the time we have left today, then, is three things. First, I'll tell you a little about what we'll be doing in the next few sessions. Second, 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. And third, I want to ask you whether there is someone who might be able to help and support you as we work together.**

## 2.6b. Initiating Involvement of an SSO.

**2.6b.1 Considering SSO Involvement.** An important element of CBI is the active positive involvement of an SSO in the treatment sessions. Previous research has shown that SSO involvement can help to improve treatment outcomes. The SSO is invited to attend the sessions to learn more about the client's alcohol problems, offer constructive feedback about the treatment plans, provide ongoing support for sobriety, and in general, become an important motivator for change.

The SSO is not involved in sessions until Phase 1 is completed so that you have an opportunity to develop rapport and understanding about the client's current circumstances. Introduce the concept of SSO involvement in the first and

second sessions, but the SSO does not actually become involved 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 have the opportunity to explore underlying ambivalence and uncertainty about SSO involvement *before* deciding whether to involve the SSO (see box below). The first step is to follow the general approach outlined in the text box on this page to introduce the topic. Responding to your client's uncertainty and ambivalence with acceptance and respect may help to minimize his/her resistance to involving an SSO in treatment. Remember to use a motivational interviewing style when exploring SSO involvement.

Begin by asking the client if he/she has 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 nonverbal behavior in response to your open-ended questions, because this topic may elicit resistance or

### Introducing the Concept of 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

discouragement. Use motivational interviewing strategies to evoke information and explore your client's thinking about having the SSO involved. Emphasize the fact that the SSO's role 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 the client may raise about SSO involvement.

Table 2.4 below describes some of the most common client objections to SSO involvement.

**Table 2.4 Common Client Objections and Possible Solutions to SSO Involvement**

Objection	Intervention
Limited social resources (e.g., social isolation, homelessness)	If your client has 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 he/she lives, transportation, or scheduling difficulties often signify that the involvement of that SSO will have to be limited. His/her involvement may be as little as attending one 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 <b>Important People</b> worksheet (Form nn; from baseline assessment) 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 the client need not select an SSO 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	To determine if the client's negative feelings are really the concern, ask the client how he/she would feel about an SSO being there and what the client thinks 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 about having either the client or the therapist ask the SSO to participate. If the client still is reluctant, explore the risks and advantages of asking the SSO.

Do not proceed with the SSO selection process until you have the client’s agreement to have the SSO participate in the sessions. If the client remains resistant to involving an SSO, delay further discussion of SSO participation. If your client declines to have an SSO participate at this stage, make a note to *ask him/her again in Phase 2* and use the method outlined above when making this query. If the patient declines again in Phase 2, you must query again in Phase 3 using the procedure outlined above.

**2.6b.2. Selecting an SSO.** Use the **Important People** (IP) worksheet (Form nn), which the client completes during the baseline assessment, to provide guidelines for SSO

**REFERENCE**  
**Form nn: Important People**

selection. The IP worksheet identifies people who are important to the client, not necessarily those who can fulfill the role of an SSO. Within the present context, the IP worksheet provides you with a reference to initiate the discussion of selecting a SSO from an existing pool of potential candidates. To prevent miscommunication, give the client the glossary of terms included

**Glossary of Terms for SSO Selection**

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**Sober:** abstinent or drinks sparingly.

**Supports sobriety:**

- Will not drink in the company of the client
- Will not suggest or invite the client to drink
- Will not report on his/her own experiences related to drinking
- 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.

below. These common terms are defined as they relate specifically to an SSO’s requirements.

Table 2.5, which is the same as the **Supportive People** form (Form ll), is a decision tree designed to evaluate potential SSO candidates. It offers you and the client the opportunity to define key requirements for selecting an SSO, to anticipate potential barriers to the SSO’s participation, and to form possible solutions for overcoming problems that may have an impact on a potential SSO’s ability to commit to this process. The decision tree also exposes the client to concrete and organized methods of decisionmaking. It is a tool for the client to operationalize the level of support necessary for an SSO to meet the goals and objectives of the intervention.

**REFERENCE**  
**Form ll: Supportive People**

Before meeting with the client, have all necessary forms ready: the **IP** form; several **Supportive People** forms, in the event that there is more than one potential candidate for this role; the SSO selection glossary of terms (below); and the Supportive People scoring guidelines (see “Decision Tree Criteria” following table 2.5). After greeting the client, remind him/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, explaining it as the decision tree described earlier. Explore all potential candidates with the client in case his/her first choice for SSO is unable or unavailable to participate so that you will not have to dedicate part of another session to this task. The client should experience choosing an SSO as a way to include a person who is important to him/her and supportive in the treatment process, not as a way to exclude people whom the client values.

Ideally, the SSO meets all of the recommended criteria outlined in table 2.5 (i.e., the **Supportive People** form). However, if the SSO's ranking falls below any of the recommended minimum percentages (see the decision tree criteria following table 2.5), ask the client to clarify. There may be an area in which the obstacle can be overcome with help from COMBINE staff or you or a combination of all involved. For instance, if trans-

portation is a problem (i.e., in table 2.5, under the "Supportive of Treatment," "Available for sessions" category, the SSO is available to attend sessions rarely [25 percent] or never [0 percent]), perhaps arrangements can be made to alleviate that concern. If you determine that a particular SSO has a significant number of low ratings on the different criteria, encourage the client to identify another potential candidate for

**Table 2.5 Decision Tree: Selecting a Supportive Significant Other\***

<b>Supportive of Treatment</b>					
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%
<b>Supportive of Me</b>					
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%
<b>Readily Available to</b>					
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%

\*NOTE: White areas are recommended criteria for SSO selection.

**Decision Tree Criteria for Table 2.5:****Supportive of Treatment:  
Sections 1 to 4**

1. Minimum score=75%
2. Minimum score=75%
3. Minimum score=75%
4. Minimum score=75%

**Supportive of Me: Sections 1 to 5**

1. Minimum score=75%
2. Maximum score=25%
3. Minimum score=50%
4. Minimum score=75%
5. Minimum score=75%

**Readily Available to: Sections 1 to 3**

1. Minimum score=75%
2. Minimum score=50%
3. Minimum score=75%

screening. Low ratings may represent obstacles for the SSO that may be insurmountable (or may require more effort than is reasonable). If the client is unable to identify another potential candidate, consider postponing the involvement of an SSO. You may also decide to invite this person in for no more than three sessions, with the understanding that the 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 this type of situation, refer to section 2.7h (“The Problematic SSO”).

In the example below, the therapist demonstrates to the client how to use the *Important People* list with the *Supportive People* form (table 2.5) to select an SSO for CBI treatment.

**THERAPIST:** Now that we have discussed what we mean by SSO, why don't you 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 whom 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 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 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 it 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 wife 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 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 wife 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 that person 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 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 3 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 Supportive People sheet, the supportive person should support your sobriety and maintain his/her own sobriety and your goals for treatment. How do you rate your brother on these categories?**

CLIENT: I'd have to say 110 percent. Actually, in some ways, I think he might be better at this than my wife. Not that I haven't hurt or worried him, but my wife 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 sessions, and you should be able to rate him or her 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 an 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 he/she has about having someone attend the sessions. Ask questions about the benefits and costs of having an SSO attend the sessions such as, "What is the worst and best

thing that could happen if your SSO attends?” Reflect back the unfavorable and favorable responses about SSO attendance, as shown in the following example:

**THERAPIST: 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 will come back to the issue (i.e., SSO involvement) later on in treatment. Then keep trying periodically to encourage the client to involve an SSO in treatment.

If the client agrees to involve an 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/her to give a letter to the SSO that defines the SSO’s role and provides important information on how the SSO can contribute to the therapeutic process. Show the letter to the client and ask if he/she has any specific concerns about its contents. If the client has serious reservations, postpone handing out the letter until you have

had a chance to resolve these concerns. Below is a sample letter:

Dear [SSO]:

This letter is an invitation for 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. [Client] 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 toward goals agreed upon at the beginning of treatment.

The purpose of 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 helping in this way. Your support could make a big difference.

### **2.6b.3. Summary of SSO Recruitment Process.**

**Step One:** Therapist initiates involvement of an SSO. If client agrees, therapist proceeds to review of *Supportive People* questionnaire (Form II) and selection of SSO.

**Step Two:** If client disagrees, therapist elicits concerns and responds with motivational interviewing style as outlined in section 2.6.b, “Initiating Involvement of an SSO”; in the “Introducing the Concept of Involving the SSO in Treatment” box; and in table 2.4, “Common Client Objections and Possible Solutions to SSO Involvement.”

**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 2 and Phase 3.

**2.6c. Completing Assessment Needed for Phases 1 and 2.** All clients need to complete three questionnaires in preparation for the second session of Phase 1 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 the client has completed these assessments (they require about 15 to 20 minutes). 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* (Form G, used in section 3.2b, “Consequences”), *What I Want From Treatment* (Form H, used in section 3.5b, “Reviewing Options”), and *Client Services Request Form* (Form F, used in section 4.3c, “Introducing the Module”).

Explain the questionnaire administration with a transitional statement such as the one below:

#### **REFERENCE**

**Form F: Client Services Request  
Form G: Desired Effects of Drinking  
Form H: What I Want From Treatment**

**THERAPIST: As I mentioned earlier, there are some questionnaires you’ll need to complete in preparation for our next session together. After you finish them, 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 the client completed all items.

**2.6d. Ending the First Session.** Allow at least 10 minutes to close the session. Conclude the first session with a summary statement, drawing together all that has happened, including self-motivational statements the client offered during the session. Then explain what happens in treatment from there on, as in the example below:

**THERAPIST:** Next time, I will be giving you some feedback from the interviews and questionnaires you completed, answering any questions you may have about them. 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 16 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 within a few days of the first session. During the first 4 weeks of treatment, it is recommended that sessions be held at least twice weekly (permissible range: one to three times weekly during the first 4 weeks in which treatment is delivered). Thereafter, sessions will normally be reduced to once weekly (permissible range: one to two times weekly during Weeks 5 through 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 Handwritten Note.** After the first session, prepare a handwritten note to mail to the client. This is not a form letter but is rather a personalized message. 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, personalized to the client, listed below:

- A “joining message” [e.g., “I was glad to see you”]
- Affirmations of the client
- A reflection of the seriousness of the problem
- A brief summary of highlights of the first session, especially self-motivational statements that emerged
- A statement of optimism and hope
- A reminder of the next session.

Below is a sample note:

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.** You must complete a *Session Record Form* entry (Form A) 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, he/she must start a new **Session Record Form**. Also record the 16-week date that 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** To indicate that the client had a positive BAC (>.05) and the 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 4 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** To indicate a face-to-face counseling session with SSO only; the client was not present.
- TC** To indicate a telephone contact with the client, regardless of length and regardless of whether it was initiated by the therapist or client. This code is also used if a telephone con-

**REFERENCE**  
**Form A: Session Record Form**

tact included both the client and the SSO in the same call.

- TH** To indicate that a session was canceled by the therapist (e.g., as a result of illness).
- TS** To indicate a telephone contact with the SSO but not the client, regardless of length and regardless of whether it was initiated by the therapist or SSO.
- UC** To indicate an unscheduled contact, face to face (e.g., walk-in).

Record the date of the session (month/day/year) and the time that the session actually began—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 an SSO 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 (1–4) 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*, use the appropriate Therapist Checklist during each and every session. There is a special *Therapist Session 1 Checklist* (Therapist Form 1a) for you to complete 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 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 (handwritten note) to be completed after Session 1.

**2.6i. Beginning the Second Session.** Normally the second session begins with a brief status check and 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 the following two procedures at the beginning of the second and every subsequent session:

- *Status Check.* Initiate 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. Although 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 such as CBI.
- *Structuring Statement.* Make a brief structuring statement to review what you and the client have done thus far and explain what will be happening today, such as “Last time we . . .” or “So far we . . .” (including checking on any homework assignments that were given to do between sessions), and “Today, we . . .” Make a gentle transition and then proceed.

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 checkup format. Personal feedback with normative comparisons can itself alter behavior, and when combined with a motivational interviewing style, it 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, Session 2 proceeds with your giving feedback to the client from the pretreatment assessment. Do this in a structured way, pro-

viding your client with a written report of his/her results (see the *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 ("CBI Therapist Guidelines for Presenting the Personal Feedback Report").

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. Below are some examples of client reactions and therapist responses:

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 questions such as these:

- 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, so you need to be familiar with the assessment battery and its interpretation. (Additional interpretive information is provided on the PFR and in "Understanding Your Personal Feedback Report" [Appendix D], which the client takes home.)

If you do not complete the PFR during the second session, return it 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 of what you have 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." Explain that the latter contains information helpful in remembering what the various PFR scores mean and that he/she is welcome to ask more questions about the feedback now or in future sessions.

**2.6k. Completing Therapist Checklists.** Use Therapist Checklists in all sessions throughout CBI. After Session 1 (covered in section 2.6h), there is not a separate checklist for each session. Instead, checklists document procedures that you may deliver across sessions. Start using the *Therapist Checklist for Phase 1 Completion* (Therapist Form 1b) during Session 2, and continue to follow it until you have completed all Phase 1 procedures. Then proceed to the Phase 2 checklist and continue to use it until you have completed all Phase 2 procedures (Therapist Form 2). In Phase 3, there is a separate checklist for each module that you and your client select which allows you to document the procedures you have completed within modules. You can work 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 section 2.6i), there is also a normal procedure for bringing sessions to a close. About 5 to 10 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 provide the client with an opportunity to ask for clarification or add something. Below is an example of a summary reflection:

**THERAPIST: 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, but it is important to draw together in your summary the following points:

- 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, and so on
- 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 Involving the SSO in CBI Treatment

**2.7a. Overview.** Typically, the first SSO-involved session is the third session of CBI treatment, but only after the therapist has provided feedback on the baseline measures to the client. The overall purposes of the initial SSO-involved session are as follows:

1. To orient the SSO to his/her role/function in CBI treatment
2. To obtain the SSO's commitment in supporting the client's efforts to change
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/her supportive behaviors. Other activities include helping the SSO determine when to, and when not to, offer support. For example, there are certain circumstances in which it may be desirable for the SSO to "back off" rather than to continue 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 being 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 or consequences of his/her choices and actions. This process can help mobilize a client's inner resources to deal with the drinking problems.

**2.7b. Orienting the SSO to CBI.** SSO selection should occur by the second CBI session (see section 2.6b "Initiating Involvement of an SSO"). If the client agrees, invite the SSO to the third session, but only if you have completed assessment feedback. 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/she received the invitation letter to participate in the client's treatment (see section 2.6b.2 for discussion of the letter). If the SSO did not receive it, briefly review the letter's contents. Ask the SSO whether he/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 among you, your client, and the SSO that could result in compliance problems later on, review the goals and objectives of the client's treatment, as listed below:

- Clarify what roles the SSO might play in the sessions.
- Remind the SSO that he/she knows much more about the client than you do and consequently could be helpful in several ways, such as by providing constructive feedback on the plans that you and the client have devised to maintain abstinence.

- Explain that the SSO is not expected in any way to be a cotherapist, and assure the SSO that you will not ask him/her to do anything that he/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 that the SSO's role does not include any policing or enforcing but that 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 the following areas:
  - Offering helpful ideas and input
  - Giving encouragement
  - Supporting and reinforcing the client's efforts to stay sober
  - Helping—in ways the client wishes—to carry out plans for staying sober.
- Tell the SSO that in general, by becoming an ally for change, he/she can help to improve the effectiveness of treatment. However, 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 the client has achieved treatment goals or a determination is made that he/she has derived optimum benefit from such involvement.

In the example below, the therapist welcomes the SSO to the initial session and explains what her role will be:

**THERAPIST: I appreciate your willingness to attend these sessions and to help David 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 ways 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 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.

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

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

**THERAPIST: 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 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. That 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.

**THERAPIST: 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 she really wants to. (*Turning to the SSO*) 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?**

Below is a list of points to make after you have given your introduction and described the SSO's role:

- 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 about how the SSO will be involved.
- Ask the SSO what steps he/she has found are helpful to the client in achieving sobriety. If the SSO is unable to respond, give him/her a few examples, such as maintaining a sense of optimism, praising the client for his/her efforts, spending time with the client in activities incompatible with alcohol use, and celebrating the achievement of an important step, such as refusing to drink with a special friend.

In the example below, the therapist teaches the SSO (Janet) how to effectively support the client (Bob):

**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 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 3 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 have meant a lot to me. I find it easier to handle my urges when I know Janet is behind me.

JANET: He 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.

In this example, the therapist discussed the importance of the reinforcing behavior with Janet. At the same time, the therapist helped to

build Janet's confidence by linking her change efforts with Bob's outcomes.

Continue the discussion on the importance of these reinforcing activities. Explore other ways that the SSO could be helpful to the client in sustaining sobriety. Examine how the presence of the SSO could lead to an improvement in the client's drinking.

In the following example, the therapist explains how reinforcing behavior has a positive impact 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 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 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 such as 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 without drinking.

In this example, the therapist helped Bob understand how Janet's presence enabled him to refrain from alcohol use. He helped Bob identify the coping mechanism used in this situation to forestall alcohol use. Bob learned 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 is the client. As a result, discrepancies often occur between them concerning what the client needs to do to overcome his/her drinking. Such differences need to be normalized and resolved. In the example 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 and what might happen if it is not served. 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 don't want to be made the fool.

JANET: Bob's 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 (to Janet):** You 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, he just loses it.

BOB: This time it will be different because you will be there.

JANET: I am not so sure. You still drank the 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, such as 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 don't 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 (to 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.

In the illustration above, Janet demonstrated her support for and confidence in Bob's ability to handle the pressure of his friends to drink. Janet recognized 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 when 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 that conceivably could negatively affect the therapeutic process (e.g., undermine the client's self-efficacy 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/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 drinking.

These activities by the SSO have been termed "enabling behavior" (Meyers et al. 1998). Such behavior allows the client to shift responsibility for the drinking away from him/herself and on to the SSO. Not allowing the client the opportunity to experience the negative consequences of the drinking can undermine his/her commitment to change (Meyers et al. 1998). Thus, it may be useful to discuss alcohol use *while the client is still sober or before heavy drinking occurs*. At the same time, the SSO and client should devise a constructive plan to deal with the drinking when or if it occurs (see the list

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 drinking episodes.

Below is a list of ways to help the SSO and client deal with the client's resumed drinking:

- 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.
- Indicate that the client him/herself is responsible for addressing the problem.
- Mention that procedures have been developed (see section 4.4, "Resumed Drinking") for helping the client deal with these episodes. Discuss the methods used for helping clients who have resumed drinking.
- 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 he/she is drinking. This might mean not participating in drinking-related events such as bowling 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 phone numbers and hours when you are available in the event that he/she needs to contact you. Also, give the SSO an appointment card so that he/she may feel like an integral part of the treatment process.

**2.7e. Audiotaping.** When an SSO arrives for the first time, do not turn on the tape recorder until you 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 (see 2.7f below). If the SSO prefers not to be taped during the first session, proceed without taping but explain that future sessions the SSO attends will have to be audiotaped. If the SSO is unwilling to be audiotaped at all, 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 form to be taped that acknowledges 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 Institutional Review Board (IRB), and the SSO should sign it before taking part in the second session.

**2.7g. The Basic CBI Approach.** Although having an 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 an SSO. Keep your focus on the client. *Do not shift into a marital/family therapy strategy*, in which you focus on changing the relationship.

Below is a list 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
- Using material contained in the “Communication (Listening) Skills” (COMM) module (section 5.2).

Here are some inappropriate therapeutic responses involving the SSO:

- Discussing family-of-origin issues
- Constructing a genogram
- Giving advice on parenting strategies
- Providing sex therapy.

**2.7h. The Problematic SSO.** If the SSO’s presence poses a temporary problem, it is permissible to gently excuse the SSO from part or all of a session. In some circumstances, however, the SSO’s involvement poses more persistent problems, described in detail in this section.

*Problems caused by the SSO.* If you screen properly, you should be able to identify potential

SSOs who would interact negatively with the client before you ask them to become involved in treatment. Nevertheless, there may be cases in which the SSO poses serious problems in the sessions, as in the following circumstances:

- The SSO undermines the client’s efforts to change his/her drinking behavior. The SSO meets the client’s optimistic comments about change with skepticism or derision. The SSO repeatedly reminds the client 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. He/she frequently cancels appointments without rebooking, does not show up to 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 SSO interactions, begin with motivational strategies described for Phase 1. Reflective listening and reframing can be effective with problematic SSOs (Zweben 1991). Understand and acknowledge the SSO’s viewpoint. You can do this 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/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 that can be covered in one or two sessions, such as the client's condition with respect to drinking and the importance of the study medication(s). Advise the SSO about steps the client could take to change the drinking pattern such as attending mutual-help groups, sustaining a period of abstinence, and actively participating in CBI treatment.
- If the SSO and client are interested and willing, offer them the opportunity to participate in the "Communication (Listening) Skills" module (section 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 you have addressed these communication issues, redirect the focus of the sessions 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 Communications module, ask whether he/she 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.

In the example below, the therapist deals 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 David's 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 to deal with the drinking problem. Once you have sufficient understanding about these issues, Martha, 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 another option, though. We offer some communication-skills training. 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. Martha, 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 the 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 in this chapter 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 he/she is sufficiently motivated; that is one focus of Phase 2 (Miller and Rollnick 1991).

Timing is a key issue—knowing when to begin moving the client toward making a commitment to action. Within the Prochaska/DiClemente model



(1985, 1986; Prochaska et al. 1992), 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 you delay the transition to action too long, the client can lose his/her determination.

Although there are no universal signs of when the client is ready to cross over into the preparation stage, you may observe the following changes in your client (Miller and Rollnick 1991):

- The client's 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, such as these:
  - "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, saying things such as the following:
  - "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 your client's motivation and readiness may also emerge when you are further along in Phase 2 or Phase 3 of treatment. The following questions can help you gauge 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/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/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 that the client is not ready for change, it is wise to defer obtaining the client's firm commitment to a change plan. Instead, explore further the client's ambivalence, making sure you understand your client's views of the pros and cons of drinking and of change, and using generous amounts of reflective listening.

For many clients, there will not be any clear moment of decision or commitment to change. People often tentatively 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.

It is also important to remember that even when a client appears to have made a decision and is taking steps to change, he/she is still likely to feel ambivalent. Avoid assuming that once the client has decided to change, you no longer need Phase 1 strategies. Likewise, proceed carefully with clients who make a commitment to change too quickly or too emphatically. Even when you are working with a person who seems to enter treatment already committed to change, it is useful to pursue some of the motivation-building and feedback strategies mentioned in earlier sections of this chapter 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 (illustrated in section 2.5g, "Summarizing"), this time also incorporating information from the review of feedback. You then follow this up by a key question, an open-ended question, in which you ask, in essence, "What now?" or "What's the next step?" Below are some examples of these questions.

- 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 client has the first responsibility for deciding what to do rather than your announcing what he/she "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, described in the following section.

**2.8c. Assessing Motivation.** As was discussed at this chapter's outset, motivation for change has various components, as suggested by the phrase "ready, willing, and able" (see section 2.2, "Stages of Change"). 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/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 are 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 be *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 for him/her to be ready to do it now? Usually the problem is that he/she has higher priorities to deal with first. Sometimes it is an event that stands between the person and this particular change ("Not until after \_\_\_\_\_ happens").

## REFERENCE

**Form I: Personal Rulers Worksheet**

As you prepare to make the transition to Phase 2, use the *Personal Rulers Worksheet* (Form I) to assess quickly where your client stands on these three dimensions: importance, confidence, and readiness. This will be helpful in deciding not only on whether to proceed but how. Below is an example of how to use the *Personal Rulers Worksheet* to obtain these three ratings:

## 1. Importance

**THERAPIST:** 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 0 to 10. *(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 0 means not important at all and 10 means extremely important? What would you say? *(Circle the one number that the client indicates. Marks between numbers are not allowed.)*

## 2. Confidence

**THERAPIST:** 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 10 means you are certain you could do it. How confident would you say you are? *(Circle the number that the client indicates.)*

## 3. Readiness

**THERAPIST:** Now third, how ready would you say you are now to change your drinking? Zero is not ready at all, and 10 is completely ready. How ready do you think you are? *(Circle the client's rating.)*

At this point, you need to make 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 of less than a 6 bears further exploration. If the client made 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 (section 2.8d). If after you have explored the client's ratings with this procedure you believe that further Phase 1 work is needed, you can follow two other optional procedures: "Constructing a Decisional Balance" (section 2.8e) and "Reviewing Past Successes" (section 2.8f). Otherwise, proceed directly to Phase 2 (section 2.8g, "Closing Phase I").

**2.8d. Optional: Exploring Motivation Ratings.** If the client reports low (less than 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 this section (sections 2.8e, 2.8f).

For each of the three ratings that a client gives, ask these questions for each scale score that is lower than 6 (you may ask them for other scales as well). Each of these questions tends to elicit self-motivational statements to which you should respond with reflective listening and summarizing. Accompanying these questions are explanations in brackets of what the client's ratings could indicate:

1. THERAPIST: 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 is not viable for the rare client whose score is zero, in which case you should skip to Question 2.*)

2. THERAPIST: And what would it take to get you from a [current score] to a [higher score] on this scale? (*For the higher score, choose a number that is 1 to 5 points higher than the client's current score but is 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.*)

When you have completed the *Personal Ruler Worksheet*, 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. Below is an example of such a summary:

**THERAPIST:** So pulling all this together, you said that you are around a 5 on the Importance ruler 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 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 Confidence 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 Readiness rating, a 3, that you are mostly not

## REFERENCE

*Form J: Decisional Balance Worksheet*

ready to make any change yet. Does that sound about right?

**2.8e. Optional: Constructing a Decisional Balance.** If you need to do additional Phase 1 work to enhance motivation for change, ask the client (and SSO) to consider the pros and cons of change. Use the *Decisional Balance Worksheet* (Form J) for this purpose.

Below is an example of a therapist using this worksheet interspersed with therapist responses and sample followup questions, when appropriate, in brackets:

**THERAPIST:** 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 use this Decisional Balance Worksheet 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 "Good things about continuing to drink as before" box of the worksheet. If the client states motivations appropriate to other boxes on the worksheet, write 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 "Not-so-good things about changing my drinking" 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 followup questions include: 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? "In what ways . . ." questions [or requests for examples or elaborations] pertinent to problems reported by the client on the DrInC questionnaire may be appropriate here. If an SSO is present, ask what he/she has noticed. Spend time eliciting self-motivational statements here, and respond with*

*reflective listening. Fill in the "Not-so-good things about drinking" 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? *(Elicit and reflect self-motivational statements. Fill in the "Good things about changing my drinking" 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 the client's low confidence is an impediment to motivation, review how the client and others have changed successfully in the past. Begin by asking the client to recall times when he/she decided to make a change and did so successfully, as shown in this example:

**THERAPIST:** 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 to changing his/her 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 did he/she encounter? How did the client overcome them? How does the client explain his/her success? What does this imply about the client's personal strengths and skills? Avoid jargon here, and use the client's own language. Below is an example of such an exchange:

**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 me 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?**

It may also be helpful to describe how others have succeeded in making changes similar to those the client is contemplating. In one form, you can describe the generally 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 favorable outcomes of treatment for alcohol problems (Hester and Miller 1995; Project MATCH Research Group 1997a, 1998a) and more generally of efforts to change addictive behavior (Miller and Heather 1998; Sobell and Sobell 1992). Look for ties between approaches that have worked for others and what the client tells you about his/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 (sections 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 the one below:

**THERAPIST:** 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/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, he/she will do about his/her drinking.

Use the *Phase 1 Completion Checklist* (Therapist Form 1b) 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 section 2.6g). If Phase 1 continues to Session 3, you should also give the *Working Alliance Inventory* (WAI) (Form oo) 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 think the client is ready for it. The assignment must be consistent with one of the CBI modules, but this still allows for considerable latitude. For example, invite a client to visit a mutual-help group meeting (section 3.5c) or sample an enjoyable alcohol-free activity (section 5.8). It would be possible to start a client on mood monitoring (section 5.6) or completing a referral to an agency that provides a needed service (section

### REFERENCE

*Form oo: Working Alliance Inventory*

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.



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## 3. Phase 2

# Developing a Plan for Treatment and Change

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### 3.1. Beginning a Plan

Before beginning Phase 2, be sure your client has completed the additional questionnaires that will be needed (see section 2.6c, “Completing Assessment Needed for Phases 1 and 2”) and that you have a copy of the *Alcohol Abstinence Self-Efficacy–Temptation (AASE–T)* (Form K) questionnaire that the client took during the pretreatment assessment.

**REFERENCE**  
*Form K: Alcohol Abstinence  
Self-Efficacy—Temptation*

The key shift in Phase 2 goes 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 the client will do about his/her drinking. Offer a simple transitional structuring statement to mark this shift, such as the example below:

**THERAPIST:** 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 the client generates more self-motivational statements and ideas.

Continue to stress the client’s responsibility and freedom of choice. Include reminders of this theme during the commitment-strengthening process. Below are examples of ways to convey this message:

- 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 Reviewing Past Successes 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 in section 2.8b (“Making the Transition to Phase 2”). 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.

Below is a sample structuring statement that connects directly with the transitional material offered in section 2.8g (“Closing Phase 1”). Note that it begins with a key question as prescribed in section 2.8b.

**THERAPIST: 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, as shown in these sample questions:

- 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 are about change, complete a functional analysis in every case during Phase 2. The primary focus here is on the client’s alcohol use, and the functional analysis examines common antecedents and consequences of drinking behavior. Do not use technical jargon such as “functional analysis”

and “antecedents” with most clients, of course. Introduce this part of Phase 2 with a structuring statement such as this:

**THERAPIST: 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.**

**3.2a. Antecedents.** Inquire about common antecedents of drinking, using the *New Roads Worksheet* (Form L). Be careful here to use past tense language as illustrated in the sample below, because present and future tense verbs may alienate or alarm currently abstinent clients:

**THERAPIST: 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 with specific people, or certain 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 Worksheet*. Then ask, “When else have you felt like drinking or getting drunk?” and follow up with reflection, recording each response. (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.) Involve the SSO (if present) in generating ideas as well.

## REFERENCE

**Form L: New Roads Worksheet**

After you have exhausted your client's spontaneous offerings of antecedents, turn to his/her pretreatment AASE–T questionnaire. The AASE–T contains 20 possible triggers that the client has ranked from 1 (not tempted at all) to 5 (extremely tempted to drink). Note items that the client rated as 3 (moderately tempted) or higher. The example below addresses a way to discuss triggers the client has not already mentioned:

**THERAPIST: I notice on this (AASE–T) 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 *New Roads Worksheet* "Triggers" column.

**3.2b. Consequences.** When inquiring about the client's desired consequences of drinking, 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" the client's expectancies. Note that you are to fill in both the "Triggers" column and the "Effects" column in the *New Roads Worksheet* before you begin exploring the links between the two. Below is an example of how to lead in to discussing the client's desired consequences:

**THERAPIST: 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 some of the attractions of drinking were 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 the desired consequence 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 have exhausted the client's spontaneous offerings of consequences, turn to the client's pretreatment *Desired Effects of Drinking* (DED) questionnaire (Form G). The DED lists 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. The sample sentence below shows a way to bring up any desired consequences not already mentioned by the client:

**THERAPIST: 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 of the *New Roads Worksheet*.

## REFERENCE

**Form G: Desired Effects of Drinking**

**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 helps the client put his/her drinking in context with other drinkers. The example below is a way to use this qualification:

**THERAPIST:** All people who drink have 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. The example below is a way to use this qualification:

**THERAPIST:** 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.** The next step ties antecedents to consequences. Below is an example of how to make this connection using the *New Roads Worksheet*. Show the complete *New Roads* form to your client. If you have used two sheets, line them up vertically so that there are continuous "Triggers" and "Effects" columns.

**THERAPIST:** 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. 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 another, usually somewhere else you'd rather be. Does that make sense to you?

Pick out an item from the "Triggers" column and one from the "Effects" column that clearly seem to go together; the example below discusses these connections:

**THERAPIST:** 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/her in that situation and have him/her draw a line to the appropriate box in the "Effects" column. Sometimes there is not yet a corresponding box in the "Effect" column, suggesting something that the client needs to add. Similarly, for unpaired entries in the "Effects" column, identify the likely antecedent and add entries to the "Triggers" column as needed. Proceed until you have identified all useful pair-

ings. 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 and Pechacek 1987). Below is an example of how to lead in to such a discussion:

**THERAPIST:** Some of the pairs you have drawn here are pretty common, but these patterns are different for each person. What we are talking about here is what is sometimes referred to as “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 in Phase I to defuse rather than increase uncooperative client responses. Below are more examples of ways to introduce finding alternatives:

**THERAPIST:** 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 alterna-

tives. 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 the following question:

**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 the 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.”)

To suggest a treatment module that might address an area of concern, try asking the following:

**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: Below are some examples of this type of question:

- 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?
- 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?

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 Worksheet* functional analysis, a client's poor functioning or a lack of coping skills in a specific area (the triggers) can also increase his/her 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, the client's effective coping and a sense of well-being tend to go hand in hand.

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

This section expands the focus of treatment for all clients by identifying areas of functioning that could, if enhanced, have a beneficial impact in reducing their drinking and related problems. There are eight broad areas for the client to review and prioritize, described below. 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 the client's psychosocial functioning is to identify important life areas that may be related to his/her drinking problems.

#### REFERENCE

***Form M: Personal Happiness Form***

This in turn informs the process of setting goals for treatment and change.

The *Personal Happiness Form* (Form M) identifies areas of the client's psychosocial functioning that sometimes affect and/or are affected by his/her excessive drinking. These are based upon but extend beyond the life problems card sort used in the Comprehensive Drinker Profile (Miller and Marlatt 1984).

Below is an example of a structuring statement that can make the transition to this topic:

**THERAPIST: There is one more area to consider before we are ready to discuss a possible change plan. Researchers have discovered much over the past 20 years, and one thing that is clear now is that a person's drinking is often linked to many other areas of his/her life. If things are going well in these other areas, it's much easier to stay free from alcohol problems. However, 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.

Give the client the *Personal Happiness Form*; below is an example of instructions to use:

**THERAPIST:** 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 1 (which means that you are completely unhappy or dissatisfied in this area of your life) to a 10 (which means that you are completely satisfied and happy in this area of your life). There are 20 life areas here, and I'd like you to rate them all from 1 to 10. If an area does not apply to you, though, circle "NA" for "not applicable." 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 tell the SSO, "This is the form (the client) 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 the client left no items blank. If the client did not rate some items, have the client rate them or circle "NA."

**3.3b. Card Sorting.** Have ready a small table or flat surface. Hand your client the card sort version of the *Personal Happiness Form*; be

sure that all 20 of the cards are included (except the title card and the YES and NO cards) and are arranged in numerical order. What follows is an example of how to explain using the cards:

**THERAPIST:** These cards cover the same areas as the *Personal Happiness Form*, with one area printed on each card. What I'd like you to do is to sort these cards into two piles. 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 if 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. When the client has finished sorting, set the NO pile aside, take up the YES pile, and put check marks in the "Link" column on the *Personal Happiness Form* that corresponds to each of the YES cards (the card numbers correspond to the matching numbered areas in the "Change" column). Also notice on the *Personal Happiness Form* those areas for which the client has indicated dissatisfaction (rating of 4 or lower), because you will soon need to use this information.

Recombine the YES and NO cards, give the full deck back to the client, and tell him/her to go

**REFERENCE**  
**Form N: Personal Happiness Card Sort**

through the cards again. Below is an example of how to explain this second card sort:

**THERAPIST:** This time, think about areas of your life in which you might like to make a change or in which you think it may be important for you to make a change. When you sort the cards into piles, put on the YES pile those areas in which you might like to make a change. For areas where you don't think it's important for you to make a change, put the card on the NO pile.

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, take up the YES pile, and put check marks in the "Change" column on the *Personal Happiness Form* that correspond to each of the YES cards.

If an SSO is present in this meeting, check in with him/her 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. For example, you could ask the client, "Would it be all right to mark this one as possibly related to drinking?"

**3.3c. Reviewing the Personal Happiness Form.** Set aside the cards and work from the *Personal Happiness Form*; it includes three pieces of information for each area of psychosocial functioning: (1) the client's self-rating of satisfaction, (2) the client's appraisal of whether the area is related to his/her drinking, and (3) the client's current judgment as to whether or not it is important to make a change in this area. Below is an example of how to begin discussing the form:

**THERAPIST:** 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 you checked as YES in the "Change" column, ask one or more followup questions, such as those listed below. Start with those "Change" areas in which the client has expressed the greatest dissatisfaction (lowest ratings). Your goal is to elicit self-motivational statements that reflect the client's perception of problems, concerns, desire or need for change, intention to change, optimism regarding change, and so on. After you ask a question, follow up by reflecting what the client offers. Don't ask three questions in a row without reflecting in between. Below are examples of followup 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 percent 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 "Link" column] In what ways do you think this area is related to your drinking?

This may leave some areas in which the client indicated dissatisfaction (rating of 4 or lower) but did not pick out as important for change.



At your own discretion, ask about one or more of these. Below is an example of a way to approach this:

**THERAPIST: I notice that you marked on the Personal Happiness Form that 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, ask about one or more of these. Below are examples of how to approach this:

- 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/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 an 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 these areas. Below is an example of a summary reflection:

**THERAPIST: 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 are 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. The extra focus here is on

**REFERENCE**  
**Form O: Options**

areas where the client will need to change to succeed in stopping drinking or at least reducing alcohol-related problems. Below is an example of a way to discuss these priorities, using the *Options* form (Form O):

**THERAPIST: 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 change 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.]**

**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. For example, in the area of relationships, 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, coworkers may engage in conversations about drinking escapades or may drink at lunch or after work. Joining in such activities may be what is expected “to belong.” As you explore the possibilities in each of these functional areas, be sure to maintain your empathic style. Although 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 the 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 addressed 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.

When you complete this review of psychosocial functioning, 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; close with a structuring statement that tells the client 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, some of which are listed below:

- Focusing so much attention on the client's problems and deficits requires balancing the picture.
- Having the client describe his/her 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 the one below:

**THERAPIST: 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 the following:

**THERAPIST: 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?**

**REFERENCE**  
**Form P: Characteristics  
of Successful Changers**

Some CBI therapists like to use with their clients the prompt form, *Characteristics of Successful Changers* (Form P), and introduce it here at the very beginning of the procedure. 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 section 2.8f, "Reviewing Past Successes"). Though there is some overlap, here you are focusing on your client's positive attributes that can be resources during the change process. If the SSO is present, involve him/her in identifying the client's strengths as well. This is also a 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 followup 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. In the example below, the therapist elicits statements from the client describing her personal strengths:

**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 6 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 the client identifies several strengths, and offer summary reflections along the way. Ask the SSO, "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 on the *Characteristics of Successful Changers* form and invite the client and SSO to look through it for words they think accurately describe the client. When they offer one of these, follow up again with elaboration and then say, "What else on this list?"

When you have accumulated a reasonable set of strengths, offer a summary reflection, such as the one below, and then move on to discussing resources.

**THERAPIST: 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?" prompts. 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, 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. Below is an example of how you might structure this section of treatment:

**THERAPIST: 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 togeth-**

er 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 you and your client identify issues (during the functional analysis and the review of psychosocial functioning) that could be addressed in this treatment, print 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. Below is a list of possible entries on the **Options** sheet:

- Decrease stress.
- Feel better about self.
- Explore AA.
- Cope with urges to drink.
- Learn to say no.
- Develop conversation skills.
- Improve marriage communication.

Be sure to leave *at least two* bubbles empty. The possible options you entered are a starting point for this discussion. To begin this module, show the **Options** sheet to your client. Below is an example of a way to begin this discussion:

**THERAPIST: On this sheet, 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 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: (*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?

#### REFERENCE

#### **Form H: What I Want From Treatment**

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 (Form H).

The WIW lists 42 things that clients might want from treatment that the client has marked YES or NO. Note items marked by the client as YES to determine whether these areas suggest other desired goals of treatment the client has not already mentioned. Below is an example of a way to discuss this questionnaire:

**THERAPIST: 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?**

**3.5c. Recommending Mutual-Help Programs.** At some point during Phase 2 for all cases (usually while completing the **Options** sheet), discuss with your client the possible use of mutual-help programs such as AA. Below is an

example of a way to raise the subject and provide a rationale for attending such a group:

**THERAPIST:** 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. AA 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. Below are some examples of ways to discuss this, with different approaches depending on the client's experience with such groups:

**THERAPIST:** 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 a good experience:* I'm glad you've already had some good experi-

ences 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 a 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 ("Mutual-Support Group Facilitation").

The availability of mutual-help groups varies by geographic areas. AA is most widely available, and larger communities may offer a broader range of options. More detailed information about mutual-help programs is provided in module 5.7. Familiarize yourself with the different groups 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. Below is an example of a way to discuss prioritizing the options:

**THERAPIST:** 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.

**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 the client mentions 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 be good options, saying something such as: “What about \_\_\_\_\_. Is that something that we might work on together?”

It is important for you to remember that you will not address all items on the treatment plan 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. Take care that you convey this to your client so that he/she does not think he/she has been promised something that you will not deliver. Rather, consider the treatment plan as a wellness plan that will include some items that you can address together with the client and some items

**REFERENCE**  
**Form Q: Treatment Plan**

that 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 Q) 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. Below is an example of a way to introduce this to your client:

**THERAPIST: 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* is used to specify one problem that will be addressed by treatment (or in some cases, by referral). Problems are numbered sequentially, and you can use a *Treatment Plan Continuation* sheet (Form R) if you identify more than five problems 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 (X) through all problem boxes in unused rows. If, for example, you specify only four problems, cross through the Problem #5 box. The *Treatment Plan* may be (and often is) modi-

**REFERENCE**  
**Form R: Treatment Plan Continuation**

fied later in treatment, and this can be done with a new *Treatment Plan Continuation* sheet. You cannot change a *Treatment Plan* sheet once it has been signed and dated, so you must use a new sheet for all addenda and modifications. If you add a new problem, give it the next unused sequential number. If you modify a prior problem (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.

For each problem (row), there are columns in which you specify three things. In the first col-

umn, “Problems to be addressed by treatment and referral,” specify these problems. Problem #1 will always be alcohol problems and/or dependence. The content for Problem #1 should have emerged in the transition and key question segment discussed in section 2.8b, “Making the Transition to Phase 2.” 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 section 3.5f below, “Emphasizing Abstinence”). Bubbles from the *Options* sheet identify potential problems for the *Treatment Plan* but are included only by mutual agreement between you and your client. You may state a problem on the *Treatment Plan* even if you will not directly address it in treatment; for example, if financial problems are a serious concern for your client, enter these with a problem number, and the plan might be referral to consumer credit counseling.

In the second column, “Broad goals and specific objectives to be achieved,” be specific about objectives; try to state them in observable or measurable terms. Include goals that are *positive* (wanting to begin, increase, improve, do more of something), not just goals that could be accomplished through general anesthesia (to stop, avoid, or decrease behaviors).

In the third column, “Treatment plan,” specify how you plan to address the stated problem to achieve the stated goal(s). Identify specific modules that will be included in Phase 3. Specify referrals and 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 it was carried out. You should also state at least a tentative timeline for each problem: *when* will this be done? Progress notes that you keep throughout treatment will correspond to the problems, goals, and plans stated here.

**3.5f. Emphasizing Abstinence.** At some point during Phase 2, give your client a rationale for abstaining from alcohol. It is important to remember here the difference between the *treatment program’s* goal—abstinence—and the *client’s* goals. It is inconsistent with a motivational interviewing style for you to coerce or impose a goal, nor can you realistically do this. The goals that clients make during pretreatment can predict outcomes (Miller et al. 1992a). Clients who are assigned a goal of abstinence, regardless of their wishes, show no better outcomes than those who state their own goals (Graber and Miller 1988; Sanchez-Craig and Lei 1986). It is also important to remember that it is not 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, commend to clients 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, such as 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, or to please your spouse. (See the “Sobriety Sampling” module [section 4.1] for more detail.)
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 your client against a goal other than abstinence if the client appears to be deciding in that direction. Again, you must do this 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 to work toward complete abstinence are the following:

- Pregnancy
- Medical conditions (e.g., 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 3.1 may be useful in determining cases in which you should strongly discourage moderation. Use the client’s Alcohol Dependence Scale (ADS) score administered at intake for this comparison. The norms in table 3.1 are derived from long-term followups (3 to 8 years) of problem drinkers attempting to moderate their drinking (Miller et al. 1992a). “Total Abstainers” are those who had been continuously abstinent for at least 12 months at followup, 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.

**Table 3.1 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 AB:AS
		<i>n</i>	<i>p</i>	<i>n</i>	<i>p</i>	<i>n</i>	<i>p</i>	<i>n</i>	<i>p</i>	
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

In addition to a general commendation of the merits of abstinence that you give in all cases, you should offer further counseling to clients who fall into Ranges 3 or 4 in table 3.1 if they are entertaining a nonabstinence goal. Inform them 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. Tell clients who fall in Range 4 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 and Page 1991). Consult the Sobriety Sampling procedures described in module 4.1.

In any event, remember that it is a goal to keep your client engaged in treatment and that ultimately it is the client who chooses his/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. 1992a).

**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 and Rollnick 1991). This may include a repetition of the reasons for concern uncovered in Phase 1 (see section 2.5g, “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. Below is an example of a grand recapitulation:

**THERAPIST:** 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 several 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 AA, 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 AA 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 3 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 week-ends. 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. Note them on the *Treatment Plan* as well.

**3.5h. Asking for Commitment.** After you have recapitulated the client's situation and responded to any additional points and concerns the client (and SSO) raises, 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. Below are some examples of the key questions to ask after you have made the grand recapitulation:

- Are you ready, then, to go ahead with this plan?

- Is that what you are going 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, and so on.

Some clients are unwilling to commit themselves to change goals. In cases where a client remains ambivalent or hesitant about making a written or verbal commitment to deal with the alcohol problem, ask him/her to defer the decision until a later time. Agree on a specific time to reevaluate and resolve the decision after a few more sessions. If you allow the client the opportunity to postpone such decisionmaking, he/she may be favorably influenced by motivational processes over time (Goldstein et al. 1966). Such flexibility enables the client to explore more fully the potential consequences of change and prepare him/herself to deal with the consequences. Otherwise, the client may feel maneuvered into making a commitment before he/she is ready to take action and may decide to withdraw prematurely from treatment rather than lose face over the failure to follow through on a commitment. Below is an example of what to say to an unwilling client:

**THERAPIST: 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?**

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 on the *Treatment Plan* might be to "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 on the plan 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.

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## 4. Pull-Out Procedures

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The nine pull-out procedures described in this section are to be used in particular circumstances and only as the need arises. This may happen anytime during treatment, so you may use these procedures during Phase 3, Phase 2, or even Phase 1. It is also possible that you will not need to use any of these procedures.

The nine pull-out procedures are described as follows:

**SOBR Sobriety Sampling (4.1)**

Use this procedure if your client is not committed to long-term abstinence or has been drinking throughout sessions to date.

**CONC Raising Concerns (4.2)**

Use this procedure 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)**

Use this procedure when a client needs help or social services that are not available within the treatment protocol and you refer him/her to community resources (e.g., clergy, cooking

and household management, family therapy, money management, parenting).

**RESU Resumed Drinking (4.4)**

Use this procedure when a client who has been abstaining reports he/she has resumed drinking since the last session.

**SOMA Support for Medication Adherence (4.5)**

Use this procedure when your client states a desire or a plan to discontinue medication or has stopped taking trial medication.

**MISS Missed Appointment (4.6)**

Use this procedure when a client misses an appointment.

**TELE Telephone Consultation (4.7)**

Use this procedure when clients or SSOs contact you by telephone between sessions.

**CRIS Crisis Intervention (4.8)**

Use this procedure 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)**

Use this procedure when your client expresses disappointment at the first CBI session over not being randomized to a medication condition.

## 4.1. SOBR: Sobriety Sampling

**4.1a. Rationale.** Research evidence suggests that a person who abstains for a sustained period may improve his/her responsiveness to alcoholism treatment (Sanchez-Craig 1984; Project MATCH Research Group 1997a). In Project MATCH, aftercare clients who entered treatment after sustaining at least a brief period of abstinence (i.e., 10 to 28 days while in residential or day treatment) (Project MATCH Research Group 1997a) generally fared better than outpatient clients who lacked this abstinent period, despite having had more severe problems at intake: 35 percent of these aftercare clients maintained continuous abstinence throughout the 15-month followup period, whereas 20 percent of outpatient clients abstained for this long (Project MATCH Research Group 1998c).

Other data indicate that people's cognitive capacities can be improved by a period of abstinence (Sanchez-Craig 1984). This would seem particularly important for treatments such as cognitive-behavioral therapy that are geared to developing and enhancing the clients' intellectual resources (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 3.2e, "New Roads"), to become aware of triggers for alcohol misuse, and to learn alternative coping responses to these problematic situations. At

the same time, CBI places emphasis on recognizing and enhancing the clients' sense of confidence (i.e., self-efficacy) in handling these events. CBI also places emphasis on (re)building relationships with family members and friends who are interested in helping clients change their drinking. Friends are especially important for people whose social relationships center mainly around drinking-related activities (Longabaugh et al. 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 3.5f, "Emphasizing Abstinence").

Before using this module, review the two procedures mentioned above—"Emphasizing Abstinence" (section 3.5f) and "New Roads" (3.2e)—and your client's responses to them (if you have already completed them). The immediate goal of SOBR is to enhance the client's awareness of the importance of achieving an initial period of abstinence. The emphasis here is on reasons that are important *to your client*, rather than a standard litany of reasons or those reasons that seem important to you. Remember that your goal is to facilitate at least a trial period of alcohol-free living. A client who succeeds with a short period of abstinence has a greater likelihood of sustaining a longer period of sobriety. Those who try abstinence often find they like it! 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.

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, ask your client to come up with some advantages of abstaining for a while. Employ strategies described earlier (Phase 1 and 2) for this purpose, such as these listed below:

- 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.
- Going without alcohol and other drugs for a while helps you get clear about ways in which you have come to depend on them. 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 like they have more energy or are less depressed, relationships can improve, and so on. It doesn't fix everything, of course, but often it gives you a good head start.

If needed, you can also suggest some advantages. Don't fall into the trap of trying to sell an 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 him/her. From the list of points below, choose the ones that seem 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.

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.** After you explore possible advantages, ask your client if he/she is willing to consider the possibility. Below is an example of such a request:

**THERAPIST: 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/she might succeed. If your client balks at a month, try obtaining an agreement on a shorter period of time (e.g., 2 weeks, 1 week, 3 days)—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/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 decision. This section addresses the following six steps for helping your client implement abstinence.

1. *How long?* Ask your client to determine a reasonable length of time to try being free from alcohol. For some, the 1-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?* Discuss a clear quit date. Usually clients feel that the best choice will be “starting now”—no time like the present—but some clients will choose a date in the near future. If your client chooses a future date, either call or schedule an appointment with the client on that day to discuss initiation of abstinence.

In the example below, the therapist and client discuss when to begin implementing abstinence:

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 be 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 go to 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?* Ask your client how he/she could be most likely to succeed. Ask how confident your client is that he/she can succeed in abstaining for this length of time, or break it down into shorter spans of time. The AA perspective of taking it 1 day at a time can be very helpful here. Although the client's goal is to remain abstinent for a longer time, he/she only needs to stay sober *today*. Explore who could help the client to succeed (e.g., 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 go 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 section 3.2e, "New Roads"), and so on. Rather than offering solutions first, ask the client how he/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.

In the example below, the therapist, client, and SSO discuss a potentially dangerous situation that may undermine the client's ability to stay abstinent:

**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 weekend.

**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 me about my clothes, hair, weight, makeup, 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 two is 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?**

As shown in this dialogue, there are three basic steps to handling dangerous situations:

- Call the client's attention to risky situations or triggers.
- Draw upon his/her coping resources (and those of the SSO).
- Develop a specific action plan.

If a client can successfully handle an event that in the past has led to excessive drinking, it can be an important boost to his/her 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 dealt with anticipated problems that could interfere with the sobriety plan. The recurrence of drinking, however, often occurs in problem situations that the client did not anticipate and for which he/she had no specific coping plans developed. In this step, develop some general "fire escape" plans for deal-

ing with any unanticipated problems. What will the client do in the case of a strong urge or craving to drink? What if he/she actually has a drink? How could he/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 (such as a visit to Mom, as in the above example) 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 in which the client evidences little control over his/her 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 in which it is not feasible or acceptable for the client to even temporarily avoid the situation, help him/her develop specific *coping* strategies to stay sober. 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/her misgivings about an abstinence plan. Meeting reluctance head on tends to be counterproductive and can result in the client increasing his/her defensiveness or prematurely terminating treatment (Miller et al. 1993; Zweben et al. 1988). Instead, delay decisionmaking about

sobriety sampling, and continue to rely on motivational counseling methods such as normalization, reflective listening, reframing, and summarizing (see Phase 1 strategies).

In the example below, the therapist uses Phase 1 strategies in proposing an abstinence plan to a reluctant client; the different strategies are identified in brackets:

**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 (*emphasizing personal control*). 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 decisionmaking 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 1 day. But if you want to think about a specific period for evaluation, how about 1 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.

When you use nonconfrontational strategies, you often gain the cooperation of initially defensive and uncooperative clients (Miller and Rollnick 1991). In this interview, the therapist recognized that the client is still ambivalent about abstaining. Rather than pushing hard directly, the therapist continued with basic Phase 1 methods to work toward initial sobriety sampling. The therapist and the client negotiated a 1-week abstinent period. Had that failed, the therapist might have tried negotiating a shorter period. Gaining that initial foothold on sobriety is the purpose of this sobriety sampling procedure.

## 4.2. CONC: Raising Concerns

**4.2a. Rationale.** You can use this procedure at any time during treatment when your client is expressing a goal or plan that concerns you. Below are examples of such situations:

- 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 she is just substituting one hazardous drug for another and that your client's increased marijuana use will result in new problems (or more of the same).

How should you respond in situations such as these? The general strategy parallels a central idea in the “Assertive (Expressive) Communication Skills” module (section 5.1). It is a middle ground between passive (e.g., saying nothing or stating your concern indirectly or weakly) and aggressive “roadblocking” strategies (e.g., 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.

As with assertiveness, the approach to use here is between these extremes. Its goal is to communicate your concern effectively and 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. 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 “bad” position. Becoming aware of your discomfort should trigger the thought, “Use the ‘Raising Concerns’ procedure.” Inhibit the temptation to argue, and follow the four steps detailed below:

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. 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 might make one of the following statements:

- 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 6:00 and 8:00 last night, 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. Ask your client's permission to express your concern. Below 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 that 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,” as shown below:

**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. Below are a few examples of appropriate open questions:

- 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 in which you argue for change and 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 words, 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<sup>1</sup>

**4.3a. Rationale.** People with alcohol problems frequently have other needs and problems that are directly or indirectly related to their excessive drinking. They may require assistance dealing with social, legal, economic, or child care problems; budgeting; domestic abuse; housing; and medical disorders. These complex issues are often difficult to address within the confines of a specialized treatment program; therefore, it is important to draw upon a variety of health care and social service settings to address the range of difficulties your clients may be confronting. The challenge is to implement an effective referral strategy so that ancillary problems are addressed *before* they interfere with the primary goals of alcoholism treatment (Rose et al. 1999).

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

Use this module when you wish to refer a client for ancillary services. It is designed to address potential obstacles to a successful referral and approaches referral as a negotiation process between therapist and client. You will encourage your client to have input into and be actively involved in decisionmaking about the need, acceptability, and feasibility of referral.

<sup>1</sup> The "Case Management Module" is adapted from Lisa M. Najavits, *"Seeking Safety": A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford Press. Copyright © 2001 by Guilford Publications, Inc. Used with the permission of publisher.

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 section 2.6c, “Completing Assessment Needed for Phases 1 and 2”). If your client marked “Yes” or “Maybe” next to any areas on this form, it is worth exploring whether your client would like to know about his/her resources for help there.

#### **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 (site location, bus routes, etc.), waiting lists, and other pertinent matters related to service delivery. In developing such a sourcebook, 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 hot-lines. Talk to local experts in your area. Some programs and communities will already have well-developed resource lists, but usually there are many resources available but no convenient way to identify them. If your facility has an on-site computer network, use it to keep the resource list updated and to make it available to project staff.

For frequently needed services, obtain a supply of brochures or other written information to distribute to clients. Establish formal linkages with regularly utilized services to enhance the referral process; for example, in a social welfare agency, develop a relationship with an internal contact who can reduce the amount of time between your first referral call and the client’s first appointment.

**4.3c. Introducing the Module.** Introduce the CASM module to your client in statements similar to those below:

- It is important for us to focus not only on your drinking but on what is happening in your life more generally.
- Our goal is not just for you to stay away from alcohol but more importantly for you to have a good life without alcohol.
- Earlier you filled out this questionnaire (show the client the *Client Services Request Form*), on which you indicated areas where 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

#### **REFERENCE**

#### **Form F: Client Services Request Form**

have a more satisfying and happy life without alcohol. Would that be all right with you?

**4.3d. Beginning the Case Management Process.** The primary steps for implementing case management within this pull-out are summarized in the acronym ARISE, described below:

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, financial difficulties) in 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 the referral.
5. Follow up to ENSURE that your client completed the referral.

As mentioned in sections 4.3a and 4.3c, your client 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 helping your client achieve and sustain abstinence. Below is an example of an introductory structuring statement:

**THERAPIST: 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 the ones below, and follow up with reflective listening to evoke and reinforce self-motivational statements.

- You marked \_\_\_\_\_ as an area in which 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.** Clients can be overwhelmed by the referral process, especially if they have many areas of need. Develop a sense of which goal(s) your client is most interested in pursuing, and focus on those (Najavits 2001). 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.

In the example below, the therapist and client prioritize 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, especially parents.**

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* (Form S). 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. You can continue referral procedures in subsequent sessions along with work on other modules. If you encounter a problem area for which you do not know a suitable resource, tell the client you will research it, and

#### REFERENCE

##### *Form S: Case Management Goal Sheet*

try to find an appropriate referral before your next session.

**4.3f. Making a Referral.** After completing one or more *Case Management Goal Sheets*, discuss which problem area the client should work on first. Usually this will be the one your client identified as the highest priority. Set at least one specific case management goal, along with a deadline, to complete before the next session. If a client can take on more than one goal assignment, make two or even more assignments, but be sure that each is specific and that you agree to an actual 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 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 *Case Management Goal Sheet*, drawing on your site's resource directory. Write down on a *Resource Sheet* (Form T) the name of the contact person, telephone number, address, and

#### REFERENCE

##### *Form T: Resource Sheet*

other relevant information, along with the specific assignment and deadline.

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 (e.g., is the agency located in a high-crime or drug-use neighborhood?). Consider whether and how the client's SSOs might be involved for support and other assistance (e.g., driving). Give the client the Resource Sheet to take home, and suggest that he/she keep it in a visible place (such as the refrigerator or dashboard of the car) as a reminder.

Encourage a consumerist view with clients; suggest that they shop around until they find services they like and feel are beneficial (Najavits 2001). Explore clients' ambivalence or uncertainty about addressing a particular case management goal. You'll find motivational interviewing is useful with clients who are not following through on case management needs. It may be helpful to have the client role-play how to make the contact and how to deal with obstacles that could arise. There's nothing wrong with allowing the client to make a referral call from your office during a session, either.

Be careful not to pressure the client to make a premature commitment to a goal. This can happen particularly if a problem seems urgent to you but not to your client. Clients usually resist doing what they are not ready to do, and they may drop out of treatment as a result. Instead,

Client ID#: 02-6435

Goal #: 6  
*(from Treatment Plan)*

### Sample Case Management Goal Sheet

<b>Broader goal:</b> To receive regular health care		<b>Specific objectives:</b> 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
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		

explore the client's ambivalence, reflect back your understanding of the client's misgivings, clearly state your own concern (see section 4.2, "Raising Concerns"), 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 et al. 1995).

In a genuine emergency, however, you may need to take action against your client's immediate wishes. Examples include situations that present clear danger to the client or others or to children, or when the client comes to a session intoxicated and intends to drive. In such life-threatening instances, you should consult with on-site clinical personnel about what course to follow.

Follow up on your client's progress toward achieving the agreed-upon goals at each session until all his/her 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. Below is a list of options to try with clients who have not completed their case management goals:

- 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 an SSO 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 (e.g., you call the client, the client calls your voice mail).
- Ask the client to talk you step by step through what he/she needs to do.
- If the client lacks confidence, encourage him/her to try an experiment and specify a part of the task he/she will complete.
- Encourage the client and/or SSO to arrange for a "celebration" reward (not drinking, of course) when he/she has completed the task.

## 4.4. RESU: Resumed Drinking

**4.4a. Rationale.** Use these procedures if your client resumes drinking after a period of abstinence during treatment. The goals of this procedure are to help your client do the following:

- Explore the competing motivations of continuing drinking and resuming abstinence.
- Identify specific triggers for drinking and determine whether abstinence can be aided by learning new coping skills.
- Explore the client's cognitive-affective reactions to resumed drinking.
- 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, which include: (1) the client has experienced a change in motivation to remain abstinent, (2) the client is having difficulties coping with specific trig-

gers 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”) (Marlatt and Gordon 1985).

If your client has not established abstinence but continues to drink, consult the “Sobriety Sampling” procedures (section 4.1) rather than this section.

#### **4.4b. A Few Words About Language.**

Motivations for abstinence instead of drinking often fluctuate over time. As stated earlier, it is common for people with serious problems related to drinking to make several attempts before maintaining stable abstinence. In this sense, it is not surprising that a person undergoes alternating periods of drinking and abstinence when trying to change a long-standing pattern.

It makes a difference how you, as therapist, think and talk about resumed drinking; this resumption is often described in dichotomous terms that have strong moralistic overtones (e.g., slipping, falling off the wagon). In preparing this manual for therapists, we have specifically avoided use of the term “relapse” for this reason. This is not a matter of using politically correct language or of finding euphemistic ways to communicate the same concept. Our intent is to develop a nonjudgmental way to think and talk about clients’ periods of drinking on the road to recovery. Ideally, such language would do two things: (1) forego moralistic good/bad connotations, and (2) communicate realistic expectations about the typical course of recovery. We particularly rejected absolute thinking that places the client into one of two binary categories based on recent behavior (e.g., dirty/clean, wet/dry, drunk/sober, relapsed/not relapsed). This turns out to be challenging in a field in which even professional terminology has been so interwoven

with societal attitudes. Similar shifts in language and conceptualization have been achieved in other fields in which moralistic terms once dominated diagnosis and treatment (e.g., sexual dysfunction, developmental disorders).

The key is to describe the *behavior* rather than an inferred personality state. Awareness of this difference has been emerging in substance use disorders treatment. Within AA, 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.** The first step in dealing with your client’s 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? Below are some ways to talk with your client about resumed drinking that draw on Phase 1 methods:

- Help your client weigh the positive and negative consequences of continued drinking against the positive and negative consequences of resumed abstinence. (Reviewing the positives of drinking here is part of weighing them against the negatives.) In particular, elicit from the client the advantages of resumed abstinence and the risks/costs involved in continued drinking (self-motivational statements). Avoid the situation in which 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 (e.g., medical, emotional, financial, legal, social, relationship)? 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 did not occur?
- Reassess the client’s goal with regard to drinking, emphasizing his/her autonomy and responsibility for making this choice. Revisit “Emphasizing Abstinence” (section 3.5f) 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 (section 2.8c, “Assessing Motivation”).

- Use or revisit the Decisional Balance procedure (section 2.8e, “Constructing a Decisional Balance”), particularly if the client’s perceived importance of change seems to have diminished.
- Use or reuse the “Reviewing Past Successes” procedure (section 2.8f), particularly if the client’s low confidence seems to be a factor in his/her resumption of drinking.

In the example below, the therapist and client explore motivational issues related to the client’s resumption of drinking; motivational techniques the therapist employs are in italics:

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 (the therapist asks 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 *(the therapist paraphrases and reflects the client's 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 *(the therapist uses reflection, continues the paragraph, also emphasizes 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 hungover, 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 hungover, but you don't want to make a big deal out of it *(the therapist uses 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 hungover 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 hungover 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. Below is an example of a summary statement:

**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. On the one hand, 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, you might have some health problems and 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 you 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? (*The therapist asks a key question.*)

#### **4.4d. Situational Risks and Coping Issues.**

A client may resume drinking not because his/her motivation has changed but because he/she 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 has difficulty in doing so. To determine whether resumed drinking has such a functional importance, 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 (section 3.2, "Doing a Functional Analysis"). If there is not a specific circumstance that explains why the client resumed drinking, explore more global lifestyle issues that may make it difficult for the client to remain abstinent. Remember that factors which contributed to the client's resumption of drinking may differ from those that you uncovered in your initial functional analysis (section 3.2), and also that people continue drinking as a result of different contingencies than those that prompted their initial (resumed) use. For example, clients may continue to drink after an initial episode in response to the following:

- Anticipated or unanticipated reinforcement that followed initial use
- The belief that once they have a drink, control is impossible
- A feeling of guilt or shame about drinking or a sense of having "blown it" in the initial episode.

On the first session you have with your client after he/she resumes drinking after at least 1 full week of abstinence, directly discuss the conditions that surrounded his/her initiation of

drinking. If the problem appears not to be primarily motivational but instead related to situational or coping factors, give your client the ***Understanding Resumed Drinking*** handout (Form U), and elicit his/her answers to the questions on it. These questions address, in essence, the antecedents and consequences of the initial episode of resumed drinking. As you explore the client's answers to these questions, you will see where additional attention is needed to prevent future episodes. Below is a list of questions that elaborate on the questions listed on the handout:

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 did the client have at the time? What thoughts did the client have 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 in which 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, work with the client to determine if there is an alternative route to obtaining these benefits other than by drinking. It may be a good idea to revisit the "New Roads" procedure (section 3.2e).
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 he/she would continue drinking in this or other situations? 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? 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 actually beginning to drink. 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 him/herself in risky situations in which he/she was more likely to drink without consciously acknowledging an intention to drink? If the client chooses to initiate drinking as a way of dealing with an ongoing stressor, then he/she needs to focus on coping strategies. Focus on coping if the client appears to lack coping skills rather than if the client already has the requisite skills but is 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 he/she will

continue drinking. Clients who resume drinking may experience a strong reaction to drinking if they 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 adaptively, “I just didn’t handle the situation well—next time, I’ll stay away from those friends,” a client may reexamine 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: *Understanding Resumed Drinking***

In the example below, the therapist and client use the *Understanding Resumed Drinking* form to examine whether the client’s resumed drinking appears to be triggered by 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 a clearer idea about what happened and what you need to do. (Gives client the *Understanding Resumed Drinking* worksheet.)**

CLIENT: Okay. Well, the first time I had a drink, I was at a party with some friends that I hadn’t seen for a while.

**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 a while 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 a while. 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 Question 5 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, moodwise, 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 (*the therapist makes a statement that is an 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 such as 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—such as 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 your client needs skills for handling a particular kind of situation, proceed to the appropriate Phase 3 module(s). In the above case, the therapist and client would move on to “Assertive (Expressive) Communication Skills (ASSN)” (section 5.1) and “Social and Recreational Counseling (SARC)” (section 5.8) modules.

If your client's problem seems to be a secondary cognitive-emotional reaction to abstinence violation, however, help your client reframe what happened. The client may find helpful the following messages to decrease the negative impact of his/her episode of drinking:

1. Achieving sobriety is a process during which “mistakes,” such as an episode of unplanned drinking, can occur.
2. If you drink, the situation 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 (1 day at a time).

The *Recovering From an Episode of Drinking* handout (Form V) may provide

**REFERENCE**  
**Form V:**  
***Recovering From an Episode of Drinking***

some helpful tips for your client as well. Use this handout only after your client has had a drinking episode. Do not give it to clients who are abstaining successfully.

## 4.5. SOMA: Support for Medication Adherence

**4.5a. Rationale: The Importance of Medication Adherence.** Some clients whom you treat will be taking medications prescribed as part of treatment. Alcoholism treatment studies clearly show that medication adherence is strongly associated with better outcomes. In particular, research on the effects of naltrexone shows that clients who take their medication fare much better than clients taking placebos. It is also the case that clients can feel the effects of not taking the medication when their adherence slips below high levels. For example, Volpicelli and colleagues (1997) found that naltrexone-taking clients who adhered to their medication schedule (defined as taking medication or placebo on 90 percent or more of the study days) were abstinent on 98 percent of study days, compared with placebo-taking clients who adhered to their medication schedule, who were abstinent on 89 percent of study days; this was a significant difference that replicated an

earlier finding (Volpicelli et al. 1992). Among clients with lower medication adherence (less than 90 percent of study days), there were no significant differences between clients taking naltrexone and clients taking placebo on drinking measures. Thus, it is important to support the clients' high levels of adherence to study medications.

Medication monitoring and adherence are the primary responsibility of medical practitioners. Nevertheless, it is vital that you understand and fully support the use of medications, and you have something unique to offer in this regard.

**4.5b. Why Do Clients Not Adhere to Medications?** There are many reasons why clients sometimes fail to adhere to the assigned medication regime, three of which are detailed below:

*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., they dislike the large pill size). Some simply don't believe that medications will help them.

*Interpersonal reasons.* A client may react against a concerned spouse who closely monitors and polices his/her medication adherence. Therapist style can increase or decrease a client's level of defensiveness or 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 his/her alcohol problems. If these differences are not resolved, 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 client's 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 a client's nonadherence, but they 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 and Turk 1987; Pettinati et al. 2000; Carroll and O'Malley 1996; Volpicelli et al. in press):

- *Current beliefs and misperceptions about the alcohol problems.* Does the client see his/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, ther-



apist, research demands, 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 the client's expectations and beliefs about the medications? Does the client have negative associations with taking medications (e.g., as a "crutch," not wanting to become addicted)?
- *Comprehension.* Does the client have difficulty understanding and following medication procedures, that is, have 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, such as "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 and Turk 1987). Stay close to the general counseling style of CBI (i.e., reflection, clarification, reframing, and so on) to

maintain rapport and to obtain more information. In the example below, the therapist and client discuss why the client has not been taking her medication:

**THERAPIST: So you missed taking the morning dose of your medication for the last 3 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 medical 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 straightforward problem-solving strategy is to ask your client about his/her 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. In the example below, the therapist and client discuss the client's past medication history as a clue to her current lack of adherence:

**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 3 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 dialogue, the client offers important clues so the therapist can 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, the client will strengthen medication adherence when he/she 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 such as reflective listening, affirming, reframing, and normalizing, and it may be particularly useful to elicit the 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 on 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 section 4.2, "Raising Concerns"). Focus first, though, on eliciting the client's own concerns and self-motivational statements.

In the example below, the therapist and client talk about the fact that the client feels the medications are ineffective after he resumed 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.

**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 drugstore 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.** Regardless of efforts to motivate them otherwise, some clients will remain adamant about not taking medications. If this is the case with your client, don't struggle further over the issue; try the steps listed below:

- Ask him/her what his/her alternative plans are (other than taking medication) for maintaining sobriety.
- Review the pros and cons of these plans.
- Ask about a backup plan (which might include medication adherence).
- Ask whether the client would be willing to delay the final decision about not taking medications until he/she has tried these other options.
- Suggest that whatever happens, the client is in a "win-win" situation.

In the example below, the therapist and client discuss these options:

**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 weekends 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 backup plan in case you find that your cravings come back again?**

CLIENT: I guess then I could try the meds again. Maybe try AA. But I like the 30-day trial idea.

**THERAPIST: All right. So you think the meds or AA 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 may 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.**

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. A person facing an initially aversive task (e.g., taking medication) may respond more favorably to the task over time (Kelman and Hovland 1953). Emphasizing freedom to delay the decision can sometimes buy the time needed to stabilize sobriety.

**4.5g. Overcoming Practical Obstacles.** People who present for alcohol dependence treatment usually have multiple problems such as child care issues, housing needs, financial and legal concerns, family conflict, and medical and emotional disorders. These other concerns can inter-

fere with medication adherence. Meichenbaum and Turk (1987, p. 105) state the problem succinctly: Such people typically have “difficulty fitting the treatment into their daily lives.”

If your client is facing such problems, explore with him/her the kinds of obstacles that might interfere with him/her taking 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, the SSO's active involvement 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 remind them regularly about taking their pills; other clients might only want their SSO to provide encouragement to them in carrying out the medication plan. Before deciding on specific action steps, make sure that both your client and his/her SSO are committed to the plan.

In the absence of an SSO, ask your client to draw upon other resources, such as an AA sponsor who is supportive of pharmacotherapy, to fulfill this treatment need. Some clients might need additional services to help structure or regain control of their social environment so they can adhere to the medication plan. If this is the case, introduce the “Case Management” module described earlier in this chapter (section 4.3), but first make sure that you have obtained the client's agreement about the need for additional services. In the example below, the therapist suggests using social resources to sustain the client's 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 problems 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 help sustain her commitment to treatment.

## 4.6. MISS: Missed Appointment

When a client misses a scheduled appointment, respond immediately. It is your job as the therapist to actively re-engage your client rather than to wait for the client to get back in contact. First try to reach the client by telephone, and when you do, cover the six points listed below:

1. Clarify the reasons for the missed appointment.
2. Affirm the client—reinforce him/her 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.

Conduct a brief functional analysis of how the client missed the appointment. What led up to the client 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 the client offers no reasonable explanation for missing the 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 people to express their reluctance (frustration, anger, etc.) by not coming to appointments, being late, and so on. Encouraging the client to voice his/her concerns directly may help to reduce the possibility of him/her expressing them indirectly by missing future appointments. Use Phase I strategies to handle any defensiveness. 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 2 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 et al. 1980; Panepinto and Higgins 1969). Place a copy of this note in the clinical file. Use this procedure when the client misses any appointment. Make at least *three attempts* (new appointments) to reschedule a missed session. Finally, send an additional handwritten note 2 weeks after the first. This note should (1) acknowledge the client’s decision to leave treatment, (2) encourage the client to return, and (3) provide information about how he/she can accomplish this.

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. Keep such contacts brief (5 minutes or less) rather than providing additional sessions by telephone. 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.

Early in the telephone call, comment positively on the client’s openness and willingness to contact you. Reflect and explore any expressions of uncertainty and ambivalence that the client makes with regard to goals or strategies discussed in a previous session. It can be helpful to

normalize such ambivalence and concerns, as in the example below:

**THERAPIST: 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 the client makes and indications of his/her willingness to change. Reassure the client that people really do make changes in their drinking problems, often with a few consultations. Then end the phone call by indicating 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, the client or SSO may contact you in a condition of crisis. In many cases, you will be able 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., impending drinking, client is acutely suicidal or violent), consult with your supervisor about the best way to intervene for the protection of those involved. If a client's urgent needs require more treatment than is provided, make a referral using procedures outlined earlier in this chapter in section 4.3 ("Case Management").

Below are some standard counseling procedures used in crisis intervention that 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.

You should refer cases in which the client's drinking problems appear to be worsening or you see evidence of other new and serious difficulties (e.g., suicidal thoughts, psychotic behavior, violence) to the senior clinician of your team for further evaluation and consultation. The senior clinician will determine what action is warranted based on his/her own evaluation and the defined procedures of the study.



## 4.9 DISS: Disappointed to Receive CBI-Only Condition (Study-Specific Procedures)

Use this procedure when at the first session, your client expresses 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. Your four-level response, listed below, is designed to avoid the situation in which you argue for continuation while the client argues against it.

1. Listen empathically and reflect your client's concerns. Your client may have fantasized that the medication is a "miracle cure" or "the only thing" that will help him/her. Convey an understanding and acceptance of the client's disappointment through your reflective responses.
2. 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 a client who still seems ambivalent, ask if he/she would be willing to consider listing the pros and cons of continuing with CBI. Write down points that the two of you 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 he/she might have overlooked. These might include the following:

- CBI is a 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 that describes both sides, and then ask what the client wants to do at this point. Your client may resolve his/her ambivalence about participating in the CBI-only condition once he/she has heard this list of options, perhaps hearing some perspectives from you that he/she had not considered. If your client remains ambivalent or does not seem ready to proceed, move to the fourth level of intervention.

4. Emphasize your client's personal choice and control. In a genuine and gentle fashion, emphasize that

although you would like to proceed, it is not up to you, but it is the client's choice whether to continue in CBI. Acknowledge that the client can withdraw from the trial and obtain one of the study medications (naltrexone) from a private physician, since it is already marketed in the United States. This medication can be costly (about \$2 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/she will remain in the study. Above all, avoid the persuasion trap in which you attempt to convince the client he/she should remain in the study while the client responds with all the reasons he/she should not.

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## 5. Phase 3

# Assisting With Change

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Phase 3 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, though no single module is required. You and your client select the modules that are most appropriate for his/her needs through a process of discussion and negotiation. You also have discretion regarding 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 you had not planned for at the outset of Phase 3, and you can renegotiate your treatment plan to include it. You also 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. They actively involve the client in learning skills that will support a positive, rewarding, alcohol-free lifestyle. The following list describes how to use them:

- Remember the rhythm of TELL–SHOW–TRY. First describe what to do, then model for your client how it's done, then ask your client to try it.
- 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.
- Praise any and all steps your client has taken to learn and apply new skills.
- Give plenty of positive reinforcement in the practice process—point out what your client did well, gently coach on points for improvement, then try it again.

On the next page is a list of the Phase 3 modules from which you and your client can choose, accompanied by the more common indications for using each module. Remember that it is fine to be working on two modules at the same time, although you should not discuss more than two modules in any single treatment session. Use the Therapist Checklist provided for each module to help you remember the procedures that are included.

### 5.1. ASSN: Assertive (Expressive) Communication Skills

**5.1a. Overview.** Assertiveness training has come to be used in treating alcohol problems because of evidence that interpersonal conflicts

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, and so on 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 and Urges	To learn skills for dealing with urges and craving without drinking
5.4	DREF	Drink Refusal and Social Pressure Skills Training	To learn skills for refusing drinks and resisting social pressure to drink
5.5	JOBF	Job-Finding Training	To learn skills for finding and keeping a rewarding job that will support stable sobriety
5.6	MOOD	Mood Management Training	To learn skills for managing and reversing negative emotions without drinking
5.7	MUTU	Mutual-Support 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

and anger can cause clients to return to drinking. Researchers have found that social skills training has improved 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 6 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. It 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 (section 5.2). These two modules work well together. Use the module in the following ways:

1. Teach clients to identify situations in which they may need to communicate their feelings, particularly in stressful situations.
2. Define assertive behavior and differentiate assertive communication, passive communication, and aggressive communication.
3. 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 in which assertive communication is needed (see section 5.1c, “Identifying Situations That Call for Assertive Communication”), don’t simply recite the list to your client but make it personally relevant by asking something such as, “When was the last time you . . . (criticized someone, were criticized, etc.)” Exploring each situation will give you further information about where the client needs to develop particular skills.

It is also important to note that what constitutes assertive communication (as distinct from *aggressive* or *passive* communication) varies widely across cultures and subcultures. 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 rea-

sonably well, but you will need to be culturally sensitive in determining what constitutes appropriate assertive behavior in your client’s social contexts.

### **5.1b. Rationale and Basic Principles.**

People drink for a variety of reasons. One common reason, especially in situations in which they feel negative emotions (e.g., angry, nervous, shy, depressed), is they believe drinking will help them relax, speak their mind, express their feelings, or stand up for their rights. People also drink to cover up the emotions that correspond with not asserting themselves in a difficult or intimidating situation.

Assertiveness skills are directed at the source of the client’s problem, making it less likely that he/she 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.

#### **REFERENCE**

***Form W: Examples of Situations Where Assertive Communication Is Needed***

**5.1c. 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 make him/her feel strong emotional states such as anger, resentment, embarrassment, or frustration. Frequently, clients are adept at naming particular situations that produce strong emotions, but if your client cannot do so, it helps to have a list of such situations available. A few examples are shown in the ***Examples of Situations Where Assertive Communication Is Needed*** form (Form W). 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 module 5.4, “Drink Refusal and Social Pressure Skills Training”).

In the following example, the therapist introduces this module and uses Form W to 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 skills 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. 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? (*Shows Example of Situations Where Assertive Communication Is Needed form.*)

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 2. 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 Form W, 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, and so on.

**5.1d. Step 2: Defining Assertive Communication.** Assertive communication occurs when a person expresses opinions, feelings, or requests without alienating or hurting others. As shown on Form W, sometimes assertive communication just involves the statement of opinion; at other times, it involves a request for a behavioral change in another person. At still other times, assertive communication can involve taking responsibility for one's own actions and trying to make amends. Below are the ways to explain these concepts to your client.

**Basic Beliefs.** The first step is to explain that for a person to be effective in assertive communication, there are two general beliefs that he/she should hold or at least agree with, listed below:

1. 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. 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/she agrees with each of them. In the process, you may uncover some basic assumptions that the client needs to address to accept assertive communication. (For basic cognitive therapy procedures, see section 5.6, "Mood Management Training.")

**Contrasting Passive, Aggressive, and Assertive Communication.** The next step is to explain assertive communication as a middle road between the two extremes of passive and aggressive. Some people lean to one extreme, some to the other, and some vacillate back and forth between them. Ask your client to tell you the disadvantages of each approach.

*Passive communication.* The passive communicator gives up his/her rights whenever it appears there might be a conflict between what he/she wants and what someone else wants. A speaker who engages in passive communication keeps silent, downplays how he/she feels about something, or tries to get a message across through indirect means such as withdrawing, pouting, or isolating from others. Because the speaker does not express directly to his/her listener thoughts or feelings that might create conflict, the other person may not

know about them. This can result in the passive communicator bottling up feelings out of habit, even when the situation does not require it, and a consequence can be anxiety or resentment. Alternatively, people who engage in passive communication sometimes suffer from depressive symptoms because they may feel 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/her rights and feelings are not respected. The person who relies on passive communication seldom gets what he/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.* The aggressive speaker presses his/her rights while disregarding the rights and feelings of others. An aggressive, coercive style often satisfies the speaker’s 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 will thwart his/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.* The assertive speaker expresses him/herself directly and in a manner that also honors the rights and feelings of

others. There is a planned-out element in assertiveness: the speaker is clear about his/her own material (feelings, needs, goals), thinks through the most appropriate way to express these to the people involved, and then acts on the plan. Usually, the most effective plan of action is to openly and directly state feelings and opinions or to make specific requests for the changes desired. In different situations, however, the assertive communicator 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.

In the example below, the therapist defines these communication styles to the 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, aggressive, and assertive.**

CLIENT: Okay, let’s see. I know that if I shout at someone or tell him off, that’s aggressive.

**THERAPIST: Very true; that is indeed aggressive communication. Aggressive communication occurs whenever people act 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 you 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 week?**

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 thought of it that way, but I really haven't been enjoying my job much, and I'm 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 your 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. 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 to 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—try them out.

Begin by giving your client a copy of the *Basic Tips for Assertive Communication Form* (Form X). Then proceed with role-play practice of assertive communication skills.

**REFERENCE**  
**Form X: Basic Tips for**  
**Assertive Communication**

The first tip on the form concerns using an "I" message (Gordon 1970). The basic idea is that when you express a feeling or opinion, you should begin the sentence with "I" rather than "You." This makes it clear that you are expressing a personal feeling or opinion, and it 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 because if the word "that" can be logically inserted, the person is not expressing a feeling. In a true feeling statement, the word "that" doesn't fit, as shown in the two examples below:

- I feel that 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 more clear, less likely to be perceived as blame, than a “You” message; examples of both types of sentences are below:

- 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 that is quickly lost unless you help your client apply and practice it in personally meaningful contexts. Tell–Show–Try. Ask about recent situations in which your client had a strong feeling and things didn’t turn out as well as he/she would have liked. Explore how (if) your client expressed his/her own feelings, opinions, or preferences in this situation. Practice different ways in which your 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 the *Basic Tips for Assertive Communication* form, discuss in more specific detail how assertive people express themselves. A good place to start is to rehearse with your client how to ask someone for a change in his/her behavior. The assertive person decides what he/she wants, plans an appropriate way to involve other people, and then acts on this plan. Explain to your client that the most effective plan usually is to clearly state one’s own feelings or opinions in a respectful way and to directly request the changes that one would like from others. Assertive people do this without threatening, demanding, blaming, or using negative statements directed at others. When communicating assertively, a person is more likely to say what he/she means and is less likely to get sidetracked into other issues. As a result, the person is more likely to have his/her needs met.

In the example below, the therapist explains assertive communication, including the three parts of assertive change messages (Huszti 1997):

**THERAPIST:** 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” compared with “I feel frustrated when I think you’re not listening to me.”

To be an effective assertive communicator, you need to learn how to use three types of description-of-change messages. I’ll explain each one. The first is, 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.

The second is, 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.**

**The third is, describe 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 a person becomes more comfortable with over time. It is important in this module that you actually *practice* assertive expression. Give your client specific home assignments 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 section 5.1c (“Step 1: Identifying Situations That Call for Assertive Communication”). In the example below, the therapist and client are practicing assertive expression:

**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 we have been discussing, what would you say is the typical style of communication between you two? Passive, aggressive, or assertive?**

CLIENT: Well, it’s 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 before he staggered off and fell asleep on the couch. When I went to make coffee, I could not 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 rewrite 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: All right. 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: Hmm—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:** All right, all right. 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/her own side of the conversation. It can be useful for you to model appropriate communication, but always have the client take his/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. Having assertive communication skills can help clients deal effectively with differences or conflicts with other people. Since most people

#### REFERENCE

#### **Form Y: Tips on Assertive Communication in Conflict Situations**

view criticism as a negative or unpleasant event, it is useful to practice assertive communication in conflict situations. These points detailed below are summarized on the ***Tips on Assertive Communication in Conflict Situations*** handout (Form Y).

**Receiving Criticism.** Explain to your client that regardless of how people live their lives, they all face situations in which people make critical statements or give them feedback about themselves that they perceive to be critical. Justifiable or not, criticism can leave people 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 interactions with others is to receive criticism gracefully; however, people can view criticism as a valuable chance to learn things about themselves and how they affect others. This gives them an opportunity to make positive changes in themselves.

Below is a way for the therapist to initiate a conversation about criticism:

**THERAPIST: 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 four strategies described below can help the client to work toward a positive outcome when someone confronts him/her about a situation, regardless of whether the criticism is delivered in a *constructive* or *destructive* manner. If the client has available an effective response (not a “comeback”) to criticism, he/she can reduce conflicts and the probability of drinking.

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 those of the other person. Make a conscious effort to calm down. Sometimes the old custom of counting to 10 will help. Other times, you should stop the conversation and continue 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 this is the case, try to postpone the interaction 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 his/her 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 that would suit you both.

2. *Listen: show you understand.* Let the other person have his/her say without interrupting; hear him/her out (see module 5.2, “Communication [Listening] Skills”). Let the person know that you understand the substance of his/her criticism. It can be helpful to reflect back what the person says to you. This helps to clarify the complaint and shows that you are treating him/her with respect. This is also a way of checking that you really do understand, because if you have misunderstood, the person 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 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 admit 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/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 directly about whatever is troubling him/her 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.

Below are some suggested questions to put to your client for discussing this issue:

- Can you remember a situation where you had to confront another person about his/her behavior? How did that interaction end?
- Can you think of any situation that has deteriorated because you have put off confronting another person about his/her behavior?
- In your experience, are there occasions when it is better not to confront another person about behavior that is causing you problems?

Below are some tips to share with clients 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 that interfere with how he/she hears your message.

*Choose the right time and place.* Decide when it is the right time and place for talking to someone about his/her 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 gives the other person the chance to apologize if the mistake is his/hers.

*Don't blame.* If there are no misunderstandings between you but the other person does not understand your problem, help him/her to see things from your point of view. It will be difficult to achieve cooperation, however, if you antagonize the person. 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 the person from listening to you and, therefore, stops him/her from seeing your point of view.

*Use "I" language.* Use your assertive communication skills and deliver "I" messages. If you need to confront another per-

son, tell him/her how the stated 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. Ask the client to tell you something he/she hasn't liked about the way you have worked with him/her so far and what the client wishes you had done differently. This can also be a good opportunity to show how to respond appropriately when receiving criticism.

**5.1h. Giving Encouragement and Making Positive Comments.** Assertive communication also involves the expression of positive feelings and comments. Providing positive reinforcement to others strengthens communication and relationships. It also sometimes reverses decays in the close relationships of problem drinkers. A final emphasis in this module is to

#### REFERENCE

#### **Form mm: Communicating Positive Feelings and Comments**

increase the positive level in communications. The *Communicating Positive Feelings and Comments* handout (Form mm) provides some examples of ways to make positive statements.

Suggest to the client (and SSO) that they keep track of the number of positive statements they make to other people each day and the people to whom they make the positive comments. You can describe these comments as being like little deposits into the relationship piggy bank.

The comments might sound a little hollow at first, but bit by bit, they become more solid.

The other side of this activity, of course, is to decrease the “withdrawals”—not to give in to opportunities to criticize, judge, blame, or hurt others. When you discuss your client’s communication pattern, you may be able to point to aversive communications that need to be interrupted. Suggest that your client and his/her primary partner keep track of positive and negative communications they have with each other each day. This helps your client become aware of his/her communication style, and discrepancies in the two records can be revealing.

When both client and SSO are present in sessions (whether or not you use this module), keep their communications on a positive tone. Don’t allow them to “play back tapes” of argument, blame, criticism, and so on. Actively intervene if this begins, pointing out that rehearsing the negatives is more hurtful than helpful. Focus on how their 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. 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: Communication (Listening) Skills

This module is for those clients you determine would benefit from learning more effective

social communication skills. This module 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 “Assertive (Expressive) Communication Skills” (section 5.1), which focuses on expressive communication skills. For clients with alcohol problems, lack of good communication skills can hinder their progress in several ways. Some clients may never have developed good communication skills, while other clients’ skills may have diminished as a result of drinking-related isolation. 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 because of 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 a client’s ability to cope with high-risk situations and can strengthen the social support network that is important to maintaining sobriety.

You can deliver this module to the client alone or when his/her SSO is attending treatment. In the latter case, use this module to strengthen communication within the client’s primary relationship.

The overall aims of this module are to help the client achieve the following:

- 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.
- 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 several 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). People talk, listen, observe, and react to each other, exchanging all kinds of information in many ways. Although 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 does not 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, as in the following examples:

- Think of someone you know who you think is a really 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 the client 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 thought that the person to whom he/she was talking did not listen well and did not really understand what the client had to say.)

Explain to your client that everyone likes to be understood, but for each person who is understood, there needs to be someone who understands.

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. Below is an example of a therapist explaining the concept of communication using this handout:

**THERAPIST: 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 (Intention)” box on the form (*point out correct box*). 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, and with this particular topic; any feelings you might be having; and your expectations of how the other person might react. 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 "Message Sent [Words]"*) 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/she doesn't even receive the words accurately. Why might it be that the listener doesn't get your words right? (*Discuss factors such as 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 sound quite different from the one you were intending to send.

Ask your client whether this makes sense and if it reminds him/her of any experiences he/she has had, broken down into the following steps: the message he/she intended, the words he/she

## REFERENCE

### *Form Z: How Communication Happens*

said, the words the listener received, and the message the listener heard. If the client cannot provide an example from his/her experience, offer an example that is appropriate to the client's situation. The overall point here is to motivate the client to learn effective communication skills: 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 the client does something to keep it straight.

**5.2b. Communicating Effectively.** Discussing the process of communication leads naturally to describing the skills necessary for clear communication. Do the following practice exercises first in session, and then have your client work on them as home assignments to provide practice in his/her own world.

**5.2b.1. Attending.** Draw on the earlier discussion (section 5.2a, "The Process of Interpersonal Communication") 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 without interruption. In the example below, the therapist explains the importance of being a good listener:

**THERAPIST:** 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 such as "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 a topic that most people have a lot to say about: 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?**

the person to keep talking (e.g., hmm, ah, mm-hmm).

Assure the client that often listening to someone in this way is as valuable as discussing a problem. In fact, often what people want from others is not problem solving but just for them to listen and understand. Good listeners show by their encouragement that they are interested, that the speaker is not boring them, and that they are putting the speaker's needs first. People who feel someone is really listening to them are encouraged to communicate what is on their minds and can sometimes sort out problems for themselves. For clients who need to establish new relationships, point out that good listening is one of the most effective conversational skills and that it helps to build friendly relationships quickly.

As the client talks for a few minutes until he/she reaches what seems a natural stopping point, illustrate some nonverbal aspects of listening, such as the ones below:

- Devote your whole attention to what the other person is saying. Don't do anything else (look at a watch, look around, read, etc.). Even if you "can do two things at once," don't.
- Keep your body and head turned toward 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 giving the speaker the feeling of being stared at. 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 nonword sounds that encourage

Next, as appropriate, have the client be the listener while using the same skills you illustrated. Choose an appropriate topic about which you can talk for a few minutes while the client listens. If an SSO 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, reverse roles and have the client be the speaker and the SSO the listener.

**5.2b.2. Avoiding Roadblocks.** In a good conversation, of course, the listener talks as well as listens—there is some give and take. But there are many things people do, often with the best

of intentions, that are not part of good listening and are in fact impediments to conversation. Most of these have to do with the listeners putting in their own “stuff”—advice, opinions, suggestions, and so forth. Sometimes this is okay, but such insertions tend to put up roadblocks to the speaker’s natural flow of thought that he/she has to detour around (Gordon 1970). Most often the conversation goes off in a different direction and never gets back to the speaker’s original road.

Below is a list of common roadblocks listeners can erect:

- Giving advice, making suggestions, or telling the speaker what to do
- Agreeing or disagreeing with what the speaker 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. For example, the listener learns about things of interest by asking questions. But in good listening, the listener lets the speaker talk. In that way, good listening is a sacrifice. The listener give up his/her own “stuff” for a while and devotes his/her whole attention to listening.

**5.2b.3. Guessing About Meaning.** The third piece of this module helps the client learn what to say to be a good listener.

Go back to the *How Communication Happens* worksheet and point out that when communication is going well, the “Message Heard (Interpretation)” box—what the listener thinks

the speaker means—closely matches the “Message Meant (Intention)” box—what the speaker really means. Most people react to their *interpretation* as if it were what the speaker really meant. A good listener checks out whether what he/she thinks the speaker means (“Message Heard (Interpretation)” box) is what the speaker really means (“Message Meant (Intention)” box).

One way for listeners to do this is to tell the speaker what they thought he/she was saying and ask the speaker if that is what he/she meant. Though this does work, it tends to get in the way of a smooth conversation. Nevertheless, it’s worth demonstrating. Again, you be the listener first while the client is the speaker, then reverse roles. The roles are described below:

Speaker: 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 the listener is “guessing” what the speaker means; often the guess is incorrect. It also becomes clear that a speaker often means more than one thing—there are levels of meaning.

After going through this exercise with the client as the listener, find out what he/she was feeling and experiencing in that role. People in the listener role often feel frustrated because they wanted to hear more than yes or no. Similarly, people in the speaker role usually feel frustrated because they wanted to say more than yes or no. This exercise 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 SSO came to the session, have the client practice this with the SSO as the 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.

**5.2b.4. Understanding Statements.** As shown in the previous section, asking questions is not the best way to listen. Teach your client how to form understanding statements: to say as a statement what the client believes the speaker means. It’s a short step from the “Do you mean . . .” exercise. Just 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. Examples of such statements are below:

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.

Discuss 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 listener gets the speaker to say what he/she meant.

To consolidate this next step, have the client practice making understanding statements. As before, you go first to show how it’s done, then reverse roles with the client. The roles are explained below:

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/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. Below is an example of a conversation with understanding statements helping to keep it going:

Speaker: One thing about myself that I’d like to change is that I’m scatterbrained.

Listener: You have a hard time concentrating on more than one thing at a time.

Speaker: No, it’s not really that. But I’m losing things all the time, even in my small apartment.

Listener: And that doesn’t seem normal to you.

Speaker: 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.

Listener: It's like you're out of touch with what's going on around you.

Speaker: Yes, and even with what's going on inside me.

Listener: And that's pretty upsetting. You feel a little out of control.

Speaker: I feel *a lot* out of control. . . .

If the 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 be the speaker, and coach the other on making understanding statements while offering a few yourself. 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/her own social environment. The client can try out these listening skills with a partner who knows that it's practice or with someone unaware that the client is practicing. After one or two practices, the client can fill out the **Reflection Sheet** (Form aa), which will be a helpful aid for discussing his/her progress at the next session.

**5.2c. Increasing Positive Interactions.** The final component in this module pertains particularly to clients who have a primary relationship, whether or not his/her significant other is participating in treatment. Decreasing negative patterns of communication and replacing them with more positive patterns of communi-

## REFERENCE

### *Form aa: Reflection Sheet*

cation is only one piece of the puzzle. Cognitive-behavioral relationship therapy also typically includes helping the client increase 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 people having fun together. During dating and courtship, most of the time that a couple spends together is focused on pleasant activities: sharing meals, dancing, physical intimacy, and so on. Over the course of a relationship, it's possible that the couple could start to spend less time in pleasant activities and more time in routine or even aversive activities. When people share positive experiences, it strengthens their relationship (including friendships) and deepens the good feelings they have for each other. Make sure that this rationale makes sense to the client (and SSO) before proceeding.

The key to this part of the module is to help your client find fun, pleasant, positive activities that he/she can share with someone else and that do not involve drinking (see "SARC," module 5.8). For a client involved in a long-term relationship, ask how it began—what attracted him/her to his/her partner, what enjoyable things they did together early on in the relationship, and so on. 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 the positive aspects the client and SSO offer (a relationship-building form of self-motivational statements). Brainstorm with the client and SSO things they enjoy that they could do together that would be pleasant 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 the client and SSO had fun together, start small and simple. The goal is for them to have a good time—without drinking. Integrate positive communication practice into these assignments. For example, assign a “sofa session” in which each partner takes turns talking about his/her day, feelings, hopes, and so on—perhaps 5 minutes each at first—while the other gives full attention to listening without erecting roadblocks. If the client’s SSO is participating in treatment, it is wise to try this in the office first to make sure that they have the necessary skills or so you can coach them if they do not. 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. CRAV: Coping With Craving and Urges

**5.3a. Rationale.** Clients experience craving and urges to drink most often early in treatment, but these symptoms 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 your clients to experience cravings from time to time, and be prepared to cope with it.

The words “urge” and “craving” refer to 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 (e.g., tremulousness), emotions (e.g., feeling anxious), and behaviors (e.g., pausing while passing the beer display in a store). The funda-

mental 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 lack of ability to abstain (to distinguish it from an experienced inability to stop drinking once started).

In this regard, the most important and central message of this module is that the client’s experiences of urges and craving are *predictable and controllable*. Below is a list of particularly important messages to convey to your 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 it is possible to identify them. 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. Thoughts can include imagining how good it would feel to use alcohol or other drugs, remembering drinking times past, planning how to go about getting a drink or other 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. However, when you learn how to cope with them, urges become weaker and less frequent over time.
6. You are not helpless in the face of craving or urges to drink: there is something you can do about them.

**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/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.) Below is a list of sample questions that can clarify craving situations:

- What *specifically* was the experience like? How did you know that you were having an urge to drink or were craving? Was it a thought, a physical sensation, an emotion?
- What was happening just *before and during* the experience? Where were you— with whom, doing what? What was going on; what did you see, hear, smell, taste, feel?
- What happened *after* the experience or urge or craving? Did you drink? If not,

how did you succeed in staying sober?  
What did you think, feel, and so on 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/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* form from Phase 2 (“Triggers” column) that you filled out with the client may give you some good material here. The best initial source is likely to be the client’s own recollections of situations in which he/she felt craving or urges, even though the client may not know initially what it was about the situation that triggered a desire to drink. Below is a list of common external triggers:

- Exposure to alcohol itself
- Seeing other people drinking
- Contact with people, places, and things previously associated with drinking (e.g., 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 (e.g., hospital, aspirin, morning).

Other triggering stimuli are internal rather than external (though none of them are eter-

nal). These can be puzzling to the person feeling them because they do not seem to occur in predictable situations but “just pop up.” Below are two examples of internal triggers:

- Particular types of emotions (e.g., frustration, fatigue, feeling stressed out). Even positive emotions (e.g., elation, excitement, feelings of accomplishment) can be triggers.
- Physical feelings (e.g., 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.** Because it is hard to recognize some triggers by discussing them during a session, it is a good idea to help the client self-monitor urges.

As with any home assignment, first provide a rationale for urge monitoring. Describe benefits that are likely to mean something to your client (better self-awareness, greater self-control, feedback of improvement, and so on.). Better still, *ask your client* how keeping these records for a while might be beneficial, eliciting self-motivational statements. Set a time limit on the monitoring (usually 2 to 3 weeks), at the end of which you will reevaluate together what you and the client have learned and whether it is useful to continue.

#### REFERENCE

##### **Form bb: Urge Monitoring Card**

Give the client *Urge Monitoring Cards* (Form bb) to make this process easier (see next page).

Below are the instructions to give the client when you hand him/her 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 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.
3. Write down the following four things with each entry:
  - The date and time of day
  - The situation: where you were, who 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/her from keeping good records? What can the client do to keep good records? Any problems the client foresees? Never get in a power struggle over this; just understand the client’s perspective and see whether he/she is willing to try at least 1 more week of recording.

## 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. A 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.

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 recordkeeping. If the client had problems following the assignment, troubleshoot briefly, but don't spend a lot of time discussing the client's 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.** The four basic strategies for coping with external triggers are: Avoid, Escape, Distract, or Endure, described in detail below.

**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? Below is a list of common examples:

- Get rid of alcohol at home.
- Avoid parties or bars where drinking occurs.
- Reduce contact with friends who drink, meeting them only in nondrinking 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 is not possible to avoid all high-risk situations. The unexpected occurs, and in fact, people often start drinking again in unanticipated risk situations. What happens, then, when the client finds him/herself in a high-risk situation—either because he/she did not anticipate it or because he/she was unable to avoid it? A second line of defense is to escape—to get out of the situation as quickly as possible. Below are examples of unexpected high-risk situations. Ask your client to brain-

storm ideas for how to get out of each situation quickly and gracefully. Practice the dialogue that would be involved in these social situations.

- You go over to a friend's house for dinner and hadn't realized (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.

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 such as evenings, weekends, and holidays.

**Distract.** Urges pass relatively quickly as long as they aren't indulged. If your client can't avoid or physically escape from a situation, he/she should find an enjoyable distracting activity such as reading, making something, going to a movie, exercising (e.g., walking, running, biking), or calling someone. Explain that urges tend to pass more quickly when you get interested in something else. Have your client brainstorm things to do to provide distraction from an urge.

**Endure.** Then there are those situations that are difficult to avoid or escape 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 people find that it's no problem to be on previously "slippery slopes"—the ice has melted. At other times, people need tools to hang on. Below is a list of such tools:

- *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 that would help you to endure through an urge? A reminder card? A treasured object? A photo? A cell phone? No money?

**5.3e. Coping With Internal Triggers.** With a few modifications, the client can apply the same strategies to internal triggers. The exception is avoidance; it is a particularly poor strategy for coping with subjective experiences such as thoughts and feelings. Trying *not* to experience something often backfires. Trying to avoid one's internal world can be futile. 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. Discuss with your client how having a thought does not mean that he/she needs to pursue it or keep thinking about it. Certain feelings your client may have, such as anger, can persist only if he/she keeps fueling them through thoughts of resentment, revenge, rejection, and so on. Experiencing thoughts as they pass through, without follow-

ing them, is a key aspect of transcendental meditation.

Another way the client can let go is to refute the thought that drives the urge. The essential methods of the “Mood Management” module (section 5.6) can be applied here—recognize the thought, stop it, analyze the error in it, and replace it. Below 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 they experience a craving, many people have a tendency to remember only the positive effects of alcohol and minimize the negative consequences of drinking. Therefore, when they experience a craving, some people find it helpful to remind themselves of the benefits of not drinking and the negative consequences of drinking—what they stand to lose by drinking. Some people find it helpful to write down these benefits of sobriety and consequences of drinking on a small reminder card that they keep with them.

Taking part in a distracting activity (see section 5.3d) is yet another way the client can let go of an internal trigger experience—moving on to

something interesting and not dwelling on the urge.

**Enduring.** These approaches might be said to go *through* the experience rather than around it. The client may find that the endurance strategies from section 5.3d are useful here—talking it through, asking for help, waiting it out, using protection.

Explain to your client that another enduring approach is to *go with it*. He/she shouldn't try to make the thought or feeling go away but to accept it as a normal and temporary event that will pass, and experience it, focus on it. Tell your client to pay attention to exactly what the experience is like—the physical feelings, emotions, thoughts, and so on. 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. Explain to your client that he/she can initially join with an urge (as opposed to meeting it with a strong opposing force) as a way of keeping balance. What the client 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. Have the client sit in a comfortable chair, feet flat on the floor and hands in a comfortable position, and give him/her the instructions described below:

**THERAPIST: 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. For example, “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 is 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 he/she can use, ask your client to select two or three that seem to fit best, that seem most realistic to use in his/her daily life, and 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 (such as reminder cards) that might be helpful. When you make home assignments, 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 Skills Training**

### ***5.4a. Social Pressure and Drink Refusal.***

Many clients resume drinking in response to social pressure. There are two distinct types of social pressure exerted by contact with other drinkers: *indirect* and *direct*. By learning to cope with both types of social pressure, the client can keep from returning to drinking, but he/she needs good decisionmaking and practice to develop the skills to cope with both types of social pressure.

This module can be useful even if your client does not anticipate direct social pressure to drink. A client may experience *indirect social pressure* in which he/she feels tempted to drink as a result of being around other people who are drinking, even if he/she is not offered a drink.

Because of your client’s past experience of drinking in social situations, he/she may be more likely to feel the temptation to return to drinking in the following situations:

- There is an expectation built into the situation that everyone will be drinking (e.g., at a wedding).
- The client is with people who have been drinking companions in the past.
- The client is in an environment that encourages drinking (e.g., at a bar).
- The client is in a situation in which he/she lacks confidence in his/her ability to cope without using alcohol (e.g., when socially anxious).

One way for the client to cope 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 decisionmaking* about the types of situations he/she should avoid. However, alcohol plays a role in many social occasions, so 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 these situations because they are significant events, such as an anniversary or holiday party. In these situations, it may be necessary for him/her to develop coping strategies to avoid a return to drinking, such as those below:

- Leaving open the possibility of escape from the situation if the temptation is too strong
- Relying on sober support to cope with temptation during the event
- Planning alternative activities during the event, such as drinking soda, to minimize the urge to drink.

A client may experience *direct social pressure* when he/she is offered an alcoholic beverage or a drinking opportunity, resulting in 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, or may respond to a refusal with varied levels of assertiveness. For example, a client may be faced with a waitress in a restaurant who innocently 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!” or 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* to avoid returning to drinking. The client may need to practice to develop good refusal skills and to learn how to cope with offers from different people and a variety of responses to his/her refusal. There are some general guidelines that a client can learn for a skillful drink refusal, although the response may vary depending on 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, your client may need one type of response for a friendly and casual offer from a waitress or coworker to have a drink and a different type of response for persistent, aggressive offers from a close friend or family member.

**5.4b. Using Cognitive-Behavioral Therapy to Develop Drink Refusal Skills.** Refusing a drink is often much more difficult than the client anticipates it will be. Practice various refusal responses, especially if your client has difficulties being assertive or responding effectively when he/she is feeling anxious. When



your client practices a refusal in the context of treatment via behavioral role-play, he/she receives feedback from you about the effectiveness of his/her drink refusal response, acquires some mastery over his/her refusal skills, and increases his/her confidence in facing direct social pressure.

How a client responds to social pressure is likely to be influenced by his/her relationship with the people who are drinking or offering him/her a drink. Therefore, it is important to examine the client's ability to cope with social pressure from specific people and practice refusal skills for a variety of personal relationship contexts. For example, your client may find it more difficult to avoid family gatherings than the local bar, or he/she may find it more difficult to refuse an offer to drink from a close friend who is insulted by the client's refusal than to refuse an offer from a polite casual acquaintance.

Thoughts as well as behavior are involved here. How a client thinks about his/her decision to avoid a social situation involving drinking or refuse a drink to stay abstinent can influence how successfully he/she copes with social pressure. Below is a list of common thoughts that clients have:

- Other people will see them as “weak” or a “goody goody” for deciding that they will no longer drink.
- They are “boring” or will be rejected if they do not drink.
- It will be impossible for them to make new friends or maintain old friendships if they are not drinking.
- It is not “right” to refuse a drink when everyone else is sharing an occasion involving drinking.

- They do not want to give up a relationship with a heavy drinker simply because they have stopped drinking.
- 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. Clients commonly think early in sobriety, “I *can't* drink,” or “I am *not allowed* to drink,” as if some external authority were imposing rules and limits on them. This can set the stage for a kind of “cognitive claustrophobia” against which the client ultimately rebels, making 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. Tell the client that indirect social pressure is related to observing other people drinking, even if no one is directly encouraging him/her to drink or offering him/her a drink. Direct social pressure is when other people directly offer him/her a drink, encourage him/her to drink, or give him/her 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 ***Identifying Social Pressure Situations and Coping Responses*** worksheet (Form cc) to record specific risk situations and possible coping responses. For some clients, only

#### REFERENCE

***Form cc: Identifying Social Pressure Situations and Coping Responses***

one type of social pressure may seem important. If this is the case, it is not necessary to prepare for both direct and indirect social pressure coping.

First, help your client generate a list of potential *indirect social pressure situations*—when your client will feel tempted to return to drinking as a result of being around other people who are drinking or intoxicated. To generate this list, ask your client to think about situations from the past in which he/she felt tempted to drink primarily as a result of just being around other people who were drinking, such as attending weddings, anniversaries, or holiday parties; hanging out with friends who drink; working with people who drink on the job; facing family members who show up at his/her house intoxicated; or going to a drinking establishment with coworkers. Ask your client to think about new situations in which he/she 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 in the left-hand column, “Situations,” of the Identifying Social Pressure Situations worksheet.

Next, ask your client to think about *direct social pressure situations*—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 include friends, neighbors, relatives, coworkers, an employer, and a former drinking companion. The client may have mentioned some of the people who could offer him/her a drink in the indirect social pressure situations described above. Examples of situations in which these offers might occur include places where alcohol is served (e.g., in a bar or restaurant that serves liquor), where drinking is encouraged (e.g., at a party where alcohol is served), or where other people with

drinking problems are present. Again, record these on the worksheet in the “Situations” column.

You may also have your client complete the optional *Checklist of Social Pressure Situations* worksheet (Form dd) to suggest potentially problematic situations and learn your client’s perception of how much of a prob-

**REFERENCE**  
**Form dd: Checklist of Social  
Pressure Situations**

lem each is likely to be. This can provide a basis for further discussion.

**5.4d. Developing Skills for Coping With Social Pressure to Drink.** As you make the transition from assessment to focusing on coping skills, emphasize to the client that he/she will find it very helpful to think through and practice ways to cope with the situations just discussed. Tell your client that he/she will probably confront unanticipated situations, but the more he/she can prepare, the better. Discuss the importance of rehearsing a variety of different coping strategies so that he/she will be able to handle the unexpected. Being prepared can make the difference between not drinking and drinking. This section helps the client develop several skills for coping with social pressure. (Remember to practice and not just talk about coping strategies.)

There are two ways of coping with social pressure:

1. *Avoid* situations in which social pressure is likely to occur.
2. Have *specific coping strategies* ready before you enter the situation. Include an *escape plan* for leaving the situation if temptation feels too strong.

The first of these involves conscious decision-making and is a strategy that people who successfully abstain use earlier in their course of recovery. Using the *Identifying Social Pressure Situations and Coping Responses* worksheet, ask your client to identify which situations it would be best for him/her to avoid altogether to reduce the temptation to drink. Write “avoid” as one coping response in the “Coping Strategies” column for each situation the client plans to avoid. Anticipate and explore thoughts, feelings, and problems that could occur when the client tries to avoid these situations or that could interfere with his/her appropriate use of avoidance as a coping strategy for these situations. Does the client anticipate any negative consequences 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, he/she may still be exposed to them by accident or choice. Emphasize the need to develop several possible strategies for situations that he/she cannot or will not be able to avoid. (Record two or more possible strategies in the “Coping Strategies” column.)

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 is 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/she could cope with the social pressure situations*. This includes explor-

ing times he/she successfully refused drinks 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. 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 section 2.4a, “Differences From a Denial-Confronting Approach”), 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” (section 4.2).

For situations in which your client believes he/she could be tempted to return to drinking as a result of direct or indirect social pressure, ask what strategies might help him/her to avoid drinking. Below is a list of coping strategies you could suggest:

- Bring along a sober friend.
- Plan an escape if the temptation gets too great.
- Ask others to help you not drink by refraining from pressuring you or drinking in your presence.
- Practice effective “I don’t drink” responses.

Remember to not only draw on your client’s expertise but also to use plenty of reflective listening and positive reinforcement.

In the example below, the therapist and client are discussing social pressure and how to cope with it. The situation involves both indirect and direct social pressure, but the initial focus is on how it will feel to be around other people who are 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 let's 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 treatment, 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: I don't pay much attention to what other people are drinking. No one makes a big deal out of the drinking, real-

ly, 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 avoiding 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 50 years. 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 party, what do you think could create the most temptation for you?

**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 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 let's 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 alcoholic 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 the 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 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. Okay, 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 he/she needs active coping strategies. 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 articulate the appropriate responses. The following section illustrates this important component through helping your client refuse 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, it may be necessary to have a more assertive reply if the person persists, as shown below:

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 in which a person persists. The goal is to find a refusal that is clear and firm yet friendly and respectful (e.g., see module 5.1, "Assertive (Expressive) Communication Skills").

Below is a list of points to use when coaching your client to develop an assertive, effective refusal response:

- Look directly at the person, make eye contact, and state your response.
- Vague excuses are not necessary and can be dangerous (e.g., "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, recommend an activity that does not involve drinking, such as, "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 repeats a single, clear message in response to each pressuring statement. The client can also acknowledge some part of the other person's statement

and then go back to 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 your client already has reasonably good social skills, begin with the client taking the refusal role while you try to persuade him/her to have a drink. If your client is not confident with his/her assertive skills, start with reversed roles in which the client pressures 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 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 made him/her want 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 your client feels particularly stressed when refusing an offer, even though he/she is able to do it skillfully, then it may be appropriate for the client to practice seeking support after refusing an offer. Whom would the client call, and what would he/she say to this person to obtain support?

In the example below, the therapist and client discuss direct social pressure and rehearse refusal techniques:

**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! Your 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:** Let's 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 referred to as "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.**

Repeat the role-play with some variations so that the client gets practice in handling different twists and becomes comfortable responding with a consistent message. It is also important to try different situations, such as in the example below:

**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, she usually comes over and says, "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 nonalcoholic 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 let's 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 (*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 an SSO may be included in treatment sessions, you can involve a friend who might pressure your client to drink. This has a double benefit. First, the client is practicing drink refusal skills with an actual 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 create yet another SSO ally to support the client in efforts toward sobriety.

At the end of each session, summarize the situations your client feels are risky for resuming drinking as a result of social pressure. If your client has raised both indirect and direct situations, include both types. Also, review the kinds of coping strategies your 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 he/she needs additional practice to sharpen or gain confidence in drink refusal skills before moving on to whether he/she feels ready to move on to

another topic. Continue to record risk situations and coping strategies on Form bb 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.** Having a job is one of the more consistent correlates of being sober. 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, nondrinking activities. Steady and rewarding employment, with its accompanying financial rewards and security, can assist the client in reaching long-term life-stabilizing goals such as owning a home and 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 Besale's *Job Club Counselor's Manual* (1980), this job counseling module is a step-by-step approach to teach clients skills in obtaining and keeping a job.

Use this module only if your client expresses some desire to have a job or to 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 “Case Management” module (section 4.3).

**5.5b. Introducing the Module.** It is appropriate at the outset to clarify to your client the advantages of having a good job. Although you can certainly describe these 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. In the example below, the therapist and client discuss finding a job:

**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. Résumé Development.** In the job-finding process, a strong résumé is a first step to success. Many clients have never had one. The main reason to have a résumé is to obtain an interview; thus, the résumé should describe the client in the most favorable light possible. One telltale problem on a résumé is large periods of time between jobs. There are at least two ways to address this problem. The first way is to prepare a *functional résumé* that describes the client's skills and experience without detailing a chronology of jobs. The second way, if a position requires a chronological résumé, as is often the case, is to display periods of temporary unemployment as periods of self-employment or as times when the client was rethinking career goals. Once the client obtains an interview, he/she can give a more thorough and personal explanation of the problems and how he/she resolved them.

During the initial JOBF session, be sure to discuss in considerable detail your client's employment history, including prior jobs and training. This will acquaint you with what information should be included in the résumé. Often, clients will fail to bring up many valuable skills, duties, or jobs. Strongly urge your client to describe former job duties at length, and develop a list of all the skills involved. Positive personal characteristics such as attention to detail, patience, thoroughness, good communication skills, and so on should also be included on a résumé. Even when a position requires a chronological résumé, it is helpful to include a list of skills and positive attributes as well. Ask your client about positive feedback that past employers or coworkers have given to help generate his/her personal characteristic list.

A résumé should be neatly typed and include a cover letter. There are excellent computer programs to assist in developing quality résumés. Use one of these as a resource in addition to the *Job Club Counselor's Manual* (Azrin and

Besalel 1980), which contains forms to help in résumé development. If the client does not have access to a word processor, prepare the résumé and cover letter for the client through your office staff.

In the example below, the therapist and client discuss how to develop a résumé:

**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 such as 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 résumé. The role of the résumé 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 résumé that those were times when you were self-employed or rethinking 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: Okay, 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 résumé 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 coworkers said about your work?**

CLIENT: A few coworkers 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 cus-**

**tomers (*notes additions to quality list*). Great! We can make a solid résumé with all these positive things.**

Below is a list of steps for involving the client in his/her résumé development:

1. Clearly explain that the task of finding a good job is a full-time job in itself and that the client will have to give it a lot of attention and time.
2. Tell the client to bring in an old résumé if he/she has one, or assign the client to list all the previous jobs he/she had over the last 5 to 10 years with the dates he/she held them, and bring the list to the next session.
3. Together, go over the old résumé or job list. Look for employment gaps and explain to the client how these can be described as times of self-employment or as periods during which he/she was thinking about changing career paths. Make sure the client understands the reasons behind this, and practice how to talk about these times in the interview (e.g., focusing on the positives accomplished with relation to alcohol use).
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 he/she possesses that make him/her valuable in the workforce. Prompt by asking about feedback employers or coworkers gave in the past. Reword feedback to emphasize the client's positive qualities (e.g., persistent, honest, hard-working, dedicated).

6. Have the client neatly type the résumé and a cover letter. If necessary, help the client find a typewriter or word processor, and assist in formatting the résumé, wording the résumé, or preparing it in other ways. If it is not realistic for the client to prepare the résumé, provide support through office staff.

**5.5d. Identifying and Avoiding Jobs With High Relapse Potential.** Now that you are familiar with the types of jobs your client has held in the past, you will be able to talk about the potential for drinking that may be associated with each job. You can then direct the client away from those that may pose a greater risk for encouraging drinking. For example, your client may have had some higher-paying positions that were coupled with environments that led to drinking. Even though the client may be confident that he/she can maintain sobriety and expresses interest in returning to these jobs, help your client explore better alternatives.

In the example below, the therapist and client discuss the risks of drinking connected with different jobs:

**THERAPIST: I now have a good idea of the types of jobs you have had in the past or were 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. . . .**

**5.5e. Completing Job Applications.** Review with your client the basic skills he/she needs to complete a job application properly, including using a computer or printing legibly and neatly. Emphasize the importance of a clean job application and how this is his/her opportunity to make a favorable first impression with a potential employer.

Ask your client to bring in job application forms for actual employment opportunities. It's a good idea to have on hand job applications from the community so your client can practice answering a variety of questions and can receive your feedback. Coach your client on how to handle particularly difficult questions. 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 how he/she is resolving them. The client may not gain an initial interview if he/she simply states the existence of alcohol problems on an application and would therefore be deprived of an opportunity to discuss in person his/her skills for the job and recent success at dealing with this issue.

In the example below, the therapist and client discuss how to fill out an application:

**THERAPIST: I have several different job applications from the community, including some from big employers such as 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 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 as well as any other questions that directly ask about alcohol or other drug problems. In doing this, you may get an interview that otherwise 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.

**5.5f. Generating Job Leads.** After your client completes an acceptable résumé and becomes proficient in completing application forms, he/she is now ready to generate job leads. Some clients look for employment opportunities by randomly walking or driving around town. This is not a good strategy for at least three reasons. One, it just is not a particularly effective method for finding a good job. Two, it does not allow the client time to prepare for and become comfortable with the interview process. And three, it leaves little room for the client to discuss with you how the job might benefit or impact his/her goals in treatment (including the risk potential of the position). Instead, recommend that your client 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; some are described in the following list:

- Most jobs are obtained through word of mouth; ask friends or family members if they know of any job openings or possibilities.
- Ask former employers or coworkers for job leads.
- Check job postings at large firms, at employment agencies, and in newspaper want ads.
- Look in the yellow pages for lists of potential employers in specific interest areas. Help your client broaden the search to include the widest possible number of opportunities; for example, if your client is interested in working with shoes, encourage him/her to also look under shoe retailers, manufacturers, distributors, repairs, and other related areas.

Your client should generate at least 10 job leads before starting to make phone calls to prospective employers. Give him/her the *Job Leads Log* handout (Form ee) and help him/her develop a log in which to keep a record of the names of possible jobs, contacts, and phone numbers. The *Job Leads Log* should also contain the date the client called the company, the name of the person in charge of hiring, the telephone number, the address, and the outcome of the call. The log can help create a call-back list for agencies that are not hiring currently but may be in the future. Look over the list to ensure the

**REFERENCE**  
**Form ee: Job Leads Log**

leads are appropriate before you encourage the client to begin calling.

In the example below, the therapist and client are discussing how to generate leads and are using the *Job Leads Log*:

**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, checking newspaper want ads, or going through 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 all the people 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 it may

be 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 okay. Where do I start then?

**THERAPIST: What about employment agencies, newspaper want ads, or the yellow pages?**

CLIENT: I think I could make phone calls.

**THERAPIST: Good. But before you start calling, make a list of good 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 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 this Job Leads Log. The log helps you keep track of the employers you have called, their phone numbers, and the time and**

**date that you called. Let's practice filling out a few entries in this log.**

**5.5g. Telephone Skills Training.** Before encouraging your client to start calling to make contacts and arrange interviews, train him/her to be *brief, clear, and positive* when communicating over the phone. Go over the list below with your client of concrete steps for making a cold call about a job possibility:

1. Introduce yourself to the person who answers the phone, and ask for the person who does the hiring.
2. Once you reach the person in charge of hiring, address the person by name and introduce yourself.
3. Briefly state your qualifications and request an interview.
4. If you are not invited to interview for a current position, inquire about an interview in the event that an opening occurs in the future.
5. If you do not receive an interview for future openings, ask the person if he/she knows of any other job openings.
6. Ask permission to use this person's name for job leads.
7. Inquire about a reasonable time to call back about future job openings.

Role-play with your client until he/she has mastered the steps. While your client practices making telephone calls, it can be helpful to sit back to back. Practice different scenarios such as what to do if the supervisor is not available (get the hiring contact's name so the client can ask for him/her directly on the next call). If appropriate, have the client

## Sample Job Leads Log

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	Dillard's	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 Reimer	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 Dillard's	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

make one or more calls from your office. If you have an extension phone, 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.

In the example below, the therapist and client rehearse making cold calls:

**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. (Explains the recommended procedures.) Okay, why don't we practice? Do you want to be the caller?**

CLIENT: Okay, 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 person. Why don't you try first just asking for the hiring supervisor.**

CLIENT: Hi, my name is John. May I please speak with the person in charge of hiring?

**THERAPIST: Yes, her name is Judy Turner. Let me connect you.**

CLIENT: Hello, Ms. Turner. 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 at a later date, and if she knew of any other stores hiring.**

CLIENT: Okay, 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 10 a.m.**

CLIENT: Thank you! Do you know of any other stores hiring currently?

**THERAPIST: I believe Dillard's 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 10 a.m. (out of role). Now that was just perfect, John! Can we try something a little different now, for other situations that may come up?**

Below are some steps to help your client practice cold calling:

1. Emphasize being brief, clear, and positive on these phone calls.



2. Role-play the phone procedures with your client until he/she has 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 your client could respond effectively to enhance his/her flexibility in making cold calls.

**5.5h. Interview Skills Training.** Your client will find that looking for a job is easier when he/she has good interviewing skills, and you need to help him/her gain confidence in his/her abilities in this area. Below are some ways to do this:

- Review the basics about arriving for an interview clean and wearing the proper attire, being prompt, and arranging reliable transportation to the interview.
- Hold a practice interview, going over commonly asked questions and appropriate responses. The *Job Club Counselor's Manual* (Azrin and Besalel 1980) is a good source.
- As you rehearse interviewing techniques, graduate the difficulty of the interview questions from less to more challenging, exposing your client to a variety of questions.
- Give positive feedback generously.

Discuss with your client the possibility of rejection as well. Explain that rejection is part of the job-finding process and that the “yes” response usually follows a long series of “no” responses. Again focus on the positive, helping the client view “unsuccessful” interviews as successful practice opportunities and good learning experiences. Carefully monitor the client’s motivation for job finding, and return

to motivational enhancement as needed. Praise your client for any and all efforts he/she makes toward finding a job.

## 5.6. MOOD: Mood Management Training

**5.6a. Background.** Mood, in essence, is normal human emotional change. A person’s mood normally shifts in response to events in his/her world and might be sad, worried, angry, or merry. A key aspect, however, is that a mood state is relatively temporary or transitory and passes within minutes, hours, or at most, a few days.

Mood Management Training is a structured program designed to help clients whose efforts to stop heavy drinking may be compromised by the daily—and normal—occurrence of bad moods. 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 by drinking) with more positive responses.

Mood Management Training consists of the following three phases:

1. You will teach your client a model of emotion to help him/her understand negative moods.
2. You will help your client identify automatic thoughts that lead to negative emotions. Your client will monitor his/her subjective mood states, and together you will use this self-monitoring information to assess and address cognitive themes.
3. You and your client 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 returning to drinking are frequently accompanied by negative mood states. Other researchers showed that negative affectivity is associated with abuse of and dependence upon a variety of substances (Cannon et al. 1992; Cunningham et al. 1995; Shiffman 1982). In retrospective accounts that subjects gave concerning their return-to-drinking episodes, they often indicated that they had been experiencing unpleasant moods at the time of their first drink. Prospective ratings of mood provided by subjects at the close of their treatment have sometimes shown that those 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 a client's negative mood states may improve his/her treatment outcome.

Researchers continue to add to the literature on treatment for negative moods in alcohol-dependent populations. Recent research is indicating that optimal programs go beyond teaching clients how to cope with a negative mood itself and move into coping with both the antecedents and sequelae of the 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 are a sequence of events occurring within a particular context. The acronym STORC helps spell out this

cycle: Emotions occur in a particular SITUATION that is interpreted through the client's THOUGHTS. ORGANISMIC responses, such as physical bodily sensations, are usually involved, and the client'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. Below is the list of steps to take to present this module to your client:

1. Teach your client to identify the five factors that make up human experience (STORC), and discuss the connections between them, drawing on examples from the client's own life.
2. Start your client with self-monitoring to identify the particular STORC components of moods that he/she experiences in different situations.
3. Focus on automatic thoughts that support or exacerbate negative mood, along with the idea that your client's ability to change his/her thoughts and style of thinking can improve mood.
4. Explore automatic, maladaptive behaviors and help your client plan cognitive and behavior change.

In essence, you will be teaching your client how to have greater self-control over the frequency and intensity of his/her negative moods by restructuring automatic thoughts and changing maladaptive behaviors. It is important to make the STORC model directly relevant and applicable to your client's life by using real-life examples and assignments.

**5.6d. Explaining the STORC Model.** Give your client a copy of the *STORC: Understanding*

## REFERENCE

**Form ff: STORC: Understanding Emotions and Moods**

*Emotions and Moods* handout (Form ff), which outlines the basic model that underlies this module, and explain that it describes how moods occur. The steps the handout lists 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 explain the importance of each step in the STORC model. Do not present this level of detail to your client. 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. How much emphasis you place on each component depends on what you think is best for your client.

An optimistic aspect of the STORC model is that a person can do something about negative moods at every point in the cycle. These are highlighted in the following review of the five components of STORC.

**5.6e. Situational Factors.** The SITUATION refers to the people, places, and things that surround the client 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 worst of situations has the power in itself to control a person's moods. Viktor Frankl (1963), describing conditions within the Nazi death camps of World War II, recalled people 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 followup study of people who had been 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 et al. 1996).

Nevertheless, certain kinds of situational factors do seem to increase the probability that a person will get into a negative mood. To be sure, people 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 a person's prolonged exposure to stressors such as significant loss, crowding, noise, and so on. Another important area to explore is the amount of positive reinforcement (as opposed to criticism, punishment, and other aversive conditions) that a person experiences in daily life. Positive reinforcement and pleasant events appear to be important in helping a person maintain a positive mood and outlook, much as vitamins are important in promoting a person's good physical health. Some people have lifestyles or occupations that provide them with very little regular positive input, and these are combined with a rich diet of criticism and negative evaluation. Sometimes (e.g., when a person is in a new relationship or job), the reinforcement a person receives starts out at a high level but then drops off gradually over time. When people experience such a drop in positive reinforcement, they describe it as "being taken for granted," or not being appreciated. If people are continually exposed to conditions of low reinforcement, they can succumb to 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. In the following example, the therapist engages the client in identifying mood-important aspects of his environment:

**THERAPIST:** 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 getting 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:** 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. . . .

Getting to know the client's environment can provide clues for where to intervene cognitively and behaviorally.

What can the client do at the level of *situational* factors to prevent or reduce negative mood states? The main emphasis here is on helping the client plan and arrange for a "balanced diet" in daily life, as in the list below:

- The client can 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.
- The client can self-monitor by keeping a daily record of pleasant and unpleasant events so as to be aware of the daily balance.
- The client can plan time for additional positive experiences if the unpleasant or stressful events seem to dominate and overbalance pleasant events.
- The client can try to arrange for regular social support as a source of such positive and balancing experiences.
- The client needs to seek ways to decrease negative and stressful experiences.
- The client needs to plan for additional pleasant events and social support to counterbalance those that are unavoidable, especially when he/she can anticipate negative experiences.

When the client plans a balanced psychological diet, he/she needs to avoid a common pattern: that of packing all of the negative or stressful events together during the day and then having a sudden shift to positive time represented symbolically by the “happy hour” during the evening. Marlatt and Gordon (1985) have associated this pattern with a risk for alcohol and other drug abuse and propose that 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 a person’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—the person’s THOUGHTS. For example, 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 has no idea of the danger it poses. Similarly, “depressing” events are not inherently depressing, and a person’s reaction depends upon how he/she perceives them. Take the classic film “It’s a Wonderful Life.” George Bailey (played by Jimmy Stewart) experiences a sudden series of major setbacks on Christmas Eve. George perceives his situation as hopeless and his life as worthless and falls into a suicidal mood, wishing 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. Afterward this 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 that a person might otherwise consider to be 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 what caused certain life events. Two dimensions affect the way a person perceives attributions. The first is whether they are *internal* or *external*. An internal attribution is a perception that a particular event was caused by one’s own actions. An external attribution is a perception that a specific event was caused by factors beyond one’s own influence. The second dimension is whether the attribution is *stable* or *unstable*. Stable attributions explain an occurrence as being the result of something that is not likely to change. Unstable attributions explain an occurrence as being the result of a situation 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 usually have a somewhat optimistic attitude, attributing 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 the result of 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 type of attributional style is one that encourages a positive outlook and continued personal effort.

Negative mood and depression are associated with a different attributional pattern. When people are in the midst of depression, they tend to attribute negative outcomes to stable, general negative characteristics of themselves: “That’s how it always goes; I mess up everything I touch.” “I’m a loser in every relation-

ship; who could care for somebody like me?” In this type of mood, people attribute positive outcomes to external causes: “I just got lucky.” “They let me win because they feel sorry for me.” “She’s nice to everybody.”

Researchers have found that changing a person’s self-statements has an impact on mood. Cognitive therapies, which focus on altering thought processes, are beneficial in treating anxiety and affective disorders. Cognitive intervention typically begins by identifying the person’s thought patterns that may be fostering negative moods (Beck 1976; Burns 1980), such as unrealistically high expectations of oneself or others, hopelessness, pessimism, and excessive self-criticism. The therapist then challenges and changes these cognitive patterns by helping the client seek new beliefs and self-talk to 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 people may experience this in physical changes such as dry mouth, cold hands, a hot face, and stomach contractions. What physical sensations does your client connect with being upset, angry, sad, afraid, or other emotions? Often physical sensations are 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 expe-

riences, 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 alter directly physical states (e.g., medication, relaxation training, physical exercise). None of these is included in CBI, in part because they have a disappointing track record as components of treatment for alcohol problems (Miller et al. 1995). In fact, substance abuse may be the client’s attempt to modify directly the O component in negative emotionality. CBI puts primary emphasis 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/she responds to this feeling can make a big difference. Be alert for two generally maladaptive response patterns: *avoidance* and *aggression*, described below.

**Avoidance.** A common and often unhealthy response is avoidance, or withdrawal. The reaction may seem understandable, even natural. When people are down or are experiencing low self-esteem, they feel like poor company. They may not feel up to usual social contacts or may not want others to see them in this dejected state. Feelings of fatigue may contribute to the urge to avoid and withdraw. Yet avoidance tends to strengthen negative emotions. If a person, once thrown from a horse, continues to avoid horses, he/she will become even more afraid of them. The depressed person who withdraws from his/her social support network is cutting him/herself 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 people feeling down and suffering from general low moods.

**Aggression.** Another maladaptive way in which people respond to negative moods is to strike out, to react aggressively. This pattern, as with avoidance, is often exacerbated by substance use. Aggression can be reinforced by having the desired *immediate* effect. Continued aggression, however, changes the person's social environment in ways that make him/her feel even worse.

In part, the problem here can be the lack of an important coping skill. Deficient social skills, for example, can prevent a person from developing a reinforcing and supportive network of friends, which in turn decreases resistance to depression. Social skill deficits can also perpetuate depression. 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 with your client, it may be useful to include other CBI skill-building modules in treatment.

**5.6i. Consequences.** People's mood and depression are influenced by how others in their social environment respond to their behavior. A person in an environment that provides very little positive reinforcement for prolonged periods may feel helpless and pessimistic, which feeds negative emotionality.

Ironically, some social settings strongly reward a person for negative mood. Consider this scenario. A woman has poor social skills and consequently has no close friends. Her everyday life is uneventful and empty. In time, she becomes depressed and confides to several people in the church community of which she is a member that she is feeling suicidal and very

down. Suddenly this community comes alive for her and rallies around her. The pastor calls regularly. People 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 woman's "sensible" response to these contingencies is to become depressed again.

Change at this level involves rearranging one's 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 described in the above scenario. 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. If a person explores new activities, just for the fun of it, that 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. Such clients may respond to reflective listening, and you may be able to infer your client's mood from his/her more general description of the STORC elements of a particular event.

In the example below, the therapist is using the STORC concept to explore a recent situation that left the client in a negative 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!

**REFERENCE****Form gg: Feelings From A to Z**

**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 the *Feelings From A to Z* worksheet (Form gg), which provides a broad list of feeling names. Show your client the list, and ask which words might best describe how he/she felt in the situation you are discussing.

**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 Self-Monitoring Sheet* (Form hh) based on the most recent time he/she experienced a negative feeling. In the "Mood-Level rating" box, ask the client to rate his/her mood



level from  $-10$  (very negative feeling) to  $+10$  (very positive feeling).

Next, ask the client to describe the situation to you, and then have the client make a brief note in the “Situation” box (S) to indicate the external circumstances.

Sometimes people have difficulty filling out the “Thoughts” component (T) of the sheet because they are unaware of any specific thoughts that occurred in between the situation and the mood. If this happens, skip down to the “Feelings” (O) box, and then come back to the “T” box 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 that they result from thoughts that occur often so quickly and automatically that one is unaware of them.

In the “O” box, have your client fill in specific physical sensations as well as a name for the emotional state. How did the client feel in this

#### REFERENCE

##### *Form hh: Mood Self-Monitoring Sheet*

situation? Help him/her 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: it conveys a cognition, a mental interpretation, rather than an emotion. If you hear a “that” in the statement, the person is not expressing an emotion.

For the “What I did (R)” box, ask what the client said or did in response to the situation, thought, and feeling. Have the client make a brief note about it.

Finally, in the “What happened (C)” box, indicate what happened as a result. How did others react, or what changed?

In the example below, the therapist and client are filling in the *Mood Self-Monitoring Sheet*:

**THERAPIST:** Okay, now let’s try 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 10, which is feeling about as bad as you can feel, to plus 10, 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 7, 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 a 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 lighthearted, gaining some distance from what was a significant emotional event.

Once your client seems comfortable with how to fill in the *Mood Self-Monitoring Sheets*, assign him/her to keep the sheets as a diary between this session and the next and bring them back at the next session. Give your client a supply of the forms, asking him/her to complete at least three of them (that is, nine specific events). Make sure this is agreeable and that the client understands what you are asking him/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 Self-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/she grasps the idea. Those with experience in AA may link this to the concept of “stinking thinking.” Use examples from the *Mood Self-Monitoring Sheets* to explore how thoughts are linked to emotions. As your client begins to break his/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. You could use the analogy that these thoughts are like weeds in the garden, and the client is

plucking them out, one by one, to allow room for what he/she wants to grow.

Emphasize that emotions are transient—they tend to come and go. For an emotion such as 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, the fire eventually goes out.

Another important point, strange to some clients, is that they can choose how they 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, the client needs to learn to recognize the automatic thoughts, to catch them as they go by. Second, the client needs to 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 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.

Below is a list of some common erroneous thought processes as described by David Burns (1990):

- *Filtering* involves selective attention, look-

ing 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 molehill.”
- *Mind reading* is making assumptions about what others are thinking and feeling, what motivated their actions, and so on.
- *Catastrophizing* means assuming 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 pain.
- *Shoulds or oughts* can be rules that are rigid, not flexible enough to take into account human frailties.
- *Emotional reasoning* means feelings overrun reality-checking: if you feel it, it must be true.
- *Fallacy of external control* is the perception that you have no power or responsibility for what happens in your 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).

Do not recite this list to your client; it is provided here to help you think clearly about what systematic, automatic distortions may be occurring in your client’s thought processes. With your client’s collaboration, identify the content or process errors in thinking that lead to negative emotionality (Burns 1990).

It is inconsistent with CBI’s overall style to argue with your client about whether or not his/her 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, do not say, “You’re wrong,” but show how different ways of thinking about situations actually lead to different realities (O, R, and C). Explain that no matter the situation, he/she always has the freedom to choose how to think about and understand the situation. This perspective, in turn, provides your client the freedom to choose how he/she feels about life as well. (For clients with AA experience, explore this concept in relation to the idea of serenity.)

**5.6m. Challenging Toxic Thoughts.** The preceding exercises lead 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 perspective 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 has some choice about how to feel (O) and act (R) as well, which in turn influences what happens (C) in his/her

#### REFERENCE

***Form ii: Thought Replacement Worksheet***

external world. It is also not your job to prescribe for your client the “correct” or “rational” thoughts that he/she ought to have. It is fine to suggest different possible interpretations if your client gets stuck, but always first invite him/her to suggest different ways of looking at situations and feelings. 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 ’til 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 the *Thought Replacement Worksheet* (Form ii). Often it is best to introduce it by working through a specific example or two (see sample on pages following). In the example below, the therapist and client go over the *Thought Replacement Worksheet*:

**THERAPIST:** You have completed several of these Mood Self-Monitoring 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 it is 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-percent 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-percent chance that things will get better?

CLIENT: No, I'd say there's a 10-percent chance that things will improve.

**THERAPIST: Now there is a bad mood magnifier! The doctor only gives you a 10-percent 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-percent 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 Worksheet.*)**

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 "Toxic 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 "Replacement Thought" 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.

## Sample Thought Replacement Worksheet

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	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
	Depressed		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	Wait a minute. I've already tried that. If I drink now, I'll feel a whole lot worse. Who am I kidding?	Relieved
	Thirsty		Stronger
	Helpless		

**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? . . .**

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. Common examples of behaviors that may serve to reinforce negative moods include: withdrawing, arguing, sulking, drinking, driving aggressively, smoking, overeating, 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* he/she could have done and what different consequences might have

followed. A problem-solving approach works well in this context.

In the example below, the therapist and client work together to generate a list of different response options that could have varying 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 20.

**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 are good task assignments to perform between sessions. For your client, 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 "Social and Recreational Counseling" module (SARC, section 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 Self-Monitoring Sheets* during this period when your client is trying new thoughts and responses.

**5.6n. Applying STORC With Urges to Drink.** If your client experiences urges to drink, this module's procedures may be particularly helpful. You can analyze urges 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, as described below:



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. Below is a list of replacement thoughts that people have used successfully in sobriety:
  - *Where is the evidence?* What is the evidence that if I 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 myself—they are more like craving a particular food when I 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 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 et al. 1995) with an important change: it gives encouragement to mutual-support groups more generally and does not restrict clients to 12-step groups; consequently, the module does not emphasize helping clients work the early steps of the 12-step program. Instead, the module focuses on facilitating the client’s sampling of available mutual-support groups as an aid for sobriety. Below is a list of the MUTU module’s specific objectives:

- 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 participa-

tion 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 clients 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. This process has been described as “self-help” or “mutual aid” (McCrary and Delaney 1995), terms synonymous with the one that is used in this manual: “mutual support.” Self-help, or mutual-support, groups have proliferated for people with substance abuse problems. Many of the mutual-support groups had their beginnings in the fertile climate for alcoholism treatment services in the United States after the post–World War II 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; McCrary and Delaney 1995).

#### ***5.7c. Overview of Mutual-Support Programs.***

Alcoholics Anonymous is the earliest of the contemporary mutual-support groups. Founded in

Akron, Ohio, in 1935, AA claims to have 2 million members and more than 90,000 registered groups in more than 140 countries (Alcoholics Anonymous 1994). AA is a fellowship of men and women who help one another 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). Several other groups based on AA’s steps and traditions have developed to help people 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 nonprofessional, relying on its volunteer 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 people with any kind of addiction as well as to others who consider themselves codependent. The Calix Society, a program for Catholics who are recovering from alcoholism, was founded in 1947 and operates 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 based on 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 countertherapeutic to the needs of women. WFS believes that many women develop drinking problems as a way of coping with negative emotional states. Although 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 advocating a scientific (as opposed to spiritual or religious) method of achieving sobriety. SOS emphasizes 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 and 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 other drug problem but also stresses personal decision-making. RR groups are peer led, but all groups have a professional therapist who functions as an adviser.

**Moderation Management (MM)**, founded by Audrey Kishline (1994), is the newest

American addition to mutual-support programs. 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” (Kishline 1994 p. 25). Meetings 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.

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 those 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” (Delgado 1996 p. 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 (see table 5.1).

**5.7d. Matching Considerations in Mutual-Support Referrals.** The recommended method for utilizing mutual-support groups is to integrate them into your treatment approach (Ouimette1998). Several researchers have indicated that therapists should routinely offer a referral to AA or another support program to clients with an abstinence goal (Edwards 1980; McCrady and Delaney 1995). Glaser (1993) specifically recommended that all clients should be encouraged to try mutual-support

groups and recommended also that no one should be required to attend. This is the approach taken in CBI: to encourage, but not require, all clients to sample mutual-support options as potential aids to recovery.

Below is a list of possible considerations in matching clients with optimal mutual-help programs.

- *Availability.* One obvious limitation is the range of mutual-support programs available in the community. There is likely to be at least one AA group. In some areas, it will be the only mutual-support resource. A broader range of alternatives is often

**Table 5.1 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	High
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	High
Rational Recovery	Peers	Anyone with an alcohol or other drug problem	Rational-emotive therapy	High
Secular Organizations for Sobriety	Peers	Anyone sincerely seeking sobriety	Secular and scientific approach to recovery	High
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	High

Adapted from McCrady and Delaney 1995

available in more populated areas.

- *Program Philosophy.* There are substantial differences in the philosophy, structure, orientation, and leadership of the mutual-support groups. Even within large organizations such as AA, there can be wide variety in the group environment of meetings (Tonigan et al. 1995). If you know the leanings of 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 (e.g., RR, SOS, WFS) is the emphasis placed on spirituality—a central and consistent component of AA. It is not necessary for clients to be “religious” to be comfortable in or respond to AA. Nevertheless, some clients may be offended by the God language, open prayer, and spiritual steps of AA meetings, or these aspects may be alien to them.
- *Similarity.* An important determinant of social affiliation is perceived similarity. Consider whom the client is likely to encounter at various programs and groups in terms of gender, age, or ethnicity.

**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 clients 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 not be helpful to these people. Indeed, mutual-support group members will reinforce these clients’ decision to abstain and may provide useful role models for long-term drug-free coping. For these reasons, if you have

clients with good social support for abstinence, encourage mutual-support group attendance as you would other possible strategies for maintaining behavior changes (Snow et al. 1994).

Clients whose social networks are supportive of continued drinking, however, do substantially better in treatment that specifically and concretely attempts to get them involved with AA (Longabaugh et al. 1998). The MATCH study cited above revealed that people who attended AA groups during the first year following treatment were “immunized” against the temptation offered by their social networks, and they were more apt to remain abstinent (Project MATCH Research Group 1998a). This finding is consistent with the folk advice in AA that suggests that sobriety is promoted by “going to meetings, reading the ‘Big Book,’ and talking to your sponsor.”

**5.7f. Initiating Mutual-Support Group Involvement.** Below is a list of steps for involving your client in mutual-support groups:

1. *Provide a rationale.* Begin by providing a clear rationale for mutual-support group involvement that is both factual and congruent with your client’s beliefs or circumstances. Ask your client for reasons why having additional support could be helpful (invoke 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.
2. *Explore attitudes about mutual-support groups.* Ask about your client’s prior experience with mutual-support groups. Most clients will have had some exposure. What did the client like or appreciate about the groups he/she attended?

What did he/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.

3. *Give information about available groups.* Offer information that is pertinent to this particular client, in language he/she will appreciate. Draw on your knowledge of the available groups.

Below is an example of a way to explain AA to a male client who is unfamiliar with 12-step programs:

**THERAPIST: AA was started in 1935 by a 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 when attending a meeting. Below is an example of such a description.

**THERAPIST: 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 1 of the 12 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. Most programs allow people not in recovery to attend; AA has specific “open” meetings. Give a fair and accurate description of the various groups available in your area.

4. *Encourage sampling.* Particularly if your client is new to mutual-support groups, encourage him/her 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/her own situation. Give your specific endorsement to participating, as in the example below:

**THERAPIST: 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 togeth-**

**er 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?**

5. *Provide referral information.* Give your client contact information, such as local or toll-free numbers, introductory literature, and a list of local meeting times and places. Use officially approved literature when you are referring clients to 12-step meetings.
6. *Make a specific plan.* For many clients, it is not enough just to give the information. Consider specific steps to help your client get to meetings. Which mutual-support group is the client interested in visiting? When and where? How will the client get there? Troubleshoot any obstacles to attendance. For example, contact a group member in advance and arrange to call that person during the session, with your client's permission; give the phone to your client so that the member can offer to meet him/her at the group, perhaps provide transportation, and so on. Following practical steps such as these can make a big difference in whether clients actually get to meetings (Sisson and Mallams 1981).

**5.7g. Emphasizing Action.** Contrary to some aphorisms, a person needs to do more than simply attend mutual-support groups to achieve positive change. Several 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 AA members for assistance and having a sponsor were the most important activities predicting whether an AA member would relapse or not. Similarly, Montgomery and colleagues (1995)

reported that the extent of involvement or active participation in AA processes (e.g., working the steps, using a sponsor), 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. Below are some examples of ways to encourage 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 of the group. It's not just going to more meetings but also things such as 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 influence whether or not they are likely to follow through (Meichenbaum and 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., by complaints) or indirectly (e.g., by not attending) 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 attend. If the client is not ready to consider going now, put the topic on hold and come back to it later in treatment when he/she may be more receptive, as in the example below:

**THERAPIST: 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 come for treatment, they have few outside interests and activities. As people develop alcohol dependence, drinking occupies more and more of their time, and drinking companions displace prior associates. Conversely, an important part of your client's process of recovery is rebuilding a life without drinking. This rebuilding may include the client 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 section 5.5, “Job-Finding Training”).

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. You may not need to devote the entire session to SARC and can easily combine the SARC module with another module.

**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, have your client offer reasons why it is important to have activities and companions not associated with drinking. Avoid lecturing your client on matters it is likely he/she already knows. 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 do you think might be the advantages of having fun, finding some new interests, or being with friendly people without drinking?” As your client makes self-motivational statements, reinforce them with reflection.

Below is a list of points that often arise in discussions of this kind. If your client does not come up with advantages, mention these points and ask which of them seem like the best reasons for finding nondrinking friends and activities. Rephrase them as necessary.

- 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.



- Getting positive reinforcement is like taking 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 he/she often associated with drinking. Similarly, ask your client to describe recreational events, people, and places that he/she enjoyed in the past that are not associated with drinking. Compare the two lists and discuss how they are different to clarify patterns that support both drinking and sobriety.

#### **REFERENCE**

***Form jj: Menu of Possibly Pleasurable Activities***

Sometimes it has been so long since your client had a sober lifestyle (if he/she ever did as an adult) that he/she cannot list enjoyable alcohol-free activities, people, or places. Here it can be helpful to offer a menu of options. This menu should be tailored for your specific area, but the *Menu of Possibly Pleasurable Activities* worksheet (Form jj) provides a generic head start. Local newspapers sometimes carry weekly lists of clubs, free activities, support groups, volunteer opportunities, and/or entertainment options. Have your client review the worksheet and identify things that he/she might enjoy or is unsure about enjoying. Besides using this worksheet, ask the client to think of activities, hobbies, and interests of friends or acquaintances who do not drink or to think of activities, pleasurable or not, that do not involve drinking.

If possible, move smoothly from discussing enjoyable nondrinking activities to making a specific plan for increasing ones the client currently takes part in or at least for trying a few new ones. This is easier when your client already knows of activities, people, and places that are fun and do not involve or emphasize drinking.

In the example below, the therapist and client discuss ways to find nondrinking activities:

**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: Okay 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 you have associated with drinking 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 coworkers that doesn't involve drinking. We have a softball league that I'm 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 coworkers. 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 the 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!**

As shown in the example, it is a good idea to find activities that occur during times when the client previously was most likely to be drinking. Have your client pick 5 to 10 activities that sound the most pleasant or exciting.

**5.8c. Developing a Nondrinking Support System.** Another purpose here is for the client to create and maintain friendships with those who will support him/her in his/her 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 his/her sobriety.

When you discuss local activities such as concerts, outdoor events, sports organizations, and social clubs that are alcoholfree or place little emphasis on alcohol use, make sure that you

are familiar with such activities so you can make informed recommendations that will not end in a bad experience for your client.

Other suggestions for building social support for sobriety can be found in sections 5.6 (“Mood Management Training”) and 5.9 (“Social Support for Sobriety”).

**5.8d. Reinforcer Sampling.** Reinforcer sampling is the process by which clients try out or experiment with new social activities. The idea here is that when your client tries a variety of new activities, particularly activities that bring him/her into contact with other people outside of drinking contexts, he/she will most likely find at least one that is rewarding. Below is a list of ways to interest your client in trying nondrinking activities:

- Sometimes clients are reluctant to sample new activities while sober. Explain to your client that trying an activity once does not mean a lifetime commitment to it. He/she will be sampling activities to find one or more that is enjoyable and that can support him/her in staying sober.
- Find a suitable analogy, such as 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.
- Assign between-session tasks that involve sampling at least one new activity. The more specific the plan, the more likely the client is to carry it out. The client stating,

“I’ll go to the softball practice on Saturday afternoon” is better than his/her saying, “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 do not have the skills, are embarrassed, or are not well prepared to begin something new. Systematic Encouragement, a three-step process for motivating your client to plan and complete the process of reinforcer sampling, is described below:

1. Once your client has agreed on an activity, do not assume he/she will make the first contact. Instead, practice how the client will go about contacting the organization and what he/she 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 he/she does well while gaining valuable behavioral information about how the client interacts with others.
2. Whenever possible, call a contact person from your resource list to meet the client at the door or to introduce him/herself to the client. If a client knows that someone will be there to meet him/her, it will set him/her more at ease socially, and it increases the likelihood he/she will follow through. If possible, arrange for a contact person to provide transportation to and from the activity.
3. Review with your client the reinforcement value of the activity. Was the activity something he/she enjoyed and would like to do again? Problem-solve any barriers to reattending such as transportation to the activity or child

care. If the client did not attend, problem-solve to create a plan that will assist him/her in attending the following week.

In the example below, the therapist and client discuss how to get involved in an activity:

**THERAPIST: 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 the church’s 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 Saturday 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 non-drinking activities until he/she finds several that he/she enjoys and is likely to stick with. Continue to assign the sampling of a new activity each week while you work on other modules.

<sup>1</sup> The “Support for Sobriety” module is adapted from Lisa M. Najavits, *“Seeking Safety”: A Treatment Manual for PTSD and Substance Abuse*. New York: Guilford Press. Copyright © 2001 by Guilford Publications, Inc. Used with permission of the publisher.

## 5.9 SSSO: Social Support for Sobriety<sup>1</sup>

**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 section 2.7, “Involving the SSO in CBI Treatment”). Clients are surrounded by people who can influence their recovery for better or worse. Those people may be family members, friends, counselors, and self-help group members. Below is a list of things clients may say about such people:

- 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 such as 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 non-supportive of 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.** There are three groups of clients with problematic social support:

- Those who have no support in general
- Those with low support for abstinence
- 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.* These clients are likely to be depressed, isolated, and perhaps undersocialized. These clients may experience difficulties attending mutual-help meetings because they may find the level of interaction to be too stressful, so they avoid them. Despite their reservations, members of this group need social support enhancement, and mutual-support groups are one source of easily accessible help (see module 5.7, “Mutual-Support Group Facilitation”). You can connect a client who is isolated and depressed through case-management activities such as arranging a 12-step contact or putting the client in touch with groups and activities that will bring him/her into contact with others (see module 5.8, “Social and Recreational Counseling”). Once the client makes such social connections, monitor his/her attendance to see if he/she has second thoughts, experiences adverse events, or has other problems that may interrupt his/her ongoing social involvement.

*Clients with low support for abstinence.* These clients are less likely to be anxious and depressed but still need social support enhancement. These people probably have close relationships that are relatively undamaged by their excessive drinking, so members of their social network may be unaware of or indifferent to the fact that they are undergoing treatment. Explore your client’s network to identify people who might be educated about his/her 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 people 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 for saving money.

Consider inviting one of these people 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 about the client's drinking in particular. This then 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, "Mutual-Support Group Facilitation") can 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.

*Clients with high network support for drinking.* These clients are the most likely to have drinking peers and perhaps a drinking spouse/partner who represents an active threat to their commitment to abstinence during or after treatment. Addressing this set of problems

#### REFERENCE

##### ***Form kk: A Letter to People in Your Life***

will require tact, skill, and patience, in that these clients 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 strate-

gies have lower rates of successful change (Prochaska and DiClemente 1986). Encourage your client to sample mutual-support groups (even within a single program such as AA), looking for a good fit, because involvement in such groups is particularly helpful to people with high network support for drinking. Your client can accomplish this by attending one group several times or several groups one time. Discuss these experiences during therapy sessions as you would any other home task assignment (see module 5.7, "Mutual-Support Group Facilitation").

**5.9c. Educating Significant Others.** A principal goal here is to help your client articulate what he/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). Ask questions to help the client process the material in this handout. Below is a list of such questions:

- 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 your client:

- The letter is designed for the client to hand to important people in his/her life who want to help the client recover (e.g., friends, spouse or significant other, AA sponsor).
- It is up to the client to decide whether and to whom to give the letter. The only excep-

tion: 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 your client to rehearse aloud what support he/she would want from others. This can be useful even if in real life there are reasons he/she cannot express it (e.g., the client is too afraid to say it). Below is a list of the ways a client might directly ask a significant other for support:

- 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 him/her on seeking more help from other sources. It is an important goal to try to help the client start new relationships with healthier people, but this can take a while. Look for more immediate sources of support from mutual-help groups, professionals or agencies, or churches or other supportive communities (see modules 5.7, "Mutual-Support Group Facilitation" and 5.8, "Social and Recreational Counseling").





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## 6. Phase 4

# Maintenance Checkups

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Phase 4 is the maintenance phase of treatment. It consists of periodic checkup 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, or (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 to 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, or (c) your client stops attending sessions, missing three or more sessions in a row without formally announcing

that he/she 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.

3. You end the 16th week after the first session. No further CBI treatment sessions may be delivered after this date. If Phase 3 treatment has extended to within the 2-week deadline, do not initiate Phase 4. Simply terminate treatment (see chapter 7, "Termination") when Phase 3 is finished or you reach the end of the 16th 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 checkup until you reach the 16-week anniversary date. Even for clients who are doing very well, it can be useful to have them check in periodically throughout the 16 weeks. Ask whether your client is willing to come back periodically for the next X-number of weeks (until the 16-week anniversary date), and schedule the first checkup

session. If your client declines, explain that you will be able to see him/her for further sessions up until the 16-week anniversary date, after which treatment is over. Invite your client to call you back if he/she feels that a session might be useful.

Do not use “relapse” language. The rationale for Phase 4 sessions is *not* to keep from relapsing. Present these sessions as a free option that can be useful in maintaining health, like routine health checkups with a doctor or dentist.

### 6.3. The Basic Structure of Checkup Sessions

Think of Phase 4 as “booster” sessions to reinforce the motivational processes and cognitive-behavioral skills developed in Phases 1 through 3. As before, the SSO should be involved in these sessions. Because several weeks normally pass between Phase 4 sessions, routinely send your client a handwritten note, or telephone your client a day or 2 before the appointment. This serves as a reminder and also expresses your continued active interest.

The three essential components of a checkup session are as follows:

1. *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 your client has had a drinking episode, review what happened in a nonjudgmental way, with a goal of gaining an accurate understanding.
2. *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 your client’s ambivalence has been resolved and that his/her 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?

3. *Redo Commitment.* Complete each checkup 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) followup 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 followups) serve as periodic checkups 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, as well as resuming Phase 3, can be explored, described below.

1. *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. Use key questions 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.

2. *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 they 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.

3. *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 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. You can continue weekly sessions throughout the 16-week treatment period if needed.



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# 7. Termination

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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 by saying, “This is our last session.” From the beginning, you should make it clear that treatment ends within the 16 weeks, and it is wise to remind clients from time to time of the approximate ending date you are working toward. Three sessions before the last (termination) session, say to your client something like this: “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, saying something like, “Next time will be our last session together, and your followups 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 followup interview.

## 7.3. Timing

Normally the termination session will occur within the last 2 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 wrapup session at some scheduled time before the end of the 16 weeks, saying something like, “I just want to review together what we have done, and what you want to do after we’ve finished.”

In rare cases in which a client refuses to return even for one more session, complete

the termination session procedures (section 7.4) during the current (and last) session.

## 7.4. Essential Elements of the Termination Session

Make sure you follow the 10 steps outlined below:

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/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/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 a while, 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/she would like to make? What new goals does he/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 section 4.3, “Case Management”).
9. *Followup reminder.* Remind the client that his/her COMBINE experience is not over. There are very important followup interviews ahead. Say something like,

“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 fol-

lowup interview will be (the client can even schedule it at this point), and remind the client that he/she will be paid for the time and inconvenience involved in helping 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

## Section 1. Alcohol Use

### Your Drinking

Number of standard "drinks" per week: \_\_\_\_\_ drinks

Your drinking relative to American adults (same gender): \_\_\_\_\_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+)
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### Alcohol Dependence Level

0	1	2	3	4	5	6	7
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## Section 2. Other Drug Use

Percentiles (U.S. Adults)					
	Tobacco/ Nicotine	Marijuana/ Cannabis	Stimulants/ Amphetamines	Cocaine	Opiates



### Section 3. Consequences

Men								Women					
17-24	23-30	23-24	17-36	16-21	86-135	10	High	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		11-12	13-14	18-19	9-10	9	53-60
10-11	13-14	16-17	9	9	53-59	6	Medium	10	11-12	15-17	8	8	48-52
9	11-12	14-15	8	8	46-52	5		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
<b>Ph</b>	<b>Re</b>	<b>Pe</b>	<b>Im</b>	<b>Sr</b>	<b>Tot</b>			<b>Ph</b>	<b>Re</b>	<b>Pe</b>	<b>Im</b>	<b>Sr</b>	<b>Tot</b>

**Ph** = Physical consequences; **Re** = Relationship (interpersonal) consequences; **Pe** = Interpersonal (emotional, self-esteem, etc.) consequences; **Im** = Impulsive actions; **Sr** = Social responsibilities; **Tot** = Total negative consequences

### Section 4. Desired Effects of Drinking

Assertion	Drug Effects	Mental	Negative Feelings	Positive Feelings	Relief	Self-Esteem	Sexual Enhancement	Social Facilitation	
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

### Section 5. Preparation for Change in Drinking

<b>Very Ready for Change</b>	<b>Support for Abstinence</b>	<b>High Confidence</b>	<b>Low Temptation</b>
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
<b>Not Ready for Change</b>	<b>Support for Drinking</b>	<b>Low Confidence</b>	<b>High Temptation</b>

### Section 6. Mood States

<b>Tension</b>	<b>Depression</b>	<b>Anger</b>	<b>Vigor</b>	<b>Fatigue</b>	<b>Confusion</b>
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	1	1	3-4	2	2
1	0	0	1-2	1	1
0			0	0	0

### Section 7. Blood Tests

<input type="text"/>	<b>Your Score</b>	<input type="text"/>	<b>Your Score</b>	<input type="text"/>	<b>Your Score</b>	<input type="text"/>
M: 10-45 F: 10-36	<b>Normal Range</b>	M: 6-48 F: 6-37	<b>Normal Range</b>	M: 7-74 F: 5-49	<b>Normal Range</b>	M: 79-97 F: 79-98
<b>AST (SGOT)</b>		<b>ALT (SGPT)</b>		<b>GGT (GGTP)</b>		<b>MCV</b>



## APPENDIX B

# INSTRUCTIONS FOR PREPARING THE PERSONAL FEEDBACK REPORT

Prior to your second session with a CBI client, the client's **Personal Feedback Report** (PFR) should be prepared. We recommend that the CBI therapist do this, although at some sites, a research assistant will prepare the PFR.

The following information from the client's file is required:

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 et al. 1993).

### Section 1. Alcohol Use

#### Your Drinking

Number of Standard Drinks per Week—Tell the client the average number of standard drinks he/she consumed during a week of drinking, 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. Two figures are considered; the higher of the two is the number entered on the first line of Section 1 of the PFR. The two numbers are:

1. The number of standard drinks per week as reported on the Steady Pattern chart
2. 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; if so, use the 90-day average figure.

Your Drinking Relative to American Adults—Use the Alcohol Consumption Norms for U.S. Adults chart (below) to obtain the client's percentile among American adults, then enter the percentile figure for the client's gender.

**Level of Intoxication**

Estimated BAC Level—This figure 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, double check your figures and, if correct, enter 700 (never higher) as the estimated value.

**Alcohol Consumption Norms for U.S. Adults**

<b>Drinks Per Week</b>	<b>Men</b>	<b>Women</b>
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 et al. 1991).

**Alcohol Tolerance Level**

Mark the correct box according to the level of intoxication entry. For example, if the client's BAC was 145 mg%, circle "High."

**Alcohol Dependence Level**

Circle the number of *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (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 also comes from Form 90-AIR. The critical information is the number of days of use during the 90-day baseline window for each of the 5 drug classes shown. Use the following table to determine the percentile for U.S. adults for each of the drug classes.

**Tobacco/Nicotine**

	<b>Men</b>	<b>Women</b>
No use	0	0
Any use	69	72
Pack (20 cigarettes) or more/day	85	89

**Marijuana/Cannabis**

Use the total days of use in this 90-day period.

<b>Days Use</b>	<b>Men</b>	<b>Women</b>
0	0	0
1-2	93	96
3-11	94	97
12-50	96	99
51 or more	99	99.5

**Stimulants/Amphetamines**

	<b>Men</b>	<b>Women</b>
No illicit use	0	0
Any illicit use	99.1	99.5

**Cocaine**

<b>Days Use</b>	<b>Men</b>	<b>Women</b>
No use	0	0
Any use	99.1	99.7

**If Crack**

	<b>Men</b>	<b>Women</b>
No use	0	0
Any use	99.5	99.8

**Opiates**

<b>Days Use</b>	<b>Men</b>	<b>Women</b>
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 older.

**Section 3. Consequences**

Score the DrInC-2R and record the client's raw scores in the boxes. 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 gender side of the profile.

**Section 4. Desired Effects of Drinking**

Use the key below to score this questionnaire. Each item can contribute up to 3 points to the subscale score, and each subscale contains 4 items, for a maximum possible score of 12 on each subscale. Circle the total score for each of the nine subscales.

**Desired Effects of Drinking Key**

	<b>Scale</b>	<b>Items</b>				<b>Totals</b>
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	
<b>Total Score</b>						

*Source:* Tracy L. Simpson, Ph.D., Judith A. Arroyo, Ph.D., William R. Miller, Ph.D., and Laura M. Little, Ph.D.

## **Section 5. Preparation for Change in Drinking**

Get the Readiness score from the URICA scale. Use the norms in the chart below to determine the client's decile, then circle it.

The Support score reflects the degree of Support for Drinking, and you can get it from the **Important People** (IP) interview. Use the norms in the chart below to determine the client's decile, then circle it.

Get the Confidence score from the **Alcohol Abstinence Self-Efficacy (Confidence)** scale. Use the norms in the chart below to determine the client's decile, then circle it.

Get the Temptation score from the **Alcohol Abstinence Self-Efficacy (Temptation)** scale. Use the norms in the chart below to determine the client's decile, then circle it.

<b>Decile</b>	<b>URICA Readiness</b>	<b>IP Support for Drinking</b>	<b>AASE Confidence</b>	<b>AASE Temptation</b>	<b>Decile</b>
<b>10</b>	12.9 or higher	66.8–100	4.4 or higher	4.0 or higher	<b>10</b>
<b>9</b>	12.3–12.8	58.4–66.7	3.9– 4.3	3.7–3.9	<b>9</b>
<b>8</b>	11.7–12.2	50.1–58.3	3.5– 3.8	3.5–3.6	<b>8</b>
<b>7</b>	11.3–11.6	41.8–50.0	3.3–3.4	3.2–3.4	<b>7</b>
<b>6</b>	10.7–11.2	37.6–41.7	3.0–3.2	3.0–3.1	<b>6</b>
<b>5</b>	10.3–10.6	33.4–37.5	2.8–2.9	2.8–2.9	<b>5</b>
<b>4</b>	9.9–10.2	25.1–33.3	2.6– 2.7	2.4–2.7	<b>4</b>
<b>3</b>	9.4–9.8	16.8–25.0	2.3–2.5	2.0–2.3	<b>3</b>
<b>2</b>	8.9–9.3	8.4–16.7	1.9–2.2	1.6–1.9	<b>2</b>
<b>1</b>	8.8 or lower	0–8.3	1.8 or lower	1.5 or lower	<b>1</b>

## **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. Interpretive ranges shown in the lower boxes should be the lab normal values for the laboratory performing the assays.





# APPENDIX C

## CBI THERAPIST GUIDELINES FOR PRESENTING THE PERSONAL FEEDBACK REPORT

This information is to help you in interpreting the PFR to your clients. Following the general motivational counseling style described in this manual, your task is to provide to your client a clear explanation of his/her feedback in understandable language.

Give the original copy of the PFR (Appendix A) to your client (and SSO), and retain a copy for your file. When you have finished presenting the feedback, the client may take home the PFR as well as a copy of "Understanding Your Personal Feedback Report" (Appendix D). If the session ends before you have finished going over the PFR, however, retain the original; send 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. Below are some additional points you may find helpful in reviewing the PFR with clients.

### Section 1. Alcohol Use

*Number of Standard Drinks per Week*—The idea of a "standard drink" is an important concept here. Explain that all alcoholic beverages—beer, wine, spirits—contain the same kind of alcohol, ethyl alcohol. They just contain different amounts of this drug. A "standard drink" is defined as any beverage that contains half an ounce of ethyl alcohol. Thus, the following beverages are each equal to one standard drink:

Beverage	Usual %	Multiplied by	Ounces	Equals	Alcohol Content
Beer	.05	X	10	=	0.5
Table Wine	.12	X	4	=	0.5
Fortified Wine	.20	X	2.5	=	0.5
Spirits					
80 proof	.40	X	1.25	=	0.5
100 proof	.50	X	1	=	0.5

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 table "Alcohol Consumption Norms for U.S. Adults" (in Appendix B, "Instructions for Preparing the Personal Feedback Report") provides an estimate of the client's standing among American adults of the same gender 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. You could explain this percentile figure by saying something like, "This means you drink more than

\_\_\_\_\_ percent of American [men/women] do, or that (X) percent 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 such as 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/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 (have a 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 want to compare this with the usual decimal expressions of BAC, move the decimal point three places to the left, as shown below:

80 mg%	=	.08	
100 mg%	=	.10	
256 mg%	=	.256	and so on

Note that the “normal social drinking” range is defined as from 20 to 60 mg% in peak intoxication (see Appendix D). 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%. Here, 700 mg% is used as a cutoff for estimates, even though it is possible to survive somewhat higher levels.

The behavioral effects as shown in “Understanding Your Personal Feedback Form” are 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 pretreatment assessment period. Below are four points to cover (in language appropriate for your client):

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 one to two 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 his hand is on a hot stove would be the smell of the smoke. Similarly, for tolerant drinkers, they do not feel the first signs of intoxication until they reach high BAC levels.

*Alcohol Dependence Level*—Although 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 a person's life. Below are four points to cover (in language appropriate for your client):

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. To make a diagnosis of alcohol dependence, the current standard is meeting at least three of these. You had \_\_\_ out of seven signs. [If appropriate, it is okay to review the symptoms, briefly described below:

- Tolerance
- Withdrawal (physiological dependence)
- Using (drinking) more or longer than intended
- Persistent desire or failed efforts to cut down or quit
- Much time spent in obtaining, using, and recovering from the drug
- Giving up important social, occupational, or recreational activities
- Continued use despite persistent problems.]

Your assessment report will contain the specific symptoms of dependence that are positive for your client.

## **Section 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 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 the Tobacco/Nicotine 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 percent of American adults use this drug as much as the client does.

These numbers may seem high to a client. Explain that this is because the vast majority of U.S. adults do not use these drugs at all. This fact is often surprising to clients whose social circle is composed primarily of users.

### **Section 3. Consequences**

For the client's recent negative consequences of drinking (as scored from the DrInC-2R), the client's raw scores for the total scale and for five specific subscales are printed in the boxes at the bottom (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 *people 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; it comes from Project MATCH.)

Explain that this shows the extent to which the client has experienced negative consequences (problems) related to his/her drug use compared with people who are being treated for such problems.

Below is some basic information to help you interpret the subscales. This information is also on the client's copy of the “Understanding Your Personal Feedback Report.”

- |                               |   |
|-------------------------------|---|
| <b>Physical (Ph)</b>          | 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.   |
| <b>Interpersonal (Re)</b>     | 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.                     |
| <b>Interpersonal (Pe)</b>     | 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 ability to have the kind of life that one wants.                                     |
| <b>Impulsive Actions (Im)</b> | 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. |

<b>Social Responsibility (Sr)</b>	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.
-----------------------------------	--

## Section 4. Desired Effects of Drinking

These are derived from the *Desired Effects of Drinking* questionnaire, which you administered in Session 1. 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 as follows:

<b>Assertion</b>	To feel more powerful or courageous, to express anger
<b>Drug Effects</b>	To get drunk, to get over a hangover, to sleep, to stop shakes or tremors
<b>Mental</b>	To feel more creative or mentally alert; to think, work, or concentrate better
<b>Negative Feelings</b>	To feel less depressed, angry, ashamed, or fearful
<b>Positive Feelings</b>	To feel better about oneself, less guilty, disappointed, or angry with oneself
<b>Relief</b>	To relieve tension, forget problems, avoid painful memories
<b>Self-Esteem</b>	To feel better about oneself, less guilty, disappointed, or angry with oneself
<b>Sexual Enhancement</b>	To feel more romantic and sexually excited, to enjoy sex more, to be a better lover
<b>Social Facilitation</b>	To be sociable and comfortable in social situations, to meet and enjoy people

## Section 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 client's self-reported level of readiness for change is a summary index scored from the URICA by adding together the contemplation, preparation, and action items, then subtracting the precontemplation items. The decile norms here are from Project MATCH, and they 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*—This measurement (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) in ability 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.

## **Section 6. Mood States**

This section reflects your client's mood state during the week before pretreatment evaluation. These mood states fluctuate widely; therefore, 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.

## **Section 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. Members of the medical staff will review elevations with your client if they have not already done so. Advise clients who are concerned and want more information to discuss their results with medical staff members (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 aminotransferase, 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 the metabolism of food and energy, and it also filters and neutralizes poisons and impurities from the blood. (The analogy to an oil filter 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 the liver, blood, and the brain that is more specifically sensitive to alcohol's effects. If the client continues drinking, elevations of this enzyme predict later serious medical problems related to drinking, including injuries, illnesses, hospitalizations, and death. This enzyme is often elevated first, with AST and ALT rising into the abnormal range as the client continues heavy drinking. 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; rather, it is *mean corpuscular volume*, the average size of red blood cells. Heavy drinking causes blood cells to not 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. Although this enlargement does not indicate serious immediate consequences, 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 client 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** (PFR) 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 seven sections. They summarize information from interviews, questionnaires, and blood tests completed as part of your pretreatment evaluation.

### Section 1. Alcohol Use

#### Your Drinking

*Number of Standard Drinks per Week*—The first line in this section shows the average number of drinks per week that you reported consuming during the months before entering this program. Because different alcoholic beverages vary in their strength, we have converted your regular drinking pattern into standard “one drink” units. The list below shows different types of standard one-drink units:

10 ounces of beer	5 percent alcohol
4 ounces of table wine	12 percent alcohol
2.5 ounces of fortified wine (sherry, port, etc.)	20 percent alcohol
1.25 ounces of 80 proof liquor	40 percent alcohol
1 ounce of 100 proof liquor	50 percent 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.)

*Your Drinking Relative to American Adults*—To give you an idea of how this compares with the drinking of American adults in general, the second number 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 percent of Americans of your gender (or that 40 percent drink as much as you reported, or more).

**Level of Intoxication**

Your total number of drinks per week tells only part of the story. It is *not* healthy, for example, to have 10 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.

*Estimated BAC Level*—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 you 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 the following table of common effects of different levels of intoxication:

<b>BAC Level</b>	<b>Common Effect</b>
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 most 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 to 700 mg% 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 that has been written in the level-of-intoxication blank 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 to 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.

***Alcohol Tolerance Level***

The level of alcohol tolerance is based on your BAC peak. Tolerance refers to your 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.

### ***Alcohol Dependence Level***

Although many people think of dependence as having physical withdrawal from alcohol, alcohol dependence is actually much broader. In fact, a person can be alcohol dependent without experiencing withdrawal symptoms when he or she stops. Alcohol dependence is a pattern of a person's life becoming more centered on drinking. In essence, drinking (and recovering from its effects) gradually dominates more and more of a person'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. If a person decreases use of one drug, he or she may simply increase 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. If you use other drugs, then, it 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 written 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" in the Tobacco/Nicotine box, for example, would mean that 90 percent of Americans use less (or none) of this drug than you reported. Said another way, a "90" would mean that only 10 percent of Americans use as much of this drug as you reported.

## **Section 3. Consequences**

This section summarizes the 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 but would be a very high score for Americans in general.

Five specific scales show the level of problems you reported in five areas, described below:

- |                           |   |
|---------------------------|---|
| <b>Physical (Ph)</b>      | 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.   |
| <b>Interpersonal (Re)</b> | 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. |

<b>Interpersonal (Pe)</b>	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 ability to have the kind of life that one wants.
<b>Impulsive Actions (Im)</b>	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.
<b>Social Responsibility (Sr)</b>	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.

The last score in this table shows the total level of negative consequences of drinking that you reported for the months immediately preceding the time you entered 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. The nine groups of reasons are described below:

<b>Assertion</b>	To feel more powerful or courageous, to express anger
<b>Drug Effects</b>	To get drunk, to get over a hangover, to sleep, to stop shakes or tremors
<b>Mental</b>	To feel more creative or mentally alert; to think, work, or concentrate better
<b>Negative Feelings</b>	To feel less depressed, angry, ashamed, or fearful
<b>Positive Feelings</b>	To change mood or feel good, to relax or celebrate
<b>Relief</b>	To relieve tension, forget problems, avoid painful memories
<b>Self-Esteem</b>	To feel better about oneself, less guilty, disappointed, or angry with oneself
<b>Sexual Enhancement</b>	To feel more romantic and sexually excited, to enjoy sex more, to be a better lover
<b>Social Facilitation</b>	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 factors that can help (or stand in the way of) your changing. Scores toward the *top* of these four columns show things that should make it easier for you to change. Scores toward the *bottom* of these four columns 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 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 or getting ready for, and have already started 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 you think you could do it. A low score reflects some doubt about your ability to quit.

**Temptation.** 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. Therefore, they may or may not reflect how you are feeling now. There are six mood groups shown here: (1) tension and anxiety, (2) sadness and depression, (3) anger and frustration, (4) vigor, (5) fatigue, and (6) confusion. Your scores here are compared with those of 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 a person 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 (such as 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 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 such as 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 PFR 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:***

AA General Service Office  
475 Riverside Drive  
New York, NY 10015  
(212) 870-3400  
Fax: (212) 870-3003  
<http://www.alcoholics-anonymous.org>

*Al-Anon:* For relatives and friends of alcoholics  
(800) 344-2666  
<http://www.al-anon-alateen.org>

*Al-Ateen:* For younger relatives and friends of alcoholics  
(800) 344-2666  
<http://www.al-anon-alateen.org>

*Families Anonymous:* Follows 12-step model, for friends and relatives of children with drug and alcohol problems  
(800) 736-9805

***National Clearinghouse for Alcohol and Drug Information:***

(301) 468-2600  
<http://www.health.org>

***National Council on Alcoholism Information Line:***

(1-800) NCA-CALL (622-2255)

***Moderation Management:***

<http://www.moderation.org>

***Secular Organizations for Sobriety:***

SOS National Clearinghouse, the Center for Inquiry–West  
5521 Grosvenor Blvd.  
Los Angeles, CA 90066  
(310) 821-8430  
Fax: (310) 821-2610  
<http://www.secularhumanism.org/sos>



SMART Recovery:

24000 Mercantile Road, Suite 11  
Beachwood, OH 44122  
(216) 292-0220  
Fax: (216) 831-3776  
E-mail: [srmail1@aol.com](mailto:srmail1@aol.com)  
<http://www.smartrecovery.org>

Women for Sobriety:

(800) 333-1606  
AOL chat room: WOMEN4SOBRIETY CHAT  
<http://www.womenforsobriety.org>

## Appendix F

# FORMS USED IN THE COMBINED BEHAVIORAL INTERVENTION (CBI)

	Form	Manual Parts To Be Used With	By/For
A	Session Record Form	Every Session	CBI Therapist
B	COMBINE MM Treatment Coordination Checklist	Every Session	MM Clinicians
C	Support for Sobriety	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	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-Temptation (AASE-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	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	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	5.2b.4	Client
bb	Urge Monitoring Card	5.3c	Client
cc	Identifying Social Pressure Situations and 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 Sheet	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
nn	Important People Initial Interview	2.6b.2	CBI Therapist
oo	Working Alliance Inventory for CBI	2.8g	Client

# COMBINE

## CBI Session Record Form (CBI ver. C/revised)

Center		Participant #		Participant Initials	

Staff ID	F-up Wk #	Seq #	Session #	Session Code (if not regular session)	Session Date mo/day/yr	Time Began HH:MM	Time Ended HH:MM	Total Minutes	SSO Present?		Phase	Modules & Pullouts Covered	Comments	Reason for Termination	<input type="checkbox"/> if entered in DMS
									Yes	No					
					/ /				<input type="checkbox"/>	<input type="checkbox"/>					
					/ /				<input type="checkbox"/>	<input type="checkbox"/>					
					/ /				<input type="checkbox"/>	<input type="checkbox"/>					
					/ /				<input type="checkbox"/>	<input type="checkbox"/>					
					/ /				<input type="checkbox"/>	<input type="checkbox"/>					
					/ /				<input type="checkbox"/>	<input type="checkbox"/>					

**Follow-up Week #: 0-16** (It is possible to have more than one session in any given week #. The week # would remain the same but the **sequence #** would change (i.e., week 1, sequence 01; week 1, sequence 02, etc.)

**Session #: 1-20**

**Session Code:** 1=BA (BAC>.05, session rescheduled) 2=CA (participant cancelled session (4+ hours of notice)) 3=NS (no show) 4=TH (therapist cancellation) 5=TC (telephone consult with client) 6=UC (unscheduled in-person contact) 7=OS (only SSO) 8=TS (telephone consultation with significant other only) 9=RE (rescheduled visit)

**Phase:** 1=Phase 1 (Building motivation for change) 2=Phase 2 (Developing a change plan) 3=Phase 3 (Implementing selected coping skills modules) 4=Phase 4 (Monitoring goal attainment and maintenance)

**Modules covered:** Phase 1 MOTI (motivational interviewing), METF (motivational enhancement feedback), COIN (concerned other involvement), TRAN (transition from phase 1 to phase 2) Phase 2 FUNC (functional analysis), ANPF (analysis of psychosocial functioning), CPWS (change plan work sheet), ABEM (abstinence emphasis), MHGI (mutual-help group introduction), TRPL (treatment plan) Phase 3 ASSN (assertion skills training), COMM (communication skill training), CRAV (coping with craving and urges), DREF (drink refusal and social pressure skill training), JOBF (job finding training), MOOD (mood management training), MUTU (mutual support group facilitation), SARC (social and recreational counseling), SSSO (social support for sobriety) Phase 4 REV (review of goals and progress), SUM (concluding session), Pull-out procedures SOBR (sobriety sampling), CONC (raising concern), CASM (case management), RESU (resumed drinking), SOMA (support for medication adherence), MISS (missed appointments), TELE (telephone consultation), CRIS (crisis intervention), DISS (disappointed to be CBI only)

**Reason for termination:** 1=mutual agreement 2=20<sup>th</sup> session 3=16-week limit 4=client stopped attending unilaterally 5=PI/MD initiated withdrawal from treatment

**Form B: COMBINE MM Treatment Coordination Checklist**

# 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 client 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:

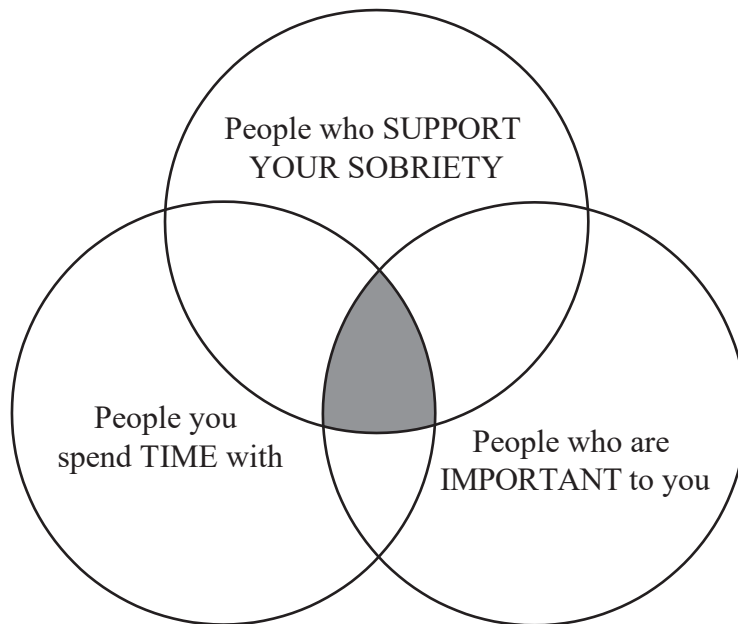
CBI Therapist signature: \_\_\_\_\_

**Return form promptly to your Project Coordinator**

## **Support for Sobriety**

Please choose someone whose support you would like to have during treatment. The ideal person would have the following characteristics:

- Someone who is important to you
- Someone whom you see and spend time with regularly
- Someone who cares about you and understands and listens to you
- Someone who has been helpful to you in the past
- Someone who would help support your sobriety
- Someone who would be willing to come with you to sessions.



# Sample Permission Form

## PROJECT COMBINE GETTING SUPPORT IN TREATMENT

In this program, we ask each client to bring along a special person to each treatment session so that he or she can understand and offer you support during treatment. 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 knows you well, cares about you, has been helpful to you in the past, and would be willing and able to give you support to become free of alcohol during the months of treatment. This person would not need to come to every session, although that would be helpful if possible.

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: \_\_\_\_\_

# Hours of Drinking Form

Client's body weight: \_\_\_\_\_ pounds

<b>Date of Most Drinking (from Form 90-AIR)</b>	<b>Total Alcohol Consumed (from Form 90-AIR)</b>	<b># of Standard Drinks</b>	<b>Hours of Drinking</b>	<b>BAC (BACCuS)</b>

Note: This form is now incorporated into Form 90-AIR.

**Form F: Client Services Request Form**

## Client Services Request Form

**Client #:** \_\_\_\_\_

**Therapist:**

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
16.	Any other areas in which you need assistance? (If so, please write them below)	Yes	Maybe	No
17.		Yes	Maybe	No
18.		Yes	Maybe	No



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 3 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

Source: Tracy L. Simpson, Ph.D.; Judith A. Arroyo, Ph.D.; William R. Miller, Ph.D.; and Laura M. Little, Ph.D.

**Form H: What I Want From Treatment**

Client # : \_\_\_\_\_

Therapist: \_\_\_\_\_

## What I Want From Treatment

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.

	<b>Is this something that you would like from treatment? (Circle YES or NO for each item below)</b>	<b>YES</b>	<b>NO</b>
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 such as 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
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 healthier 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

Source: William R. Miller and 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

Client # : \_\_\_\_\_

Therapist: \_\_\_\_\_

## Decisional Balance Worksheet

<b>Cons (Reasons Not to Change)</b>	<b>Pros (Reasons to Change)</b>
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

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Alcohol Abstinence Self-Efficacy–Temptation (AASE-T)

Listed below are several situations that lead some people to drink. How tempted would 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

Source: Carlo C. DiClemente, Department of Psychology, University of Maryland Baltimore County.

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## New Roads Worksheet

Triggers		Effects

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Personal Happiness Form

How happy or satisfied are you with each of these areas of your life? (Circle only one number for each item)												Link	Change
Life Areas	Completely dissatisfied		Somewhat dissatisfied		Somewhat satisfied		Mostly satisfied		Completely satisfied		Doesn't apply	✓	✓
	1	2	3	4	5	6	7	8	9	10	NA		
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		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			

## Personal Happiness Card Sort

(Copy onto card stock and cut into cards)

<p><b>Personal Happiness Card Sort</b></p>	<p><b>Friends and Social Life</b> 1 PH-01</p>	<p><b>Job/Work</b> 2 PH-02</p>
<p><b>Where I Live</b> 3 PH-03</p>	<p><b>Money and Financial Security</b> 4 PH-04</p>	<p><b>Education and Learning</b> 5 PH-05</p>
<p><b>Leisure Time and Fun</b> 6 PH-06</p>	<p><b>Mood and Self-Esteem</b> 7 PH-07</p>	<p><b>Anger and Arguments</b> 8 PH-08</p>
<p><b>Stress and Anxiety</b> 9 PH-09</p>	<p><b>Physical Health</b> 10 PH-10</p>	<p><b>Spirituality</b> 11 PH-11</p>

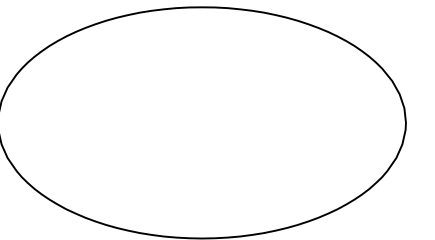
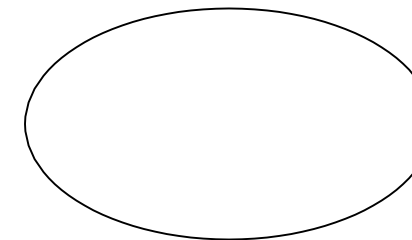
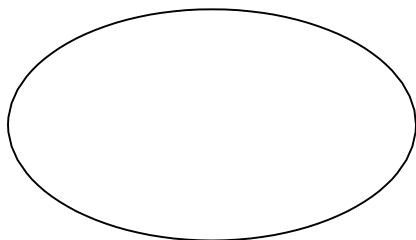
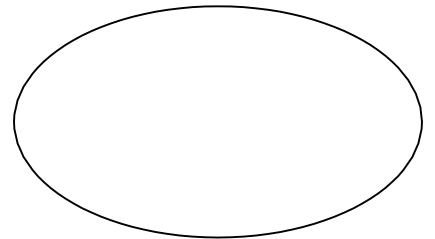
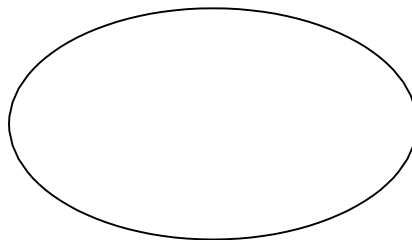
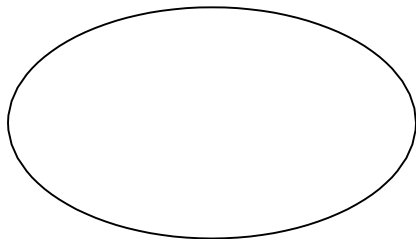
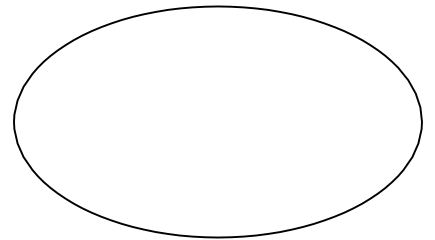
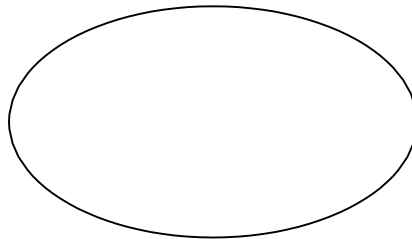
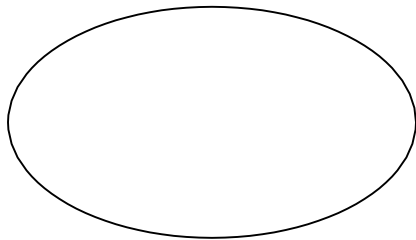
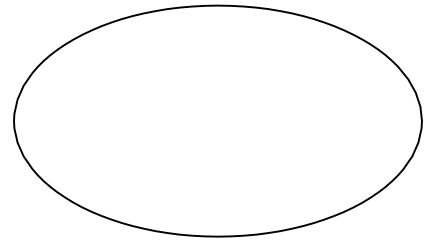
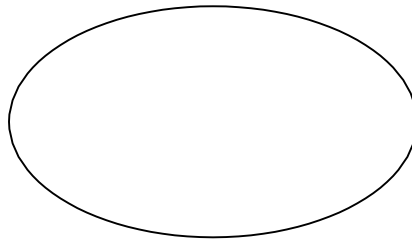
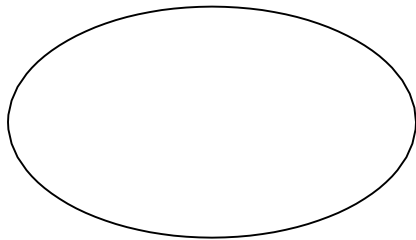


<p style="text-align: center;"><b>Love and Affection</b></p> <p style="text-align: center;">12</p> <p style="text-align: right;">PH-12</p>	<p style="text-align: center;"><b>Family Relationships</b></p> <p style="text-align: center;">13</p> <p style="text-align: right;">PH-13</p>	<p style="text-align: center;"><b>Relationship with Spouse/Partner</b></p> <p style="text-align: center;">14</p> <p style="text-align: right;">PH-14</p>
<p style="text-align: center;"><b>Sexuality</b></p> <p style="text-align: center;">15</p> <p style="text-align: right;">PH-15</p>	<p style="text-align: center;"><b>Eating and Weight</b></p> <p style="text-align: center;">16</p> <p style="text-align: right;">PH-16</p>	<p style="text-align: center;"><b>Physical Activity and Exercise</b></p> <p style="text-align: center;">17</p> <p style="text-align: right;">PH-17</p>
<p style="text-align: center;"><b>Giving/Caring for Others</b></p> <p style="text-align: center;">18</p> <p style="text-align: right;">PH-18</p>	<p style="text-align: center;"><b>Mental Ability and Memory</b></p> <p style="text-align: center;">19</p> <p style="text-align: right;">PH-19</p>	<p style="text-align: center;"><b>Personal Safety and Security</b></p> <p style="text-align: center;">20</p> <p style="text-align: right;">PH-20</p>
<p style="text-align: center;"><b>YES</b></p>	<p style="text-align: center;"><b>NO</b></p>	

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Options Sheet



## **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

*Source:* Shelby Steen 1999, University of New Mexico.

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## 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: \_\_\_\_\_

## 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 S: Case Management Goal Sheet

Client ID#: \_\_\_\_\_

Goal #: \_\_\_\_\_  
*(from Treatment Plan)*

## Case Management Goal Sheet

Broader goal:		Specific objectives:		
Specific task to be completed	By (person)	Goal date	Notes	Completed (date)

# Resource Sheet

Prepare small sheets like this for giving case management referral contacts to clients. Print them on a colored paper for emphasis. An example of a completed sheet is shown below.

Resource Sheet	
<b>Contact:</b>	
<b>At:</b>	
<b>Address:</b>	
<b>Telephone:</b>	
<b>Ask for:</b>	
<b>To be completed by:</b>	

*Example:*

Resource Sheet	
<b>Contact:</b>	Ima Helper
<b>At:</b>	University Dental Clinic
<b>Address:</b>	1234 University Avenue
<b>Telephone:</b>	456-7890
<b>Ask for:</b>	an appointment to have your teeth cleaned and examined
<b>To be completed by:</b>	Monday, March 3

## 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?
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?





# **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 in which you drank.
3. Each day is a new day. Even though it can be unsettling to have had one drink (or several), 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!

**Form W: Examples of Situations Where Assertive Communication Is Needed**

## **Examples of Situations Where Assertive Communication Is Needed**

1. 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).
2. When expressing anger or criticism, especially to people who are important to you.
3. When receiving criticism from someone, especially from people who are important to you (as in explaining yourself, taking responsibility for your actions, apologizing to someone or making amends).
4. When expressing positive feelings or complimenting someone.
5. When accepting a compliment or receiving positive feedback from someone.
6. When refusing a direct request from someone.
7. When making a request or asking for help, a favor, or support from someone.
8. When expressing an opinion.
9. When ...
10. When ...
11. When ...

## 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, and so on.

### 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. 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 Y: Tips on Assertive Communication in Conflict Situations

## Tips on Assertive Communication in Conflict Situations

### Three Parts of an Assertive Message

1. Describe the behavior.
2. Describe your own feelings or reactions.
3. Describe what you want to happen.

### When Receiving Criticism

1. Keep cool; avoid escalation.
2. Listen carefully; show that you understand the other perspective.
3. Correct any misunderstandings.
4. Take partial responsibility and apologize when appropriate.

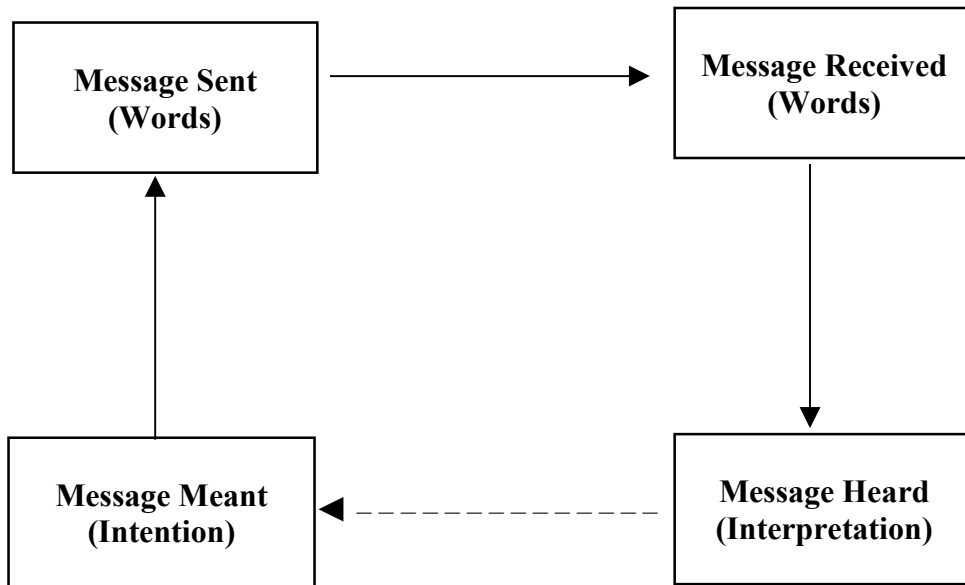
### When Giving Negative Feedback (Constructive Criticism)

1. Keep calm; don't speak in anger or hostility.
2. Choose the right time and place.
3. Be specific; describe behavior and don't blame.
4. Check out misunderstandings.
5. Use "I" language.
6. Take partial responsibility or offer to help, as appropriate.

### When Asking for Change

1. Describe what the person is doing—the specific behavior that you would like to change.
2. Describe your own feelings or reactions using an "I" message.
3. Describe what you want to happen.
4. Take partial responsibility or offer to help, as appropriate.

## How Communication Happens



# Reflection Sheet

I practiced listening with (person): \_\_\_\_\_

On (date and time): \_\_\_\_\_

The other person knew that I was practicing my listening skills:       Yes       No

Here's how I think I did as a listener:

	<b>Not Well</b>		<b>OK</b>	<b>Really Well</b>	
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 cc: Identifying Social Pressure Situations and Coping Responses

## Identifying Social Pressure Situations and Coping Responses

<b>Client ID:</b>	<b>Date:</b>
<b>Situation (Person, Place, etc.)</b>	<b>Coping Strategies</b>

**Form dd: A Checklist of Social Pressure Situations**

**Client #:** \_\_\_\_\_

**Therapist:** \_\_\_\_\_

## Checklist of Social Pressure Situations

**To what extent do you expect that these situations could pose a problem for you in staying sober?**

	U No Problem	U Some Problem	U 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.	_____	_____	_____

## Job Leads Log

**Job Title or Type:**

**Source of Job Lead:**

**Name of Company:**

**Address:**

**Telephone:**

**Hiring Contact:**

**Call Date(s):**

**Notes:**

## 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

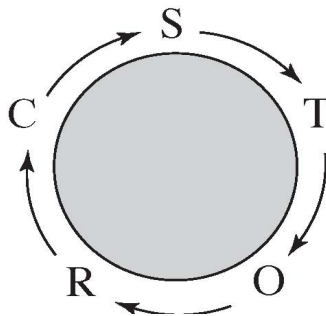
What is happening inside your body is also an important part of the moods or emotions that you experience. Many emotional experiences involve a particular kind of physical arousal that can be experienced as being agitated, angry, upset, afraid, and so on. Which particular emotion you feel depends in part on how you *interpret* or name what is going on inside your body.

### R Your Response or Reaction

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.



## Feelings From A to Z

Afraid	Free	Resentful
Agitated	Frenetic	Reserved
Alive	Funny	Sad
Angry	Giddy	Safe
Annoyed	Guilty	Satisfied
Anxious	Happy	Scared
Awful	Hurt	Shy
Awkward	Impish	Silly
Bashful	Irritated	Sympathetic
Betrayed	Joyful	Terrible
Bored	Jumpy	Terrific
Carefree	Kaput	Tired
Confused	Kind	Trusting
Cozy	Lonely	Uneasy
Cranky	Loving	Upset
Crazy	Mad	Vicious
Crushed	Mean	Violated
Depressed	Naughty	Vivacious
Distressed	Open	Wild
Down	Overjoyed	Wonderful
Elated	Passionate	Yucky
Embarrassed	Peaceful	Zany
Empty	Relaxed	Zonked
Excited	Relieved	

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Mood Self-Monitoring Sheet

Mood Level: rating: _____ -10 .....0.....+10 Very Negative      Neutral      Very Positive	Mood Level: rating: _____ -10 .....0.....+10 Very Negative      Neutral      Very Positive	Mood Level: rating: _____ -10 .....0.....+10 Very Negative      Neutral      Very Positive
<b>S</b> Situation:	<b>S</b> Situation:	<b>S</b> Situation:
<b>T</b> Thoughts:	<b>T</b> Thoughts:	<b>T</b> Thoughts:
<b>O</b> Feelings:	<b>O</b> Feelings:	<b>O</b> Feelings:
<b>R</b> What I did:	<b>R</b> What I did:	<b>R</b> What I did:
<b>C</b> What happened:	<b>C</b> What happened:	<b>C</b> What happened:

Form ii: Thought Replacement Worksheet

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Thought Replacement Worksheet

Toxic Thought	Resulting Feeling	Replacement Thought (Antidote)	Resulting Feeling

Form jj: Menu of Possibly Pleasurable Activities

## Menu of Possibly Pleasurable Activities

Below is a list of different ways in which people enjoy themselves. You might find some of these fun or enjoyable.

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 along 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 back rubs 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  
Research 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



## COMBINE: Combined Behavioral Intervention Manual

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Play a musical instrument (or learn to)  
Visit a wildlife 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  
Join a gym and workout  
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  
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

*Source:* Shelby Steen 1999.

# A Letter to People in Your Life

## 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" moodswings and problems such as isolation, difficulties sleeping, and anger at small events. In early months of abstinence, it is common for this person to experience such changes while readjusting to sober living.

**Be patient.** It can be tempting to say, "Just get over it!" If it were that simple, though, the person would have changed 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 you will be making a valuable contribution if you can focus on the person's needs, listen without judgment, and give the person time and space to change.

**You can help 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. Below is a list of ways you can help:

*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/she would find helpful.

*Never offer the person alcohol or other drugs of any kind.* Don't buy alcohol or other drugs for him/her or promote drinking or other 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/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 it is 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/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.

**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 his/her 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).

**The resources listed below are free.**

### ***Alcohol/Substance Abuse Resources***

*Al-Anon* (800-344-2666). For relatives and friends of alcoholics.

*Ala-teen* (800-344-2666). For younger relatives and friends of alcoholics.

*American Council for Drug Education* (800-488-DRUG [3784]).

*Cocaine Helpline* (800-COCAINE [262-2463]).

*Families Anonymous* (800-736-9805). 12-step program for friends and relatives of children with alcohol or other drug problems.

*National Council on Alcoholism Information Line* (800-NCA-CALL [622-2255]).

*National Clearinghouse for Alcohol and Drug Information* (800-729-6686).

*Center for Substance Abuse Treatment Clearinghouse* (800-662-HELP [4357]).

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## **Appendix F: Forms Used in the Combined Behavioral Intervention (CBI)**

*National Institute on Drug Abuse Info-Fax Service* (888-NIH-NIDA [644-6432]). Offers free, faxed information on treatment, substance abuse trends, statistics, and drug effects.

### ***AIDS***

*AIDS Hotline* (English: 800-235-2331); (Spanish: 800-637-3776).

### ***Parenting***

*Parents Anonymous* (800-421-0353).

### ***Mental Health***

*National Alliance for the Mentally Ill* (703-524-7600).

*National Mental Health Association* (703-684-7722).

*National Mental Health Consumers' Association* (215-735-2465).

*Source:* This letter is adapted from Lisa M. Najavits. *“Seeking Safety”*: *Cognitive-Behavioral Therapy for PTSD and Substance Abuse*. New York: Guilford Press, 2001. Copyright © by Guilford Publications, Inc. Used with permission of the publisher.

# 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%

## 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 plus asking to help.)

# Important People Initial Interview (IPI ver. A)

Center		Participant #		Participant Initials		Week		Sequence	
								0	1

	Date		Staff ID
mo.	day	yr.	

“Hi, my name is \_\_\_\_\_ and during the course of our interview, I am going to ask you some questions about the people that have been important to you and with whom you've had contact during the past four months. These people may be family members, friends, people from work, or anyone that you see as having had a significant impact on your life, regardless of whether or not you liked them. Should you have any questions during the interview please don't hesitate to ask. Now before we begin, do you have any questions?”

A) Name	B) Relationship	C) During the past 4 months on average, how frequently have you been in contact with ... ?	D) How important has this person been to you?	E) ...Generally supportive of you ... ?*
(first name and last initial)	Specify relationship and enter code # 1=Parent 2=Spouse 3=Significant other 4=Child 5=Sibling 6=Other relative 7=Friend 8=Coworker 9=AA member 0=Other	7=Daily (7 times a week) 6=Three to 6 times a week 5=Once or twice a week 4=Every other week 3>About once a month 2=Less than monthly 1=Once in past 4 months	6=Extremely important 5=Very important 4=Important 3=Somewhat important 2=Not very important 1=Not at all important	6=Extremely supportive 5=Very supportive 4=Supportive 3=Somewhat supportive 2=Not very supportive 1=Not at all supportive
1a)	1b) #:	1c)	1d)	1e)
2a)	2a) #:	2c)	2d)	2e)
3a)	3b) #:	3c)	3d)	3e)
4a)	4b) #:	4c)	4d)	4e)
5a)	5b) #:	5c)	5d)	5e)
6a)	6b) #:	6c)	6d)	6e)
7a)	7b) #:	7c)	7d)	7e)
8a)	8b) #:	8c)	8d)	8e)
9a)	9b) #:	9c)	9d)	9e)
10a)	10b) #:	10c)	10d)	10e)
#	#:			
#	#:			

\*“To what extent is this person generally supportive of you, by being sensitive to your personal needs, helping you to think about things, solve problems, and by giving you the moral support you need?”

# IMPORTANT PEOPLE Initial Interview (IPI ver. A) *(continued)*

Center		Participant #						Participant Initials			Week		Sequence	
													<b>0</b>	<b>1</b>

Date		Staff ID					
mo.		day		yr.			

First name from page 1	F) Drinking status	G) How often does this person drink alcohol?	H) How has this person reacted to your drinking? Or How would this person react to your drinking?	I) How has this person felt about your coming for treatment?
	5 = Heavy drinker 4 = Moderate drinker 3 = Light drinker 2 = Abstainer 1 = Recovering alcoholic 8 = Don't know	7 = Daily 6 = Three to 6 times a week 5 = Once or twice a week 4 = About every other week 3 = About once a month 2 = Less often than monthly 1 = Once in past 4 months 0 = Not in past 4 months 8 = Don't know	5 = Encouraged 4 = Accepted 3 = Neutral 2 = Didn't accept 1 = Left, or made you leave when you're drinking 8 = Don't know	6 = Strongly supports it 5 = Supports it 4 = Neutral 3 = Mixed 2 = Opposes it 1 = Strongly opposes it 8 = Don't know how they would feel about it
1)	1f)	1g)	1h)	1i)
2)	2f)	2g)	2h)	2i)
3)	3f)	3g)	3h)	3i)
4)	4f)	4g)	4h)	4i)
5)	5f)	5g)	5h)	5i)
6)	6f)	6g)	6h)	6i)
7)	7f)	7g)	7h)	7i)
8)	8f)	8g)	8h)	8i)
9)	9f)	9g)	9h)	9i)
10)	10f)	10g)	10h)	10i)





## Working Alliance Inventory for CBI (WAC ver. A) *(continued)*

Center		Participant #						Participant Initials			Week		Sequence	
													<b>0</b>	<b>1</b>

Date		Staff ID			
mo.		day		yr.	

3. I believe \_\_\_\_\_ likes me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

4. I believe \_\_\_\_\_ is genuinely concerned for my welfare.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

5. \_\_\_\_\_ and I respect each other

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

6. I feel that \_\_\_\_\_ is totally honest about his/her feelings toward me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

7. I am confident in \_\_\_\_\_'s ability to help me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

8. I feel that \_\_\_\_\_ appreciates me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

9. \_\_\_\_\_ and I trust one another.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

# Working Alliance Inventory for CBI (WAC ver A) (continued)

Center		Participant #						Participant Initials			Week		Sequence	
												0	1	

Date		Date				Staff ID		
mo.	day	yr.						

10. My relationship with \_\_\_\_\_ is very important to me.

- |            |             |                   |                |            |                 |             |
|------------|-------------|-------------------|----------------|------------|-----------------|-------------|
| 1<br>Never | 2<br>Rarely | 3<br>Occasionally | 4<br>Sometimes | 5<br>Often | 6<br>Very Often | 7<br>Always |
|------------|-------------|-------------------|----------------|------------|-----------------|-------------|

11. I have the feeling that if I say or do the wrong things, \_\_\_\_\_ will stop working with me.

- |            |             |                   |                |            |                 |             |
|------------|-------------|-------------------|----------------|------------|-----------------|-------------|
| 1<br>Never | 2<br>Rarely | 3<br>Occasionally | 4<br>Sometimes | 5<br>Often | 6<br>Very Often | 7<br>Always |
|------------|-------------|-------------------|----------------|------------|-----------------|-------------|

12. I feel \_\_\_\_\_ cares about me even when I do things that he/she does not approve of.

- |            |             |                   |                |            |                 |             |
|------------|-------------|-------------------|----------------|------------|-----------------|-------------|
| 1<br>Never | 2<br>Rarely | 3<br>Occasionally | 4<br>Sometimes | 5<br>Often | 6<br>Very Often | 7<br>Always |
|------------|-------------|-------------------|----------------|------------|-----------------|-------------|

## 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	2.7
P1	Sobriety Sampling	4.1
P2	Raising Concerns	4.2
P3	Case Management	4.3
P4	Resumed Drinking	4.4
P5	Support for 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 Craving 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-Support Group Facilitation	5.7
3h	Social and Recreational Counseling	5.8
3i	Social Support for Sobriety	5.9
4a	Maintenance	6.0
4b	Termination	7.0

**Client #:** \_\_\_\_\_

**Therapist:** \_\_\_\_\_

## Therapist Checklist: Session 1

	Materials Needed: Alcohol breath tester <b>Support for Sobriety</b> card (Form C) Permission form to contact SSO <b>What I Want From Treatment</b> form (Form H, blank) <b>Client Services Request Form</b> (Form F, blank) <b>Desired Effects of Drinking</b> questionnaire (Form G, blank)	Completed <b>IPi</b> form (Form nn) <b>Supportive People</b> form (Form ll)
	Administer alcohol breath test. Turn on tape recorder.	
	<b>Beginning Phase 1</b>	
	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 [SMS]). 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.	
	<b>Engaging an SSO in Treatment</b>	
	Initiate discussion of inviting SSO into treatment (use <b>Support for Sobriety</b> card, Form C). 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.	
	<b>Completing Assessment</b>	
	Have client complete three questionnaires. Scan questionnaires for any items not completed.	
	<b>Wrapping Up</b>	
	Offer a structuring statement for the next steps in treatment. Schedule next session (preferably within a few days).	
	<b>After Session 1</b>	
	Write and send handwritten note to client (include photocopy in client file). Fill in <b>Session Record Form</b> and write client contact note.	

Therapist Form 1b: Phase 1 Completion

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Therapist Checklist: Phase 1 Completion

	<p>Materials Needed:</p> <ul style="list-style-type: none"> <li>Alcohol breath tester</li> <li>Client's completed PFR packet including <b>Understanding Your PFR</b> information</li> <li><b>Personal Rulers Worksheet</b> (Form I, blank)</li> <li><b>Decisional Balance Worksheet</b> (Form J, blank)</li> <li>Letter to SSO</li> <li><b>Working Alliance Inventory</b></li> </ul>
	<b>Getting Started</b>
	<ul style="list-style-type: none"> <li>Administer alcohol breath test.</li> <li>Turn on tape recorder.</li> <li>Status check: Ask client open question and follow by reflective listening.</li> <li>Offer structuring statement (review of last session and direction of this session).</li> </ul>
	<b>Providing Assessment Feedback (PFR)</b>
	<ul style="list-style-type: none"> <li>Provide transition and structuring statement to introduce assessment feedback.</li> <li>Provide PFR to the client.</li> <li>Review PFR with client.</li> <li>Elicit and attend to client reactions to feedback.</li> <li>Respond to client's concerns and statements with reflection.</li> <li>Give the client the PFR copy and <b>Understanding Your Personal Feedback Report</b>.</li> <li>Offer transitional summary, incorporating SMS and feedback information.</li> <li>Ask a key question and respond with reflection.</li> </ul>
	<b>Closing Phase 1</b>
	Provide transitional summary and ask key question. Reflect.
	<b>Assessing Motivation</b>
	Obtain three motivation ratings using the <b>Personal Rulers Worksheet</b> (Form I) (if any rating is less than 6, explore using optional module 2.8d; otherwise, begin Phase 2).
<b>Optional</b>	<b>Exploring Motivation Ratings</b>
	<ul style="list-style-type: none"> <li>Discuss <b>Personal Ruler</b> scores ("Why x and not 0? What would it take for you to go from x to higher score?") and reflect.</li> <li>End with a summary reflection.</li> </ul>

<b>Optional</b>	<b>Constructing a Decisional Balance</b>
	<p>Introduce <b>Decisional Balance Worksheet</b> (Form J) 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.</p>
<b>Optional</b>	<b>Reviewing Past Successes</b>
	<p>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.</p>
	<b>After Session</b>
	<p>Give client the <b>Working Alliance Inventory</b> if Phase I extends to Session 3.                  Fill in <b>Session Record Form</b> and local site client contact note.</p>

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Therapist Checklist: Phase 2

	<p>Materials Needed</p> <ul style="list-style-type: none"> <li>Alcohol breath tester</li> <li>Client's completed <b>What I Want From Treatment</b> form (Form H)</li> <li><b>Personal Happiness Card Sort</b> (Form N) (deck arranged in order)</li> <li>Client's completed <b>Client Services Request Form</b> (Form F)</li> <li>Client's completed <b>Desired Effects of Drinking</b> form (Form G)</li> <li>Copy of Client's completed <b>AASE-T</b> form (Form K)</li> <li>Mutual-help group contact and schedule information (local)</li> </ul>	<ul style="list-style-type: none"> <li><b>New Roads Worksheet</b> (Form L, blank)</li> <li><b>Personal Happiness Form</b> (Form M, blank)</li> <li><b>Options Sheet</b> (Form O, blank)</li> <li><b>Characteristics of Successful Changers</b> (Form P)</li> <li><b>Treatment Plan</b> (Form Q)</li> <li><b>Working Alliance Inventory</b></li> </ul>
	<p>Administer alcohol breath test. Turn on tape recorder.</p>	
	<p><b>Beginning Phase 2</b></p>	
	<p>Introduce Phase 2 with a structuring statement and open question. Explore client's <i>own</i> ideas about what and how to change. Respond with reflection.</p>	
	<p><b>Functional Analysis</b></p>	
	<p>Provide introductory structuring statement. Ask for triggers and record on <b>New Roads Worksheet</b> (Form L) (use past tense). Review <b>AASE-T</b> items (Form K): record any additional triggers. Ask for past effects (positive consequences) and record on <b>New Roads Worksheet</b>. Review DED for additional consequences: record any additional effects. Review <b>New Roads Worksheet</b> 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 <b>Options Sheet</b>.</p>	
	<p><b>Reviewing Psychosocial Functioning</b></p>	
	<p>Present and have client complete <b>Personal Happiness Form</b> (PHF) (Form M). Have client complete <b>Personal Happiness Card Sort</b> (Form N)—which are at least partly related to drinking? Check off in "Link" column of PHF. Have client resort 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 <b>Options Sheet</b> (Form O).</p>	



	<b>Identifying Strengths and Resources</b>
	Provide transitional structuring statement. Identify personal strengths. Ask for elaboration. "What else?" <i>Characteristics</i> list? Offer summary reflections. Identify additional sources of support.
	<b>Developing a Plan for Treatment and Change</b>
	Provide structuring statement. Introduce <b>Options Sheet</b> (Form O) and review options already recorded. Review any additional YES areas from " <i>What I Want</i> " as possible <i>Options</i> . Recommend use of mutual-help programs and encourage client to sample. If client shows openness to programs, add to bubble on <i>Options</i> sheet. Prioritize options with client. Offer structuring statement: developing a treatment plan together. Develop <b>Treatment Plan</b> (Form Q) 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. State concerns as needed.
	<b>Consolidating Commitment</b>
	Recapitulation: summarizing SMS and change plan. Ask for client's commitment to the plan. Affirm. Client and therapist sign and date completed <b>Treatment Plan</b> .
<b>Optional</b>	<b>SOBR—Sobriety Sampling</b>
<b>Optional</b>	<b>CONC—Raising Concerns</b>
<b>Optional</b>	<b>CASM—Case Management (including referral)</b>
<b>Optional</b>	<b>RESU—Resumed Drinking</b>
<b>Optional</b>	<b>SOMA—Support for Medication Adherence</b>
<b>Optional</b>	<b>MISS—Missed Appointments</b>
<b>Optional</b>	<b>TELE—Telephone Consultation</b>
<b>Optional</b>	<b>CRIS—Crisis Intervention</b>
<b>Optional</b>	<b>DISS—Disappointed to Receive CBI-Only Condition</b>
	<b>After Session</b>
	Give client the <b>Working Alliance Inventory</b> at end of Session 3, if not completed in Phase I. Fill in <b>Session Record Form</b> and local site client contact note.

Therapist Form S: When an SSO Attends for the First Time

Use this checklist whenever an SSO attends a session for the first time.

Client #: \_\_\_\_\_ Therapist: \_\_\_\_\_

## Therapist Checklist: When an SSO Attends for the First Time

<b>Date:</b>	<b>SSO's name:</b>
	<b>When SSO is present for the first time</b>
	<p>Welcome and thank the SSO for participating.</p> <p>Introduce audiotape and have the SSO sign consent to be part of treatment sessions and to be audiotaped.</p> <p>Explore how the SSO has tried to be supportive in the past.</p> <p>Reflect.</p> <p>Clarify the SSO's role and ask whether the SSO is willing to help in this way.</p> <p>Ask whether the client is willing to have the SSO help in this way.</p> <p>Ask whether the SSO has any questions that you could answer.</p> <p>Ask whether the client has any questions or concerns about the SSO's participation.</p>

**Client #:** \_\_\_\_\_

**Therapist:** \_\_\_\_\_

## Therapist Checklist: Sobriety Sampling

	<p>Materials Needed:                  May want to review client's responses to completed <i>Treatment Plan</i> (Form Q) and <i>New Roads Worksheet</i> (Form L)</p>
	<b>Assessing Motivation for a Period of Sobriety</b>
	<p>Elicit SMS (e.g., ask open-ended questions about benefits to abstaining).                  Reflect SMS.                  Summarize with emphasis on reasons that client has stated for a trial period of sobriety.</p>
	<b>Probe Willingness</b>
	<p>Ask whether client is willing to consider possibility of abstinence.                  Respond with reflection.</p>
	<b>Discuss Implementation</b>
	<p>How long? (Begin by suggesting 1 month).                  Starting when?                  How to do it?                  Discuss obstacles and problems, and problem-solve (fire escape, avoiding).</p>
	<b>Reluctant Clients</b>
	<p>Delay decisions.                  Emphasize personal choice.</p>

Therapist Form P2: Raising Concerns

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Therapist Checklist: Raising Concerns

	Basic Procedure
	<p><i>Reflect</i> the goal, plan, or intention about which you are concerned.</p> <p><i>Ask</i> permission to express your concern.</p> <p><i>State</i> your concern.</p> <p><i>Ask</i> client to respond to concern.</p>

**Client #:** \_\_\_\_\_

**Therapist:** \_\_\_\_\_

## **Therapist Checklist: Case Management**

	Materials Needed: Completed <b><i>Client Services Request Form</i></b> (Form F) Access to resource listing of potential referral sources <b><i>Case Management Goal Sheet</i></b> (Form S) and <b><i>Resource Sheet</i></b> (Form T)
	<b>Beginning the Case Management Process</b>
	After introducing the module, implement steps summarized in acronym ARISE.
	<b>Prioritizing</b>
	Fill in <b><i>Case Management Goal Sheet</i></b> (Form S).
	<b>Making a Referral</b>
	Follow up on client's progress (Form T).

Therapist Form P4: Resumed Drinking

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Therapist Checklist: Resumed Drinking

	<p>Materials Needed:</p> <p>May want to use <b>Decisional Balance Worksheet</b> (Form J), <b>Understanding Resumed Drinking</b> (Form U) and <b>Recovering from an Episode of Drinking</b> (Form V)</p>
	<p><b>Assessing Motivation</b></p>
	<p>Employ Phase 1 strategies for assessing motivation.</p> <p>May revisit Emphasizing Abstinence, <b>Decisional Balance Worksheet</b> (Form J), or Reviewing Past Successes</p> <p>Summary reflection, key question, setting new goals.</p>
	<p><b>When Drinking Is Resumed as a Result of Situational Risks and Coping Issues</b></p>
	<p>Elicit responses to <b>Understanding Resumed Drinking</b> (Form U).</p>
	<p><b>Recovering from an Episode of Drinking</b></p>
	<p>Use <b>Recovering From an Episode of Drinking</b> with eight practical tips (Form V).</p>

**Client #:** \_\_\_\_\_

**Therapist:** \_\_\_\_\_

## **Therapist Checklist: Support for Medication Adherence**

	<b>Assessing Motivation</b>
	Identify sources of nonadherence. Explore past medication adherence.
	<b>Elicit Self-Motivational Statement for Adherence</b>
	Use Phase 1 strategies to increase motivation for adherence.
	<b>Delaying the Decision</b>
	Review pros and cons of nonadherence. Elicit backup plan (which may include adherence). Ask permission to delay decision.
	<b>Overcoming Practical Obstacles to Nonadherence</b>

Therapist Form P8: Crisis Intervention

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Therapist Checklist: Crisis Intervention

	Counseling Procedures
	<p>Listen.</p> <p>Assess urgency.</p> <p>Focus on problem-solving.</p> <p>Mobilize support.</p> <p>Follow up.</p>



Therapist Form P9: Disappointed to Receive CBI-Only Condition

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Therapist Checklist: Disappointed to Receive CBI-Only Condition

	<b>Level I: Listening Empathically</b>
	<p><i>Listen</i> empathically.</p> <p>Convey an understanding and acceptance of the client's disappointment through reflective responses.</p>
	<b>Level II: Provide Reassurance</b>
	<p><i>Inform</i> the client that previous research has indicated that CBI is effective even without medication.</p> <p><i>Inform</i> the client that CBI was constructed from the treatment methods with the strongest evidence of efficacy.</p>
	<b>Level III: Pros and Cons</b>
	<p><i>Ask</i> the client if he/she would be willing to consider listing the pros and cons of continuing with CBI.</p> <p><i>Beginning with the negatives</i>, write down a list of the costs and benefits that the two of you generate about pursuing CBI.</p> <p><i>Prompt</i> the client, as appropriate, to consider some that might have been overlooked.</p> <p><i>Offer</i> a summary reflection when you have completed the list that describes both sides.</p> <p><i>Ask</i> what the client wants to do at this point.</p>
	<b>Level IV: Emphasize Personal Choice and Control</b>
	<p>In a genuine and gentle fashion, emphasize that although you would like to proceed, it is ultimately up to the client.</p> <p>Acknowledge that the client can withdraw from the trial.</p> <p>Avoid persuasion.</p>

Therapist Form 3a: Assertive Communication Skills

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Therapist Checklist: Assertive Communication Skills (ASSN)

	<p>Materials Needed:</p> <p><b><i>Communicating Positive Feelings and Comments</i></b> (Form mm), <b><i>Examples of Situations Where Assertive Communication Is Needed</i></b> (Form W), <b><i>Basic Tips for Assertive Communication</i></b> (Form X), and <b><i>Tips on Assertive Communication in Conflict Situations</i></b> (Form Y).</p>
	<b>Identifying Situations That Call for Assertive Communication</b>
	<p>Ask clients to identify experiences that elicit strong emotional states.</p> <p>Use <b><i>Examples of Situations Where Assertive Communication Is Needed</i></b> (Form W).</p>
	<b>Defining Assertive Communication</b>
	<p>Discuss basic beliefs.</p> <p>Contrast passive, aggressive, and assertive communication.</p> <p>Discuss pros and cons of each.</p>
	<b>How to Communicate Assertively</b>
	<p>Review four basic tips on <b><i>Basic Tips for Assertive Communication</i></b> (Form X) (give copy to client).</p> <p>Tell–Show–Try the “I” message and how to ask for a change in behavior.</p>
	<b>Using Assertive Communication to Deal With Interpersonal Conflicts</b>
	<p>Review tips on how to receive and give constructive criticism.</p> <p>Review giving encouragement and making positive statements.</p>
	<b>Closing a Session</b>
	<p>Review and negotiate a home assignment.</p>

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Therapist Checklist: Communication Skills (COMM)

	Materials Needed: <b><i>How Communication Happens</i></b> (Form Z) and <b><i>Reflection Sheet</i></b> (Form aa) Involve SSO in exercises
	<b>Introducing the Process of Interpersonal Communication</b>
	Ask client about communication situations.  Give client a copy of <b><i>How Communication Happens</i></b> (Form Z) and discuss.
	<b>Communicating Effectively</b>
	Complete attending exercise.  Discuss communication roadblocks.  Engage in guessing about meaning exercise using <b><i>How Communication Happens</i></b> (Form Z).  Practice forming understanding statements exercise (home assignment of <b><i>Reflection Sheet</i></b> [Form aa]).  Assign homework of keeping track of positive statements.
	<b>Increasing Positive Interaction</b>
	Discuss how good relationships are fostered by doing positive things together.
	Negotiate shared positive nondrinking activities to do during the week.

Therapist Form 3c: Coping With Craving and Urges

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Therapist Checklist: Coping With Craving and Urges (CRAV)

	Materials Needed: <b>Urge Monitoring Card</b> (Form bb)
	<b>Rationale</b>
	<p>Discuss reality of craving and urges.</p> <p>Discuss predictability/triggers for craving (internal and external).</p> <p>Discuss course of craving.</p>
	<b>Discovering and Coping With Trigger Situations</b>
	<p>Identify recent craving situations client encountered.</p> <p>Have client describe experience (be specific).</p> <p>Check in with client regarding potential triggering of craving experience session.</p>
	<b>Monitoring Urges</b>
	<p>Discuss rationale for urge monitoring (try to elicit self-motivational statements).</p> <p>Give client <b>Urge Monitoring Card</b> (Form bb) and discuss using it.</p> <p>Troubleshoot any obstacles.</p> <p>Practice with example.</p> <p>Assign homework: 2 to 3 weeks of urge monitoring.</p>
	<b>Coping With External Triggers</b>
	<p>Discuss each of the four identified strategies for coping with external triggers (Avoid, Escape, Distract, Endure).</p>
	<b>Coping With Internal Triggers</b>
	<p>Discuss two strategies for coping with internal triggers (Let Go and Endure).</p>
	<b>Developing an Individual Coping Plan</b>
	<p>Have client select two to three strategies that fit him/her best.</p> <p>Develop selected strategies in detail.</p>

**Therapist Form 3d: Drink Refusal and Social Pressure Skills Training**

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

**Therapist Checklist: Drink Refusal and Social Pressure Skills Training (DREF)**

	<p>Materials Needed:</p> <p><b><i>Identifying Social Pressure Situations and Coping Responses</i></b> (Form cc), <b><i>Checklist of Social Pressure Situations</i></b> (Form dd); optional to have an SSO/friend participate in practice</p>
	<b>Social Pressure and Drink Refusal</b>
	<p>Explain direct and indirect social pressure.</p> <p>Identify social pressure situations and coping responses (<b><i>Identifying Social Pressure Situations and Coping Responses</i></b> (Form cc); <b><i>Checklist of Social Pressure Situations</i></b> (Form dd) (optional).</p> <p>Identify specific examples of social pressure as well as specific people.</p>
	<b>Developing Skills for Coping With Social Pressure to Drink</b>
	<p>Discuss rationale for thinking through and rehearsing drink refusal.</p> <p>Explain two ways of coping: Avoid or Escape.</p> <p>Elicit and problem-solve strategies for coping with social pressure.</p> <p>Reflect and affirm.</p>
	<b>Coping Behavior Rehearsal</b>
	<p>Introduce importance of being prepared to react in pressure situation.</p> <p>Discuss idea of having a sequence of responses.</p> <p>Introduce importance of behavior rehearsal.</p> <p>Rehearse predetermined drink refusal strategies with gentle coaching, variations on scenarios, and increasing difficulty.</p>
	<b>Closing Session</b>
	<p>Summarize and review coping strategies.</p> <p>Discuss where client thinks that additional practice is needed.</p> <p>Continue to record on worksheet throughout module.</p> <p>Give client copy of worksheet to take home and keep copy in file.</p>

Therapist Form 3e: Job-Finding Training

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Therapist Checklist: Job-Finding Training (JOBF)

	Materials Needed: <b>Job Leads Log</b> (Form ee); sample job applications from community
	<b>Introducing the Module</b>
	Clarify the advantages of having a job by eliciting the good things about having a job. Reflect and summarize.
	<b>Résumé Development</b>
	Teach difference between a functional résumé and a chronological résumé. 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 to 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 résumé and cover letter.
	<b>Identifying and Avoiding Jobs With High Relapse Potential</b>
	<b>Completing Job Applications</b>
	Teach skills for completing an application. Practice completing sample applications. Problem-solve any problems or concerns (e.g., alcohol questions).
	<b>Generating Job Leads</b>
	Familiarize client with <b>Job Leads Log</b> (Form ee). Generate list of 10 job leads to create a job log.
	<b>Telephone Skills Training</b>
	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.
	<b>Interview Skill Training</b>
	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.

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Therapist Checklist: Mood Management Training (MOOD)

	<p>Materials Needed:</p> <p><b>STORC: Understanding Emotions and Moods</b> (Form ff), <b>Feelings From A to Z</b> (Form gg), <b>Mood Self-Monitoring Sheet</b> (Form hh), and <b>Thought Replacement Worksheet</b> (Form ii)</p>
	<b>Rationale for MOOD Module</b>
	<p>Introduce and explain STORC acronym (give out Form ff).</p> <p>Explore situational factors, thoughts, organismic experiences, responses, and consequences.</p> <p>Explore negative mood states (optional <b>Feelings From A to Z</b> [Form gg]).</p> <p>Begin self-monitoring (<b>Mood Self-Monitoring Sheet</b> [Form hh]).</p> <p>Practice with one identified event, completing each column and discussing.</p> <p>As home assignment, suggest client monitor mood over the next week.</p>
	<b>Automatic Thoughts</b>
	<p>Teach connection of thoughts and emotions and rationale behind thought changing.</p> <p>Review mood-monitoring sheets, looking for consistent patterns that lead to negative moods (content and process).</p> <p>Explore other ways to view or interpret situation.</p>
	<b>Challenging Toxic Thoughts</b>
	<p>Review rationale for challenging and replacing negative patterns.</p> <p>Emphasize choice.</p> <p>Introduce two ways of changing thoughts: think or act differently.</p> <p>Present <b>Thought Replacement Worksheet</b> (Form ii).</p> <p>Practice completing worksheet using situations from mood sheets.</p> <p>Explore situations and ask client what he/she could have done instead.</p> <p>Negotiate home assignment.</p>
	<b>Applying STORC to Urges to Drink</b>
	<p>Identify STORC components that make up an urge to drink.</p> <p>Find ways to challenge the toxic self-talk with replacement thoughts and responses (elicit client's own ideas).</p>

Therapist Form 3g: Mutual-Support Group Facilitation

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Therapist Checklist: Mutual-Support Group Facilitation (MUTU)

	<b>Definition and Background of Mutual Support</b>
	Discuss rationale/importance of support groups.
	<b>Initiating Mutual-Support Group Involvement</b>
	Explore attitudes about mutual support. Give information about available groups. Encourage sampling. Provide referral information. Make a specific plan.
	<b>Emphasizing Action</b>
	Once client finds a group that is acceptable, ask about and encourage active involvement. Explore potential obstacles (client beliefs and attitudes).
	<b>Handling Negativity About Mutual-Support Group Attendance</b>
	Explore roots of negativity. If client is not ready to attend, put on hold and return to topic later.



Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Therapist Checklist: Social and Recreational Counseling (SARC)

	Materials Needed: <b><i>Menu of Possibly Pleasurable Activities</i></b> (Form jj)
	<b>Explaining the Rationale</b>
	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.
	<b>Assessing Sources of Reinforcement</b>
	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 nondrinking activities that client approves. Assign homework assignment.
	<b>Developing a Nondrinking Support System</b>
	Identify supportive people either from nondrinking activity discussion or from client's discussion with family and friends.
	<b>Reinforcer Sampling</b>
	Have client pick one activity from <b><i>Menu of Possibly Pleasurable Activities</i></b> (Form jj). 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.
	<b>Systematic Encouragement</b>
	Practice contacting organizations. Call contact person to meet client at meeting. Review reinforcing value of activity.

Therapist Form 3i: Social Support for Sobriety

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Therapist Checklist: Social Support for Sobriety (SSSO)

	Materials Needed: <b><i>A Letter to People in Your Life</i></b> (Form kk)
	<b>Rationale</b>
	Elicit from client ways in which he/she would like support from significant others. Give client a copy of <b><i>A Letter to People in Your Life</i></b> (Form kk). Have the client read the letter, then 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**

	<b>Presenting the Rationale for Phase 4</b>
	Explain that meetings will continue (every few weeks) until the 16-week date. Present as free option, without using relapse language.
	<b>Basic Structure of Checkup Sessions</b>
	Review progress. Renew motivation. Discuss (if they occurred) drinking situations with possible decision to resume regular sessions as new challenges arise until the 16-week date. Review nondrinking situations. Resume Phase 3 if you and client agree that it could be helpful.

Therapist Form 4b: Termination

Client #: \_\_\_\_\_

Therapist: \_\_\_\_\_

## Therapist Checklist: Termination

	<b>Preparing Your Client</b>
	Three sessions before the last session, remind your client that you have three more sessions.
	<b>Preparing Yourself</b>
	Review progress. Discuss termination with your supervisor three sessions before ending treatment. Consider whether the client may need additional services elsewhere (beyond available 20). Confirm the date for the followup interview.
	<b>Essential Elements of the Termination Session</b>
	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 followup reminder. Closing.



## APPENDIX H

# CLINICAL CARE GUIDELINES FROM COMBINE PROTOCOL<sup>1</sup>

### Guidelines for Discontinuation of Clients From Study Treatment

For reasons of ecological validity, the guidelines for having clients discontinue the study treatment will be flexible. Because the treatment period is 16 weeks, it will be easier to resolve clinical problems that would be more difficult to address in a briefer intervention period (i.e., less than 3 months). Consequently, if clients engage in drinking and other drug use that might require detoxification or undergo inpatient/partial hospitalization during the 16-week study period, they will not have to be removed from the protocol. However, clients who are incarcerated for criminal activity will not continue in the study during their incarceration. Therefore, 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 clients in the protocol.

Because COMBINE is an intention-to-treat clinical trial, clients will *not* be required to complete a finite number of sessions or adhere to the medication regime (after random assignment) to be considered as participants in the protocol. Within this context, clients who fail to appear for scheduled appointments, refuse medication, or evidence other compliance problems (e.g., failing to return blister pack) will be allowed to remain in the clinical protocol. *Clients who have been absent from the protocol for 4 or more weeks will need to be rescreened prior to going back on study medication. They will have to undergo full laboratory tests, including a urine drug screen and a pregnancy test.* These matters will be addressed by therapists/counselors utilizing procedures and strategies developed in the medical management (MM) and CBI manuals and clinical supervision.

Some cases cannot be safely managed in the clinical protocol, however. These cases include, but are not limited to, the following categories:

- Acute psychosis (e.g., hallucinations, impaired reality testing, paranoid ideation) requiring medication and/or hospitalization or intensive outpatient intervention
- Suicidal or homicidal ideation that results in a credible threat of violence directed at oneself or others
- Hospitalization for psychiatric symptoms.

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<sup>1</sup> These guidelines from COMBINE are presented as an example of identification and management of clinical deterioration in the context of a randomized clinical trial combining psychotherapy and medication.

Clients requiring more intensive treatment resulting from acute psychosis or suicidal/homicidal behavior will be referred to local treatment centers, but study staff will not provide them with medication or psychotherapy. It should be noted that these guidelines are meant for nonemergency situations. The local clinical staff will deal with emergency situations. In cases where it is unclear whether a client should be discontinued from study treatment (e.g., transient suicidal ideation in the context of acute intoxication), sites are encouraged to consult with a Clinical Care committee representative. Clients will be permitted one medical detoxification and still be allowed to continue in the study. Clients who are started on antidepressants or other psychotropics will be discontinued from study medication but will be allowed to continue in the protocol. The Principal Investigator (PI) *and* the Coordinating Center must be notified in all cases involving the removal of clients from the protocol or from taking medication.

**Pregnancy.** Clients who become pregnant during the course of the treatment will be discontinued from the study medication.

**Elevated liver enzymes.** Clients whose ALT/AST is greater than five times the normal rate will need to repeat the ALT/AST test within 1 to 2 weeks, and if it is still greater than five times the normal rate, the client's medication will be stopped. If the repeat values are less than five times the normal rate but are still elevated, the client should be monitored using clinical judgment. Clients whose total bilirubin is above 50 percent baseline level but within the normal range will be evaluated by a study physician to determine whether they should stop taking the study medication. Clients whose total bilirubin is greater than 10 percent above ULN will be taken off the study medication immediately.

**Renal insufficiency.** Clients whose serum creatinine level is 1.3 or 1.4 will be evaluated by study physicians to ascertain whether they should stop taking study medications. However, a client with a creatinine level cutoff of 1.5 should be removed from the study medication.

**Opioid medication.** If clients need opioid medication while participating in the study, they will no longer receive study medication. The clients will undergo a 10-day delay after their last dose of opioid medication before they resume taking study medication (except if they have been on methadone). Before the clients resume study medication, they will need to produce a negative urine. The study medication may need to be retitrated when it is restarted, according to the instructions provided in the MM treatment manual. The clients also should receive warnings about not resuming opioid medication while on the study medication, with an emphasis on the fact that they risk having a severe withdrawal if they were to take naltrexone while taking opiates.

**Physical illness.** Clients with certain disabling conditions will not be able to take the study medication. The MM clinician is responsible for referring the clients to a physician if a previously untreated or new medical problem is identified during the MM sessions.

**Psychotropic Medications.** Clients who require psychotropic medication will be discontinued from study medication. Clients may receive one medical detoxification and remain on study medication. Clients may receive hydroxyzine (Vistaril) for anxiety, nausea, dizziness, nervousness, or insomnia, as outlined in the MM treatment manual, and remain on study medication.

Local medical management staff will make the decision about whether to discontinue a client temporarily or permanently from the study medications. Clients 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 clients at the discretion of the treating physician according to the MM treatment manual recommendations, but it is suggested that clients who have been off medication for less than 4 weeks not be retitrated.

All clients must be managed clinically. This means that clients 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 in the MM manual for a list of procedures to use in managing side effects). The medical staff may reduce the client's 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, the client may stop taking study drug medication until the physician believes it 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, which should 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 trialwide criteria for retention (or removal) of clients in the clinical arm of the trial. However, the final decision to remove deteriorated clients from the treatment arm will be made at each site by a joint decision of the Project Coordinator (PC), therapist, and Principal Investigator. Reports of a client's withdrawal as a result of clinical deterioration will be forwarded to the Coordinating Center; staff there will review the 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 Clinical Care committee is to safely manage clients in the clinical protocol. Another purpose is to attend to issues involving client removal and possible reintroduction to the study medications. In addition, the committee will provide consultation dealing with the removal of deteriorated clients. This will entail the following:

1. Further defining and operationalizing adverse consequences occurring during the course of treatment that would cause clients to be removed from the treatment protocol



2. Providing consultation in determining whether a client can be managed within the assigned COMBINE treatment
3. Assisting the CRUs in safely managing clients in the clinical protocol
4. Assisting in dealing with the withdrawal of clients from the protocol if deemed necessary.

**Procedures.** In most instances, the decision about whether to retain a client 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 client's behaviors that constitute cause for removal from the treatment protocol (e.g., impairment of mental health) and the potential risks of maintaining the client in a COMBINE treatment. The second is to assist PIs/PCs and therapists in developing a plan for stabilizing the client so that he/she can remain in the study treatments. The third is to assist in the handling of the removal of clients 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 retaining clients. The PC will contact the Coordinating Center to determine the appropriate representative to review a case and to make recommendations about whether a client should be maintained in the clinical protocol. If there appears to be a consensus that the client should stay, a plan will be developed for stabilizing the client's condition so that he/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 the therapist of the local CRU. The local PI/Co-PI/PC and therapist will consult jointly to make the final decision about retention.

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