Community Reinforcement Approach for Seniors (CRAS)
Treatment Manual for Project Elderly Standard Condition (MET)
Study Version

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Foreword

ELDERLY is an international, multicentre randomized single-blind study to test two manualised psychotherapy treatment programmes for older people (60 years +) with alcohol use disorders. The study was conducted and evaluated in Denmark (3 sites in Copenhagen, Aarhus, and Odense), Germany (2 sites in Munich and Dresden), and the USA (one site in Albuquerque) from 2014 until 2017. Joint principle investigators of the study are Anette Søgaard Nielsen (coordinator), Kjeld Andersen (Denmark), Michael Bogenschutz (USA), and Gerhard Bühringer (Germany). For further information on project design, methods and procedures see Andersen et al. (2015); regarding the primary outcome Andersen et al. (in preparation).

The manual you have in your hands represents the work of many people. Some of those contributions are noted in the author string, but there are others that are hidden or have been lost in the wandering of one project to another. Some of the content in this intervention was taken from the Combined Behavioral Intervention used in The COMBINE Research Project (https://pubs.niaaa.nih.gov/publications/combine-form.pdf), though modified for an elderly population in a primary care setting. We wish to acknowledge explicitly the contribution of those authors to this manual, and hope we have conveyed their ideas faithfully. The manual describes the content of the Standard Treatment (MET) in the Elderly Study.

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The authors

Preparing for Change

1.0 Session One: Engaging the Patient

1.1 What is motivation?

What is motivation? If you hold the view that motivation is a kind of inner life force, such as willpower, which patients possess in varying amounts, you may be less optimistic with patients who "aren't really motivated" or may use confrontation or pep talks in an attempt to pump up the patient'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 patient motivated to do?'' you are in this sense asking, 'What is the patient likely to do?" Once you understand motivation in this way, your task becomes that of increasing the probability that your patient will take action toward change.

As it turns out, a patient's doing something-sometimes described as "compliance" or "adherence"- is one of the better predictors of positive treatment outcome. Common sense suggests that when patients take active steps toward change they are more likely to succeed. Patients 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 Session 1, your job is to increase the likelihood that your patient will take active steps toward change.

Motivational interviewing is a patient-centered yet directive style of counseling designed to do just that - to help the patient resolve ambivalence about a problem behavior and initiate change (Rollnick and Miller 1995). It is the clinical style you will use throughout CRAS. Based on principles of motivational psychology, it is designed to initiate rapid, internally motivated change. Motivational interviewing (MI) differs from other treatments in the way that it relies explicitly on the therapist's attitudes toward the patient – what is called the "spirit" of MI. The spirit of MI consists of elements: Partnership, Acceptance (nonjudgementalness) and Evocation. This will be the underlying foundation of your interaction with the patient during the entire intervention.

1.2 Stages and Processes 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.

What is it that people do in each of these stages? Prochaska and Diclemente (1998) have described a set of processes (for example, skills, behaviors or activities) that people use to make the changes they need to make, as they move through the stages of change. These processes are included in many different kinds of treatment for addictive behaviors, including this one. They are also used by people who change themselves without formal treatment. These processes include things like values clarification, learning and practicing new coping strategies for high risk situations, expressing feelings about a problem with others, substituting different alternatives for drinking, avoiding situations where alcohol is present and giving rewards to oneself for making changes (Prochaska, Norcross & DiClemente, 2013).

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. Often, people will try new processes for changing as they try again, so the recycling becomes an opportunity for new learning. 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 patient 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 A to consider three aspects of motivation reflected in the expression "ready, willing, and able." The "willing" component has to do with how important patients 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). Increased importance to change drinking can happen in many different ways. Often this occurs because of an external event such as a health crisis or ultimatum from a life partner. But in the CRAS intervention, increasing importance occurs by helping the client to give voice to their own reasons to change and to explore those reasons within a supportive environment. Simply speaking these “self-arguments” to another person who listens compassionately

will tend to increase their salience to the client. While exploring these reasons to change in an environment that does not provoke reactance, the client begins to take them more seriously. Sometimes the therapist will hear the client say things like: "Well, now that I am saying it…" or "I never thought of it quite like that before". The client's own reasons to change, called "change talk" when they are spoken aloud, are the golden thread that the therapist gently follows in the CRAS intervention

Next is the patient's perceived ability to change (self-efficacy). The patient 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 patient 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 patients develop a firmer commitment to take action toward change.

1.3. Motivational Interviewing in the CRAS Intervention

1.3.a Four Processes in MI

Motivational interviewing encompasses four distinct processes (Miller & Rollnick, 2013) all of which are present in the CRAS intervention. First is the Engaging processes. Here, the therapist works to provide a safe atmosphere while the client considers what to say about their drinking. The Engaging Process within motivational interviewing relies heavily on the therapist's interpersonal skills, including especially the use of reflective listening to convey empathy (see below). For some clients, engaging will happen quite quickly, and they will be ready to move forward to the next process. For others, engaging will take longer. Within the CRAS intervention, the therapist is given wide latitude to prioritize Engaging, and to return to it when needed as the treatment progresses.

Once the client is engaged, the process of Focusing can begin. The Focusing process allows the patient and therapist to decide collaboratively what change they should work on together. In some settings, the Focusing process can be quite complicated and requires special attention from the motivational interviewer. In the CRAS intervention, a focus has already been chosen by the patient before they see the therapist for the first time. If clients are reluctant or defensive about their drinking, the therapist should not assume that some other topic would be more useful. Instead, this should be viewed as the natural ambivalence that comes with making a difficult change. Remember, clients have volunteered to be in this study with the explicit goal of changing their drinking. They have experienced an extensive assessment process. It will not be a surprise to the client that the therapist is focused on discussing alcohol problems.

After a target change has been agreed upon, in this case problem drinking, the process of Evoking begins. The Evoking process is based on the idea that when clients are ambivalent about a change, both their arguments for and against it will be present in their mind. The therapist's task in Evoking is to make sure that the arguments for change get a chance to "take the floor and be heard". Often, this is accomplished by simply asking the client directly about their concerns and desires to change. Evoking can also occur by paying special attention to change talk when choosing what to

include in a reflection, since reflecting change talk means there will likely be more of it. There are many examples in the CRAS manual of how to pay attention to the client's language so that you will hear more change talk and less about keeping things as they are. The important point to remember about Evoking is that clients will naturally have good reasons to change their drinking and it is the therapists job to draw out those concerns, rather than supply them for the client.

The final process in motivational interviewing is Planning. Here is where the nuts and bolts of how change will happen are spoken and formalized. Planning within MI, and in the CRAS intervention, is collaborative and relies heavily on the client's ideas about what ought to happen. More therapist expertise might naturally become valuable as the client pursues strategies to change, but the therapist never becomes the "prescriber" who tries to convince the client to take a certain path. A spirit of collaboration is as important in Planning as in the other processes in MI. Many opportunities for collaborating are built in to the CRAS intervention, beginning with the negotiation of the client's drinking goal. Although abstinence is discussed, it is not a mandatory goal for the treatment. As with other treatment goals, the therapist honors the client's ultimate autonomy in deciding whether and how to change.

1.3.b. Goals of the MI Therapist

Motivational interviewing begins with the assumption that the responsibility and capability for change lie within the patient. Your task is to create a set of conditions that will enhance the patient's own motivation for and commitment to change. You will seek to mobilize the patient's own inner resources as well as those inherent in the patient's natural helping relationships. The idea is to evoke and support internal motivation for change, which will lead the patient to initiate, persist in, and comply with behavior change efforts. There are some basic strategies that will be helpful in all of the processes.

a. *Express Empathy*. In motivational interviewing, the therapist seeks to communicate support and respect for the patient. Communications that imply a superior/inferior relationship between therapist and patient are avoided. The therapist's role is a blend of supportive companion and knowledgeable consultant. The patient's freedom of choice and self- direction are respected. Indeed, in this view, it is only the patient 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 patient. 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 patients as they are while also supporting them in the process of taking steps toward change.

b. *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 patient's attention on such discrepancies with regard to drinking behavior. In

certain cases (e.g., pre- contemplators in Prochaska and DiClemente's model [1984, 1986]), the therapist may first need to develop such discrepancy by raising the patient's awareness of the personal consequences of his/her drinking. In other cases (e.g., contemplators), the process is one of clarifying and resolving patient 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 patient's perceived importance of change. As a result, the patient may be more willing to enter into a frank discussion of change options to reduce the perceived discrepancy. In still other cases, the patient 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, patients still experience ambivalence about change, and motivational enhancement processes can be useful throughout therapy.

c. *Avoid Argumentation*. Motivational interviewing explicitly avoids direct argumentation, which tends to make the patient defensive. The therapist does not attempt to have the patient 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. Minimizing patient 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 patient defensiveness head on but rather rolls with the momentum, with a goal of shifting patient perceptions in the process. The therapist invites new ways of thinking about problems but does not impose them. The therapist views the patient's ambivalence as normal, not pathological, and it is explored openly. The patient usually invokes solutions instead of the therapist providing them.

e. *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 patient 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 patient have an overall optimistic nature. What is crucial is the patient's specific belief that he/she can change the drinking problem. Unless the patient 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.

1.4. Comparison With Other Approaches

1.4.a. 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 patient's defenses.'' Miller (1999) characterized the following contrasts between approaches, outlined in table 1.4 below:

Table 1.4: 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 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 patient of the diagnosis	Therapist provides objective evaluation but focuses on eliciting the patient'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
Patient defensiveness is met with argumentation and correction	Patient defensiveness is met with reflection and reframing

It is a goal in motivational interviewing for the therapist to evoke from the patient statements of problem perception and a need for change, commonly called Change Talk or 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 patient of their truth. Motivational interviewing emphasizes the patient's ability to change (self-efficacy) rather than the patient's helplessness or powerlessness over alcohol. The therapist carefully avoids arguing with the patient, and strategies for responding to defensiveness are reflective and gentle. Within a motivational interviewing style, therefore, the therapist does not do the following:

- Argue with the patient
- Impose a diagnostic label on the patient
- Take responsibility for explaining why the patient must change
- Tell the patient what he/she "must" do

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

1.4.b. Differences From Nondirective Approach.

Motivational interviewing draws heavily on the patient-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 patient's direction wherever it may lead. There is no prescription for differential responses to the patient's statements. In such nondirective counseling, the therapist meets whatever the patient offers with unconditional positive regard.

In contrast, motivational interviewing is goal- directed and employs systematic strategies to reach specific objectives (see table 1.4.b.). The therapist seeks to actively create discrepancy and to channel it toward behavior change (Miller 1983; Miller and Rollnick 2002). The therapist consciously uses reflection and reframing in a contingent manner to strengthen the patient's intrinsic motivation for change.

Table 1.4

Comparisons Between Nondirective Counseling Approach and Motivational Interviewing Approach

Nondirective Counseling Approach	Motivational Interviewing Approach
Allows the patient to determine the content and direction of counseling	Systematically directs the patient 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 patient's conflicts and emotions as they are currently, without specific goals for change	Seeks to evoke and amplify the patient's dis-crepancy to enhance motivation for change

The material is still the patient's own; the therapist does not provide or install motivations. Instead, the therapist directs the patient's salient attention to discrepancies between the problem

behavior and his/her own intrinsic interests and values. Thus, motivational interviewing is a directive, patient-centered, and change-oriented approach.

1.4.c. 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 and negotiation of change strategies (Phase A). Only after the engaging process is complete does the therapist introduce specific skills and strategies for change as options. Rigid prescription of a particular change method, however, would be incompatible with the emphasis on patient choice and autonomy. Providing a menu of change options from which the patient can choose is compatible with motivational interviewing.

The transition to the topic of skills training occurs once the engaging process has been completed, during Session 1 and 2. Then, in Session 3 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 changes that form the core of the Self Change Plan.

As mentioned earlier, the therapist is meant to continue the empathic clinical style of motivational interviewing throughout the course of the entire CRAS treatment. This style serves as a platform on which to build further interventions. The therapist should employ reflective listening to the patient in all sessions from Session 1 through termination. Patients 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 B), the therapist balances suggesting coping strategies with drawing upon the patient's own ideas and resources.

1.5. Clinical Style

Patients will vary widely in their initial readiness to change. Although some may come to treatment largely decided and determined to change, the engaging, focusing and evoking processes should be pursued to explore the depth of such apparent motivation and to begin consolidating commitment. Other patients will be reluctant or even hostile at the outset; for them, engaging and evoking in Session 1 and 2 is likely to be particularly important. At the extreme, some patients who are genuinely in the precontemplation stage may be coerced into treatment by family members, an employer, or legal authorities. Most patients, however, are likely to enter the treatment process somewhere in the contemplation or preparation stage. They may already be dabbling with taking action but still need consolidation of motivation for change.

A good way to think of Phase A is that it has specific techniques for drawing out the patient's own motivation that is "stuck" because of the back and forth of the ambivalence see-saw. From this perspective, the therapist does not create motivation. Rather, the therapist facilitates the growth of it.

In much the same way that a midwife assists with the birth of a child, the therapist helps the patient to experience, release and express their own internal motivation. Thinking of motivation as a natural part of change, something that is almost certainly present when patients engage in problematic drinking, frees the therapist from feeling as if they must force the change to occur. Instead, they can focus on ways of enhancing the motivation that they assume is already there.

1.5.a General Strategies for Motivational Interviewing.

Miller and Rollnick (1991) have described the following *general strategies* that characterize the clinical style of motivational interviewing, outlined below:

1.5.a.1 Evoking Change Talk.

It is true that one can "talk oneself into" a change. Social psychology has amply demonstrated 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 (Bern 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 patient 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 patient responses: "No, I'm not, and no, I don't." Unfortunately, counselors are sometimes trained to interpret such a response as further evidence of patient "denial" and to push all the harder. The likely result is a higher level of patient 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 the patient’s own statements about desires, abilities, reasons and needs to change (Miller and Rollnick, 2013). They include four kinds of statements, described below:

1. Problem Recognition. This is a cognitive/ factual acknowledgment by the patient of the risk (potential) or presence of negative consequences of drinking. This should not be equated with the patient 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 patient's recognition of his/her problem may or may not be accompanied by the patient'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 patient 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.

More recent formulations of MI have focused on change talk that encompasses the following:

Desire to change: "I want to change"

Ability to change: "I could (can) change"

Reasons to Change: "If I changed, something would be better"

Need to Change: "I have to change"

Commitment to Change: "I will change"

These four types of change talk from patients have been studied extensively and have been shown to predict better patient outcomes, especially in treatments for problem drinking (Miller & Rollnick, 2013). From reading this far, it should be apparent that there are many ways that patients can offer change talk. The important thing is not to be especially concerned about which *type* of change talk is occurring but *how you are responding to it*. Therapists who use MI well recognize change talk when it is offered in the session, and respond to it with reflections and evocative questions. Really *good* interviewers go one step further and use strategies to evoke change talk from their patients. How is this done?

There are many ways to elicit change talk from patients. The simplest is to ask for it 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 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?
-
- 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?

- What kind of changes do you look forward to when you are successful in changing your drinking?

- What is the most important reason you have for changing right now?

- How do you see things moving forward if you decide not to make a change in your drinking?

- What kinds of things have you been able to change in your life before this?

- You mentioned that your doctor expressed concern about your drinking. What did she say to you?

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1.5.a.2. Asking Open Questions.

Most counselors ask far too many questions. It is especially common when therapists are anxious (such as when they are offering a new treatment for the first time!). It is easy to fall into a question/answer pattern with patients, particularly in early sessions, but you should avoid this pattern for several reasons. For one, although questions direct the patient to what interests you, they tend to derail the patient's own process of exploration and become barriers to learning about your patient (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. Using motivational interviewing 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 patient's response, and reply with empathic reflection.

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

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 patient's responses to them. Therefore, it is important to follow an open question not with another question but with sustained reflective listening. Questioning is no substitute for good reflection, although it is far easier. Motivational interviewing seeks to evoke internal motivation from the patient, and therapists are unlikely to accomplish this solely by firing questions. Ask an open question, then reflect on the answer.

When a therapist finds herself asking fact-finding questions it is best to stop as soon as possible and recover with an open question and several reflections. Very, very few facts are needed to practice MI. Often fact-finding questions are a by-product of counselor anxiety, since gathering facts is something that is almost always “right” in other approaches. Furthermore, the counselor is always “right” when fact-gathering because it is the patient who supplies the answers. Instead, within MI, there is a focus on facilitating the patient’s self-exploration and expression of her own concerns about her

dilemma, which requires no particular facts to be spoken. Though a fountain of information is likely to come forward, no particular set of facts is especially privileged in the MI process.

1.5.a.3. Listening With Empathy.

The eliciting strategies just discussed are likely to evoke some initial offerings from your patient, but where therapy goes from there will depend on how you respond to your patient's statements. The therapeutic skill of accurate empathy (sometimes also called active listening, reflection, or understanding) is the preferred response within CRAS, and it helps the patient 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 patient is saying, then reflects it back to the patient, often in a slightly modified or reframed form. The therapist may also acknowledge the patient's expressed or implicit feeling state. This way of responding offers several advantages, listed below:

1. It is unlikely to evoke or exacerbate patient defensiveness.

2. It encourages the patient 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 patient means.

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

This fifth characteristic is an important one in motivational interviewing. You can reflect selectively, choosing to reinforce certain components of what the patient has said while bypassing others. In this way, patients not only hear their own change talk but also hear you saying that they said it. Furthermore, this style of responding is likely to encourage the patient to elaborate upon the reflected statement, as shown in the example below.

THERAPIST: What else concerns you about your drinking?

PATIENT: 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 ...

PATIENT: 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.

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

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

PATIENT: Well, I know it is sometimes.

THERAPIST: You're pretty sure about that.

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

THERAPIST: Wonder if ...

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

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

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

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

PATIENT: 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.

PATIENT: 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 patient'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 patient's own processes. (Egan 1982; Gordon 1970.)

The example below contrasts reflective listening with other types of therapist responses to patient statements:

a. “I don’t have a problem”

PATIENT: 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."

REFLECTION OF CHANGE TALK: You worry a little about your drinking.

PATIENT: 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.

“What about friends?”

PATIENT: 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 patient 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 patient ('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 patient'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.

1.5.a.4. Affirming the Patient. Affirmation involves recognizing the patient's positive characteristics, strengths and efforts and making that recognition explicit. Such affirmations can be beneficial in several ways. They can (1) strengthen the working relationship, (2) enhance the patient's attitude of self-responsibility and empowerment, (3) reinforce the patient's effort and change talk, and (4) support the patient'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.

I've never seen a list of triggers this well done.

You've taken a big step today, and I really respect you for it.

You've done a great job of keeping your health as you get older.

You really recognize the contribution you can make as a grandparent.

You are determined to stay young at heart.

It is likely that the appropriate use of affirmations will differ across cultural settings. In some settings explicit affirmations may feel "over the top" or uncomfortable for therapists. The important thing to remember about affirmations is the therapists ability to notice the client's strengths and make those explicit in their interactions. Therapists who are good at noticing client's strengths can often find ways to weave these into the conversation without seeming inappropriate.

1.5.a.5. Responding to Defensiveness.

Patient 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" patient 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 patient behaviors associated with a lack of long-term behavior change:

- Interrupting: cutting off, or talking over the therapist

- Arguing: challenging the therapist, dis- counting 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, blam- ing others, rejecting the therapist's opinion, being unwilling to change, alleging impunity, showing pessimism.

As discussed above, it is important to be aware that the extent of such patient 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 offered only half as much change talk as those in the latter group. Patient 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 patients' defensive and uncooperative behavior went up and down markedly in response to therapist behaviors. The picture that emerges is one in which the therapist dramatically influences patient defensiveness, predicting in turn the degree to which the patient 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 patient 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 or sustain) statements from the patient. Expressed more bluntly, defensiveness or denial is not so much a patient problem as it is a therapist skill issue.

Remember this rule: never meet counter- change statements head on. If you do, the patient is likely to become more defensive, backing herself further into a corner resulting in 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 patient is "resisting' (e.g., Why do you think that you don't have a problem?) will almost certainly make the patient 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 patient to acknowledge a problem and the need for change, it's time to shift strategies.

Remember that you want the patient to offer change talk (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 patient is saying. This tends to 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 patient is saying to the point where the patient 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:

PATIENT: But I'm not an alcoholic, or anything like that.

THERAPIST: You don't want to be labeled.

PATIENT: 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.

PATIENT: 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 patient 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:

PATIENT: 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:

PATIENT: But I can't quit drinking. I mean, all of my friends drink!

THERAPIST: I wonder if you'd be willing to 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. I don't want you to think that you have to decide anything right now.

- Emphasizing personal control. Ultimately it is the patient who decides whether or not to change. This, of course, is the truth. No one can decide for the patient. The fact that there may be clear negative consequences of behavior (e.g., with a patient for whom abstinence is a condition of probation) does not alter this truth. Directly acknowledging that decision and choice are in the patient's hands tends to defuse defensiveness, decreasing the need for the patient to continue to assert personal control.

PATIENT: 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.

- Reframing. Reframing is a strategy whereby the therapist invites the patient 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 patient 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). Patients 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 your patient 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 patient's own views, words, and perceptions as you develop a reframe, as shown in the example below.

PATIENT: 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.

PATIENT: 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 patient 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 patient 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 patient to take action to change the problem. It invites the patient 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.

1.5.a.6 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 patient has said. It is especially useful to repeat and summarize the patient's self-motivational statements. Include elements of reluctance or defensiveness in the summary to prevent a negating reaction from the patient, but give particular emphasis to self-motivational themes to reinforce them. A summary serves the function of allowing the patient to hear his/her own self- motivational statements yet a third time, after the initial statement and your reflection of it.

1.5.a.7 Responding to Rule Violations Concerning Drinking: The Rule Violation Effect (RVE)

No matter what your patient’s drinking goal might be (abstinence or harm reduction) it is possible that he or she may experience a failure to keep to that goal. This is sometimes called a “slip” or “relapse”. It is actually a violation of the rule the patient has set for him/herself about alcohol. The patient themselves might bring this up during a session, or it might come as a response to your queries

concerning progress. Two important points should be kept in mind while responding to these rule violations using a motivational interviewing style.

The first point is to address the Rule Violation Effect (Marlatt & Gordon, 1985), which is a common human response when failing to live up to a desired change. Once a person has violated a drinking standard they have genuinely embraced, it is not unusual for them to respond with the thought "Since I have already broken my rule, I might as well make the most of it and drink as much as I like". What is happening here is that the impact of the "slip" is to demoralize the person, and this demoralization encourages further rule violations. Your job as a CRAS therapist is to gently inquire about possible RVE when appropriate and explore with your client other possible ways of thinking about their "slip". It can be useful to help the client consider:

1) The cyclical nature of changing human behavior (most people have to try many times before success)

2) The fact that they are able to glean knowledge from the slip to be better prepared in the future

3) The possibility that they are underestimating their overall success (for example, compared to when they began the change process)

In responding to rule violations, it is best to assume that the patient is experiencing some degree of distress even if it is not expressed directly. An approach emphasizing empathy, listening skills and evoking change talk is just as important as in any other area.

1.6. Implementing Session One

1.6.a Structuring Statement

Begin your first meeting by greeting your patient, introducing yourself, and then briefly explaining what will be happening in the first session. Below is an example of a structuring statement:

THERAPIST: We're going to be talking for an hour or so 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?

1.6.b Reflective Listening and Responding to Change Talk

The motivational interviewing phase starts simply, with an open question followed by reflective listening. From your review of the patient's assessment information, you will already have some sense of his/her situation, which may guide you in your choice of an opening question. Don't fall into the trap of asking a fact-gathering question that attempts to "fill in the blank" with some missing piece of

information from the assessment. In essence, ask a broad question that invites the patient 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*, consider one or two questions about some general areas listed below, but always with the goal of steering the patient toward self-exploration rather than gathering specific facts. Once the patient becomes more willing to speak freely, it is time to forego these assessment-type questions in favor of more open, evoking questions such as those discussed above. Think of the kinds of questions below as a “key” to open the door to the patient’s self-exploration. Like a key, they are not useful in and of themselves, but only for the larger purpose of gaining access to an important place. Once the door is open, the key is no longer useful.

•Tolerance. Does the patient seem to be able to drink more than other people without showing as much effect?

•Memory. Has the patient 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 patient's drinking, and what have their concerns been?

•Health. Is the patient aware of any areas in which alcohol has or may have harmed his/her health?

•Legal. Has the patient had any arrests or other brushes with the law because of his/her behavior while drinking?

•Financial. Has drinking contributed to money problems?

Remember to ask few questions, and rely primarily on reflective listening. Keep in mind that your goal is to *evoke change talk*, which can then be reinforced by reflection, accumulated, and gathered together in summaries. If the patient becomes defensive, use strategies outlined above in section 1.5.a.5. (Responding to Defensiveness) to respond to and defuse it.

In listening to the patient's perceptions and concerns, offer interim summary reflections, particularly by gathering up the patient’s change talk. 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 patient's concerns, or when time is growing short (e.g., after 30 to 40 minutes), draw together what your patient 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 patient's reluctance, what the patient 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 patient 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 you make these changes in your life.

1.6.c Providing a Rationale for the Intervention

An important component of successful treatment is providing a rationale for why and how it occurs. Research has shown that when therapists and clients have confidence in the treatments they offer, outcomes are improved. That is why it is important to understand the explanation behind both treatment conditions, and provide them to the patient with optimism.

Because your patients have agreed to enroll in a research study they know a lot about the treatment already, so your first task in transitioning to this topic is to ask them what they already know about the CRAS intervention. Do not be concerned about acknowledging the differences between the two conditions – your patients already know this from the consent procedure.

Therapist: I wonder what you already know or have been told about this intervention?

Once the patient responds with their ideas, you can reflect and add any important information they might need such as the duration of the intervention, how often you will meet, and what will happen in

the treatment planning process. These details will be slightly different depending on the condition to which the patient is assigned. Next, you will provide a rationale for why the treatment is expected to be effective.

Rationale for CRAS Standard Intervention

The Standard Intervention in the CRAS study is based on the theory that human beings are resilient and have inherent tendencies toward healing, integration and wholeness. The natural change process involves client's exploring their thoughts and behaviors and actively selecting methods for solving their problems. From this perspective, the process of therapy should occur in much the same way that human beings prosper and thrive in their everyday lives. The job of the therapist is to assist the client in accessing their internal resources, wisdom and experience to approach problem drinking with the same perspective and skills that have helped them live a successful life so far. In other words, "the real therapy is living" (Tallman & Bohart, 2003, pg. 111). The Standard CRAS Condition (SC) is intended to facilitate this active and creative problem solving and empower patients to create their own treatment program by making their lives their laboratories. The four sessions of the SC help to focus the patient on naturally occurring corrective experiences in their own lives, for example the benefits of improved mental functioning, peacefulness, physical well-being and intimacy with others that come with changing problem drinking.

Therapists sometimes wonder if self-change is real, but there is a substantial body of evidence to show that patients often change with minimal interventions such as being given a self-help manual or receiving one 15 minute session of brief advice (Bohart & Tallman, 2006). In two very large research studies to help patients reduce problem drinking (one in the United States and one in the United Kingdom), the patients assigned to a four-session condition just like the SC in CRAS did just as well as those assigned to the longer, more intensive treatment (MATCH & UKATT cites)*. In fact, in the area of addictions there is pretty good evidence that *most* patients change without ever accessing treatment of any kind (Miller & Carroll, 2006). As therapists, this is hard to recognize because we see a biased sample of the people who have not been able to change, instead of a representative sample that includes those who have tried and succeeded. As therapists we are naturally skeptical because we do not have a lot of contact with the natural changers

What do these natural changers do to help themselves succeed? Research shows that they use methods and techniques very much like the ones in the transtheoretical model mentioned earlier: they change their environments, they change their thinking, they increase their social support and they practice new skills to manage their challenges. All of these elements are exactly what we deliver in the Enhanced Condition (EC), with the difference being that in the SC we place the emphasis on empowering the client toward making this change for themselves rather than "delivering" it through the hands of the expert therapist.

Important Things to Remember When Providing the Rationale for the Standard Condition:

1) Shorter treatment could easily be just as good

2) Patients lives and circumstances can provide the experiences they need to change once they are motivated to do it

3) People have changed successfully for many thousands of years without therapists

Sometimes therapists wonder if just learning skills can really make that much of difference for drinkers. Here the research is also quite strong in telling us that acquiring new coping skills is an excellent way to change drinking. It is not an exaggeration to say that skills training is supported by more research than any other behavioral treatment for changing drinking. It is often the "gold standard" against which other treatments are measured. So when you are using this approach with patients, you are offering them a proven, time-tested intervention for reducing their drinking.

1.6.d. Initiating Involvement of a Supportive Significant Other.

1.6.d.1 Considering SSO Involvement.

An important element of CRAS 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.

You will introduce the concept of SSO involvement in the first session, but the SSO does not actually become involved until the fourth session. The SSO will participate in only the fourth and final session of the intervention.

SSO involvement is encouraged and supported but not imposed upon the patient. The first step is to follow the general approach outlined in the box below to introduce the topic. Responding to your patient'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.

Table 1.5: 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 patient's thoughts, reactions, and concerns Summarize Ask for Involvement

Begin by asking the patient if he/she has social support in general and support for changing drinking in particular. Introduce the idea of identifying someone from the patient's social network to engage in the treatment process. Pay careful attention to the patient's verbal and nonverbal behavior in response to your open-ended questions, because this topic may elicit resistance or discouragement. Use motivational interviewing strategies to evoke information and explore your patient's thinking about having the SS0 involved.

1.6.d.2. Selecting an SSO. The ideal SSO will be a person who meets the following characteristics:

- Will not drink or drink immoderately in the company of the patient
- Will not suggest or invite the patient to drink
- Will not report on his/her own experiences related to drinking
- Will encourage the patient's efforts to achieve stated drinking goals.

1.6.d.3 Responding to Patient Concerns About Including an SSO

There are common concerns about including a Supportive Significant Other, even when an appropriate person can be identified. It might be useful to remind the patient that they alone will decide if an SSO will attend, and that your goal is to explore the pros and cons of this with them, not to make any decision for them. Below are some common concerns and corresponding reassurances the therapist can offer, if appropriate.

Table *1.6 Responses to Patient Concerns about Including an SSO

Limited social resources (e.g., social isolation, homelessness)	If your patient has limited social resources, inclusion of an SSO may not be feasible at this time. Let your patient 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.
The patient does not feel his/her social network is emotionally supportive	Reflect the patient's view that the network is unsupportive. If all evidence points to the unsupportiveness of the network, this suggests that the patient need not select an SSO at this time. Share with your patient that you'll revisit this issue later in treatment. If it becomes evident that one or more members of the network have supported the patient in the past, explore with your patient specific ways in which these people were supportive. Then talk with your patient about having these people participate in treatment.
The patient believes a potential SSO will be reluctant to participate	To determine if the patient's negative feelings are really the concern, ask the patient how he/she would feel about an SSO being there and what the patient thinks the role of an SSO is. If the SSO's reluctance (as perceived by the patient) 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. If the patient still is

	reluctant, explore the risks and advantages of asking the SSO.

1.6.e. Completing Assessments for Future Sessions.

All patients need to complete the Desired Effects of Drinking Form (Form A). Allow enough time to administer this at the end of the first session so that you can obtain additional information you will need for future sessions.

1.6.f. 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 especially any change talk the patient 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 a plan to help you meet your goals once our sessions have ended.

1.6.g. Scheduling the Next Session. Schedule the next session within a few days of the first session.

1.7. Sending a Handwritten Note.

After the first session, prepare a handwritten note to mail to the patient. This is not a form letter but is rather a personalized message. If your hand- writing 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 patient, listed below:

A "joining message" [e.g., "I was glad to see you"]

Affirmations of the patient

A reflection of the seriousness of the problem

A brief summary of highlights of the first session, especially self-motivational state- ments 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.

Finally, indicate the correct Phase for the session (Phase A = 1-4 and Phase B = Sessions 5-8) and which modules you delivered, at least partially, during the session on the Therapist Checklist.

1.8 Completing the Therapist Checklist. At the end of every session you will review the Treatment Documentation Form. The form helps you to remember important elements of treatment and also allows you to document whether you have delivered each of them.

2.0 Session Two: Personalized Feedback and Evoking Change Talk

2.1. Beginning the Second Session.

Normally the second session begins with a brief status check and then proceeds with the process of assessment feedback. If your patient does not show readiness to discuss a change plan, 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 patient 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 CRAS.

Structuring Statement. Make a brief structuring statement to review what you and the patient 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.

2.2. Providing Assessment Feedback Using the Personalized Feedback Form (PFR)

The style of motivational interviewing has been combined with personal feedback in a motivational checkup format. Personal feedback 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.

Session 2 proceeds with your giving feedback to the patient from the pretreatment assessment. Do this in a structured way, providing your patient with a written report of his/her results (see the Personal Feedback Report, Appendix A; See Appendix B for information about how to prepare the PFR for the patient). To initiate this phase, give the patient the Personal Feedback Report (PFR), retaining a copy for your own reference and the patient's file. Go through the PFR step by step, explaining each item of information, pointing out the patient's score, and comparing it with the normative data when it is provided. The details of this feedback process are provided in Appendix C ("Therapist Guidelines for Presenting the Personal Feedback Report").

A very important part of this process is your own monitoring of and responding to the patient during the feedback. Observe the patient as you provide the feedback. Allow time spaces for the patient 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 patient reactions and therapist responses:

PATIENT: Wow! I'm drinking a lot more than I realized.

THERAPIST: It looks awfully high to you.

PATIENT: 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.

PATIENT: 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.

PATIENT: More bad news!

THERAPIST: This is pretty difficult for you to hear.

PATIENT: This gives me a lot to think about.

THERAPIST: A lot of reasons to think about making a change.

Often a patient 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 patient 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?

Patients will have questions about their feed-back 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 patient takes home.)

When you have completed your review of the patient's feedback, give the patient 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.

2.3. Evoking Client Change Talk

A useful way to end the Personal Feedback Report is with a transitional summary reflection that pulls together all of the patient's change talk (illustrated in "Summarizing'' section), 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 patient has the first responsibility for deciding what to do rather than your announcing what he/she "must" do. Respond with empathic reflection, then move on with Building Motivation.

2.4. Building Motivation.

As was discussed at this chapter's outset, motivation for change has various components, as suggested by the phrase "ready, willing, and able". A person needs to be willing to change, which involves perceiving that the change is important or beneficial. The reasons to change must outweigh the reasons to stay the same.

A person can be willing to change but doubt his/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").

As you prepare to make the transition to Session 3, use the Personal Rulers Worksheet (Form B) to assess quickly where your patient 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 patient the Personal Rulers Worksheet Form B). 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 patient 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 patient 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 patient's rating.)

2.5 A Decision Concerning Building Motivation or Beginning the Change Plan.

At this point, you need to make an important clinical judgment call: Should you proceed directly to the Treatment Planning or spend your treatment time continuing to strengthen motivation for change? As a guideline, any patient rating of less than a 6 bears further exploration. If the patient made a rating of 5 or less on any one of the scales, or if you decide for other reasons that it would be more valuable to the patient than moving forward, proceed to the optional "Exploring Motivation Ratings" procedure. If after you have explored the patient's ratings with this procedure you believe that further motivational building work is needed, you can use an optional procedure and "Reviewing Past Successes". Otherwise, proceed directly to the Functional Analysis.

2.5.a. Optional: Exploring Motivation Ratings.

If the patient reports low (less than 6) ratings or you otherwise decide that additional Phase A 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

For each of the three ratings that a patient 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 patient'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 patient's arguments for importance, ability, or readiness, and empathic listening is the appropriate response. Question 1 is not viable for the rare patient 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 patient's current score but is not more than 8. Question 2 evokes from the patient statements about the conditions under which perceived importance, ability, or readiness could increase, offering you some clues about what is needed for Treatment Planning. Again, reflective listening is your primary response to what the patient offers. If the patient'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 change talk 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 concerns 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 ready to make any change yet. Does that sound about right?

2.5.b. Optional: Reviewing Past Successes.

For some patients, 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 patient's low confidence is an impediment to motivation, review how the patient and others

have changed successfully in the past. Begin by asking the patient 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 patient's own initiative (rather than being imposed) and about which the patient seems to feel happy or proud. Then for these, explore what the patient 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 patient statements about personal ability to change. Rather than asking baldly, "How did you do it?" it may be helpful to have the patient walk you through what changed and how it happened. How did the change process start-what triggered it? What did the patient do? What difficulties did he/she encounter? How did the patient overcome them? How does the patient explain his/her success? What does this imply about the patient's personal strengths and skills? Avoid jargon here, and use the patient'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.

PATIENT: 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.

PATIENT: 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?

PATIENT: 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?

PATIENT: 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.

PATIENT: 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 patient is contemplating. 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. 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 patient 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 patient will find something that works, even if it's not on the first try.

2.6 Identifying Strengths and Resources

At this point, there are several good reasons to identify your patient'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 patient's problems and deficits requires balancing the picture.

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

Completing the session on a positive note is likely to reinforce commitment at the final step.

Knowing your patient's strengths and resources that support sobriety can be helpful in carrying out Phase B treatment.

2.6.a Eliciting Strengths with Open Questions

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 already to make this big change?

Here you are focusing on your patient's *positive attributes* that can be resources during the change process, not necessarily what they have accomplished in the past. This is also a good place for you to point out and affirm strengths that you see in your patient. You're looking here for stable, internal positive attributes of your patient, and when you hear them, reflect and reinforce them.

Ask the patient to elaborate. "In what ways are you a_____person? Give me an example.

Then ask “What strengths and resources 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 patient needs further prompting, try the following:

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

As the patient elaborates on the change talk statements 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 patient 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?

PATIENT: 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.

PATIENT: 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.

PATIENT: 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. 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 patient identifies several strengths, and offer summary reflections along the way.

2.6.b Characteristics of Successful Changers (Optional)

One additional way to elicit client strengths is the Characteristics of Successful Changers form (Form D). Invite the patient to look through it for words they think accurately describe them. 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 patient describes additional resources, follow the same procedure of asking for elaboration, reflecting, and moving on with "who else?" prompts. Patients 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

2.7 Closing Summary for Session 2.

Whether or not you have used the optional module, 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. This is what we will start with in the next session. We can also start considering the "how" of change-what you think you might want to do.

If the patient 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 patient's personal choice and control here, that whatever you do together, it will always be the patient's decision what, if anything, he/she will do about his/her drinking.

2.8 Ending Sessions.

In addition to a standard opening for sessions (see section 2.1) 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 patient 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

Change talk that has emerged during the session (and before)

Honest affirmation of the patient's efforts, strengths, intentions, and so on

Any tasks that the patient is to do between now and the next session

Scheduling of the next session.

3.0 Session 3: Functional Analysis (Evoking and Planning)

3.1. Beginning a Plan

You will need:

Alcohol Abstinence Self-Efficacy-Temptation (AAS-T) (Form V)

Desired Effects of Drinking Form (Form A)

Personal Happiness Card Sort (Form F)

Two Yes Checklist (Form F.a)

Options Worksheet (Form G)

And:

New Roads Worksheet (Form C)

Thoughts About Abstinence (Form E)

The key shift in Session 3 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 patient some ideas and ultimately a plan for what the patient 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 patient generates more self-motivational statements and ideas.

Continue to stress the patient'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 patient has about how to succeed in changing. If you have used the optional Reviewing Past Successes procedure in Session Two, you will already have some relevant material. It is also possible that this

discussion will have begun naturally when you asked a key question. Continue to use the style of motivational interviewing during this process. If this discussion did not flow naturally from Session 2, start the process with a structuring statement.

Below is a sample structuring statement that connects directly with the transitional material offered in the "Closing Session 2" section. Note that it begins with a key question as prescribed. You may want to refer to the Thoughts About Abstinence form the patient has filled out.

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 patient 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. Functional Analysis.

Whatever the patient's current thoughts are about change, move forward with the functional analysis in Session Three. This process should be called The New Roads Exercise when discussing it with the patient. "Functional analysis" is fine for treatment providers, but sounds a bit strange to the average ear.

The primary focus here is on the patient's alcohol use, and the functional analysis examines common antecedents and consequences of drinking behavior. Do not use technical jargon such as "antecedents" and "consequences" with most patients, of course. Introduce this part of Session 3 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. Triggers (also called "Antecedents").

Inquire about common antecedents of drinking, using the New Roads Worksheet. 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 patients:

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 patient 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.)

After you have exhausted your patient's spontaneous offerings of antecedents, turn to his/her AASE-T questionnaire. The AASE-T contains 20 possible triggers that the patient has ranked from 1 (not tempted at all) to 5 (extremely tempted to drink). Note items that the patient rated as 2 (moderately tempted) or higher. The example below addresses a way to discuss triggers the patient 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.

3.2.b. Effects (also called “Consequences”).

When inquiring about the patient's desired consequences of drinking, remember that you are inquiring here about the patient's *own perceived or expected effects of alcohol*, which need not correspond to the actual effects of ethanol. This is not the time to "correct'' the patient'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 patient'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 patient 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 patient's spontaneous offerings of consequences, turn to the patient's Desired Effects of Drinking (DED) questionnaire. The DED lists 37 possibly desirable expected consequences that the patient has ranked from 0 (never drank for this reason) to 3 (always drank for this reason). Note items rated by the patient as 3 (frequently) or higher. The sample sentence below shows a way to bring up any desired con- sequences not already mentioned by the patient:

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.

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

Normalizing helps the patient 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 patient 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 patient's language).

3.2.d. 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 patient. 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 patient confirms, draw a line from that "Trigger" box to the corresponding "Effect" box.)

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

For triggers that have not been paired, ask the patient 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 patient 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 pairings. It is not absolutely necessary to pair all entries.

3.2.e 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 patient says throughout this process. If objections or disagreements arise, continue to use the nonconfrontational methods described in Session 1 and 2 to defuse rather than increase uncooperative patient 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 alternatives. For others you may not, and we can talk about options or skills you might like to have. Having new roads to get from here to here is an important part of sobriety.

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

Proceed to review the pairs that have been identified, starting with the ones that the patient 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 patient'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.")

3.2.f Positive Connections.

Finish up your functional analysis by asking about antecedents (Triggers) and positive consequences (Effects) 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 patient'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 patient'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. CRAS focuses not only on drinking but also on a range of other life problems to which drinking can be linked. Patients 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 patients by identifying areas of functioning that could, if enhanced, have a beneficial impact in reducing their drinking and related problems. This is a further step toward developing a treatment plan that will address the patient's unique concerns and thereby enhance motivation for change.

3.3.a. Card Sorting.

Have ready a small table or flat surface. Hand your patient the Personal Happiness Card Sorting Task (Form F); 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: The first thing I'd like to do is explore how satisfied or happy you are in various parts of your life. On each card is printed one area of your life. 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 patient'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 patient's right side).

Give the patient time to complete the card sort. Circle "Yes" areas in the "Impacted by Alcohol" Column in Form F.a, *after* the card sort is completed.

Recombine the YES and NO cards, give the full deck back to the patient, and tell him/her to go 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 or complete some other task rather than watching as the patient sorts. When the patient has finished sorting, set the NO pile aside, take up the YES pile, and circle the YES in the second column of the Two Yes Form (Change Wanted). Finally, make a check in the 2 Yes Column for every item that is a "yes" in both the Impacted by Alcohol Column AND the Change Wanted Column.

3.3.b. Reviewing the "Two YES List"

Set aside the cards and work from the Two Yes Checklist

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. First, I want to ask you about the areas where you said that making a change might be important.

For each of the areas that were checked as YES for "Change", ask one or more follow-up questions, such as those listed below. Start with those "Change" areas in which the patient has expressed the greatest dissatisfaction (lowest ratings). Your goal is to elicit self-motivational statements that reflect the patient'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 patient offers. Don't ask three questions in a row without reflecting in between. Below are examples of follow-up questions:

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

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?

In what ways do you think this area is related to your drinking?

There may also be areas that the patient 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 (name of card) 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 patient to clarify his/her own thoughts and feelings about these life areas and to experience discrepancy. Focus on evoking change talk statements for change. If the patient has little desire to make any changes in an area, reflect/accept and move on.

3.3.c. Summarizing.

Once you have completed the Card Sorting Task and the Review of the Two Yes Sheet, 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 alcohol is having an impact on your life, and where you think a change is needed.

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?

3.3.d. Identifying Priorities.

A last step in reviewing psychosocial functioning is to draw on the patient's wisdom with regard to priorities for change. The extra focus here is on areas where the patient 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 Sheet (Form G):

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 patient 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 patients 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 patient may not want to make changes in this area. Your task is simply to help the patient 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 patient has identified more areas for change than can be addressed within the limits of the CRAS protocol and more areas than can be worked on at any one time. Several considerations are pertinent here, including the amount of distress the patient 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 CRAS treatment. The next step will be to prioritize goals.

When you complete this review of psychosocial functioning, close with a structuring statement that tells the patient that in the next session (ideally scheduled within a few days), you will work together to develop a change plan.

3.4 Closing the Session

Summarize and review change talk from the session, offering genuine affirmations as you can. Remind the patient that the SSO will be taking part in the fourth and last session.

4.0 Developing a Plan for Change and Involving the Supportive Significant Other

4.1 Involving the SSO in the Planning Session

The therapist begins by discussing with the SSO of their role in the session. The therapist should emphasize the SSO's role of offering suggestions about how they might support the patient's goal of changing their drinking. It is important here to help the SSO understand that the session should not be used to hear about the patient's shortcomings, the "real" picture of their drinking, or the state of the marriage more generally, although such topics might seem natural to discuss from the SSO's. perspective.

THERAPIST: Jane, I want to thank you for coming in today. I already know that you will be an important part of Bob's self-change plan because he has told me how much your marriage means to him. As Bob and I work during this session to make his plan to change his drinking, there might be ways he could use your support, and I will encourage him to ask for it. Of course, your cooperation is completely up to you, and it might be the case that you refuse some of these requests. It might also be that you have a different perspective about Bob's drinking, or you might disagree with some of his plans for changing. Again, it will be up to you how much you choose to support him, using your own wisdom about your situation. In general, this session today will be about what will happen in the future, rather than what has happened in the past even though that might be on everyone's mind. If you have concerns about offering your support in this way, I hope you will tell me now.

4. 2 Change Planning

4.2.a. Structuring Statement.

Use a structuring statement to provide transitional and structuring language when you shift to the planning process. 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 together what goals you want to pursue as we work together here. Obviously we can't cover all of the areas we've discussed, so we need to figure out what would be most helpful for you-how 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.

Using open questions and reflections to evoke from the patient what are the items that should be in the self-change plan, the therapist should complete the Self Change Plan (Form H) using the patients language and ideas. Any previous forms used in the treatment may be reviewed to help the patient generate ideas about what might be included in the plan. The problems to be addressed should be

those that contribute to the patients risk for drinking, but that is defined broadly and in a way that makes sense to the patient. The time frame of “the next two months” should be used (although many changes would take longer to finish), and there will typically be at least two to four items on the change plan. Examples of items on the plan might be “find a sober friend”, “find the nearest senior citizen center”, “improve communication with my wife (husband, partner)”, “find some nature walks for me and my dog” and so on. These goals should reflect the patient’s language and the patient’s ideas. Even if the therapist does not think the goals are ideal or the most important ones to be selected, the patient’s ideas should be prioritized in the self-change plan.

The therapist should always query the goal concerning alcohol, and it should form the number one item on the self-change plan. Although abstinence is the advised goal of the CRAS intervention, it is not imposed if the patient prefers to try to moderate their drinking instead. The Thoughts About Abstinence (Form E) should be reviewed if needed. If the patient expresses an interest in a non-abstinence goal, the Emphasizing Abstinence Procedure below should be used. The goal here is to show a preference for abstinence as a safe and more-likely-to-be-successful outcome, but not to insist upon it at the expense of patient cooperation.

4.2.b. Emphasizing Abstinence

At some point during Session 4 (or sooner, as appropriate) give your patient a rationale for abstaining from alcohol. It is important to remember here the difference between the treatment program's goal-abstinence-and the patient'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 patients make during pretreatment can predict outcomes (Miller et al. 1992a). Patients 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'' patients to make choices. The choice is always theirs, regardless of your recommendations. Nevertheless, in all cases, commend to patients 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.

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 patient against a goal other than abstinence if the patient 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 patient 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 patient to abstain
- Use/abuse of medications that are hazardous in combination with alcohol
- A history of severe alcohol dependence.

4.2.c Self Change Goals

THERAPIST: For the rest of our session, I'd like to make a plan together that spells out exactly what changes you would like to prioritize in the next few months. Let's start with your goal regarding alcohol. You've mentioned that you have decided to quit drinking entirely because you don't want to take any more chances that alcohol might ruin your life. Let's put that right here in the top row. What specific ideas do you have about how you are going to do that?

Once each goal is identified, the therapist will help the patient to specify how they will be accomplished, using goals that are measurable, achievable and have a "finish-line" date specified. This means, for example, that goals should be listed as specific active behaviors ("call Welcome Center in town to find a list of walking paths") rather than vague aspirations ("change my exercise habits"). A tentative timeline for the patient to complete them should also be noted. The most important thing about the self change goals is that they should come from the patient and they should reflect the patient's language when they are written down.

THERAPIST: Great. You've decided that you are going to let your close friends and family members know that you have stopped drinking so they can support you. You've also decided to remove any alcohol from your house. You are thinking about asking your doctor about medications that might help you with your cravings and you also plan to take a walk each day around 5 pm for about a month or so when your cravings are likely to be at their worst. Any other thoughts about how to meet your abstinence goal? Ok, what else should be on your change plan? What other areas of your life do you want to make a change to help with your drinking.

Once the Self Change Plan has been concluded the therapist should proceed with termination of the session and the treatment.

4.3. Recommending Mutual-Help Programs.

At some point during Phase A for all cases (usually while completing the Options sheet), discuss with your patient the possible use of mutual-help programs such as AA. Below is an example of a way to raise the subject and pro- vide 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 _____ (local mutual help groups named here). I wonder if you have been to any of these groups, and if so, what your experience has been.

Listen carefully to what the patient has to say about mutual-help groups, and respond with reflective listening. During the discussion, encourage the patient 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 patient'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 patients 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 patients who have previously attended and had a good experience: I'm glad you've already had some good experiences in _____. As I said, being involved in a group like this is one good source of support. If you like the group(s) you've attended, I certainly encourage you to keep going.

For patients 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?

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. 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 patients get involved.

4.4. Preparing the Self Change Plan.

The final step in Session 4 is to develop a specific self change plan, which closes the Treatment. The Self Change Plan (Form H) 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 patient, based on all of your discussions thus far. Below is an example of a way to introduce this to your patient:

THERAPIST: What we need to do now is to develop a change plan- This will be a record of what you plan to change in the next few months. This would include any changes in your drinking and can also include other changes that are important in your life.

Each row of the Self Change Plan is used to specify one problem that will be addressed by treatment (or in some cases, by referral).

For each problem (row), there are columns in which you specify three things. In the first column, "Problems I want to Change,'' specify these problems. Problem #1 will always be alcohol problems and/or dependence.

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, "Plan and Timeline," specify how you plan to address the stated problem to achieve the stated goal(s). Specify referrals and change activities that the patient is to pursue (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.

5.0. Consolidating Commitment.

As you and your patient negotiate the Self Change Plan, you will want to “cement” that commitment by taking time to summarize the change that the patient has indicated (abstinence or otherwise). This is the time to “collect up” all the change talk the patient has given you. It might sound something like this:

THERAPIST: Let me see if I have a picture here of what you are planning to change in the next few months. You’ve decided that you want to stop drinking completely, even though you are a little worried about whether or not you can do it. Because you are worried, you’ve decided to let your friends and family members know that you have stopped drinking. Mary has agreed to serve no alcohol at your holiday parties this year and the two of you have decided to treat yourselves to a wonderful dinner at your favorite restaurant when you reach your “one month sober” mark. In addition, you’ve decided to find some ways to increase your exercise by using walking paths in the parks by your house. You want to purchase a bicycle with the money you save from not buying alcohol in your first six months. Finally,

you've decided to look up some of your old friends from your soccer league because that might help with the isolation and sad feelings you have been having lately. Does this sound about right?

5.0.a. Asking for Commitment.

After you have recapitulated the patient's situation and responded to any additional points and concerns the patient (and SSO) raises, move toward a formal commitment to change. In essence, the patient 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 final summary:

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

Is that what you are going to do?

If the patient says yes, this is a good time to sign the Treatment Plan or the Self Change Plan together. Be sure to affirm your patient's decision, intentions, efforts, and so on.

5.0.b Patient will not commit to change in drinking

For patients who are not willing to commit to a change in their alcohol use even after the four sessions of the CRAS program are nearly complete, the therapist can still have a positive impact on the patient's future likelihood of drinking. The therapist simply acknowledges that the patient does not wish to make a decision at this time, and that he or she must have the final word in their own life. The therapist is careful to convey this in a respectful, and not sarcastic, manner. Understanding of the patient's dilemma is the attitude to strive for.

6.0 Terminating Session Four

Save at least 10 minutes at the end of the session to end the treatment and say goodbye to the patient and the SSO. Acknowledge gains the patient has made during the four sessions you have been working together (including especially any progress in changing drinking). Express any optimism you can about the patients' chances for change in the future as well as your best wishes for their success. Listen carefully for change talk and affirm it.

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APPENDIX A: PERSONAL FEEDBACK REPORT

Section 1. Alcohol Use

Your Drinking

Number of standard "drinks" per week: _____ drinks

Your weekly alcohol consumption is considered:

☐ "Low risk" drinking

☐ "At-risk" or "heavy" drinking

Level of Intoxication

Estimated blood alcohol concentration (BAC) level
on the day you drank the largest amount of alcohol: _____ mg %

This blood alcohol concentration is ☐ is not ☐ above the legal level of intoxication.

Section 2. Consequences

Subscales with "high" scores:

SUBSCALE	HIGH SCORE
Physical	☐ yes ☐ no
Emotional (intrapersonal)	☐ yes ☐ no
Social Responsibilities	☐ yes ☐ no
Relationships (interpersonal)	☐ yes ☐ no
Impulsive Actions	☐ yes ☐ no

Section 3. Medical Risks

Several medical conditions may be exacerbated by alcohol use.

Medical Condition	Yes	No
Myocardial Infarct	☐	☐
Congestive Heart Failure	☐	☐
Peripheral vascular disease	☐	☐
Cerebrovascular disease	☐	☐
Dementia	☐	☐
Ulcer Disease	☐	☐
Liver Disease ☐ Mild ☐ Moderate/Severe	☐	☐
Diabetes ☐ without complications ☐ with end organ damage	☐	☐
Renal Disease	☐	☐

Section 4. Preparation for Change in Drinking

Importance

1 2 3 4 5 6 7 8 9 10

Not at all Important — Extremely Important

Confidence

1 2 3 4 5 6 7 8 9 10

Not at all Confident — Extremely Confident

Readiness

1 2 3 4 5 6 7 8 9 10

Not at all Ready

Extremely Ready

APPENDIX B: INSTRUCTIONS FOR PREPARING THE PERSONAL FEEDBACK REPORT

Prior to your second session with a patient, the *Personal Feedback Report* (PFR) should be prepared. You should also allow yourself some time prior to the session to review the PFR in detail as well as the information contained in Appendix C (Guidelines for Presenting the PFR).

The following information from the forms the patient completed on the tablet PC is required:

- ✓ **Form 90**
- ✓ **DrInC questionnaire**
- ✓ **Charlson Comorbidity Index**
- ✓ **Personal Rulers**

Section 1. Alcohol Use

Your Drinking

Number of Standard Drinks per Week- This calculation is based on the 90 days preceding the most recent drink (not on the entire period covered by the baseline Form 90, which may include a period of abstinence prior to the interview). Two figures are considered based on calculations from the Form 90. 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.

Level of Intoxication

Estimated BAC Level-This figure is estimated from the Hours of Drinking section of Form 90. 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.

Section 2. Consequences

Score the DrlnC and record the patient's raw scores in the boxes using the scoring sheet shown below. Use the norms shown in the table below to determine the patient's decile for each of the five subscales. Be sure to use the correct gender profile table. For each subscale that falls in the "high" range, check mark the "yes" box on the PFR next to the corresponding subscale with the elevated score. Check "no" next to subscales in which scores are not in the high range.

Drinker Inventory of Consequences (DrInC-Recent)-Scoring

Instructions:

Sum answers for questions from the Drinker Inventory of Consequences:
Physical answers number: 1, 8, 11, 13, 24, 29, 33, and 48
Interpersonal answers number: 4, 7, 17, 21, 27, 30, 31, 39, 43, and 46
Intrapersonal answers number: 2, 12, 16, 18, 34, 36, 37, and 38
Impulse Control answers number: 9, 10, 19, 22, 23, 28, 32, 41, 42, 47, 49, and 50
Social Responsibility answers number: 3, 6, 14, 20, 26, 40, and 44
*Control Scale answers number: 5, 15, 25, 35, and 45

**Zero scores on control scale items may indicate careless or dishonest responses. Totals of 5 or less are suspect.*

DrInC Profile Sheet

Profile form for WOMEN

DECILE SCORES	Total Score	Physical	Inter-personal	Intra-personal	Impulse Control	Social Responsibility
10	81-135	17-24	22-30	23-24	15-36	14-21
9 Very High	68-80	14-16	18-21	22	12-14	12-13
8	61-67	13	15-17	20-21	11	10-11
7 High	53-60	11-12	13-14	18-19	9-10	9
6	48-52	10	11-12	15-17	8	8
5 Medium	41-47	9	9-10	14	6-7	6-7
4	36-40	7-8	8	12-13	5	5
3 Low	29-35	6	6-7	10-11	4	3-4
2	22-28	4-5	3-5	7-9	3	2
1 Very Low	00-21	0-3	0-2	0-6	0-2	1

RAW SCORES:						

Drinker Inventory of Consequences (DrInC-Recent)

DrInC Profile Sheet

Profile form for MEN

DECILE SCORES	Total Score	Physical	Inter-personal	Intra-personal	Impulse Control	Social Responsibility
10	86-135	17-24	23-30	23-24	17-36	16-21
9 Very High	75-85	15-16	20-22	21-22	14-16	14-15
8	68-74	13-14	18-19	19-20	12-13	12-13
7 High	60-67	12	15-17	18	10-11	10-11
6	53-59	10-11	13-14	16-17	9	9
5 Medium	46-52	9	11-12	14-15	8	8
4	39-45	7-8	9-10	12-13	7	6-7
3 Low	32-38	6	7-8	10-11	6	5
2	24-31	4-5	5-6	7-9	4-5	3-4
1 Very Low	00-23	0-3	0-4	0-6	0-3	0-2
RAW SCORES:						

Section 3. Medical Risks

Using information from the Charlson Co-morbidity scale, put a check mark next to each of the conditions the patient has experienced.

Section 4. Preparation for Change in Drinking

Transfer scores from personal rulers worksheet to PFR, circling number on the PFR.

APPENDIX C: THERAPIST GUIDELINES FOR PRESENTING THE PERSONAL FEEDBACK REPORT

This information is to help you in interpreting the PFR during the feedback session. Following the general motivational counseling style described in this manual, your task is to provide the patient with a clear explanation of his/her feedback in understandable language.

Give the original copy of the PFR (Appendix A) to your patient, and retain a copy for your file. When you have finished presenting the feedback, the patient 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 patient 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 patients.

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. Explain that the average number of standard drinks per week was calculated from the patient's own report of drinking in the pretreatment interviews and was converted into standard units.

United States:

In the US, 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 in the US:

Beverage	Usual%	Multiplied by	Ounces	Equals	Alcohol Content
Beer	.05	**X**	12	=	0.6
Table Wine	.12	**X**	5	=	0.6
Fortified Wine	.20	**X**	3	=	0.6
Spirits					
80 proof	.40	**X**	1.5	=	0.6
100 proof	.50	**X**	1.20	=	0.6

Germany/Denmark:

In Germany/DK, a "standard drink" is defined as any beverage that contains 1.5 cl (12 grams of ethanol) of 100% alcohol. Hence, the following beverages are each equal to one standard drink in Germany/DK:

Beverage	Usual%	Multiplied By	cl	Equals	Alcohol Content (12 grams)
Beer	.045	**X**	33	=	12
Table Wine	.12	**X**	13	=	12
Fortified Wine	.20	**X**	8.3	=	12
Spirits					
80 proof	.40	**X**	4.1	=	12
100 proof	.50	**X**	3.0	=	12

Is this drinking pattern risky?

Based on the patient's average consumption of drinks per week, we can compare that information to national guidelines that have established cutoffs on low risk vs. high risk drinking. For healthy adults in general, drinking more than these single-day or weekly limits is considered "at-risk" or "heavy" drinking:

United States:

Low risk drinking is defined differently for men and women. These limits have been set by the National Institute on Alcohol Abuse and Alcoholism (NIAAA). The reason for this is that research shows that women start to have alcohol-related problems at lower drinking levels than men do. One reason is that, on average, women weigh less than men. In addition, alcohol disperses in body water, and pound for pound, women have less water in their bodies than men do. So after a man and woman of the same weight drink the same amount of alcohol, the woman's blood alcohol concentration will tend to be higher, putting her at greater risk for harm. For men, low level limits are defined as no more than four drinks on any day AND no more than fourteen drinks per week. For women, low level limits are defined as no more than three drinks on any day and no more than seven drinks per week. To stay low risk, patients need to stay within BOTH the single-day AND weekly limits.

"Low risk" is *not* "no risk." Even within these limits, drinkers can have problems if they drink too quickly, have health problems, or are older (both men and women over 65 are generally advised to have no more than 3 drinks on any day and 7 per week). Based on your health and how alcohol affects you, you may need to drink less or not at all.

For healthy adults in general, drinking more than these single-day or weekly limits is considered "at-risk" or "heavy" drinking. For men, more than four drinks on any day or fourteen per week is considered

heavy drinking. For women, more than three drinks on any day or seven per week is considered heavy drinking.

About 1 in 4 people who exceed these limits already has an alcohol use disorder, and the rest are at greater risk for developing these and other problems. Again, individual risks vary. People can have problems drinking less than these amounts, particularly if they drink too quickly.

Denmark:

Low risk drinking is defined differently for men and women. The reason for this is that research shows that women start to have alcohol-related problems at lower drinking levels than men do. One reason is that, on average, women weigh less than men. In addition, alcohol disperses in body water, and pound for pound, women have less water in their bodies than men do. So after a man and woman of the same weight drink the same amount of alcohol, the woman's blood alcohol concentration will tend to be higher, putting her at greater risk for harm. For women, low level limits are defined as below seven standard units (7 *12 grams of ethanol) per week. For men, low level limits are defined as below fourteen standard units (14 * 12 grams of ethanol) per week.

“Low risk” is *not* “no risk.” Even within these limits, drinkers can have problems if they drink too quickly, have health problems, or are older. Based on your health and how alcohol affects you, you may need to drink less or not at all. People can have problems drinking less than these amounts, particularly if they drink too quickly.

For women, drinking more than fourteen standard units (14 * 12 grams of ethanol) per week is considered high risk. For men, drinking more than twenty-one standard units (21 * 12 grams of ethanol) per week is considered high risk. Also, drinking more than five standard units (5 * 12 grams of ethanol) per drinking occasion is considered binge drinking. Binge drinking is considered high-risk.

Germany:

Low risk drinking is defined differently for men and women. The reason for this is that research shows that women start to have alcohol-related problems at lower drinking levels than men do. One reason is that, on average, women weigh less than men. In addition, alcohol disperses in body water, and pound for pound, women have less water in their bodies than men do. So after a man and woman of the same weight drink the same amount of alcohol, the woman's blood alcohol concentration will tend to be higher, putting her at greater risk for harm. For women, low level limits are defined as below 7 * 12 grams of ethanol per week. For men, low level limits are defined as below 7 * 24 grams of ethanol per week.

“Low risk” is *not* “no risk.” Even within these limits, drinkers can have problems if they drink too quickly, have health problems, or are older. Based on your health and how alcohol affects you, you may need to drink less or not at all. People can have problems drinking less than these amounts, particularly if they drink too quickly.

For healthy adults in general, drinking more than these weekly limits is considered "at-risk" or "heavy" drinking.

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 patients). If you or your patient wants to compare this with the usual decimal expressions of BAC, move the decimal point three places to the left, as shown below:

80mg%	=	.08	
100mg%	=	.10	
256mg%	=	.256	and so on

Note that the "normal social drinking" range is usually defined as 20 to 60 mg% in peak intoxication (see Appendix D). In fact, the vast majority of drinkers do not exceed 60 mg% when drinking.

Legal intoxication in the US (for most states) is defined as 80 mg%. In Denmark and Germany, 50 mg% is above the legal level for driving. Having the presence of any alcohol in your system, however, can result in increased legal consequences (e.g., even a level of 10 mg% in the US could results in a DUI if you were pulled over or in an accident; in Germany and Denmark, if someone was involved in an accident and the person was found to have an alcohol level of 30 mg %, that person would be faulted for the accident).

Although 500 mg% is a lethal dose of alcohol for most adults, some people with alcohol problems 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.

Because of tolerance, people may reach very high BAC levels without feeling very different from their usual self. 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-You may want to discuss tolerance as a risk factor, particularly if a patient seems to view his or her high BAC as something positive, the ability to “hold his or her liquor” rather than as a sign of possibly drinking too much. The idea of tolerance is counterintuitive for many patients, 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 patient during the pretreatment assessment period. Below are four optional points to cover (in language appropriate for your patient):

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.

Section 2. Consequences

For the patient's recent negative consequences of drinking (as scored from the DrlnC), patients are receiving feedback on which areas their consequences are high relative to *people currently seeking treatment for an alcohol use disorder*. Explain that this shows the extent to which the patient has experienced negative consequences (problems) related to his/her alcohol 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."

Physical	This score reflects unpleasant physical effects of alcohol use such as hangovers, sleeping problems, and sickness; harm to health, appearance, eating habits, and sexuality; and injury while drinking.
Interpersonal	These are 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.
Intrapersonal	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.

Impulsive Actions	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.
Social Responsibility	These are negative consequences more easily seen by others. They include work/school problems (missing days, poor quality of work, being fired or suspended), spending too much money, getting into trouble, and failing to meet others' expectations.

Explain to patients that they are receiving feedback only on subscales with scores elevated to the point that their consequences in a particular area are high even among people who are currently seeking treatment for alcohol. This does not mean that they are not experiencing significant consequences in other areas.

Section 3. Medical Risks

Below is some basic information to help you understand these different medical comorbidities your patient has been diagnosed with. Explain the way alcohol may exacerbate these medical conditions.

This information is also included, in less detail, in the patient's copy of the "Understanding Your Personal Feedback Report."

Myocardial Infarction: Your heart is a pump that keeps blood moving around your body. It delivers oxygen and nutrients to all parts of your body, and carries away unwanted carbon dioxide and waste products. When your heart, the arteries around your heart, or your other blood vessels are damaged, this pumping system doesn't work properly. Such problems are collectively known as cardiovascular disease. Coronary heart disease is the most common type of heart disease and can lead to sudden death from a heart attack. Someone has a heart attack when their coronary arteries become blocked. This stops blood flowing freely to the heart, so it can't get the oxygen it needs. Drinking more than the daily unit guidelines regularly and over a long period of time can increase your risk of developing heart disease. This is because, drinking at this level can:

- Increase the risk of high blood pressure. Drinking excessive amounts of alcohol causes raised blood pressure which is one of the most important risk factors for having a heart attack or a stroke. Alcohol is thought to do this through its effects on the kidneys and the blood vessels. Increases in your blood pressure can also be caused by weight gain from excessive drinking.
- Weaken the heart muscle. This means the heart can't pump blood as efficiently. It's known as cardiomyopathy and can cause premature death, usually through heart failure.
- Lead to an enlarged heart. This is a sign that the heart is unable to effectively pump blood around the body, and is known as heart failure.

Congestive Heart Failure: Congestive heart failure means the heart does not pump as well as it should to meet the body's oxygen demands, often due to heart diseases such as cardiomyopathy or cardiovascular disease. CHF can result from either a reduced ability of the heart muscle to contract or from a mechanical

problem that limits the ability of the heart's chambers to fill with blood. When weakened, the heart is unable to keep up with the demands placed upon it; blood returns to the heart faster than it can be pumped out so that it gets backed up or congested—hence the name of the disorder. Drinking alcohol in large quantities has a toxic effect on the heart. Alcoholic cardiomyopathy is a form of a condition in which the heart becomes enlarged and the heart muscle thins due to alcohol use. Alcoholic cardiomyopathy causes the weakened heart muscle to pump inefficiently, leading to heart failure. In severe cases, the lack of blood flow affects all parts of the body, damaging many tissues and organs.

Peripheral Vascular Disease: Drinking too much alcohol can raise blood pressure to unhealthy levels. Research indicates that having more than three drinks in one sitting temporarily increases your blood pressure, and repeated heavy drinking can lead to long-term increases. High blood pressure (hypertension) can severely damage your blood vessels, increasing the likelihood of developing a cardiovascular disease such as peripheral vascular disease. In PVD, a build-up of fatty deposits in the arteries restricts blood supply to arteries that supply blood to your limbs. The good news is that alcohol's impact on blood pressure seems to be quite reversible, meaning making a change in your drinking can almost immediately significantly decrease your blood pressure.

Cerebrovascular Disease: Cerebrovascular diseases are conditions that develop as a result of problems with the blood vessels that supply the brain. To function properly, the brain needs oxygen and nutrients that are provided by the blood. However, if the blood supply is restricted or stopped, brain cells will begin to die. This can lead to brain damage and possibly death. The most common risk factor for developing cerebrovascular disease is high blood pressure. Drinking too much alcohol can raise blood pressure to unhealthy levels. Research indicates that having more than three drinks in one sitting temporarily increases your blood pressure, and repeated heavy drinking can lead to long-term increases. High blood pressure (hypertension) can severely damage your blood vessels. Cutting down on drinking can help to lessen the risk of further strokes.

Dementia: Excessive drinking over a period of years may lead to a condition known as Alcohol Dementia, which can cause problems with memory, learning and other cognitive skills. Alcohol has a direct effect on brain cells, resulting in poor judgment, difficulty making decisions and lack of insight. Nutrition problems which often accompany long-time alcohol abuse can be another contributing factor, since parts of the brain may be damaged by vitamin deficiencies. Those suffering from dementia may have very little ability to learn new things, while many of their other mental abilities are still highly functioning. Along with the decline in cognitive skills, sometimes noticeable personality changes take place.

Ulcer Disease: Peptic ulcer disease refers to painful sores or ulcers in the lining of the stomach or the first part of the small intestine, the duodenum. Normally, a thick layer of mucus protects the stomach lining from the effect of its digestive juices. But many things can reduce this protective layer, allowing for ulcers to occur. People who drink regularly are more likely to get ulcers. Alcohol can irritate and erode the mucous lining of your stomach, and it increases the amount of stomach acid that's produced.
If not properly treated, ulcers can lead to serious health problems by damaging the stomach lining.

Liver Disease: 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. As liver disease becomes moderate or severe, blood can no longer flow easily through the liver and blood begins to get backed up into the veins of the esophagus and abdomen. These veins can burst open and cause life threatening bleeding. Backed up fluid can also accumulate in the abdominal cavity and become infected. Research indicates that stopping drinking will often allow liver functioning to improve. The longer a person continues drinking, however, the more difficult it is to reverse the physical damage that is done.

Diabetes: Diabetes is a problem with your body that causes blood glucose (sugar) levels to rise higher than normal. Alcohol consumption by diabetics can worsen blood sugar control. While moderate amounts of alcohol can cause blood sugar to rise, excess alcohol can actually decrease your blood sugar level -- sometimes causing it to drop into dangerous levels because the liver is occupied by metabolizing alcohol and cannot produce sugar (which the liver actually does between meals so the blood sugar level is kept fairly stable). Beer and some types of wine contain carbohydrates and may raise blood sugar. Alcohol stimulates your appetite, which can cause you to overeat and may affect your blood sugar control. Alcohol can also interfere with the positive effects of oral diabetes medicines or insulin. As diabetes worsens, it damages delicate blood vessels in important organs including eyes and kidneys. Since alcohol also contributes to kidney disease, the kidneys are subjected to double the insult.

Renal Disease: The normal function of the kidneys is to filter and remove the metabolic wastes that build up in the body. If you have chronic renal disease then your kidneys are not working as well as they once did. People with renal disease have an increased risk of developing heart disease or a stroke. Alcohol destroys this delicate balance of the ions and water in the body by altering the filtering ability of the kidneys. Kidney complications are even greater if a person has also been diagnosed with liver damage due to alcohol consumption. High blood pressure is a major cause of renal disease. Drinking too much alcohol can raise blood pressure to unhealthy levels. Research indicates that having more than three drinks in one sitting temporarily increases your blood pressure, and repeated heavy drinking can lead to long-term increases.

Cancer: Cancer is an overgrowth of mutated cells. When cells become mutated they grow in a disorganized and often aggressive way. Cancer cells can invade normal body parts, damaging them and interfering with their proper function. Alcohol increases the risk of cancer by causing mutations in cells. It can cause mutations either through direct toxic effects to cells – such as in the liver and esophagus- or by being turned into other toxic chemicals that cause cancer- as in the case of breast or mouth cancer. No matter which way alcohol causes mutations, there is clear evidence that alcohol in a dose-dependent pattern increases the risk of cancer in many organs, including oropharynx, larynx, oesophagus, liver, colon-rectum and breast.

Section 4. Preparation for Change in Drinking

This section contains three different variables that make up the three components of motivation—importance to change, confidence in the ability to change, and readiness to change. Explain that these are important indicators of how prepared your patient is for change in drinking and what potential obstacles to change are present. Explain that just because someone may feel that making a change is very important, it may be possible that he or she doesn't feel able to make a change, reflecting low confidence scores.

Importance: High scores here reflect a belief that there is significant value in making a change. Patients with low scores are indicating less of a desire in and fewer reasons for making a change.

Confidence: High scores here reflect a high degree of confidence (self-efficacy) or ability to make a change in drinking. Patients with low scores are not reporting much confidence in their ability to make a change.

Readiness: High scores here reflect someone's readiness to make a change in drinking. Patients with low scores don't feel ready to make a change.

Here it is helpful to begin exploring the patient's perception of these motivational components and begin to elicit change talk.

After presenting the number the patient indicated on each of the rulers, ask the following question:

Why are you a [circled number] and not a [lower number, 2-3 away from circled number]?
Reflect, elaborate, summarize and affirm as appropriate.

Then ask:

What would it take for you to go from [circled number] to [higher number, 2-3 away from circled number]?
Reflect, elaborate, summarize and affirm as appropriate.

APPENDIX D: UNDERSTANDING YOUR PERSONAL FEEDBACK REPORT

The Personal Feedback Report (PFR) summarizes results from your pretreatment evaluation. Your therapist 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. 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.)

The list below shows different types of standard one-drink units:

UNITED STATES:

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.

DENMARK/GERMANY:

One 33 cl beer	4.5 percent alcohol
One 13 cl glass of wine	12 percent alcohol
One 8.3 cl glass of fortified wine (sherry, port, etc.)	20 percent alcohol
One 4.1 cl glass of liquor	40 percent alcohol
One 3 cl glass of liquor	50 percent alcohol

All of these drinks contain the same amount of the same kind of alcohol: 1.5 cl (12 grams) of ethyl alcohol.

Low Risk vs. At-Risk or Heavy Drinking

United States:

Low risk drinking limits: For men, no more than four drinks on any day AND no more than fourteen drinks per week. For women, no more than three drinks on any day and no more than seven drinks per week. To stay low risk, keep within BOTH the single-day AND weekly limits.

"Low risk" is *not* "no risk." Even within these limits, drinkers can have problems if they drink too quickly, have health problems, or are older (both men and women over 65 are generally advised to have no more than 3 drinks on any day and 7 per week). Based on your health and how alcohol affects you, you may need to drink less or not at all.

At-Risk or Heavy Drinking: For healthy adults in general, drinking more than these single-day or weekly limits is considered "at-risk" or "heavy" drinking. For men, more than four drinks on any day or fourteen per week is considered heavy drinking. For women, more than three drinks on any day or seven per week is considered heavy drinking.

About 1 in 4 people who exceed these limits already has an alcohol use disorder, and the rest are at greater risk for developing these and other problems. Again, individual risks vary. People can have problems drinking less than these amounts, particularly if they drink too quickly.

Denmark:

Low risk drinking limits: Low risk drinking is defined differently for men and women. The reason for this is that research shows that women start to have alcohol-related problems at lower drinking levels than men do. One reason is that, on average, women weigh less than men. In addition, alcohol disperses in body water, and pound for pound, women have less water in their bodies than men do. So after a man and woman of the same weight drink the same amount of alcohol, the woman's blood alcohol concentration will tend to be higher, putting her at greater risk for harm. For women, low level limits are defined as below seven standard units (7 *12 grams of ethanol) per week. For men, low level limits are defined as below fourteen standard units (14 * 12 grams of ethanol) per week.

"Low risk" is *not* "no risk." Even within these limits, drinkers can have problems if they drink too quickly, have health problems, or are older. Based on your health and how alcohol affects you, you may need to drink less or not at all. People can have problems drinking less than these amounts, particularly if they drink too quickly.

At-Risk or Heavy Drinking: For women, drinking more than fourteen standard units (14 * 12 grams of ethanol) per week is considered high risk. For men, drinking more than twenty-one standard units (21 * 12 grams of ethanol) per week is considered high risk. Also, drinking more than five standard units (5 * 12 grams of ethanol) per drinking occasion is considered binge drinking. Binge drinking is considered high-risk.

Germany:

Low risk drinking limits: Low risk drinking is defined differently for men and women. The reason for this is that research shows that women start to have alcohol-related problems at lower drinking levels than men do. One reason is that, on average, women weigh less than men. In addition, alcohol disperses in body water, and pound for pound, women have less water in their bodies than men do. So after a man and woman of the same weight drink the same amount of alcohol, the woman's blood alcohol concentration will tend to be higher, putting her at greater risk for harm. For women, low level limits are defined as below 7 * 12 grams of ethanol per week. For men, low level limits are defined as below 7 * 24 grams of ethanol per week.

"Low risk" is *not* "no risk." Even within these limits, drinkers can have problems if they drink too quickly, have health problems, or are older. Based on your health and how alcohol affects you, you may need to drink less or not at all. People can have problems drinking less than these amounts, particularly if they drink too quickly.

At-Risk or Heavy Drinking: For healthy adults in general, drinking more than these weekly limits is considered "at-risk" or "heavy" drinking.

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.

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.

80 mg% is the legal definition of intoxicated in most states in the US.

50 mg% is the legal definition of intoxicated in Denmark and Germany.

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). Crucial abilities such as memory, judgment and perception are impaired at a level of 40 to 60 mg%. 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.

Section 2. Consequences

This section summarizes the negative consequences of drinking—the harmful effects alcohol has had on your life-- during the months immediately preceding the time you entered this program. Here your own personal scores are being compared *with other people who are already in treatment for alcohol problems.* Your personal feedback report indicates which of these specific scales were in the "high" range. The high range means you're your scores are quite elevated, even among people who are already experiencing enough problems from alcohol that they are seeking treatment.

The specific scales show the types of problems you may be having in these areas:

Physical (Ph)	This score reflects unpleasant physical effects of alcohol use such as hangovers, sleeping problems, and sickness; harm to health, appearance, eating habits, and sexuality; and injury while drinking.
Interpersonal (Re)	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.
Intrapersonal (Pe)	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.
Impulsive Actions (Im)	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.
Social Responsibility (Sr)	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 3. Medical Risks

Your pretreatment evaluation also included a questionnaire on your physical health. Many chronic health conditions have been shown to be negatively affected by heavy drinking.

Drinking more than the daily unit guidelines regularly and over a long period of time can increase your risk of developing

Heart attack or Heart Failure. Drinking at this level increases the risk of high blood pressure, poisons the heart muscle, and leads to a weak heart that does not pump blood well. This can cause swelling in your legs, trouble breathing, chest pains and death.

Peripheral Vascular Disease and Cerebrovascular Disease (stroke). When you drink, your blood pressure increases. When your blood pressure increases to dangerous levels, important blood vessels in your body and brain can become damaged. This can lead to the need to amputate legs, permanent weakness or paralysis, trouble speaking and possibly death.

Dementia. Alcohol leads to high blood pressure which can damage brain cells. This can cause severe memory loss and inability to care for yourself.

Ulcer Disease. Alcohol can damage the lining of your stomach. This can lead to bad stomach pain and bleeding from your stomach.

Liver Disease. Drinking can cause damage to the liver. If the liver is damaged enough it will gets scarred (called cirrohosis) and not work properly. This can lead to problems with severe swelling in the stomach and legs, confusion, bleeding from the stomach and throat, liver cancer and death.

Diabetes or worsen diabetes. Alcohol can worsen blood sugar control and cause both an increase in blood sugar level as well as a drop in blood sugar level. Blood vessels may become damaged and result in problems with your kidneys and eyes, as well as increase the risk of developing ulcers.

Cancer. Alcohol can damage healthy cells or be turned into chemicals that cause mutations in cells turning them into cancer cells. Alcohol has been proven to increase risk of cancer of many different parts of the body including the liver, breast, mouth, esophaghus, stomach and intestine.

Section 4. Preparation for Change in Drinking

How prepared are you to make a change in your drinking? This section reviews three factors that can help (or stand in the way of) your changing. Consider why you chose this number rather than a lower number. What makes you believe you can make a change in your alcohol use? What do you need, or what would help you to succeed in making a change in your alcohol use?

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.

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.

Importance. Are there good reasons to make a change? A high score indicates you want to do it. A low score reflects some hesitation in thinking you need to make a change.

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: Forms for the Standard Treatment

List of Forms

A	Desired Effects on Drinking
B	Personal Rulers Worksheet
C	New Roads Worksheet
D	Characteristics of Successful Changers
E	Thoughts About Abstinence
F	Personal Happiness Card Sorting Task
G	Options Sheet
H	Self Change Plan

A. 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 B: Personal Rulers Worksheet

Client # :_____ Therapist:_____

Personal Rulers Worksheet

Importance Ruler

0	1	2	3	4	5	6	7	8	9	10
Not at all important		Somewhat important		Fairly important		Important		Very important		Extremely important

Confidence Ruler

0	1	2	3	4	5	6	7	8	9	10
Not at all confident		Somewhat confident		Fairly confident		Confident		Very confident		Certain

Readiness Ruler

0	1	2	3	4	5	6	7	8	9	10
Not at all ready		Somewhat ready		Fairly ready		Ready		Very ready		Completely ready

Form C: New Roads Worksheet

Client#:_____ Therapist:_____

New Roads Worksheet

Triggers		Effects

Form D: Characteristics of Successful Changers

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

Form E: Thoughts About Abstinence

Patient_____ Therapist_____

We would like to know what GOAL you have chosen for yourself about drinking alcohol at this time.

Please read the goals listed on this page and mark an X next to the one goal that best represents your own goal at this time.

_____ (1) I really don't have a clear goal in mind.

_____ (2) I want to use alcohol in a controlled manner – to be in control of how often I use and how much I use.

_____ (3) I want to be totally abstinent from all alcohol use for a period of time, after which I will make a new decision about whether or not I will drink alcohol again in any way.

_____ (4) I don't want using alcohol to be a habit for me anymore, but I would like to occasionally use alcohol when I really have an urge.

_____ (5) I want to quit using alcohol once and for all, even though I realize I may slip up and use alcohol once in a while.

_____ (6) I want to quit using alcohol once and for all, to be totally abstinent, and never use alcohol ever again for the rest of my life.

_____ (7) None of the above applies exactly to me.

_____

_____

Form F: Personal Happiness Card Sorting Task

Personal Happiness Card Sort
(Copy onto card stock and cut into cards)

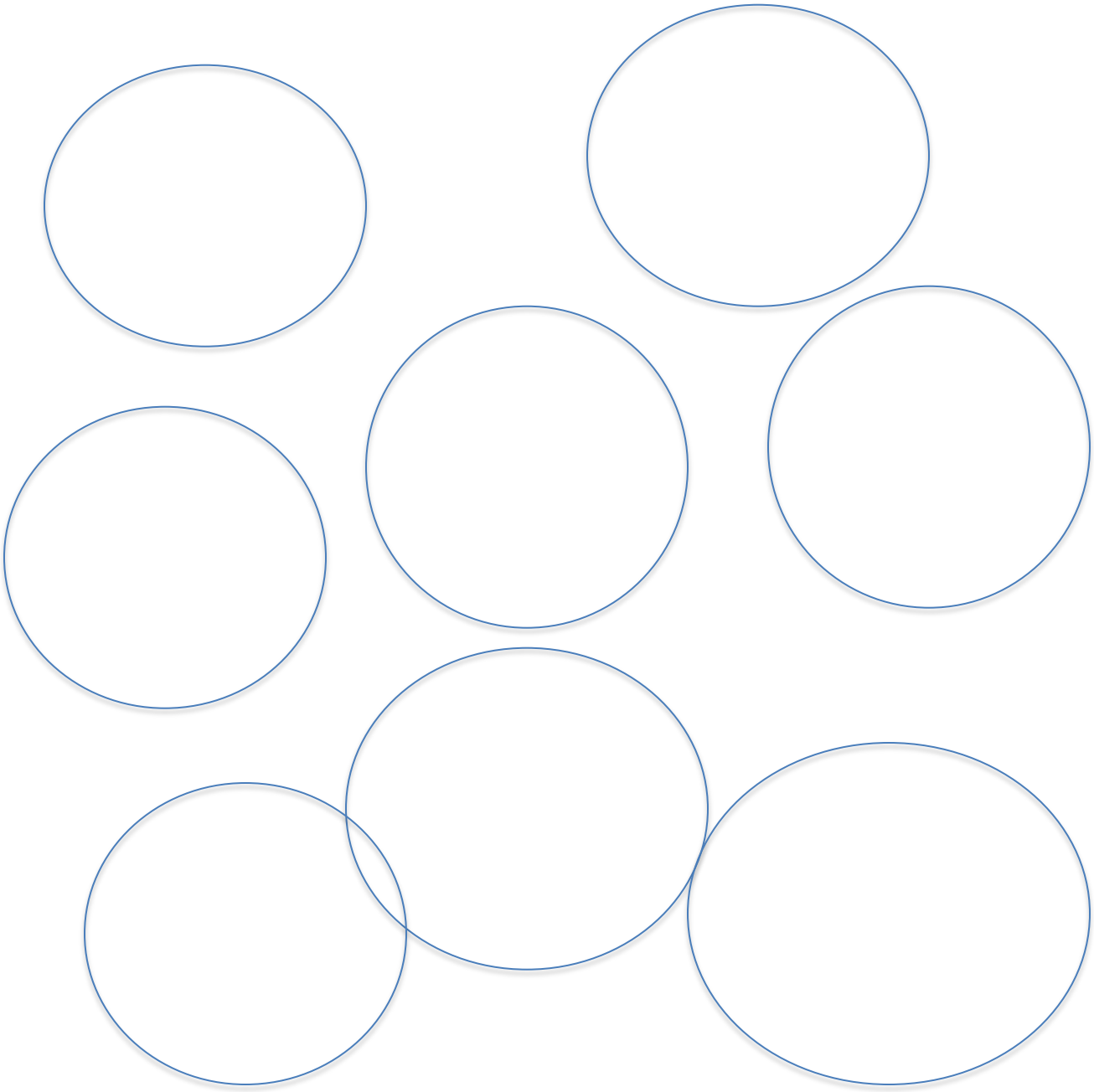
Personal Happiness Card Sort	Friends and Social Life 1	Job/Work 2
Where I Live 3	Money and Financial Security 4	Education and Learning 5
Leisure Time and Fun 6	Mood and Self-Esteem 7	Anger and Arguments 8
Stress and Anxiety 9	Physical Health 10	Spirituality 11

Sexuality 15	Eating and Weight 16	Physical Activity and Exercise 17
Giving/Caring for Others 18	Mental Ability and Memory 19	Personal Safety and Security 20
YES	NO	

Form G: Options Worksheet

Patient_____ Therapist_____

Options Worksheet



Form H: Self Change Plan

Client#: _ _ _ _ _ _ _

Therapist:

Self Change Plan

Problems I Want Change	How I Want Things to be Different	Plan (How) and Timeline (When)
# 1 Alcohol		
#2		
#3		
#4		
#5		

Therapist Signature:

Client Signature: Date: