Community Reinforcement Approach for Seniors (CRAS)
Treatment Manual for Project Elderly, Extended Condition (MET+CRA)
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 Extended Treatment (CRA-S) 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 discrepancy 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 treatment plan. The functional analysis, in turn, suggests particularly helpful changes that form the core of the Treatment 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?
-

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 a questionnaire 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 questionnaire 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 Extended Intervention

1.6.c.2 Rationale for the Extended Condition

For most therapists, the rationale for the Extended Condition fits easily within their conceptualization of "treatment" for substance use problems. The EC is based on the notion that problem drinking occurs, at least in part, because of a lack of skills and adaptive behaviors. The idea behind the treatment modules in the EC is to provide knowledge about these skills and help patients to practice them in a supportive context. For example, if patients do not have very good strategies for coping with depression, drinking will be a natural and expected coping response. However, if patients can acquire new skills for managing negative emotions, they are in a position to make a more positive coping choice when they are depressed. The modules for the EC have identified the most common areas where problem drinkers lack coping skills. Some of these skills are relevant to the client's life in general (Recreation, negative moods, , challenges of aging) and some are specific to changing drinking (craving). The job of the therapist is to provide expert knowledge about these skills and assistance to the client in trying them out. The skills themselves "do the work" of helping the client to change, and the therapist is the expert coach in helping the client to acquire them.

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.

Important Tips to Remember When Providing the Rationale for the Extended Condition

1) Learning new skills to reduce drinking has strong research support

2) Learning new skills requires a therapist with expertise to teach and coach

3) Patients need both information and practice to be successful with new skills

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 also has the opportunity, based on patient choice, to attend any CRAS session after the fourth session.

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 form a plan together to help you meet your goals during our treatment sessions.

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 and Invitation to the SSO.

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.

Here is a sample letter of Invitation to the SSO:

Dear [SSO]:

This letter is an invitation for you to participate in a treatment program in support of [patient], who believes you could be particularly helpful. I am currently working with [him/her] in our program, which is one of a number of treatment centers in the United States participating in the development of state-of-the-art treatment for alcohol problems. This treatment works best when a supportive person participates in the treatment sessions. [He/She] values your help and has named you as a trusted person who could fulfill this important role. [He/She] views you as someone who is available and supportive as well as positive about [his/her] seeking treatment for alcohol problems.

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

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

I hope that you will agree to come to at least one session to explore how you might support [his/her] efforts toward change. He/she can tell you the date and time of [his/her] next appointment so that you may attend.

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

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 Documentation Form.

1.8 Completing the Therapist Checklist.

At the end of every session you will review the Therapist Checklist. 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.

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 identifying strengths and resources discussion (2.6) 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 Identifying Strengths and Resources section.

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 (2.5.b. and 2.6.b).

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 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.

2.7. a Interim Homework Assignments: Extended Condition Only

Some patients will come into treatment much more ready to change than others. One way to address this eagerness is to provide a home task assignment at the end of the second or even first session, if you think the patient is ready for it. The assignment must be consistent with one of the CRAS modules, but this still allows for considerable latitude. For example, invite a patient to visit a mutual-help group meeting or sample an enjoyable alcohol-free activity. It would be possible to start a patient on mood monitoring or completing a referral to an agency that provides a needed service. Choose an assignment that is consistent with where you anticipate treatment will be going, based on what you already know about your patient. The SSO may or may not be involved in this assignment, though it is often a good place to start in initiating SSO support.

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

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)

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.

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. 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 your extended treatment sessions might focus. For example, if a patient mentions negative mood, it will be important to highlight the Mood Management module as a possible strategy for addressing it. Do not assume patients will want the module you offer, nor should you insist they accept it. Neverthless, it is likely that when patients identify a problem, they will be curious about your ideas for how it might be improved. You can expect that patients will be interested in your ideas at this point.

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 treatment 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 session and any subsequent sessions where there is agreement that it would be helpful.

4.0 Session 4. Developing a Plan for Change and Involving the Supportive Significant Other

4.1 Understanding and Involving the SSO in the Extended Treatment

The therapist begins by discussing with the SSO 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.

Involving the SSO in EXTENDED treatment.

To prevent misunderstandings among you, your patient, and the SSO that could result in compliance problems later on, review the goals and objectives of the patient's treatment, as listed below:

The overall purposes of the initial SSO- involved session are as follows:

1. To orient the SSO to his/her role/function in CRAS treatment

2. To obtain the SSO's commitment in supporting the patient's efforts to change

3. To enhance the SSO's skill in providing clear and meaningful support to the patient.

Efforts are made to find opportunities for the SSO to increase his/her supportive behaviors. Other activities include helping the SSO determine when to, and when not to, offer support. For example, there are certain circumstances in which it may be desirable for the SSO to "back off' rather than to continue to offer support. Such situations may involve a patient's failure to adhere to treatment goals, such as not taking medications or not being willing to "sample" abstinence. Under these circumstances, it may be valuable for the SSO to withdraw her/his support to allow the patient the opportunity to experience the costs or con- sequences of his/her choices and actions. This process can help mobilize a patient's inner resources to deal with the drinking problems.

4.1.a Explaining Involvement to SSO

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

Explain that the SSO is not expected in any way to be a co-therapist, and assure the SSO that you will not ask him/her to do anything that he/she is not comfortable doing.

If the SSO is a family member, explain that you will not be doing marital or family therapy (in which the relationship is the focus of treatment). You may discuss issues that have to do with

communication in relation- ships, but the primary purpose of treatment is to help the patient get and stay sober.

Explain that the SSO's role does not include any policing or enforcing but that the main focus is to be supportive of change.

Explain clearly that the SSO's role is to provide support for sobriety during treatment, both inside and outside of sessions. This will include the following areas:

Offering helpful ideas and input

Giving encouragement

Supporting and reinforcing the patient's efforts to stay sober

Helping-in ways the patient wishes- to carry out plans for staying sober.

Tell the SSO that in general, by becoming an ally for change, he/she can help to improve the effectiveness of treatment. However, remind the patient that no one else can make the ultimate decision about change or take responsibility for it.

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

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

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

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

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

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

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

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

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

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

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

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

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

Ask whether the SSO is willing to help in this way.

Ask whether the patient is willing to have the SSO help in this way.

Ask whether the SSO has any questions that you could answer.

Ask whether the patient has any questions about how the SSO will be involved.

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

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

THERAPIST: Based on my previous discussions with Bob, you appear to be his strongest supporter. You seem really committed to helping him over- come the drinking problem, and I applaud your

coming to the sessions with him. Maybe you can start by saying something about the steps you have taken that have been helpful to him.

JANET: Well, I am just so proud that he has been sober for the past 3 weeks, and I told him so. I have encouraged him to open up to me about how hard it is to stop drinking.

THERAPIST: How did you do this?

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

THERAPIST (to Bob): How has this helped?

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

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

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

In this example, the therapist discussed the importance of the reinforcing behavior with Janet. At the same time, the therapist helped to build Janet's confidence by linking her change efforts with Bob's outcomes.

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

In the following example, the therapist explains how reinforcing behavior has a positive impact on the treatment process:

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

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

THERAPIST: Janet, how did you feel?

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

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

BOB: Having Janet there really helped. I was able to control my desire to drink because I did not want to disappoint her. Also, it helped to talk to her beforehand about the difficulties of attending a ball game on a hot summer afternoon without having a beer.

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

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

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

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

In this example, the therapist helped Bob understand how Janet's presence enabled him to refrain from alcohol use. He helped Bob identify the coping mechanism used in this situation to forestall alcohol use. Bob learned that just "keeping Janet in mind" may be an effective coping mechanism in dealing with future alcohol use.

4.1.b When Differences Occur Between the SSO and Patient.

It is not uncommon to find that the SSO is more committed to changing the drinking practices than is the patient. As a result, discrepancies often occur between them concerning what the patient needs to do to over- come his/her drinking. Such differences need to be normalized and resolved. In the example below, Janet's proposed action steps are in conflict with Bob's.

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

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

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

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

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

JANET: Absolutely!

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

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

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

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

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

JANET: You can handle your friends. You're not afraid to tell them off about other things, such as when they owe you money. When you feel right about some- thing, you can be really strong.

BOB: That's true.

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

BOB: You're not coming to the party?

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

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

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

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

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

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

4.1.c What Does the SSO Do If the Patient Resumes Drinking?

There may be times during the course of treatment when the patient will resume drinking, which in turn could pose problems for the SSO. Some SSOs might become angry, frustrated, or disappointed with the patient and leave treatment abruptly, an act that conceivably could negatively affect the therapeutic process (e.g., undermine the patient's self-efficacy in dealing with the drinking). Alternatively, some SSOs might intervene to protect the patient from the costs or consequences of the drinking. Examples of such behavior include making excuses for the patient to his/her employer, friends, or family for the alcohol use; cleaning up after him/her after a drinking episode; and in general, continuing to play a supportive role despite the patient's drinking.

These activities by the SSO have been termed "enabling behavior" (Meyers et al. 1998). Such behavior allows the patient to shift responsibility for the drinking away from him/herself and on to the SSO. Not allowing the patient the opportunity to experience the negative consequences of the drinking can undermine his/her commitment to change (Meyers et al. 1998). Thus, it may be useful to discuss alcohol use while the patient is still sober or before heavy drinking occurs. At the same time, the SSO and patient should devise a constructive plan to deal with the drinking when or if it occurs (see the list below). Otherwise, there is a risk that the SSO may inadvertently diminish the effectiveness of the treatment. In short, taking a proactive stance with the SSO and patient can better pre- pare them for dealing with drinking episodes.

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

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

-Indicate that the patient him/herself is responsible for addressing the problem.

- Discuss the methods used for helping patients who have resumed drinking and options the SSO might have in dealing with the drinking. Refer to discussion on rule violation effect (1.5.a.7).One option is to withdraw support from the patient while he/she is drinking. This might mean not participating in drinking-related events such as bowling and parties. If the SSO is a spouse, this might mean having separate sleeping arrangements, not sharing the evening meal, and in general spending more time apart from each other while the patient is still drinking. Mention that such an approach has been shown to be effective in facilitating positive change.

Another option might be for the SSO to stop attending the sessions and seek help elsewhere (e.g., attendance at Al-Anon) while the patient is still drinking. This may be useful for SSOs who are having a great deal of difficulty in coping with the negative feelings resulting from the patient's alcohol use.

4.1.d Acceptable Types of SSO Participation.

In the EXTENDED CONDITION, SSO's might participate in several sessions and have substantial interaction with the CRAS therapist. Although having an SSO involved in treatment can be very

helpful, it does not fundamentally alter the nature of CRAS. Maintain the same motivational and problem-focused style, staying within the procedures prescribed in each module. Some modules contain specific guidelines for how to involve an SSO. Keep your focus on the patient. Do not shift into a marital/ family therapy strategy, in which you focus on changing the relationship.

Below is a list of appropriate therapeutic ways to involve the SSO:

-Discussing how the SSO responds to patient drinking

-Reflecting SSO statements

-Encouraging the SSO to provide positive reinforcement for sobriety

- ***Here are some inappropriate ways of involving the SSO:***

-Discussing family-of-origin issues

-Constructing a genogram

-Giving advice on parenting strategies

-Providing sex therapy.

4.1.e. The Problematic SSO.

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

Problems caused by the SSO. If you screen properly, you should be able to identify potential SSOs who would interact negatively with the patient before you ask them to become involved in treatment. Nevertheless, there may be cases in which the SSO poses serious problems in the sessions, as in the following circumstances:

•The SSO undermines the patient's efforts to change his/her drinking behavior. The SSO meets the patient's optimistic comments about change with skepticism or derision. The SSO repeatedly reminds the patient of previous failures in implementing a change plan. Overall, the SSO displays a negative attitude toward the change process.

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

•The SSO demonstrates a weak commitment to the CRAS treatment. He/she frequently cancels appointments without rebooking, does not show up to the sessions, arrives late or leaves before the session ends, and does not spontaneously participate in the sessions except to comment unfavorably.

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

•Limit the SSO's role to information sharing and clarifying factual material that can be covered in one or two sessions, such as the patient's condition with respect to drinking. Advise the SSO about steps the patient could take to change the drinking pattern such as attending mutual-help groups, sustaining a period of abstinence, and actively participating in CRAS treatment.

, Ask whether he/she might want to try some- thing else such as Al-Anon or individual counseling (outside the Project). In Al- Anon-based programs, SSOs are often asked to detach themselves from the patient's drinking. Such an approach might be preferable when the SSO's active involvement in treatment seems to be detrimental.

In the example below, the therapist deals with a problematic SSO:

THERAPIST: David and Martha, I know that you both agreed to attend these sessions together because of a concern for each other. However, since attending, there have been serious disagreements about what is best to do about David's drinking. Each of you has your own firm solutions to the problem. As a result, these sessions have become frustrating to both of you. Do you agree?

PATIENT: We are getting nowhere at this point.

SSO: He fights with me on every issue. Everything I say becomes a put down. If I tell him to stay home, he tells me that I am babying him. I can't take it!

THERAPIST: Might I suggest some options? Are you willing to give them serious consideration? I don't want you to make a quick decision about what you ought to do. I just want you to give these alternatives serious thought.

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

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

SSO: All right

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

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

THERAPIST: At least not in the therapy sessions, but you're always going to have an important part in what happens for the two of you.

THERAPIST: There is a second option too. Martha, you might want to consider attending Al-Anon meetings or some other mutual-support group while David is receiving treatment here.

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

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

4.1.f Planning Subsequent Sessions with SSO Involvement.

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

4. 1.g SSO Consent.

Consent procedures for the SSO will differ by site. Be aware of the proper procedures for Consent of the SSO at your site.

4. 2 Treatment 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 Treatment Plan (Form I)) using the patients language and ideas to link to appropriate modules. Remember that ONLY material from the modules may be discussed in the future sessions, but any ideas or goals the patient has should be encouraged.

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 treatment 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. The therapist should encourage and provide suggestions from the available modules as appropriate.

Patient: Well, my mood has always been a problem and it always leads to more drinking. I've known this for a long time and I've been trying lately to figure out something to help with that. I have a good friend who sees a Holistic Therapist to get crystals. She says they help her because of their molecular structure or something like that. She has them hanging all over her house. Since it seems to help her, I want to give that a try for sure.

Therapist: I can see you have been curious about ways to help with your mood. One of the things you are going to try is crystals. There are also some specific skills that we could look into to help lighten your moods. Research has shown that there are specific behaviors and habits that lead to better moods for people who are making changes in their drinking. What if we explored Mood Management as a way to approach this for you in our sessions?

The therapist should always query the goal concerning alcohol, and it should form the number one item on the treatment 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. 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. If the patients still express an interest in a non-abstinence goal, encourage the patient then to monitor his drinking closely in order to increase the probability that it does not exceed the level that he is aiming for. You may recommend him to keep a diary of his drinking, see below.

4.2.a.1 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 motivation al 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.a.1 Monitoring drinking

If the patient is still aiming for controlled drinking and wishes to try, then encourage the patient to continuously monitor his drinking. You may suggest to him that he even notes what he is drinking in his diary *before* he drinks the beverage Explain to him that this inself may serve as a strategy to stay in control of his drinking. Ask him to note the type and amount of alcohol, and perhaps a small note about the situation, he is in, when he is drinking the alcohol. This information is useful when he gives you a short status in the beginning of the following sessions on how he is managing. The information may also be useful if or when you are working together in the module on coping with craving.

4.2.b Reviewing Options Sheet

Use the Options Sheet that you and your patient have been using to “park” concerns and ideas during the functional analysis and the review of psychosocial functioning. Print ideas about change in the bubbles now, if appropriate. If you have some time for reflection before this session, review your notes to generate possible option bubbles. Below is a list of possible entries on the Options sheet.

Decrease stress.

Feel better about self.

Explore AA.

Cope with urges to drink.

Learn to say no.

Develop conversation skills.

Improve marriage communication.

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

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

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 Setting Priorities.

Once you have filled in bubbles on the Options sheet with possible topics to be addressed in treatment, review the sheet with the patient. Below is an example of a way to discuss prioritizing the options:

THERAPIST: Of these things we've come up with together as options for your treatment plan, I see several that we can work on together. Our treatment program can help with these. Which ones would you like for us to discuss in the weeks ahead? Which ones seem most important to you?

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

It is important for you to remember that you will not address all items on the treatment plan in CRAS sessions. The patient may feel it is important to address childhood trauma, for example, and that would not be included in the CRAS sessions. Take care that you convey this to your patient so that he/she does not think he/she has been promised something that you will not deliver. Rather, consider the treatment plan as a wellness plan that will include some items that you can address together with the patient and some items that the patient will address alone, with supportive others or through a referral.

4.5. Preparing the Treatment Plan.

The final step in Session 4 is to develop a specific treatment plan, which closes Phase A. The Treatment Plan (Form I) 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 treatment plan-what we will work on together in the time we have. Once we have filled in this plan and agree about it, we're ready to start the next phase. Now the things you've said you want to work on are….. .

Each row of the Treatment Plan is used to specify one problem that will be addressed by treatment (or in some cases, by referral). The Treatment Plan may be (and often is) modified later in treatment, and this can be done with a new Treatment Plan Continuation sheet. You cannot change a Treatment Plan sheet once it has been signed and dated, so you must use a new sheet for all addenda and modifications. If you add a new problem, give it the next unused sequential number. If you modify a prior problem (e.g., new goals or plans), use its original problem number and enter the new information on a new Continuation sheet.

For each problem (row), there are columns in which you specify three things. In the first column, "Problems to be addressed by treatment and referral,'' specify these problems. Problem #1 will always be alcohol problems and/or dependence. The content for Problem #1 should have emerged in the transition and key question segment discussed in ''Making the Transition to Session 4." If not, ask, "And what are you thinking about drinking at this point? What do you want to do?" Reinforce the emphasis on abstinence as appropriate (see section below, "Emphasizing Abstinence"). Bubbles from the Options sheet identify potential problems for the Treatment Plan but are included only by mutual agreement between you and your patient. You may state a problem on the Treatment Plan even if you will not directly address it in treatment; for example, if financial problems are a serious concern for your patient, enter these with a problem number, and the plan might be referral to consumer credit counseling.

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

In the third column, "Treatment plan," specify how you plan to address the stated problem to achieve the stated goal(s). Identify specific modules that will be included in Phase B. You can use the List of Modules (Form V) to provide an overview of each module and what it has to offer. (Clients may be given a copy of this list to take home and refer to later if they wish). During treatment planning, specify referrals and change activities that the patient is to pursue outside of treatment (such as attending AA meetings). The plan should be stated in terms that are sufficiently specific to allow a clear judgment as to whether or not it was carried out. You should also state at least a tentative timeline for each problem: when will this be done? Progress notes that you keep throughout treatment will correspond to the problems, goals, and plans stated here.

5.0. Consolidating Commitment.

As the patient completes the Treatment 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:

Here is an example of a summary for a client in the Extended Condition:

THERAPIST: Let me see if I understand where you are, then. Last time, we reviewed the reasons why you and your husband have been concerned about your drinking. There were several of these. You were both concerned that your drinking has contributed to problems in the family, both between you and with the children. You were worried, too, about the test results you received indicating that alcohol has been damaging your health. Your drinking seems to have been increasing slowly over the years, and with it, your dependence on alcohol. The accident that you had helped you to realize that it was time to do something about your drinking, but I think you were still surprised, when I gave you your feedback, just how much in danger you were.

We've talked about what you might do about this, and you and your husband had different ideas at first. He thought you should go to AA, and you thought you'd just cut down on your drinking and try to avoid drinking when you are alone. We talked about what the results might be if you tried different approaches. Your husband was concerned that if you didn't make a sharp break with this drinking pattern you've had for so many years, you'd probably slip back into drinking too much and forget what we've discussed here. You agreed that that would be a risk and could imagine talking your- self into drinking alone, or drinking to feel high. You didn't like the idea of AA because you were concerned that people would see you there, even though, as we discussed, there is a strong principle of anonymity.

Where you seem to be headed now is toward trying out a period of not drinking at all, for 3 months at least, to see how it goes and how you feel. Your husband likes this idea too and has agreed to spend more time with you so you can go and do things together in the evening or on week- ends. You also think that you might get involved again in some of the community activities you used to enjoy during the day or maybe look for a job to keep you busy, and that's one of the first things that we will focus on together in treatment. You are also interested in learning some ways for managing your moods with- out using alcohol. Do I have it right? What have I missed?

5.1 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 together. Be sure to affirm your patient's decision, intentions, efforts, and so on.

5.2 Patient will not commit to change in drinking

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

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

Another way to proceed is to modify the Treatment Plan to reflect the patient's state of readiness. In such a case, the provisional goal on the Treatment Plan might be to "consider and decide whether or not to make a change." It is also possible to proceed with Phase B modules even if the patient is unwilling to commit to change. This could be described on the plan as "in the meantime" working on something of value to your patient, or as material that "might be useful if you do decide later that you want to make a change in your drinking." Before beginning Phase B, however, you should agree on and sign at least a provisional treatment plan.

6.0 Terminating Session Four

Save at least 10 minutes at the end of the session to review the session with the patient (and the SSO if one has attended). Acknowledge the value of the treatment plan and express optimism if you can about the possibility that the patient will profit from it. Negotiate with patient about which module will begin the next session and consider interim homework if appropriate.

Phase B: Implementing Change

7.0 Introduction to Psychosocial Skills Training Modules

This section is completely individualized to your patient's situation and needs. Following the four-sessions of MET, patients randomized to receive the Extended Treatment will begin working with you through modules drawn from a menu of five cognitive-behavioral skill-training areas. This section is completely individually tailored because it makes little sense to have the same standard skill-training package for everyone. People enter treatment with very different sets of skills, so no single area is required. You and the patient you are working with have selected the areas for skill training and now within those larger skill areas, you will discuss and negotiate the specific modules that are most appropriate for his/her needs. As treatment proceeds, you and the patient may discover the need for an additional skill area that you had not planned for during the treatment planning process, and you can renegotiate your treatment plan to include it. Remember that you can work on more than one module at a time, and you can include work from two modules within a single session.

The modules included within each area for skills training are designed to be practical, not just didactic. They actively involve the patient in learning skills that will support a positive, rewarding, alcohol-free lifestyle. The following list describes how to use them:

- Remember the rhythm of TELL-SHOW- TRY First describe what to do, then model how it's done for the patient, then ask the patient to try it.
- Practice through role-plays.
- Use the worksheets.
- Assign home tasks to try between sessions.
- Check on previously assigned tasks at the beginning of each session.
- Praise any and all steps the patient has taken to learn and apply new skills.
- Give plenty of positive reinforcement in the practice process-point out what the patient did well, gently coach on points for improvement, then try it again.

On the next page is a list of the five areas for psychosocial skills training that you and your patient discussed during sessions 3 and 4 of MET, accompanied by the more common indications for using each skill. Remember that it is fine to be working on two skills at the same time, although you should not discuss more than two skills in any single treatment session. Use the Therapist Checklist provided for each module to help you remember the procedures that are included.

7.1 List of Psychosocial Skills Modules

Module Name	Topic	Common Reasons to Use this Module
COPE	Coping with Craving, Urges and Social Pressure to Drink	To learn skills for resisting drinking when faced with urges, cravings and pressures to drink
MOOD	Mood Management Training	To learn skills for managing and reversing negative emotions without drinking
SOBN	Building a Sober Network	To increase positive social support from others and engage in recovery programs helpful to maintain stable change in drinking
SARC	Social And Recreational Counseling	To find and become actively involved in pleasant recreational activities that do not involve drinking
AGE	Coping with Concerns Related to Aging	To learn skills for coping with the sadness and loss that is a natural part of aging

Coping With Craving, Urges and Social Pressure to Drink (COPE)

8.0 Coping with Cravings and Urges

8.1 Rationale

Patients experience craving and urges to drink most often early in treatment, but these symptoms may persist for weeks or even months after a person stops drinking. These experiences may be uncomfortable, but they are very common and do not mean something is wrong. Expect your patients to experience cravings from time to time, and be prepared to cope with it.

The words "urge" and "craving' refer to a broad range of subjective experiences that include thoughts ('Wouldn't it be nice to have a drink now"), positive expectancies ("I'd feel better if I just had a couple of drinks"), physical sensations (e.g., tremulousness), emotions (e.g., feeling anxious), and behaviors (e.g., pausing while passing the beer display in a store). The fundamental phenomenon is a subjective experience of increased risk (probability) of drinking despite at least some desire not to do so. This can be experienced as an actual or potential loss of control, in the sense that Jellinek (1960) called lack of ability to abstain (to distinguish it from an experienced inability to stop drinking once started).

In this regard, the most important and central message of this module is that the patient's experiences of urges and craving are predictable and controllable. Below is a list of particularly important messages to convey to your patient:

1. Urges to drink are common and normal in the course of recovery. They are not reason for alarm or a sign of failure. Instead, learn from them.

2. Urges to drink or craving tend to occur in certain predictable situations; they are triggered by things in the environment. The person may not initially be aware of the environmental triggers for these experiences, but it is possible to identify them. Typically they are sensory experiences-seeing, hearing, smelling something that has been associated with drinking (or withdrawal).

3. Sometimes the triggering event is internal - such as a thought or physical sensation. Physical sensations may include tightness in the stomach, mouth dryness, or a vaguely nervous feeling. Thoughts can include imagining how good it would feel to use alcohol, remembering drinking times past, planning how to go about getting a drink, or thinking "I need a drink."

4. Craving and urges are time-limited, that is, they usually last only a few minutes and at most a few hours. Rather than increasing steadily until they become unbearable, they usually peak after a few minutes and then die down, like a wave. You can "surf' over them. (For skiers, the image of skiing over or around moguls without falling might be better.)

5. You win every time you surf (ski) over an urge without drinking. Indulging an urge only feeds and strengthens it. However, when you learn how to cope with them, urges become weaker and less frequent over time.

6. You are not helpless in the face of craving or urges to drink: there is something you can do about them.

8.2 Social Pressure to Drink

Avoiding situations in which social pressure is likely to occur is one way to cope with social pressure. Of course, however, people cannot avoid all situations in which other people are drinking or where they will experience direct pressure to drink. Even if the patient's intent has been to avoid certain situations, he/she may still be exposed to them by accident or choice. Emphasize the need to develop several possible strategies for situations that he/she cannot or will not be able to avoid.

Refusing a drink is often much more difficult than the patient anticipates it will be. It is important to practice various refusal responses, especially if your patient has difficulties being assertive or responding effectively when he/she is feeling anxious. When your patient practices a refusal in the context of treatment via behavioral role-play, he/she receives feedback from you about the effectiveness of his/her drink refusal response, acquires some mastery over his/her refusal skills, and increases his/her confidence in facing direct social pressure.

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

• Other people will see them as "weak'' or a "goody goody" for deciding that they will no longer drink.

• They are ''boring'' or will be rejected if they do not drink.

• It will be impossible for them to make new friends or maintain old friendships if they are not drinking.

• It is not "right" to refuse a drink when everyone else is sharing an occasion involving drinking.

• They do not want to give up a relationship with a heavy drinker simply because they have stopped drinking.

• They are imposing on or offending other people if they are assertive about not drinking.

Explain to your patient that it can be helpful to think through and practice ways to cope with the situations when there is social pressure to drink. Tell your patient that he/she will probably confront unanticipated situations, but the more he/she can prepare, the better. Discuss the importance of rehearsing a variety of different refusal strategies so that he/she will be able to handle the unexpected.

8.3 Discovering Trigger Situations

A first step is to identify the particular cues or situations in which the patient experiences urges or craving. Ask your patient to describe a few recent situations in which he/she experienced craving or an urge to drink. (Note: Some patients do not identify with the term "craving" but will talk about weaker and stronger urges to drink. For others, "craving'' is a meaningful term that describes their experience. Use the terminology that is comfortable for your patient.) Below is a list of sample questions that can clarify craving situations:

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

Be aware that talking in detail about a craving experience can itself trigger sensations of urge or craving. This is not something to fear - in fact, it can be a good opportunity. It is wise, however, not to start this process at the end of a session before you have time to discuss and debrief it. Check in with your patient periodically during the sessions of this module to find out whether he/she is experiencing urges or craving right there and then.

The point of this step is to identify urge triggers so that you can plan coping strategies for them. Most likely, there will be multiple cues that can trigger urges, so make a list of higher-risk situations. The best initial source is likely to be the patient's own recollections of situations in which he/she felt craving or urges, even though the patient may not know initially what it was about the situation that triggered a desire to drink. Below is a list of common external triggers:

- Exposure to alcohol itself
- Seeing other people drinking
- Contact with people, places, and things previously associated with drinking (e.g., drinking companions, parties and bars, watching football on TV)
- Particular days or times of day when drinking tended to occur (getting home from work, weekends, payday, sunset)
- Stimuli previously associated with withdrawal (e.g., hospital, aspirin, morning).

Other triggering stimuli are internal rather than external (though none of them are eternal). These can be puzzling to the person feeling them because they do not seem to occur in predictable situations but "just pop up." Below are two examples of internal triggers:

- Particular types of emotions (e.g., frustration, fatigue, feeling stressed out). Even positive emotions (e.g., elation, excitement, feelings of accomplishment) can be triggers.

• Physical feelings (e.g., feeling sick, shaky, tense, having a headache). These are often misattributed; they occur for a reason that is not immediately apparent to the person (e.g., normal anxiety, high or low blood sugar, caffeine intake) and are misinterpreted as craving, withdrawal, or a "dry drunk."

8.4. Monitoring Urges

Because it is hard to recognize some triggers by discussing them during a session, it is a good idea to help the patient self-monitor urges.

As with any home assignment, first provide a rationale for urge monitoring. Describe benefits that are likely to mean something to your patient (better self-awareness, greater self-control, feedback of improvement, and so on). A primary benefit of monitoring is that it gives the person some insight into when and where he or she is experiencing strong urges. This information will allow you and your patient to think of strategies for how to reduce these specific instances and be prepared mentally for situations that evoke strong urges. Better still, ask your patient how keeping these records for a while might be beneficial, eliciting change talk. Set a time limit on the monitoring (usually 2 to 3 weeks), at the end of which you will reevaluate together what you and the patient have learned and whether it is useful to continue.

Give the patient *Urge Monitoring Cards* (Form J) to make this process easier.

Below are the instructions to give the patient when you hand him/her a supply of blank *Urge Monitoring Cards:*

1. Keep a couple of cards and a pen or pencil with you all the time. (Discuss how your patient can do this - where to carry the cards, etc. Elicit your patient's own ideas.)

2. Any time you feel an urge to drink, write it down as soon as possible. Records are much less accurate and useful if they are made later. Do not, for example, wait until the end of the day and then try to reconstruct your day. Still - better late than never.

3. Write down the following four things with each entry:

• The date and time of day

• The situation: where you were, who you were with, what you were doing or thinking

• Rate how strong the urge was, from 0 (no urge at all) to 100 (strongest you've ever felt)

• What you did - how you responded to the urge. If you do have a drink, write that down. If you don't, write down what you did instead.

Take some time to work through an example of what to write down in session, perhaps using a recent experience the patient has described. Troubleshoot - what could go wrong that might prevent him/her from keeping good records? What can the patient do to keep good records? Any problems the patient foresees? Never get in a power struggle over this; just understand the patient's perspective and see whether he/she is willing to try at least 1 week of recording.

Again, as with all home assignments, give priority to reviewing these cards at the beginning of the next session. Reinforce - comment positively on any amount of recordkeeping. If the patient had problems following the assignment, troubleshoot briefly, but don't spend a lot of time discussing the patient's failure to adhere. Ask for the patient's own ideas about how to keep more complete records in the week ahead. This discussion may also unearth patient doubts about the importance of monitoring.

Sample Completed Urge Monitoring Card

Date/Time	Situation	0-100	How I Responded
5/16 3:30 pm	Feeling stressed out. Had an argument with a salesman about a price discrepancy.	75	Walked out of the store, sat on a bench, closed my eyes and relaxed. Felt better after 20 minutes.
5/17 11:00 pm	Feeling antsy at bedtime. Had trouble getting to sleep. A drink would help.	60	Took a hot bath, listened to music.
5/19 Noon	Went to Andy's Diner for lunch. Angry that I can't have a drink like before.	80	Ordered tonic with lime. Felt like a close call – dumb to go back there.
5/20 5:30 pm	Invited to a neighbor's house for a Meal. Know he drinks a lot.	50	Suggested we go for coffee instead. He said okay!! Surprised.

8.5 Coping with External Triggers

The four basic strategies for coping with external triggers are: Avoid, Escape, Distract, or Endure, described in detail below.

Avoid

Perhaps the easiest way to deal with high-risk situations is to avoid them in the first place. How could the patient reduce exposure to people, places, and situations that trigger urges to drink? Below is a list of common examples:

- Get rid of alcohol at home.
- Avoid places where drinking occurs.
- Reduce contact with friends who drink, meeting them only in nondrinking contexts.

It is noteworthy that people who successfully quit drinking, smoking, or using other drugs typically avoid such situations altogether, particularly early in the quitting process. It just seems to be easier not to deal with unnecessary high-risk situations during the early months of abstinence.

Escape

Of course it is not possible to avoid all high-risk situations. The unexpected occurs, and in fact, people often start drinking again in unanticipated risk situations. What happens, then, when the patient finds him/herself in a high-risk situation - either because he/she did not anticipate it or because he/she was unable to avoid it? A second line of defense is to escape - to get out of the situation as quickly as possible. Below are examples of unexpected high-risk situations. Ask your patient to brainstorm ideas for how to get out of each situation quickly and gracefully. Practice the dialogue that would be involved in these social situations.

- You go over to a friend's house for dinner and hadn't realized (or hoped against it) that there would be a lot of drinking.
- You are in a new social situation, and someone who doesn't know that you are sober hands you a drink.
- At home you find a bottle that you had forgotten about.

One alternative to drinking - either to avoid or to escape - is to go to a mutual-help group meeting. In most areas, they are available throughout the day and particularly at higher-risk times such as evenings, weekends, and holidays.

Distract

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

Endure

Then there are those situations that are difficult to avoid or escape and where distraction isn't enough. These are riskier earlier in sobriety, but as sober time passes, people often find it less necessary to restrict their contact with previously risky people, places, and things. Sometimes people find that it's no problem to be on previously "slippery slopes" - the ice has melted. At other times, people need tools to hang on. Below is a list of such tools:

• ***Talk it through***. Talk to a friend, family member, or sponsor about craving when it occurs. Talking about cravings and urges can be very helpful in pinpointing the source. Often talking about craving helps in itself to relieve the feeling.

• ***Ask for help***. In the midst of a risky situation, take someone with you or ask someone to help you get through it without drinking.

• ***Wait it out***. Everything passes with time, especially something as temporary as an urge. Don't try to make it stop, just wait it out and don't drink.

• ***Take protection***. Other than a helpful friend, what could you take into a high-risk situation that would help you to endure through an urge? A reminder card? A treasured object? A photo? A cell phone? No money?

8.6 Coping with Internal Triggers

With a few modifications, the patient can apply the same strategies to internal triggers. The exception is avoidance; it is a particularly poor strategy for coping with subjective experiences such as thoughts and feelings. Trying not to experience something often backfires. Trying to avoid one's internal world can be futile. That leaves basically two strategies: let go (a parallel to escape or distract), and endure.

Letting Go

Letting go means moving on, not dwelling on the experience. Discuss with your patient how having a thought does not mean that he/she needs to pursue it or keep thinking about it. Certain feelings your patient may have, such as anger, can persist only if he/she keeps fueling them through thoughts of resentment, revenge, rejection, and so on. Experiencing thoughts as they pass through, without following them, is a key aspect of transcendental meditation.

Another way the patient can let go is to refute the thought that drives the urge. The strategy is to recognize the thought, stop it, analyze the error in it, and replace it. Below is an example of such an internal process.

> It sure would be nice to have a drink right now. It couldn't hurt just to have one little drink....
>
> Wait a minute! Hold on here! What am I thinking? It really COULD hurt. How much pain have I been through because of drinking? I know the "just one" stinking thinking routine.

> Who am I kidding? What good is one drink going to do me? I think I'm just feeling sorry for myself that I can't drink.
>
> But the truth is that I could drink - nobody is stopping me. The truth is that I CHOOSE not to drink today because that's how I want my life to be. Why play with fire?

When experiencing a craving, many people have a tendency to remember only the positive effects of alcohol and minimize the negative consequences of drinking. Therefore, when they experience a craving, some people find it helpful to remind themselves of the benefits of not drinking and the negative consequences of drinking - what they stand to lose by drinking. Some people find it helpful to write down these benefits of sobriety and consequences of drinking on a small reminder card that they keep with them.

Taking part in a distracting activity (see SARC module) is yet another way the patient can let go of an internal trigger experience - moving on to something interesting and not dwelling on the urge.

Enduring

These approaches might be said to go through the experience rather than around it. The patient may find that the endurance strategies from module 3 are useful here -- talking it through, asking for help, waiting it out, using protection.

Explain to your patient that another enduring approach is to go with it. He/she shouldn't try to make the thought or feeling go away but to accept it as a normal and temporary event that will pass, and experience it, focus on it. Tell your patient to pay attention to exactly what the experience is like - the physical feelings, emotions, thoughts, and so on. Trying to make it stop usually has the opposite effect, like trying not to think about white elephants.

Going with it is the most common meaning of the term "urge surfing." Urges are a lot like ocean waves. They start small, grow in size, and then break up and dissipate. The idea behind urge surfing is similar to the idea behind many martial arts. In judo, one over-powers by first going with the force of the attack. By joining with the opponent's force, one can take control of it and redirect it to one's advantage. It's a lot easier to swim with a wave than to stand up against it. Explain to your patient that he/she can initially join with an urge (as opposed to meeting it with a strong opposing force) as a way of keeping balance. What the patient is "going with" here, of course, is not drinking but the experience of the urge itself.

If a patient experiences an urge or craving during a treatment session, it can be useful to practice such coping in vivo. Have the patient sit in a comfortable chair, feet flat on the floor and hands in a comfortable position, and give him/her the instructions described below:

THERAPIST: Take a few deep breaths and focus your attention inward. Allow your attention to wander through your body. Notice where in your body you experience the craving and what the sensations are like. Notice each area where you experience the urge, and say what you are experiencing. For example, "I have a dry feeling in my mouth and nose, and a kind of cold sensation in my stomach."

Focus on one area where you are experiencing the urge. Notice the exact sensations in that area. For example, do you feel hot, cold, tingly, numb ...what? Are your muscles tense or relaxed? How large an area is involved? Notice the sensations, and describe them to yourself. Notice the changes that occur in the sensation. For example, ''Well, my mouth feels dry and parched. There is tension in my lips and tongue. I keep swallowing. As I inhale or swallow, I can imagine the smell and tingle of booze."

Repeat the focusing with each part of your body where you experience craving. Pay attention to and describe the changes that occur in the sensations. Notice how the urge comes and goes. Many people find that after a few minutes, the urge is gone or is very weak. The purpose of this exercise, however, is not to make the urge go away but to experience it in a new way - as an experience in itself.

8.7 Developing an Individual Coping Plan

Develop with your patient a specific plan to cope with future urges or cravings. After reviewing the general strategies that he/she can use, ask your patient to select two or three that seem to fit best, which seem most realistic to use in his/her daily life, and develop these in detail. For example, if getting involved in a distracting activity seems helpful, which activities would be best? Are these reliably available? Which of these might take some preparation? For strategies amenable to practice (as most of these are), use in-session role-play or home assignments. Develop any practical aids (such as reminder cards) that might be helpful. When you make home assignments, check on them at the beginning of the next session. What seemed to work, and what did not? Adjust the patient's individual coping plan accordingly.

8.8 Handling Pressures to Drink

Many patients resume drinking in response to social pressure. A patient may experience direct social pressure when he/she is offered an alcoholic beverage or a drinking opportunity, resulting in an increased temptation to return to drinking. The person who offers the patient a drink may or may not know that the patient is trying to stop drinking, may make the offer with varied levels of insistence, or may respond to a refusal with varied levels of assertiveness. For example, a patient may be faced with a waitress in a restaurant who innocently asks, 'What would you like to drink this evening?" or a neighbor who asks, "How about joining me for a few beers later on?" However, the patient may also be faced with a relative at a wedding who says, "Oh come on, it's a party. You've got to join us in the toast!" or an old drinking companion who responds to a refusal by saying, "I thought we were good friends, and now you're saying you can't drink with me? You've tried to stop drinking lots of time and never made it, so do us both a favor and give up."

Refusing a drink is often much more difficult than the patient anticipates it will be. Practice various refusal responses, especially if your patient has difficulties being assertive or responding effectively when he/she is feeling anxious. When your patient practices a refusal in the context of treatment via behavioral role-play, he/she receives feedback from you about the effectiveness of his/her drink refusal response, acquires some mastery over his/her refusal skills, and increases his/her confidence in facing direct social pressure.

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

It is not enough to talk about possible coping behaviors. Be sure that you actually rehearse social situations to make sure that the patient can articulate the appropriate responses. The following section illustrates this important component through helping your patient refuse an offered drink.

Introduce the idea of having an escalating sequence of responses for handling a social situation. For some situations, a single simple refusal will suffice. For others, it may be necessary to have a more assertive reply if the person persists, as shown below:

> First offer: No, thank you.
>
> Second offer: No, thanks. I really don't want a drink.
>
> Third offer: Look, I'm not drinking now, and this is very important to me. I would really appreciate it if you would help me out here as a friend and stop trying to convince me to drink.

Engage your patient in coming up with escalating refusals for situations in which a person persists. The goal is to find a refusal that is assertive. The response should be clear and firm yet friendly and respectful.

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

> • Look directly at the person, make eye contact, and state your response.
>
> • Vague excuses are not necessary and can be dangerous (e.g., "I don't want a drink right now because I have a headache, but maybe later,'' or "Not right now, it's too early in the day") because they leave the door open to another invitation.
>
> • Keep it short, clear, and simple. Long explanations are not necessary and tend to prolong the discussion about whether you should have a drink.
>
> • If the situation warrants an alternative suggestion, recommend an activity that does not involve drinking, such as, "Let's go out to dinner or the movies instead of a bar." This shuts the door on drinking but leaves it open to social activity.

A useful strategy here is the ''broken record'' technique. In this approach, the patient repeats a single, clear message in response to each pressuring statement. The patient can also acknowledge some part of the other person's statement and then go back to the simple broken-record assertion.

Introduce behavior rehearsal by emphasizing the importance of being prepared and practicing ''drink refusal" ahead of time to enhance skills and confidence. Present the idea of participating in a practice situation with you in which you take one role and the patient takes the other. (Patients often find "practice'' a more comfortable concept than "role-play.") If your patient already has reasonably good social skills, begin with the patient taking the refusal role while you try to persuade him/her to have a drink. If your patient is not confident with his/her assertive skills, start with reversed roles in which the patient pressures you to have a drink while you model good assertive refusal.

To construct a role-play situation, ask your patient to provide details about the person(s) who might make the offer, where the offer might occur, who else might be in the situation, and anything else that might influence his/her drinking at the time the offer is made. Let the patient know that this type of specific information helps you construct a more realistic role-play so that he/she can get the most out of the practice.

Then try it out. When the patient is in the assertive refusal role, take it easy at first, then build up to more difficult scenarios. Following each practice, review with the patient whether the role-play made him/her want to drink, how he/she felt refusing the offer, and whether he/she felt the refusal was effective or could be improved. Provide lots of honest feedback about his/her responses. Look for specific things that your patient did well, and point them out. Let the patient know what was skillful about his/her response and also how he/she might improve the response. Coach gently. Practice the same situation several times as needed to improve confidence and performance.

If your patient feels particularly stressed when refusing an offer, even though he/she is able to do it skillfully, then it may be appropriate for the patient to practice seeking support after refusing an offer. Whom would the patient call, and what would he/she say to this person to obtain support?

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

THERAPIST: You've said that you also have had some difficulty avoiding the temptation to drink when you are in situations where other people are pressuring you to drink. Let's talk about some of those situations and see if we can come up with a plan to help you avoid drinking. Okay?

PATIENT: Sure.

THERAPIST: You mentioned earlier that you thought someone at your anniversary party might offer you a drink. Is that right?

PATIENT: Yeah-it could happen. Probably will.

THERAPIST: Who do you think might be the one to offer you a drink?

PATIENT: Could be lots of people. Maybe one of my brothers. They all drink except the one I mentioned to you is sober. Probably not my kids - they've been trying to get me to stop drinking.

THERAPIST: Let's pick one of your brothers who might be likely to offer you a drink. Which one would it be?

PATIENT: I'd say Al.

THERAPIST: Okay, tell me a little bit about Al. What is he like when he's asking you if you want something to drink?

PATIENT: Well, he's always got a drink in his hand. He'll probably be drinking as soon as he gets there. He might walk over and say, "Hey guy! Your hand is empty and this is your celebration. What are you having to drink?"

THERAPIST: So he would take it for granted that you would want something to drink.

PATIENT: Yes.

THERAPIST: How hard would he push you to have a drink? How loud would his voice be when he asked you?

PATIENT: He's kind of a big guy and he talks pretty loud, especially if he's been drinking.

THERAPIST: So he would be sort of forceful in offering you a drink.

PATIENT: Yes, I guess you could say that.

THERAPIST: Can you show me again what his offering you a drink might be like? Give me his voice.

PATIENT: "Hey guy! How's it going? Big celebration today! What are you drinking?"

THERAPIST: Okay, I have an idea what that would be like. Now, what might you say to him to avoid drinking?

PATIENT: I guess I could say, "Nothing right now, I just got here."

THERAPIST: How do you think he would take that?

PATIENT: I don't know. He might be insulted, like I was blowing him off. After all, he was offering to get me a drink.

THERAPIST: So he doesn't know you've stopped drinking?

PATIENT: He knows. He just doesn't believe it.

THERAPIST: Let's talk a little bit more about how to refuse that offer in a way that you'll feel comfortable with and also will give your brother a clear message. Do you feel comfortable that your brother would leave you alone if you said, "Nothing right now, I just got here."

PATIENT: I don't know. I've never said that before. Seems okay to me.

THERAPIST: I like the directness of it. You're saying "no" clearly. There is one concern I have about the way you said it, though. May I tell you?

PATIENT: Sure.

THERAPIST: I wonder if it leaves the door open to the possibility that you might want something to drink later. You say, "I just got here," which kind of implies that you'll have something later.

PATIENT: I see what you mean.

THERAPIST: How about a response that is short, simple, and polite. And you might have to give it more than once. There's a technique referred to as "broken record" that can be handy. In this approach, no matter what the other person says, you come back with the same clear, simple message. You can acknowledge what the person said, but your message is always the same, like a broken record that repeats the same thing over and over again. What would your clear, simple message be?

PATIENT: How about, "I'm not drinking anymore."

THERAPIST: Great! That's simple and clear. Now let's try this situation again. This time I'll be Al and you be yourself. Respond as you would if your brother were offering you a drink. Let's say we're at your party. You just walked in. You see your brother headed toward you with a drink in his hand. You can tell he's had a couple and is feeling pretty good. He says, in a loud and booming voice, "Hey, what's happening, guy?"

PATIENT: Not much.

THERAPIST: So, your hand's empty there. What are you drinking? There's a great bar here.

PATIENT: Nothing, thanks. I'm not drinking.

THERAPIST: What do you mean you're not drinking? It's your party!

PATIENT: Really, I'm not drinking anymore. That's it.

THERAPIST: Man, you always do this at the worst times. What's with you? You know you're not going to stick with this.

PATIENT: What's with me is that I decided not to drink, and I'd really appreciate it if you'd support me on this as your brother. I've decided to stop drinking, and let's leave it at that. Now I've got some other people I need to say hello to. I'll talk to you later.

THERAPIST: Whatever.

THERAPIST (*out of role*): So, how did that feel to you?

PATIENT: I felt kind of tense, but actually I think it went pretty well. I felt like I really got my point across and didn't hang around too long to get into an argument.

THERAPIST: I agree. I felt like you were clear with your brother without being defensive. Sounds like you might need to talk to him at a later time if he continues to bug you. What do you think?

PATIENT: Probably, he would.

THERAPIST: What do you think you might say?

PATIENT: Same thing. I've decided to stop drinking and I don't want you to keep asking me about it. If you don't back off, I'm not talking to you anymore.

THERAPIST: Sounds pretty clear. You know, I liked even better what you said before - asking him to be your brother and help you out. But you're right - you might have to set a hard line if he doesn't support you.

PATIENT: I just hope I can say that when the time comes.

THERAPIST: Why don't we practice it one more time.

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

THERAPIST: Is there another situation in which someone might offer you a drink?

PATIENT: Another one that comes to mind is Friday nights. A group of us go out on Fridays to the same restaurant - mostly the same guys who play poker once a month. They have cheap pitchers of beer on Fridays, so every time we go, that's what we order.

THERAPIST: Tell me a little bit more about what happens after you sit down at the table.

PATIENT: Well, a lot of the waitresses know us pretty well. If we get someone we know waiting on us, she usually comes over and says, "Hello. Are you guys having the usual tonight?"

THERAPIST: And that means a few pitchers of beer?

PATIENT: Right. Two to start, anyway.

THERAPIST: Who usually does the ordering when the waitress asks you this?

PATIENT: Any one of us. It doesn't really matter. The answer is always, "Yes."

THERAPIST: Does anyone ever order anything else?

PATIENT: Once in awhile, someone from work who doesn't usually come with us will order a mixed drink or someone's spouse will come along and order something else. Once one guy's wife who was on some medication that she couldn’t drink alcohol on came, and she ordered a soda.

THERAPIST: So it's possible. How do people react when someone orders something different?

PATIENT: Well, no one said anything about the guy's wife drinking a soda. They understood. One guy even complimented her for not drinking.

THERAPIST: How about the other people who have ordered something else?

PATIENT: I think one of the guys gave someone a hard time once. It's no big deal.

THERAPIST: What do you think it would be like for you to ask the waitress for soda after the guys ordered their beer?

PATIENT: I think it would be really awkward. Everyone would be wondering what was wrong with me. I don't really want them asking me a lot of questions, and I definitely don't want the waitresses to know I don't drink anymore.

THERAPIST: What would that mean to you if they knew you had stopped drinking?

PATIENT: That I was a wimp. They might think I was sick. I don't know.

THERAPIST: I can see why it would be uncomfortable if you think that's how they would think about you. Is that how you thought about other people who didn't drink?

PATIENT: To tell you the truth, I really never thought much about what other people ordered. I didn't really care.

THERAPIST: So, you're feeling like it would be pretty awkward for you to order something nonalcoholic in this situation. Remember, one option you always have is to avoid the situation altogether, at least for a while. Have you thought about whether you want to continue going out with people to this restaurant, given the way you feel?

PATIENT: I do want to stay sober. It's important to me.

THERAPIST: This really does matter to you! Okay-so you could avoid the situation, but if you're willing, let's just try out how you might respond to the waitress if you did go. Would that be okay?

PATIENT: Sure.

THERAPIST: I'll be the waitress now, and let's assume that when I ask, "The usual?" someone immediately says, "Yeah-bring the pitchers." I start to turn to go to the bar, and that's when you need to catch my attention. What's my name?

PATIENT: Sally.

THERAPIST: Okay. Here we go (*stands up*). Hi guys! You're looking good tonight! The usual? Okay, I'll be right back with those pitchers (*turns to walk away*).

PATIENT: Hey, Sally, could I have a club soda please?

THERAPIST: Sure - no problem. Feeling a little under the weather?

PATIENT: No, I'm fine. Just a club soda.

THERAPIST: Okay (*breaks role*). How did that feel?

PATIENT: Fine. I think that would be okay. It's what the guys say to me next that I worry about.

THERAPIST: Okay, let's try that. By the way, I thought what you said was great. It was clear, assertive, comfortable. Very nice.

PATIENT: Thanks.

Because an SSO may be included in treatment sessions, you can involve a friend who might pressure your patient to drink. This has a double benefit. First, the patient is practicing drink refusal skills with an actual SSO who can offer highly realistic social pressure. Second, by engaging the SSO in this session for the purpose of helping the patient learn how to refuse drinks, you create yet another SSO ally to support the patient in efforts toward sobriety.

At the end of each session, discuss with the patient where he/she feels that he/she needs additional practice to sharpen or gain confidence in drink refusal skills before moving on or whether he/she feels ready to move on to another topic.

Coping with Problems of Aging (AGE)

9.0 Coping with Aging

9.1 Background.

As a person grows older he or she passes through different phases of life. The person goes through different transitions from child to adolescent to adult (to middle-aged) to elderly and to being old, which is the final phase before death. In 1989 Laslett proposed the concept of the third age, equivalent to being elderly (Laslett 1989):

1. The first age is growing up characterized by dependence, socializing, and education
2. The second age is adulthood characterized by responsibilities, independence, and income)
3. The third age is elderly characterized by retirement, free of responsibilities and still no limitations because of bad health
4. The fourth age is being old characterized by dependence, decline, and degeneration

At least in the Nordic countries the chronological ages when a person transcends from one "age" to another is in general early twenties (first age to second age), early sixties (from second to third age), and around the 80th birthday (from third to fourth age) (Daatland, 1994; Daatland, Solem & Valset, 2006). However, this sharp distinction is not evident at person level where there is great variability and flexibility. Laslett (1989) points out that this unclear distinction between the third and fourth age may cause many elderly (and healthy) people to be viewed as fragile and not able to fulfill for example a job any more. The attitude and approach towards elderly by younger people and the society as a whole may limit the fulfillment of the elderly (Levy, 2003; Rothermund & Brandtstadter, 2003). Further, the unclear distinction in the social construct of age provides a possibility for people to choose a certain "social" age. Typically people choose to view themself as younger than they are chronologically, which has been reported in several studies. For example, in a Norwegian study middle aged and elderly people (between 40 and 79 years old) on average *felt* they were 7.5 years younger compared to their chronological age, and they actually *wished* they are 18 years younger than their actual age (Daatland, 2005). Another study reported that Americans felt almost 10 years younger than actual age and German felt to 6.4 years younger (Westerhof, Barrett & Steverink, 2003). This may have positive consequences as better life quality (Gana, Alaphilippe & Bailly (2004) but also negative consequences as adjusting to decline, frailty and death.

Elderly may in various degrees face different life circumstances that can affect domains of living, as well as age and aging in itself can influence quality of life as one has to face the fact that life is approaching the end. Often these circumstances pertain to loss or losses that subsequently can lead to loneliness or difficulties with activities of daily living or being able to do some of the activities a person have enjoyed earlier in life. This may be a contributing factor to developing an alcohol use disorders.

Loss or losses

Old age is a period of transitions and a time of experiencing inevitable losses, for example retirement and loss of friends and family members. People cope very differently with such significant changes. As a result of more free time during retirement and/or struggles in coping with a change in routine and losses of important people, old age is a time when alcohol use may increase. A recent review found that retirement per se does not influence the drinking pattern of retirees; however, contextual aspects and individual attributes have an impact on drinking behaviour (Kuerbis and Sacco, 2012). Low pre-retirement job satisfaction, involuntary retirement, and pre-retirement workplace stress as well as retirees with a history of problem drinking seems to be associated with higher consumption of alcohol and a greater likelihood of alcohol problems. Some may cope with losses and loneliness by drinking (Adlaf and Smart, 1995). Losing one's spouse, particularly wife, may lead to increasing alcohol consumption, which at least partly can be explained by loss of "health monitoring" (Umberson, 1992). Excessive alcohol intake may also lead to self-neglect, which may lead to less attention to basic needs such as nutrition and treatment of acute and chronic medical problems, or less attention to safety needs resulting in injuries, or psycho-social needs thereby cause or aggravate isolation (Blondell, 2000). Further, alcohol abuse can decrease the ability to perform activities of daily living and instrumental activities of daily living (Moore et al, 2003). Whether or not drinking is a problem, the loss of sources of positive reinforcement is a significant life transition as people age. Retirement from employment may separate the person from work and people who were important sources of meaning and pleasure in life. The loss of friends and loved ones further deprives people of relationships that have been important to them.

As physical abilities are narrowed, prior sources of pleasurable activity may be lost. A significant decrease in positive reinforcement is a common precipitant of problem drinking (Marlatt & Donovan, 2005).

Loneliness

Loneliness is an emotional response to isolation or lack of companionship. When feeling lonely there is a discrepancy between one's desired and achieved levels of social interaction (Perlman & Peplau, 1984). Therefore you can feel lonely even when surrounded by other people; if a person thinks they are lonely then they are lonely. In addition to many different effects of feeling lonely, for example increased inflammatory and neuroendocrine responses (Hackett et al, 2012), increased mortality risk (Patterson & Veenstra, 2010), and decreased life satisfaction (Salimi, 2011), loneliness is associated with alcohol abuse. The association is complex as loneliness may increase the risk of alcohol abuse, both as a contributing and maintaining factor, but alcohol may reversely aggravate loneliness (Åkerlind & Hornquist, 1992).

Existential loneliness. Many view loneliness as a basic and unavoidable fact of life. Each person comes into the world alone, travels through life as a separate unique person, and ultimately dies alone. As death approaches, a person often gets thoughts about life and death and the life one has had, including the choices and (the lack of) possibilities this life has provided. This form of loneliness pertains to age and aging, e.g. *the end is near*.

Social and Emotional loneliness. Losing someone or something of value to one self will often result in loneliness. This will impair quality of life, e.g. life satisfaction. Losing the ability to engage in previous activities and perhaps thereby losing (social) friends (social loneliness) is a negative predictor of life satisfaction, although to a lesser degree compared to losing close friends or family members (emotional loneliness) (Salimi, 2011).

Loss and loneliness are closely linked, e.g. loss often leads to loneliness. However, in some cases a participant may emphasize one aspect more than the other (having a sense of loss without feeling lonely or perhaps feeling lonely without a sense of loss).

In a recent meta-analysis four different strategies for treating loneliness have been compared (Masi, Chen, Hawkley & Cacioppo, 2011). The four strategies are 1) Improving social skills, 2) Enhancing social support, 3) Increasing opportunities for social contact, and 4) addressing maladaptive social cognition. The latter was most successful in studies designed as randomized studies. Treatment for concerns about agingin the CRAS manual is based on a pragmatic coping strategy approach, guided by the problems reported in the Personal Happiness Form. Depending on the problem and the given participant, one of two strategies (or elements from both) may be applied. The two strategies are "problem-focused" coping and "emotional-focused" coping.

9.2 Introducing the Module

Regardless of the patient's age or your own perceptions about aging concerns that are likely relevant to the person you are working with, this module *should only be used if aging concerns are identified* by the patient during the Functional Analysis that was completed earlier in the treatment process.

It is appropriate at the onset of the module to clarify to your patient that it is common to struggle with adjusting to the fact that we all grow older and suffer from various losses. You will need to spend some time on eliciting from your patient how your patient feels about aging. For the most part, the aging module is a relatively straight forward application of cognitive-behavioral principles; yet it is important to note that some aspects of the module focus more on helping a patient *accept* their current situation rather than teaching the person to better control his or her thoughts and feelings. Note that the exercises below exploring existential loneliness and storytelling are focused on acceptance, helping the person emotionally cope and accept what is rather than attempt to make changes to change his or her situation. Acceptance should be understood as distinct from approval. Acceptance does not mean that the person must agree with what is happening or believe it must continue. Patients can still feel frustrated with aspects of aging and wish things were different. What acceptance offers is the skill of developing a new mindful relationship with reality. This approach is in contrast to the behavioral change strategies that are more common in the rest of the manual.

Depending on how your patient describing his or her coping difficulties, you may choose one of two strategies.

9.3 Problem-focused Coping

This strategy is aiming at solving stress-creating problems and expanding the individual's possibilities for action (courses of action):

- Defining and demarcating the problem
- Analyzing the course(s) behind the problem
- Comparing with previous experience(s)
- Aiming at an objective and realistic evaluation of the problem
- Testing different coping strategies intellectually
- Reformulating the problem with inclusion of both positive and negative aspects
- Seeking information, knowledge, guidance etc.
- "Damage-control", not to increase the severity of the problem
- Actively pursue changing the situation/problem
- Taking active steps to change the situation

9.4 Acceptance-focused Coping

This strategy is aiming at mastering the feelings and emotions in certain stressful circumstances or situations or life conditions that may be difficult or impossible to change. This strategy is used when the situation or the feelings about it cannot be changed. Instead the strategy aims at consciously trying to control emotions by re-directing thoughts, focusing on something pleasant, rewarding oneself when succeeding, etc.

- Reversely trying to endure and accept the unpleasant thoughts by deliberately staying with the emotion(s), by talking about the emotion(s), etc.
- Emotionally processing and reformulate the feeling(s) by writing diary, day dreaming, etc.
- "Using" defense mechanisms as repression, displacement, intellectualization, etc.
- Decrease emotional stress by relaxation exercises, pleasant activities, etc.

9.5 Assessing which strategy to choose

Use an evocative style to assess which strategy to use. Rely on open questions that allow the patient to reflect on their own experiences. When your patient expresses his or her feelings about getting older, ask the patient to describe: What does he miss the most: Physical contact? Talking to someone? Laughing? Being treated like a sensible adult by others? Being visible? The patient and you may even wish to rank what he misses the most and what he doesn't miss as much, or what he or she even likes about growing older. Often at the end of an open discussion of this kind, the therapist will have grounds for choosing between the two strategies. Itoften wise to include the patient by asking for their opinion about which strategy makes the most sense.

Therapist: Now that we've talked about some of your experiences in getting older, I wonder if you have an idea about how we should approach them? One idea might be to try to improve some of these problems by figuring out things for you to do to make things better. We would do that together. Another strategy might be to focus on accepting things as they are as a normal part of

growing older. Sometimes life is difficult but we can't expect to change it ourselves and we are better off learning to make the best of it. Which of these strategies seems best to you?

9.6 Choosing Problem-Focused Coping

If the loss or the unbearable situation is not that recent or/and if there are ways for changing the situation or aspects of the situation, you may choose to use Problem-Focused Coping. In essence, the strategy then is to start working on what changes to the situation are possible, instead of focusing on how to live with the inevitable. This is an active approach, which assumes that circumstances can change.

9.6.a Perspectives on Aging (Form K)

Begin by asking the patient to describe what he is missing from his earlier years. Write down two or three things that the patient is missing in the first column of the form. It is important not to spend too much time enumerating things that have been lost. The idea is to empathize with the experience of grieving about losses, and then seek to put those losses in another perspective.

Once you have listed and reflected a few losses, turn your attention to the second column. Are there parts of the patient's younger life that it was OK to let go of? What is he allowed to do instead? Sometimes patients will respond to the idea that the benefits of aging have been a surprise to them. The idea here is to allow patients to explore the idea that aging has some benefits as well as costs. Remember that you will be using an evocative style to elicit these ideas, rather than supplying them to the patient.

Therapist: Over here you've written Ambition About My Career as one of the less good things about your younger life. Can you tell me about that?

Patient: It's the same with young people today. You always have to worry about getting ahead and making progress in your career. I was a salesman and I was only as successful as my last sale. I had that pressure for 30 years.

Therapist: You are relieved not to have that kind of pressure any more.

Patient: Yes, it takes the fun out of life that's for sure

*Therapis*t: And now you have a chance to breathe and enjoy some freedom.

9.6.b Looking Ahead Exercise (Form L)

The Looking Ahead Exercise is intended to focus on the patient on what still might be meaningful about the time left in his or her life. The idea in this discussion is to encourage a sense that important values can still inform how the client spends time and effort. Using Form L, begin by asking :

What would the patient do with his life, if he had only 1 week left to live?

If he had 1 month left to live?

1 year left?

10 years left?

Write these ideas down together with the patient in the Looking Ahead Form. Use the list to discuss with the patient what conclusions he might draw in relation to the importance of the various topics on the list and what he might decide to do in the near future. Make sure to attend to language that indicates a sense of meaning and contribution in the way the client chooses to spend the time left.

9.6.c Who Am I? Exercise(Form M)

If the patient in particular suffers from what looks like a loss of identify due to stopping on the labor market or due to not being a wife/mother or husband/father anymore, you may consider the Who Am I? exercise.

9.6.c.1 Describing Myself.

Begin my asking the patient to describe what really characterizes him. Who is he – really? What is he missing? What could be fun to do (if anything)? What did he like when he was a kid? Or when he was an adolescent? Use the answers to complete Form in collaboration with the patient.

9.6.c.2 Brainstorming.

Ask the patient to take part in a brainstorming exercise with you: What activities might he take up again? (brain storm). Based on the brain storm, does he picture a route to stage where he can feel important again? Develop a plan together with the patient.

9.6.c.3 Telling My Life Story.

For homework, you may also ask the patient to write down a list of things/skills/characteristics that he or she wants his/her grandchildren to remember about him/she (if appropriate). If it seems meaningful, the list can be followed by writing or telling the patient's story for the grandchildren, if the patient would regard this to be a meaningful and fun activity.

9.6.d Assertive Communication

If you discover that the patient is struggling with others treating him or her as if he or she was capable of only a child-like understanding, consider the Assertive Communication Exercise.

9.6.d.1 Identifying Situations.

Ask your patient to describe situations where he or she is spoken to as if they were not mentally capable. Usually patients can provide examples, but if not you can prompt with examples from interactions with medical providers, children or service providers (waiters, clerks, etc.).

9.6.d.2 Defining Assertive Responses.

Explain to your patient that an assertive response is one that gives the best chance of getting what they want in most situations. Contrast assertive responses to those that are aggressive or passive.

9.6.d.3. Generating possible alternatives.

Ask your patient to generate possible assertive responses to the situations they described in the Identifying Situations exercise.

9.6.d.4 Role-playing exercise.

Create a role-play in which the therapist takes the part of the person attempting to be assertive. The patient takes the part of the person who is treating the patient in a childlike way. Once the roleplay is complete, ask the patient to comment about how he felt receiving the assertive response. Next, do the roleplay again with the patient taking the role of being assertive. As appropriate, use increasingly difficult examples and challenges in your roleplays.

9.7 Choosing Acceptance-Focused Coping

For a variety of reasons, it might be best to focus on accepting difficult situations, rather than trying to change them. This often occurs when a person has just lost someone to death or has experienced a major setback in their own health. If this is the case Acceptance Focused Coping might be the best choice. This might also happen if you conclude that problem-solving strategies are not sensible for the patient's problem.

9.7.a Bereavement.

If the patient is grieving and asks you how long one should expect grieving to last, you may be clear about that grief takes the times it needs. Perhaps it never stops. You may then move on to discussing with the patient how to live with grief, rather than trying to make it end. Introduce the idea of staying with the feeling of loss and being patient with grief.

9.7.a.1 Writing a letter.

Introduce the idea of writing a letter to the lost one, describing how much the patient misses him/her (or the situation, for instance workplace or ability to walk). Introduce also the idea of the patient subsequently writing a letter to himself/herself, in which the patient allows himself/herself to grieve and miss, but that also allows himself/herself to move on when he/she is ready. Ask the patient to write those two before the next session.

At the next session, ask the patient to evaluate on the process of writing the letters. When your patient has described how he/she felt about that and his/her conclusions, you may move on to brainstorming how to decrease emotional stress and grieve.

9.7.a.2 Brainstorming ways of living with grief.

If possible, elicit the ideas from the patient, and wait on adding your ideas to the pool of possibilities till the patient has described whatever ideas he or she can find. Make sure that attending self-help is among the ideas on the list. Elements of the Mood Module, for example strategies for increasing enjoyable activities may be especially helpful. The patient may find inspiration on the Menu of Possible Pleasurable Activities.

9.7.a.3 Develop a plan.

When you have developed a list of activities and strategies for decreasing emotional stress, develop a plan together with the patient for how to seek the chosen reinforcement.

9.7.b. Making Peace with Negative Thoughts (Form N)

If the patient complains about continuously being overwhelmed by depressing thoughts on aging or on the losses that he or she has suffered, even if it is quite a while ago, you may find it helpful for

your patient to complete the Grain of Truth Exercise. This exercise uses traditional cognitive behavioral strategies for identifying toxic thoughts (some of these are found in the Mood Module).

9.7.b.1 Identifying Toxic Thoughts.

Generate an example of a toxic thought that is causing the patient pain, depression, anger or distress. Using Form N, write the thought in the patient's words in the first column, regardless of how distorted it seems.

9.7.b.2 Finding the Grain of Truth.

Ask your client what is true about this distorted thought. This is sometimes surprising for clients and it is a departure from the traditional approach to responding to toxic thoughts. Try to encourage the client to generate different language for the second column, rather than simply repeating what was written in the first column. You can ask the client to take the perspective of another person (not himself) viewing this same situation – what would that person say? If necessary, the therapist can supply the grain of truth. Here is where the therapist might be creative in using non-blaming or less toxic language.

9.7.b.3 Creating the Balancing Thought.

Introduce the concept of a see-saw or a weighing scale, in which we will look for both sides to be even. Once the Grain of Truth has been put on the scale, what is the thought that balances it? Usually, this is much easier for patients to imagine than responding to the entire toxic thought. There is something about accepting the grain of truth that makes a balancing thought easier to imagine. Often, the balancing thought will be one of simply acknowledging a difficult truth. Sometimes it will be something the client can do, and then it might be appropriate to move to Problem-Focused Coping Strategies.

Therapist: So here is your toxic thought: "I was a terrible father because I spent too much time working and not enough time with my kids"

Patient: That's exactly right.

Therapist: So if we use the idea that this is one of those toxic thoughts we talked about earlier, then this idea might be poisoning your thinking and your mood. But people have upsetting thoughts for a reason, so maybe there is some part of it that it true. What part of this is really true, do you think?

Patient: I was a terrible father, really.

Therapist: Ok, I'm guessing there might be some truth in that. What do you think someone looking from the outside would say about this thought of yours?

Patient: Everyone always said I worked too much. They would probably say that I put too much emphasis on being a provider for my kids and not enough emphasis on their childhood experiences.

Therapist: Ok, so let's write that here under the Grain of Truth column. "I put too much emphasis on providing for my children instead of enjoying their childhood with them". Is that right?

Patient: Yes, exactly.

Therapist: So, like a see-saw, we want to look for the balance to that thought. What thought could you have that would bring the see-saw a little more even after that grain of truth is on it?

Patient: Well, at least my children knew that I loved them because I worked very hard to give them what they needed. They had plenty of advantages from my work, like those piano lessons and skiing vacations.

Therapist: So what if we wrote in the balancing thought column "I missed a lot of time with my children, but I was a good provider for them."

9.8 Closing the Session

Provide a summary for the patient for whatever portion of the module has been completed. If homework has been agreed upon, remind the patient about it and make a note in your chart to ask about it for the next session. If there are additional parts to the Aging Module that seem appropriate to take up in another session, ask the patient if you might bring them up again.

Mood Management Training (MOOD)

10.0 Mood Management Training

10.1 Background

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

Mood Management Training is a structured program designed to help patients whose efforts to stop heavy drinking may be compromised by the daily - and normal - occurrence of bad moods. This training module instructs patients in the use of cognitive-behavioral techniques to manage negative feelings. Patients learn to replace destructive and avoidant ways of responding to negative moods (such as by drinking) with more positive responses.

Mood Management Training consists of the following three phases:

1. You will teach your patient a model of emotion to help him/her understand negative moods.

2. You will help your patient identify automatic thoughts that lead to negative emotions. Your patient will monitor his/her subjective mood states, and together you will use this self-monitoring information to assess and address cognitive themes.

3. You and your patient will plan ways to counter automatic thoughts and related negative moods with cognitive and behavioral challenges.

The use of mood modification programs in addiction treatment grew out of theoretical and empirical work suggesting that negative mood is linked to a return to addictive behaviors. Marlatt and Gordon (1985) reported that situations which pose high risk for returning to drinking are frequently accompanied by negative mood states. Other researchers showed that negative affectivity is associated with abuse of and dependence upon a variety of substances (Cannon et al. 1992; Cunningham et al. 1995; Shiffman 1982). In retrospective accounts that subjects gave concerning their return-to-drinking episodes, they often indicated that they had been experiencing unpleasant moods at the time of their first drink. Prospective ratings of mood provided by subjects at the close of their treatment have sometimes shown that those with more negative mood fare less well following treatment (e.g., Brown et al. 1997). Thus, interventions targeting negative mood are supported by retrospective, predictive, and correlational data. On this basis, it is plausible that addressing a patient's negative mood states may improve his/her treatment outcome.

Researchers continue to add to the literature on treatment for negative moods in alcohol-dependent populations. Recent research is indicating that optimal programs go beyond teaching patients how to cope with a negative mood itself and move into coping with both the antecedents and sequelae of the negative mood. That is the approach taken in this module.

10.2 Rationale for Mood Modification

Negative moods do not occur or continue in a vacuum. Indeed, emotions are a sequence of events occurring within a particular context. The acronym STORC helps spell out this cycle: Emotions occur in a particular SITUATION that is interpreted through the patient's THOUGHTS. ORGANISMIC responses, such as physical bodily sensations, are usually involved, and the patient's behavioral RESPONSES to this chain of events lead to certain CONSEQUENCES, which in turn become part of the patient's SITUATION, thus repeating the cycle.

The MOOD module is a relatively straightforward application of cognitive-behavioral principles. Below is the list of steps to take to present this module to your patient:

1. Teach your patient to identify the five factors that make up human experience (STORC), and discuss the connections between them, drawing on examples from the patient's own life.

2. Start your patient with self-monitoring to identify the particular STORC components of moods that he/she experiences in different situations.

3. Focus on automatic thoughts that support or exacerbate negative mood, along with the idea that your patient's ability to change his/her thoughts and style of thinking can improve mood.

4. Explore automatic, maladaptive behaviors and help your patient plan cognitive and behavior change.

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

10.3 Explaining the STORC Model

Give your patient a copy of the *STORC: Understanding Emotions and Moods* handout (Form O), which outlines the basic model that underlies this module, and explain that it describes how moods occur. The steps the handout lists are useful both in understanding negative moods and in finding ways to change them.

The background material provided in the following sections is intended to help you explain the importance of each step in the STORC model. Do not present this level of detail to your patient. Use the material to tailor an explanation appropriate to your patient's cognitive style and level of conceptual understanding. Each section describes how one component affects mood and suggests therapeutic interventions that can be directed at that component. How much emphasis you place on each component depends on what you think is best for your patient.

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

10.3.a Situational Factors

The SITUATION refers to the people, places, and things that surround the patient at a particular point in time. Patients often attribute their moods to these external sources. It is important to explain that the situation is only one part of how moods occur. Not even the worst of situations has the power in itself to control a person's moods. Viktor Frankl (1963), describing conditions within the Nazi death camps of World War II, recalled people who spent their time encouraging and comforting others. Rather than being defeated by the seeming hopelessness of their situation, they held on to hope and shared it with others. A follow up study of people who had been treated for alcohol dependence found that it was not the number of stressful situations to which they were exposed but rather how they coped with stressful situations that influenced whether or not they returned to drinking (Miller et al. 1996).

Nevertheless, certain kinds of situational factors do seem to increase the probability that a person will get into a negative mood. To be sure, people differ in their susceptibility to such situational influence, and the other elements of the model (T, O, R, and C) play a role in determining what impact the situation will have. All else being equal, however, there are conditions that promote negative mood and depression. These include a person's prolonged exposure to stressors such as significant loss, crowding, noise, and so on. Another important area to explore is the amount of positive reinforcement (as opposed to criticism, punishment, and other aversive conditions) that a person experiences in daily life. Positive reinforcement and pleasant events appear to be important in helping a person maintain a positive mood and outlook, much as vitamins are important in promoting a person's good physical health. Some people have lifestyles or occupations that provide them with very little regular positive input, and these are combined with a rich diet of criticism and negative evaluation. Sometimes (e.g., when a person is in a new relationship or job), the reinforcement a person receives starts out at a high level but then drops off gradually over time. When people experience such a drop in positive reinforcement, they describe it as ''being taken for granted,'' or not being appreciated. If people are continually exposed to conditions of low reinforcement, they can succumb to negative moods and depression.

As you explore situational aspects of mood with your patient, focus particularly on what seem to be the most mood-relevant aspects of the patient's environment. In the following example, the therapist engages the patient in identifying mood-important aspects of his environment:

THERAPIST: So if the SITUATION refers to people, places, and things around you, suppose you were sitting in your living room at home, alone in the house. Is that an okay example for starters?

PATIENT: Yes, I guess that's one situation.

THERAPIST: But that only gives me a general idea of the situation. Tell me more about it, things that might relate to your mood. Picture it - you're sitting in your living room at home - and tell me about it. How are you feeling there?

PATIENT: Bad. My mood is negative.

THERAPIST: Okay, that's a start. What's going on in the living room that might contribute to your negative mood? How's the temperature?

PATIENT: Our air conditioner is broken and the temperature is getting higher every day, which may make me more irritable than usual.

THERAPIST: Good. What else might be going on that would affect your mood?

PATIENT: The noise from the neighbors is ridiculous. We ask them to keep it down, but they never listen.

THERAPIST: Great - what else?

PATIENT: Well, one other thing really gets me. Fran was supposed to be cleaning the house earlier this week, but it's still a mess. There's dust and piles of stuff everywhere.

THERAPIST: You've given me some really good examples of aspects of one situation that seem to contribute to your negative moods. Now let's talk about some other situations, especially those where you might have some bad feelings....

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

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

- The patient can plan intentionally for each day to include some pleasant events, large or small, that function like "psychological vitamins" to help keep the rest of the day in balance.
- The patient can self-monitor by keeping a daily record of pleasant and unpleasant events so as to be aware of the daily balance.
- The patient can plan time for additional positive experiences if the unpleasant or stressful events seem to dominate and overbalance pleasant events.
- The patient can try to arrange for regular social support as a source of such positive and balancing experiences.
- The patient needs to seek ways to decrease negative and stressful experiences.
- The patient needs to plan for additional pleasant events and social support to counterbalance those that are unavoidable, especially when he/she can anticipate negative experiences.

When the patient plans a balanced psychological diet, he/she needs to avoid a common pattern: that of packing all of the negative or stressful events together during the day and then having a sudden shift to positive time represented symbolically by the "happy hour" during the

evening. Marlatt and Gordon (1985) have associated this pattern with a risk for alcohol and other drug abuse and propose that it is healthier to distribute positive events throughout the day.

10.3.b Thought Patterns

Although situational factors do play a role in mood, there is another sense in which nothing in the external situation is really responsible for a person's mood. Positive and negative emotions are not direct reactions to the "real" world but rather are responses to how the person perceives that world-the person's THOUGHTS. For example, encountering a rattlesnake along a wilderness trail might evoke considerable arousal for a person who recognizes it for what it is but could result in little more than curiosity for a person who has no idea of the danger it poses.

Similarly, "depressing'' events are not inherently depressing, and a person's reaction depends upon how he/she perceives them. Take the classic film "It's a Wonderful Life." George Bailey (played by Jimmy Stewart) experiences a sudden series of major setbacks on Christmas Eve. George perceives his situation as hopeless and his life as worthless and falls into a suicidal mood, wishing he had never been born. In a transforming vision, he gets his wish, seeing life in his town as it would have been had he never existed. Afterward this same life looks entirely different to him (hence the film's title). All that has changed is his perspective. Within the context of a positive or optimistic attitude, events that a person might otherwise consider to be stressful or depressing can have a diminished or different impact.

Attributions are particularly important cognitions when it comes to mood. Attributions are explanations of why things happened (or did not happen), or what caused certain life events. Two dimensions affect the way a person perceives attributions. The first is whether they are internal or external. An internal attribution is a perception that a particular event was caused by one's own actions. An external attribution is a perception that a specific event was caused by factors beyond one's own influence. The second dimension is whether the attribution is stable or unstable. Stable attributions explain an occurrence as being the result of something that is not likely to change. Unstable attributions explain an occurrence as being the result of a situation that is highly changeable.

As a general rule, people do not expect things to change when they attribute a situation to a stable cause but do expect change when they attribute a situation to an unstable cause. People usually have a somewhat optimistic attitude, attributing successes to internal causes but failures to external and/or unstable causes: ''My successes are because of my abilities and efforts, but my failures are the result of insufficient effort, interference of others, or just plain bad luck." Even psychotherapists may see the world this way: ''My successes are because I am a good therapist; my failures occur when the case is just impossibly difficult, or the patient isn't motivated enough." Though perhaps a bit self-deluding, this type of attributional style is one that encourages a positive outlook and continued personal effort.

Negative mood and depression are associated with a different attributional pattern. When people are in the midst of depression, they tend to attribute negative outcomes to stable, general negative characteristics of themselves: "That's how it always goes; I mess up everything I touch." "I'm a loser in every relationship; who could care for somebody like me?" In this type of mood,

people attribute positive outcomes to external causes: "I just got lucky." "They let me win because they feel sorry for me." "She's nice to everybody."

Researchers have found that changing a person's self-statements has an impact on mood. Cognitive therapies, which focus on altering thought processes, are beneficial in treating anxiety and affective disorders. Cognitive intervention typically begins by identifying the person's thought patterns that may be fostering negative moods (Beck 1976; Burns 1980), such as unrealistically high expectations of oneself or others, hopelessness, pessimism, and excessive self-criticism. The therapist then challenges and changes these cognitive patterns by helping the patient seek new beliefs and self-talk to promote healthier functioning.

10.3.c Organismic Experience

Some think of moods as purely physical sensations. Certainly there are neurobiological processes involved, many of which operate below conscious awareness. There is a diffuse autonomic arousal associated with many emotions, and people may experience this in physical changes such as dry mouth, cold hands, a hot face, and stomach contractions. What physical sensations does your patient connect with being upset, angry, sad, afraid, or other emotions? Often physical sensations are similar across subjectively different emotions. In fact, research has shown that given autonomic arousal, the emotion that a person experiences is influenced by how the person interprets the arousal and the situation. Sometimes emotions are aroused or amplified in direct response to an internal physical sensation, as in fear of fear.

The ORGANISMIC component is the person's experience, both physical sensations and the emotional name that is given to it. It is often helpful to clarify exactly what your patient experiences, physically, as a negative emotion or mood. Emphasize that these physical (organismic) responses are a part, but only a part, of the chain of events experienced as emotion.

There are various strategies to alter directly physical states (e.g., medication, relaxation training, physical exercise). None of these is included in CBI, in part because they have a disappointing track record as components of treatment for alcohol problems (Miller et al. 1995). In fact, substance abuse may be the patient's attempt to modify directly the 0 component in negative emotionality. CBI puts primary emphasis on modifying cognitive (T), behavioral (R), and environmental (S, C) elements in the chain.

10.3.d Response Patterns

When your patient experiences mood-relevant physical changes, what happens? What does the patient do in response to emotional arousal? Once a person begins to experience a negative mood, how he/she responds to this feeling can make a big difference. Be alert for two generally maladaptive response patterns: avoidance and aggression, described below.

Avoidance

A common and often unhealthy response is avoidance, or withdrawal. The reaction may seem understandable, even natural. When people are down or are experiencing low self-esteem, they feel like poor company. They may not feel up to usual social contacts or may not want others to

see them in this dejected state. Feelings of fatigue may contribute to the urge to avoid and withdraw. Yet avoidance tends to strengthen negative emotions. If a person, once thrown from a horse, continues to avoid horses, he/she will become even more afraid of them. The depressed person who withdraws from his/her social support network is cutting him/herself off from important sources of feedback and reinforcement, which in turn amplifies the depression. The general remedy here is to do the opposite of the seemingly natural tendency to withdraw. For the depressed person, it is important to continue seeing friends and engaging in previously pleasurable activities, even though it requires an effort and may not immediately feel pleasant. The same applies to people feeling down and suffering from general low moods.

Aggression

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

In part, the problem here can be the lack of an important coping skill. Deficient social skills, for example, can prevent a person from developing a reinforcing and supportive network of friends, which in turn decreases resistance to depression. Social skill deficits can also perpetuate depression. It is important for the person to learn a new coping style, a new way of responding that promotes healthier moods and adjustment. If this appears to be the case with your patient, it may be useful to include other CBI skill-building modules in treatment.

Consequences

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

Ironically, some social settings strongly reward a person for negative mood. Consider this scenario. A woman has poor social skills and consequently has no close friends. Her everyday life is uneventful and empty. In time, she becomes depressed and confides to several people in the church community of which she is a member that she is feeling suicidal and very down. Suddenly this community comes alive for her and rallies around her. The pastor calls regularly. People begin telephoning and dropping in, often bringing food, helping with chores, or even sitting with her through the night. What had been a largely inattentive group of people becomes, almost overnight, a warm and supportive community. Amazed, she begins feeling better, and as she does, her friends go back to their previous business, leaving her alone again. The woman's "sensible" response to these contingencies is to become depressed again.

Change at this level involves rearranging one's social environment, as much as possible, to reinforce healthy behavior instead of unhealthy, disabled behavior. It is not enough just to stop reinforcing depression. Consider again the woman described in the above scenario. Suppose her

friends had decided to abandon her in sickness and in health! Likely her depression would not be lessened. Instead she needs to learn better social skills for forming personal and lasting relationships with others. A key is to establish a social support network that provides ongoing reinforcement for healthy and adaptive functioning.

Still another possibility is to try new activities, new sources of potential enjoyment and reinforcement. There is a tendency for adults to fall into predictable patterns of social and leisure activities. Substance dependence also commonly involves a steady withdrawal from previously enjoyed people and activities. Some people are reluctant to try new skills because they might not excel at them; consequently they do only what they are sure they can do well. Such limitations unnecessarily restrict a person's possibilities. If a person explores new activities, just for the fun of it, that can lead to new and rewarding relationships and involvements.

10.4 Exploring Negative Mood States

Sometimes people have a difficult time naming or describing their own moods directly. They may describe their thoughts rather than their feelings. Such patients may respond to reflective listening, and you may be able to infer your patient's mood from his/her more general description of the STORC elements of a particular event.

In the example below, the therapist is using the STORC concept to explore a recent situation that left the patient in a negative mood:

THERAPIST: So - give me an example. When was the last time you felt a strong negative feeling?

PATIENT: Well, yesterday, when I was stuck in traffic, I thought all those people were jerks.

THERAPIST: You were in a traffic jam and you were feeling a strong mood. What name would you give that mood?

PATIENT: I didn't feel anything in particular; I just thought about what jerks people are, and how I wished I was anywhere but there. I kind of wanted a drink.

THERAPIST: Interesting! So you're not sure what to call your feeling, but it was pretty negative. It sounds, even in your tone of voice right now, like you were a little irritated.

PATIENT: I guess you could call it irritated. And it was more than a little.

THERAPIST: We agree, then, that you got kind of angry in traffic yesterday. And that's when you felt this urge to drink.

PATIENT: I suppose so. It's strange to think about it that way. I just blamed it on the traffic. At least I didn't drink!

THERAPIST: What a good example! That's not unusual to think that your feeling is the direct result of what's happening out there. One of the things we are focusing on here with this STORC approach is how the situation is only one small part of how negative moods happen.

PATIENT: I guess I was more irritated than I realized.

THERAPIST: And now you see it. Good for you! It's pretty common for people to feel like drinking when they get into a negative mood like that, and it sounds like for you, feeling angry is a particularly strong one. The point, though, is that you have a lot to say about your own mood. You can, to a large extent, decide how you feel about something. And as this experience shows, even if you do get into a negative mood, you don't have to give in to the urge to drink that goes with it....

Another option is to use the ***Feelings From A to Z worksheet (Form P),*** which provides a broad list of feeling names. Show your patient the list, and ask which words might best describe how he/she felt in the situation you are discussing.

10.5 Self-Monitoring

After you have explained the STORC model, the next step is to have your patient begin self-monitoring mood states. Start by having your patient complete one column of the *Mood Self-Monitoring Sheet* (Form Q) based on the most recent time he/she experienced a negative feeling. In the "Mood-Level rating'' box, ask the patient to rate his/her mood level from -10 (very negative feeling) to +10 (very positive feeling).

Next, ask the patient to describe the situation to you, and then have the patient make a brief note in the "Situation'' box (S) to indicate the external circumstances.

Sometimes people have difficulty filling out the "Thoughts" component (T) of the sheet because they are unaware of any specific thoughts that occurred in between the situation and the mood. If this happens, skip down to the "Feelings" (O) box, and then come back to the "T' box and ask, ''What might (or must) you have thought to get from here [S] to here [O]?" Emphasize again that feelings are not automatic results of the situation but that they result from thoughts that occur often so quickly and automatically that one is unaware of them.

In the "O" box, have your patient fill in specific physical sensations as well as a name for the emotional state. How did the patient feel in this situation? Help him/her to distinguish between thoughts and feelings. For example, when a person says, "I felt that..." it is almost always a thought rather than an emotion (for example, "I felt that I was being treated unfairly''). Listen for an implicit "that'' in the statement: it conveys a cognition, a mental interpretation, rather than an emotion. If you hear a "that'' in the statement, the person is not expressing an emotion.

For the ''What I did (R)" box, ask what the patient said or did in response to the situation, thought, and feeling. Have the patient make a brief note about it.

Finally, in the ''What happened (C)" box, indicate what happened as a result. How did others react, or what changed?

In the example below, the therapist and patient are filling in the *Mood Self-Monitoring Sheet*:

THERAPIST: Okay, now let's try keeping a mood diary on these sheets. What will be most helpful is if you keep a record of times when you have a particularly positive or negative feeling. You don't

have to put every feeling in the diary, or you could be at it all day, but when there is what seems like a significant feeling - something especially positive or negative - write it down. As an example, think back to the last time this week when you experienced a particularly negative feeling. When was that?

PATIENT (laughs): Just before I came in here. I had a big fight with one of my grandkids.

THERAPIST: Okay, fine. Now in this first box, I want just a rating of how good or bad you were feeling. It's a rating scale from minus 10, which is feeling about as bad as you can feel, to plus 10, which is feeling on top of the world, about as good as you can feel. Where would you rate your mood in that situation?

PATIENT: During it? I was so mad, I could hardly talk. Minus 8 or 9, maybe.

THERAPIST: So, a very negative feeling - almost as mad as you ever get.

PATIENT: Well, minus 7, maybe.

THERAPIST: Okay, write that down. Now what was going on just before this feeling happened? What was the situation?

PATIENT: Toni, my 18-year-old granddaughter, showed up with her navel pierced and bleeding and then accused me of overreacting when I told her she needed to see a doctor. She decided to have one of her friends pierce it to put in one of those rings. I was furious she did that.

THERAPIST: She wasn't concerned at all about the bleeding and you felt like it was really irresponsible.

PATIENT: Livid. Just livid. And I know she didn't go home to her mother because her mother would have reacted even worse than I did.

THERAPIST: All right. Just make a note in the "Situation" box there - maybe, "Toni came over with navel ring." Now what were you thinking to yourself when you saw her with the ring?

PATIENT: I thought, how stupid can you be? That's going to get infected. What were you thinking?

THERAPIST: What else?

PATIENT: I think that if she's doing this, she's probably doing a bunch of other bad stuff as well.

THERAPIST: Great! Write that in there. So then come the feelings. Really mad, you said.

PATIENT: Yup. Fried. I felt that I was about at the end of my rope with this kid.

THERAPIST: Put that in there: "Really mad. Fried." That's good! The last thing you said, though, goes up in the "Thoughts" box.

PATIENT: Why is that?

THERAPIST: What you said, I think, is that you felt that you were at the end of your rope. That's not a feeling really, though it certainly leads to a feeling. It's a thought flashing through your mind: "I've had it. I shouldn't have to be dealing with this kind of stuff. Her mom needs to deal with this." Something like that, right?

PATIENT: Right, I see what you mean. That's what I was thinking to myself, but I didn't say it to her, thank goodness.

THERAPIST: Okay - you're thinking, "I'm at the end of my rope. This kid did something stupid." And then you feel fried, angry. So what did you do?

PATIENT: I said something like, "How could you be so stupid? I'm calling your mother right this second." I wasn't thinking. I couldn't even see straight, I was so mad.

THERAPIST: Actually you were thinking - says so right there. And what you were thinking got you pretty hot.

PATIENT: Yeah, I see what you mean. Anyhow, she called me a name and ran out of the house.

THERAPIST: All right. So in the "R" box there, just make a little note about what you said. There's not a lot of room, so just make it enough to remember what you did. And then in the "C" box, make a note that Toni yelled at you and ran out of the house.

PATIENT: Right then - I almost had a drink. I really felt like it.

THERAPIST: That sounds important. Let's explore that a little and keep going with this. The consequences - what happened - become part of a new situation for you, and the process continues. So let's do the next column. The situation is that Toni just yelled at you and ran out of the house. That goes up there in the next "S" box. And you think to yourself, "I'd really love to have a drink." What were you actually feeling at that point?

An important quality of a discussion like this is that you and your patient are standing back and reflecting on the flow of events involved in feelings. Some of this discussion can even be fairly lighthearted, gaining some distance from what was a significant emotional event.

Once your patient seems comfortable with how to fill in the ***Mood Self-Monitoring Sheets***, assign him/her to keep the sheets as a diary between this session and the next and bring them back at the next session. Give your patient a supply of the forms, asking him/her to complete at least three of them (that is, nine specific events). Make sure this is agreeable and that the patient understands what you are asking him/her to do. Emphasize that you want the patient to record situations in which either positive or negative emotions occurred. Both are useful.

If time permits, you can continue with the next section or postpone this until your patient returns with completed Mood Self-Monitoring forms.

10.6 Automatic Thoughts

Start this section with a discussion of how certain types of thoughts lead to negative emotions. Ask your patient for examples to determine the extent to which he/she grasps the idea. Those with experience in AA may link this to the concept of "stinking thinking." Use examples from the ***Mood Self-Monitoring Sheets*** to explore how thoughts are linked to emotions. As your patient begins to break his/her negative mood sequences down according to the STORC model, a pattern of automatic thoughts that are mood magnifiers should emerge. You're looking for patterns, for themes or consistencies. You could use the analogy that these thoughts are like weeds in the garden, and the patient is plucking them out, one by one, to allow room for what he/she wants to grow.

Emphasize that emotions are transient - they tend to come and go. For an emotion such as anger to persist, it has to be fueled by thoughts. Going over and over certain thoughts is like putting logs in the fireplace. If you stop feeding the fire or pull out the wood, the fire eventually goes out.

Another important point, strange to some patients, is that they can choose how they think about things. This is a crucial point, because mood management involves changing thought patterns, pulling weeds, pulling fuel out of the fire.

The thought-changing process is a two-step process. First, the patient needs to learn to recognize the automatic thoughts, to catch them as they go by. Second, the patient needs to learn to replace them with more balancing thoughts. Again, for patients with AA background, this will be familiar territory, though they may not have explored it in quite this way. ''Resentment" is a common theme in AA meetings and serves as a good example of how thoughts fuel negative feelings, which in turn can lead toward drinking.

As with all task assignments, when you have asked your patient to keep mood-monitoring records, give this priority at the beginning of the next session. Ask for the records, lavishly praise the patient for keeping them, and take time to go over them together. Look particularly for consistencies in thought patterns that lead to negative emotions. Consider both consistencies of content as well as distorted thought processes.

Below is a list of some common erroneous thought processes as described by David Burns (1990):

- **Filtering** involves selective attention, looking only at certain elements of a situation while ignoring others.

- **Black-and-white thinking** classifies reality into either/or categories without recognizing the many degrees of difference.

- **Overgeneralization** involves broad conclusions based on limited evidence, such as "making a mountain out of a molehill."

- **Mind reading** is making assumptions about what others are thinking and feeling, what motivated their actions, and so on.

• **Catastrophizing** means assuming that the worst will happen.

• **Personalization** is the error of seeing every experience as related to your own personal worth.

• **Blaming** is holding other people responsible for your pain.

• **Shoulds or oughts** can be rules that are rigid, not flexible enough to take into account human frailties.

• **Emotional reasoning** means feelings over-run reality-checking: if you feel it, it must be true.

• **Fallacy of external control** is the perception that you have no power or responsibility for what happens in your life.

• **Fallacy of omnipotent control** is the opposite pattern: believing that you control (or are responsible for) everything. This is another common theme discussed in AA meetings (see Kurtz 1979).

Do not recite this list to your patient; it is provided here to help you think clearly about what systematic, automatic distortions may be occurring in your patient's thought processes. With your patient's collaboration, identify the content or process errors in thinking that lead to negative emotionality (Burns 1990).

It is inconsistent with program's overall style to argue with your patient about whether or not his/her thoughts and beliefs are correct. Instead, invite your patient to consider how else it would be possible to view or interpret the same situation. The point is, do not say, ''You're wrong," but show how different ways of thinking about situations actually lead to different realities (O, R, and C). Explain that no matter the situation, he/she always has the freedom to choose how to think about and understand the situation. This perspective, in turn, provides your patient the freedom to choose how he/she feels about life as well. (For patients with AA experience, explore this concept in relation to the idea of serenity.)

10.7 Challenging Toxic Thoughts

The preceding exercises lead naturally to the next step of challenging and finding antidotes to toxic thoughts - trying out new ways of thinking and being. Once you have identified thought patterns that lead to negative emotions, work together to find ways to challenge and replace those thoughts. Again, emphasize that this perspective is a matter of choice. The patient does not have to think differently. In fact, to say so would be to practice a distortion. Rather your patient can choose how to think (T) about situations (S) and thus has some choice about how to feel (O) and act (R) as well, which in turn influences what happens (C) in his/her external world. It is also not your job to prescribe for your patient the "correct" or "rational" thoughts that he/she ought to have. It is fine to suggest different possible interpretations if your patient gets stuck, but always first invite him/her to suggest different ways of looking at situations and feelings. Again, think of it as developing a menu of options from which the patient chooses.

There are at least two basic ways to intentionally challenge toxic thoughts. One is to think (T) differently - in essence, talking to yourself. Another is to act (R) differently, to live as if different assumptions are already true. (In AA, this is sometimes described as "fake it 'til you make it."). Just as negative moods can be magnified by either thoughts or actions, they can also be counteracted in the same two ways.

This is where you can use the *Thought Replacement Worksheet* (Form R). Often it is best to introduce it by working through a specific example or two (see sample on pages following). In the example below, the therapist and patient go over the ***Thought Replacement Worksheet*:**

THERAPIST: You have completed several of these Mood Self-Monitoring Sheets. What we're going to focus on today is how your thoughts affect your moods and what you can do about that. Sound okay?

PATIENT: Sure.

THERAPIST: Well - let's see what you have here (*looks over sheet*). I see that you had some pretty strong negative moods on this sheet, with some urges to drink.

PATIENT: Yeah - that one night was especially tough.

THERAPIST: And I see some real mood magnifiers here.

PATIENT: I don't know what you mean.

THERAPIST: Well - close your eyes for a minute, and imagine it is Friday night again. You're sitting in the chair at home alone, channel surfing. What are you saying to yourself?

PATIENT: Here I am on a Friday night, watching television by myself. My life is pointless.

THERAPIST: And that kind of says, "It's just how I am. It will never get better." Does that sound right?

PATIENT: Uh-huh.

THERAPIST: So how are you feeling? Can you feel it now?

PATIENT: Lonely. Depressed ... discouraged.

THERAPIST: Exactly. If the problem is who you are - if this is something hopeless that can never change, then of course you feel demoralized. It follows! The thought is a mood magnifier.

PATIENT: I can see that.

THERAPIST: Are you willing to try to pick some weeds here, clean out the garden a little?

PATIENT: How do I get rid of thinking that way?

THERAPIST: Well - let's look at that thought that things will never get better. How accurate do you think that is? Are you 100-percent sure that things will never get better?

PATIENT: Not really - but I do think that there's a good chance things won't improve.

THERAPIST: What are the odds you would give yourself, in your head? 50/50? There's a 50-percent chance that things will get better?

PATIENT: No, I'd say there's a 10-percent chance that things will improve.

THERAPIST: Now there is a bad mood magnifier! The doctor only gives you a 10-percent chance of having a life. You gonna take the doctor's word for it?

PATIENT: Maybe I should get a second opinion (*laughs*).

THERAPIST: Yes! A second opinion. That's good! Choose yourself a better doctor.

PATIENT: It would be nice.

THERAPIST: Your tone of voice sounds a little hesitant.

PATIENT: Yeah - I don't know about this.

THERAPIST: You're not too sure you can do this-maybe a 10-percent chance?

PATIENT: (*Smiles*).

THERAPIST: I agree. It's not easy. Here - let's take a look at that thought about things never getting any better. I'm going to use this new sheet here. (*Takes out the Thought Replacement Worksheet.*)

PATIENT: Okay. How do you want to look at it?

THERAPIST: Well, you said that your mood was really negative on Friday night. How did you feel on Saturday morning?

PATIENT: Okay, I guess. Yeah - I had some stuff to do, and I hadn't had anything to drink, so I was feeling a little better.

THERAPIST: So - you were improved the next day?

PATIENT: Well, yeah – somewhat - but I wasn't totally happy or anything.

THERAPIST: Not perfect - and that's a point well taken. We're not looking for total perfection here - we're just looking for what moves your mood one way or the other. What if you had drunk on Friday night?

PATIENT: Would have been much worse. Okay - I see where you're headed with this. I have some choice about what happens.

THERAPIST: So let's try a little mind experiment here. This is your initial thought on Friday night – hopeless - I'm writing it in the "Toxic Thought" box. And we know where that one leads - you felt lonely, depressed, discouraged. I'm writing that in here.

PATIENT: Right.

THERAPIST: Now, just use your imagination. What else could you have said to yourself, sitting there at the television, besides, "My life is pointless and it is always going to be pointless."

PATIENT: Something like, "I may feel miserable right now, as if I was never going to feel better, but chances are I will feel better tomorrow."

THERAPIST: All right! That's a much more balanced thought. Good work! I'm writing that in here, in the "Replacement Thought" box. And what do you suppose your feeling would have been if you had said that to yourself instead?

PATIENT: A little more peaceful, maybe.

THERAPIST: Peaceful. Okay. I'll put that in here. You get the idea?

PATIENT: Uh-huh. I think so.

THERAPIST: Okay. Now you try one. Here's the sheet. Let's look back at your mood diary for this week and find another place where you had negative feelings. How about this one. "Upset," it says. And under "Thoughts" you have "Unfair." What's the mood magnifier there? ...

In the same way, examine what the patient does in negative mood situations (R) and how this may be a mood magnifier. Similarly, explore what else the patient could have done instead. As with thought substitution, the idea is to emphasize choice. Common examples of behaviors that may serve to reinforce negative moods include: withdrawing, arguing, sulking, drinking, driving aggressively, smoking, overeating, criticizing, or blaming.

As before, it is not your job to confront, criticize, or correct your patient's behavior. Instead, invite the patient to consider with you, as a mental experiment, what else he/she could have done and what different consequences might have followed. A problem-solving approach works well in this context.

In the example below, the therapist and patient work together to generate a list of different response options that could have varying effects on moods.

Sample Thought Replacement Worksheet

Toxic Thought	**Resulting Feeling**	**Replacement Thought (Antidote)**	**Resulting Feeling**

I'm a real loser. It's never going to change. I'm always going to be this way.	Discouraged Depressed	I'm feeling lonely right now, but I'll probably feel better in the morning. What else could I be doing besides sitting here watching TV?	More peaceful More hopeful
I'd really like to have a drink. I'd feel better. If I don't have a drink, this feeling is just going to get stronger and stronger.	Panic Thirsty Helpless	Wait a minute. I've already tried that. If I drink now, I'll feel a whole lot worse. Who am I kidding?	Relieved Stronger

THERAPIST: Now a piece we haven't talked about yet is how what you do can also be a mood magnifier. Looking back at your Friday night, you say you were watching TV alone and eating chips. And doing that, you felt lonely, discouraged, depressed. Now what are some other possibilities? What else could you have done when you were feeling that way?

PATIENT: I could have had a drink or 20.

THERAPIST: Right - and you chose not to. What if that's what you had done? What would have happened?

PATIENT: Like I said, I would have felt a lot worse on Saturday. I would probably have stayed home on Saturday and drank all day, instead of going out and getting things done.

THERAPIST: All right. There's one thing you could have done differently that would have led to much worse feelings and consequences. It would have magnified your negative mood. Now the opposite is true too. What else could you have done differently on Friday night, besides staying home alone, that might have had better results?

PATIENT: What else am I supposed to do? I'm not supposed to go to bars, and there's not much else to do out there on a Friday night.

THERAPIST: It's a real challenge sometimes to figure out what to do instead of a mood-magnifying behavior. First identify the behavior that's magnifying your mood, and then try some healthier options.

PATIENT: I don't know - maybe it's best just to be alone.

THERAPIST: I hear some mood-magnifying thoughts right there!

PATIENT: Well, the being alone thing really bugs me. I know I don't want to be alone, which is a more balanced thought, I guess, but at the same time, I'm nervous about meeting people. I guess that's what AA meetings are for.

THERAPIST: You can meet people at meetings. You can also meet them at a ton of other places. The Thursday night newspaper every week has pages of things that are happening in the community, most of which don't involve drinking. And going out and doing something around other people is just one set of possibilities. What else could you do?

PATIENT: You mean like call somebody on the phone?

THERAPIST: There's a good idea! What if you had done that instead on Friday night? ...

Thought substitution and response substitution are good task assignments to perform between sessions. For your patient, the spirit here is one of experimentation - of trying out different thoughts and different behaviors, to see what happens. It's the same idea expressed in Developing/Deciding on Recreational Activities skill straining area--sampling different possibilities to find what is more rewarding. Negotiate specific assignments, drawing heavily on your patient's own ideas whenever possible. It can be useful to continue keeping the ***Mood Self-Monitoring Sheets*** during this period when your patient is trying new thoughts and responses.

10.8 Applying STORC With Urges To Drink

If your patient experiences urges to drink, this module's procedures may be particularly helpful. You can analyze urges with the same STORC model, and positive changes may occur at any link in the chain. Urges often involve a good deal of self-talk, which can have a magnifying effect. Similarly, thought and response substitution can counteract and weaken urges to drink.

Hidden automatic self-statements about urges can make them harder to handle ("Now I want a drink. I won't be able to stand this. The urge is going to keep getting stronger and stronger until I blow up or drink.") Other types of self-statements can make the urge easier to handle ("Even though my mind is made up to stay sober, my body will take a while to figure this out. This feeling is uncomfortable, but in a few minutes, it will pass. I'll surf over it.")

The two basic steps are the same, as described below:

1. Identify the STORC components that make up an urge to drink. What is the situation? What self-talk is involved? What are the automatic thoughts that make it harder to cope with an urge? How does the patient respond when experiencing (and labeling) an "urge"?

2. Find ways to challenge the toxic self-talk ("stinking thinking") with replacement thoughts and responses. Below is a list of replacement thoughts that people have used successfully in sobriety:

- Where is the evidence? What is the evidence that if I don't have a drink in the next 10 minutes, I will die? Has anyone who has been detoxed ever died from not drinking? Who says that successfully sober people don't have these feelings from

time to time? What is the evidence that there is something uniquely wrong with me that means I can't stay sober? Who do I think I am?

• What is so awful about that? What's so awful about feeling bad? Of course I can survive it. Who said that sobriety would be easy? What's so terrible or unusual about experiencing an urge to drink? If I hang in there, I will feel fine. These urges are not like being hungry or thirsty or needing to relieve myself - they are more like craving a particular food when I see it or an urge to talk to a particular person-they pass in short order.

• I don't have to be perfect. I'm not God. So I make mistakes. I can be irritable, preoccupied, or hard to get along with sometimes. Other times I'm more centered, loving, and lovable. Human beings make mistakes. It's part of being alive and human.

Similarly, there are many possible responses to try instead of drinking. Call someone. Go to a movie. Take a hot bath. Go to a meeting. As always in this program, it is best to elicit the patient's own ideas. It can sound terribly trite to list things a person can do instead of drinking, and patients generally have better ideas anyhow.

Social and Recreational Counseling (SARC)

11.0 Social and Recreational Counseling

11.1 Background

Often when patients come for treatment, they have few outside interests and activities. This may be especially true for elderly individuals who may not feel as interested in activities they used to be involved in because of increasing physical restrictions or fewer interactions with others because of retirement. As people develop an alcohol use disorder, drinking occupies more and more of their time (which elderly individuals may have more of because of retirement), and drinking companions displace prior associates. Conversely, an important part of your patient's process of recovery is rebuilding a life without drinking. This rebuilding may include the patient finding a nondrinking peer group and sampling and pursuing positive social-recreational activities that do not involve drinking.

The central goal in this skill area is to help your patient connect with reliable sources of positive reinforcement that do not involve or depend on drinking. You may not need to devote the entire session to SARC and can easily combine the SARC module with another module.

11.2 Rationale for SARC

Start by discussing with your patient the importance of healthy, supportive relationships and rewarding recreational activities. As much as possible, have your patient offer reasons why it is important to have activities and companions not associated with drinking. You may want to begin with something like, "Social and recreational activities are important in most people's lives. They provide…" Here is a list of some possible points you may want to raise:

- A source of enjoyment that can be looked forward to after a stressful day.
- A way to decrease boredom when you have free time.
- A way to feel physically healthy.
- An outlet for developing a skill that makes you feel good about yourself.
- A chance to be with people you like to develop friendships.

Explain that these activities can play a very important part in becoming and staying alcohol free. When you give up using alcohol, you have to do something else during the times you were using. If the things you do are not satisfying or enjoyable, or you don't do anything but sit around and feel lonely or bored, you are more likely to go back to drinking.

Avoid lecturing your patient on matters it is likely he/she already knows. You might say, "Drinking has occupied a lot of your time and energy in the past, and it sounds like many of your regular contacts were drinking companions. One of the important challenges is to develop new interests, friends, and rewarding ways to spend your time that don't involve alcohol. What do you think might be the advantages of having fun, finding some new interests, or being with friendly people without drinking?" As your patient offers change talk, reinforce them with reflection.

Below is a list of points that often arise in discussions of this kind. If your patient does not come up with advantages, mention these points and ask which of them seem like the best reasons for finding nondrinking friends and activities. Rephrase them as necessary.

• Drinking friends, even if they don't pressure you, can be powerful triggers for drinking, especially early in sobriety.

• Empty time (including time spent in relatively mindless activities) is not rewarding, tends to promote low moods, and does not support self-esteem.

• If you're sober but not enjoying it, you're not likely to stay that way.

• Getting positive reinforcement is like taking vitamins. It helps to be sure you have some every day.

Finish up with a summary reflection that draws together the important reasons for developing alcohol-free sources of positive reinforcement.

11.3 Assessing Sources of Reinforcement

Have your patient describe people, places, and activities that he/she often associated with drinking. Similarly, ask your patient to describe recreational events, people, and places that he/she enjoyed in the past that are not associated with drinking. Compare the two lists and discuss how they are different to clarify patterns that support both drinking and sobriety.

Sometimes it has been so long since your patient had a sober lifestyle (if he/she ever did as an adult) that he/she cannot list enjoyable alcohol-free activities, people, or places. Here it can be helpful to offer a menu of options. This menu should be tailored for your specific area, but the *Menu of Possibly Pleasurable Activities* worksheet (Form S) provides a generic head start. Local newspapers sometimes carry weekly lists of clubs, free activities, support groups, volunteer opportunities, and/or entertainment options. Have your patient review the worksheet and identify things that he/she might enjoy or is unsure about enjoying. Besides using this worksheet, ask the patient to think of activities, hobbies, and interests of friends or acquaintances who do not drink or to think of activities, pleasurable or not, that do not involve drinking.

If possible, move smoothly from discussing enjoyable nondrinking activities to making a specific plan for increasing ones the patient currently takes part in or at least for trying a few new ones. This is easier when your patient already knows of activities, people, and places that are fun and do not involve or emphasize drinking.

In the example below, the therapist and patient discuss ways to find nondrinking activities:

THERAPIST: One life area that has been shown to have an effect on treatment success is social and recreational activities. When people have strong social supports for staying sober, they are more likely to succeed. Social support for not drinking can come in a variety of ways including nondrinking friends or family, clubs or associations that don't emphasize drinking, and activities that are fun to do but don't involve drinking.

PATIENT: I can see how that might help. I never drink with my husband because he's been so encouraging throughout treatment and feels it has helped our relationship a lot.

THERAPIST: That is exactly what I'm talking about. Walter wants to see you succeed in treatment and you've told me that he's helped by planning weekend hiking trips for the two of you because you never drink when you go hiking. Can you think of other fun activities, places, or friends that aren't associated with drinking? How does Walter spend his time?

PATIENT: He's pretty involved in our church. I never drink when I go to church with him. I don't drink when I'm with Walter anywhere, or when I'm around my kids. My kids have been worried about my drinking too.

THERAPIST: Good! What else?

PATIENT: I do love to take water aerobics, and of course I don't drink when I'm exercising. In fact, when I'm finished exercising, I don't feel like drinking either.

THERAPIST: So the exercising has a triple benefit. It's a good way to be healthy and feel good, you don't drink while you're doing it, and you don't feel like drinking after you've been exercising. What else?

PATIENT: I enjoy painting. I went to a class with one of my friends the other day and I really liked trying my hand at watercolors.

THERAPIST: Okay that's a good list to start! Now, for the other side of the picture, I'd like you to tell me about people, places, or activities that you have associated with drinking in the past.

PATIENT: My best friend, Barbara, and I always drink together because we usually go out to try a new restaurant and like finding good new wines. And I also drink a lot when I go to the casino.

THERAPIST: Okay. It sounds like restaurants with Barbara and the casino may be smart things to stay away from. On the other hand, you have a lot of activities that you enjoy when you're not drinking. Hiking, working out, swimming, going to church, and being with Walter and your family are all positive social supports for not drinking.

PATIENT: Yeah, it does seem like certain activities make me drink. I really like going out with Barbara, though, and I wish I could continue that.

THERAPIST: I wonder if there is a restaurant you could try that doesn't serve alcohol. It may be a good way for you to continue doing something you enjoy but with people who aren't drinking.

PATIENT: I think maybe Barbara actually mentioned this little café where they just serve coffee and teas. I'll check into that this week. I'm sure Barbara would be excited to go there with me. She told me she's been dying to try it.

THERAPIST: Perfect! I'm writing down that you will get the information about the new café and ask Barbara to join with you as an assignment for this week! Is that okay? You really have the hang of this!

As shown in the example, it is a good idea to find activities that occur during times when the patient previously was most likely to be drinking. Have your patient pick 5 to 10 activities that sound the most pleasant or exciting.

11.4 Discussing Alcohol-Free Activities

The first step in social/recreational counseling is to develop a list of potentially reinforcing activities that patients are interested in pursuing. Therapists should gather possibilities from patients by asking about -

- Current activities.
- Activities enjoyed in the past.
- Things patients have always wanted to do, but have never done

Once possible activities are identified, therapists and patients should attempt to categorize activities by amount of interest, cost, others' involvement, time commitment, likelihood of engaging in the activity, and whether it is physical or sedentary

Therapists can also help in this area by providing patients with listings of local activities, recreational facilities, continuing education classes, and other community resources and activities. In essence, the therapist or another staff member can function as a source of information about available social/recreational opportunities in the community. This means therapists will need to review local newspapers, bulletin boards, and radio advertisements and make contact with community agencies prior to sessions.

When you discuss local activities such as concerts, theatre, outdoor events, senior center activities, and social clubs that are alcohol free or place little emphasis on alcohol use, make sure that you are familiar with such activities so you can make informed recommendations that will not end in a bad experience for your patient.

11.5 Developing a Nondrinking Support System

Another purpose here is for the patient to create and maintain friendships with those who will support him/her in his/her sobriety. If possible, start with an activity that involves someone who is already supportive of the patient's abstinence. It is useful for the patient to discuss with friends and family how they might be helpful in supporting his/her sobriety.

Work with the patient to create a list of people who might participate in activities with the patient. This can be very difficult, because patients will often report that they don't know anyone who is not a drinker; this is rarely true. With gentle prompting by therapists about extended family and old acquaintances, patients can usually name at least one safe person to target as a contact.

Other suggestions for building social support for sobriety can be found in the Mood Management Training Module and the Building a Sober Network Module.

11.6 Reinforcer Sampling

Reinforcer sampling is the process by which patients try out or experiment with new social activities. The idea here is that when your patient tries a variety of new activities, particularly activities that bring him/her into contact with other people outside of drinking contexts, he/she will most likely find at least one that is rewarding. Below is a list of ways to interest your patient in trying nondrinking activities:

• Sometimes patients are reluctant to sample new activities while sober. Explain to your patient that trying an activity once does not mean a lifetime commitment to it. He/she will be sampling activities to find one or more that is enjoyable and that can support him/her in staying sober.

• Find a suitable analogy, such as tasting different kinds of ice cream.

• Take some time to discuss any apprehension or fears about trying something new.

• Problem-solve factors that might interfere with the patient trying or enjoying a designated activity. This may mean reviewing communication skills training for interacting with strangers, asking a nondrinking friend to go along, or generating a plan for transportation.

• Assign between-session tasks that involve sampling at least one new activity. The more specific the plan, the more likely the patient is to carry it out. The patient stating, "I'll go to the senior center for the pottery class on Saturday afternoon" is better than his/her saying, "I'll look for something fun to do."

11.7 Systematic Encouragement

It's a common problem: many patients have good intentions of sampling a new activity, yet do not follow through, perhaps because they do not have the skills, are embarrassed, or are not well prepared to begin something new. Systematic Encouragement, a three-step process for motivating your patient to plan and complete the process of reinforcer sampling, is described below:

1. Once your patient has agreed on an activity, do not assume he/she will make the first contact. Instead, practice how the patient will go about contacting the organization and what he/she will say on the phone. Role-play the phone interaction, and if possible, have the patient make the phone call during the session. This will allow you to encourage your patient in the things he/she does well while gaining valuable behavioral information about how the patient interacts with others.

2. Whenever possible, call a contact person from your resource list to meet the patient at the door or to introduce him/herself to the patient. If a patient knows that someone will be there to meet him/her, it will set him/her more at ease socially, and it increases the likelihood he/she will follow through. If possible, arrange for a contact person to provide transportation to and from the activity.

3. Review with your patient the reinforcement value of the activity. Was the activity something he/she enjoyed and would like to do again? Problem-solve any barriers to reattending such as transportation to the activity or child care. If the patient did not attend, problem-solve to create a plan that will assist him/her in attending the following week.

In the example below, the therapist and patient discuss how to get involved in an activity:

THERAPIST: You talked last time about the church's senior softball league as a new activity you could try. That sounds like a good idea to me too. How about if we give the church a call now to see what we can find out.

PATIENT: I don't have the church's phone number with me.

THERAPIST: We have a phone book right here in the drawer. We can look up the number and call together.

PATIENT: The name is First Baptist Church.

THERAPIST: Here's the number. Ready to call?

PATIENT: From the office? I wouldn't know what to say.

THERAPIST: Well, how about starting by asking if the church still has a senior softball league and the name and number of the person to call if you're interested in signing up?

PATIENT: Okay. I think I can do that.

THERAPIST: All right then, how about if we practice it once before making the actual call. I'll start you out. Hi, my name is Alley and I'm interested....

PATIENT: I'm interested to know if there is still a softball league and how I could sign up for it.

THERAPIST: Great! Sounds like you're ready!

PATIENT (*dials the number*): Hello? My name is Alley. I want to know if there is still a senior softball team at the church... A-L-L-E-Y ... Saturday afternoons? ... Well, I don't know ... Phillips? ... Okay, thank you.

THERAPIST: Wonderful! They meet on Saturdays? Is that a good time for you?

PATIENT: Yeah. I've gone to Saturday aerobics class a few times, but I'd be getting exercise at softball. I'll ask Michael to go with me to sign up. He likes to play softball and told me that he enjoys spending time with me when I'm not drinking. The lady on the phone said they were looking for men and women to play.

THERAPIST: That's great! I'll look forward to hearing how the first practice went at our next session!

Help your patient to keep sampling new non-drinking activities until he/she finds several that he/she enjoys and is likely to stick with. Continue to assign the sampling of a new activity each week while you work on other modules.

Building a Sober Network (SOBN)

12.0 Building a Sober Network

12.1 Background

In addition to the support you are providing through treatment, it is likely that your patients will need additional support during and after the treatment process. Research shows that when a patient has a strong support system, chances of staying sober are increased. There are two aims as part of the building a sober network skills training area:

(1) First, to help patients get important people in their life to support their recovery. Patients are surrounded by people who can influence their recovery for better or worse. Those people may be family members, friends, counselors, and self-help group members. Below is a list of things patients may say about such people:

- *My neighbor keeps offering me alcohol and won't stop.*
- *My AA sponsor told me that I shouldn't be on any psychiatric medications, that those are just as bad as drugs such as heroin or cocaine.*
- *I get into unbelievable fights with my kids about my drinking. They call me a "crazy old alcoholic" and tell me I can't see the grandkids. Before I know it, I'm yelling.*

The modules helping patients help get important people in their life to support their recovery are designed to teach patients to assess whether people in their lives are supportive or nonsupportive of their sobriety. Patients are encouraged to educate others about how to be most helpful during the difficult process of change. A letter is provided to give to people in their life to promote this process of education.

(2) Second, to facilitate not only the patient's recovery, but to facilitate building a sober network that is rewarding to the patient. Such sober networks may be mutual-support groups, but may also be other kind of networks that are social but does not include alcohol. Specific objectives for this aim are:

- To identify patients who have a particular need for sober networks because of inadequate social support for sobriety
- To educate patients about the anticipated benefits of different mutual-support programs or other sober networks and what to expect (procedurally) from different support groups
- To assist patients in finding an appropriate and acceptable sober network or mutual-support group.

12.2 Rationale

12.2.a Support for Sobriety from Significant Others

Support for sobriety makes a big difference. There are three groups of patients with problematic social support:

- Those who have no support in general
- Those with low support for abstinence
- Those with high support for continued drinking.

These may seem like fine distinctions, but each connotes a slightly different need in regard to the emphasis of social support enhancement. Assess your patient's support resources through a discussion of important people in the patient's life and whether they are supportive or unsupportive of abstinence.

Patients with few or no general support resources.

In an elderly population, this may be the most common patient problem with social support. These patients are likely to be depressed, isolated, and perhaps undersocialized. These patients may experience difficulties attending mutual-help meetings because they may find the level of interaction to be too stressful, so they avoid them. Despite their reservations, members of this group need social support enhancement, and mutual-support groups are one source of easily accessible help, and so for patents experience difficulties with finding support, facilitating engagement in mutual-support may be the most important piece of this skill training area. You can connect a patient who is isolated and depressed through case-management activities such as arranging a 12-step contact or putting the patient in touch with groups and activities that will bring him/her into contact with others (see Social and Recreational Counseling Module). Once the patient makes such social connections, monitor his/her attendance to see if he/she has second thoughts, experiences adverse events, or has other problems that may interrupt his/her ongoing social involvement.

Patients with low support for abstinence.

These patients are less likely to be anxious and depressed but still need social support enhancement. These people probably have close relationships that are relatively undamaged by their excessive drinking, so members of their social network may be unaware of or indifferent to the fact that they are undergoing treatment. Explore your patient's network to identify people who might be educated about his/her circumstances and thereby converted into a resource supporting abstinence. With some encouragement and planning, your patient may decide the best way in which to approach these people to ask for their support for abstinence. This is a similar strategy that someone might use to garner support for beginning an exercise program or for saving money.

Consider inviting one of these people to participate as an SSO in one or more treatment sessions. A joint session provides you an opportunity to educate the person about alcohol use disorders and explore his/her attitudes and feelings toward the patient in general and about the patient's drinking in particular. This then gives you an indication of the level of support the patient can expect and allows you to proceed with additional joint sessions if appropriate. The person may also be a problem drinker, so be prepared to provide screening, advice, and referral if the need arises. Mutual-support groups can also augment the social network, providing alcohol-free friends and an orientation toward long-term sobriety and recovery. This is likely to increase the resiliency

of the patient's decision to abstain, particularly in light of environmental triggers or developmental pressures that come to bear after treatment has ended.

Patients with high network support for drinking.

These patients are the most likely to have drinking peers and perhaps a drinking spouse/partner who represents an active threat to their commitment to abstinence during or after treatment. Addressing this set of problems will require tact, skill, and patience, in that these patients are likely to experience the greatest loss on a personal and social level when they stop drinking. Be prepared to blend the concept of social support into other change activities that are part of other skills training modules you incorporate into treatment. Long-term sobriety usually requires the balanced use of multiple coping strategies. Patients who rely on one or two change strategies have lower rates of successful change (Prochaska and DiClemente 1986). Encourage your patient to sample mutual-support groups (even within a single program such as AA), looking for a good fit, because involvement in such groups is particularly helpful to people with high network support for drinking. Your patient can accomplish this by attending one group several times or several groups one time. Discuss these experiences during therapy sessions as you would any other home task assignment.

Now, we turn to another possible scenario. How about patients who have good social support for abstinence? Is it still recommended that you work with them to facilitate engagement in mutual support groups?

Patients with high network support for abstinence.

A clinical trial investigating patient-treatment matching showed that AA (and by extension, other mutual-support group) involvement may be less important for patients who already have a high level of social support for abstinence (Project MATCH Research Group 1998). This does not mean that AA or other group attendance will not be helpful to these people. Indeed, mutual-support group members will reinforce these patients' decision to abstain and may provide useful role models for long-term drug-free coping. For these reasons, if you have patients with good social support for abstinence, encourage mutual-support group attendance as you would other possible strategies for maintaining behavior changes (Snow et al. 1994).

Patients whose social networks are supportive of continued drinking, however, may in particular benefit from either mutual support groups or sober networks. do substantially better in treatment that specifically and concretely attempts to get them involved

12.2.b Support for Sobriety through Sober Network Involvement

People with problems in their lives seek many routes to alleviate their distress. One common response is to seek the help of others with similar problems. Research consistently supports a modestly positive association between involvement in Alcoholics Anonymous (AA) and more favorable treatment outcomes (Emrick et al. 1993). Particularly for patients whose current social systems support drinking rather than abstinence, involvement in a sober networks or

mutual-support group can provide a new support system for sobriety and may significantly improve treatment outcome (Project MATCH Research Group 1998a).

While people should be encouraged to engage in mutual support groups or mutual support groups, no one should be required to attend. Consistent with the motivational interviewing approach, it is helpful to give people options while letting them find their own way. Because there are a range of sober organizations, networks or mutual support groups, modules here emphasize sampling from the options available.

Sober networks are not "treatment" or "therapy" per se, but may be a step towards building up a satisfying social life without alcohol, and at the same time support to stay sober during the process. They fall outside the context of people seeking help from an expert professional. Rather they represent either an alternative or an adjunct to treatment. In many areas, mutual help groups or sober social networks are available free of charge seven days a week, with growing presence on the internet. This can be particularly helpful for people whose current social systems support using substances rather than abstinence. Involvement in sober networks can provide a new support system for sobriety and may significantly improve outcomes. Overall Objectives of this skill training area:

Give patients a rationale for not only focusing on recreational activities that involves the constant temptation of alcohol or is carried out alone, but using social supports from sober networks as a primary mechanism for stabilizing and maintaining good outcomes.

Discuss different types of sober networks or social activities that do not include alcohol, but may be the first step towards building a sober network.

Help your patient articulate what he/she needs from others in the way of social support for sobriety

Assist patients in finding an appropriate and acceptable sober and social networks

12.3 Educating Significant Others

A principal goal here is to help your patient articulate what he/she needs from others in the way of social support for sobriety. A good start is the handout, *A Letter to People in Your Life* (Form T). Ask questions to help the patient process the material in this handout. Below is a list of such questions:

- Is there anything you'd like to add or delete from the letter?
- Would it be helpful to give it to someone in your life? If so, who?
- What do you most want people in your life to understand about your recovery?
- What help can people in your life give to you? Can you ask for this help?

Also, you may want to keep in mind the following points as you work with your patient:

• The letter is designed for the patient to hand to important people in his/her life who want to help the patient recover (e.g., friends, spouse or significant other, AA sponsor).

• It is up to the patient to decide whether and to whom to give the letter. The only exception: if the patient is being domestically abused, do not give the letter to the abuser; it is risky to intervene in any way with an abuser, even with something as simple as this letter.

12.4 Rehearsing How to Ask for Support

Encourage your patient to rehearse aloud what support he/she would want from others. This can be useful even if in real life there are reasons he/she cannot express it (e.g., the patient is too afraid to say it). Below is a list of the ways a patient might directly ask a significant other for support:

• Please don't ever offer me alcohol.

• Please do not give me feedback on your opinions about me or my drinking.

• Please do not ask me to take on new demands right now.

• Please do not criticize me right now: at this point, only supportive statements are helpful to me.

• Please accept that sometimes I need to cry and get upset.

• Please do not use alcohol when you are around me.

• I need you to just respect where I am right now in the process of change.

• Please do not ask me about my drinking.

• This is a difficult time - you can be helpful by ... making dinner ... coming with me to my appointment ... checking in by phone ...

If the patient has only people who support continued drinking or is totally isolated with no family or friends, focus him/her on seeking more help from other sources. It is an important goal to try to help the patient start new relationships with healthier people, but this can take a while. Look for more immediate sources of support from mutual-help groups, professionals or agencies, or churches or other supportive communities, as outlined in modules included in the social and recreational counseling skill area.

12.5 Understanding the Patient's Experience with Mutual Help Groups

People with problems in their lives seek many routes to alleviate their distress. One common response is to seek the help of others with similar problems. This process has been described as "self-help" or "mutual aid" (McCrady and Delaney 1995), terms synonymous with the one that is used in this manual: "mutual support." Self-help, or mutual-support, groups have proliferated for people with substance abuse problems. Many of the mutual- support groups had their beginnings in the fertile climate for alcoholism treatment services in the United States after the post-World War II era. However, mutual-support groups are not simply an artifact of the U.S. treatment system but are becoming more common in other countries as well, where they are seen increasingly as an important adjunct to alcoholism treatment (Makela 1993; McCrady and Delaney 1995).

Ask your patient to share what they know about some of the programs and ask for reasons why having additional support (apart from loved ones/friends) could be helpful (evoke change talk statements). Explore attitudes about mutual-support groups, specifically what has the patient heard about mutual-help groups? What have they experienced during meetings? Did they find the meetings helpful? Why or why not?

12.6 Matching Considerations in Sober Network Referrals

The recommended method for utilizing mutual-support groups or other sober networks is to integrate them into your treatment approach (Ouimette1998). Several researchers have indicated that therapists should routinely offer a referral to AA or another support program to patients with an abstinence goal (Edwards 1980; McCrady and Delaney 1995). Glaser (1993) specifically recommended that all patients should be encouraged to try mutual-support groups and recommended also that no one should be required to attend. This is the approach taken in CRAS: to encourage, but not require, all patients to build and secure a sober network, either by the means of sampling mutual-support options as potential aids to recovery, or by engaging in social networks and activities that are entirely without alcohol. .

Below is a list of possible considerations in matching patients with optimal mutual-help programs.

- **Availability**. One obvious limitation is the range of sober networks and mutual-support programs available in the community.

- **Program Philosophy**. There are substantial differences in the philosophy, structure, orientation, and leadership of mutual-support groups and sober networks. If you know the leanings of both your patient and the available programs and groups, you may be able to provide helpful guidance in the selection of initial meetings to try.

- **Spirituality**. A major distinction between 12-step and the more secular organizations (e.g., RR, SOS, WFS) is the emphasis placed on spirituality - a central and consistent component of AA. Parallel to this, the local church may provide sober network activities and social groups, but so may other organizations, too, without the spiritual dimension.

• **Similarity**. An important determinant of social affiliation is perceived similarity. Consider whom the patient is likely to encounter at various programs and groups in terms of gender, age, or ethnicity.

12.7 Initiating Sober Network or Mutual-Support Group Involvement

Below is a list of steps for involving your patient in mutual-support groups:

1. **Provide a rationale**. Begin by providing a clear rationale for developing social network in a safe, sober surrounding, either by the means of mutual-support group involvement or other sober networks. Note that this rationale should be both factual and congruent with your patient's beliefs or circumstances. Ask your patient for reasons why having additional support could be helpful (invoke self-motivational statements). It may be useful to provide information from research or from personal experience about sober networks, emphasizing its value in maintaining long-term, stable abstinence.

2. **Discuss prior attitudes about engaging in new sober networks or mutual-support groups and how this might be different**. Tie this in to your patient's prior experiences and what the patient liked or appreciated about the groups he/she attended? If the patient described specific barriers to attending, discuss strategies for overcoming those barriers. For patients with no prior experience with social activities in groups that do not involve alcohol, ask what they could imagine would be helpful about participating in such groups. Consistent with the motivational style of CRAS, be careful not to get into a disagreement with your patient in which you argue for participation in sober social activities and the patient argues against it.

3. **Give information about available possibilities**. Offer information that is pertinent to this particular patient, in language he/she will appreciate. Draw on your knowledge of what is available in the area. The more you know and the more details you can provide about general and practical information, the better! Provide specific referral information by giving patients contact information from the Handout About Sober Networks that is specific to your site.

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.

Concluding Extended Treatment. End of last session

13.0 Terminating Session 12

13.1 Terminating Session 12 (or terminating the last session, if the patient and you have agreed on a shorter treatment course)

Save at least 10 minutes at the last session to end the treatment and say goodbye to the patient. Acknowledge all gains the patient has made during the 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 — Extremely

Ready 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 CRAS 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
I	Treatment Plan
J	Urge Monitoring Cards
K	Perspectives on Aging
L	Looking Ahead Exercise
M	Who Am I? Exercise
N	Making Peace with Negative Thoughts
O	STORC: Understanding Emotions and Moods
P	Feelings from A to Z Worksheet
Q	Mood Self-Monitoring Sheet
R	Thought Replacement Worksheet
S	Menu of Possibly Pleasurable Activities
T	A Letter to People in Your Life

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)

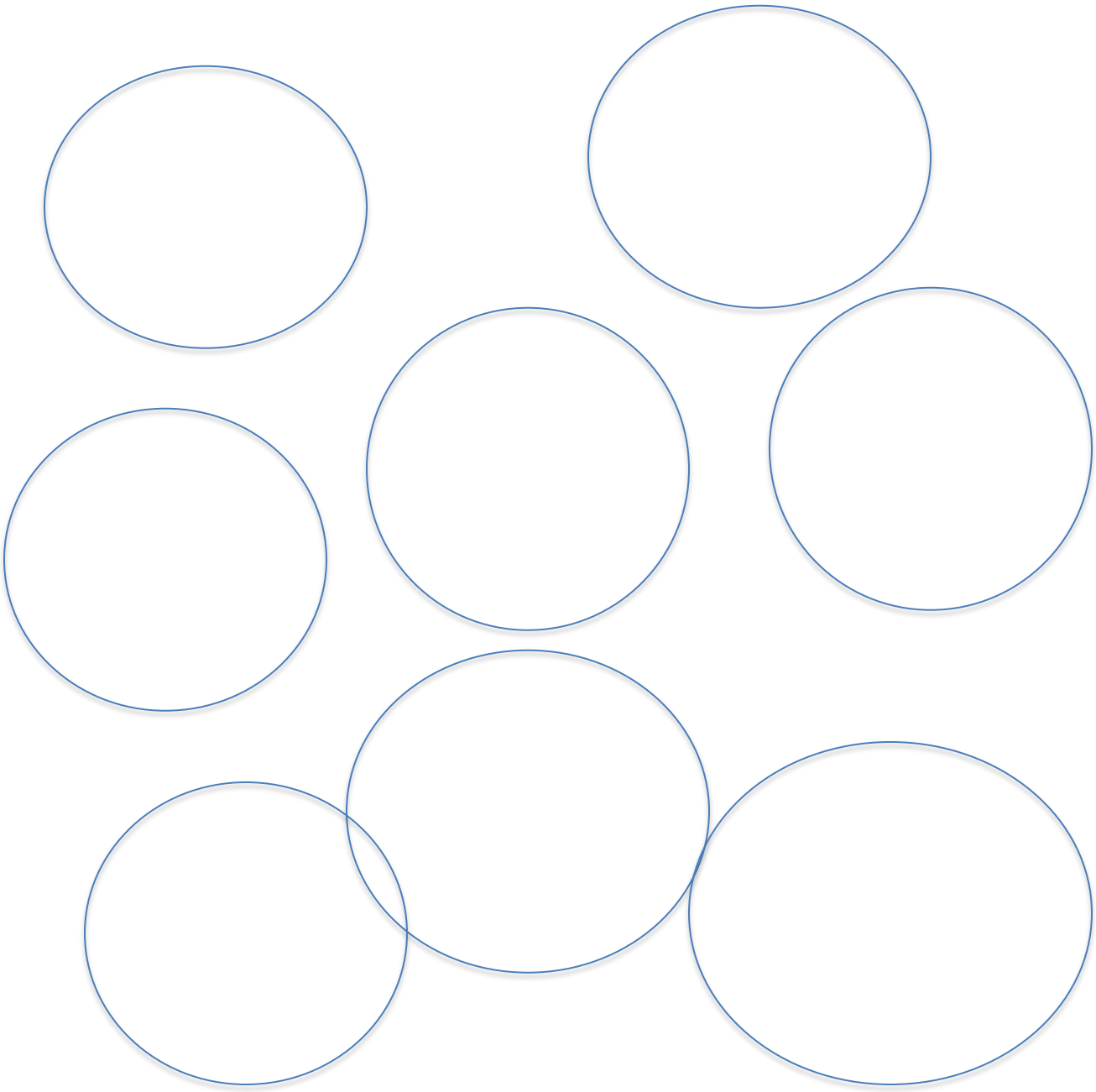
Personal Happiness Card Sort	Friends and Social Life 1	Job/Work 2
Where I Live 3	Money and Financial Security 4	Education and Learning 5
Leisure Time and Fun 6	Mood and Self-Esteem 7	Anger and Arguments 8
Stress and Anxiety 9	Physical Health 10	Spirituality 11

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:

Form I: Treatment Plan

Client#: _ _ _ _ _ _ _ _

Therapist: _____

Treatment Plan

Problems to be addressed by treatment or referral	Broad goals and specific objectives to be achieved	Treatment plan (how) and anticipated timeline (when)
# 1 Alcohol		
#2		
#3		
#4		
#5		

Therapist Signature:

Client Signature:

Date:

Form J: Urge Monitoring Card

Urge Monitoring Card

Client ID:			
Date/Time	Situation	0-100	How I Responded

Perspectives on Aging

Losses I have experienced in growing older	Gains I have experienced in growing older

Looking Ahead Exercise

What would I do with my life, if I had only 1 week left? 1 month left? 1 year left? 10 years left?

	What I would do:	Priorities:
If I had only 1 week left, I would:		
If I had 1 month left, I would:		
If I had 1 year left, I would:		
If I had 10 years left, I would:		

What are my priorities in what I have written? What is the most important thing I want to do with the time I have left?

Form M: Who Am I?

	Write characteristics and activities	What could I take up again
What kind of person am I?		
What do I enjoy doing?		
What do I miss doing the most?		
What did I find fun to do, when I was a kid?		
What did I find fun to do, when I was an adolescent?		

Form N: Grain of Truth Exercise

Grain of Truth Exercise

Distressing Thought	Grain of Truth	Balancing Thought

Form O: STORC

STORC: Understanding Emotions and Moods

S Your Situation

These are the people, places, and things around you. People often think that they feel certain moods or emotions because of what is happening around them, but this is only one part of the complete picture.

T Your Thoughts

No situation affects you until you interpret it. How you think about what is happening has a powerful influence on how you feel about it. Different thoughts or interpretations lead to different feelings.

0 Your Organismic (Physical or Bodily) Experiences

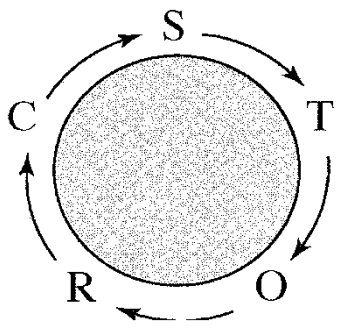
What is happening inside your body is also an important part of the moods or emotions that you experience. Many emotional experiences involve a particular kind of physical arousal that can be experience d as being agitated, angry, upset, afraid, and so on. Which particular emotion you feel depends in part on how you interpret or name what is going on inside your body.

R Your Response or Reaction

How you react, what you do in response to S, T, and 0 also has a large effect on how you feel. Different behavioral reactions lead to different moods and emotions.

C Consequences of Your Response

How you respond, what you do, in turn has certain effects or consequences. This is how your environment (especially other people) reacts to what you do. These consequences also influence your mood and feelings, and become part of your situation, repeating the cycle.



Form P: Feelings From A to Z

Afraid	Free	Resentful
Agitated	Frenetic	Reserved
Alive	Funny	Sad
Angry	Giddy	Safe
Annoyed	Guilty	Satisfied
Anxious	Happy	Sacred
Awful	Hurt	Shy
Awkward	Impish	Silly
Bashful	Irritated	Sympathetic
Betrayed	Joyful	Terrible
Bored	Jumpy	Terrific
Carefree	Kaput	Tired
Confused	Kind	Trusting
Cozy	Lonely	Uneasy
Cranky	Loving	Upset
Crazy	Mad	Vicious
Crushed	Mean	Violated
Depressed	Naughty	Vivacious
Distressed	Open	Wild
Down	Overjoyed	Wonderful
Elated	Passionate	Yucky
Embarrassed	Peaceful	Zany
Empty	Relaxed	Zonked

Form Q: Mood Self-Monitoring Sheet

Client#: _____ Therapist:_____

Mood Self-Monitoring Sheet

Mood Level: rating: _____ -10 • • • • • • • • • • • • • •O• • ••• • •• • • • •••+10 Very Neutral Very Negative Positive	Mood Level: rating: _____ -10 • • • • • • • • • • • • • •O• • ••• • •• • • • •••+10 Very Neutral Very Negative Positive	Mood Level: rating: _____ -10 • • • • • • • • • • • • • •O• • ••• • •• • • • •••+10 Very Neutral Very Negative Positive
S situation:	**S** situation:	**S** situation:
T thoughts:	**T** thoughts:	**T** thoughts:
O feelings:	**O** feelings:	**O** feelings:
R what I did:	**R** what I did:	**R** what I did:
C what happened:	**C** what happened:	**C** what happened:

Form R: Thought Replacement Worksheet

Client#:_____ Therapist: _____

Thought Replacement Worksheet

Toxic Thought	Result Feeling	Replacement Thought (Antidote)	Resulting Feeling

Form S: Menu of Possibly Pleasurable Activities

Menu of Possibly Pleasurable Activities

Below is a list of different ways in which people enjoy themselves. You might find some of these fun or enjoyable.

Take a drive to see something new	Hunt for bargains at a thrift store
Relax and read the newspaper	Trade back rubs for 20 minutes
Help your child with homework	Take a relaxing hot bath
Plant something to watch it grow	Indulge in your favorite childhood treat
Go for a walk	Enjoy one perfect flower in a vase
Take a nap	Compliment someone
Build something from wood	Babysit for someone who needs relief
Feed the birds or ducks	Send a care package to a student
Hang a hummingbird feeder	Call someone special in your family
Enjoy a special dessert	Write to an old friend
Go for a run	Go to a movie, perhaps with a child
Get up early to watch the sun rise	Make a big bowl of popcorn
Walk a dog	Have or give an oil massage
Play Frisbee	Listen to your favorite music
Sew something	Read a book you've heard about
Have a relaxed breakfast	Bake a batch of cookies
Spend an hour in a favorite store	Make some food for a friend
Have a makeup demonstration	Add an item to your collection
Visit a shopping mall	Hum or sing
Add one new item to your wardrobe	Write in a diary or journal
Pamper your feet in a basin of warm water	Ride a motorcycle
Massage your feet with a cooling lotion	Play golf or miniature golf
Write a letter to someone who helped you	Clean out your purse
Work on a quilt	Read old letters you have kept
Pray	Read poetry
Visit an old friend	Write poetry
Cook a favorite meal	Start a memory box
Lie on the grass	Read your favorite children's book
Go out for a special meal	Rearrange the furniture
Rent a funny movie	Call a friend who makes you laugh
Play tennis	Bake biscuits or tortillas
Try a new recipe	Daydream a little
Go to a yard sale or garage sale	Enjoy the quiet of an early morning
Have coffee with a friend	Have lunch with a friend
Visit a museum	Roll down a hill
Walk along the water	Polish your nails a new color

Visit someone who is homebound	Grow (or shave off) a beard or mustache
Walk or ride along a bicycle path	Try a new hairstyle
Buy a small gift for a friend or child	Enter a contest
Find a place for a moment of solitude	Research your family history
Make a pizza	Volunteer to be a coach
Visit the library	Paint a room
Play a card or board game	Wash and wax your car
Buy thick fluffy new bath towels	Lie under a tree and watch the sky
Put fresh sheets on the bed	Do some gardening
Play a musical instrument (or learn to)	Go dancing
Visit a wild life refuge	Sing in a chorus
Visit (or volunteer at) the zoo	Go downtown
Go horseback riding	Go to an open house
Look at maps for places to visit	Have dinner at a romantic restaurant
Cover a bulletin board with family pictures	Give and receive a foot massage
Meditate	Visit an aquarium
Go camping	Ski or play in the snow
Search the web	Build a fire
Take a creek walk-the stream is your path	Work on a car or truck
Pick fresh fruit or berries	Plan a holiday or trip
Make homemade ice cream	Smile
Read a favorite magazine	Find shapes in the clouds
Go to a demonstration in a store	Draw a cartoon
Join a gym and work out	Roast hotdogs and marshmallows
Go to a sporting event with someone	Cut, chop, or carve wood
Spend an hour aloe with your child	Go for a swim
Be creative- try out a new kind of art	Listen to a favorite radio station or program
Make a family scrapbook	Frame a picture
Build a swing in a tree	Put your feet up
Refinish old furniture	Skip stones across water
Call someone you'd like to talk to	Go to the mountains
Wash your windows	Ride a train
Have a picnic in the park	Go to a talk or concert
Find a good spot and watch the night sky	Take a class
Go fly a kite	

A Letter to People in Your Life

Helping Someone Overcome Alcohol Problems

Your genuine support can make all the difference. The more support people have for making an important change in their lives, the more likely it is to happen.

Alcohol problems are serious. Although heavy drinking sometimes seems to be encouraged in society and in the media, it is one of our nation's most serious health problems. More than 100,000 deaths each year are linked to heavy and risky drinking. People who drink heavily can become truly dependent on alcohol.

Overcoming alcohol dependence can be difficult. The person you care about may have "roller-coaster" mood swings and problems such as isolation, difficulties sleeping, and anger at small events. In early months of abstinence, it is common for this person to experience such changes while readjusting to sober living.

Be patient. It can be tempting to say, "Just get over it!" If it were that simple, though, the person would have changed long ago. The process of recovery can be slow at times, up and down, and even painful to watch someone go through. Mistakes and setbacks are common when people undertake a major change. It's progress in the long run that counts. It is natural to become impatient or frustrated at times, but you will be making a valuable contribution if you can focus on the person's needs, listen without judgment, and give the person time and space to change.

You can help in specific ways if the person wants your help. It is entirely up to that person to decide whether and how you could help; however, don't impose help where it is not wanted. Below is a list of ways you can help:

Ask the person you care about how you might be supportive. You may or may not be willing to do everything the person would like, but make sure you at least understand what he/she would find helpful.

Never offer the person alcohol or other drugs of any kind. Don't buy alcohol or other drugs for him/her or promote drinking or other drug use in any way.

Don't protect the person from the natural consequences of drinking. Never lie to protect the person, pretend that alcohol use is not a problem, or "clean up after" the consequences of drinking.

Read about alcohol problems.

Support the treatment process. Ask the person about how treatment is going and what seems to be helpful. There may be new skills that you can help the

person to practice. If the person asks you to come along to a treatment session, consider doing so.

Encourage the person you care about to stick with treatment even if he I she doesn't feel like it or is discouraged. It is normal for the person to have mixed feelings about treatment, but the only way to move forward is to show up and talk about those feelings.

Listen without judgment. Often is it very helpful to have a trusted person who just listens. Earning trust means listening without judgment, without "solving" the problem, and without being shocked or offended by what is said. Also, respect what the person does and does not want to tell you. For example, if he/she does not want to talk to you about drinking, don't insist on it. Encourage honesty, but also honor privacy.
Support self-control. People with alcohol problems have often lost control over their lives and may feel powerless. The more you allow the person to take healthy control, the better. Avoid power struggles (arguments, coercion), as they rarely help and often harm.

Don't blame, attack, or judge the person. Deciding "who's to blame" is not helpful. For people who are dependent on alcohol, drinking has often been a way to cope with life; it may take awhile to learn other ways to cope.

Remember that it is up to the person to change. You can be supportive and encouraging, but no one can make the choice or force someone else to give up alcohol. Punishment, guilt, and threats are not likely to make any positive difference.

If you find yourself frequently having intense negative feelings toward the person, consider getting yourself some support. A list of resources for you is provided below. For example, Al-Anon provides self-help to family and friends of people with alcohol problems. You may want to consider brief therapy to help you manage the stress of the relationship.

If you feel you cannot be helpful during recovery, it is best to do nothing rather than to do harm. Respect the person's feedback about how helpful or hindering you are being to his/her change process. If the person asks you to back off, back off.

Treat the person you care about with great kindness and respect. "A loving heart is the truest wisdom" (Charles Dickens).