

Integrated Change Therapy

Brief Treatment for Adults With Substance Use and Co-Occurring Mental Health Disorders

Substance Abuse and Mental Health Services Administration
SAMHSA
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JBS International, Inc., under contract with the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT), prepared this guide on Integrated Change Therapy, incorporating works developed by grantees of SAMHSA's Screening, Brief Intervention, and Referral to Treatment (SBIRT) program. These State grantees are from Connecticut, Massachusetts, and Missouri. Other works in brief treatment, motivational interviewing, and cognitive behavioral therapy have also been included. This guide was authored by Win C. Turner, Ph.D., in Vermont and Missouri; Karen Steinberg Gallucci, Ph.D., in Connecticut; Lee Ellenberg, M.S.W., in Massachusetts; and Joseph Hyde, LMHC, SBIRT technical expert lead at JBS international, Inc.

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Introduction

The brief treatment approach for substance abuse and co-occurring disorders described in this guide—Integrated Change Therapy (ICT) for Substance Abuse and Co-Occurring Disorders—is a new clinical approach that draws essential elements of brief treatment from multiple sources. Specific innovations in this new practice are influenced by Screening, Brief Intervention, and Referral to Treatment (SBIRT) models, integrated with motivational interviewing (MI), motivational enhancement therapy (MET), functional analysis, and cognitive behavioral therapy (CBT).

A primary goal in creating this guide is to respond to the needs of the working clinician in today's changing service delivery environment, with particular attention to behavioral health clinicians practicing in primary care settings. Students in social work, psychology, and counseling represent an important target audience, which is the next generation SAMSHA is seeking to reach. ICT's approach enables ease of adoption of this new clinical practice without large changes to existing programs and systems. ICT is currently being practiced by clinicians working in community health centers, community-based substance abuse and mental health agencies, and a program serving soldiers of the Army National Guard. The information presented here should serve as a relevant and practical resource for use on a daily basis to provide individualized, patient-centered treatment.

The knowledge and practices presented here for delivery of ICT are derived from several bodies of work on evidence-based brief treatment for substance abuse and co-occurring mental disorders. These works include recent accomplishments in brief treatment by the University of Connecticut Health Center as part of the Connecticut SBIRT initiative (LETSPAY), the Brief Treatment Manual developed by the Massachusetts SBIRT initiative, and the Brief Treatment Manual developed by the Missouri SBIRT team. Each of these three organizations, funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), developed evidence-based brief treatment manuals for adults with substance use disorders. These documents build on foundational works in CBT, MI, and other previous works in treating addictions, including the following:

Beck, J., & Aaron, A. T. (2011). *Cognitive behavior therapy: Basics and beyond.* (2nd ed.). New York, NY: Guilford Press.

Carroll, K. M. (1998). *A cognitive-behavioral approach: Treating cocaine addiction*. Manual 1: Therapy Manuals for Drug Addiction Series. NIH Publication No. 94–4308. Rockville, MD: National Institute on Drug Abuse.

Marlatt, G. A., Barrett, K., & Daley, D. C. (1999). Relapse prevention. In M. Galanter & H. D. Kleber (Eds.), *The American Psychiatric Press textbook of substance abuse treatment* (2nd ed.). Washington, DC: American Psychiatric Press.

Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change* (3rd ed.). New York, NY: Guilford Press.

Sampl, S., & Kadden, R., (2001*). Motivational enhancement therapy and cognitive behavioral therapy for adolescent cannabis users: Five Sessions.* Cannabis Youth Treatment Series, Vol. 1. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Steinberg, K. L., Roffman, R. A., Carroll, K. M., McRee, B., Babor, T. F., Miller, M., . . . & Stephens, R. (2005). *Brief counseling for marijuana dependence: A manual for treating adults.* HHS Publication No. (SMA) 05-4022. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

The following features should help make this guide practical for use:

1. Across many evidence-based practices, clinical researchers have identified a common set of practice elements (Chorpita, Daleiden, & Weisz, 2005; Chorpita & Regan, 2009), and some have proposed that our health care system focus on training and disseminating these essential skills and/or more universal clinical interventions (Barlow, 2008). This guide is informed by such research.
2. As a measure of utility for the behavioral health workforce, the guide's core interventions are designed to fit within conventional models of service and can span diverse practice settings, such as general outpatient services embedded within primary care settings, including federally qualified health centers (FQHCs), and general outpatient substance abuse or mental health settings.
3. In consideration of the high rate of staff turnover in the behavioral health workforce, this guide can serve as a model rooted in evidence-based clinical skills and interventions that are easily transferable from one setting to another. The clinical sessions are clearly laid out without being overly prescriptive or restrictive. The interventions are flexible enough to be integrated into clinicians' personal styles and creativity.

The guide is organized into three main sections. The first provides a review of MI, MET, CBT, the personal reflective summary as a treatment tool, and some of the newest thinking on the processes of therapy. The second section describes 15 clinical sessions. Some sessions focus on engagement, building motivation, clarifying treatment priorities for the patient, and developing a patient-clinician agreement. Other sessions address skills training, effective and healthy replacement activities, building personal awareness, developing specific skills to manage cravings and urges to use substances, and managing distressing thoughts and emotions. Two sessions cover known beneficial strategies equally useful with all treatment approaches: (1) use of medications in support of treatment and recovery, and (2) engagement with self-help. The format of each session in this guide facilitates delivery of ICT according to a common framework, while at the same time tailoring delivery of selected sessions to a patient's individual needs.

The third section of the Guide provides a discussion of techniques and tools that support adoption and sustained implementation of interventions with a focus on enhancing fidelity. The techniques include a discussion of proven strategies for enhancing clinical supervision to increase competency in essential clinical skills. The tools will help clinicians learn and understand delivery of each session, facilitate specific session feedback, and reduce paperwork

burdens. Session handouts and forms, other supporting materials, and references appear at the end of the guide.

Users of this guide are encouraged to first read it through and then use the session outlines and fidelity tools to support delivery of the interventions. Worksheets, handouts, and other support materials appear in corresponding sections at the end of the guide and may be copied and used as needed in sessions. Live and online trainings are available and recommended.

Section 1. An Overview of Proven Tools and Techniques for Brief Treatment

Current approaches to understanding the treatment of substance use and co-occurring disorders are driven by empirical advances in neuroscience and behavioral research rather than by theories alone. There is now good evidence that both biological factors and psychosocial experiences influence the development and continuation of disorders. Contributing experiences may occur at home, at work, or in the community, and a stressor or risk factor may have a small or profound effect, depending on individual differences. The following review of motivational interviewing (MI), motivational enhancement therapy (MET), personal reflective summary (PRS), and cognitive behavioral therapy (CBT) provides context for the treatment sessions and methodology described later in this guide.

Motivational Interviewing and Motivational Enhancement Therapy

MI is an effective, evidence-based method for helping patients with a variety of health and behavioral concerns. Motivational approaches, as developed by William Miller and Stephen Rollnick (2012), seek to foster the intrinsic drive people have for healing, positive change, and self-development. Since Miller and Rollnick's original work was published in 1983, more than 25,000 articles citing MI and 200 randomized clinical trials of MI have appeared in print. MI's efficacy has been substantiated by several MI training research projects (Miller, Yahne, Moyers, Martinez, & Pirritano, 2004).

MET is a structured intervention approach that uses MI techniques. MET interventions typically involve both a specific feedback discussion following screening and/or assessment and goal-setting interactions (planning). The descriptions of MET sessions in this guide include scripts illustrating the effective use of MI techniques.

Integrating motivational enhancement and cognitive behavioral skills building to elicit change—how it works:

- Motivation enhancement is achieved by building rapport through reflective discussions, helping patients understand the pros and cons of use, and helping to establish collaborative goals based on the patient's needs.
- Motivational enhancement strategies assess and increase the patient's readiness, willingness, and ability to change.
- The clinician's first and primary task is to understand how to engage and collaborate with the patient to build internal motivation.
- In cognitive behavioral therapy, substance use is viewed as an intrapersonal and interpersonal issue, a relapsing and habitual disorder that can be successfully treated.
- Through treatment, the patient learns to become aware of situations and emotions and how to avoid, cope, and replace substance use to achieve wellness.

MI categorizes helping interactions according to the following three styles: directing, guiding, and following (see figure 1). With a directing style, the helper provides information, instruction, and advice. This is in contrast to a following style, defined by listening, understanding, and not influencing another's choice. In the middle of these styles is a guiding approach, which emphasizes listening and offers expertise and direction when requested or needed.

Figure 1. The Three Types of Helping Interactions

MI research has demonstrated that the clinician's choice of interaction style (directing, guiding, or following) directly affects the process for the patient's readiness for change. Intrinsic desires for change and accompanying "change talk" increase when the clinician helps the patient explore the discrepancies between current behaviors and goals. Change talk refers to a patient's discussion of his or her desire, ability, reason, and need to change a behavior, and a commitment to changing. If the clinician mistakenly offers too much unsolicited advice, the patient's arguments against change increase and thus become "sustain talk," the opposite of the desired effect (Miller & Rollnick, 2012). Sustain talk is usually characterized by talking about why change cannot happen.

It is helpful when the clinician seeks a collaborative partnership with patients, a respectful evoking of their own motivation and wisdom, and the knowledge that ultimately whether or not change happens comes down to each person's own choice, an autonomy that cannot be taken away no matter how much one might wish to at times. This approach is often referred to as encompassing the MI spirit. Buber (1971) describes such interactions as an "I–thou" manner of interacting that values the opinions of others and does not objectify them to manipulate ("I–it") (Miller & Rollnick, 2012).

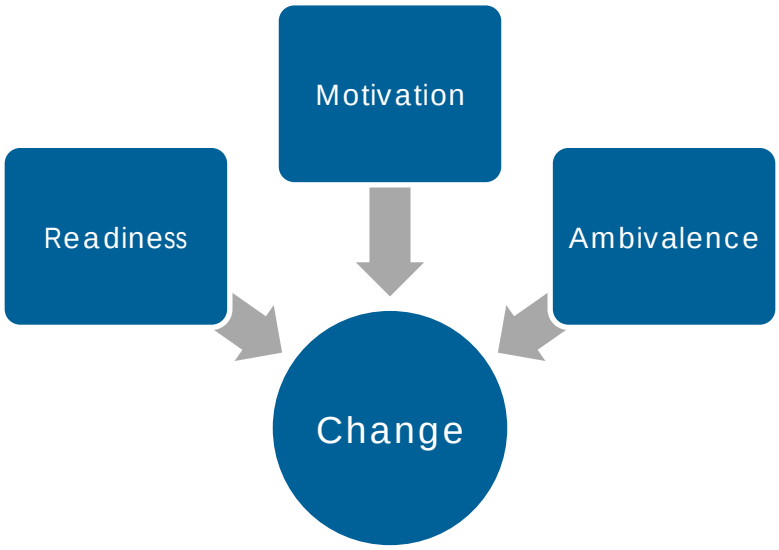
To assist in learning and practicing the techniques briefly described here, there are several excellent clinician workbooks and easy-to-use competence scales. For those with limited exposure to MI, it would be beneficial to read about MI and to participate in MI skills training. See http://www.motivationalinterviewing.org/mi-resources for more information. The first three sessions of ICT presented in section 2 of this guide are based on MET techniques.

Motivational Interviewing and the Process of Change

Change occurs all the time as a natural and self-directed event. Examples of natural changes are going back to college, getting married or divorced, changing jobs, and taking a vacation. There is well-documented evidence of natural recovery from substance use disorders and smoking (DiClemente, 2006). For example, an individual may stop drinking after an accident, eliminate marijuana use prior to applying for a job, increase alcohol use during a divorce, and decrease alcohol use after leaving college or military service.

Three elements of any change are readiness, motivation, and ambivalence (see figure 2). Miller and Rollnick (2012) break down readiness to change into three components: an awareness of the problem, a commitment to doing something, and the action of making a change. This model is based on the theory of change developed by Prochaska and DiClemente (1998). The theory proposes stages of change model consisting of precontemplation, contemplation, preparation, action, and maintenance. The model is viewed as cyclical rather than linear, with relapse occurring, so the individual may cycle back through the stages several times.

Figure 2. The Elements of Change



Traditional views of motivation held that it was static, and therefore clinicians had little or no influence over a patient's motivation. Patients were viewed as either motivated or not. If a patient was not motivated, this was considered the patient's problem or a sign of resistance to treatment, and sometimes the individual was blamed for not being motivated. Individuals who were motivated agreed to follow all instructions and accepted the labels (e.g., alcoholic) given to them. Individuals who were not motivated resisted the idea of having a problem and refused to follow treatment protocol.

It has since been discovered that motivation, rather than being fixed, is fluid and changing. It is influenced by internal life and life circumstances and, in the case of therapy, by the style of the clinician (Miller, Benefield, & Tonigan, 1993), the clinician's expectations (Leake & King, 1977), and the patient's expectations (Anonymous, 2001). Motivation is influenced positively by clinicians who listen empathetically and negatively by clinicians who are confrontational. A clinician's bias about a patient can also have an adverse effect on the patient's motivation.

Characterizing a patient as resistant, unmotivated, lazy, manipulative, or difficult often becomes a self-fulfilling prophecy leading to more self-defeating attitudes, such as fear of failure, reluctance to being dependent on others, or a hypersensitivity to feeling controlled by someone else. The MI approach suggests that if the clinician changes the way of interacting with a patient, the patient will interact differently with the clinician. Change is more likely when

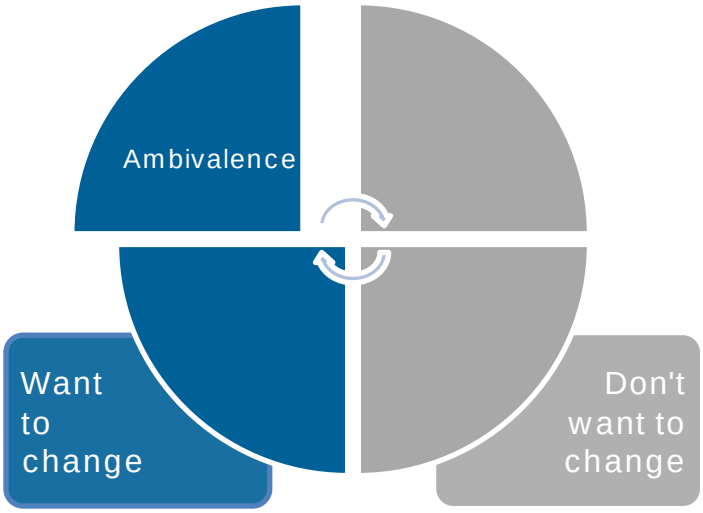
the clinician maintains a perspective of hope, optimism, and possibility and views the patient as capable of evolving and engaging meaningfully in a transformation process.

Motivation can be elicited and reinforced by others. Understanding motivation as interactional leads to clinicians viewing lack of motivation as a strategy to protect against fear of failure, loss, unwanted dependence on others, or having others in control. This in turn increases the clinician's acceptance of the individual and decreases the need to control and confront the individual.

Ambivalence is the third element of change and is the result of simultaneous, competing motivations that lead in different directions (see figure 3). Examples include the following:

- Desire to gain medication benefits and avoid side effects
- Desire to be strong and healthy and to relax and eat enjoyable foods
- Hope for change and fear of failure

Figure 3. How a Patient Might Experience Ambivalence Toward Change



MI is based on the idea that people generally are not unmotivated but rather have multiple motivations that compete against one another. This is where people get stuck. Individuals might know they should make a change or that things could be better, but they also are attached to something that holds them back, such as drugs, friends, a relationship, convenience, familiarity, or security. Ambivalence is a normal component of psychological problems, although the specifics are unique to each person and sometimes each situation. Ambivalence protects the side that does not want to change.

While a clinician's natural tendency might be to support or protect a viewpoint, it is wise to avoid "taking a side" prematurely because this will invoke reactance in the patient. MI assumes people have the capacity to solve their own problems and come up with resourceful solutions if given help removing the barriers.

The Two Phases of Motivational Interviewing

There are two phases of MI. In phase 1, the clinician helps the patient resolve ambivalence and build motivation, and in phase 2 the clinician helps to strengthen commitment and create a plan for change. Phase 1 generally demonstrates the patient-centered aspect of MI, with more directive interactions taking place in phase 2. In some cases, it is first necessary to raise the awareness of ambivalence or conflicting motivations before resolving the ambivalence.

Phase 1 of Motivational Interviewing: Engaging, Resolving Ambivalence, and Building Motivation

The work of phase 1 is based on the MI spirit, applying specific principles using identified strategies.

Spirit. The MI spirit is the underlying assumption that individuals can develop in the direction of health and adaptive behavior, given the tools and opportunity to do so. This belief is essential for the full and effective use of MI, along with a willingness to entertain the possibility of—

- Collaboration—Work in partnership with the patient
- Evocation—Listen and elicit from the patient
- Autonomy—Accept the patient's ability to choose
- Compassion—Nourishing another's well-being and growth

Steps. The four steps generally considered essential to MI include—

1. Develop discrepancy
2. Reduce discord
3. Express empathy
4. Support autonomy

The purpose of **developing discrepancy** is to create a disconnection between where the person has been or currently is and where the person wants to be. The goal is to resolve the discrepancy by changing behavior. Resistance is seen as a behavior and as such is a state and not a permanent trait of an individual.

The principle of **reducing discord** implies it takes two to resist. It is interpersonal. Fortunately, discord is highly responsive to the clinician's style. Specific suggestions for reducing discord are described below.

Expressing empathy is one of the most important elements of MI. High levels of empathy during treatment have been shown to be associated with positive treatment outcomes across different types of psychotherapy. The key to expressing empathy is reflective listening—a specific and learnable skill. By listening in a supportive, reflective manner, the clinician

demonstrates understanding of the concerns and feelings of the patient. An empathetic style will—

- Communicate respect for and acceptance of the patient and his or her feelings
- Encourage a nonjudgmental, collaborative relationship
- Establish a safe and open environment for the patient that is conducive to examining sensitive issues and eliciting personal reasons and methods for change
- Allow the clinician to be a supportive and knowledgeable consultant
- Compliment rather than denigrate
- Gently persuade with the understanding that change is the patient's choice

When a clinician **supports autonomy**, the patient's ability to make decisions and choices is recognized and respected. This implies that responsibility for the patient's behavior resides with himself or herself. The clinician also supports the patient as the only one who can make choices about changing behavior.

Motivational Interviewing Strategies

The first and core MI strategy is described using the mnemonic OARS. The OARS consist of—

- Open-ended questions
- Affirmations
- Reflections
- Summaries

Open-ended questions cannot be answered with a yes or no response or with brief specific information (e.g., I'm from Jefferson City). Rhetorical questions are not open ended and avoid socially desirable responses. Open-ended questions enable the clinician to explore widely for information and assist in uncovering the patient's priorities and values. Open-ended questions engage and draw out the patient.

Examples of open-ended questions

Where did you grow up?

Tell me a bit about your work.

What brings you here today?

Affirmations affirm a person's struggles, achievements, values, and feelings. They emphasize strength of the individual or notice and appreciate a positive action. Affirmations should always be genuine and express positive regard and caring.

Examples of affirmations

It takes courage to face such difficult problems. This is hard work you're doing.

You really care a lot about your family. Your anger is understandable.

Reflections are statements made after a patient's communications. They provide a way for the listener to confirm understanding of what was said or meant. A reflection can be a guess or hypothesis about what was really meant. Reflections are made as statements where the inflexion goes down at the end of the statement. They are the primary way to respond to patients. As a guess, the statement may not be accurate, and the patient will respond and clarify what was meant.

There are two types of reflections—simple and complex. Simple reflections express exactly what was heard. They rephrase (repeat with new words) the patient's comments.

Example of simple reflection

Patient: I didn't want to come in.

Clinician: You don't want to be here today.

Complex reflections paraphrase (makes a guess about unspoken meaning) or reflect the feeling, or both. Generally, simple reflections are more common at the beginning of the relationship, and complex (deeper) reflections occur more frequently as understanding increases. There are several types of complex reflections:

- Double-sided reflection—presents both sides of what the patient is saying; extremely useful in pointing out ambivalence
- Amplified reflection—amplifies or heightens the resistance that is heard
- Reframing or "getting a new pair of glasses"—suggests a new way of looking at something that is more consistent with behavior change or change talk of the patient

Examples of complex reflection

Patient: There is no question my children come first. However, after I put them to bed, I do not really see any problem in continuing to smoke weed every night. I am very careful where I buy it so I don't get caught in a bust.

Clinician: So, on the one hand you seem to be very clear your children are very important to you and they come first. However, you also appear to be saying you really don't see anything wrong with your regular use of weed and even appear to discount any risk you might be taking. (double-sided)

Patient: I could not quit. What would my friends think?

*Clinician: You are telling me there would be a **lot** of pressure from your friends if you tried to stop.* (amplified)

Summaries are statements that pull together the comments made and transition to the next topic. They are helpful for moving the conversation along. Summaries should only be used after a minimum of three reflections.

Example of a summary

> *You mentioned a number of things about your current lifestyle, such as cutbacks at work and the stress you feel. You spoke of having little energy for doing some of the things you used to like to do and did to relax. What do you think might help you get back to doing some of the things you once enjoyed?*

Giving Advice

Clinicians frequently ask when during MI they may give advice or provide information. Giving advice or information at the wrong time or with the wrong approach is one way to encourage resistance from patients. There are three situations where giving advice is appropriate:

- Patient asks for advice or information
- Clinician asks permission to give advice
  - "May I make a suggestion?"
  - "Would you be interested in some resources?"
  - "Would you like to know what has worked for some other people?"
- Clinician qualifies the advice to emphasize autonomy
  - "A lot of people find that [____] works well, but I don't know if that's something that interests you."

When a patient asks for advice, it is important the clinician not jump in if the patient does not seem ready or sincere. In these situations, it is more appropriate to ask permission to get more information before giving advice.

Example of giving advice

> *You know, that's certainly something I can do, but I'm wondering if I really have enough information about the problem to give you good advice right now. Would you mind telling me a little bit more about the situation?*

Too often in addiction treatment settings, patients are labeled "resistant" if they do not want to change and/or argue against recommendations to do so. Miller and Rollnick intentionally have moved away from using the term "resistant" as it is negative, not accurate in its implications, and not useful in training MI skills to help patients with change. Instead, MI theory considers these interactions as composed of two elements: ambivalence residing in the patient and the skill level of the provider. When arguments or sustain talk are present, it is predictive of no change. These types of patient expressions are a signal of cognitive dissonance and often are reactions to the provider's counseling style.

In simple terms, cognitive dissonance is an uncomfortable feeling caused by contradictory ideas such as when beliefs and values contradict one's behavior. People are motivated to reduce the dissonance by changing attitudes, beliefs, and behaviors or justifying or rationalizing attitudes, beliefs, and behaviors. When encountering discord and/or expressions of "sustain talk," it is

important to avoid arguments with the individual. Do not push back as this puts the individual in the position of defending the opposite side. The old term "rolling with resistance" implied that to help elicit change, the clinician would go with the direction of the conversation rather than confronting, preaching, or trying to control the conversation. The use of reflections, particularly complex reflections, is one way a clinician can help reduce sustain talk. It is also helpful to remind the patient (and for the clinician to remind himself or herself) about autonomy and to let the patient know that change is ultimately his or her choice.

Phase 2 of Motivational Interviewing: Building Change Talk and Strengthening Commitment

Change talk can flow naturally by simply using OARS. The application of OARS is primarily a patient-centered mode and serves the purpose of exploring the patient's ambivalence about behavior change. Often through empathic, reflective listening, the patient's ambivalence shifts toward the "change" side and away from the "status quo" side of the ambivalence. During this phase, trust and rapport have been established to an extent that the patient is ready to collaborate in resolving the ambivalence.

Recognizing Change Talk Versus Sustain Talk

Change talk and sustain talk are opposites. Sustain talk supports keeping things the same. Change talk expresses movement in the direction of change.

Examples of change talk and sustain talk

Sustain talk: "Marijuana has never affected me."

Change talk: "It ain't worth it to be landing in jail."

There are seven types of change and commitment talk, represented by the mnemonic DARN-CAT:

- D—Desire to change ("want, like, wish…")
- A—Ability to change ("can, could…")
- R—Reasons to change ("if…then…")
- N—Need for change ("got to, have to, need to…")
- C—Commitment
- A—Activation
- T—Taking steps

The MI goal in phase 2 is to increase the change talk and decrease the sustain talk.

Change Talk Discussion

When change talk does not occur naturally, tools can be used to elicit change talk. When trust is developed, questions that would earlier have been classified as roadblocks that engendered resistance are now classified as techniques for eliciting change talk. Thus, it is important to not introduce the change talk discussion too early—that is, not before the patient has sufficiently explored the ambivalence about the behavior and is now ready to explore and resolve ambivalence about change. It is only at this point that the more directive techniques can be employed. The following are strategies for eliciting change talk:

- Ask evocative questions.
- Explore the decisional balance (weighing costs and benefits).
- Ask for elaboration or examples.
- Use a looking-back question (to a time when things were ok).
- Use a looking-forward question (how does the patient want life to be different?).
- Query the extremes (worst that could happen if patient quit and best that could happen if patient quit).
- Use the change rulers.
- Explore goals and values.

Commitment Talk

Commitment is the language that confirms something different will happen. The difference between change talk and commitment talk lies in the strength of the statement. During change talk, the idea of change is explored; with commitment talk, the intention is expressed to make the changes. Good questions to use for eliciting commitment talk are: "Will you do it?" If so, "Where, when, and with whom?" The more specific the answer generated, the more likely the action will take place. Being accountable to oneself and others is often part of the lesson learned in the treatment process. Clinicians are encouraged to elicit commitment talk and subsequent follow-through at the end of each session to affirm patient engagement and skills practice and gradually shape commitment for dramatic behavior change.

Examples of change talk and commitment talk

Change talk: "I know my kids want me to."

Commitment talk: "I'll definitely give it a go."

Bridging Screening and Assessment to Treatment: The Personalized Reflective Discussion

The SBIRT type of brief intervention, MI, and MET all use assessment results to generate a specific type of reflective discussion aimed at gently increasing readiness and the desire to change. Although individuals may be aware they are using a particular substance, they may not

realize they are at significant risk for negative health and other consequences. Or, they may not realize they are using at a rate, or in amounts, that are much higher than the majority of the population. Simply hearing information reflected back—summarized to include the pros and cons/risks they themselves have shared—can be a powerful motivator.

The Personal Reflective Summary

Clinicians in clinic settings often conduct evaluations or review results from assessments with patients in treatment. Earlier work using personalized feedback reports (e.g., Sampl & Kadden, 2001) often gathered the following information during the assessment meeting(s):

- Alcohol and/or substances used by the patient
- Perceived benefits of use
- Levels of use, such as frequency and quantity
- Problems associated with using alcohol or other substances (e.g., physical/emotional health, relationships, work, role functioning)
- Current and past abuse or dependence symptoms
- Reasons to quit or to make a change
- Current motivational level regarding substance use and change
- Feelings of confidence or efficacy in being able to accomplish desired changes
- Other co-occurring concerns

Personalized reports based on results from the Alcohol Use Disorders Identification Test (AUDIT); the Drug Abuse Screening Test (DAST); the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST); and typical screener questions are already used in SBIRT practice. However, higher patient risk levels in brief treatment demand a more **comprehensive reflective discussion** than is typical of briefer interventions, which are more focused on immediate feedback and health advice.

ICT makes use of the "personal reflective summary" (PRS) as an enhancement of previous reflective summary approaches, which focus on motivation only. The following describes the ICT PRS process:

- Prior to meeting with the patient for the first time, the clinician prepares the PRS using information from the screening and assessment process. Supportive tools are available in the session guide. The clinician and patient then discuss the PRS together at the first ICT session. In this session, the clinician uses the PRS to evoke from the patient his or her own personal and compelling concerns regarding substance use, helping to increase patient motivation as an important goal during this initial phase.

- As a next step, the PRS is used to help identify and plan treatment sessions by applying functional analysis strategies (Carroll, 1998; Leahy, 1996; Longabaugh, Zweben, LoCastro, & Miller, 2005; Agostinelli, Brown, & Miller, 1995; Davis, Baer, Saxon, & Kivlahan, 2003; Juarez, Walters, Daugherty, & Radi, 2006). The strategies help identify treatment needs and help the patient to commit to engaging in specific treatment sessions that target those needs.

For the important second phase, the primary objective is to identify functional relationships between patient intrapersonal and interpersonal processes that are linked and that can trigger substance use behavior. Such "functional analysis conversations" often occur in a somewhat mechanistic fashion. Clinicians are encouraged to use a more dynamic approach. The approach develops when rapport between the clinician and patient is built, collaboration strengthens, and there is increasing awareness of the pros and cons of behaviors. The discussion can begin to shift toward more specific identification of the patterns of substance use. Importantly, this process facilitates a clearer understanding of the patient's co-occurring symptoms, how they affect substance use, and vice versa. Figures 4 and 5 illustrate personalized reflective discussions with the two interrelated processes.

Figure 4. Personalized Reflective Discussions, Phase 1, Enhancing Motivation and Commitment to Treatment

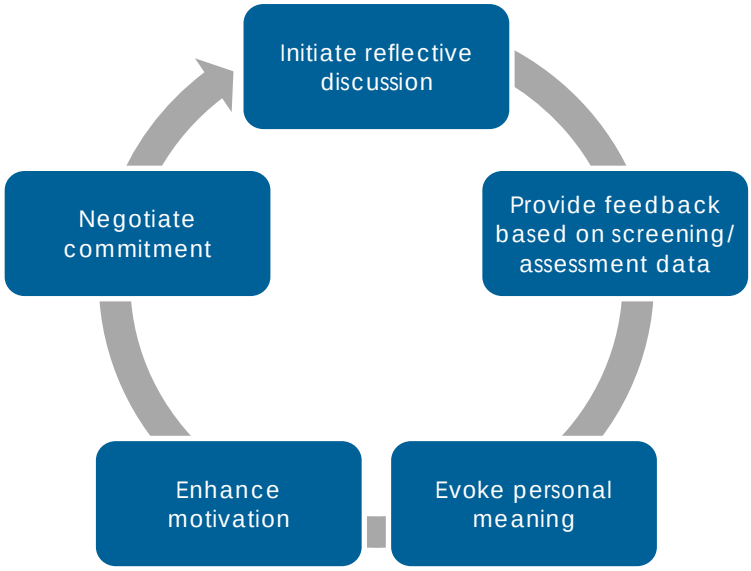
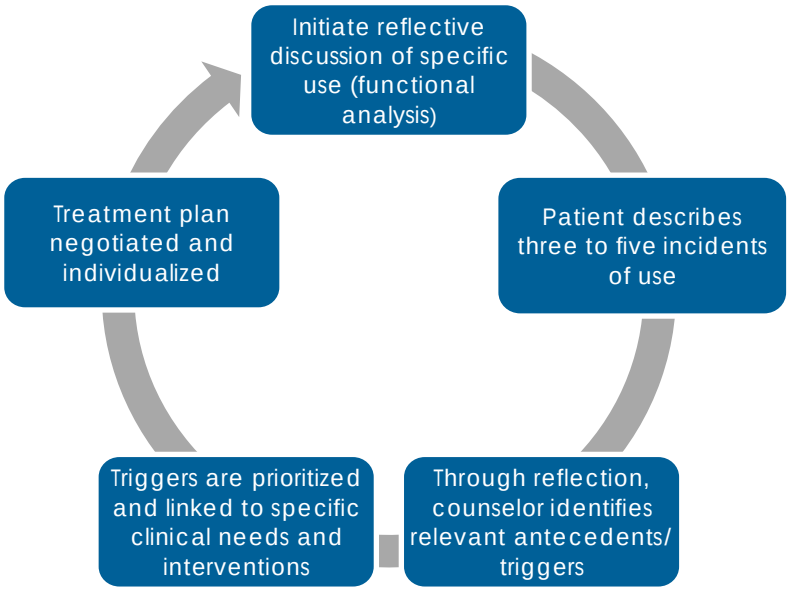


Figure 5. Phase 2, Using Functional Analysis To Identify Treatment Priorities and Individualize Treatment



The types of dialogue illustrated in the two figures can help facilitate readiness for change and enable the patient to focus on what needs to be done as preparation for that change. The discussion following routine engagement conversations is focused on having the patient describe three to five previous incidents when they used substances. The clinician elicits the antecedents, the patient's internal experience, the interpersonal or situational factors, the perceived benefits, and the consequences.

Through this dynamic conversation, the clinician listens for and reflects on what the patient identifies as skills deficits and other needs that may be addressed within the treatment process. Following this discussion, the clinician summarizes the identified needs and seeks concurrence from the patient to address them within the treatment sessions. Through this process, every treatment experience is individualized and tailored to the unique needs of the person seeking services. The clinician gains insight into which specific skills-oriented and/or recovery-support sessions to cover in treatment.

Clinicians are encouraged to use the sample forms provided with the session descriptions in section 2, or to develop their own format based on their particular style or the information that is collected at their clinics. Creating and sharing the PRS gives a focus to the critical information within the screening and assessment process.

As a patient expresses increasing interest in modifying use, the clinician carefully supports the efforts to change without actually prescribing the change. When the patient expresses a commitment to change, the clinician asks the patient about the steps that will be taken to make the change. The clinician provides a menu of self-change and clinician-assisted change options, depending on the patient's inclinations and experience in making changes. Self-change advice may be in the form of a brief written handout concerning behavioral changes. The clinician-assisted change takes place through the agreed-upon brief treatment sessions.

Cognitive Behavioral Therapy

ICT also incorporates the principles of CBT. Models of CBT are the most extensively evaluated interventions for the treatment of alcohol and other drug use disorders. Multiple meta-analyses (Magill & Ray, 2009) have repeatedly demonstrated efficacy in the treatment of addictions and mental health disorders such as depression, traumatic stress, and anxiety. CBT is primarily based on the original work of Marlatt and Gordon (1985), and from this have grown models for relapse prevention for substance use disorders and applications addressing other issues. These interventions for relapse prevention have targeted cognitive, behavioral, affective, and situational triggers for substance use and provided clearly defined skills trainings in support of abstinence and recovery. CBT manuals have been developed since 1985 and adapted for use in a variety of clinical settings, with CBT interventions tested to examine their utility in real-world settings and their cost-effectiveness (Carroll, 1996; Marlatt & Gordon, 1985).

All people develop habits to more efficiently and effectively address life's complexities. CBT clinicians view addiction, in part, as a negative and repeated habit reinforced by the neuropsychological effects of use. The role of the clinician is to elevate the seemingly unaware substance-linked habits into conscious awareness. Awareness is created through a functional analysis discussion that reviews the relationships between substance use and internal and external factors. The clinician's integration and proficient use of MI skills to create a therapeutic alliance founded on nonjudgemental trust is a critical element in utilizing CBT, especially functional analysis, to realize and change negative habitual patterns like substance use. By providing the "therapeutic environment" for honest dialogue, the triggers, feelings, thoughts, and underlying belief systems that help drive repeated patterns are more readily brought into cognitive awareness. The clinician must be adept at using MI to promote readiness and evoke awareness and equally adept at teaching and coaching to help patients develop new skills.

The value of skills training in the treatment of substance use and mental disorders has been described in previous writings on CBT (Monti, Kaden, Rohsenow, Cooney, & Abrams, 2002). Determining the targeted skills to be addressed requires some form of assessment (functional analysis is loosely defined as situational and personal awareness, knowledge is power, the ABCs of CBT, etc.). For each issue defined as a priority, the clinician works in partnership with the patient to assess readiness to address the issue, identify mastering the necessary skills as priorities, and help the patient develop reasonable expectations as to the intended outcomes.

Skills deficits are significant factors to be addressed as these challenges often lead to or perpetuate use of alcohol and drugs as a maladaptive coping strategy. To the extent the individual does not develop more healthy coping skills, the risk for relapse remains high if the deficits are not addressed. Similarly, certain kinds of skills deficits are associated with anxiety and depression (addressed in ICT sessions). Managing these affective states is important in recovery and to the overall well-being of the patient.

Within this treatment guide, sessions are organized into three broad and interrelated categories—intrapersonal skills training, interpersonal skills training, and recovery support. These categories are based on the most common factors supporting recovery: situational

awareness, managing uncomfortable feeling states, assertiveness, healthy committed relationships, replacement activities, guilt-free intimacy, and engagement with a spiritual community/connection to something greater than the self. Skills training also addresses causes of relapse, such as interpersonal and intrapersonal challenges resulting in negative emotional states that lead to continued substance use, relapse, and other associated problems (Marlatt, 1996).

Why Focus on Skills?

Motivation Leads to Skills Development

Once the individual commits to changing his or her behavior, treatment focuses on building and strengthening skills for becoming and remaining abstinent from substance use. The patient's motivation and commitment may vary, so use of MI techniques and MET strategies remain integral to treatment. The clinician begins by reexploring the patient's commitment to abstinence or a reduction in use and using motivational strategies (e.g., identifying discrepancies, increasing change talk) when the patient's motivation wavers. In these sessions, the clinician and patient work on developing specific skills (e.g., refusing offers, coping with cravings). This approach is usually slower and somewhat less structured than typical CBT approaches, but many individuals find this emphasis on collaboration and internal motivation helpful.

What Is a Skills-Building Approach?

The brief treatment skills-building approach is founded on the CBT social learning model, which focuses on learning interpersonal and self-management skills (CSAT, 1999). The emphasis is skill building rather than a deficit-oriented approach. Substance abuse or dependence is considered a learned behavior and negative habit that developed in response to external (e.g., environmental, relational) and internal (e.g., beliefs, feelings, thoughts, neurobiology) conditions. The skills-building brief treatment model suggests the addictive behavior has become a favored strategy because of its repeated associations with predictable outcomes. For example, someone uses substances when sad, angry, lonely, or upset; feels less bad when using; and associates substance use with feeling better (at least in the short term). Over time, alcohol or other substances may be selected more often as a strategy to escape negative feelings or thoughts.

Skill-building approaches view compulsive or addictive behaviors and certain negative moods as learned and not the result of character defects. Because these behaviors are seen as learned, they can be unlearned. The unlearning occurs through learning and practicing new skills and enhancing the patient's capabilities. The patient develops skills to identify and cope with high-risk internal states and external situations that increase the likelihood of a slip. The clinician assigns the patient take-home challenges to practice the new skills and elicits patient commitment to when, where, and how the skills will be practiced in the upcoming week. The patient's participation and the clinician's positive feedback enhance patient confidence in

managing situations and create long-lasting behavior change. This perspective of addiction as learned is therapeutic because it—

- Reduces blame and criticism
- Fosters hope and optimism
- Identifies development and improvement processes

This brief treatment approach differs from less structured "talking" models of treatment because it—

- Addresses interpretations of events as important cues for compulsive behavior
- Provides structure (every week the clinician devotes a specific amount of time at a specific time in the session to a particular activity)
- Informs and teaches (but is still collaborative)

With the use of ICT, the clinician selects skills sessions from a menu of possible choices based on information that emerged during the earlier motivation enhancement sessions. The sequence of the sessions corresponds to those in many researched, combined MET and CBT intervention manuals (Moyers & Huck, 2011). The purpose of the sequence of sessions is to immediately offer patients simple methods for increasing awareness and developing coping strategies.

Even though a sequence is offered, the clinician and patient should collaboratively decide which topics or skills to focus on, based on the patient's particular needs and presentation. For example, one patient may describe struggling with depression or other difficult emotions and might benefit from the sessions that focus on emotions. Another patient may present with a history of difficulty expressing thoughts and feelings constructively and might be helped by assertiveness skills. Mindfulness and meditation may be helpful for the large majority of patients who are referred for brief treatment as these strategies have broad applications for treating difficulties with mood, substances, and anxiety.

Intrapersonal Skills Training

Intrapersonal skills training begins with building personal awareness (mindfulness); identifying and managing thoughts and urges to use substances; managing powerful emotions such as fear or anger; and addressing negative and self-defeating thoughts such as those associated with low self-esteem, low sense of self-efficacy, catastrophic expectations, and feelings of helplessness and hopelessness. On the positive and strengths-based side of treatment, skills training helps patients learn how to become calmer, problem solve situations, internally assess thoughts and feelings, and successfully manage and navigate what can be powerful and uncomfortable emotional states. Other skills that have proven useful and effective include relaxation training, skills for positive use of unstructured time, mastering healthy physical and mental activities, decisionmaking, and planning for the unexpected.

Interpersonal Skills

Interpersonal skills target management of situations where other people are an important factor or are actually part of the problem. Developing refusal skills in social situations is important for substance use patients because most will be confronted with the opportunity to use substances and will be faced with a choice. Learning how to say no convincingly and in a manner that works for the patient in his or her world and context is an important skill to develop.

Developing appropriate boundary management and assertiveness skills is important in multiple domains of a person's life. Failing to develop these skills often leads a person to feel imposed upon and resentful and can serve as a trigger for substance use. Addressing potentially contentious situations is important. It is challenging to be the recipient or the bearer of criticism; both can provoke feelings of frustration or anger.

Building and strengthening intimate relationships is essential for most people's happiness. Many patients experience difficulty expressing their feelings, communicating their thoughts, and being sensitive to the thoughts and feelings of others, especially when there has been considerable conflict in the past. Skills sessions can help patients learn how to self-disclose appropriately, to share both positive and negative feelings in appropriate ways, and to develop listening skills to become better partners in relationships.

Too often, intimate relationships become problem saturated and problem focused. Strengthening intimate relationships can include learning how to make the best use of positive and restorative time for a couple or within a family. In one effective model for couples therapy (O'Farrell & Fals-Stewart, 2006), an initial task is given to plan and have an enjoyable time with each other in the coming week.

Enhancing Social Support

Adequate social support is fundamental for most people. When individuals have been involved in substance use, they often perceive their social networks as threats to continued sobriety. Nurturing a vibrant social support system helps manage stress and reduce isolation and loneliness.

Treating Co-Occurring Disorders

Behavioral health clinicians in primary care settings who are trained in SBIRT protocols provide ideal capacity for the identification, brief treatment, and referral of patients with co-occurring mental health and substance use conditions. Large-scale, population-based epidemiological surveys have shown that people with a mental illness are more likely to have a substance use disorder, and the more incapacitating disorders have a higher incidence of substance use problems. Lifetime prevalence rates of 25–30 percent of patients with depression or anxiety have co-occurring substance use disorders (Miller & Carroll, 2006). Persons with primary

substance use disorders have similarly high incidents of co-occurring mental disorders (37 percent of alcohol-abusing/dependent adults and 53 percent of drug-abusing/dependent adults (Regier et al., 1990). The incidence rates of PTSD in our health care systems have increased in part because of the number of male and female veterans returning home after serving in recent wars. Prevalence varies by a population's traumatic exposure but is estimated to be 12 to 14 percent among troops returning from Afghanistan and Iraq and 7 percent of all patients in routine primary care. Primary care clinicians who maintain a high sensitivity for traumatic stress associated with symptoms of depression or anxiety or other signs of psychological distress, alcohol or substance abuse, or excessive health care service use may increase the recognition rate of this disorder in their practices (Lecrubier, 2004).

The ICT model helps to reduce the gap in care by providing a structured treatment protocol that integrates two effective clinical interventions (MET and CBT) and medications when appropriate. The session activities are common to many evidence-based interventions for addiction, mental health, and co-occurring disorders. ICT employs a model for care that is staged and recovery based and uses MI and skill building. Clinicians can address the disorders and their symptoms in stages, while delivering the chosen session activities. The session activities known to be effective across common mental health conditions (depression, anxiety, and trauma stress) and substance use disorders are the following:

- Reflective assessment discussions
- Motivational enhancement strategies
- Self-awareness (situational and mood)
- Monitoring (functional analysis)
- Cognitive restructuring
- Relaxation training
- Problem solving
- Communication skills
- Social support skills
- Increasing pleasant/mastery activities
- Relapse prevention

Table 1 below illustrates the functionality of ICT addressing substance use and co-occurring disorders.

Table 1. ICT Clinical Interventions Addressing Substance Use and Mental Disorders

Treatment Sessions	Substance Use	Depression and Anxiety	Traumatic Stress
Session 1 Enhancing Motivation and Treatment Engagement	✓	✓	✓
Session 2 Use of Functional Analysis in Care Planning	✓	✓	✓
Session 3 Making Important Life Decisions	✓	✓	✓
Session 4 Enhancing Self-Awareness	✓	✓	✓
Session 5 Managing Craving and Urges	✓		✓
Session 6 Enhanced Social Supports	✓	✓	✓
Session 7 Problem Solving	✓	✓	✓
Session 8 Assertiveness	✓	✓	✓
Session 9 Mindfulness and Meditation	✓	✓	✓
Session 10 Working With Thoughts	✓	✓	✓
Session 11 Working With Emotions	✓	✓	✓
Session 12 Wellness Planning	✓	✓	✓
Session 13 Medication	✓	✓	✓
Session 14 12 Steps, Self-Help	✓		
Session 15 Traumatic Stress	✓	✓	✓

Recovery Supports

While many recognized recovery support services have emerged over the past 20 years—driven substantially by an appreciation of recovery-oriented systems of care principles—this guide addresses only two widely used recovery supports: the use of medications and self-help. The reason for this choice is there is firm evidence supporting the benefits of medications as a method of recovery support (Kelly & Yeterian, 2011), and not all recovery support services are

available and accessible in all communities. However, nearly every community in the United States and elsewhere is home to 12-step, self-help meetings.

Session 13 addresses decisionmaking related to the use of medications in the treatment of substance use and other disorders. Session 14 includes information about Alcoholics Anonymous and Narcotics Anonymous. The placement of these sessions after the skills training sessions is not intended to reflect when and how a clinician would use this information. The handouts and discussion tips may be used to inform patients about these essential recovery tools during any phase of treatment. In fact, depending on patient needs, it could be beneficial to introduce both addiction medication and self-help strategies early in ICT treatment.

Section 2. Clinician Guidance for 15 Sessions of Integrated Change Therapy

Introduction

As a framework for treatment, this section provides detailed guidance to clinicians for delivering any or all of the 15 sessions of ICT. Each session is organized according to the following headings:

- Introduction to the session
- The patient's experience: what the patient learns (intended outcome)
- Clinician preparation for the session
- Session outline, steps
- Protocol with scripts (and sidebar tips; some appear in the appendices)
- Handouts (appearing in corresponding sections at end of guide)

Sessions 1, 2, 4, 5, and 6 are viewed as core to ICT and should be completed by all patients. Session 1 addresses engagement and motivation for change. Session 2 initiates the process of functional analysis to help the patient build situational awareness of internal and interpersonal factors affecting substance use and is used to individualize treatment strategies. Sessions 4, 5, and 6 are universally beneficial and necessary skill-training sessions supporting substance abuse recovery. The clinician and patient may decide to complete more sessions based on identified needs. While there is flexibility in the model, the clinician should not assume the patient has the sole responsibility for deciding the number of sessions. Rather, the clinician should guide the course and plan for treatment with considerable input from the patient. The clinician must balance patient motivation and needs with clinician judgment when deciding on a reasonable duration of treatment for each patient.

Clinicians using the ICT approach are encouraged to integrate the skills and techniques described in detail in section 1 of this guide. In preparation for using the ICT approach, clinicians are encouraged to undertake the following activities and practice the skills outlined:

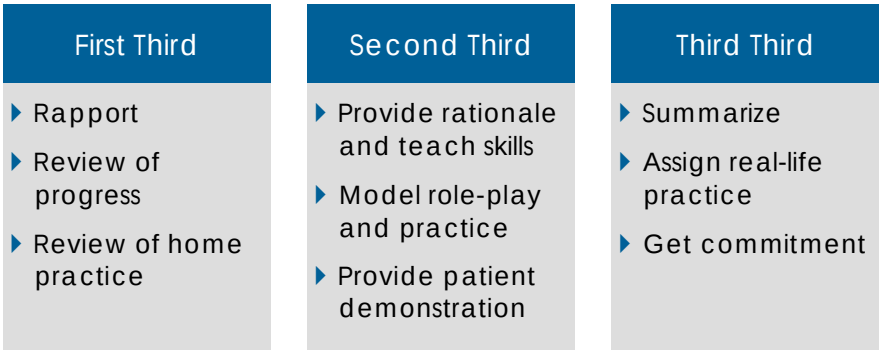
- Review relevant sections of the manual before each session.
- Develop a natural style of conveying the material; avoid reading text to the patient or appearing overly didactic, dogmatic, or as though presenting a lecture.
- Maintain a motivational style; use open-ended questions and reflections; and avoid a directive, resistance-building style.
- Encourage involvement and participation by the patient.
- Allow time for role-plays and feedback.

- Build self-efficacy; help the patient identify and acknowledge skills already in use.
- Avoid overwhelming the patient; present only one or two new skills per session.
- Remember to take a few minutes to review the between-session exercises at the start of each session.
- Attend to shifts in the patient's motivation and readiness for change.
- Explain practice exercises carefully; probe for the patient's understanding.

Law of Thirds

ICT follows the guidance of the "law of thirds." Studies in psychotherapy have determined that most successful therapy sessions occur in three phases. This came to be known informally as the law of thirds (Carroll, 1996) or the 20/20/20 rule. The law of thirds describes the first third of the therapy session as engaging, building, or reestablishing rapport and reviewing progress since the last contact and home practice assignments. The second third is the core of that session's activity. In the example in figure 6, the second third addresses a particular skill to be introduced and practiced during the session. The final third summarizes what took place during the session. When delivering ICT, the clinician affirms the patient's attendance and participation, with a focus on building motivation, following through, and transferring skills into the real world. During the last third, the clinician and patient identify a real-life practice opportunity and make a mutual commitment to practice the new skill in the coming week.

Figure 6. Sample Therapy Sessions According to the Law of Thirds



Before Treatment: Providing the Rationale and Sharing Session Agendas

Prior to delivering any intervention activity, the clinician should explain the rationale for using it to the patient. This helps the patient understand the activity, increases the patient's confidence in the method and the clinician's expertise, and sets up positive expectations. In the ICT sessions that follow in this guide, the reasons for using the specific session agenda and the choice of treatment activities are provided for each session. This is referred to as "providing the rationale" to the patient.

The following checklist can help:

1. Provide a rationale for the skill: Ask the patient if he or she understands the reasons why the activity or skill will help build recovery strength.
2. Demonstrate the skill: Be clear and ensure the patient understands the lesson.
3. Lead the patient in a role-play of the skill to model the way it is done to see if there are questions.
4. Make sure the patient can demonstrate and/or explain the activity.
5. Have the patient lead a role-play of the skill; the patient can use creative, fun examples and then use real-life examples.
6. Begin to complete the relevant form in the session; this is intended as real practice for the next week.
7. Obtain a specific commitment for the practice assignment as to when the patient will complete it; if there is no specific time frame, identify when the patient will fill out the worksheet (prior to the next session).

Session 1. Rapport, Collaboration, and Personal Reflections

Introduction

Session 1 takes place after the patient has been assessed and referred to the brief treatment clinician. The clinician should receive a copy of the assessment or screening tool used[1] along with the referral.

Personal Reflective Summary

As described in detail in section 1, the PRS is an important part of ICT. Prior to the first session, the clinician uses the patient's assessment and screening information to craft the PRS. Then, the clinician and patient discuss the PRS during the initial treatment session as a way to begin the conversation about where the patient stands in relation to alcohol or other substance use and what he or she would like to accomplish. The clinician identifies the patient's overall risk level related to substance use to share with the patient during the first session.

See the session 1 handouts at the end of the guide, which provide the necessary framework to facilitate and deliver competent PRS discussions. The handouts include forms for preparing a brief summary PRS and longer version PRS, both titled *Bridging to Treatment*. The forms can easily be filled with the summarized results from the screening/assessment instruments.

Bridging Screening and Assessment to Treatment

During session 1, eight essential motivational questions can be used to help understand the patient's readiness to change and address the health risks of substance use. The information gained can be used to form a more detailed PRS for discussion (see the handout).

In addition to addressing the answers to the eight essential questions, the clinician provides a one-page summary of the information obtained during the intake interview and screening/assessment (see handout). This simple feedback form is used to develop discrepancy, enhance motivation, and elicit change talk. Before the session if possible, the clinician fills out the overall risk level and the four questions that emphasize the most critical results and explains them to the patient during session 1.

The Patient's Experience

With the approach described here, the patient experiences a nonjudgmental conversation with a skilled health person providing support, empathy, and a desire to collaborate on a journey toward wellness. The patient develops an awareness of substance-related health risks and

[1] Examples are Alcohol, Smoking, and Substance Involvement (ASSIST) Summary Sheet; Alcohol Use Disorders Identification Test (AUDIT); Drug Abuse Screening Test (DAST); and CRAFFT (a mnemonic acronym for the first letters of key words in the six questions of the screen).

begins to question his or her readiness to address the risks now. The patient commits to following through on any number of "readiness" tasks prior to the next meeting.

Clinician Preparation

Session 1. Rapport, Collaboration, and Personal Reflections

Materials

- Personal Reflective Summary
- Brief Treatment Information Sheet
- Learning New Coping Strategies
- Optional: Change Plan and Quit Agreement
- Worksheet: Planning To Feel Good

Session Length

45–60 minutes

Delivery Method

MET-focused individual therapy

Strategies

- Follow OARS: Open-Ended Questions, Affirmations, Reflections, Summary.
- Make use of EDARS: Express Empathy, Develop Discrepancy, Awareness of Ambivalence, Roll with Sustain Talk/Discord, Support Self-Efficacy.
- Identify stage of change.
- Discuss and offer feedback to help emphasize personal reasons for change.
- MI readiness ruler and decisional balance
- Develop a "real-life practice challenge" and generate commitment.

Goals for This Session

- Build the alliance between the patient and clinician.
- Orient the patient to what might be expected in treatment sessions, the demands on time to attend, and the time needed for practice between sessions.
- Present the data gathered during the assessment session concerning substance use, the consequences of substance use, and the likely benefits and costs of stopping or reducing use.
- Review the completed PRS report.
- Explore the patient's experiences with using alcohol or other substances.
- Discuss substance use and associated health and wellness problems.
- Facilitate the patient's candid reflection on the consequences of substance use.
- Explore the patient's attitudes about change, including ambivalent attitudes.
- Elicit, acknowledge, and reinforce the patient's expressions of motivation to change.
- Affirm any patient expressions of readiness to develop a "change plan," and identify change strategies.
- Develop a between-session "challenge" appropriate for increasing self-efficacy toward change.

Session 1 Outline and Overview

The following is a checklist for the clinician undertaking the first session of ICT:

1. Assess the patient's readiness to proceed:
    - Welcome the patient and build rapport.
    - Share the session agenda.
    - Ask the patient for his or her feelings and thoughts about the assessment session.
    - Ask whether any changes have occurred since the last meeting.
    - Reinforce expressions of motivation.
2. Review the PRS (A Bridge to Well-Being):
    - Review the assessment summary and risk levels.
    - Elicit the patient's "most personal and important" benefits of continued use of substances.
    - Elicit any problems (the good and the not so good) caused by use (decisional balance).
    - Discuss the current identified risk factors.
    - Use the MI readiness ruler strategy to enhance motivation
    - Discuss current patient reasons for reductions in use and/or quitting.
    - Reinforce confidence in efforts to reduce use and/or quit.
3. Summarize the PRS discussion emphasizing "ambivalence" and readiness.
4. Elicit and reinforce the patient's readiness to change; if the patient is ready to make change—
    - Assist the patient in preparing for change; complete the "change plan."
    - If appropriate, discuss and help the patient develop a specific reduction target, a "sampling sobriety period," or a stop date (if the patient has not already stopped using).
5. For the patient ready to make change—
    - Assist the patient in preparing for change.
    - Ask and elicit a commitment from the patient to complete the "Change Plan."
    - If appropriate, discuss and help the patient develop a specific reduction target, "sampling sobriety period," or a stop date (if the patient has not already stopped using).

Discuss—

- What the patient will do with the current supply of alcohol or other substances and paraphernalia
- How the patient will disclose plans to family and friends
- How the patient will address problems in maintaining abstinence
- In the next session, communicate that you will explore what may be effective strategies, skills, and supports for the patient to reach his or her personal goals.

If the patient is not ready to make changes, ask to have an open discussion about use. The goal is to explore and build awareness regarding the patient's experience of substance use. An effective and nonconfrontational approach is to ask the patient to discuss an episode or episodes in the recent past where the patient has used substances. The clinician's role is to be open and reflective and to clarify the pros and cons of the patient's use. The discussion also starts to build situational awareness of factors associated with continued use. What might the patient do with a current supply of alcohol or other substances and paraphernalia? Will the patient disclose risky use to family and friends? How will the patient address problems in maintaining risky use?

6. For the patient not ready to change, elicit and discuss the patient's current use
    - Discuss the benefits and risks
    - Discuss the Quit Agreement and Learning New Coping Strategies (session 1 handouts)
    - Discuss barriers to quitting and vulnerabilities to slipping:
        - Managing general stress (HALT)
        - People, situations, and thoughts that increase vulnerability
        - Significant life changes likely to produce stress
        - Supportive people who will provide help
    - Review previous successful experiences at quitting to identify useful strategies.
7. Assign an appropriate between-session challenge
    - Discuss with the patient the rationale and need to adopt or continue doing substance-free pleasurable activities.
8. Ask the patient to invite a supporter to the next session (only if appropriate).
9. Review and conclude the session.

Assess the Patient's Readiness To Proceed

The clinician asks the patient to express his or her thoughts regarding the assessment process and any major changes that have occurred since the assessment session. Possible responses from the patient might be—

- Abstinence since entering treatment
- A reduction in substance use
- Seeking additional treatment or attendance at a mutual-help program
- Conversations about his or her use with others

The clinician responds empathically, uses opportunities to support the patient's self-efficacy for change, and reinforces expressions of motivation. See two examples below.

Clinician (C): Thank you for coming in today. How are things going?

Shirley (S): After answering all those questions about my using, I am more aware of it than ever! Nothing has changed yet, but I'm thinking about it. My husband has been very supportive.

C: And his support means a lot to you.

S: You bet! He's someone I can count on.

C: That's good to hear. Let's be sure to talk about specific requests you might make of him for support in the future.

C: You arrived a little late for your appointment. Is this a good time for you, or would a different time work better?

Doug (D): No; this is fine. There was a lot of traffic.

C: How are things?

D: Worse. My wife and my son are on my back; they're treating me as if I'm a leper.

C: That sounds like an uncomfortable situation for you.

D: Yeah. I feel like everyone is against me.

C: How has this affected your using?

D: At times I find myself using just to prove that it's not a problem for me!

C: It's more of a problem for them.

D: That's right. I don't think either one really understands me.

C: You'd like them to understand you; that might remove some reasons for getting high.

D: Yeah. At least I wouldn't be trying to get back at them.

Engaging in Discussion About the Personal Reflective Summary

The clinician explains that discussion about the PRS will facilitate better understanding of the reasons for and against changing and help identify problems that might arise. Using a PRS worksheet during the discussion, the clinician gives the patient an opportunity to explore each point and avoids simply verifying information obtained during the assessment session. Periodically, the clinician seeks to evoke the patient's thoughts and feelings regarding the feedback helping to bring forward the patient's own personal concerns.

An excellent starting place is to ask the patient what he or she "really likes about use," eliciting a thoughtful description of the feelings and situations related to substance use. The clinician listens reflectively to acknowledge the importance of the perceived benefits and expressions of potential readiness for change. This is an opportunity to use MI techniques; for example, expressing empathy, identifying discrepancy, eliciting self-motivational statements, rolling with sustain talk/discord, and supporting self-efficacy.

The patient may respond to elements in the PRS review with disagreement about the validity of the items ("I didn't say using was causing me money problems!"). In such cases, the clinician maintains a nondefensive tone, acknowledges the patient knows best what parts of life have been affected by substance use, and moves on to the next item. The clinician may also affirm with the patient his or her active and thoughtful engagement in this process (rolling with resistance).The clinician may make changes to the PRS based on the patient's feedback during the review. In keeping with the MI/MET approach, the clinician uses open-ended rather than closed-ended questions. For example, "Did you say you used in unsafe situations?" is a closed-ended question that invites a mere yes or no answer and possible disagreement with the PRS item. Saying instead, "Tell me about using in unsafe situations" invites elaboration and discussion.

The clinician spends more time on the sections of the PRS likely to produce the most constructive discussion. The sections on associated problems and reasons for quitting are especially conducive to use of MI. After reviewing the PRS with the patient, the clinician asks the patient for reactions and responds to them with empathy. Before moving on to the next phase of this session, the clinician ensures the following PRS items are discussed:

- A review of assessment findings, particularly those identified as moderate or high risk
- Problems caused by substance use
- Reasons for quitting: To reinforce the patient's motivation, the clinician reviews the reasons the patient gave during the initial meeting and asks the patient whether he or she would like to add other reasons to the list.
- Risk factors for relapse: The clinician points out possible risky situations the patient identified as risk factors for relapse. The clinician explains that risk factors are warning signs that require the patient's attention and indicate a susceptibility to problems associated with substance use.

Summarize the Personal Reflective Discussion

The clinician summarizes the highlights from the PRS, including the consequences and benefits of use, thoughts, reactions, and modifications offered by the patient during this session:

Clinician (C): Let's review and summarize what we've talked about so far. How does that sound to you?

Shirley (S): I'm ready!

C: You stated your evening smoking and drinks are the only way you've found to really relax and reduce stress. But you also acknowledged that the amount of regular drinking and smoking has caused several problems including missing work, difficulty sleeping, and feeling bad about your use. Is there anything else you want to add?

S: No; those are the main problems.

C: You mentioned the main reasons for quitting are to stop your husband nagging you so you won't lose the privilege of teaching and because you have health concerns.

S: Being a good teacher is really important.

C: Being a good teacher is important to you, and your using gets in the way. You can't properly prepare for class; the kids can find out; you can lose your job.

S: It's my biggest reason for wanting to stop.

C: When you talk about being a teacher, you get enthusiastic, but when you talk about your using, you get discouraged.

S: I never noticed that before, but you're right.

C: You also stated that high-risk situations for you would include being with others who smoke and seeing them enjoy it. Anything else?

S: Not really, but that is a major concern for me as I try to quit. So many people in my life use alcohol or other substances.

C: You've already identified how difficult it may be, but you've also identified some very strong reasons for changing your using habits.

S: I know it'll be difficult, but I think it's worth it.

C: Despite the obstacles, you're ready to take on this challenge.

S: I really am.

Elicit and Reinforce the Patient's Readiness To Change

When the patient expresses motivation to change, the clinician acknowledges these expressions, seeks elaboration, and offers reinforcement:

Clinician (C): You said your using has caused problems, including feeling that you have lower energy. Could you tell me about that?

Pat (P): I find I mean to do things, but they never get done. It seems that I'm tired all the time. I can't help thinking it's related to my using.

C: Related to your using?

P: I don't think it affected me when I was young. But now, well, I'm not getting any younger!

C: You think using is affecting you more as you get older. You feel less productive.

P: I think that's related to the lower energy. I don't finish my work at my job, and I'm not as creative. I feel that I'm drowning in backed-up work at home, at my job, everywhere.

C: And you think that if you quit using, you will increase your productivity.

P: Yeah.

C: That's important to you. You'd like to regain your creativity and productivity.

P: I really would like that.

Assist the Patient in Preparing for Change

The clinician assists the patient in preparing to reduce, and if ready, stop using alcohol or other substances by discussing several key issues. The clinician provides the rationale for goal setting by explaining that most successful change processes, including this treatment, begin with a roadmap of where the "driver" (the patient) wants to go and what he or she would like to accomplish in a specific time period. This helps the patient choose options for achieving the goals. Writing down goals for change also helps measure progress once started. The idea is to plan a journey with the best potential for success within a specific period of time. The journey may change as the process unfolds, but it is critical to identify the goal, the reasons for wanting to achieve it, and specific directions for success—called the "action steps."

If the patient has not stopped using, the clinician might ask if the patient is willing to select a day to begin the process by reducing use by a specific amount, thus "sampling sobriety" or quitting. The clinician helps the patient consider several alternative stop dates. Topics to consider include what the patient will do with his or her substance supply and paraphernalia, how the patient will disclose the plan to family and friends (both supporters and those who might sabotage the patient's efforts), and how the patient will address challenges to maintaining abstinence (e.g., sleep difficulties, boredom, anxiety, restlessness) in the first week.

If Appropriate, Help the Patient Identify Specific Initial Behavior Change Strategies

The clinician discusses specific coping strategies to handle vulnerabilities to slipping. The clinician gives the patient the handout *Learning New Coping Strategies* (see handouts for sessions 1 and 5). If time permits, the clinician reviews the forms with the patient, highlighting sections that seem particularly relevant to the patient. The clinician explains that many concepts touched on in the forms are discussed in detail in later sessions, and the patient should bring the forms to session 2. Because managing one's stress level is important, particularly in the early weeks and months of treatment, the clinician advises the patient about

HALT:

- Don't let yourself become too **Hungry**.
- Don't let yourself become too **Angry**.
- Don't let yourself become too **Lonely**.
- Don't let yourself become too **Tired**.

The clinician asks the patient to think about people, situations (e.g., certain times of day, days of the week, places, moods), and thoughts that can increase vulnerability to slipping. For example, a patient may describe plans to spend time with a using buddy. A patient may face significant life changes (e.g., job or relationship changes, illness of a family member or close friend) likely to produce stress that could place the patient at risk for slipping. The clinician and patient identify and discuss coping strategies for each situation. The clinician helps the patient identify people who can provide support. The clinician encourages the patient to consider several options, rather than only one or two, and to think creatively. With the clinician, the patient can practice making requests and benefit from the clinician's modeling and feedback. Practicing interactions during treatment sessions (i.e., encouraging patients to try new ways of interacting and expressing themselves) can lessen the anxiety the patient may have about asserting himself or herself with friends and family. See the sample language below.

> *Mary (M): I'll be going away for a few days, and I have concerns that no one will be watching me.*
>
> *Clinician (C): What concerns do you have?*
>
> *M: I'll be at a meeting with several people who smoke. For years we've gone out and partied after the meetings. I don't know what I'll do.*
>
> *C: You just identified a high-risk situation.*
>
> *M: Yeah. What should I tell them? I thought about saying I had a cold, but that's lying.*
>
> *C: You would prefer to tell them the truth. What are your concerns about that?*
>
> *M: I guess I'm afraid they would think I'm judging them. I really like these people.*
>
> *C: That is a difficult situation for you. Maybe if you and I rehearsed a couple of different ways to tell them, it would make it easier for you. Would you be willing to try that?*
>
> *M: Sure, what should we do?*
>
> *C: Why don't I play the role of one of your colleagues on this trip, and you try different ways you might handle it. Ready?*

Assign Between-Session Challenges

The clinician summarizes the patient's readiness by briefly reviewing the main reasons for and against changing use. Then, regardless of the patient's stage of change, the clinician provides the rationale for adopting or continuing substance-free pleasurable activities and completing the other challenge to fill out and review the *Change Plan*, the *Quit Agreement*, and *Learning New Coping Strategies* worksheets.

Clinician (C): Regardless of how ready you are to change your use, it is important for you to remain healthy and happy. One of the most proven approaches to feeling good is doing pleasurable activities. These pleasurable activities increase chemicals in the body that make us all feel good and can also help us remain calm through daily stressors like a decision to cut back or not use substances. Here is a two-sided worksheet that defines some of the types of activities that can be beneficial. Take a quick look at the following worksheet (clinician provides the worksheet on Planning to Feel Good).

Mary (M): These activities make sense, and while I do feel better after taking a walk or other stuff, it's just a lot easier to smoke.

C: I get that, but if you continue to try other rewarding or pleasurable activities, they also become easier to do without the negative side effects and possible legal hassles. So, if it's ok with you, I'm going to ask you to commit to filling out the Planning To Feel Good worksheet and following through with doing at least one really pleasurable activity while not using.

M: Ok.

C: There are a few other worksheets that will be helpful for you to look over and fill out prior to next session.

The clinician gives out *The Change Plan*, *The Quit Agreement*, and *Learning New Coping Strategies* and explains that the worksheets help reaffirm the following:

- The patient's chosen goal
- The patient's date for quitting or reducing use
- The patient's reasons for seeking to change
- Strategies the patient will use

C: When can you agree to taking time to figure out and do a pleasurable activity and review and fill out these other worksheets?

M: I always have some free time on the weekend early in the morning.

C: Great. Most patients find the between-session "challenge" never takes too long, but it makes a real difference as it gives them time to think about our work here and then try some new ways to feel good.

Optional: Encourage the Patient To Invite a Supporter to the Next Session

One of the most effective ways of reducing substance use and improving significant relationships is including others in the process of recovery. The clinician asks the patient to invite someone to attend the next session and to think carefully about the pros and cons of particular people to invite. For example, a friend who is dependent on another drug or alcohol is not a good prospect. Factors to consider include closeness to the patient, emotional characteristics of the relationship, emotional availability of the supporter regarding the patient's desire to quit use, substance use by the supporter, and accessibility during times of stress. The ideal person is a good listener, cares about the patient, and is interested in providing support. The person chosen would be expected to be in frequent contact with the patient, agree to engage in healthy rewarding activities, and help problem solve should the need arise.

Review and Conclude the Session

The clinician reviews the session, asks the patient for feedback, responds empathically to his or her comments, troubleshoots any difficulties, and reminds the patient to review the handouts over the next week.

Note to Clinician: There is much material to successfully address in this session. If in your judgment, the patient is still processing this information and appears undecided or ambivalent, continue the discussion in a second or even third session to address the motivational concerns. To move forward before your patient is ready invites greater resistance to change and a higher likelihood of prematurely leaving services. See the sample language provided.

Specific Suggestions for Some Common High-Risk Situations

Below are several high-risk situations that confront people who use and suggestions for coping without using.

Tension Relief and Negative Emotions (e.g., depression, anxiety, nervousness, irritability). Develop relaxation techniques, exercises; write down your feelings or talk to a friend or clinician; do something enjoyable that requires little effort; figure out what you're feeling and whether you can do anything about it.

Anger, Frustration, and Interpersonal Conflict. Try to handle the situation directly rather than hiding your feelings; if appropriate, be assertive; get some release by squeezing a rubber ball, pounding a pillow, or doing some physical activity; write down your feelings or tell them to someone; take deep breaths.

Fatigue and Low Energy. Do muscle relaxations; take a brisk walk; do something enjoyable; eat properly and get enough sleep.

Insomnia. Don't fight being unable to sleep. Get up and do something constructive or relaxing. Read a book, watch television, or do muscle relaxations until you feel sleepy. Remember that no one dies from losing a night's sleep.

Timeout. Read, do a crossword puzzle, prepare a healthy snack, take up a hobby, knit or do other needlework (things you can carry with you for easy access).

Self-Image. Try a new image: get a new haircut or buy new clothes.

Social Pressure. Be aware when others are using. Remember your commitment not to use. Be assertive and request that people not offer you alcohol or substances. If appropriate, ask that they not use around you for a while. If necessary, be prepared to leave the situation, especially when you've recently quit.

Cravings and Urges. The only way to interrupt cravings is to break the chain of responding to them. That is, don't give in. Eventually they will decrease. Do something to distract yourself; use the techniques suggested; breathe deeply; call a friend; go for a walk; move around; time the urge. You'll find that it will disappear like a wave breaking.

The handout related to a change plan is optional and offered to patients ready to think about immediate ways of changing. This will be reviewed with the patient during session 2.

Session 2. The Change Plan and Supporter Involvement

Introduction

This session focuses on further building rapport, defining the goals of the upcoming therapeutic journey, and including the support of others if they are available. The clinician continues to use motivational strategies to increase change talk and reduce sustain talk and introduces the process of functional analysis to help the patient build situational awareness of internal and interpersonal factors affecting substance use. Clinicians may refer to the eliciting change talk strategies presented in section 1 and reinforce any successful efforts at initiating change. If a supporter is present, discuss how and when assistance may be offered by the friend or relative invited by the patient. The clinician will need to exercise judgment as to whether the supportive person is in the room for certain portions of this session, such as discussions focused on functional analysis that may involve interpersonal factors where the supportive other plays a role.

The Patient's Experience

As the clinician expresses genuine interest in the patient's well-being since the last meeting, the patient experiences how a therapeutic relationship can provide the necessary guidance to push past obstacles and begin to make steps toward change. The patient can receive support, guidance, and assistance in creating a personalized plan for change. As a result of the second portion of the personal reflective discussion, the patient can gain a deeper understanding of his or her substance use, including internal and situational factors associated with use.

Supportive Others in the Treatment Process

If supportive others are involved, the patient can begin to realize the change process will be rewarded by expressions of closeness from others and that the supportive others can play a role in progress. However, it is not uncommon for family members and significant others to have strong concerns and powerful emotions related to the problems of the patient. If unbridled anger is conveyed, for example, it is important for the clinician to manage the process, perhaps by validating the experience of the supportive other, while at the same time containing the process. As needed, the clinician may wish to either provide information to the supportive other during the session or schedule a separate appointment. If a separate session is scheduled, it should be made clear to all parties that the focus will be to respond to the needs of this person and to help mobilize support and understanding for the patient in treatment.

The *I Promise To Support* handout for this session is designed to obtain commitment to the treatment process, which focuses more on the present recovery attempt than on the past. (This document includes the concept of a daily check-in with the patient, to include eye-to-eye contact.) Using MI techniques, the clinician listens and reflects to help significant others understand and avoid treatment disruptions caused by the need for immediate and intense emotional expression.

Without clinician management of this process, there is risk this can escalate situations, resulting in a patient prematurely exiting the treatment process and continuing with substance use behaviors. The clinician is encouraged to state to the patient and supportive others that there will be a time and place where these feelings can be worked through successfully for all; however, the first priority now is to address the substance use issues of the patient. The clinician may need to negotiate a truce for a period of time while progress is being made related to the substance use and an appropriate time in the near future when these issues can be addressed. If the supportive other demonstrates imminent personal needs, a collateral referral for supportive services should be negotiated.

Clinician experience suggests that a patient with more significant substance use history and problems often needs to remain substantially focused on his or her needs, and if family is available to be engaged in the process, this is best done at the conclusion of the second session or in a third session specifically for mobilizing the supportive capacity of family members. The overarching priorities of the session are to continue building engagement and patient motivation and to initiate a process of functional analysis within the second phase of the PRS discussion. This ensures the identification of skills needed and challenges faced to determine subsequent treatment sessions.

Clinician Preparation

<table>
<tr><th colspan="2">MET Session 2. The Change Plan and Personal Involvement</th></tr>
<tr><td>Materials
Copy of patient's PRS
Learning New Coping Strategies
Blank copy of the Change Plan and Quit Agreement
Supporter Strategies, Daily Trust Discussion, and I Promise To Support
Two blank copies of the supporter agreement</td><td>Total Time
1 hour
Delivery Method
MET-focused individual therapy with case conference elements</td></tr>
<tr><td colspan="2">Strategies
OARS (Open-Ended Questions, Affirmations, Reflections, Summary)
EDARS (Express Empathy, Develop Discrepancy, Awareness of Ambivalence, Roll with Sustain Talk/Discord, Support Self Efficacy); identify stage of change
Discuss and offer feedback to help emphasize personal reasons for change.
Develop "real-life practice challenge" and generate commitment.</td></tr>
<tr><td colspan="2">Goals for This Session
Help the patient develop a change plan with coping strategies for high-risk situations.
Specify how a supporter can help the patient achieve and maintain change.</td></tr>
</table>

Session 2 Outline and Overview

1. Continue building rapport:
    - Welcome the patient, and if present, the support person.
    - Quickly check in on the past week.
    - Ask about any positive experiences.
    - Share the session agenda; invite items from the patient.
2. Assess the patient's progress and readiness to proceed:
    - Ask the patient how he or she feels about continuing therapy.
    - Address patient comments and questions about session 1 handouts.
    - Review the patient's work regarding the Change Plan, Quit Agreement, and Learning New Coping Strategies.
3. Welcome the supporter (if in attendance):
    - Reinforce the importance of the supporter's participation.
    - Provide basic information and orientation about ICT.
    - Offer optional supportive session as part of the process.
    - Answer questions.
4. Examine the patient's recent experiences (supporter attendance optional):
    - Did the patient make an effort to stop? cut down?
    - Did he or she experience any high-risk or tempting situations?
    - Did the patient use any strategies from *Learning New Coping Strategies*?
    - Were the strategies successful?
    - Have the patient describe three to five incidents of use in recent history (functional analysis).
5. Identify internal and external factors/triggers associated with use.
6. Discuss associated skills and associated treatment sessions.
7. Establish a change plan:
    - Suggest interim goals if the patient is not ready for abstinence.
    - Encourage the patient to set general and specific goals.
8. Involve the supporter and review supporter strategies and the supporter agreement:
    - Elicit the supporter's concerns and hopes for the patient.
    - Give the patient and the supporter the *I Promise To Support* handout.
    - Complete the supporter agreement.

- Review the supporter agreement.
- Help the patient and the supporter decide which items they can agree to.
- Review the supporter agreement with patient, even if no supporter attends.
- Review daily trust discussion, asking for support, and role-play.

9. Assign a between-session challenge and elicit a specific commitment for completion.
10. Review and conclude session.

Session 2 Protocol With Scripts

The clinician welcomes the patient and provides an overview of the second session, in which the clinician helps develop and support the patients' change plan and obtains support from an important person in the patient's life (if present).

Assess the Patient's Progress and Readiness To Proceed

The clinician asks the patient how he or she feels about the previous session and responds to concerns, addressing any comments or questions about the PRS, *Learning New Coping Strategies*, the *Change Plan*, or the *Quit Agreement*. If the patient has completed the *Change Plan* or *Quit Agreement*, he or she is asked to read them and discuss the choices. The clinician reaffirms the patient's written statements and discusses adjustments (e.g., is the patient setting unrealistically high standards that may set him or her up for failure? has the patient identified salient reasons for wanting to make changes in alcohol or other substance use?). The clinician photocopies the agreement as a record of the patient's goals.

If **no** forms were completed, the clinician elicits the patient's reasons for not engaging in the change process at home to assess, for example, ambivalence, other obstacles, or both. If the reason appears to be ambivalence, the clinician uses MI strategies described in section 1, asking open-ended questions, reflecting, etc. Specific MI strategies depend on the nature of the sustain talk and the assessed stage of change (i.e., precontemplation or contemplation). If the patient still is uncertain or unaware of any need to change, the clinician can focus the discussion on reflections, normalizing uncertainty, reviewing health risks again, asking future-oriented questions, or imagining extreme questions (e.g., "What would it take or what would have to happen for you to want to make a change?").

If there is awareness of a need to change, the clinician can use the *Decisional Balance* form (session 3 handout) and reemphasize the benefits and risks. This technique can help the patient develop further discrepancy and swing the balance toward change. If the lack of follow-through was the result of more simple obstacles such as being too busy or forgetting, the clinician can brainstorm solutions and have the patient choose and commit to the choice. (One method for problem solving—I-SOLVE—will be presented in session 5.) An example of a strategy that can help a patient remember the between-session practice is to encourage use of a smartphone calendar, typing in the assigned challenge using the alarm function. Regardless of why the

assigned challenge was not completed, the clinician should reinforce the need to complete the practice work to achieve goals.

Welcome the Supporter

If the patient has brought a supporter, the clinician welcomes him or her and thanks the individual for his or her willingness to participate. The clinician provides general information about the intervention and asks if there are questions. In the course of the session, the clinician formulates a change plan, explains the positive effect of the supporter's daily brief recovery check-in with the patient (this is called the "trust" conversation), and identifies how the supporter can help the patient with treatment goals and abstinence. The clinician may ask the supporter to leave while speaking with the patient about recent events. A sample conversation appears here.

> *Clinician: I want to thank you both for coming today. Shirley has told me how much help you've been to her. We'll meet for about an hour today to discuss your role as a supporter for Shirley. Do either of you have any questions?*
>
> *Husband: I want you to know how proud of her I am; I'm willing to do whatever I can to help her out.*
>
> *Clinician: That's very encouraging to hear. Before we begin, I'd like to take a few minutes to ask Shirley how things have been going since we last met.*

Examine the Patient's Recent Experiences

The clinician asks the patient to describe his or her recent experiences with alcohol or other substances:

- Did the patient stop use since the previous session?
- Did the patient make an effort to stop?
- Was the patient confronted with any high-risk or tempting situations?
- What strategies did the patient use? Did the patient try any of the strategies in *Learning*
- *New Coping Strategies*? Were they successful?
- Were there any instances when the patient effectively handled a "hot" situation (i.e., very high risk)?
- Describe three to five instances in recent history when substances were used; discuss and reflect on these instances using functional analysis.
- Suggest skills for identified coping deficits; for each of the trigger and effect relationships, the clinician should consider what skill deficits may maintain the relationship and build patient motivation for learning new coping skills.

- Consider ancillary services; some patients may benefit from and ask for treatment alternatives the clinician would normally not provide; for example, patients who use substances to cope with feelings of depression may ask about antidepressant medications (see session 13).

As the patient talks, the clinician's objective is to elicit information and to use that information to provide reflections, express empathy, identify discrepancies, elicit self-motivational statements, and roll with sustain talk/discord. See the sample language provided.

Shirley (S): Well, I've almost completely stopped using since our last session.

Clinician (C): You seem very pleased with yourself! How did you do that?

S: Right after the last session I kept thinking about how alcohol has kept me from doing the things I want to do. I really want to be a teacher, and I realized that as long as I kept drinking, I would always feel bad. So I went home and drank one last time, then poured out the remainder of my stash into the sink! During the last week I've wanted to drink several times, but I didn't.

C: What did you do when you felt like drinking?

S: Well, I talked to my husband. I read about that in the handout you gave me last week.

Examine Patient's Experience With Supportive and Nonsupportive Relationships

The clinician helps the patient reevaluate relationships that have enhanced or impeded change:

C: Talking to someone else helped.

S: Yes, it did. And I kept cards and notes from my students in my purse and would take them out and look at them. Boy, I love those kids!

C: Your love for the children you teach and your husband's support are powerful tools!

S: You bet!

Or

Doug (D): My wife chose not to come today. She says this is my problem, and I need to solve it or find a new wife. After all these years of my using around her, now she wants immediate change and doesn't want to help me!

C: As you work on making changes, you may not have the support you would like. How are things different since we met last?

D: I've tried to cut down to a couple of days a week, but it's harder than I thought.

C: When you were successful, what did you do differently?

D: I didn't take pot to work 2 days last week, so I couldn't smoke. It wasn't that bad. If I didn't have it in my car, I didn't leave work on an "errand" to smoke.

C: You found that you could make changes if you didn't have marijuana in easy reach, and it may have been easier than you thought it might be. Did other things help?

Discussing Ambivalence

The patient may be reluctant to disclose ambivalence in front of a supportive person for fear of disapproval. However, strong ambivalence may be manifested in nonverbal behavior (e.g., level of comfort, reluctance to establish treatment goals). The clinician must be vigilant about maintaining the patient's level of motivation for change and engagement in treatment.

Reviewing and/or Developing a Short- and Long-Term Change Plan

The clinician helps the patient review and establish both a short- and long-term plan for behavior change, focusing particularly on the next 15–30 days to 12 months. The clinician summarizes indications of motivation the patient has already made. If the patient has given no indication of a desire to change, he or she may not be ready to commit to change, and the clinician points this out. The clinician again elicits the reasons for change and any possible steps toward movement in the direction of change and reducing risk. The clinician reemphasizes the need to articulate realistic and attainable short- and long-term goals to make counseling meaningful and useful. For patients whose goal is immediate and permanent abstinence, articulating goals is straightforward. However, many patients are not at this stage of change early in treatment. If a patient indicates no readiness to give up alcohol or other substances, the clinician suggests setting other interim goals such as learning more about the skills that will help in quitting or reducing use.

The clinician reviews the possible options, ranging from continued assessment of the pros and cons of use, to specific reductions, to sampling sobriety, to quitting completely. The clinician emphasizes it is normal to be worried about making a change to any long-term coping habits (such as substance use), and it is ultimately the patient's decision. It is equally important for the clinician to remind the patient that he or she was referred because of risky substance use and that by engaging the treatment strategies (even slowly) and using available support, a positive outcome can be achieved.

Based on the second part of the personal reflective discussion focusing on functional analysis, the clinician can identify which skills would be most beneficial for this patient as a basis for the next phase of treatment. In this way, the treatment is individualized according to patient need.

Tip for Clinicians

Goals may be general, such as quitting use within the next 2 weeks or reducing use to no more than a certain amount per week. Other goals may be more specific. Clinicians can use the acronym SMART, which stands for specific, measurable, attainable, realistic, revisitable, and timely, as part of a goal-setting process. While envisioning longer-term goals can be motivating, most patients benefit from initially focusing on more immediate actions that can be realized in 1–3 weeks. For example, the patient may set goals of figuring out how to stay away from substance use opportunities, identifying ways to get past cravings, learning new social skills, and participating in activities that are incompatible with using substances. Although the goal is

to help the patient achieve abstinence, the clinician needs to meet the patient where he or she is to keep the door open for possible future abstinence.

Optional: Involve the Supporter and Review Supporter Strategies

Supporter sessions can take more time than individual sessions. They may be thoughtfully integrated into a standard session, or a few extra sessions may be added. Research supports the use of significant others in behavioral therapy for substance abuse. For example, behavioral couples therapy (BCT) is the family therapy method with the strongest research support for its effectiveness in substance abuse. Studies show a consistent pattern of greater abstinence and fewer alcohol-related problems, happier relationships, and lower risk of marital separation for alcoholic patients who receive BCT than for patients who receive only individual treatment (Azrin, Sisson, Meyers, & Godley, 1982; Bowers & al-Redha, 1990; McCrady, Noel, Stout, Abrams, & Nelson, 1991; O'Farrell, Cutter, Choquette, Floyd, & Bayog, 1992).

Specialized "Significant Other" Sessions

In "significant other" sessions, the emphasis is on getting the patient and significant other or family members to renew their relationship in a more positive way by changing the behavior first and focusing on increasing the relationship factors conducive to abstinence. The session topics include daily trust-building activities, rewarding caring activities, commitment-focused activities, and communication and conflict resolution skills. A behavioral approach assumes family members can reward abstinence and that alcohol- and drug-abusing patients in happier, more cohesive relationships with better communication have a lower risk of relapse. There is also a focus on decreasing family member behavior that directly rewards and/or triggers use. (Clinicians may refer also to Hazelton's Recovery Bookstore at http://www.hazelden.org/OA_HTML/ibeCCtpItmDspRte.jsp?item=14684&sitex=10020:22372:US)

If a supporter is attending a session, the clinician shifts the focus to the relationship between the patient and supporter. The clinician asks the supporter why he or she wants to participate, eliciting the supporter's concerns and hopes for the patient. The clinician introduces the supporter agreement, and the patient and supporter read it to determine which items they will agree to. See the sample conversation on this topic.

> *Clinician (C): We have a list of ideas and strategies that have been helpful for some people. Let's see whether any of these could work for you two. [To husband] As we begin to look at ways that you and your wife can work together on this change, what concerns do you have?*
>
> *Husband (H): Shirley has a habit of getting excited about something and then giving up when things get tough. I want to help, but I'm not going to nag her. This is something she's going to do, not me. I'll help, but I won't push her.*
>
> *C: You recognize that Shirley needs to make her own decisions, and you don't want to be a policeman. Is that right?*
>
> *H: Pretty much, but I don't want to give you the idea that I won't support her.*

C: Great, the first way we can ensure this all goes well is to have you both commit to some basic rules. How does that sound?

H: Fine by me. We can get very mad at each other, especially if Shirley starts blaming me for all the problems her use has caused.

S: I'll make whatever promise is necessary for things to feel better between the two of us.

C: Shirley can you please read and sign the Promises sheet and then pass it to your husband so he can do the same.

[H and S sign the promises sheet.]

C: It sounds as if you have some ideas of what you would be willing to do. I've given the two of you a picture and example of the daily trust discussion and the Supporter Agreement. The daily trust discussion is a brief 2–3-minute discussion where Shirley will announce her commitment to her recovery or recovery goals every day with you. We find this brief eye-to-eye discussion can become the best way to build trust during recovery. We've also listed some ways Shirley might reach her goals. As we look at these together, I'd like you to identify some things you might be willing to do. How does that sound?

Even if the patient has not brought a supporter to the session, the clinician reviews the supporter agreement and any options for enlisting a daily trust discussion person. The patient may choose to identify a supporter later. The clinician and patient can role-play ways of asking for support.

Assign a Between-Session Challenge and Elicit Commitment

The clinician asks the patient to continue reviewing the materials handed out at this session and last week's session. The clinician also asks the patient to commit to completing one of the newly developed specific steps in the change plan. If the patient is uncertain which one to choose, discuss options and indicate that one good initial choice would be the step the patient is most ready to complete. If a significant/supportive other is involved in the session, the clinician elicits a commitment to follow through with a daily trust check-in, the recovery contract, and the support plan.

Review and Conclude the Session With a Discussion About the Remaining Sessions

The clinician reviews the session, asks the patient for feedback, responds empathically to his or her comments, and troubleshoots any difficulties. The clinician and patient should also discuss the likely scenarios for future treatment sessions. At this point, the clinician reminds the patient they will be meeting for 4–10 more sessions (in most cases) and that they have some flexibility as to what they can do for those meetings. The clinician should suggest the kinds of skill topics they might cover and seek input from the patient about how to spend the remaining sessions. Explain that the sessions focused on skills are meant to provide the patient with new tools for being able to make the important changes he or she has begun. See the sample language.

Clinician: I appreciate being able to get to know you over these few weeks and admire your courage in undertaking the important goals you have started to work on regarding

your use of cocaine. We will be meeting for 6 to 10 more weeks, and what I'd like to do is help you learn some new skills that are meant to help you with keeping your resolve. One of these sessions focuses on learning a skill called mindfulness, which can be very helpful for people trying to make a change the way you are. I also want to help you with the problem you described where you said it's sometimes difficult to say no when your friends offer you cocaine or invite you to a party. There are some other tools I want to share with you that I think will be useful. How do these ideas sound to you? Any questions so far? Okay, I look forward to meeting with you next time.

Tip for a Supporter

The clinician can explain to a supporter that if an event occurs without a chance to plan for it, the supporter might distract the partner or friend or offer support, depending on the situation. The clinician might say: You don't have to point out that you're doing it to prevent a return to using unless you think that would be helpful. Chances are a slip will happen. A slip is use that occurs after a period of abstinence. A slip doesn't mean a person will return to regular use. That would be a relapse. Slips occur when motivation is lagging or when a high-risk situation occurs unexpectedly. Slips do not mean that all the success and progress to date have been lost. How your partner or friend responds to a slip can mean the difference between returning to abstinence or going into a relapse. Figure 7 indicates some strategies for a supporter to help a partner or friend deal with a slip.

Figure 7. A Supporter's Guide To Helping a Partner or Friend Cope With a Slip

- Ask your partner or friend how the slip came about. Did he or she see it coming, or was it a sudden urge related to a situation? What was the situation? How was your friend feeling before using? Was he or she feeling down or angry or bored or wanting to celebrate?
- Ask about any attempts at avoiding the situation or coping strategies used in the situation. If he or she anticipated the situation and made little effort to avoid or cope with it, there is likely a motivation problem. Refer to the ideas in the section above on maintaining motivation.
- Ask whether any clues could have warned of a difficult situation. If the urge to use came up suddenly or the coping strategies used simply weren't effective, help your friend learn from this slip to prevent more slips in the future. Help him or her find new coping strategies to use in the future. Suggest other ways of coping.
- Help your partner or friend regain motivation and learn from what happened. Come from a position of support and encouragement. If your friend says things like, "I guess I just can't quit," or "using alcohol or other substances is not really that bad," challenge these statements. You know neither is true. Your goal is to get your partner or friend back on track, not to punish him or her for slipping. Attack the rationalization (I'm only going to smoke this one time), not the person. Say that those statements are rationalizations, they're a symptom of losing motivation, and it's time to focus on getting motivation back. Don't put the person down, criticize his or her willpower, or say the situation is hopeless. Making the person feel bad is likely to promote a return to use. When you show the person how his or her actions are a sign of losing motivation and show how to get that motivation back, you can help a slip stay merely a slip.

Feeling Appreciated

Does your partner or friend appreciate your efforts? Do you feel you're working harder at this than he or she is? If so, it's time to talk to him or her about it. You won't be any help if you are feeling burned out and unrewarded. Let your partner or friend know how you feel without accusing him or her of neglecting you. Point out that this would be a good time to renegotiate the supporter agreement. Start your conversation with the words "I feel," not "You haven't." Make sure you ask for what you want—a little acknowledgment, a relaxing or fun evening, a chance to talk, or other rewards for your efforts.

Session 3. Making Important Life Decisions

Introduction

Session 3 extends the motivational activities following the initial reflective and change plan discussions. It is designed primarily for patients in contemplation who may not be ready as yet to commit to any concrete change. This session is applicable to anyone making an important life decision. After normalizing ambivalence and supporting the patient to identify clear areas where decisions need to be made, the clinician focuses on providing the patient with a consistent decisionmaking method designed to provide clarity while increasing readiness and eliciting change talk. The handouts for this session include readiness rulers and the decisional balance, while the primary discussion strategies include scaling (using pre- and postreadiness rulers), pros and cons of change (using a decisional balance sheet), looking ahead, looking back, and imagining extremes.

A supportive other person may be invited to join session 3 to provide additional statements about the benefits of making a decision to stop using (or another important prosocial change) and if necessary an accurate recollection of "negative events associated with continued use." It is important for the clinician to monitor and prevent this from becoming a negative or overwhelming experience for the patient (e.g., the supporter is angry or frustrated with the patient over past use and threatens dire consequences).

Session 3 focuses on the following:

- Identifying key decisions that need to be made
- Decisional balance to tip the scales in favor of change
- Readiness rulers
- Affirming the patient's ability to take action on a decision

The Patient's Experience

- The patient experiences a nonjudgmental conversation about ambivalence and decisions regarding continued use or other important life decision.
- The patient learns a process for making decisions intentionally with comprehension and clarity.
- The patient develops a thorough understanding of current reasons for using and current reasons for making a different choice.

The patient commits to a "mini" sampling of reducing use to see if his or her assumptions are accurate and to experience any associated consequences and benefits. If a significant other is involved in the session, the patient also experiences additional concern and motivational statements supporting efforts toward engaging in treatment, discussing change, and considering a trial or sample of sobriety.

Clinician Preparation

MET Session 3. Making Important Life Decisions	
Materials ▸ Personal Reflective Summary ▸ Readiness Rulers (Pre and Post) ▸ Decisionmaking Guide	**Session Length** 45–60 minutes **Delivery Method** MET-focused individual therapy
Strategies ▸ OARS (Open-Ended Questions, Affirmations, Reflections, Summary) ▸ EDARS (Express Empathy, Develop Discrepancy, Awareness of Ambivalence, Roll with Sustain Talk/Discord, Support Self-Efficacy); identify stage of change ▸ MI Eliciting Change Talk, Current Motivation (Prereadiness Ruler), Elaboration, Looking Back, Looking Forward, Pros and Cons (Decisional Balance), Imagining Extremes, Readiness (Postruler) ▸ Develop "real-life practice challenge" (sampling sobriety)	
Goals for This Session ▸ Further explore the patient's attitudes/decision to continue using. ▸ Elicit ambivalence and increase verbalized discrepancies in favor of change. ▸ Use MI to strengthen change talk strategies and tools to enable visual record of the patient's goals. ▸ Provide patient with clear set of strategies for making important life decisions. ▸ Elicit commitment from patient to take one action step to reinforce decision made during session.	

Session 3 Outline and Overview

1. Engagement and assessment of the patient's readiness to proceed
    - Welcome the patient and continue to build rapport; address any obstacles to the therapeutic alliance.
    - Share the session agenda.
    - Ask whether any changes have occurred since the last meeting.
    - Discuss the decision to continue use, the benefits, and any consequences.
    - Review the between-session challenge(s).
    - Review the daily check-in and supporter plan completion.
2. Motivational strategy involving readiness for change?
    - Introduce important life decision of concern for patient (e.g., abstinence from substances, leaving or remaining in uniformed service, marriage or divorce, disclosure of sensitive information to an important other).
    - Introduce the readiness ruler.

- Elicit the patient's readiness score.
- Seek elaboration for current use levels, situation, and outcomes.
- Discuss the history of patient's life prior to substance use or situation.
- Discuss real and potential future for patient without change and with change.

3. Introduce and teach decisionmaking steps
    - Discuss concept of decisionmaking, normalizing ambivalence as part of the process.
    - Provide a rationale for focusing on decisionmaking.
    - Introduce idea that certain steps can make the decisionmaking process less overwhelming and potentially clearer.
    - Emphasize that while these steps can be used for any decision, today's session focus will be on the decision as to whether to continue use of substances or ____.
    - Give patient Decisionmaking Guide and review steps 1 through 5.
4. Complete steps 1 through 3 of the Decisionmaking Guide for decision regarding use.
    - Elicit the decision topic from the patient and options the patient can choose.
    - Using Decisionmaking Guide, explore pros and cons of each choice, including how the choice relates to patient's short- and long-term goals and the feelings each decision evokes.
    - Discuss the history of patient's life prior to use.
    - Discuss real and potential future for patient without change and with change.
    - Elicit the patient's top three statements in each category; end with the benefits of changing.
5. Using the readiness ruler in the Decisionmaking Guide, ask the patient to rate his or her readiness.
6. Summarize the change talk discussions, emphasizing any change in readiness:
    - Illustrate any increased readiness or continued ambivalence.
7. Have patient complete step 5 of the Decisionmaking Guide.
8. If appropriate, assign a between-session challenge, and elicit a specific commitment to complete the challenge:
    - If appropriate, discuss and help patient develop a specific reduction target, "sampling sobriety period," or stop date (if the patient has not already stopped using).
    - If the patient is not ready to make changes but is willing to engage in continued exploration, suggest committing to accurately monitoring use to identify any possibility of change or reduction.

- If the patient has decided to end treatment, affirm the patient's efforts to date and end in a positive fashion. It may be possible to ask the patient to think it over, talk about it with a significant other, and then call with a final decision in a day or two.

9. Conclude the session.

Session 3 Protocol

The clinician welcomes the patient, asks about the week in general, and proceeds to focus on use behaviors. The clinician uses rapport-building strategies to understand and nonjudgmentally reflect the patient's reasons and decision to continue using.

Clinician (C): Thanks for sharing the highlights of your week with me. You paint the picture of how busy you are at work and how much you need to find quick, easy ways to relax when you get home.

Michael (M): That's right. My time feels so limited and my energy is pretty low by the time I get home, and I just look forward to a couple of cold beers and a few hits off my pipe. Then I can settle into being with my wife and family for dinner, or whatever else is on the schedule.

C: You've identified an efficient and nice way of taking care of yourself to ease the transition from work to home life.

M: Right, and so when my doctor asked me to see you, I was a bit annoyed and wondered why, in the scope of all the possible problems, she figured I needed to address this first. Anyway, I'm still not convinced I need to change, even though the assessment and our first discussions make it clear that my regular and long-term use of alcohol and weed, combined with my lack of exercise, is contributing to my risks for heart trouble.

C: That makes sense because your habit of relaxing works well, and why bother changing if there is no immediately obvious sign of damage to your health but rather a risk in the future.

M: You said that perfectly. There's just not enough reason for me to change right now.

The clinician takes out the readiness ruler sheet and asks the patient to respond to the first ruler by marking the appropriate level of "readiness." The clinician explains this will also be looked at after talking today. (The delivery of the prereadiness ruler can be adjusted in any way that is appropriate for the patient; it can be handed out in the second session as part of the between-session challenge and then discussed at the beginning of session 3 as a way to get into the conversation about readiness.)

C: All right, you sound pretty definite about your position here. And it can be helpful to actually state a number on where you stand now with regard to changing your use, a baseline marker (similar to a cholesterol test), so if for any reason you decide to make changes, we can see where you started. Here is a ruler and I'd like you to score where you believe you stand right now.

M: That's easy. I'm like 10 percent on this. I know there are a few important health reasons to do something, but like I said, it's just not enough now.

The clinician takes out the Decisionmaking Guide and readiness ruler sheet and introduces the idea of learning a decisionmaking process. The clinician could say something like:

C: I get it. While you care about your health, being able to use is really important to you. Given that you're not really in a place to want to make a big change right now, would you be willing to talk with me just a little bit more today? I'd like to talk to you about a few strategies that can help you make and commit to important life decisions. Many individuals wrestle with making important life decisions: a soldier telling his commander that he has an alcohol problem; partners deciding whether to stay in or leave a relationship; stopping drinking or drug use are a few examples. Sometimes, when we feel overwhelmed or unsure of what direction to go, being able to go through a set of steps can slow things down, help us to think logically, and remind us of our goals and how our choices can affect our ability to reach our goals. While these steps can be used for any type of decision, I thought it might be helpful if we use them to go through your choices around your use. How does that sound to you?

The clinician reviews steps 1 through 5 generally on the Decisionmaking Guide. After briefly teaching the patient about the five steps, the clinician then begins to engage the patient in a decisionmaking discussion about use using the five-step process. The clinician should have the Decisionmaking Guide out to complete with the patient.

The clinician may use strategies to elicit change talk but clearly realize the patient is on the low end of desire and perceived reasons for needing to change. The clinician asks the patient to think back to a time when he did not regularly use to relax and to discuss the differences. The clinician probes for other strategies the patient used in the past to feel good after a busy day. Then the clinician asks the patient to look ahead, assuming there are no changes, to predict what life and health will feel like. The clinician reflects and illuminates the differences between the two descriptions: (a) when not using but doing other activities and (b) when use is continued into the future. The patient is asked to look at the Decisionmaking Guide and asked to list the pros and cons.

- Accept all answers (do not argue with answers given by patient).
- Explore answers.
- Be sure to note both the benefits and costs of current behavior and change.
- Explore the costs/benefits with respect to patient's goals and values.
- Summarize the costs and benefits.

After the patient completes a few statements for each category, the clinician asks the patient to read them aloud, finishing with the benefits of changing use. The clinician summarizes the benefits and returns to the *Learning New Coping Strategies* handout describing a few potential replacements for the patient's stated benefits of use. Next, the clinician switches gears and asks the patient to imagine some possible extremes in a real future without change.

C: What will it be like in a few years if you continue using and go back to your doctor for a cardiac wellness visit? What's the worst news you can imagine getting?

M: I never really like to think about that. Like I said, I just live day to day and that kind of thought is above my pay grade, but since you're asking….I guess I could find out my cholesterol is too high and be told to take Lipitor or some pill like that. My doc might also tell me that he strongly recommends I quit substances to avoid some kind of stroke or heart attack or something. (My relative had a heart attack at 54. That was really scary)

C: The risks get worse until you are forced to take medication and live with the chances of a serious heart condition.

M: Yeah, but we all take risks every day. This is one my doc, my family, and now you care to talk about.

The clinician summarizes the Decisionmaking Guide discussion. The clinician then reassesses the patient's readiness to stop using the readiness ruler. If there is a shift, the clinician should evoke from the patient his or her thoughts and feelings about the shift. The clinician can then shift the discussion by asking the patient in an open-ended manner, what she or he intends to do around their use. If interest in any degree of change is stated, negotiate a plan for reduction of use or stopping altogether.

Review and Conclude

There are several possible outcomes after this motivational enhancement change talk discussion. If remaining undecided, the patient may be encouraged to continue exploration and remain in treatment until reaching a clear decision. The clinician might ask him or her to try "sampling a sobriety period" or suggest continuing to raise self-awareness and committing to accurately monitoring use to identify any easy targets of change or places to make reductions in use. If the patient commits to stopping use of substances, the clinician can introduce change plan tools from sessions 1 and 2.

Session 4. Enhancing Self-Awareness

Introduction

Session 4 focuses on helping the patient begin to understand and make sense of the way alcohol or other substances have been used. Patients often view themselves and their behavior as somewhat of a mystery. They may feel puzzled and confused about what they do and why they do it. By helping a patient take greater notice of how things are happening in life, with specific focus on alcohol and substances, the clinician provides a powerful tool and builds the important capacities for reflection and self-awareness.

There are many ways to increase self-awareness. The CBT approach makes use of "functional analysis," a way to carefully examine the patterns of alcohol and substance use. Even if a patient has been involved with substances for a long time and sees himself or herself as highly self-aware, the person may be surprised by what is revealed during an indepth inquiry.

The clinician is encouraged to discuss with the patient many aspects of use patterns. It is helpful to learn about the conditions where the patient is more and less likely to use. Conditions may be external (e.g., being with particular people or in certain places), and they may be internal (e.g., feelings, thoughts, general states of mind, associations).

The Patient's Experience

In session 4, the patient is able to explore patterns of use in a nonjudgmental atmosphere. He or she is encouraged to share many aspects of experience with alcohol or other substances, such as when, where, and under what circumstances use is likely. The patient is also supported in discussing the positive and negative impacts of use to develop better self-knowledge and a fuller picture for the clinician. The patient may begin to identify potentially useful coping strategies to reach goals in relation to substance use.

Clinician Preparation

CBT Session 4. Enhancing Self-Awareness	
Materials ▸ Knowledge Is Power handout ▸ New Roads worksheet ▸ Learning New Coping Strategies/Menu of Options ▸ Future Self Letter ▸ Relaxation Training	**Total Time** 1 hour **Delivery Method** CBT-focused individual or group therapy
Strategies ▸ OARS (Open-Ended Questions, Affirmations, Reflections, Summary) ▸ Support self-efficacy ▸ Demonstrate skill, role-play ▸ Follow CBT skills session reminders	
Goals for This Session ▸ Begin to learn and practice skills that enhance self-awareness. ▸ Introduce the patient to the rationale for coping skills training. ▸ Examine the patient's high-risk situations, triggers, and coping strategies.	

Session 4 Outline and Overview

1. Build rapport and review:
    - Welcome the patient; check in about the week in general.
    - Review the patient's cravings, recent use experiences, and successes.
    - Review the between-session challenge.
    - Attend to the therapeutic alliance and address any obstacles, concerns.
    - Assess motivational factors and change readiness.
2. Explore the development of addictive patterns:
    - Provide rationale, such as the learned or associative nature of addiction (pairing with alterations in thinking and feeling).
    - Using the patient's own experiences, illustrate how using alcohol or other substances can change one's feelings; if the patient has not stated any examples, provide examples that are appropriate to his or her situation.
    - From the patient's stated use situations, identify examples of environmental triggers for use; ask the patient for other triggers he or she has experienced.
    - Elicit examples of feelings, beliefs, or automatic thoughts people may have about substances; use examples provided by the patient, and ask the patient for more examples.

- Suggest that the patient start the process of change by understanding his or her behavior; ask, "Does this make sense to you?"

3. Empower though self-knowledge; understand high-risk situations and triggers. Explore with the patient—
    - Typical use situations (places, people, activities, time, days)
    - Triggers for use
    - A recent use situation
    - Thoughts and feelings at use times (tense, bored, stressed, etc.)
    - Complete *Knowledge Is Power* and summarize the list
4. Put the pieces together: draw connections, consider new roads, and build coping strategies:
    - Emphasize the importance of coping strategies.
    - Reintroduce Learning New Coping Strategies.
    - Introduce a drawing connection exercise and identify new pathways toward desired outcomes.
    - Ask patient to identify strategies he or she has tried and those that might work best.
5. Develop or elicit a specific between-session challenge that incorporates material from the session.

Session Protocol

The clinician welcomes the patient and provides an overview of the session. In this session, the clinician draws on information from previous sessions to increase the patient's understanding about use patterns.

Building Rapport and Review

To continue building rapport with the patient, begin the session by eliciting information about life during the past week. Initially, try to focus on nonproblem areas. This is an opportunity to learn about the patient's interests and strengths. Such information can be used later to develop strategies for addressing the patient's substance use. The clinician continues to use MI skills to do this and always expresses genuine curiosity about the patient's life.

> *"How have things been since we last met?" Or, "Tell me about something enjoyable you did during the past week?"*

If the patient cannot think of anything enjoyable during the past week, ask about interests and activities the person is likely to engage in, even if not during the past week.

> *"Tell me about some of your interests or hobbies?" Or, "What kinds of things do you like to do in your free time?"*

Continue by asking the patient how he or she has been doing over the past week regarding alcohol and/or drug use.

> *"Tell me about your [drug(s) of choice] use during the past week?" Or, "What has your use been like since we last met?" Or, "What thoughts have you had about your use since we last spoke?"*

Guidelines

Listen for possible changes in the patient's behaviors, thoughts, and feelings regarding use. Try to refrain from asking many questions. Let the patient tell you how she or he has been doing regarding his or her use or abstinence. Respond with reflective comments, and attempt to elicit the patient's own motivation-enhancing statements. Affirm any efforts made to reduce use and look for opportunities to support the patient's sense of self-efficacy. If there has been little or no change in the patient's use, look for opportunities to develop discrepancy through the use of double-sided reflections, exploring pros and cons, and seeking elaboration.

Explore the Development of Addictive Patterns

The clinician asks the patient to look closely at his or her behavior, environment, and beliefs to identify addictive patterns. See the sample language provided.

> *We think of repeated substance use as learned behavior. When people start to use alcohol or other substances a lot, they learn that it changes the way they feel. For example, some people use it like a tranquilizer to help them cope with stressful situations. Some use it when they feel blue. Others expect it to enhance positive feelings. Some think it makes them more confident. And some use it to avoid thinking about troublesome things. How does that fit with your experience? [Waits for answer.]*
>
> *After a while, things in the environment can trigger use, sometimes without your even realizing it. The environment can trigger cravings. Things in the environment that can trigger use include seeing or smelling alcohol or other substances, being around people who are using, or being in stressful situations. During the assessment session, we talked about the connection you've noticed between getting paid on Fridays and buying alcohol. Are there other connections like that for you?*
>
> *People often develop beliefs about substances they are using. These are ideas or "automatic thoughts" you've come to believe about you and your substance use. I've heard you say things in previous sessions like, "I can't be creative or work effectively without it," "I can't take the way I feel when I've tried to quit," "I need to change, but it's not worth the effort." What other beliefs do you have about you and [____]?*
>
> *Substances can change the way a person feels, acts, and thinks. To help you avoid or cope with the situations in which you smoke and to help you find things you can do instead of using, let's start by working on understanding your behavior. Does this make sense to you?*

High-Risk Situations, Triggers, and Patient Empowerment Through Self-Knowledge

The clinician explains that substance use behavior is learned over time. The patient's understanding of his or her use patterns can help the patient change those patterns. Understanding high-risk situations can help the patient avoid or cope with those situations. See the sample language provided.

> *If using alcohol or other substances changes the way a person acts, thinks, and feels, it's helpful to begin by identifying use patterns and habits. Once your patterns are identified, you may find it easier to change your behavior. You can find ways to cope with your high-risk situations without using. Change involves learning specific skills and strategies. Once you know about the situations and problems that contribute to your using, you can look for other ways to handle those situations. What do you think about that?*

The clinician focuses on the patient's behaviors and high-risk situations. See the sample language provided.

> *In what situations do you use alcohol/substances (e.g., places, people, activities, specific times, days)?*
>
> *What are your triggers for using (e.g., when you're in a social situation, when you've had a tense day, when you're faced with a difficult problem, when you want to feel relaxed)?*
>
> *Can you describe a recent situation when you used (e.g., a relapse story)?*
>
> *Can you remember your thoughts and feelings at the time you used (e.g., tense, bored, depressed, stressed, overwhelmed, angry)?*
>
> *What were the consequences of using?*

Guidelines

Knowing what affects someone's own use gives more personal awareness (power) to decide whether to use or not use. Looking at the pros and cons of what happens after use also increases understanding and helps the individual make the decision about use in the future. Hence, the name of the worksheet for understanding more about triggers is *Knowledge Is Power*.

Provide the patient with the *Knowledge Is Power* handout. Walk through the form as the patient fills it out as it relates to personal use from the previous week or a recent use episode.

> *Can you describe in detail the last time you used or had an opportunity to use? As you recall the incident, see if you can identify the triggers, thoughts and feelings, decision to use, and pros and cons of your use.*

Ask the patient to read the columns in the *Knowledge Is Power* handout and follow up with a series of questions to help generate statements for each required column. Get the patient to verbalize responses to each section of the handout before writing it down. This enables offering

feedback/suggestions before anything is put on paper. The patient is less likely to feel criticized this way.

For example: "Many people report that a common trigger is a negative situation such as a fight with others and the bad feelings that arise as a result." Has this happened to you recently? Generate a discussion with the patient regarding personal triggers. Then, have the patient fill in the *Knowledge Is Power* handout.

> *"Now that we've filled in your Knowledge Is Power worksheet, I'd like you to read it aloud." To emphasize nonuse decisions, it is also good to ask, "Can you give me an example of a time when the same trigger did not result in your using?"*

Indicate that this situational analysis—via the *Knowledge Is Power* worksheet—is something you hope the patient will continue using between sessions to help support decisions and steps toward reducing use and improving future wellness.

For example: "We think self-awareness and self-knowledge are essential to breaking the cycle of negative habits (such as automatically drinking) that some people get into. Instead, using the *Knowledge Is Power* worksheet makes us take a moment to think about all the elements prior and after our actions. This will help us understand how to avoid, replace, and cope with the thoughts, feelings, and situations in new ways."

The clinician asks the patient about alcohol/substance use behavior using MI techniques (e.g., reflection, expressing empathy) while learning important information about the patient's use environment. See the sample language provided.

> *Clinician (C): In what situations do you find yourself using?*
>
> *Doug (D): When things get hectic at home. Between my wife and my son, it seems as if everyone is out to get me. When I smoke, I can cope with them.*
>
> *C: Using helps you cope with stress at home. Are there other situations when you smoke?*
>
> *D: Not right now. When I go home, I should be able to relax, but with all the nagging, I end up using to escape.*
>
> *C: You want your home to be peaceful, but conflicts over your using push you to smoke.*
>
> *D: Yeah; sounds crazy, doesn't it?*
>
> *C: Your situation is difficult. Things you identify that lead you to smoke are called triggers. You've said that conflicts at home trigger you to smoke. What are your thoughts and feelings during times of conflict at your house, right before you light up?*
>
> *D: I'm thinking that if everyone would get off my back, I might be able to quit using. But they don't, and it's the only way I know how to relax.*
>
> *C: You find yourself in a bind. Let's use the Knowledge Is Power document [presents it] to list the things we're talking about. You said using [____] helps you relax. What else does it do for you?*
>
> *D: It helps me sleep. When I don't get high, it's hard getting to sleep. I used to enjoy the high a lot more than I do now. I keep using, but I don't even get that high anymore.*
>
> *C: Sounds as if you're listing the negative parts of using. Are there others?*

Together the clinician and patient fill out the *Knowledge Is Power* handout. Complete for two recent experiences (one internal, one external, if possible), or one use and one nonuse example.

Putting the Pieces Together: Draw Connections, Consider New Roads, and Build Coping Strategies

Identify Positive Effects

The patient will likely have discussed some positive effects in the course of identifying triggers and listing consequences. Summarize these and ask the patient to identify other desired effects of substance use.

> *I have already learned about some effects you look forward to when you drink, like feeling some relief from stress and forgetting about the day. I am wondering what other effects of drinking you enjoy?*

Use of evocative questions can be helpful for eliciting multiple effects. Both positive reinforcement (e.g., euphoria, drug effects) and the negative reinforcement (e.g., numb feelings, stop worrying) that may result from substance use should be considered as factors that maintain substance use.

> *What else?*
>
> *If you stopped using alcohol today, what would you miss most?*
>
> *Does drinking make some things in your life more tolerable?*
>
> *What is the feeling you are looking for when you have your first drink of the night?*

Directive questions can also be used as needed:

> *You mentioned drinking in some social circumstances. What do you think alcohol does for you in that type of situation?*

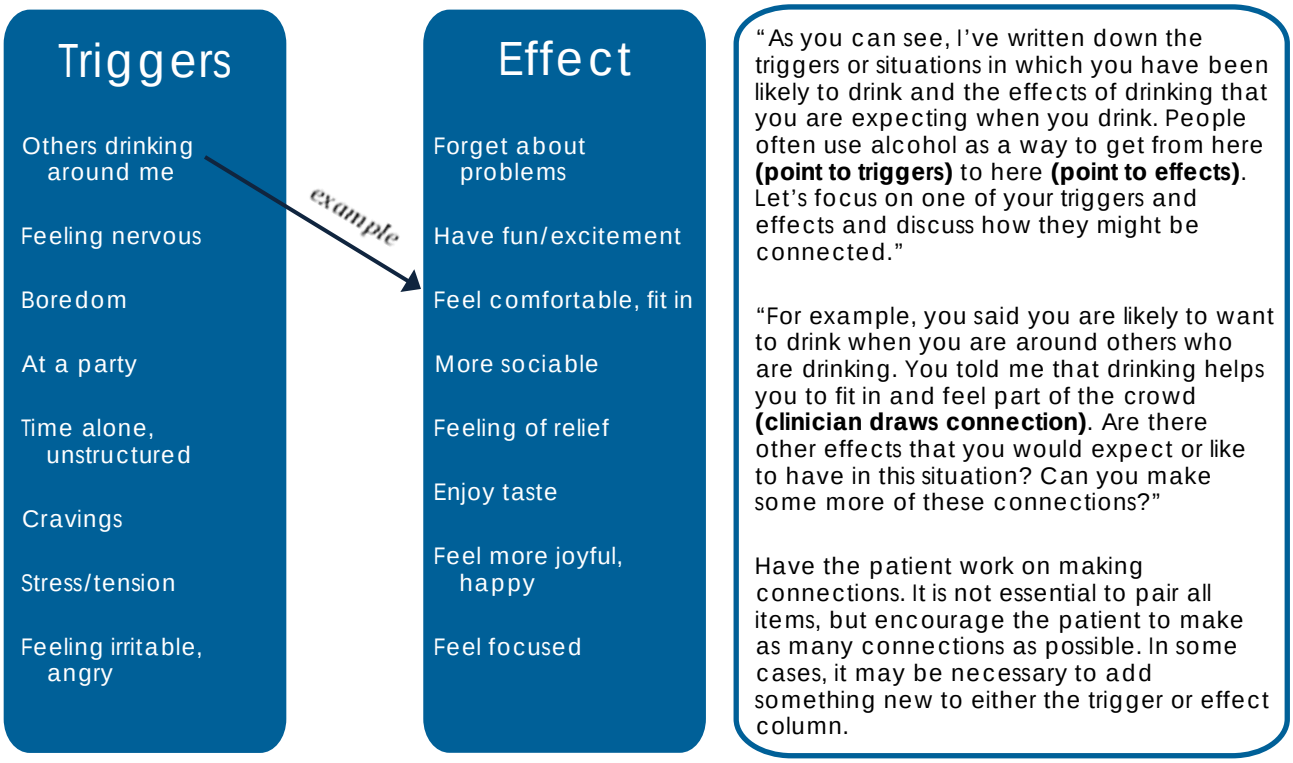
Summarize Effects

> *It sounds like we have gotten most of these. Let me read back what we have come up with so far. Some of the desirable effects of drinking that you see include reducing stress, forgetting about the day, feeling more socially confident, being able to stand up for yourself, feeling some excitement, feeling rewarded, and relieving boredom. Does that sound about right? This probably accounts for most of the effects you are looking for when you drink but perhaps not all. If you think of something else, we can always add it later.*

Draw Connections

The clinician should help the patient make a connection between the triggers and the effects on the *New Roads* worksheet (see figure 8).

Figure 8. New Roads Worksheet



Discuss Psychological Dependence

The relationship between triggers and effects is a good representation of how the patient has come to rely on substances to achieve a desired effect or to cope with some unpleasant circumstances. Attempting to cut back or quit using substances often causes an increase in discomfort for the patient, and without other options to manage the distress, continued substance use is more probable. This psychological dependence on substances will persist until the patient has addressed the deficit in coping skills and found more adaptive means for achieving these effects.

> *You have mapped this out well. One thing I noticed right away is that almost every trigger leads to this effect of "feeling relaxed." It is clear that feeling relaxed is an important effect for you, and drinking is how you get there most of the time.*

What we have here is a map of how you have come to depend on alcohol in your life. If alcohol dependence were just a physical problem, you could get a 3-day detox and come out never wanting to use again. In some way, this is a map of what keeps you using alcohol even when you may not want to. This is psychological dependence. Over time you have come to depend on alcohol to achieve these positive effects. When you stop drinking, you may begin to feel uncomfortable, not because of any physical withdrawal, but because you are not finding a way to get from this side (point to triggers) to this side (point to effects). Breaking the psychological dependence involves finding another way to get from the trigger to the effect that does not involve alcohol. If you can find ways to achieve some of these effects without drinking, I think you are going to have a lot less desire for alcohol. What do you think?"

Consider New Roads

Introduce the idea of finding a new road or path for achieving desirable outcomes in each trigger situation.

> *So I am curious. As you look at all these triggers and the desired effects, can you think of any way you could get a similar effect you are looking for without alcohol as a new road or path?*

If the patient has trouble identifying any alternative coping strategies, reminding the patient of alternative strategies that he or she talked about in previous sessions may be helpful for moving the discussion forward.

> *Earlier you told me that watching TV is a good escape from reality for the moment. This is one way to get this effect of forgetting about problems. Can you think of any other ways?*

As the patient discusses current coping strategies and possible new means for achieving the desired effects, reflect and affirm as needed.

> *Exercise has worked for you in the past when you are feeling stressed, and it may be something that could help you again now. These are great ideas you are coming up with. What else can you imagine would help you get from any of these triggers to the desired effects without drinking?*

The clinician keeps a detailed account of the new roads the patient identifies over the course of this discussion, and when the patient has run out of ideas, the clinician summarizes the patient's strategies.

> *You have really done a great job coming up with other ways to achieve these effects without needing to drink to get there. You have things you have been using for a while that work in some of these situations. You also have some ideas about new strategies you could try for a few of these trigger situations, such as exercise, distracting yourself, and leaving your house when you are bored. These are all great ideas.*

The clinician emphasizes the importance of coping strategies. See the sample language provided.

> *We've talked about your high-risk situations and triggers, and we have started to make connections between several important things. This is important because many people are unaware of how they put themselves at risk for using. Now we'll focus on coping with these situations in ways that will help you resist the urge to use. You've already read the (Menu of Options) Learning New Coping Strategies (presents session 2 handout again). Let's take a few moments to go through it and identify the strategies you've tried and others that might work. Remember, some strategies involve things you can do or specific actions you can take, some involve ways of thinking, and some involve other people or your surroundings.*

Assign a Between-Session Challenge

The clinician gives the patient a blank copy of *Knowledge Is Power* and asks the patient to document episodes of craving or desire for substances between this session and the next one. The clinician chooses an appropriate assignment from among the following and reviews the instructions with the patient:

- Write a future self letter
- Practice relaxation training

Review and Conclude

The clinician reviews the content of the session, asks the patient for feedback, responds empathically to his or her comments, and troubleshoots any difficulties. The clinician explains that the patient will report back on his or her efforts to complete the between-session exercises at the next session. The clinician prepares the patient for the upcoming session by briefly describing the topic and how the skill addressed will support the patient's needs. This emphasizes and builds a positive expectation for the upcoming work.

Session 5. Handling Urges, Cravings, and Discomfort (Urge Surfing)

Introduction

Session 5 focuses on helping the patient gain an overall understanding of urges, cravings, and triggers. After normalizing the occurrence of automatic thoughts or urges, the clinician helps the patient identify how and when he or she experiences urges or automatic thoughts. The clinician and patient collaborate on developing a menu of coping or response strategies that are relevant to the patient's experiences and his or her environment. The session concludes with the clinician encouraging the patient to track his or her urges and coping and response strategies during the week. The clinician suggests reviewing them with the patient at the next session.

The Patient's Experience

The patient will leave the session with—

- A general understanding of the nature of cravings and urges
- An increased understanding of his/her own urges and cravings
- The ability to identify specific triggers or cues for cravings
- An awareness of his or her preferred strategies for addressing cravings

Clinician Preparation

<table>
<tr><th colspan="2">Session 5. Handling Urges, Cravings, and Discomfort (Urge Surfing)</th></tr>
<tr><td>Materials
▸ Coping With Cravings and Urges
▸ Urge Surfing
▸ Daily Record of Urges To Use</td><td>Total Time
1 hour
Delivery Method
CBT-focused individual therapy</td></tr>
<tr><td colspan="2">Strategies
▸ OARS (Open-Ended Questions, Affirmations, Reflections, Summary)
▸ Support self-efficacy
▸ Demonstrate skill, role-play
▸ Discuss value of journaling-type activities
▸ Follow CBT skills session reminders</td></tr>
<tr><td colspan="2">Goals for This Session
▸ Enhance the patient's understanding about cravings and urges for alcohol or another drug.
▸ Identify specific triggers or cues for cravings (see Carroll, 1998).
▸ Review and practice specific skills for addressing cravings.
▸ Examine the patient's high-risk situations, triggers, and coping strategies.</td></tr>
</table>

Session 5 Outline and Overview

1. Provide reasons for focusing on cravings.
    - Provide basic information about the nature of cravings:
        - Cravings are experienced most often early in abstinence but can occur weeks, months, even years later.
        - Cravings may feel very uncomfortable but are a common experience.
        - An urge to use does not mean something is wrong.
    - Give patient the Coping With Cravings and Urges handout.
    - Provide a framework for understanding craving as a subset of the universal experience of longing or desire.
2. Identify cues or triggers for cravings.
    - Give the patient examples of common cues:
        - Exposure to alcohol, substances, or paraphernalia
        - Seeing other people using substances
        - Contact with people, places, times of day, or situations associated with using
        - Particular emotions and physical feelings
    - Distinguish external or environmental triggers from internal states.
    - Review the patient's experience of cravings or urges.
3. Discuss strategies for coping with triggers:
    - Avoidance
    - Escape
    - Distraction
    - Embrace
4. Complete exercises:
    - Make a list of craving triggers.
    - Make a plan for managing craving.
5. Assign between-session exercises.
    - Encourage the patient to review the handouts before the next session.
    - Encourage the patient to practice urge surfing.
    - Complete the Daily Record of Urges To Use.
6. Review and conclude the session.

Session Protocol

Welcoming Back and Strengthening Rapport

The clinician welcomes the patient and provides an overview of the session in which the clinician supports the patient's experience and efficacy in making desired changes. The clinician inquires about the previous week and the previous week's challenges, including successes and challenges that may have occurred. The clinician also asks about the patient's experiences with cravings and current coping methods. See the sample discussion provided.

> *Many people report they have strong urges to drink or get high when they first stop using. In the beginning the urges can feel overwhelming and hard to manage. Is this something you've experienced when you've tried to stop using?*

Some important messages the clinician conveys about urges during this discussion are summarized below:

- Urges are common during recovery.
- Learning to identify urges is important for gaining control over them.
- Urges are predictable and have understandable triggers.
- Identifying triggers can help in the selection of effective coping strategies.
- Everyone can learn to manage his or her urges.
- Urges are like stray cats: If you don't feed them, they go somewhere else.

Eliciting the patient's view first is the most desirable approach. However, if the patient is not able to provide this information, the clinician should be more direct in approaching the discussion to cover the points listed above. In this discussion, it is important to try to understand the patient's experience with urges in the past, including his or her overall perception of the predictability of urges and confidence in managing them. Once the clinician has reviewed the points, it is helpful to summarize what has been learned about the patient's perception of urges. See the sample discussion provided.

> *Before we move on, let me see if I've heard you correctly so far. It sounds like you've experienced quite a few urges in the past when you've tried to stop using. There have been times when you were able to deal with them, but there have also been other times when you've given into them. Your urges are generally more frequent and intense in the first few months after you stop using, but when you've been able to hang in there you've noticed you have urges even sometimes when you are really committed to not using, and you tend to feel discouraged and disappointed in yourself for having these urges. When this happens, you also feel less confident about your ability to stay sober.*
>
> *Although part of you realizes that having urges is normal and to be expected, you worry about your ability to manage them some of the time and would like some help with that.*
>
> *So, it may be helpful to talk more about how you experience urges to get a better handle on them.*

Introduce the Concept of Urges or Cravings and Their Role in Substance Use

Provide your patient with a framework for understanding the role of cravings. Explain that when someone tries to quit using alcohol or another substance, he or she often has cravings or strong urges to use that could be triggers for relapse. Normalize the experience of cravings, not just in the area of substance use. Cravings and desires for things are universal human experiences and can cause discomfort and suffering. Throughout life, people struggle with wanting things or the belief they would feel better and be happier if only they had [____] (e.g., a new house, a better job, a more satisfying relationship). The craving or urge for alcohol or substances is no different from this basic human experience. When one can recognize that craving, and the discomfort that comes from this unfulfilled experience is universal, the craving may become more manageable. It is also important to understand that giving in to the craving or urge does not usually solve the underlying problem of discontent and can reinforce it. The saying, "The only thing worse than not getting what you want is…. getting it" has relevance here. The patient can be helped to see craving as just another psychological state—like sadness, joy, or fear—that need not take on special importance.

Provide Reasons for Focusing on Cravings

The clinician gives the patient *Coping With Cravings and Urges* and explains the importance of recognizing cravings.

> *Clinician (C): Cravings often are experienced when a person first tries to quit, but they may occur weeks, months, even years later. Cravings may feel uncomfortable, but they are common experiences. An urge to smoke doesn't mean something's wrong. Many people learn to expect cravings on occasion and how to cope with them.*
>
> *Things that remind you of using alcohol or other substances can trigger urges or cravings. Physical symptoms include tightness in the stomach or feeling nervous throughout the body. Psychological symptoms include thoughts about how using alcohol or other substances feels, recollections of using, developing plans to get alcohol or other substances, or feeling that you need alcohol or other substances.*
>
> *Cravings and urges usually last only a few minutes or at most a few hours. Rather than increase until they become unbearable, they usually peak after a few minutes and then die down, like a wave. Urges become less frequent and less intense as you learn more methods for coping with them.*

Identify Cues or Triggers for Cravings

The clinician talks about triggers or cues, which can be external or environmental, or internal.

> *It's important to learn how to recognize triggers so you can reduce your exposure to them. Common triggers include—*
>
> - *Exposure to alcohol, substances, or paraphernalia*
> - *Seeing other people using substances*
> - *Contact with people, places, times of day, and situations associated with using (such as people you used with, parties, bars, weekends)*

- *Particular emotions (such as frustration, fatigue, feeling stressed), even positive emotions (elation, excitement, feelings of accomplishment)*
- *Physical feelings (feeling sick, shaky, tense)*

Some triggers are more difficult to recognize. Self-monitoring can help begin to identify them. The easiest way to cope with cravings and urges is to minimize their likelihood of occurring. You can reduce your exposure to triggers by getting rid of alcohol or substances in your home, not going to parties or bars, and limiting contact with friends who use.

Discuss the Patient's Recognition of an Urge

Discussing what the patient experiences when he or she has an urge may help the patient identify an urge early and respond before it becomes overwhelming. There are many different ways of experiencing an urge, only some of which are recognized by most patients (e.g., physical sensations). Recognizing all aspects of the experience of an urge will help the patient label the experience and prevent automatic responses (i.e., returning to alcohol or drug use). This should enhance the patient's ability to manage urges. The clinician may explore with the patient the various ways an urge may be experienced. This is important before moving on to coping strategies to ensure the patient can recognize it.

Some examples appear below:

- Physical sensations (e.g., sweating, heart racing, queasy stomach)
- Thoughts (e.g., "wouldn't it be nice to have a drink," "I'd rather be with my friends getting high tonight")
- Positive expectancies (e.g., "I'd feel better if I did some cocaine")
- Emotions (e.g., anxiety, depression, irritability)
- Behaviors (e.g., pausing while passing the beer display in a store, going by an old neighborhood where the drug dealer hangs out)
- Experiencing hunger

Open-ended questions about the patient's experiences with urges can be used to explore the patient's awareness of the symptoms of an urge.

We've spent some time talking about your general experiences with urges. Before we move on to talking about coping with urges, I'd like to get a better sense of how you know when you're having an urge. Some urges may be very easy to recognize, but others are less obvious. I'm wondering how you know when you're having an urge.

What is the first thing you notice when you are having an urge? How do you know that an urge is coming on?

What is the most obvious sign that you are craving alcohol?

If somebody were with you when you were experiencing an urge, would they notice anything?

As the discussion progresses, the clinician may want to ask more directed questions for the areas the patient has not already identified.

Physical Sensations

I'm wondering if you can tell me a bit about the physical sensations you experience when you have an urge to drink or use drugs.

Thoughts

What about your thoughts? What kinds of thoughts do you recall having when you wanted to use alcohol or drugs?

Positive expectancies

People say they imagine something positive will happen if they drink or use drugs. For instance, they think it will help them unwind after a tough day, or they will have a better time with other people, or simply help them feel better. What types of positive expectations have you had when you had an urge to use?

Emotions

Many people find their mood changes just before they use…they feel anxious or depressed. Other people report feeling excited. I'm wondering what types of mood changes you've noticed.

Behaviors

Do you find yourself becoming less tolerant or more irritable? Do you find yourself getting into more arguments or fights with people? Do you find yourself hanging around more in some of the old places, or with people that you used to drink or get high with? Have you impulsively decided to leave treatment?

Discuss the Patient's Recognition of a Trigger

At this point in the session, it might be helpful for the clinician to summarize what he or she has learned about the patient's experience of urges and transition to identifying triggers for having urges.

It sounds like you have a good sense of how you experience an urge, particularly when it comes to the physical sensations. You've noticed your heart starts racing and you feel a knot in your stomach.

The goal of the next discussion is to establish a link between triggers and urges. Triggers are generally situations associated with a patient's use of alcohol or drugs in the past. With this repeated association, the patient tends to have urges in these situations when stopping or making attempts to cut down. If a patient understands this connection, it may make the urges more predictable. If the patient feels urges are somewhat predictable, this should help the patient feel more in control and also make it easier to identify specific coping strategies that may address urges in response to specific triggers.

The clinician should follow this brief explanation and presentation of examples by asking the patient about his or her triggers for urges. Once again, it is important for the clinician to begin by asking, in an open-ended format, about the patient's understanding of triggers. Triggers can be recorded on the *Personal Triggers* handout as the patient identifies them. The *New Roads* handout completed in session 3 may provide valuable information about triggers that can be used to supplement this discussion. If information about various types of triggers is not elicited, the clinician may follow with more directive questioning and discuss some of the common triggers listed below.

Using the common triggers described below, it may be helpful to guide the discussion about internal and external triggers for urges. Primarily, it is important to let the patient know urges can be external (things that happen outside the person) or internal states (such as thoughts, feelings, ideas).

External situations

- Exposure to alcohol or drugs
- Smell, sight, and sounds of other people drinking or using drugs
- Particular times during the day when drinking or drug use tended to occur (e.g., getting off work, weekends, payday)
- Stimuli previously associated with drinking or drug use (e.g., wine glasses, bar, crack pipe, medicine bottle, ATM machine)
- Stimuli previously associated with withdrawal (e.g., hospital, aspirin, morning)

Internal states

- Unpleasant emotions (e.g., frustration, depression, anger, feeling "stressed out")
- Pleasant emotions (e.g., elation, excitement)
- Physical feelings (e.g., sick, shaky, tense, in pain)
- Thoughts about drinking or drug use (e.g., "I'll feel better if I get high")
- Beliefs or ideas such as, "I will always be an addict"

Discuss Strategies for Coping With Triggers

Since it can be expected that the patient will experience triggers for use, the clinician presents several categories and examples of coping strategies that have been found to be helpful.

> *Many times cravings can't be avoided, and it becomes necessary to cope with them. The nice part of that is there are many strategies that can be helpful for coping with cravings/urges. I want to talk about some different ways people have learned to cope with urges and cravings and we can consider which might be a good fit for you. How does that sound?*

Helpful Strategies

Avoidance. Avoidance is a strategy that involves reducing exposure to high-risk situations that trigger urges. Avoidance appears especially important early in recovery.

Examples of avoidance strategies include—

- Get rid of alcohol or drugs at home.
- Avoid parties or bars where drinking or drug use occurs.
- Reduce contact with old friends who drink or get high.
- Avoid circumstances that increase temptation (e.g., cash in pocket, unstructured free time, home alone).

Escape. Escape is a strategy that focuses on finding a safe way out of situations where an urge might occur. This may involve an unexpected situation (e.g., drug dealer shows up at the door) or a situation the patient sees as unavoidable (e.g., wedding). The patient should have a plan for getting out of the situation as quickly as possible if strong urges occur.

The clinician should recommend that the patient consider the following when making his or her plan for escape:

- Have the means ready; be careful not to get stranded without the means for getting out of a situation if necessary (e.g., transportation).
- Plan what to say or do; know what to say to people if leaving a risky situation in a hurry.
- Feel good about your choice; using escape is a sign of strength and determination to stick with your goal; don't be dissuaded by pressure from people to do what you have typically done in the past.

Distraction. Distraction is a strategy involving a shift in attention away from thoughts about using alcohol or drugs. There are numerous distracting activities that can take a patient's mind off urges to use alcohol or drugs, such as going to a movie, calling someone, reading a book, or exercising. Urges tend to pass more quickly when a person becomes involved with an alternative activity. The clinician might offer guidance as follows:

Embrace or "sit with" the urge. Sometimes patients may need to face the urge and cope with it directly, and the following embrace strategies may help:

- Talk it through with someone who is supportive and nonjudgmental. Talking can provide you with support when you need it and can help you to get through the urge without using again. Remember the "larger picture," including why you are trying to make this important change. It is important to talk with someone who won't judge or criticize you for having these feelings or urges but will give you permission to express yourself.

- Meditation or mindfulness activities can help you stay present with your experience without the need to act or react; they can also increase awareness generally.
- Wait it out; urges are only temporary.
- Take protection when faced with a high-risk situation.
- Use a reminder card.
- Urge surfing. (Give the patient the *Urge Surfing* handout and read the sheet aloud.) Delay the decision to use. Most urges to use can be likened to ocean waves—they build to a peak and then dissipate. For many patients, if they choose to wait 15 minutes, the wave will pass. Try imagining you're a surfer riding the wave of craving until it subsides, or use another image that works for you.
- Use imagery. If you feel you are about to be overwhelmed by urges to use, imagine scenes that portray those urges as storms that end with calmness, mountains that can be climbed, or waves that can be ridden. Everyone can find an image to maintain control until the urge peaks and then dissipates.

  You might envision yourself sitting at the edge of a riverbank and seeing the urge as a boat that is sailing in your direction. You can simply observe the boat from this "distance," note certain qualities or characteristics, but not feel compelled to get on the boat and ride. Just see it come and then pass you by. Images can be made vivid by using relaxation techniques and all the senses (e.g., seeing the thick green jungle, hearing the blade swishing through the leaves, smelling the tropical plants). Photographs of loved ones can also distract.

Focus on the Narrative or Story

Challenge and change your thoughts. When experiencing cravings, many remember only the good effects of using and forget the negative consequences. You may find it helpful to remind yourself of the benefits of not using and the negative consequences of using. Remind yourself you will not feel better by getting a little buzz, and that you will lose a lot by using. It is helpful to have these benefits and consequences listed on a small card to carry around.

Self-talk. People often engage in a running dialogue or commentary with themselves about the events that occur in their day and their actions. These thoughts can strongly influence the way you feel and act. What you tell yourself about your urges to use affects how you experience and handle them. Your self-talk can be used to strengthen or weaken your urges. Making self-statements is so automatic you may not notice it. For example, a self-statement that is automatic for you may be, "I am a skilled photographer," or, "I have no willpower." Hidden or automatic self-statements about urges can make them hard to handle. ("I want to get drunk now. I can't stand this. The urge is going to get stronger and stronger until I use. I won't be able to resist.") Other types of self-statements can make the urge easier to handle. ("Even though my mind is made up to stay clean, my body is taking longer to learn this. This urge is uncomfortable, but in 15 minutes or so, I'll feel like myself again.")

There are two basic steps in using self-talk constructively:

1. Try to identify the things you are saying to yourself that make it more difficult to resist an urge. One way to tell whether you're on the right track is when you hit on a self-statement that increases your discomfort. For example, "I will never be able to withstand this urge." That discomfort-raising self-statement is a leading candidate for challenge.

2. Use self-talk constructively to challenge the statement. An effective challenge makes you feel better (less tense, anxious, panicky), even though it may not make the feelings disappear entirely. The most effective challenges are ones tailored to specific self-statements. Listed below are some challenges that people find useful:

    - **What is the evidence?** What is the evidence that if I don't drink in the next 10 minutes, I'll die? Has anyone ever died from not drinking? What's the evidence that people recovering from an alcohol problem don't have the feelings I'm having? What is the evidence that I'll *never improve?*
    - ***What's so awful about that?*** What's so awful about feeling bad? Of course I can survive it. Who said that abstinence would be easy? What's so terrible about experiencing an urge? I can get through it. I've gotten through other difficult feelings and experiences and can live to tell about them. These urges are not like being hungry or thirsty; they're more like a craving for a particular food or an urge to talk to a particular person—they'll pass.
    - **I'm a human being and have a right to make mistakes**. Maybe I worry about not getting everything done that I hope to, or not being as patient as I should be. What's so bad about that? We all make mistakes, and in a situation that's complicated, there may not be a clear "right" or "perfect" way to handle things. Some of these strategies will be necessary or helpful only initially to distract yourself from persistent urges; in the long run, you'll have an easier time if you replace the thoughts with other activities. After a while, abstinence will feel more natural. The urges will diminish in intensity and will come less often. You will also know how to cope with them.

In the example below, the clinician and patient discuss craving triggers and self-talk strategies.

> *Clinician (C): You identified one of your strongest triggers as seeing other people smoking, especially family members. Let's try to pinpoint exactly what's going on.*
>
> *Shirley (S): I feel that if I don't smoke with some family members, they might think I'm above them. They already make fun of me, calling me the college girl, and I want to fit in.*
>
> *C: You're sensitive to your family members and concerned they'll think you're trying to be better than they are by not smoking. What is the evidence this will happen?*
>
> *S: Well, I guess it's more a fear than a fact. I really do love them and know they love me. But I don't know how they would respond.*

C: What thoughts have you had about telling them?

S: I almost told my uncle the other day when he lit up. But then I ended up smoking, and I just couldn't.

C: You realize that once you get high, it's difficult to make changes.

S: I've been thinking that I need to tell them when there's no chance that we would be smoking. But I dread it!

C: What are some other ways you might let them know?

Complete Exercises

The clinician introduces the following exercises. (Note: It is possible to use the *New Roads* worksheet presented in session 4, filling the blank spaces with new information as needed.)

Make a list of craving triggers. Circle the triggers you can avoid or reduce your exposure to (such as having alcohol or substances in your home).

Make up a craving plan. Pick two or three of the general strategies discussed and plan how to put them into practice if you experience an urge. Cravings can come when you least expect them! For example, if you think distracting activities would be helpful, which activities would you pick? Which are available? Which take preparation? If you were feeling a craving, whom would you call? If you haven't tried urge surfing before, practice with me before trying it when facing an urge.

Assign Between-Session Exercises

The clinician encourages the patient to review the handouts between sessions and to practice urge-surfing techniques. The clinician also gives the patient a blank *Daily Record of Urges To Use Alcohol or Substances*, shows the patient a completed form as an example, and asks him or her to complete it during the week.

Review and Conclude

Review and summarize session activities and key points. Prepare the patient for the next session by introducing the topic and explaining how it will be helpful on the path toward wellness.

Session 6. Supporting Recovery Through Enhanced Social Supports and Activities

Introduction

Effective therapy starts with building rapport and trust and enhancing the therapeutic alliance developed in earlier sessions. The therapeutic alliance is essential to honest appraisal and recall of situations, triggers, and consequences of use. In the skills sessions, the clinician teaches the patient about finding alternative rewards and pleasures in life. First, the clinician provides insights into the rationales that underlie most substance use/drinking habits and are maintained because they increase our feelings of pleasure and/or they take away pain. Such experiences result from chemical changes in the brain after drinking or using drugs. One of the primary neurochemicals involved is dopamine. Dopamine and other reward sensation chemicals such as serotonin can also be produced by activities that are healthy and pleasurable. These are called replacement activities.

One of the best ways to increase dopamine is through physically new and challenging activities that require making effort and practicing skills. In session 6, the patient brainstorms both activities that give immediate pleasure and those that require mastery experiences and commits to engaging in both types in the next weeks.

The Patient's Experience

The patient experiences the clinician's focused interest in how he or she obtains feelings of joy and pleasure in life. The patient talks about past and present ways of feeling good, and what it would take for them to reengage old activities or consider trying new ones. The patient also experiences having a supportive coach helping to exchange his or her daily routines for ones that can become new, perhaps healthier habits. The patient expresses optimism and commitment for trying to replace use by engaging in immediate pleasurable activities and longer term, skills-based activities.

Clinician Preparation

Session 6. Supporting Recovery Through Enhanced Social Supports and Activities	
Materials ▸ Engaging in Replacement Activities (handout) ▸ Increasing Pleasant Activities (handout)	**Total Time** 45–60 minutes **Delivery Method** Skill-focused individual or group therapy
Strategies ▸ OARS (Open-Ended Questions, Affirmations, Reflections, Summary), support self-efficacy, identify stage of change ▸ MI Eliciting Change Talk (Looking Back, Looking Forward, Pros and Cons, Decisional Balance Use) ▸ Brainstorm ▸ Develop "real-life practice challenge" (prescription for fun) ▸ Follow CBT skills session reminders	

Session 6 Outline and Overview

1. Welcome patient and build rapport:
    - Review patient's past week.
    - Use this as an opportunity to continue to explore patient's passions, interests, and strengths.
2. Examine patient's recent experiences and review life work practice:
    - Did patient make an effort to stop? Cut down? Maintain abstinence?
    - Did the patient experience any high-risk or tempting situations?
    - Did the patient use any strategies from *Learning New Coping Strategies in Support of Change*?
    - Were the strategies successful?
    - Did the patient complete the between-session challenge? How did it go?
    - If the patient did not complete the between-session challenge, explore what got in the way and potentially problem solve in anticipation of this week's challenge.
3. Introduce increasing pleasant activities:
    - Explain the rationale that often people use alcohol and/or other drugs because of the pleasure they get from the experience or because they alleviate boredom.
    - Over time, it can be hard to have fun or enjoy oneself without using.

- Related to this is the idea that drugs operate on specific reward centers in the brain.
- Those reward centers are also affected by other, exciting, nonsubstance-related activities such as running or playing basketball.
- Finding sober activities that are rewarding, challenging, and stimulating can help increase long-term abstinence.

4. Explore the patient's interests and passions regarding sober activities:
    - Have the patient complete the top part of the *Increasing Pleasant Activities* handout.
    - Discuss the types of activities the patient selected, including the differences between mastery and pleasure.
    - Brainstorm additional activities if needed.
5. Elicit commitment from the patient to engage in one activity two times between sessions:
    - Patient completes bottom portion of *Increasing Pleasant Activities* handout.
    - Explore with the patient what could get in the way or pose a barrier to engaging in the chosen activities.
    - Problem-solve to resolve any challenges to completing the task.
6. Introduce increasing social support:
    - Explain the rationale for building the patient's social support networks (see *Social Support* handout).
    - Elicit a discussion about the types of support patient is currently receiving or has received in the past: Who provided it? What did it look like? In what ways was it helpful? Unhelpful? What type of support does the patient feel is needed most? Why?
7. Discuss the different types of social support:
    - Continue reviewing the different types of support from the *Social Sup*port handout.
    - Elicit examples from the patient for each type.
    - Ask the patient to consider supports not used in the past but which he or she might be willing to consider.
8. Develop a plan for enhancing social support:
    - Continue reviewing the different types of support from the *Social Support* handout.
    - Elicit examples from the patient for each type.

- Ask the patient to consider supports he or she has not used in the past but might be willing to consider.
- Have the patient complete the *Plan for Seeking Support* handout.

9. Review tips on how to ask for support and address potential obstacles:
    - Continue reviewing the tips on how to ask for support from the *Social Support* handout (hint: draw from the assertiveness guidelines from previous session).
    - Discuss any potential barriers to getting the support identified in the patient's plans and engage the patient in group problem solving.
10. Assign second life work practice:
    - Elicit commitment from patient to seek out one support identified in the plan during the next week.
    - Have patient define specifically when he or she will seek out the support and how.

Session Protocol

Introduce the concept of participating in healthy replacement activities and how vital that is to creating a stimulating and fulfilling lifestyle. Share with the patient that often when reducing substance use, there is a tremendous sense of absence or loss owing to the physiological and psychological effects of no longer using, or using less.

> *Clinician: Most of our patients tell us loud and clear that their substance use produced a sense of immediate pleasure and/or reward both biologically and psychologically—feelings that they depend on to get through the daily boredom or stress of life.*
>
> *Patient: That's right! Using helps me spice up life when I need to, and at other times it chills me out so I don't feel so anxious.*
>
> *Clinician: So it does different things for you and, either way, it is mind altering and you have come to rely on that experience. To replace the sense of loss as you reduce your use, most people find they need activities that include two important aspects of their life: pleasure and mastery. Pleasure activities bring us the immediate rewards that we all need to feel good; for example, watching a movie, reading a book, listening to music, and eating a nice meal. Mastery activities, because of the challenge they present, remain novel over time, lead to a long-term sense of accomplishment, and ultimately can produce feelings of passion for life (similar to passions for substance use). Mastery activities are challenging and demand creativity and effort in either or both the use of physical and mental skill.*
>
> *Patient: That makes sense because we'd even get bored of using the same thing in the same amount every day. Besides, I always switch it up and smoke weed sometimes and drink booze on other days, or do both. It helps to give me different kinds of experiences.*
>
> *Clinician: Given the need for both pleasure and mastery activities, what can you do every day or week to engage in one type or the other so you feel passion in your life? Let's take a minute to brainstorm some possibilities, check some listed ones, and/or write down the choices in this handout on replacement activities.*

Conclude the Session and Generate a Between-Session Commitment

Once the patient has listed four or more choices for each type of activity on the sheet, the clinician elicits a commitment for the upcoming week. Next, the clinician asks the patient to write the choice in the appropriate space provided. The clinician needs to be aware and explain to the patient that all lifelong and stimulating habits take time to generate feelings of comfort. Even activities we think will be simple or enjoyable at first can become tedious or off-putting owing to the effort needed to begin and learn the basic skills (i.e., "the devil is in the details"). Mastery activities can take more initial effort to pursue, but once a patient acquires some success, the activities can become habit and enjoyable. Examples include playing a musical instrument, writing, singing, and playing a sport (golf, walking, distance running, skiing, etc.).

Cultivating the quality of persistence can be important in the development of new skills and activities, solving a problem or meeting a challenge. The ability to sustain effort in the face of difficulty or adversity is an important lifelong skill that is worth pursuing. Delay of gratification is important to being able to put off immediate rewards or benefits for the purpose of having something more valuable and lasting over the long term (e.g., sacrificing the immediate pleasure of an ice cream sundae in favor of the larger goals of health and weight management).

Session 7. Problem Solving

Introduction

Session 7 reviews the types of experiences and problems that cause stress for the patient and offers an easy-to-remember and effective method for how to choose the best possible solutions to most types of problems. The clinician explains that most relapses may be attributed to either interpersonal (the self in relation to others) or intrapersonal (within the self) stress, which often leads to unpleasant feelings such as anger, fear, shame, sadness, or guilt. The clinician explains that people successful at handling problems realize they cannot avoid all problems, but they can learn strategies to overcome them. They can develop ways of coping more skillfully and efficiently with predictable stresses that arise in the course of daily life and the larger, more life-altering and disruptive types of stressful events.

The Patient's Experience

The patient hears that she or he is not alone with troubles but shares them in common with most others as part of life's struggle. The patient also hears that the problems do not lie within oneself as flaws or deficits, but rather they reflect universal experiences that can be addressed practically and successfully in the context of supportive relationships (such as counseling). The patient also learns to approach problems or challenges in creative ways, recognizing there are multiple paths that can lead to health and healing. Using the I-SOLVE acronym (see below) helps clinicians transfer a six-step model to patients. Providing formal training in solving problems may accelerate the development of higher order coping strategies that go beyond situation-specific skills. This training helps the patient act as his or her own clinician when no longer engaged in a formal treatment situation. The problem-solving approach used in this guide is adapted from D'Zurilla & Goldfried (1971); see also CSAT (1999).

Clinician Preparation

CBT Session 7. Problem Solving	
Materials ▸ Problem-solving (I-SOLVE) ▸ Large paper, poster board, or dry-erase board to diagram problem-solving steps	**Total Time** 1 hour **Delivery Method** Skill-focused individual or group therapy
Strategies ▸ OARS (Open-Ended Questions, Affirmations, Reflections, Summary) ▸ Support self-efficacy ▸ Demonstrate skill, role-play ▸ Follow CBT skills sessions	
Goals for This Session ▸ Introduce a strategy for solving problems. ▸ Apply the problem-solving approach to alcohol or other substance use and related problems. ▸ Prepare for termination of treatment if applicable.	

Session 7 Outline and Overview

1. Discuss the importance of recognizing problems as opportunities to learn:
    - Explain the rationale that everyone has problems (the rich, the famous, the not-so-famous), and provide relevant examples.
    - Provide the rationale that we often cannot control much of what happens in life, so we say problems are not the problem; rather, how we react to problems is important. Problems can be seen as opportunities rather than roadblocks.
    - For patients, problem situations result in alcohol or substance use when people feel they have no effective coping responses to handle them or their range of abilities is narrow or constricted. However, these same situations can be managed by practicing effective problem-solving skills, so the choices diminish the negative consequences of the situations and even sometimes create opportunities.
2. Provide examples of problem-solving practice and how it is effective:
    - Explain how firemen practice setting fires to be prepared for the real fire, similar to other emergency workers who develop response routines so the incidents do not become overwhelming when they occur. This is similar to learning to do CPR or the Heimlich maneuver, gaining needed skills to respond to problem situations.

3. Brainstorm problems and describe problem-solving skills:
    - Recognize the problem.
    - Identify or elaborate on the problem.
    - Consider various approaches.
    - Select the most promising approach.
    - Evaluate effectiveness.
4. Practice problem-solving skills:
    - Work through the process, identifying and applying problem-solving skills.
    - Role-play solutions and evaluate effectiveness.
5. Review and conclude the session.
6. Assign a between-session challenge.

Session Protocol

Discuss the Importance of Solving Problems

The clinician explains the rationale for learning an approach to solving difficult problems using examples from real life and how they affect every type of person, including the rich, famous, poor, and brilliant. The clinician might use examples of people in the media, in the community, on news programs, etc. The clinician also explains that all people have problems, and the problems come in all forms, such as emergencies, illness, and loss of employment. However, even a seemingly positive event, such as a party, can be a problem for someone trying to avoid using.

> *Clinician: As you know, life throws all of us problems; they are part of the fabric of life for everyone. We like to say, problems are not the problem, it is what you do with them that matters. Every person, no matter how rich, poor, brilliant, or famous can have problems, and the problems can come in as many forms as the types of people. Some problems are emergencies caused by health issues, the stress of job demands, and money issues. Even a party can be a problem for someone trying not to use.*
>
> *Patient: So you mean that what I experience is not unusual, but that it bothers me more than people who experience the same types of things. How does knowing that help me not to feel bad and use?*
>
> *Clinician: Situations become problems when people think they have no effective coping responses to handle them. Individuals can be flooded by emotions when faced with a problem and may be unable to manage the problem constructively. People who use alcohol or other substances may encounter the following types of problems:*
>
> - *Situations where alcohol or substance use occurred*
> - *Situations that arise after substance use has been stopped (e.g., social pressure to use, cravings, slips)*

- *Difficulties developing new activities that help maintain abstinence (e.g., new recreational habits)*

Give examples of firemen and emergency responders who learn to more easily overcome adversities by practicing possible responses. The clinician will use this session to help the patient practice a problem-solving model to deal with situations that normally would trigger them to use.

The clinician describes steps to solve problems and situations where the approach is helpful. See the sample language provided.

> *Effective problem solving requires recognizing when you're confronted with a problem and resisting the temptation to respond impulsively or to do nothing. Coming up with an effective solution requires that you assess the situation to decide the best course of action. Sometimes the problem involves wanting to use alcohol or substances, such as at a party. At other times, the problem may be the urge to find a quick and easy solution. The pressure may build up and trigger using. Effective problem-solving strategies must be part of your abstinence program because the occurrence of problems can set the stage for a slip or longer periods of relapse.*

Brainstorm and Describe Problem-Solving Skills

Elicit information from the patient and review some of the problems mentioned in past sessions. Then describe the effective problem-solving approach called I-SOLVE.

I-SOLVE

I – **I**dentify the problem.

S – **S**tate the problem.

O – Consider **o**ptions.

L – **L**ook at the consequences of the choices.

V – **V**ote on the most promising approach.

E – **E**valuate effectiveness.

The clinician describes the steps in I-SOLVE, provides examples, and encourages questions and feedback from the patient as to how this fits with his or her situation.

> *Okay, so we are going to go through the steps of problem solving using a tool called I-SOLVE. I will describe each and give an example. Please ask questions or make any comments as we go along, okay?*
>
> *The first step is to **identify** the problem. What clues indicate there may be a problem? You may get clues from your body (e.g., indigestion, craving), your thoughts and feelings (e.g., feelings of anxiety, depression, loneliness, fear), your behavior (e.g., have you been able to keep up with plans and commitments you make to others or yourself?), the way you respond to others (e.g., feeling irritable, impatient, having less interest in things,*

feeling withdrawn from people who might be supportive of you), and the way others respond to you (e.g., they appear to avoid you, seem frustrated or critical of you).

*The second step is to **state** or elaborate the problem. What is the problem? Having recognized that something is wrong, you identify the problem by gathering as much information as you can. Break the problem down into smaller parts; you may find it easier to manage several parts than to confront the entire problem all at once. State the problem beginning with an "I" statement. For example, if you must complete a large project at work, it can be helpful to break it up into smaller, more manageable parts and perhaps consult with colleagues on aspects that are particularly challenging for you. "I have a project due at work and will need someone with advanced computer skills to help me finish it on time."*

*The third step is to consider **options** in addressing the problem. Develop several solutions; the first one that comes to mind may not be the best. Use the following methods to find a good solution:*

Brainstorm. Generate ideas without judging or stopping to evaluate how good or bad they are. Write down all the ideas that come to mind, even ones that seem unrealistic. Later you will review and make decisions about which you will actually try out. More is better. Don't evaluate these ideas at this stage.

Consider strategies that require action or behavior change on your part (e.g., changing your routines related to social activity) and also strategies that involve your changing how you think about a situation. For example, when the problem involves negative emotional reactions to uncontrollable events, change how you view this situation and your role in it (cognitive coping). Some problems require both behavioral and cognitive coping.

*Once you have generated a list of ideas for coping with the problem, the fourth step is to **look** at the long and short term, including positive and negative consequences of choosing those options. Consider the resources you'll need for each solution. Here it is helpful to list the options and then write either +, –, or 0 = neutral next to each choice, depending on your thoughts about the outcome.*

*The fifth step is to **vote** for the most promising approach. Rank the possibilities by their consequences and desirability. The solution with the most positive and fewest negative consequences is the one to try first.*

*Finally, the sixth step is to **evaluate** effectiveness. How did it work out? Evaluate the strengths and weaknesses of your plan. What difficulties did you encounter? Are you obtaining the expected results? Can you do something to make the approach more effective? Use the same clues as before (e.g., from your body, thoughts, feelings, other people) to decide whether your solution is effective. If you give the plan a fair chance and it doesn't solve the problem, move to your second choice and follow the same procedure.*

Tips for the Clinician

Remember to address only a problem with a solution that is within the control of the patient. The model will not work if the answer to the problem relies on someone else's control. The following is an example of someone else's problems: *I need to make it so my family stops complaining, I need them to learn to speak in a different tone…*versus: *I need to figure out a way of expressing myself so my family quits complaining about my tone of voice*.

If the patient chooses a problem where the solution is not in his or her control, work together to clarify the difference between the self's and another's ability to influence change (use examples). Then collaborate to reselect or redefine the problem to one where there is primary influence over the outcome, thus emphasizing self-efficacy.

Make sure the brainstorming of options feels fun and the spirit is creative. At this point in the I-SOLVE discussion, it does not matter if the solutions are realistic as long as the patient understands the problems can be better solved when the solutions are in his or her control. The clinician can gently guide the patient toward a realistic solution he or she has the skills and will to carry out successfully (e.g., planning to create an enormous quilt when one has never picked up a needle and thread may be a setup for failure).

When leading a patient in brainstorming, it is usually best to elicit at least five solutions to assess which option might be best. This facilitates a choice should the option chosen and evaluated turn out not to be helpful and highlights problem solving as a learning opportunity rather than a stagnant process. Problem solving can be revised to adapt to evolving awareness in a manner similar to the recovery process, which is characterized by a variety of external and internal triggers. Each situation affords another chance to problem solve and test which option leads to the healthiest outcomes.

Practice Problem-Solving Skills

The clinician encourages the patient to work through the problem-recognition stage: identifying problems, describing them, and writing solutions on paper. The clinician asks the patient to weigh alternatives, select the most promising one, and describe both advantages and disadvantages for every alternative. Finally, the patient prioritizes the alternatives. The clinician and patient role-play and evaluate the effectiveness of the most promising solutions. See the sample language provided.

> *Clinician (C): Your upcoming 4th of July picnic will put you in a difficult situation because you'll be around old friends and family members with whom you used to get high. What is the problem as you see it?*
>
> *Steve (S): Well, I have really enjoyed these parties in the past, even though they tend to be a blur because I've been so stoned. But it will be difficult to be there and not smoke with people. They will be offering me stuff for hours and I'm worried I'll just get worn down. Then I'll be mad at myself for not sticking to my guns.*
>
> *C: You anticipate it being difficult to stick to your plans when you are around people you have used with in the past.*
>
> *S: Yeah, I also don't want to let them down. I know that sounds kind of weird.*
>
> *C: It doesn't sound weird at all. It also sounds like there's a tension between staying focused on your goals and plans and worrying about disappointing people you care about by not being "part of" things as usual.*
>
> *S: Yes, I guess that's just how I feel.*

C: Have you thought about any ideas for how you might deal with this situation? Maybe we could come up with some possibilities and then see which ones might work better than others.

S: Okay.

C: Great.

The patient now uses the I-SOLVE model in the session to state the problem in a brief "I" statement, generate options, examine long-term and short-term consequences, vote, and then commit to trying the option chosen and evaluating the results of that choice. If there is enough time remaining in the session, the clinician elicits another high-risk problem situation from the patient. The clinician asks the patient to demonstrate his or her ability using the model more autonomously, unless the patient specifically asks for help.

Assign the Between-Session Exercise

The clinician asks the patient to commit to using the chosen option(s) generated and to check in next session on the outcome of the solutions. Should other problems arise, the patient is advised to use the method for continued practice.

Review and Conclude

The clinician reviews the content of the session, solicits feedback from the patient, responds empathically to his or her comments, and troubleshoots any difficulties. The clinician asks that the patient report back on his or her efforts to complete the between-session exercise at the next session. If the patient seems disinclined to complete the exercise in writing, ask him or her to think about a problem and go through the steps mentally and report back during the next session. The clinician might remind the patient that treatment will be ending soon and solicit the patient's feelings about ending treatment and the best way to spend the remaining sessions.

Session 8. Learning Assertiveness

Introduction

During session 8, the clinician first explains the critical need for effective communication in general and more specifically in trying to change substance using behaviors. The clinician then discusses the different communication styles illustrating effective and less effective communication. The clinician helps the patient identify his or her own style of communication and the style of family and friends. The clinician then assists the patient with practicing ways to be assertive in a variety of everyday situations and in challenging situations he or she is facing while moving toward recovery.

The Patient's Experience

The patient learns about effective and ineffective communication and develops increased awareness of his or her own communication and those of his or her social network. Patients become familiar with expressing their needs assertively in a variety of real-life situations and practices in and out of sessions. Patients commit to practicing assertiveness and assertive refusal in the upcoming weeks.

Clinician Preparation

<table>
<tr><th colspan="2">CBT Session 8. Learning Assertiveness</th></tr>
<tr><td>Materials
Communication Styles Handout
Between-Session Challenge: Assertiveness</td><td>Total Time
1 hour
Delivery Method
CBT-focused individual or group therapy</td></tr>
<tr><td colspan="2">Strategies
OARS (Open-Ended questions, Affirmations, Reflections, Summary)
Support self-efficacy
Demonstrate skill, role-play
Follow CBT skills session reminders</td></tr>
<tr><td colspan="2">Goals for This Session
Enhance the patient's understanding of different styles of communication and teach ways to express one's views and feelings. The following communication styles are discussed:
Passive
Passive-Aggressive
Aggressive
Assertive
Role-play scenarios of relevance to the patient and practice these different communication styles.
Identify a current situation or relationship that could benefit from the patient's communicating in a more assertive way; practice.</td></tr>
</table>

Session 8 Outline and Overview

1. Enhance rapport, review the week in general (pros and cons) and progress toward recovery goals, and review the weekly challenge.
2. Provide the rationale for assertive communication in general and assertive refusal skills.
3. Engage and elicit patient communication style:
    - Make an offer to the patient to reveal the patient's communication style.
    - Example: Offer the patient a food you know he or she dislikes or even despises.
4. Define aggressive, passive, passive-aggressive, and assertive communication.
5. Discuss benefits of assertiveness:
    - Increases likelihood person will achieve goal or objective
    - Increases chance the person will feel more satisfied with a situation
6. Demonstrations:
    - Model different styles of communication.
    - Identify scenarios exemplifying these styles.
    - Develop role-play exercise of relevance for patient.
    - Practice assertiveness in the context of role-play.
    - Identify obstacles and barriers.
7. Summarize and elicit a between-session challenge commitment:
    - Review the patient's communication style and the skill of assertiveness.
    - Hand out *Between-Session Challenge: Assertiveness*, and ask the patient to commit to a weekly between-session challenge using assertive communication in several upcoming situations**.**

Session Protocol

Step One. Greet the patient and review the previous week. Review the current status regarding alcohol or substance use and the goals of change or abstinence. Inquire about any between-session practice challenge. If appropriate, praise the patient's efforts accomplishing the between-session challenge and maintaining changes or abstinence.

Step Two. Introduce the current topic involving styles of communication.

> *Have you ever been in a situation where you wanted to tell someone how you felt but weren't able to for some reason? Can you explain to me what made it difficult? Did not saying anything help or hurt the situation or your feelings in general?*

What about having a time where you felt really upset or angry but waited to tell the person so that when you finally spoke up you ended up saying a lot of negative things that you later regretted? Many of us can identify with both of these kinds of situations.

Provide the Rationale

Provide the rationale for the benefit to use assertive communication to get needs met and the need for assertive refusal skills to strengthen the path toward recovery. Sample language follows:

Communication is much more complex than it seems, so we all struggle with miscommunication. This is because in any conversation there is a speaker and a listener, and both verbal and nonverbal expressions are used to determine the meaning. The listener has a filter already in place to influence and interpret what is seen and heard. Therefore, to be clear and have our needs met, we all must rely on practiced and effective communication strategies.

There is an extra burden to use effective communication when trying to change any behavior, especially substance use behaviors. The repetitive nature of negative habits increases the likelihood there will be an increase in situations to use along with associated thoughts and feelings. Sample language follows:

As one's use increases, there's a funneling effect or narrowing of your own thoughts and coping strategies. Your nonuse coping thoughts like your circle of nonusing friends gets smaller, while your circle of using friends gets bigger. This increases relapse risk.

When was the last time you celebrated without using? When was the last time you handled a negative situation, feeling, or thought without using?

Affirm any instances of nonuse and support these as assertive/refusal communication skills that are critical to maintaining recovery; for example:

Given the increased risk of using thoughts, behaviors, and social pressure, the best initial step is to avoid situations involving alcohol and/or other drug use. This is not always possible, and so it's important you feel comfortable refusing alcohol and other drugs when offered them in social situations. You also need to be able to tell yourself it's okay not to use and to cope or celebrate in other ways. Knowing good strategies and practicing those strategies will help your ability to refuse alcohol and other drugs.

Step Three. Begin the in-session practice of assertive communication with real situations to evoke natural skill level for being direct with refusal.

Can you tell me a food you dislike and would not eat? Pressure the patient to eat the disliked food and see how she or he responds. Use any strategy necessary to try to get the patient to accept it, such as you made it just for him or her and in a way it would not taste like that food, etc. Discuss the patient's response and how clear he or she was about refusing the food.

Incorporate the patient's communication style from the discussion above. Ask about the patient's understanding of the term assertiveness or assertive communication. Discuss whether and when the patient has been successfully assertive.

Step Four. Define different styles of communication. The clinician identifies types of communication and asks the patient to define his or her understanding of them. Next the clinician provides definitions of each style and compares them to the patient's definitions, not to evaluate, but to ensure accurate understanding. The clinician clarifies any areas of misconception according to the definitions below.

Passive communication: With this style, a person is often unable to or fearful of expressing himself or herself directly. The individual tends to acquiesce or go along with what another person wants. The person may not feel entitled to his or her opinions or believes the other person will not listen or care. An example: Someone is asked to attend an event for work that is inconvenient, and rather than asking to be excused or to reschedule, the person agrees immediately. With this form of communication, the individual does not express his or her needs and wants in a clear way.

Passive-aggressive communication: With passive-aggressive communication or behavior, someone may appear to agree or go along with a plan of action but engages in other behavior that conveys true feelings. For example, a woman asks her husband to attend a family gathering. He is not enthusiastic about family events and has somewhat difficult relationships with some of his wife's family members. He would much prefer to stay home and watch a tennis match on television. Instead of telling his wife his feelings, he agrees to go to the family party and arranges to meet her there after he completes some errands. He ends up being "held up" with some of his chores and arrives at the party 2 hours late. This would be considered passive aggressive because on the surface he seemed willing to go along with his wife's wishes, but by arriving late he conveyed his real preference indirectly. Passive-aggressive communication can be difficult to identify because often people are not aware of their behaviors. See the example provided.

> *Yes, that sounds just great. I want to go the party, but I really have a few things I must do beforehand so why don't I meet you there? It starts at 3, right? Oh, 2. Okay, see you then.*

Aggressive communication: When someone behaves or communicates in an aggressive manner, the person tends to ignore the rights or feelings of others. That person prioritizes his or her own experiences and needs above those of others. The person may communicate through loud tones, yelling, threats, and intimidation. He or she may be insensitive to how a message is conveyed to others. This individual may not be willing to hear how someone else feels or wants in a particular situation. A fairly benign example: A group of friends go out to dinner and begin talking about their children. One member of the group proceeds to comment and give unsolicited advice to each of the parents about all the mistakes they are making and how they are damaging their children through their behavior. See another example below.

I hope you understand that you are working for me. I am in charge. You'd better be willing to stay late or come in early if I tell you to, and I don't want to see any mistakes, or you won't be seeing a paycheck too much longer. Is that clear enough?

Assertive communication: With assertive communication, a person expresses thoughts, feelings, or needs directly and clearly but is respectful and sensitive to the rights and feelings of others. This person does not yell or intimidate, but he or she also does not sugarcoat a message to the point of meaninglessness. An example appears below.

When you tell me I'm stupid or will never accomplish anything important, that makes me feel hurt. In the future, I ask that you communicate in a more constructive and supportive way, or I'll have to consider how to continue in this relationship.

Assertive people decide what they want, plan a constructive way to involve others, and then act on the plan. It can be very effective to state one's feelings or opinions and request the changes one would like from others without being threatening, demanding, or negative. In sum, assertiveness means recognizing one's right to decide what to do in a given situation rather than giving in to others. Assertiveness recognizes the following rights:

- To inform others of your opinion
- To inform others of your feelings in a way that is not hurtful
- To ask others to change their behavior that affects you
- To accept or reject what others say to you or request from you

Next, the clinician discusses the patient's understanding of the terms discussed and asks for examples that could be shared of each style. The examples could be situations the patient has experienced, heard about, or imagined. The clinician also asks the patient to identify how he or she speaks to himself or herself (self-talk). For example: "Given that most of us are critical when we make mistakes, it is also important to realize the style of communication we use for self-talk and how practicing assertiveness with ourselves will likely lead to a better feeling inside and perhaps an increased desire to change."

Step Five. Explain the benefits of assertiveness. The clinician explains the benefits of assertiveness; for example, as below.

Assertiveness is the most effective way to let others know what's going on or what effect their behavior has. By expressing themselves, assertive people resolve uncomfortable feelings that otherwise build up. Because being assertive often results in correcting a source of stress and tension, it can lead to feeling more in control of life. Assertive people do not feel like victims of circumstances. However, their goals can't be met in all situations; it isn't possible to control how another person will respond. Nevertheless, behaving assertively has two benefits: it increases the chances goals will be met, and it makes people feel better about their role in the situation.

Introduce Skill Guidelines. The clinician explains that the guidelines in the *Assertiveness* handout can help the patient become assertive.

> *Take a moment to think before you speak. What did the other person do or say? Try not to assume the other person's intentions. Don't assume that he or she knows your mind. Plan the most effective way to make statements. Be specific and direct. Address the problem without bringing in other issues. Be positive. Don't put others down; blaming others makes them defensive and less likely to hear your message.*
>
> *Pay attention to your body language: eye contact, posture, gestures, facial expression, and tone of voice. Make sure your words and your expression communicate the same message. To get your point across, speak firmly and be aware of your appearance.*
>
> *Be willing to compromise. Let others know you're willing to work things out. No one has to leave the situation feeling as if he or she has lost everything. Try to find a way for everyone to win. Give others your full attention when they reply, try to understand their views, and seek clarification. If you disagree, have a discussion. Don't dominate or submit to others. Strive for equality in the relationship. If you feel you're not being heard, restate your assertion. Persistence and consistency are necessary parts of assertiveness. Changing the way you respond requires effort. The first step is to become aware of habitual responses and make an effort to change.*

The most difficult situations in which to respond assertively are those that may end with negative consequences. Examine the thoughts that prevent you from acting assertively with others and yourself ("My boss will fire me if I can't work overtime because I have my counseling session.") This examination uses many skills discussed in other sessions:

Determine the thought or fear. What am I afraid will happen? What's the worst that could happen?

Assess the probabilities. How likely is the negative consequence?

Evaluate the catastrophe. What would happen if the worst occurred? Would it really be so terrible?

Identify the rules. What assumptions and beliefs govern feelings?

Model Assertiveness

The clinician and patient role-play a situation in which the clinician plays a person refusing the offer of substances from a friend; the patient plays the person offering the substance or alcohol. The clinician models passive, aggressive, passive-aggressive, and assertive responses. After each response, the clinician asks the patient to identify the behavior and determine the success of that approach.

Step Six. Develop a role-play exercise with a relevant and current situation. After discussing and reviewing the different styles of communication, the clinician asks the patient to identify a current problem or situation where there is difficulty communicating needs in an effective

manner. The situation might be one involving alcohol or substance use, such as being able to resist or refuse offers to use at a party, or from a long-time drinking buddy. It could also involve the patient expressing feelings in an important relationship. If the patient has difficulty generating a role-play scenario, the clinician can suggest some general topics or relationships, or a specific idea based on knowledge about the patient where assertive communication could be of benefit. The clinician gives the patient the *Assertiveness: Between-Session Challenge* handout and asks the patient to try at home.

Step Seven. Summarize the assertive communication session. Then, get a specific commitment for completion of the between-session work and prepare for the next session. The summary is an opportunity to reinforce the patient's personal awareness and assertiveness refusal skill learning to increase a sense of self-efficacy. The preparation statement could sound like the following:

> *"Today we covered a lot of information about your use, what sets you up to use, and communication skills that are helpful in working toward your recovery goals. You most frequently reported your triggers are likely to be [____] and that knowing these triggers ahead of time and avoiding certain places and people has helped increase successful experiences without use." (Summarize the types of triggers: the time of day, the situation, the feelings and thoughts—positive and/or negative). "But as you've stated, you can't avoid all people, places, or situations all the time, and trying to do is also stressful. As today's lesson has demonstrated, it's possible to practice assertive refusal skills that allow you to be clear on how to get your needs met, and to refuse in ways others will understand.*
>
> *"For example: Today you practiced refusal skills in several situations with others and in self-talk to help you gain confidence in saying no and not feel guilty or confused during risky times or events in the upcoming weeks.*
>
> *"I wonder if you can tell me how you would use the assertive refusal skills in the next weeks to help you meet your goals?"*
>
> *Hand out the between-session challenge Assertiveness worksheet. Ask the patient to use assertive communication for self-talk and with others when confronted by a trigger to use (negative thought, feeling, celebration, or social pressure situation).*
>
> *"During the next week, I would like you to practice using the Knowledge Is Power worksheet and your assertive refusal skills, similar to how we did today.*
>
> *"How does that sound to you?"*
>
> *If the patient says it will be hard, try to help remove any obstacles.*
>
> *If the patient agrees, say, "I am asking you to commit to filling out the sheet and using your refusal skills in two situations between sessions." Elicit: "Please identify a specific day, time, and place when you will complete the worksheet. Is there anything I can do to help you complete the real-life practice at the times you committed to?"*
>
> *Provide a brief summary of the next session topic and how the lessons will help the patient strengthen recovery. The clinician might say: "In our next session together, we will focus on [___], working with your thoughts and learning a method to change them to enhance how you feel and what you do."*

Review and Conclude

Review and summarize session activities and key points. Prepare the patient for the next session by introducing the topic and explaining how it will be helpful on the path toward wellness.

Session 9. Mindfulness, Meditation, and Stepping Back

Introduction

Session 9 introduces the patient to the strategy of meditation and the concept of mindfulness, which have been found effective in the treatment of substance abuse, depression, anxiety, and other health and psychological difficulties (Witkiewitz, Marlatt, & Walker, 2005).

Meditation

Meditation is a well-established practice and part of many religious philosophies, particularly in the East. It has been incorporated into the Western world as a therapeutic and health strategy because of its broad appeal, relative accessibility, demonstrated efficacy, and lack of adverse consequences. Meditation is incorporated into ICT because it is a highly accessible, easily learned (though not necessarily easily practiced) strategy, and has been used successfully in the treatment of many physical and emotional health conditions. It has been used in the treatment of substance abuse and incorporated into CBT interventions for the treatment of depression.

While the learning and practice of meditation could itself be the subject of an entire treatment guide, it is included here as one of the skills-building sessions in hopes the information will encourage the patient to engage in further study and practice beyond the time involved with ICT. There are many different types of meditation, from very formal to informal. Given the brevity of the clinician's contact with each patient, an informal approach to teaching meditation is encouraged, rather than one tied to the tenets of a particular religious faith. Meditation is offered as one strategy that may be helpful in reducing or stopping use of alcohol and other substances. Patients may also look into classes in the community as a way to learn more and as a strategy for prosocial connections. Patients may also check online for free resources related to both meditation and mindfulness. Public sites such as YouTube have dozens of examples.

Mindfulness

Mindfulness refers to the practice of increasing one's capacity to remain in the present moment and accept experience without judgment. The strategy recognizes our minds are busy, distracted, reactive to events, situation, thoughts, and feelings. Building a capacity for mindfulness involves becoming increasingly aware of one's moment-to-moment experience and approaching the present moment with acceptance. The intended outcome is a move toward "present-centered"-ness, which creates greater clarity about the nature of one's struggles, builds capability for accepting situations and feelings as they are, and sheds light on new pathways for recovery and growth.

There are numerous ways to increase mindfulness or the ability to stay in the present moment, and it is easy to recognize how often one becomes "nonmindful." Meditation is one method, which can involve sitting (or lying down) and focusing on a single point of concentration (e.g., the breath, a mantra, a word or phrase, a nonword). There are other ways, such as engaging in

daily activities like washing dishes or driving to work, but with extra attention on staying present, self-aware, and connected to the here and now.

Why might increasing mindfulness be helpful for alcohol and substance abuse?

One important reason mindfulness can be useful in addressing substance use problems is because individuals tend to use substances to escape from difficult emotions or experiences. Alcohol and other substances may serve as "affective regulators," and the individual may have few other tools or options when faced with overwhelming sadness, fear, anger, etc. Building a capacity for mindfulness (for example, through meditation) may help patients learn how to withstand and "stay with" difficult internal states, rather than automatically opting for substances.

When conducting the session on enhancing self-awareness during session 4, the clinician may have learned about high-risk situations for the patient, such as feeling a certain way (e.g., powerless, discouraged). The information from the functional analysis can be helpful in teaching the patient about mindfulness and meditation. The clinician might remind the patient about certain high-risk or trigger emotions and suggest how mindfulness could help handle the feelings differently. For example, when meditating for any length of time, one becomes acutely aware of the transient nature of internal states. And yet, most people are likely to feel "attached" to these states. We feel as though our thoughts and feelings are ours, that they belong to us. If one can approach a particularly disturbing thought and note, "Oh, it's just a thought," this can change the way one feels and reacts.

Similarly, if one can step back from an intense emotional experience and observe, "Oh, that's dissatisfaction," or, "That's just longing," this ability can be tremendously empowering because one no longer has to act or do something about a particular thought or feeling. It is also not necessary to continue to feel bad about a certain kind of thought because thoughts are not necessarily true. The individual comes to see himself or herself as more than, or at least separate from, any particular emotional state, thought, or idea.

The Patient's Experience

In this session, the patient is introduced to the concept of mindfulness and the practice of meditation as strategies for achieving a state of nonjudgmental acceptance of the present moment. The patient is encouraged to develop an attitude of curiosity and interest in moment-to-moment experiences. This is seen as a mechanism for achieving important goals related to alcohol or other substance use. Mindfulness is seen as consistent with the overall objectives of cultivating self-awareness and self-acceptance. The exercises during this session may be novel and seem strange to the patient, and it is important for the clinician to both normalize this reaction and to encourage the patient to give them a try. The patient should have the experience of feeling more present and connected, and more aware of the feelings and thoughts that occupy consciousness. The patient may become aware of difficult or unpleasant

emotions that tend to distract, and this information can be useful to the clinician in building coping skills during this session and later sessions.

Clinician Preparation

<table>
<tr><th colspan="2">CBT Session 9. Mindfulness, Meditation, and Stepping Back</th></tr>
<tr><td>Materials
Knowledge Is Power
Mindfulness Exercise
Meditation Instructions
Meditation Exercise: On the Riverbank (session 10 handout)</td><td>Total Time
1 hour
Delivery Method
CBT-focused individual or group therapy</td></tr>
<tr><td colspan="2">Strategies
OARS (Open-Ended Questions, Affirmations, Reflections, Summary)
Support self-efficacy
Demonstrate skill, role-play
Follow CBT skills session reminders</td></tr>
<tr><td colspan="2">Goals for This Session
Introduce the patient to the concept of mindfulness.
Teach the patient about meditation and different approaches for focusing awareness.
Provide several experiential exercises demonstrating mindfulness and meditation.</td></tr>
</table>

Session 9 Outline and Overview

1. Build rapport and review:
    - Check in with the patient on recent experiences.
    - Attend to the therapeutic alliance and address any obstacles or concerns.
    - Assess motivational factors and change readiness.
2. Clinician introduces concept of mindfulness:
    - Awareness and acceptance of present moment
    - Connection to alcohol/substance use
    - Role of mindfulness in regulating internal states
3. Clinician conducts experiential exercises demonstrating mindfulness:
    - Mindfulness exercise (e.g., eating raisin)
    - Process patient's experience and reaction

4. Clinician discusses meditation:
    - Can be part of religious practice but is also incorporated into nonreligious health practices
    - Strategy for increasing mindfulness
    - Strategy for managing difficult emotions and thoughts
    - Approach for coping with alcohol or other substance use
5. Clinician conducts experiential meditation exercise:
    - Breathing meditation
    - Clinician processes patient's experience
6. Clinician provides the following to the patient:
    - Provides meditation instructions
    - Provides alternate meditation exercise (*On the Riverbank*)
    - Encourages daily practice
7. Clinician closes session.

Session Protocol

The clinician greets the patient and elicits information about life during the previous week. The clinician asks about any between-session exercises such as journaling, thought records, and self-awareness charts. Inquire about the patient's current feelings, change readiness, and progress on goals related to quitting or cutting back use of alcohol or other substances. The clinician continues to use MI skills, always expressing genuine curiosity. Following are some examples of how to initiate such interaction with the patient.

> *"How have things been since we last met?" Or, "Tell me about something enjoyable you did during the past week."*

If the patient cannot think of anything enjoyable during the past week, ask about interests and activities, even if he or she did not engage in them during the past week. Continue by asking the patient how she or he has been doing over the past week regarding alcohol or drug use.

> *"Tell me about your [patient's drug of choice] use during the past week." Or, "What has your use been like since we last met?" Or, "What thoughts have you had about your use since we last spoke?"*

Guideline. Listen for possible changes in the patient's behaviors, thoughts, and feelings regarding use. Try to refrain from asking many questions. Let the patient tell you how she or he has been doing. Respond with reflective comments, and attempt to elicit the patient's own motivation-enhancing statements. Affirm any efforts made to reduce use and look for opportunities to support the patient's sense of self efficacy. If there has been little or no change

in the patient's use, look for opportunities to develop discrepancy through the use of double-sided reflections, exploring pros and cons, and seeking elaboration.

Provide Overview of Session and Description of Mindfulness

Introduce the topic with brief descriptions of mindfulness and meditation. It might be helpful to begin by asking whether the patient has heard of or been exposed to these ideas and what the experience has been.

> *Well, I am pleased to talk to you today about an important concept called "mindfulness." Have you ever heard this term before? Mindfulness is simply trying to stay focused on the present moment, what's happening with you right now. You know how everyone is so busy in this world, between our computers, cell phones, televisions, rushing here to there. Well, often people don't even have time to enjoy a simple meal. Or they are so distracted by all the things they have to get done that they don't even know how they feel or what they might like to do if they had a free moment. Does this sound familiar to you?*
>
> *Some people think that using alcohol or substances is a way for them to just slow down, relax, or feel better in the face of all the stress they have. Is that how you tend to think about your substance use? But there are other ways to do this that don't have the harmful consequences that substances can. I want to teach you about mindfulness and some specific ways to increase this ability, which we all have.*
>
> *Mindfulness can be increased in a variety of ways but the overall purpose is to help you to become more "present"—that is, more aware of your experience of the present moment. It is a way to help you feel less distracted and pulled in many directions. It is a way to help you perhaps feel more grounded, focused, calm. Increasing mindfulness has been found effective for people struggling with mood, anxiety, and substance use problems. I think this could be very helpful to you as you try to make these important changes in your use of [____]. For example, you told me during our first meeting that you have a hard time "shutting off your brain" and that [substance] seems to help you do this. Developing skills related to mindfulness may help you manage when you are feeling uncomfortable without using any substances. Are you willing to give it a try? Great!*

The clinician leads the patient in several experiential exercises involving mindfulness and/or meditation. The focus of these exercises is to help the patient become more aware of how he or she experiences the present moment.

The Raisin Exercise

Give the patient (or each group member) one raisin, piece of chocolate, or other small item of food. (Ask beforehand if there are any foods that might be problematic.) Have the patient put the food item in the mouth, and ask him or her not to chew or swallow it right away. Then ask the individual to focus on various aspects, such as the taste, texture, feeling in the mouth. Ask to notice more complex experiences (e.g., the chocolate seems at first sweet, but then slightly salty), and ask about thoughts and feelings experienced while eating this small morsel. Eventually, the person may finish eating. Then inquire about any interesting observations (e.g.,

many people are astounded to realize how one small raisin can be quite satisfying when one is fully present in the moment to experience and enjoy it).

> *Okay, here is our first exercise in mindfulness. This may seem a little silly, but just bear with me. I want you to take this raisin. Now, first look at it and notice what you see. Okay, now you can place it in your mouth, but don't eat it right away. I just want you to see what happens when you stay present to eating this one, small raisin, rather than doing the automatic thing we all do of swallowing food and not even paying attention to the experience of eating. So put it in your mouth and just let it sit on your tongue…..what do you notice? (You don't have to answer out loud. I'm just going to toss out questions for you to think about if you can.)*
>
> *What sensations are there? What is the flavor? How does it feel to just sit there and not chew it right away? What happens when you think about where this raisin came from and how it got to this place so you could eat it? What is the actual texture? Does it change? How about the flavor? What do you notice about yourself as you are eating this raisin in this much slower way? Is it frustrating? Enjoyable? How does it compare to how you usually eat? Okay, now you can start to chew and swallow the raisin. Pay close attention to this as well. Notice each moment and how you feel as you eat the raisin. Are you feeling more or less hungry after this exercise? More or less satisfied? Anything else you noticed?*

The clinician discusses the patient's experience with this exercise and how it compares to his or her usual approach toward daily activities. Try to address the following points:

- Is this a significant departure from the way the patient is living?
- Discuss how making efforts to be more mindful—when it comes to eating, working, doing laundry, or spending time with friends or family—could have the effect of reducing the desire for alcohol or substances.
- Using substances actually takes one away from the present moment and may contribute to feelings of disconnection or being emotionally numb.
- One may have the belief that the substances are helping with difficult feelings; however, they often have the opposite effect since they serve to move one away from actual experiences and feelings.
- Disconnecting from feelings, or trying to get past them quickly, does not generally help one to work through difficult emotions in an effective way.
- Mindfulness-based activities such as meditation can teach one that he or she is capable of experiencing and getting through even very painful feelings.

These may be new concepts for patients. Acknowledge and explore skepticism or reluctance to consider this new way of approaching lived experience. Indicate that a goal of this treatment is to help patients learn valuable tools that can assist them in making the changes they want for themselves. Not every tool or strategy will be appealing to every patient. They can choose or focus on the ones that seem most credible, helpful, and useful. However, ask that they be open to learning new strategies, even if they seem strange at first, or unlikely to be of benefit.

Clinician Discusses Meditation

Following the mindfulness exercise, discuss meditation as a technique or practice that can also improve mindfulness, or an ability to remain present in the moment. Inquire about the patient's previous experience, understanding, and/or perspective related to meditation approaches. If the patient has little or no background, provide a general introduction. Then conduct a demonstration to practice a short breathing meditation.

The clinician can explain that meditation has been practiced for thousands of years. It is part of many religions, such as Hinduism and Buddhism, particularly in the Eastern part of the world. Many view meditation as a viable path to enlightenment, or a heightened state of being. Meditation has also been adopted in the Western world because it is seen to have many health benefits. For example, there is evidence that people who meditate can reduce their blood pressure, require less anesthesia for surgery, and improve their sleep, among other things. Meditation also seems to be beneficial in reducing depression and anxiety and helping with substance-related problems. Meditation may seem very simple, and learning it is simple. It is the consistent practice that can be challenging. It can also be difficult for some people to "just sit" or "do nothing" because this runs counter to our societal value that we should also be productive and engaged in some kind of activity. The idea of "stopping" or sitting with one's thoughts and feelings without acting on them may be quite novel. Some sample language follows.

> *I'd like you to give this a try because I think it has great potential value in relation to your goals for this treatment. You won't be graded on how well you do meditation. I'd just like you to try it. Many times people who develop alcohol or drug difficulties become accustomed to "reacting" to difficult emotional states by using. It seems in the moment that this will solve the problem, or get them past the feeling they don't want to experience. However, it is this kind of avoidance of painful states that can lead to harmful patterns and habits and contribute to beliefs about ourselves that are not constructive (for example, thinking that alcohol or drug use is the only way to deal with a particular problem or feeling). Among the benefits of meditation is the developing awareness that our thoughts and feelings are actually quite transitory. There is a sense of impermanence in that everything changes, in a dynamic state of flux. This can be unsettling for those of us who are seeking "ground" or a sense of permanence and security. However, if we accept that things are in fact changing all the time, including us, that makes it possible to fashion our own future, at least in the next moment. It can help us to be hopeful in seeing that we are capable of many, many things, despite what we may have come to believe through some unfortunate conditioning.*

Meditation Involving the Breath

> *Meditation can mean many things. In this treatment, we want to teach you a simple and straightforward meditation technique that involves sitting and focusing on your breathing for a specific period of time. You can sit in the chair or on the floor [if there's carpet, not hard floor] and cross your legs. With either position, try and keep your back straight. It's better not to lie down or become overly relaxed. This is not a relaxation exercise, although we will learn about those later. What I'd like you to do is simply turn your attention to the in and out of your breath. You don't need to change your breathing in*

any way. Just pay attention to it. You can close your eyes, or keep them open with a "soft focus" (for example, on the carpet a few feet in front of you).

I'm going to signal the start of our meditation with this sound [e.g., bell, tap, other gentle sound]. We will sit for 10 minutes. If you have never done this before, this will feel like a very long time. All I ask you to do is try to focus your attention on your breathing. Just noticing it. The in and out of it. It is inevitable your mind will wander. It will be difficult to stay focused on your breathing for this entire time. You may become aware of things you have to do, things you are happy or upset about, different sensations in your body such as hunger, discomfort, feelings of boredom or anxiety. This is totally normal. It does not mean you're doing it wrong, not trying, or that it can't help you to do this. When you notice your mind has gone astray, just gently bring your attention back to the breath. You can also make an observation to yourself such as, "Oh, thinking," and come back to focusing on your breath. At the end of the 10 minutes, I will make a signal for us to stop. Do you have any questions before we start?

The clinician conducts the 10-minute meditation. When it's complete, inquire about the patient's experiences. It is typical for someone who has never tried meditation to be astonished at how long the 10 minutes seem. The person may report becoming sleepy or physically uncomfortable (especially if sitting cross-legged) or being unable to focus on breathing. The person may report not feeling any better or different after the exercise. Reassure the patient that all these feelings are normal and typical of what most others say after meditating for the first time. Indicate that one generally does not feel better immediately after a meditation session. It is something that accrues benefits over time with repeated practice. Just like any other skill, it is something that takes some discipline and willingness to invest energy in to become proficient or notice clear benefit. Explain there are many benefits from meditation for those who practice regularly. If it seems appropriate, give examples such as lowering blood pressure, reducing cardiovascular risk, reducing anxiety and depression, improving focus and attention, and changing use of substances. Ask the patient to try over the next week to find a time of day to practice this new skill. The individual may want to designate a space at home with less likelihood of distraction and a time of day that can be built into practice most comfortably. For example, some find first thing in the morning is a good time to meditate. Ask if there are any questions or concerns.

Review and Conclude

Thank the patient for being open to hearing about these concepts and for trying the exercises, especially if there was some disinclination initially. Provide the session handouts on meditation, mindfulness, and instructions for practice. Ask the patient to try the skills over the next week each day at a convenient time and to record the experience in a journal (e.g., day, length of sitting, overall experience). Discuss the next session planned for the patient and how the topic chosen and skills learned will be valuable on the path toward wellness.

Session 10. Working With Thoughts

Introduction

Session 10 provides context for helping the patient understand and be prepared for the kind of thoughts that are likely to arise while trying to quit using alcohol or other substances. It is normal to be troubled by thoughts related to one's ability to be successful in achieving and maintaining abstinence, or any other goal. Help the patient recognize the ways he or she is thinking about themselves and the situation and the function or role of these thoughts. That is, do the thoughts help one to feel more capable and empowered, or do they weaken one's feelings of self-efficacy and resolve to stay on the right path? Assist the patient also with placing these thoughts in perspective. They are "just thoughts." Just because we have a thought does not make it true, and we do not have to act on every thought we have.

The Patient's Experience

In this session, the patient is encouraged to bring awareness to the nature and content of thoughts that may drive substance use and contribute to slips, lapses, or relapses. The clinician provides examples of the types of thinking patterns that may inadvertently lead people back to using. The patient may have some "aha" moments upon hearing some common thought patterns. As with other sessions, the patient experiences the clinician as nonjudgmental. There may be a sense of lightness and humor when examining certain thoughts that are clearly irrational, or not in the patient's best interests given what he or she is trying to achieve in treatment.

Clinician Preparation

<table>
<tr><th colspan="2">CBT Session 10. Working With Thoughts</th></tr>
<tr><td>Materials
Managing Thoughts About Alcohol and Substance Use
Meditation Exercise, On the Riverbank</td><td>Total Time
1 hour
Delivery Method
CBT-focused individual or group therapy</td></tr>
<tr><td colspan="2">Strategies
OARS (Open-Ended Questions, Affirmations, Reflections, Summary)
Support self-efficacy
Demonstrate skill, role-play
Follow CBT skills session reminders</td></tr>
<tr><td colspan="2">Goals for This Session
Identify and learn to cope with automatic thoughts associated with alcohol or other substance use.</td></tr>
</table>

Session 10 Outline and Overview

1. Maintain rapport and review.
2. Normalize thoughts about alcohol or substance.
3. Identify thought patterns associated with use.
4. Discuss automatic thoughts and strategies for coping:
    - Describe situations likely to trigger automatic thoughts.
5. Explore conceptual difficulties:
    - Review material and probe for the patient's understanding of basic concepts.
    - Use illustrations and examples.
    - Walk patient through a using episode to understand thought processes.
6. Develop skills for coping with automatic thoughts:
    - Explain general principles for coping with thoughts about using.
    - Describe specific strategies for managing thoughts about using; review *Managing Thoughts About Alcohol or Substances* form.
7. Practice skills for coping with automatic thoughts:
    - Demonstrate self-talk.
    - Have patient practice with one of his or her using thoughts.
8. Assign between-session exercises.
9. Review and conclude session.

Session Protocol

The clinician welcomes the patient and inquires about thoughts and feelings since the last session, use of information covered in earlier meetings, and engagement in practice efforts. The clinician provides an overview of the session that will help identify and cope with thoughts about alcohol or other substance use.

Clinician Normalizes Thoughts About Alcohol and Other Drug Use

The clinician discusses the relationships among thoughts, feelings, and using alcohol or other substances.

> *Clinician (C): For people who have used substances for a long time, thoughts about using are normal; almost anyone who stops using thinks about starting up again. Thinking about using is not a problem provided you don't act on those thoughts. You may feel guilty about thoughts, and you may try to get them out of your mind. This skill topic will*

help you learn new ways to manage your thoughts before you slip. Sometimes the thoughts are obvious, but sometimes they creep up on you without notice.

Identify Thought Patterns Associated With Use

The clinician explains how negative thinking relates to alcohol or other substance use:

People who have used alcohol or other substances need to be aware of a state of mind that predisposes them to a relapse. This state of mind is characterized by dangerous attitudes and thought processes and is called "negative thinking." Negative thinking is dangerous because it induces people who have used alcohol or other substances to let down their guard (decrease vigilance). The thought itself isn't the problem; it's how people cope with their thoughts. If people learn to dismiss this thinking from their minds whenever it appears, recognize it for what it is, or counter it with a challenging thought, it need not lead to a relapse. You can learn strategies for coping with these thoughts.

Discuss Automatic Thoughts and Strategies for Coping

The clinician describes situations that can trigger automatic thoughts or thoughts that could lead to problems.

Attachment. Some people who formerly used alcohol or other substances remember using nostalgically, as if alcohol or other substances were an old friend. For example, "I remember the good old days when I'd go out dancing and smoke a few joints." It may seem difficult to live without the alcohol or other drug, like losing a close friend or partner.

Testing control. After a period of abstinence, people in recovery may become overconfident. For example, "I bet I can use tonight and go back on the wagon tomorrow morning." Curiosity also can be a problem: "I wonder what it would be like to get high again?"

Crisis. A person may respond to stress by saying, "I can handle this only if I'm high" or, "I went through so much, I deserve to get high," or, "When this is over, I'll stop using again."

Feeling irritable when abstinent. Some people find new problems arise after they become abstinent and believe these problems will resolve if they start using again. For example, "I'm short-tempered and irritable around my family—maybe it's more important for me to be a good-natured parent and spouse than it is to stop using right now," or, "I'm no fun to be around when I'm not using; I don't think I should stop because if I do, people won't like me as much."

Escape. Individuals want to avoid unpleasant situations, feelings, conflicts, or memories. The tendency to want to avoid or try to escape from emotional pain is common and contributes to mistaken beliefs that one is incapable of dealing with the situation or feeling without the use of alcohol or other drugs.

Negative feelings and experiences. Failure, rejection, disappointment, fear, anger, hurt, humiliation, embarrassment, and sadness tend to demand relief. People find they want to be able to stop these negative feelings or have greater control over their impact. They may want to anesthetize or numb themselves from the emotional pain they feel they cannot control or prevent. They may seek an absence of feeling rather than dealing with the experiences they are having and become disconnected from themselves and their true needs. Or, they may seek a kind of pleasure to erase the negative feelings.

Relaxation. Thoughts of wanting to unwind are normal, but sometimes people look for a shortcut, trying to unwind without doing something relaxing. An individual may choose the more immediate route through alcohol or other substances.

Socialization. This overlaps with relaxation but is confined to social situations. Individuals who are shy or uncomfortable in social settings may feel they need a social lubricant to decrease awkwardness and inhibitions.

Improved self-image. This situation involves a pervasive negative view of oneself and associated low self-esteem. When individuals become unhappy with themselves, feel inferior to others, regard themselves as lacking essential qualities, feel unattractive or deficient, or doubt their ability to succeed, they begin to think of using alcohol or other substances again because using previously may have provided immediate, but temporary, relief from these painful feelings.

No control. The attitude of being unable to control cravings ensures relapse. Individuals give up the fight, conceding defeat before attempting to resist alcohol or other substances use; they may feel out of control in other aspects of their lives as well. Alcohol or other substance use is considered a viable option. This attitude differs from the to-hell-with-it attitude in which individuals do not necessarily feel powerless; they just do not want to continue abstaining.

Explore Conceptual Difficulties

A patient may have difficulty understanding the concepts of cognitive analysis and restructuring. If a concept is not understood, the benefits of cognitive coping skills are compromised. This may be particularly true for patients with some cognitive limitations who are overly concrete in their thinking. With these persons, more behaviorally focused skills training tends to yield better outcomes. The clinician probes for the patient's understanding before moving on to the next concept. Illustrations and examples help convey the basic principles.

Initially, a patient may be unaware of the thoughts and feelings that precede decisions to use alcohol or other substances. He or she may be unaware of triggers and states. The patient may admit that usually some external force occurs immediately before use but cannot remember what it is. The patient denies personal responsibility for actions and attributes behavior to

forces beyond his or her control, making it difficult for the patient to initiate appropriate coping skills.

To help the patient grasp cognitive concepts, the idea of "slowing down the action" (as in an instant replay or a slow-motion film sequence) of the thought process is useful. The clinician assists the patient in breaking down the sequence of thoughts and feelings that lead to particular actions. He or she learns to observe, for example, that a tense interaction with a colleague may lead to feelings of frustration and to thoughts about not being good enough (e.g., smart, competent, or skilled enough), which can lead to thoughts about wanting to use alcohol or other substances. Once the patient can analyze the series of thoughts that might have led to a previous relapse, the notions of self-reflection and of modifying one's thoughts (cognitive restructuring) can be introduced. The goal is to increase awareness about the patient's thought processes and enable the patient to replace using thoughts with coping thoughts that enhance abstinence. See some examples of language that can be used below.

> *Try to identify your thoughts about wanting or planning to resume alcohol or other substance use and any rationalizations you may be harboring for using.*
>
> *What thoughts preceded your last using episode after a period of abstinence?*
>
> *What thoughts about alcohol or other substances seem to be the most frequent or strongest?*
>
> *Under what circumstances do these resumption thoughts tend to occur?*
>
> *Although this activity may feel strange, like most skills, it becomes easier with time.*

Develop Skills for Coping With Automatic Thoughts

The clinician helps the patient identify automatic thoughts and reviews some of the techniques used in previous sessions.

> *Everyone trying to stop alcohol or other substance use has thoughts about using. It's not the thought that creates the problem but how people cope with it. If you learn to recognize these thoughts and counter them with contrary thoughts, they need not lead to a lapse.*
>
> *The three general principles for coping effectively with thoughts about using are—*
>
> 1. *It's easier to choose to remain abstinent and not to give in to persistent thoughts if you are committed firmly to quitting.*
> 2. *It's easier to challenge substance-related thoughts and change them if you are aware of them.*
> 3. *This coping skill may take a longer time to master; these thoughts can return months and years after you stop using.*

The clinician reviews strategies for managing thoughts about using alcohol or other substances and shows the patient the handout *Managing Thoughts About Alcohol or Substances.*

Challenge the thoughts. Use other thoughts to challenge the resumption thoughts. For example, I cannot get a little high without increasing my risk of using more," or "I don't have to use alcohol or other substances to unwind after work; I can use relaxation exercises," or "I can have good times without alcohol or other substances; it may feel strange at first, but in time I'll feel more comfortable."

The clinician can explain that an important aspect of challenging thoughts about using (and forms of thought distraction and substituting behaviors incompatible with using) is to avoid visualizing what you are not going to do and instead picture a behavior that you will do. You might try developing a mental picture of the new behavior when the old habit pops into mind.

List and recall benefits of not using. Thoughts about the personal benefits of abstinence can weaken excuses for using. Benefits to think about include better physical health, improved family life, job stability, more money for recreation and paying bills, increased self-esteem, and self-control. It is important to pay attention to these positive aspects and the progress you're making; don't focus on what you're giving up. Carry a card with you listing the benefits, add items as you think of them, and review them regularly.

Recall and list unpleasant using experiences. Recall the pain, fear, embarrassment, and negative feelings associated with using alcohol or other substances. Make a list of unpleasant experiences, such as memory problems, lack of motivation, procrastination, arrests, withdrawal, paranoia, and sleep disturbances on the back of the card that lists the benefits of abstinence. Read the card regularly. Counteract the positive thoughts you have about using with the negative aspects of using and the benefits of abstinence. Visualize the possible using episode to the end and include all the detrimental consequences that occur with using alcohol or other substances.

Find distractions. Think about something pleasant such as holiday plans, vacation spots, loved ones, relaxation, or hobbies. Focus on a task you want to get done.

Promote self-reinforcement. Remind yourself of your success—for example, 2 weeks of abstinence, involvement in treatment, staying in the treatment program.

Leave or change the situation. Try a different activity, such as a hobby or physical exercise.

Call your supporter or a friend.

Use self-talk. Self-talk refers to constructive things you can say to yourself that replace negative thoughts. We talk to ourselves all the time. Our thoughts have a powerful effect on how we feel and act and on our decisions. One way to be sure negative thoughts don't sabotage your effort to quit is to learn how to recognize them and challenge them effectively. Self-talk is an effective way of coping with thoughts that make staying away from alcohol or other substances difficult.

Practice Skills for Coping With Automatic Thoughts

The clinician and patient practice self-talk.

Let's practice self-talking in response to concerns about quitting. We'll choose a general concern about quitting to work on. Then you'll do two things:

1. *State the concern in your own words using an "I" statement.*

2. *After stating the concern, follow it with a challenging statement. Again, use the pronoun "I" when making a challenging statement, and say it forcefully.*

The clinician illustrates how to incorporate self-talk by focusing on a particular automatic thought that might trigger alcohol or other substance use (e.g., *"I guess I wasn't as dependent on alcohol or other substances as I thought"*). The clinician repeats the thought and follows it with a challenging statement.

1. *Automatic thought. Quitting alcohol or other substances was easier than I thought. I must not have been dependent on it in the first place.*
2. *Challenge. This makes no sense. What am I saying? Quitting hasn't been easy. I had the urge to use all the time until the last few days. If I weren't dependent on it, I could have quit long ago. I just really miss the feeling of being high, and I am doing what I have frequently done in the past, which is to talk myself out of quitting. I think I'll do something else with how I am feeling right now.*

When conducting the demonstration, the clinician makes eye contact, speaks clearly and confidently, and repeats the demonstration if necessary. After the clinician gives a few demonstrations, the patient practices using any concerns he or she has.

Other examples of automatic thoughts include, "*I'm not feeling that much better now that I've quit," or, "I bet I can smoke once in a while."*

It is important to support the patient's phrasing of the automatic thoughts and challenges. The clinician encourages the patient to be specific (*e.g., "What do you mean by, 'No one cares whether I smoke or not'?"*), delivers responses as if the situation were real, and uses the first person. If the patient gives a response that seems problematic, the clinician specifies the problem (e.g., not the first person, not specific in the challenge, not said in a forceful tone) and asks the patient to try again. The clinician praises the patient for engaging in this role-play, which can be difficult. The clinician gives constructive feedback and avoids judgments or disapproval. The following factors contribute to the patient's ability to formulate a positive response, although not all need to be present all the time:

- Acknowledgment of negative or ambivalent feelings
- Reminder of the positive side (e.g., motivation and commitment, long-term positive outcomes, enhanced self-esteem, improved health)
- Specific positive alternatives
- Humor
- Absence of self-condemnation
- Self-reinforcement or self-appreciation

Miguel: Sometimes, I just want to smoke. It's easy to forget why I wanted to quit.

Clinician: It gets easier with experience. You are changing a habit that was formed over many years and finding it difficult at times. People need to remind themselves of how hard that can be. Let's go over the skills that may help you and see whether you think they will work.

Assign Between-Session Exercises

At the end of the session, the clinician explains the between-session exercises on *Managing Thoughts About Alcohol and Substance Use*. To complete this exercise, the patient writes out lists as follows:

- Five to 10 benefits of not using
- Five to 10 negative consequences associated with using
- Five to 10 stumbling blocks or high-risk situations for maintaining abstinence

The patient uses this information (the benefits of abstinence and the negative consequences of using) to rate his or her commitment to quitting. The patient's perceived level of commitment can range from 1 (no commitment) to 10 (extremely high level of commitment).

Review and Conclude

The clinician reviews the content of the session, asks the patient for feedback, responds empathically to his or her comments, and troubleshoots any difficulties. The clinician explains that the patient will report back on his or her efforts to complete the between-session exercises at the next session. The clinician also prepares the patient for the next session by introducing the topic and explaining how it will be helpful on the path toward wellness.

Session 11. Working With Emotions: Fostering Some, Dissolving Others

Introduction

In session 11, the clinician provides the patient with information about the evolutionary role of different types of emotions and the relationships among thoughts, emotions, and alcohol and other substance use. This information, along with discussion about the patient's unique experiences and handling of various emotional states, provides a rationale for trying to cultivate certain emotions while reducing the impact of others. The clinician may find it beneficial to cover this material in more than one session, depending on its relevance for the patient.

The Perspective on Emotion in Cognitive Behavioral Therapy

According to the CBT approach, emotions do not simply rise out of nowhere, and they are not directly related to events that take place. They are intricately linked with the thoughts, interpretations, and perceptions about the things that happen. It is possible to change the way one feels about oneself or a situation by altering the way one is thinking and also by engaging in activities that produce positive or healing emotions.

The Importance of Positive Emotions

Barbara Frederickson (2000), in her article "Cultivating Positive Emotions for Optimizing Health and Well-Being," refers to her "broaden-and-build model of emotions" (p. 6) and the role of different types of emotions with regard to their evolutionary value. Positive emotions, sometimes called "approach emotions" because they lead people toward affiliative activities (e.g., joy, interest, contentment, sociability), have the benefit of helping individuals to experience a broader perspective and capacity to deal with challenges. They are the feelings that facilitate a sense of expansiveness, creativity, hope, persistence, resilience.

Daniel Goleman (2003) also highlights the value and benefit of positive emotions for their "healing properties" (p. 33). This idea of positive emotions having healing potential is of great interest to those working in health and related fields. Increasing the amount of time spent in positive emotions can be beneficial on many levels. From a psychological standpoint, it can increase problem-solving capacity by helping someone access multiple pathways for addressing a particular challenge. It may create a kind of "stress inoculation" (Meichenbaum, 2007, p. 499) whereby individuals will have greater ability to tolerate and respond constructively to stressors. Positive emotions can counteract the negative effects of stress, such as suppressed or weakened immune function.

In contrast, negative emotions, which can be referred to as "withdrawal emotions" (e.g., fear, sadness, anger), tend to be narrowing or constricting because they reduce our "momentary thought-action" repertoire. This makes sense from an evolutionary standpoint because when we are faced with life-threatening danger, it is better to hold a narrow focus and scan the

environment quickly to determine how to achieve or regain a sense of safety. The problem occurs when negative emotions become chronic or automatic, even in situations where there is no objective danger present. The example becomes clear in thinking about posttraumatic stress disorder (PTSD). An individual with PTSD becomes hypervigilant to signs of danger and may be triggered by things not objectively a threat in the present (although they may certainly have signaled danger at another time and place; for example, an adult who was physically abused as a child having a heightened sensitivity to signs of disapproval or anger in others).

Positive emotions have the ability to "undo" or reduce the hold that negative emotions can have on a person. Therefore, helping people cultivate or foster more positive feelings and experiences can reduce their experience of negative emotions. This is similar to the theory that forms the basis and rationale for using relaxation training for anxiety and phobias. It may be difficult or impossible to experience both tension and relaxation simultaneously, and therefore increasing relaxation will have the effect of competing with the anxiety and ultimately winning.

Patients who come to brief treatment are likely to be struggling with their handling of different emotional states. They will report that the alcohol or other substance helps them "feel better." However, using substances to treat difficult or painful emotional states (that is, as an "affective" or "emotional regulator") often results in more problems and does not address the primary issue of feeling bad. In fact, when substances become a routine escape from negative states, this cycle tends to create even more negative feelings because now the person has to cope with the consequences (e.g., health, relationships, legal, occupational) associated with excessive use.

In this session, the clinician also explores the patient's experience with depression and other negative states. The patient learns to recognize and cope with negative affective states. The clinician addresses the possibility of negative moods, explaining that anxiety, irritability, and depression are common among people overcoming an alcohol or substance use problem.

Some theories about the etiology and maintenance of substance abuse suggest that substances are used to regulate negative emotional states when one has not developed other, more constructive methods of self-regulation. Helping individuals reduce their experience of negative emotions may remove an important trigger for substance use. The reduction of negative emotional states may also create opportunities for more creative, expansive states and increase problem solving and feelings of self-efficacy.

Cognitive behavioral theory views the experience of negative emotional states as being affected strongly by one's thoughts or interpretations of events, while also recognizing the role of neurobiological factors. That is, an experience may be felt as highly negative when one makes personal attributions; for example, blaming oneself entirely for a negative event or outcome ("It was all my fault our soccer team lost the game"). This amplifies the extent of a negative effect (e.g., "This is terrible. I will never be able to achieve my goal of quitting smoking"). The individual may engage in other thought processes that serve to heighten a sense of negativity,

futility, and disaster. CBT describes a number of commonly employed "cognitive distortions" that tend to foster and intensify negative emotions.

The Patient's Experience

This session is intended to increase the patient's understanding of the role of different emotional states and how emotions of discovering, exploring, and practicing pleasurable activities can engender positive feelings. Many times patients who have developed risky use of substances have come to think of the substance use as fun and enjoyable. Over time, the substance use takes the place of other important activities and relationships and replaces activities that were once enjoyable. The focus of this session is on helping the patient reconnect with activities, hobbies, and other experiences that have been pleasurable in the past, or seem they would be enjoyable if the person has never tried them.

Clinician Preparation

CBT Session 11. Working With Emotions: Fostering Some, Dissolving Others

Materials

- Handout on positive emotions
- Pleasant Activities List
- Cognitive Distortions That Dampen One's Mood
- Thought Record
- Managing Negative Moods and Depression

Total Time

1 hour

Delivery Method

CBT-focused individual or group therapy

Strategies

- OARS (Open-Ended Questions, Affirmations, Reflections, Summary)
- Support self-efficacy
- Demonstrate skill, role-play
- Follow CBT skills session reminders

Goals for This Session

- Educate the patient about the role of different emotional states.
- Elicit discussion and reflection about the patient's emotional experiences and methods of handling different emotions.
- Increase patient's awareness about the value of positive and healing emotions and methods for increasing these states.
- Become aware of different experiences of negative moods and their role.
- Discuss the constricting and sometimes damaging effects of certain negative emotions.
- Become more aware of how moods affect alcohol or substance use.
- Learn strategies to recognize, process, and cope with these emotions.

Session 11 Outline and Overview

1. Maintain rapport and review previous week.
2. Introduce the concept of "working with" emotions.
3. Discuss the evolutionary value and/or role of various emotions in day-to-day life.
4. Explore the patient's experience with different emotions, connection with alcohol or other drug use, and typical ways of regulating his or her emotional state.
5. Provide a rationale for fostering positive emotions, which can be constructive and healing.
6. Review a list of pleasant activities and develop a plan for increasing opportunities for positive emotion.
7. Assign practice exercises involving pleasant activities.
8. Provide a rationale for decreasing or dissolving the effects of negative emotions.
9. Discuss thinking patterns or cognitive distortions that tend to dampen or depress one's mood:
    - Review *Cognitive Distortions That Dampen One's Mood.*
    - Explain "cognitive distortions."
    - Explore automatic thought patterns that appear to lead to negative mood states.
    - Ask the patient to identify which automatic negative thoughts he or she may engage in before or during depressed, anxious, or irritable moods.
10. Build internal resources for handling automatic thoughts:
    - Discuss with the patient guidelines for evaluating these thoughts.
    - Give the patient the *Managing Negative Moods and Depression* handout.
    - Engage the patient in problem solving to address problems contributing to his or her negative moods.
11. Link negative moods with alcohol or substance use:
    - Explore the relationship between the patient's alcohol or substance use and his or her experience of negative moods.
    - Explore methods of changing the patient's automatic thoughts that can lead to alcohol or substance use.

Session Protocol

Maintain rapport and review.

Welcome the patient**.** Review events from the previous week. Inquire about between-session exercises if they were given. Discuss the patient's current status regarding substance use, readiness to change, and progress with goals.

Introduce session topic of working with emotions.

Introduce the topic of emotions and their role in our lives. Share with patient the handout *Focus on Emotion*.

> *Hi. Today I want us to talk some about emotions and the role they play in our lives. I know you told me you had been feeling pretty sad a lot, and you think that is related to your using alcohol the way you have been. I am hoping that through our discussion today you will have a better understanding about emotions in general, and more specifically, how you experience and cope with different emotional states. I want to share some information with you about different emotions and how they all have some value.*

Discuss the evolutionary value and/or the role of various emotions in day-to-day life.

> *For example, it's important for us to feel sad when we have some kind of loss or disappointment. Or to feel scared when there is a threat to our safety. And even to feel angry when we have been treated unfairly. Those negative emotions are important because they help us to figure out what we need to be safe, or to take care of ourselves. However, those feelings can also make us feel kind of disconnected from people, withdrawn, and as though there aren't a lot of things we can do to feel better. For example, you seem to have come to believe that when you are feeling sad, drinking is the only thing you can do to feel better. There are actually many things you can do that have the potential for lifting your mood. And the really interesting thing is that when you start doing things that make you feel more positively (e.g., joyful, engaged, hopeful), you won't be feeling as negatively because it's difficult to feel both good and bad at the same time.*
>
> *It's not that we should never have negative feelings, but we might want to step back and see whether we can have some greater control, or role, in the way we feel. If we can put effort into doing things that are likely to make us feel more positively, this will help us in other ways too. When we are feeling positively, we are more likely to be creative and able to work toward goals we have. We can think of different solutions to a difficult problem, rather than feeling as though there is only one way. Does that fit with your experience? Do you notice that when you are in a good mood, you feel more capable of handling challenges? Or your problems don't seem as big and unmanageable? Whereas when you are feeling down or negative, everything seems so hard and like too much work? And no one can really seem to understand or help you?*

Explore the patient's experience with different emotions, his or her connection with alcohol and other drug use, and how the patient tends to regulate his or her emotional state.

> *Can you tell me a little about how your mood is in general? What kinds of things seem to make you feel more positively? What makes you feel more discouraged or negative? How do you deal with negative feelings? How do you suppose your use of drugs or alcohol might or might not be connected with different feelings you have?*

Provide a rationale for fostering positive emotions, which can be constructive and healing.

> *Scientists and those interested in studying the role and value of different emotions have found that it is possible and desirable to actually increase our experience of positive emotions and that this is very helpful to our overall health and well-being. For example, when we are in a positive state of mind, we tend to be more creative in our thinking and problem-solving. We can see many possibilities open to us in dealing with challenges. We feel confident in our ability to accomplish goals. We feel hopeful about the future. We experience joy and a sense of well-being. It is even good for our heart as our blood pressure may be lowered when we are feeling positively. Trying to cultivate positive emotions is helpful not only in the present moment for feeling better, but may have some longer term benefits, as we may be able build a store of capability and resources that we can access in the future as needed. Does this make sense to you? Any questions?*

Review a list of pleasant activities and develop a plan for increasing opportunities for positive emotion.

> *One thing we can do together is to figure out some other activities you could get involved with that would be pleasant for you. You may think you don't know what would be pleasant anymore, but I am going to help you. Let's start by talking about the kinds of things you like to do (or used to like to do), or you could imagine liking to do. For example, I have not gone cross-country skiing, but I really think I would like it. What kinds of things do you like to do? Do you have, or have you had, any hobbies? When did you do that? Why did you stop?.*

After a period of discussion about emotions, the patient's current strategies for handling negative emotions and positive activities the patient generates, take out the *Pleasant Activities* sheet and review it with the patient. Ask the patient to indicate which of the activities would seem enjoyable. Indicate there are no right or wrong answers, and he or she may check as many as preferred. If the patient has difficulty, use probes such as asking which activities have been enjoyed in the past even if the person does not engage in them now. Then ask if there are any other things not on the list that would be pleasant to do. Next, have the patient review the items checked and indicate how difficult or easy it would be to start doing some of them. Finally, ask the patient to select several activities from the list that he or she would be willing to try over the next week and journal or record what he or she did and how it went. Ask if the patient has any questions.

I'd like to spend some time today talking about different emotions and how your negative feelings might be related to your use of [____]. We need to be able to experience and express a lot of different feelings, both positive and negative. It's important to be able to experience grief, for example, when we've had a significant loss. The problem happens when we get stuck in negative emotions, beyond the point where they are helping us to heal or move forward. Do you know what I mean? Because although all emotions are important, negative feelings like anger, fear, and sadness can be triggers for substance use. Have you noticed that you are more likely to reach for [____] when you are feeling down or upset? Many people say they tend to use alcohol or other substances to help them feel better when they are feeling unhappy. A problem with doing this is that it can become a habit, and people may not develop other, healthier ways of dealing with these difficult feelings.

Another problem with staying for long periods in negative emotions is that they tend to take over, and we may forget that we have had times where we felt really well, or believed we could accomplish our most important goals. Negative emotions can keep us from being creative in how we approach our life and our struggles. For example, in a negative state, it's hard to see there are usually many different solutions or ways we can approach problems and challenges. Have you heard this saying: "When all you have is a hammer, everything looks like a nail"? [Discuss this analogy and its relevance for the patient.]

So, you may be able to gather that I am building a case here for us to try to reduce your experience of negative emotions and feelings. I think it could be helpful if you could learn how to move more quickly out of negative feelings when they are no longer useful to you, and to recognize the ways your own thinking about things might be contributing to your feeling negatively at times.

The clinician summarizes the links between negative moods and substance use and inquires about the patient's experience with negative states.

Moods may relate to the effects of stopping substance use or the losses in one's life (e.g., family, job, finances) resulting from substance use. Difficulties with negative mood states (e.g., depression) may have started before substance use and may serve as a trigger for continued use. Abstinence from substances usually leads to improved mood (especially as patients start to cope effectively with other problems), but some individuals experience depression or other moods even after being abstinent for several weeks. Because negative moods often pose a risk for relapse, we should address this possibility directly during treatment.

Some examples of linking negative moods and substance use

The clinician explores the relationships among substance use, the experience of negative moods, and the role of automatic thoughts.

Shirley (S): I miss drinking when I'm overwhelmed by bad feelings. I felt better after drinking.

Clinician (C): Drinking helped you cope with your negative mood.

S: Yeah, but I would get depressed again after drinking for a while, or when the buzz wore off.

C: What works for you in the short term causes other problems later.

S: Yeah.

C: Today we've reviewed ways to cope with negative thoughts. You said getting up and moving around helps. Researchers have found that often the negative feelings don't just happen. That is, they don't come from nowhere. In fact, negative feelings may be related to the way we think about things or the way we interpret situations.

Approaches to Reducing Negative and Constricting Emotions

The clinician focuses on negative moods through problem solving and increasing pleasant activities (may use handout from session 6). If during the course of this session, the clinician suspects the patient can benefit from additional counseling or psychotropic medications, the clinician should explore these possibilities with the patient, particularly with a patient who is significantly depressed, has an anxiety disorder, or has a personal or family history of mental disorders such as major depression, suicidality, or aggression. Review session 13 on the use of medication to support treatment and recovery. The clinician may wish to complete a specific depression or anxiety screen such as the Patient Health Questionnaire-9 (PHQ-9) or the Generalized Anxiety Disorder 7-Item Scale (GAD-7), copies of which are in the handout section. The clinician discusses the following strategies to help a patient with mild to moderate levels of depression identify negative feelings:

- Increase awareness of negative moods and overly negative thinking.
- Challenge negative thoughts.
- Solve problems.
- Change the patient's activity level.
- Decrease negative activities.

The clinician asks the patient whether he or she experiences mood swings, low energy level, changes in appetite and sleep, and suicidality. If indicated (e.g., in the case of suicidality), the patient should be referred for assessment by a mental health professional. The clinician encourages the patient to be aware of possible distorted perceptions that may precede or coincide with negative moods. The clinician encourages the patient to pay attention to the context associated with mood changes and to watch for times when confidence level changes.

Introduce the Concept of Cognitive Distortions

Share with the patient the theory suggesting our feelings and thoughts are often closely linked. The clinician reviews the handout *Cognitive Distortions That Dampen One's Mood*. Either have the patient read it first or review it together with one of you reading aloud. After each item, inquire whether the patient relates to it, and if it is something he or she typically does. Explain how these automatic thought processes or distortions likely contribute to feeling negatively. The clinician explains that a connection exists among how people think, feel, and behave and

that the patient can experience fewer negative moods if he or she thinks in realistic, balanced ways rather than in overly negative, self-defeating ways.

> *Clinician: One way to reduce our experience of negative feelings is to examine and then change some of our thought patterns that may be contributing to these feelings. Our feelings are often closely linked to how we are thinking about ourselves and the events in our lives. I want to talk with you about something called a "cognitive distortion," which some people think can really make us feel bad, or worse than we would have otherwise. Here is an example: You make an attempt to stop using cocaine and are able to remain abstinent for 3 months, but then you have a slip when a friend offers you some alcohol, which then leads to using cocaine for 2 days. You tell yourself you are a failure and will never be able to stop using cocaine because you just don't have what it takes.*
>
> *This is an example of a cognitive distortion called "all-or-nothing thinking." This means that situations are evaluated in terms of extremes, and there is no middle ground. Something is either great or terrible. You view yourself as either completely successful and disciplined or a loser and failure because you had a lapse with cocaine.*

The patient identifies which automatic negative thoughts he or she engages in. If the patient has difficulty identifying these thoughts, the clinician tells the patient to slow down the action (as if watching a movie in slow motion) or look at what the situation means. Sometimes writing down the most distressing thoughts helps a patient remember his or her thoughts. Once the patient identifies his or her automatic negative thoughts, the clinician gives the patient the handout *Managing Negative Moods and Depression*. The clinician asks the patient to fill out the form thinking about distressing situations to avoid and recognizing that an event often can be interpreted in more than one way (Emery, 1981).

The clinician helps the patient address some of the most prevalent cognitive distortions or thinking errors through a process of challenging these assumptions and their premises. The clinician might ask questions such as—

- What is the evidence?
- Are you certain about this?
- Are there other possible explanations/interpretations?
- So what if that were true?
- What's the worst part about that?
- What is the likelihood this (fear of something terrible happening) will actually take place?

The clinician encourages the patient to develop a practice of challenging and questioning his or her automatic negative thoughts and assumptions. The clinician asks the patient to pay attention to automatic thoughts that arise during the next week and to write them down in a journal or thought record along with other information about the situation.

Review and Conclude

Review and summarize the session. Praise the patient's efforts to stay engaged in the process and to make changes. Provide the handouts on *Pleasant Activities* and *Cognitive Distortions, Managing Negative Moods.* Elicit a between-session commitment from the patient (e.g., that he or she will review the handouts, practice challenging automatic thoughts, and engage in at least two pleasant activities over the next week). Prepare the patient for the next session by introducing the topic and explaining how it will be helpful in the path toward wellness. Schedule and confirm the next appointment.

Session 12. The Next Chapter: Wellness Planning, Writing the Story

Introduction

In session 12, which may be the final session with the patient, the clinician conducts a review, integration, and planning for the future. The clinician works with the patient to identify potential obstacles along the path ahead and strategies for handling these roadblocks. Obstacles might include upcoming high-risk situations the patient will confront or a lapse with using. It is important to highlight the nonlinear nature of recovery and to focus on the metaphor of "path" or "journey," which can include "under construction" signs, setbacks, speed limits, and detours. These obstacles can be seen as part of the trip and not an indication of failure. This session may be used to develop a project involving creative expression or writing to summarize, highlight, or celebrate the important work the patient has undertaken.

The Patient's Experience

The patient will experience support and assistance in contemplating the future after formal treatment has concluded. The patient will receive guidance regarding high-risk situations and strategies for coping with upcoming challenges, including lapses or relapses to use. The patient will receive praise for undertaking this journey of self-discovery, growth, and change and encouragement in developing a creative project that highlights and celebrates these efforts.

Clinician Preparation

CBT Session 12. The Next Chapter: Wellness Planning, Writing the Story	
Materials ▸ High-Risk Safety Plan ▸ Personal Emergency Plan: High-Risk Safety Planning ▸ Understanding My Use ▸ Recovering From an Episode of Use ▸ Learning New Coping Strategies ▸ Telling Your Story	**Total Time** 1 hour **Delivery Method** CBT-focused individual or group therapy
Strategies ▸ Open-Ended Questions, Affirmations, Reflections, Summary ▸ Supporting Self-Efficacy ▸ Closure with an open door	
Goals for This Session ▸ Review the course of treatment and evaluate learning. ▸ Identify next steps for the patient along the journey of healing. ▸ Increase preparedness for unexpected triggers and situations likely to promote relapse. ▸ Learn techniques to manage the aftermath of a lapse or relapse of alcohol or substance use. ▸ Encourage the patient to write his or her story in some form.	

Session 12 Outline and Overview

1. Review treatment:
    - Elicit the patient's experience of engaging in the treatment process.
    - Review areas of progress and strength and continued challenges.
2. Explain the effects of major life changes:
    - Identify life changes the patient has or will experience.
3. Present a personal care plan: high-risk situation.
4. Present a personal care plan: lapse.
5. Review previous skill topics:
    - Review strategies from previous skill topics the patient found helpful.
6. Encourage the patient to write or record his or her story:
    - Highlight the courage and effort the patient demonstrated.
    - Encourage the patient to develop a creative project.

- Identify a format the patient might enjoy (e.g., writing narrative, journal, expressive art, collage, dream box).

7. Close the session.

Session Protocol

The clinician welcomes the patient and provides an overview of the session, explaining the time will focus on helping the patient develop an emergency plan to follow in high-risk situations or to cope with a lapse in alcohol or substance use.

Maintain Rapport and Review Progress

Guidelines. Conduct a review and build rapport as in each session. Add new review elements from the previous session.

Slips, Lapses, and Relapse

Guidelines. The focus now turns to situations that could derail plans for the patient and increase rather than reduce substance use. First, the clinician discusses slips and relapses, then elicits high-risk situations and presents a model for problem solving. The clinician helps the patient fill out the *High-Risk Safety Planning* worksheet using the elicited problems and coping strategies, tying together the skills learned in all the previous sessions. The clinician explains that life changes, both negative (e.g., health problems, unemployment, financial losses) and positive (e.g., a new job, graduating from school, moving to a new home) can threaten a patient's efforts to remain abstinent. In these situations, the patient needs an emergency plan to cope with stressors.

The clinician emphasizes that how one deals with a lapse or relapse is most important, explaining that many people have minor lapses on the road to health and reduction of use, and there are also many people who attempt to cut back but cannot. There may be extended periods of use or even increased use levels after periods of abstinence. If the patient wants to know more facts about relapse, the clinician can further explain that more than half those ending treatment will have multiple relapses back to old patterns of using. Some will begin using more within 90 days of ending treatment. Research has demonstrated that it takes a year of abstinence before fewer than 50 percent of patients relapse; even after 3–7 years of abstinence, about 14 percent of patients relapse (Dennis & Scott, 2007).

> *What has your experience of managing your own previous cut back/recovery attempts been to date? What have your previous lapses and/or relapses taught you?*

If the patient has no past attempts at reducing use, ask what he or she has noticed during this attempt. The clinician explains to the patient that stories like his or hers demonstrate that making any change in behavior is a process, as is a lapse or relapse. When the appropriate

strategies are not used, or there is a family disagreement, increased use might result. Some important principles to convey follow:

- Patients may think that after one slip back to old use patterns (or even a fuller relapse), the whole wellness/reduction plan is ruined, and they might as well give up. Let them know this does not have to be the case.
- Patients may learn something from a slip/relapse. Tell them that by looking at the circumstances of the relapse, they may learn situations to avoid, or changes to make in their coping skills.
- Patients can choose to resume their efforts to live without substances after a lapse or full-blown relapse.
- The take-home message is this: Recovery strength is based on consistent management of "wellbriety," a lifestyle that incorporates refusal skills, sober social supports, replacement activities, and problem-solving skills.

The clinician provides the worksheet *High-Risk Safety Plann*ing to help the patient plan for emergencies.

> *Even if someone avoids situations involving alcohol and drug use, knows how to refuse such offers, increases his or her support system, and plans positive alternative activities, he or she still may encounter unanticipated high-risk (emergency) situations and may lapse and/or relapse. Having a plan in place and written down, like this one increases the likelihood you'll be able to abstain from using. Let's brainstorm potential high-risk/emergency situations—unanticipated circumstances that place you at increased risk for substance use. Let's include both negative events and positive events (e.g., a new job or a move to a better home) you are likely to encounter.*

Present a Personal Care Plan: High-Risk Safety Planning

The clinician gives the patient the *High-Risk Safety Planning* handout, and together they review the form considering the high-risk situations just identified. The patient might want to plan alternative enjoyable activities for high-risk times; the clinician can help the patient with these plans. The clinician encourages the patient to review compelling reasons for continued abstinence, as noted on the personal reflective summary or the *Future Self Letter*.

Present Personal Care Plan: Lapse

The clinician explains that lapses are not uncommon and asks what might help the patient leave a setting where a lapse occurred and whom he or she could call for immediate support. The clinician presents the *Personal Care Plan: Coping With a Lapse or Slip* handout and asks the patient to think of strategies to cope with a lapse. The clinician helps the patient specify how the strategies would be carried out, such as how to dispose of alcohol or substances (e.g., throw it away, flush it down the toilet), how to challenge negative thoughts (e.g., I'll quit again after I finish this stash; my life is just too stressful; I was so irritable when I quit last time, I

should continue using because I'm nicer to be around"). The patient already should have removed paraphernalia from his or her home, but strategies may need to be reviewed.

Review Previous Skill Topics

The clinician and patient discuss strategies from previous skill topics that the patient found helpful (e.g., urge surfing, mindfulness, challenging negative thinking) and review *Learning New Coping Strategies* and the patient's goals.

Encourage the Patient To Write or Record His or Her Story

- Highlight the courage and effort the patient demonstrated.
- Encourage development of a creative project celebrating the patient's efforts and accomplishments.
- Identify a format the patient might enjoy (e.g., writing narrative, journal, expressive art, collage, dream box).

> *I am wondering whether you might be interested in writing about your experience of our work together here in treatment. I have been impressed with your effort in considering important changes to your life. You have shown a lot of courage in being willing to meet and talk with me about so many things. I have enjoyed getting to know you. It might be interesting if you would want to capture this in some way as people often find that writing or other kinds of creative expression can be both enjoyable and therapeutic. Of course, there is no pressure on you to do this, but if you are interested, I can provide some guidance as we discuss different ideas. What do you think?*

Terminate Treatment

If this is the final treatment session with this patient, the clinician discusses termination issues, reviews the course of treatment, identifies next steps and plans for patient, and provides referral information as necessary.

Session 13. Use of Medication in Support of Treatment and Recovery

Introduction

Significant research over the past 2½ decades has greatly increased our understanding of the biological mechanisms associated with substance use, abuse, and dependence and the biological underpinnings of certain mental disorders. This knowledge has helped to advance the appropriate use of medications in the treatment of substance use disorders and mental disorders. Despite these advances, many disorders are not routinely treated with medications because of lack of information to patients, stigma associated with the use of medications, or no medication routinely available to treat the disorder.

The focus of this session is to facilitate a conversation with the patient regarding the benefits and potential risks associated with taking a prescribed medication in support of treatment and recovery. While not all patients may need this support, there is evidence an important percentage of patients benefit from medication. Medication can be used to address the substance use disorder and/or the symptoms of a co-occurring mental disorder. The clinician is encouraged to maintain an approach that supports patient autonomy in making these decisions. Often what results from a conversation of this sort is not a full commitment to take a prescribed medication but at least a willingness to meet with a prescriber as part of a medication evaluation to fully understand the potential benefits of medication use.

Goals for This Session

- Discuss the patient's thoughts and feelings about the use of medication as an adjunct to treatment services.
- Help the patient learn more about medications, their potential benefits, and the risks in the treatment of substance use and other disorders.
- Support the patient's decisionmaking regarding the use of medications.
- When indicated, actively support referral and provide followup when a medication evaluation is indicated and when medication is prescribed.

The Patient's Experience

In this session, the patient will participate in a respectful conversation about the possible benefits of medications, while being fully supported in the ability to make this decision on his or her own. The patient will learn what symptoms or issues medication may benefit, such as intense craving or withdrawal symptoms in the case of medications addressing substance use, depressed mood, mood swings, problems with sleep, and anxiety or panic. The clinician provides factual information, including handouts describing types of medications. This information will support the patient in efforts to make a more informed decision regarding treatment. The clinician addresses the patient's questions and concerns and provides

information only within the scope of practice. If and when the patient decides he or she is interested in either a medication evaluation or in actively pursuing medication support, the clinician will be actively engaged, advising of available and appropriate prescribing resources. The clinician will offer to provide information to the prescriber in advance of the medication evaluation session, but only with the patient's written permission.

Clinician Preparation

MET Session 13. Use of Medication in Support of Treatment and Recovery	
Materials ▸ Copy of the PHQ-9 ▸ Copy of GAD – 7 ▸ Medication information handouts	**Total Time** 1 hour **Delivery Method** MET-focused individual therapy with psychoeducation and care planning
Strategies ▸ OARS (Open-Ended Questions, Affirmations, Reflections, Summary) ▸ Use of decisional balance ▸ Information dissemination ▸ Support decisionmaking and planning ▸ Care coordination in support of medication evaluation	
Goals for This Session ▸ Explore the patient's thoughts and feelings about the use of medication as an adjunct to treatment services. ▸ Help the patient learn more about medications, their potential benefits, and the risks in the treatment of substance use and other disorders. ▸ Support the patient's decisionmaking regarding the use of medications. ▸ When indicated, actively support referral and provide followup when a medication evaluation is indicated and when medication is prescribed.	

As part of a clinician's professional development, knowledge of medications and their role in treatment and recovery is viewed as an essential core competency. The clinician's attitudes and beliefs regarding medications should be minimized in these patient discussions. It is important for the clinician to remain focused on what may be of greatest value to this patient. The clinician should have access to reliable and correct information regarding medications and local prescribers.

If these medication discussions are being prompted because of concerns for a co-occurring mental disorder, the clinician may choose to use a valid screening tool to gather relevant information. The most common co-occurring disorders addressed in brief treatment are those of depression and anxiety. The clinician may choose to use validated screening tools such as the PHQ-9 to screen for depression or the GAD-7 screen mentioned in session 11. These are public

domain tools readily available and easy to use (copies appear in the handout section for this session). Screening tools do not diagnose, but they help to better identify associated symptoms and inform clinical conversations.

If prescribing resources are available within the clinician's practice, knowledge of making an internal referral and shepherding that process is important. If a referral into the community is required, it is incumbent on the clinician to know of available resources and to be proactive in networking with these prescribers. Within the clinician's practice, it is often necessary to know the patient's insurance status as not all prescribers are on panels of all insurers.

Session 13 Outline and Overview

1. Enhance rapport, review the week in general (pros and cons) and progress toward recovery goals, review the weekly challenge.
2. Ask permission to discuss treatment options and provide the rationale for medication in support of recovery goals.
3. Explore patients thoughts, feelings, beliefs and prior experiences (if any) with medications
4. Provide information as necessary
5. Addressing negative perceptions
6. Facilitating patient reflection on risks and benefits
7. Facilitate decisional balance discussion
8. Negotiate plan for next steps
9. Following up on a decision for a medication evaluation (when indicated)
10. Review, summarize, and conclude session

Session Protocol

If a patient has some awareness of medications that can support recovery, he or she may be actively seeking further information and referral. In other circumstances where a patient appears to have limited knowledge about medications and in the clinician's judgment medications may be a useful adjunct, a more detailed discussion and feedback process may be indicated to explore this option.

Setting the Agenda

Patients have a wide range of knowledge, beliefs, and experiences associated with the use of medications. Discussion should be tailored to the individual. If the patient has no previous experience related to medication, the clinician may wish to initiate the conversation using

characteristic motivational interviewing approaches. The clinician may simply ask first to take a few minutes to discuss some treatment options and provide some feedback and information.

> *We have talked about ways we can work together to address your [drinking or drug use]. One of the options we haven't yet considered is for you to take one of the medications that have been approved for treating substance use problems. There are no 'magic pills' out there that will make recovery easy, but we do have some good medicines that help people who are motivated to make some changes. If you would like, we can talk about what some of these options are and consider them if this is something you want to pursue.*

When a patient has some experience with medications, the patient may be the person raising the issue. If this is the case, the initial work of the clinician is much easier. The clinician can ask open-ended questions such as exploring if previous experience with medication was helpful. Were there issues or problems taking medications? How long was the patient taking medications, and what led to stopping? The reason a patient discontinued medications is important to understand and discuss. Through this process, the clinician can elicit beliefs about the acceptability and effectiveness of the use of medications. It is important to recognize any negative perceptions the patient may have. It may be possible to address any negative perceptions by providing more accurate information or suggesting a reevaluation with a competent prescriber may be helpful. It is always important to stress the patient's right to choose and the choice is made based on an understanding of the benefits, risks, and limitations of medications.

Asking Permission

> *One of the things you have been interested in is learning more about the options for taking medication that will help you with your treatment and recovery. Would it be OK if we took some time today to talk about this?*

Getting Started

Always begin with the person, his or her needs, knowledge, attitudes, and prior experience, and then talk about what a medication may be able to provide.

> *I would like to begin by getting a better understanding of what you already know about possible options for medication. I can fill you in on some additional details and what you might expect, and try to answer questions you might have about these medications. My goal is to provide you with information about options and let you make a choice as to whether this is something you want to pursue further. If it is, I can help you find someone qualified to evaluate you for these medications.*

Addressing Negative Perceptions

There are many common reasons patients may be reluctant to take medications, including side effects, cost, the inconvenience of taking pills each day, denial about the condition

experienced, a sense of shame or stigma about taking psychiatric medications, and the negative influence of others. Among all medical conditions, there seems to be the greatest reluctance to take medications for addiction problems because of the negative perception of addiction medication.

When patients are reluctant to consider medications, it is often helpful to explore the person's view about medications in addiction treatment. It may help to ask open-ended questions and use reflective listening to fully understand the person's perception before attempting to address the negative perceptions. A common negative perception might be: "Medication isn't going to help me achieve anything that I couldn't otherwise achieve through just making up my mind or attending counseling or going to AA meetings."

Patients sometimes question whether there is a benefit to taking medications in addition to, or in place of, other types of treatment for support services. The counselor might explain that evidence suggests medication combined with counseling is often more effective than counseling alone in the treatment of opioid dependence, alcohol dependence, and nicotine dependence. While counseling and Alcoholics Anonymous (AA) are both effective, the addition of medications may address certain neurobiological factors that promote substance use and improve the chances of positive outcomes, reducing the likelihood of relapse.

> *A patient may say: I'm afraid medication is going to harm my liver or some other part of my body if I don't give my body a rest.*
>
> *Response: Some medications may adversely impact the health of the liver or other parts the body, but these medications would not be routinely prescribed to patients with significant impairment in liver or other bodily functions. The potential harm that is caused by medications is usually much less than the harm caused by the uncontrolled drinking or use of other drugs. When patients show impaired liver function from medication, dose reduction or discontinuation is usually effective in reducing any of these problems.*
>
> *The patient may say: Medication is a crutch; I need to be completely drug-free to be truly in recovery.*
>
> *Response: Abstinence from drugs of abuse certainly is important. And being 100 percent drug-free is an appealing goal for most people who have suffered through the disease of chemical dependence or other chronic diseases. Many people would choose to recover from the disease without the aid of medicine, if there was a clear chance of success. However, our role here is to provide you with the best information we can to support of your treatment and recovery. Often people who are active in the 12-step fellowships have strong beliefs about the use of medications. I would encourage you to read the documents prepared by Alcoholics Anonymous regarding the appropriate use of medication in support of treatment and recovery. Their approach is not antimedication; rather it is the use of medication appropriately prescribed.*
>
> *The patient may say: Some of these medications are addictive. Taking this medication is just trading one addiction for another.*
>
> *Response: None of the medications approved for alcohol dependence is physically addictive.*

Agonist and Partial Agonist Medications

For patients concerned about the dependency potential of medications, careful wording is recommended for those considering replacement therapies such as methadone or buprenorphine. While these medications produce physical dependency, the harm associated with unsuccessful treatment outcomes far exceeds the harm of taking the medication. Replacement therapies have a proven track record of reducing harmful consequences of opioid-dependence health problems, overdose, HIV infection, crime, and family and social problems. Replacement therapies are also associated with an increased overall quality of life with an increased chance of achieving ultimate complete abstinence at some point in the future.

Conclusion

Helping the patient resolve his or her ambivalence about taking medications for addiction treatment may take time within normal counseling sessions. Rushing the patient into a decision may elicit resistance and result in the patient committing to doing something he or she did not want. If the negative perceptions cannot be resolved, the clinician may choose to leave the topic alone but open to discussion at a later date.

The clinician should take the time to enhance his or her own knowledge about approved medications for treating substance use disorders. In the handout section for this session are informational materials on approved medications for the treatment of substance use disorders. Additional information can be found online at the National Institute on Drug Abuse's Web site, the National Institute on Alcohol and Alcohol Abuse's Web site, or the Web site of the Substance Abuse and Mental Health Services Administration.

If and when a decision has been made to participate in an evaluation process, it is the clinician's role and responsibility to facilitate this process. The passive suggestion of finding a number in the phone book or handing someone a list of names and referrals is likely to yield little if any success. The important aspect of making a referral is actively facilitating the first contact. This scheduling process may often take place in the office with the clinician and over the telephone. After the appointment is set, it is important to follow up with the patient to ensure he or she has been successful and troubleshooting when the plan is not a success.

Summarizing the Session

The clinician summarizes the content of the session, highlighting the major points and accomplishments. This may include reviewing the reasons the discussion of medication took place, reviewing what was discussed regarding potential risks and benefits of medication, identifying any commitments the patient made in either thinking about or pursuing a medication referral, reinforcing any patient efforts, and clearly identifying activities the clinician has committed to undertake. When referrals are made, the clinician should promptly take care of any specific tasks needed to make sure the process is expedited.

The clinician lets the patient know that during the next session, the clinician will follow up regarding what has taken place in the intervening time. The clinician reviews any assignments the clinician and the patient need to complete in the days ahead.

Session 14. Engagement With Self-Help

Introduction

Twelve-step programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) have benefited many lives since the founders of AA—Bill W. and Dr. Bob—first got sober in 1935. Although AA and NA meetings are occasionally depicted in films or on television, nothing is quite the same as the experience of attending a meeting firsthand. For people who are contemplating attending their first meeting, there is often a degree of anxiety. Discussion during a counseling session can reduce this anxiety and help the patient to be realistic about what to expect.

AA meetings can be held anywhere, but frequently they take place in public buildings such as churches or schools—accessible locations that usually have plenty of parking. Approaching the meeting location, one might see people gathered outside, chatting before the meeting starts (or smoking, as many AA meetings are now smoke-free).

The Patient's Experience

The patient will have the opportunity to learn more about 12-step self-help. He or she will have opportunity to discuss with the clinician the potential benefits of participation and any concerns regarding attendance. The clinician will support the patient's self-efficacy in this process, be knowledgeable about 12-step self-help, and able to direct the patient to local community resources.

Clinician Preparation

MET Session 14. Engagement With Self-Help	
Materials ▸ What Happens in an Alcoholics Anonymous (or Narcotics Anonymous) Meeting? ▸ Up to date rosters of community self-help meetings	**Total Time** 1 hour **Delivery Method** MET-focused individual therapy with psychoeducation
Strategies ▸ OARS (Open-Ended Questions, Affirmations, Reflections, Summary) ▸ EDARS (Express Empathy, Develop Discrepancy, Awareness of Ambivalence, Roll With Sustain Talk/Discord, Support Self-Efficacy); identify stage of change ▸ Link self-help involvement with increased social support for recovery ▸ Support patient decisionmaking and plan to attend self-help ▸ Develop "real-life practice challenge" and generate commitment	
Goals for This Session ▸ Clarify patients thought and feelings about self-help involvement ▸ Increase patient understanding of the role of self-help in recovery ▸ Build patient motivation and Commitment to attend or at least sample self-help meetings ▸ Develop commitment and plan for self-help attendance	

The clinician should have accurate information regarding 12-step meetings in the community. This information is frequently available through the Internet and every state has a central service committee to assist with providing up-to-date meeting locations and times. Through state central service offices, a liaison to the clinician's organization can often be arranged to assist with aiding new patients and access to meetings.

If the clinician is unfamiliar with AA and NA, the clinician is encouraged to read available literature and attend open meetings in the community to gain firsthand experience. The clinician is encouraged to become familiar with the basic tenets of self-help and to be familiar with the 12 steps and 12 traditions of AA.

Session 14 Outline and Overview

- Ask permission to discuss this topic.
- Link attendance in self-help meetings with enhancing patient need for improved social supports.
- Discuss the patient's previous experience, knowledge, and beliefs regarding AA and NA.
- Using MI skills, process patient ambivalence regarding participation in self-help.

- Negotiate an agreement to attend a certain number of meetings to learn more.
- Agree upon a concrete plan of activity in the coming week regarding patient attendance.
- Close the session.

Session Protocol

Following the engagement conversations at the beginning of the session, the clinician has several options with regard to introducing this discussion. A first strategy is to link the discussion with often-needed enhanced social supports. The clinician may wish to introduce the topic by asking permission to discuss options for enhanced social supports. Following the patient agreement with discussing this topic, the clinician then begins a discussion of self-help.

The clinician may begin this process by asking the patient if he or she has previous experience with AA or NA, either directly or by observation. If the patient has previous experience, it is useful to elicit those thoughts and beliefs. If there have been positive experiences, a discussion using MI skills can support this conversation. If the patient has negative thoughts regarding self-help, the discussion can identify the feelings and help the patient work through them. The clinician may wish to offer information to the patient about the value of meetings and the different types of meetings.

If the patient is seeing some benefits and some hesitation, reflecting both sides can be useful, along with use of the MI Readiness Ruler to further mobilize patient action. If there is agreement to "check out a meeting," it is best to secure a commitment from the patient to attend a defined number of meetings—at least four to six. It is also useful to encourage the patient to try several different types of meetings as this broadens exposure. Only after securing a commitment to attend meetings does it make sense to begin discussing dates and times of local resources in the area. It is useful for the clinician to have handouts for local meeting times and locations.

If the patient has agreed to attend self-help meetings by the end of the session, it is best to secure an agreement as to what will take place during the coming week. If the patient remains reluctant, the clinician may provide written information regarding meetings and ask the patient to read and consider it. Always, the clinician reinforces autonomy in making these decisions.

Session 15. A MET/CBT Approach for Traumatic Stress and Substance Use

Introduction

Session 15 is a cluster of three staged sessions that address posttraumatic stress disorder (PTSD). The sessions may take place any time after ICT session 1 has been completed. This protocol is included here because patients screening positive for drug and alcohol use risk are at an elevated risk for having experienced trauma(s), "trauma-type" symptoms, and/or a full diagnosis of PTSD. It is essential for health care providers integrating behavioral and medical care to be ready to identify, intervene, and if necessary, refer patients they suspect might have a history of trauma or stress-related disorder. The clinician should conduct initial and secondary screenings for trauma using the Primary Care PTSD (PC-PTSD) screen and PTSD Checklist (PCL) (military and civilian versions are included in the handouts) as soon as the need is identified and the patient agrees.

PTSD assessment measures, such as the PC-PTSD, the Clinician-Administered PTSD Scale (CAPS), and the PCL, are being updated by the National Center for PTSD to be made available upon validation of the revised instruments. Please see the Assessment section of the center's Web site (http://www.ptsd.va.gov/professional/pages/assessments/assessment.asp) for the latest information. All motivational enhancement techniques and CBT skills lessons are integrated to reduce the symptoms and interactions of trauma and substance use.

Diagnosis and Symptoms

For a diagnosis of PTSD, the patient must experience a life-threatening event or an event causing serious illness, or witness another person experiencing the event. The events most commonly associated with PTSD include combat or military experience; sexual or physical assault; a serious accident; or a natural disaster such as fire, tornado, or flood. It is helpful to note that the unexpected death of a family member or close friend from natural causes (not involving disaster or trauma) cannot cause PTSD. Traumatic events need to be clearly different from the very painful stressors that constitute the normal vicissitudes of life such as divorce, failure, rejection, serious illness, financial losses, and the like. Adverse psychological responses to such "ordinary stressors" would, in DSM-V nomenclature, be characterized as adjustment disorders rather than PTSD. The specific distinction for PTSD diagnosis is that while most individuals can cope with ordinary stress, their adaptive capacities are likely to be overwhelmed when confronted by a traumatic stressor.

Symptom criteria fall into four broad categories: (1) intrusion (memories or flashbacks), (2) avoidance (escaping negative cues), (3) negative alterations in cognitions and mood (including numbing, persistent and distorted blame of self or others, and persistent negative emotional state), and (4) alterations in arousal and reactivity (including reckless or destructive behavior).

These symptoms must last concurrently for a month (or more) and be perceived as distressing or cause functional impairment. With regard to general health symptoms, there is evidence to indicate PTSD is related to cardiovascular, gastrointestinal, and musculoskeletal disorders. Several studies have found that self-reported history of circulatory disorders and symptoms of cardiovascular trouble were associated with PTSD in veteran populations, civilian men and women, and male firefighters (Jankowski, 2013). Many trauma survivors exhibit symptoms consistent with PTSD immediately after an event; however, these rates drop by almost one half 3 months after the event (Barlow, 2008).

Prevalence and Types of Trauma

The overall prevalence rate of PTSD in a national household survey was found to be 6.8 percent (Kessler et al., 2005; Kessler, Chiu, Demler, Merikangas, & Walters, 2005). This general prevalence rate fluctuates dramatically for both women and men, depending on the type of trauma experienced. In an earlier study, Kessler, Sonnega, Bromet, Hughes, and Nelson (1995) surveyed trauma survivors and found that 20.4 percent of women and 8.2 percent of men were likely to develop PTSD following exposure to trauma. The rates varied according to the type of trauma experienced. Rape was identified as most likely to lead to PTSD for both men (65 percent) and women (46 percent). For men, the next leading causes were combat exposure (39 percent) and childhood neglect (22 percent); for women, they were childhood physical abuse (49 percent), threat with a weapon (33 percent), sexual molestation (27 percent), and physical attack (21 percent).The prevalence of co-occurring PTSD and substance use disorder has also been well documented. Jacobsen, Southwick, and Kosten (2001), for example, found that between 26 and 42 percent of individuals with drug or alcohol use disorders currently suffer from PTSD.

Combat Exposure

Given the high prevalence rates of PTSD and the number of American service members serving in and returning from the Iraq and Afghanistan wars, several studies have examined the immediate effects of trauma combat exposure. Hoge (2004) found that soldiers and marines returning from Iraq were nearly twice as likely to screen positive for PTSD, generalized anxiety, or depression (17 percent) as soldiers surveyed predeployment. A later study (Hoge, Auchterlonie, & Milliken, 2006) found the “prevalence of reporting a mental health problem was 19.1 percent among service members returning from Iraq, compared with 11.3 percent after returning from Afghanistan and 8.5 percent after returning from other locations” (p. 1023).

Treatment Integration: The Opportunity of SBIRT

The integration of behavioral and medical health presents an important opportunity to identify and intervene with patients not often motivated to seek treatment. Most individuals with either PTSD or substance use disorders (or both) do not seek treatment (Cottler, Compton, Mager, Spitznagel, & Janca, 1992; Grant et al., 2004). A study of soldiers returning from Iraq

and Afghanistan found that only 38 to 45 percent of those who showed signs of a mental disorder demonstrated an interest in receiving treatment (McFall, Malte, Fontana, & Rosenheck, 2000). Even among those who do seek treatment, many are ambivalent about the need to address important symptoms, often questioning the existence of problems altogether. In a study asking veterans diagnosed with PTSD to report problems they "definitely have," "might have," or "do not have," the largest percentages of problems were identified as "might have," including alcohol and drugs, anger, depression, among other problems (Murphy, Thompson, Rainey, & Murray, 2004). The infrequency with which these individuals seek help suggests the potential benefits of offering treatment for co-occurring PTSD and substance use disorders within the primary care or other medical setting. The rise of prescription medication abuse augments this need. Veterans often receive such medication in these settings for pain or sleep problems related to PTSD, but this can exacerbate a co-occurring substance use disorders.

Treatment Types and Efficacy

Recent studies have examined the effectiveness of four main types of interventions: coping processing therapy, prolonged exposure, cognitive behavioral skills-based therapy, eye movement desensitization (EMD—considered as a type of exposure), and combinations of these approaches adding MI. All these therapies are included in best practice guidelines for "frontline treatments"(Hamblen, Schnurr, Rosenberg, & Eftekhari, 2010) and when implemented with fidelity result in successful outcomes in nearly half the cases.

These trauma-focused ICT sessions focus on delivering a skills-based MI-CBT approach for the following reasons:

- Evidence to support effectiveness
- Delivery in a health care and/or medical environment
- Brief timeframe
- Similarity and use of several techniques in ICT already described in this guide

The Patient's Experience

In these sessions, patients suffering from the effects of trauma will benefit from a nonjudgmental, helpful approach toward understanding their current coping strategies, including substance use. They will become informed about the severity of their trauma symptoms and learn about the current science on the effects of trauma exposure. Patients will discuss how this "new understanding of the science of trauma" relates to their own experience. They may verbalize their ambivalence and demonstrate the emotional and cognitive barriers to making changes. Patients able to engage and commit to making change will learn how to (1) monitor internal and external triggers, (2) relax with different approaches, and (3) use cognitive coping skills. They will practice between-session challenges, use skills presented, and adopt those chosen as most helpful.

Clinician Preparation

Session 15. A MET/CBT Approach for Traumatic Stress and Substance Use	
Materials ▸ Copy of the AUDIT/DAST ▸ Copy of the GAD-7, PHQ-9 ▸ Copy of the PC-PTSD; PCL (civilian or military, depending on patient) ▸ Handouts: Safety Plan, Psychoeducation, ICT Sessions 4, 9, 19, 11, 13	**Session Length** 60 minutes **Delivery Method** MET/CBT
Strategies ▸ Follow OARS: Open-Ended Questions, Affirmations, Reflections, Summary ▸ Psychoeducation: Trauma Information ▸ Situational Awareness Monitoring ▸ Cognitive Coping/Restructuring	
Goals for This Session ▸ Welcome patient and continue to build rapport. ▸ Accurately screen patients for severity of trauma using the PCL-C for civilians and the PCL-M for military-based trauma to determine severity. ▸ Discuss in a personalized reflective discussion with patient the PCL results, and review results from AUDIT/DAST or similar substance use screens to determine the extent to which the patient's trauma symptoms influence the misuse of substances and vice versa. ▸ Increase the patient's knowledge of the biological, physiological, and psychological effects of trauma exposure. ▸ Provide nonjudgmental understanding when discussing the patient's current coping strategies (including the use of substances); normalize the fact that many trauma survivors struggle to find successful and healthy coping strategies. ▸ Provide hope and build positive expectations that effective treatment now exists; that by working together, it will be possible to treat and reduce both trauma symptoms and substance misuse. ▸ Reduce patient's "overreactions" based on past experiences that are not adaptive for coping appropriately with present-day situations. ▸ Reduce ambivalence to change and increase willingness to adopt new coping strategies: relaxation and cognitive coping/restructuring. ▸ Enhance patient coping skills specifically helpful in reducing both trauma and substance use disorder symptoms.	

The ICT session (s) techniques described below can be delivered as soon as significant trauma symptoms are identified by appropriate screening. As in all ICT sessions, no matter where a session ends, the structure of the session follows the "law of thirds" and incorporates rapport, review of progress, MET activity and/or CBT skills lessons, skill transfer/practice, summary, and a between-session challenge assignment.

Sessions 15-1, 15-2, and 15-3 Outline and Overview

Session 15-1: Personalized Reflective Discussion Addressing Trauma and Substance Use

1. Welcome the patient and build rapport.
    - Assess the patient's readiness to proceed
2. Introduce the topic
    - Share session model/approach: include the main activities of treatment sessions 1–3

      Personalized reflective discussion addressing trauma and substance use, safety planning, learning a (destressing) relaxation technique (through deep breathing); psychoeducation about trauma: the effects; treatment options, best pathways toward long-term wellness without substance use; identifying, understanding, and monitoring for internal and external triggers; coping reactions; positive/negative consequences; developing skills for working with feelings/thoughts to influence and realize healthy outcomes.

      Note: If the PTSD screens (the PC-PTSD and/or PC-C or M versions) have not previously been completed in the screening/assessment or in ICT sessions 1 or 2, conduct at this time, asking first for permission to do so.
    - Ask the patient for his or her reactions (feelings and thoughts) to completing the PTSD screens (the PC-PTSD and PCL-C or M versions).
    - Ask whether any changes have occurred in patient trauma symptoms and/or substance use since the last meeting.
    - Review and summarize results and risk levels of the PRS for substances and PC-TSD/PCL results (share and give the patient a copy) as part of a personalized reflective discussion. Note: If patient symptom severity is concerning, the clinician is advised to seek further evaluation and consultation with a treatment team to discuss appropriate level of care, medications, and other supports if indicated.
    - Summarize and elicit a between-session challenge, such as finding a pleasurable activity leading to decreased feeling of stress and increased feeling of relaxation not involving substances. Have the patient commit to when, where, and with whom she or he will complete the activity.

Session 15-2: Safety Planning, Deep Breathing Relaxation, and Psychoeducation

1. Welcome, build rapport, and review substance use and trauma symptoms and possible interactions. Review between-session challenge.
    - Introduce the topic.
    - Provide rationale.
    - Briefly educate the patient on the effects of trauma: the main symptoms, the best treatment and the negative long-term effects of using substances to reduce trauma symptoms (see handout on trauma psychoeducation).

    Note: The primary goal of the education is to help your patient(s) better understand how PTSD and stress-related disorders influence their feelings and behaviors and how using substances can interfere with their current and long-term wellness.

    - Ask your patients what they know about the effects of trauma experiences in general, and how the trauma is affecting them (and others).
    - Since they are using substances, how do they believe the use of alcohol/drugs is affecting their feelings and behaviors?"
    - After eliciting a personal discussion, ask the patient to specifically describe the most disturbing symptoms or feelings and behaviors experienced recently.
    - Describe ICT session activities that can address these feelings and behaviors.
2. Introduce and explain the need to create a safety plan (see handout on safety plan).
    - Safety plan rationale: *"Upsetting feelings may come up as you discuss daily feelings and stressors, or even consider talking about the past trauma experience. I am here to help with this and anything else that makes you feel unsafe while you are involved the ICT program."*
    - Elicit (screen) for past suicidal history (e.g., thoughts, incidents) and indicate that you will need to know how the patient will alert you if he or she feels unsafe, threatened, or a risk of harming himself/herself or others (see handout on Suicide Behaviors Questionnaire, Revised—SBQ-R).
    - Assess the past and current history of suicide and determine the appropriateness of ICT as a helpful intervention. Determine if there is risk of suicide based on past or current ideations, or if intentions appear minimal.
    - As appropriate, determine if it is clinically appropriate to continue and to introduce the safety plan. If the risk is determined to be great based on past or current suicidal or homicidal ideations or intentions, seek the involvement of a medical/psychiatric/crisis team for evaluation (prior to the patient's leaving the health care facility if indicated).

- Complete the patient the safety plan document specific to self-harming, suicidal, aggressive, and/or violent reactions. The plan should list contact information (names and current phone numbers with at least one person available any time (24 hours/day) and specific safe strategies the patient has used and/or can use to help reduce emotional intensity of reexperiencing overwhelming trauma symptoms should they occur. Note: Let the patient know that he or she will be learning additional strategies in treatment and can add those if they are helpful later.

3. Introduce and practice deep-breathing relaxation (DBR) as a way of tolerating negative emotions and to help reduce the urge to use substances (see handout on Deep-Breathing Relaxation).
4. Provide the deep-breathing relaxation skills training. Make sure patient practices and demonstrates initial proficiency. Elicit a commitment to a specific daily routine (e.g., twice daily for 10–15 deep breaths).
5. For more extensive relaxation training (with and without breath work), use session 9 Mindfulness, Meditation, and Stepping Back, which includes many types of practices to generate a calm state of being to enhance wellness.
6. Distribute the PTSD information sheet and explain it is helpful when patients learn how health care providers understand the reactions to trauma and the current best forms of treatment for symptoms, so the patient can help decide the best treatment plan.

   Note: Clinicians should express (when appropriate) that the patient's current trauma responses and coping strategies (including substance use, avoidance, or whatever is shared) are not uncommon. Explain that research has found that while using substances or avoiding feelings for some patients has been beneficial in the short term, it is not helpful in the long run and known to continue the trauma symptoms for longer than when other coping strategies are used.
7. In closing, summarize the session, reaffirm and elicit a specific commitment to practice DBR daily. Assign the between-session challenge.

Session 15-3: Enhancing Self-Awareness and Introducing Cognitive Restructuring

1. Welcome, build rapport, and review substance use and trauma symptoms and interactions. Review the between-session challenge (DBR practice).
2. Introduce the topic.
3. Provide rationale.

   Note: Session 15-3 builds off ICT session 4. Refer to this session 4 for detailed descriptions of enhancing self-awareness and discovering new roads. Whenever applicable, incorporate both trauma and substance use effects into the session's written protocol (use the session 15 handout on trauma/substance use awareness record).

4. Introduce and ask the patient to fill out the trauma/substance awareness record for both the patient's trauma symptoms and substance use and interactions of the two in the last month.
5. Elicit at least three to five situations triggering trauma affect symptoms and/or substance use (functional analysis).
6. Discuss the situations to get a full understanding of the external and internal triggers, cues, and beliefs.
7. Scale the intensity of situations provoking trauma symptoms and substance use from minimal = 1 to 5 = overwhelming per instructions on record. Identify and prioritize skills and strategies to address trauma symptoms.
8. Closing session and between session challenge: Elicit a specific daily commitment for patient to use the Awareness Record to monitor the external and internal triggers (intensity 1–5), behaviors, and consequences of any trauma-based cues and their responses.

ICT Sessions 10 and 11

1. Introduce and deliver ICT session 10 (Working With Thoughts) and session 11 (Working With Emotions: Fostering Some and Dissolving Others). Sessions 10 and 11 focus on cognitive restructuring and coping strategies for reducing the effects of trauma.
2. For each session listed above (10 and 11), integrate trauma-based reactions and substance misuse into the session outline and discussions. The session 15 handouts provide a good example of the types of specific trauma-related additions needed to focus the ICT intervention on reducing both trauma symptoms and substance misuse.
3. A clearer collaborative understanding of how the patient's inner and outer world leads to continued distress is generated through the personalized reflective discussion and the review of situational analysis patterns for trauma-based reactions, substance misuse, triggers, thoughts, behaviors, and outcomes in session 15.
4. Once these triggering patterns are revealed in session 15-3, follow sessions 10 and 11 steps and handouts to work on reducing cognitive distortion and automatic thinking associated with trauma-based reactions and substance misuse.
5. Assign a between-session challenge associated with the session materials delivered. Include the daily use of both the trauma/substance awareness record and deep-breathing relaxation between each session.

Section 3. Techniques and Tools Supporting Fidelity of Implementation and Clinical Supervision

Introduction

Adopting and implementing any new clinical intervention in an existing community practice can be a daunting and challenging task. This section offers clinicians research-proven methods to reduce the burden on agency administration and clinical staff, while increasing enthusiasm and motivation for the new treatment. Basic information is provided on fidelity, presenting a "best-practice" training model, describing essential clinical skills, and introducing a structured clinical supervision model. To ease implementation burdens and enhance adherence to the essential elements of ICT, the tools include a clinical supervision agenda, a clinician session review checklist, and an adherence and competency checklist.

The science of implementation and dissemination is evolving rapidly. Research findings across large-scale clinical trials are demonstrating that the quality with which an evidence-based practice is delivered can significantly affect patient outcomes. Quality in providing manual- or guide-based interventions is primarily associated with the term "fidelity" or faithful delivery of the model. Fidelity is defined by two components:

1. Adherence: the extent to which the intervention procedures are delivered as prescribed in the manual or guide
2. Competence: the qualitative measure of skillfulness in which the primary intervention components are delivered (Schillinger, 2010)

Many clinical researchers have summarized findings on evidence-based practices for medical practices, substance use, juvenile justice, and co-occurring disorders with the conclusion that fidelity is a primary factor in determining the effectiveness of an intervention; however, more investigations are needed (Schoenwald, Chapman, Sheidow, & Carter, 2009; Muck & Dennis, 2011; Wilson & Lipsey, 2005; Webb, DeRubeis, & Barber, 2010; Carroll, Patterson, Wood, Booth, Rick, & Balain, 2007).

Like most effective manualized interventions, ICT contains essential elements in each session that must be delivered. Clinicians should prepare themselves by reading and understanding basic concepts related to structured integrated interventions (MI, MET, and CBT) and practicing the delivery of each session activity. The MET component of ICT focuses on enhancing patient readiness, willingness, and confidence to change unhealthy behaviors. The skills-based CBT components focus on building self-awareness in the patient along with healthy avoidance, coping, and replacement skills.

Based on research on effective methods to learn clinical interventions (Martino, 2010), the recommended method of learning to use this model follows:

- Two-day exposure training emphasizing session skills practice with feedback from an expert clinical trainer
- Practice delivering each session using checklists and session handouts (with colleagues and with patients)
- Continued feedback from an expert supervisor based on session notes, checklists, and (preferably) digital or video recordings

To deliver ICT with fidelity, clinicians need to develop competence in primary clinical skills including how to—

- Engage patients, build rapport, and increase readiness with MI techniques
- Choose, coach, and deliver needed CBT skills activities
- Provide the rationale for each session activity chosen
- Teach, model, and effectively transfer skills to the patient using session handouts
- Coach and motivate during the in-session practice of relevant skills
- Elicit commitment from the patient to practice the skills between sessions and in the future

To guide the delivery of the model, sessions are typically broken into three parts following the 20/20/20 rule: (1) building rapport and review, (2) main session activities, (3) summary and between-session challenge and commitments (Carroll, 1998). Session handouts are included for each, and session checklists help clinicians adhere to the essentials of the main parts. There are proven clinical reasons to deliver the MET sessions prior to the skills-based CBT sessions. However, the primary framework of the intervention (i.e., number of sessions, session length, and session skill topics may be chosen by the clinician and depend patient readiness and need.

Adherence Tools and Techniques: Checklists

It is recommended that clinicians review and use the session agendas, handouts, and checklists prior to meeting with the patient. The clinician checklists facilitate a general review of the session and help staff keep track of progress. As an added convenience, this checklist can be easily transformed into the session clinical (and billing) record by changing the focus of section seven. This is simply accomplished by incorporating session notes about the patient's engagement, progress, and other clinical markers of treatment success and removing notes on the clinician's experience of the session.

The competence checklists were developed by taking the Session Protocol and Steps at the beginning of each session and grading the delivery of each step on a 3-point Likert scale from

insufficient, through sufficient, to exemplary. For greater adherence to the model, clinicians are encouraged to use the agenda in combination with the competence checklist to cross off each essential element while delivering the intervention. Supervisors are encouraged to review the checklists and elicit examples from the session discussion and activities while providing feedback.

To reinforce fidelity, clinical supervisors would be expected to model and show available videos portraying the MI, MET, and CBT specific session techniques needed. To further increase competence, it is recommended that 80 percent of the session essential activities be delivered with a sufficient or exemplary status. To most accurately assess clinical competency, most structured interventions use objective information (i.e., digital, audiotaped, or videotaped sessions). Supervisors then listen to the recordings within weekly or biweekly individual or group supervision. This method ensures all staff are involved in building a learning community based on clinical skills and techniques and not on administrative details or other clinical material.

Clinical Supervision Techniques to improve Adherence

Agencies adopting and implementing manual-based interventions like this one are presented with an exciting opportunity for changing the format of clinical supervision to include an emphasis on skill development, as well as other clinical (when necessary administrative needs). This shift will also highlight the parallel process with the "ICT" intervention focusing energy on motivating change and skill learning even for clinicians. There is added benefit when the supervisor, and the clinician further understand the challenges of changing "routines and typical habits" demands which we are asking of the patient in session. We find having a framework for clinical supervision to also be helpful, similar to the framework for delivering CBT sessions. The acronym BASIC and its essential components for the framework follow:

- **B**uild Rapport
- **A**ssess Readiness
- **S**elect Strategy
- **I**nstruction on strategy
- **C**ommitment to use strategy

The BASIC framework provides an easily remembered pneumonic and fits in both individual and group supervision sessions. As illustrated in the more detailed agenda below, to pick a specific clinical "strategy or skill," supervisors could review staff ICT *Clinician and Adherence/Competency Checklists*, noting areas of strengths and needed improvement. Then, they can select from the MET and CBT skills list.

The detailed supervision agenda below also integrates the use of new training technologies or short video clinical skills vignettes. There are many video resources available on the Web for

illustrating MET and CBT clinical skills. This type of structured approach to clinical supervision clearly highlights the focus on learning, practicing and monitoring competency in essential clinical strategies to improve outcomes.

Structured Supervision Model

Step One

1. Build rapport; find out how things are going
2. Check in on patients, general
3. Is there a case she or he wants to talk about owing to concerns?
4. Needs feedback for improvement?

Step Two

1. Assess patient and staff readiness

By reviewing the clinician and adherence/competence checklists—

2. Talk about specifics of the clinical session work
3. What strategies have been delivered by staff?
4. What strategies will now be helpful to the patients?

Step Three

Choose from the list of strategies below.

Motivational Interviewing and Motivational Enhancement Therapy

- Building rapport
- Collaboration
- Increasing change talk
- Working with resistance/unwillingness
- Providing feedback (severity, problems, reasons for quitting, motivation)
- Goal setting
- Generating commitment

Cognitive Behavioral Treatment Skills Development

- Monitoring urges/cravings
- Awareness training
- Replacement activities
- Mindfulness
- Assertiveness
- Emotions
- Just thoughts
- Social support
- Problem solving
- Medication
- Self-help

Step Four

1. State, “Let’s watch a video that applies to that patient needs"
2. Watch clinical skills video vignette (one or two)
3. Discuss the strategy or strategies and answer any questions
4. Role-play clinical skills
5. Discuss how staff will deliver the skills for the patient next week
6. State, “Let’s discuss how to use this skill in the next week with this patient”

Step Five

1. Elicit a commitment to practice and deliver using clinical skills in next week
2. Staff commits to a specific date, time, and patient session

Continuing Structured Supervision

- Review the practice of skills in upcoming supervision
- Repeat steps one through five
- Try another video and skill

To summarize, while more studies are needed across all populations and types of disorders, it is evident that factors affecting implementation and dissemination in delivering ICT and any

evidence-based practice require attention from providers and supervisors. All developers of evidence-based practices fear the pressures of "real-world" demands, including workforce factors (education, attitude, experience, turnover) and organizational factors (increasing caseloads, billing mandates, record keeping), and the like will override the importance of fidelity.

The word "drift" is used to describe the difference between the intended delivery of techniques and tools in a guide or manual and the actual delivery. The ICT tools and techniques offered in this section, along with the technical assistance available (Web-based and onsite training), should provide sufficient user-friendly resources to thwart drift and facilitate implementation and dissemination. As with any guide or manual, the feedback from clinicians and others using ICT will be critical to ICT's ultimate success in helping brief treatment become a routine practice to enhance the quality of patient care.

Brief Treatment Clinician Checklist Protocol

Brief treatment clinicians are encouraged to complete a brief checklist following each ICT session. This checklist inquires about aspects of the session from the clinician's perspective and can be used to self-monitor the quality of delivery of ICT and as a tool in supervision.

How To Complete the Clinician Checklist

1. **Patient Identification (ID)**: This ID consists of the initials for your site and a number corresponding to the patient referred to you. Assign the number based on which patient you are working with. Please keep track of this number/ID in your records by keeping a sheet that lists the name of the patient and this ID.
2. **Clinician ID**: Insert first initial and last name (e.g., GWASHINGTON).
3. **Date of Session**: Use the following format for recording the date: MM/DD/YYYY.
4. **Approximate length of session**: Record the number of minutes you met with the patient.
5. **Session conducted**: Please check **(✓)** the session that was conducted with the patient. If you planned to conduct a particular session (e.g., session 1) but needed to respond to an urgent situation or crisis, indicate this by checking the "other" space and then describe.
6. **Please indicate which elements were used in your session:** Check **(✓)** the strategies or elements that were used during the session with the patient.
7. **Please indicate your experience during the session with patient:** Circle the number that corresponds closest to your experience.

8. For these items, use the Likert scale (from 1 to 5) to describe your experience with the patient during the session. Each item asks about an aspect clinicians are often able to describe regarding a session with a patient. We are interested in (1) how engaged you felt with the patient during the session, (2) how well you felt you and the patient were working together, (3) how smoothly you felt the session went, (4) your subjective sense about whether the patient benefited from the work during the session, and (5) your sense of ease with incorporating the BT material with this patient during this session.
9. Finally, if you have any other comments to add about the session, please describe in the space provided.

ICT Clinician Checklist (based on today's session)

1. Patient ID: _____ 2. Clinician ID: _____

3. Date of Session: _____ 4. Approximate Length _____ Minutes

5. Please check ("√") which session you conducted today:

☐ MET1, First session	☐ MET2, Change Plan	☐ MET3, Readiness
☐ CBT, Awareness	☐ CBT, Just Thoughts	☐ CBT Problem-Solving
☐ CBT, Urges/Cravings	☐ CBT, Assertiveness	☐ CBT, Emotions
☐ CBT, Mindfulness	☐ CBT, Wellness Planning	☐ CBT, Replacement Activities
☐ Self-help	☐ Medication	

☐ Other, describe:_____

5. Please check ("√") any of the following that were elements of your session with this patient:

☐ PRS (Personal Reflective Summary)	☐ Change Plan/Quit agreement
☐ Supporter/ Family member	☐ Emotions
☐ Mindfulness or meditation	☐ Reviewed information on cravings/coping
☐ Thoughts/ cognitive distortions	☐ Problem solving
☐ Assertiveness	☐ Plan for handling a high-risk situation
☐ Plan for coping with a lapse or slip	☐ Gave between-session challenge
☐ Discussed termination issues	☐ Provided referral information
☐ Addressed a crisis with patient	☐ Thoughts about alcohol/substance use

6. Indicate your experience of the session with the patient (circle number that best fits):

I felt engaged in session with patient				I felt somewhat removed
1	2	3	4	5

Patient and I seemed to be working well				Patient and I had difficulty connecting
1	2	3	4	5

The session went smoothly				The session felt fragmented
1	2	3	4	5

Patient seemed to benefit from session				I'm not sure whether patient benefited
1	2	3	4	5

It was relatively easy to incorporate ICT material				Was difficult to incorporate ICT material
1	2	3	4	5

7. Comments_____

_____

_____

_____

_____

_____

_____

Adherence/Competence Checklist Protocol

This checklist provides a succinct method for evaluating the extent to which the essential elements of each session are delivered. Both clinical supervisors and clinicians will find it a useful tool in helping to provide specific direction for how the session should be delivered to avoid drift. Many clinicians print these checklists prior to delivering the session and use them as agendas to check as they go through each activity. Clinical supervisors are advised to complete the *Adherence/Competence* checklist following review of any session recorded. As the supervision agenda above illustrates, the tool can also be used for ongoing supervision/training in both individual and group formats. The following recommendations may help supervisors discuss and review competency:

1. Focus first on the clinician's strengths in delivering the session.
2. Discuss the therapeutic alliance and patient factors, such as engagement, readiness, and motivation.
3. Next, describe the overall quality in delivering the basic structure of the session including the 20/20/20 rule, providing rationales, teaching/transferring main skill, skill demonstration and practice, eliciting commitment to practice between sessions, etc.
4. Use the competency ratings for each specific element (checklist row) to provide feedback on how to further refine the technique.
5. Teach through written examples, video examples, and role-plays.
6. Elicit a commitment to incorporate feedback in upcoming sessions.

Adherence and Competence Checklists

ICT Session 1
Adherence and Competence Checklist

PT ID _____ Date_____

	Extensive	OK	Little
1. Building rapport between clinician and patient	☐	☐	☐
2. Orient patient to session agenda and rationale for session activity	☐	☐	☐
3. Complete bridging form using data gathered in screening/assessment	☐	☐	☐
4. Review bridging form/Facilitate the patient's reflection on substance use	☐	☐	☐
5. Explore the patient attitudes about change, including ambivalent attitudes	☐	☐	☐
6. Affirming readiness for change, "change plan," and change strategies	☐	☐	☐
7. Assign appropriate between-session challenge	☐	☐	☐
8. Summarize motivation, review, and conclude session	☐	☐	☐

MI Skills and Strategies Practiced

	Extensive	OK	Little
9. OARS	☐	☐	☐
10. Decisional Balance	☐	☐	☐
11. Readiness Ruler	☐	☐	☐
12. Ratio of clinician-to-patient talk	70/30	50/50	30/70

Comments_____

Name_____

Reviewer_____ Date_____

ICT Session 2
Adherence and Competence Checklist

PT ID _____ DATE_____

	Extensive	OK	Little
1. Rapport-building, check in on challenge and past week, assess change	☐	☐	☐
2. Reassess readiness	☐	☐	☐
3. Patient describes three to five incidents of use in recent history	☐	☐	☐
4. Identify internal and external factors/triggers associated with use	☐	☐	☐
5. Discuss associated skills/needs and associated treatment sessions	☐	☐	☐
6. Prioritize treatment sessions	☐	☐	☐
7. Establish a change plan	☐	☐	☐
8. Assign between-session challenge	☐	☐	☐
9. Summarize, review, and conclude session	☐	☐	☐

MI and CBT Skills and Strategies Practiced

	Extensive	OK	Little
10. OARS	☐	☐	☐
11. Decisional balance	☐	☐	☐
12. Functional analysis	☐	☐	☐
13. Planning skills	☐	☐	☐
14. Ratio of clinician-to-patient talk	70/30	50/50	30/70

Comments_____

Name_____

Reviewer_____ Date_____

ICT Session 3
Adherence and Competence Checklist

PT ID _____ DATE_____

	Extensive	OK	Little
1. Rapport-building, check in on past week, and challenge/assess progress	☐	☐	☐
2. Orient patient to session agenda and identify decision of concern	☐	☐	☐
3. Introduce motivational strategy regarding readiness ruler (preassessment)	☐	☐	☐
4. Introduce and teach decision-making steps	☐	☐	☐
5. Complete steps 1 through 3 of the Decisionmaking Guide	☐	☐	☐
6. Discuss real and potential future for patient without change and with change	☐	☐	☐
7. Reintroduce readiness ruler (postassessment)	☐	☐	☐
8. Summarize the change talk discussions emphasizing any change	☐	☐	☐
9. Complete Decisionmaking Guide	☐	☐	☐
10. Conclude session	☐	☐	☐

MI Skills and Strategies Practiced

	Extensive	OK	Little
11. OARS	☐	☐	☐
12. Decisional balance and Readiness Ruler	☐	☐	☐
13. Express empathy, develop discrepancy, awareness of ambivalence, roll with sustain talk/discord, support self-efficacy	☐	☐	☐
14. Ratio of clinician-to-patient talk	70/30	50/50	30/70

Comments_____

Name_____

Reviewer_____ Date_____

ICT Session 4
Adherence and Competence Checklist

PT ID _____ DATE_____

	Extensive	OK	Little
1. Reinforce rapport, check challenge completion and changes over week	☐	☐	☐
2. Review session agenda	☐	☐	☐
3. Discuss the importance of maintaining happiness and excitement throughout recovery, discuss the types of replacement activities	☐	☐	☐
4. Brainstorm a list of both types of activities	☐	☐	☐
5. Engage the patient in commitment discussion	☐	☐	☐
6. Negotiate a between-session challenge	☐	☐	☐
7. Review, summarize, and conclude	☐	☐	☐

MI Skills and Strategies Practiced

	Extensive	OK	Little
8. OARS	☐	☐	☐
9. Brainstorming	☐	☐	☐
10. Express empathy, support self-efficacy	☐	☐	☐
11. Ratio of clinician-to-patient talk	☐	☐	☐

Comments_____

Name_____

Reviewer_____ Date_____

ICT Session 5
Adherence and Competence Checklist

PT ID _____ Date_____

	Extensive	OK	Little
1. Reinforce rapport, check on past week, challenge completion and change	☐	☐	☐
2. Review session agenda	☐	☐	☐
3. Discuss the importance of solving problems	☐	☐	☐
4. Provide examples of problem-solving practice	☐	☐	☐
5. Describe problem-solving skills	☐	☐	☐
6. Practice (role-play) problem-solving skills	☐	☐	☐
7. Assign between-session challenge	☐	☐	☐
8. Review, summarize, and conclude	☐	☐	☐

MI and CBT Skills and Strategies Practiced

	Extensive	OK	Little
9. OARS	☐	☐	☐
10. Role-play	☐	☐	☐
11. CBT Essentials: 20/20/20, skill rationale, transferred, practiced, and assigned	☐	☐	☐
12. Ratio of clinician-to-patient talk	70/30	50/50	30/70

Comments_____

Name_____

Reviewer_____ Date_____

ICT Session 6
Adherence and Competence Checklist

PT ID _____ Date_____

	Extensive	OK	Little
1. Reinforce rapport, check on past week, challenge completion and change	☐	☐	☐
2. Review agenda, current topic styles of communication	☐	☐	☐
3. Practice exercise	☐	☐	☐
4. Defining different styles of communication	☐	☐	☐
5. Discussion: defining different styles of communication	☐	☐	☐
6. Explain benefits of assertiveness	☐	☐	☐
7. Introducing assertiveness skills guidelines	☐	☐	☐
8. Role-play exercise with relevant current situation	☐	☐	☐
9. Between-session challenge	☐	☐	☐
10. Review, summarize, and conclude session	☐	☐	☐

MI and CBT Skills and Strategies Practiced

	Extensive	OK	Little
11. OARS	☐	☐	☐
12. Role-play	☐	☐	☐
13. Support self-efficacy	☐	☐	☐
14. Ratio of clinician-to-patient talk	70/30	50/50	30/70

Comments_____

Name_____

Reviewer_____ Date_____

ICT Session 7
Adherence and Competence Checklist

PT ID _____ Date_____

	Extensive	OK	Little
1. Reinforce rapport, check on past week, challenge completion and change	☐	☐	☐
2. Review session agenda	☐	☐	☐
3. Explore the development of addictive patterns	☐	☐	☐
4. Self-knowledge, understanding high-risk situations and trigger	☐	☐	☐
5. Putting the pieces together: draw connections, consider new roads, and build coping strategies	☐	☐	☐
6. Develop or elicit a specific between-session challenge	☐	☐	☐
7. Review, summarize, and conclude session	☐	☐	☐

MI and CBT Skills and Strategies Practiced

	Extensive	OK	Little
8. OARS	☐	☐	☐
9. Functional analysis	☐	☐	☐
10. Support self-efficacy	☐	☐	☐
11. Ratio of clinician-to-patient talk	70/30	50/50	30/70

Comments_____

Name_____

Reviewer_____ Date_____

ICT Session 8
Adherence and Competence Checklist

PT ID _____ Date_____

	Extensive	OK	Little
1. Reinforce rapport, check on past week, challenge completion and change	☐	☐	☐
2. Clinician reviews session agenda	☐	☐	☐
3. Clinician introduces concept of mindfulness	☐	☐	☐
4. Clinician conducts experiential exercises demonstrating mindfulness	☐	☐	☐
5. Clinician discusses meditation	☐	☐	☐
6. Clinician conducts experiential meditation exercise	☐	☐	☐
7. Clinician provides patient with meditation guide	☐	☐	☐
8. Clinician provides between session challenge	☐	☐	☐
9. Review, summarize, and conclude session	☐	☐	☐

MI and CBT Skills and Strategies Practiced

	Extensive	OK	Little
10. OARS	☐	☐	☐
11. Role-play	☐	☐	☐
12. Support self-efficacy	☐	☐	☐
13. Ratio of clinician-to patient talk	70/30	50/50	30/70

Comments_____

Name_____

Reviewer_____ Date_____

ICT Session 9
Adherence and Competence Checklist

PT ID _____ Date_____

	Extensive	OK	Little
1. Reinforce rapport, check on past week, challenge completion and change	☐	☐	☐
2. Rapport-building and review of previous week	☐	☐	☐
3. Review session agenda and provide reasons for focusing on cravings	☐	☐	☐
4. Identify cues or triggers for cravings	☐	☐	☐
5. Discuss strategies for coping with triggers	☐	☐	☐
6. Complete exercise in session	☐	☐	☐
7. Assign between-session challenge	☐	☐	☐
8. Review, summarize, and conclude session	☐	☐	☐

MI and CBT Skills and Strategies Practiced

	Extensive	OK	Little
9. OARS	☐	☐	☐
10. Functional analysis	☐	☐	☐
11. Support self-efficacy	☐	☐	☐
12. Ratio of clinician-to-patient talk	70/30	50/50	30/70

Comments_____

Name_____

Reviewer_____ Date_____

ICT Session 10
Adherence and Competence Checklist

PT ID _____ Date_____

	Extensive	OK	Little
1. Reinforce rapport and check in on challenge completion and change	☐	☐	☐
2. Review agenda: normalizing thoughts about alcohol or substances	☐	☐	☐
3. Identify thought patterns associated with use	☐	☐	☐
4. Discuss automatic thoughts and strategies for coping	☐	☐	☐
5. Identify thought patterns associated with use	☐	☐	☐
6. Explore conceptual difficulties	☐	☐	☐
7. Develop skills for coping with automatic thoughts	☐	☐	☐
8. Practice skills for coping with automatic thoughts	☐	☐	☐
9. Assign between-session exercises	☐	☐	☐
10. Review, summarize, and conclude session	☐	☐	☐

MI and CBT Skills and Strategies Practiced

	Extensive	OK	Little
11. OARS	☐	☐	☐
12. Role-play	☐	☐	☐
13. Support self-efficacy	☐	☐	☐
14. Ratio of clinician-to-patient talk	70/30	50/50	30/70

Comments_____

Name_____

Reviewer_____ Date_____

ICT Session 11
Adherence and Competence Checklist

PT ID _____ DATE_____

	Extensive	OK	Little
1. Reinforce rapport, check on past week, challenge completion and change	☐	☐	☐
2. Introduce concept of "working with" emotions	☐	☐	☐
3. Discuss the value and role of various emotions in day-to-day life	☐	☐	☐
4. Explore the patient's experience with different emotions, his or her connection with AOD use, and how the patient tends to regulate his or her emotional state	☐	☐	☐
5. Provide a rationale for fostering positive emotions	☐	☐	☐
6. Review pleasant activities list and develop plan for increasing opportunities for positive emotion	☐	☐	☐
7. Provide rationale for decreasing the impact of negative emotions	☐	☐	☐
8. Discuss thinking patterns or cognitive distortions that depress mood; link negative moods with alcohol or substance use	☐	☐	☐
9. Build internal resources for handling automatic thoughts	☐	☐	☐
10. Assign practice exercises involving pleasant activities	☐	☐	☐
11. Review, summarize, and conclude session	☐	☐	☐

MI and CBT Skills and Strategies Practiced

	Extensive	OK	Little
12. OARS	☐	☐	☐
13. Functional analysis	☐	☐	☐
14. Support self-efficacy	☐	☐	☐
15. Ratio of clinician-to-patient talk	70/30	50/50	30/70

Comments_____

Name_____

Reviewer_____ Date_____

ICT Session 12
Adherence and Competence Checklist

PT ID _____ DATE_____

	Extensive	OK	Little
1. Reinforce rapport, check on past week, challenge completion and change	☐	☐	☐
2. Review treatment	☐	☐	☐
3. Elicit patient's experience of engaging in treatment process	☐	☐	☐
4. Summarize areas of progress, strength, and continued challenges	☐	☐	☐
5. Discuss the potential effects of major life changes	☐	☐	☐
6. Present personal care plan: high-risk situation	☐	☐	☐
7. Present personal care plan: in case of lapse	☐	☐	☐
8. Review strategies from previous skill topics that the patient found helpful	☐	☐	☐
9. Encourage patient to write or record his or her story	☐	☐	☐
10. Highlight the courage and effort the patient demonstrated	☐	☐	☐
11. Close session	☐	☐	☐

MI Skills and Strategies Practiced

	Extensive	OK	Little
12. OARS	☐	☐	☐
13. Termination and resources for self-help and continued care	☐	☐	☐
14. Support self-efficacy	☐	☐	☐
15. Ratio of clinician-to-patient talk	70/30	50/50	30/70

Comments_____

Name_____

Reviewer_____ Date_____

ICT Session 13
Adherence and Competence Checklist

PT ID _____ DATE_____

	Extensive	OK	Little
1. Reinforce rapport and check in on challenge completion and change	☐	☐	☐
2. Setting the agenda: a discussion of treatment options	☐	☐	☐
3. Initiating a discussion about the use of medications	☐	☐	☐
4. Exploring patient's knowledge and experience regarding use of medications	☐	☐	☐
5. Providing information when appropriate	☐	☐	☐
6. Addressing negative perceptions	☐	☐	☐
7. Facilitating patient reflection on risks and benefits	☐	☐	☐
8. Following up on a decision for a medication evaluation (when indicated)	☐	☐	☐
9. Assign practice exercises involving pleasant activities	☐	☐	☐
10. Review, summarize, and conclude session	☐	☐	☐

MI and CBT Skills and Strategies Practiced

	Extensive	OK	Little
12. OARS	☐	☐	☐
13. Facilitating referral process	☐	☐	☐
14. Support self-efficacy	☐	☐	☐
15. Ratio of clinician-to-patient talk	70/30	50/50	30/70

Comments_____

Name_____

Reviewer_____ Date_____

ICT Session 14
Adherence and Competence Checklist

PT ID _____ DATE_____

	Extensive	OK	Little
1. Welcome, rapport maintenance, and review of past week	☐	☐	☐
2. Review session agenda, participation in self-help	☐	☐	☐
3. Discuss patient's previous experience, knowledge, and beliefs regarding AA and NA	☐	☐	☐
4. Process patient concerns, ambivalence regarding participation in self-help	☐	☐	☐
5. Provide information as needed	☐	☐	☐
6. Negotiate a between-session challenge to attend a certain number of meetings	☐	☐	☐
7. Agree on a concrete plan for coming week regarding patient attendance.	☐	☐	☐
8. Review, summarize, and close session	☐	☐	☐

MI and CBT Skills and Strategies Practiced

	Extensive	OK	Little
9. OARS	☐	☐	☐
10. Functional analysis	☐	☐	☐
11. Support self-efficacy	☐	☐	☐
12. Ratio of clinician-to-patient talk	70/30	50/50	30/70

Comments_____

Name_____

Reviewer_____ Date_____

ICT Session 15-1
Adherence and Competence Checklist

PT ID _____ DATE_____

	Extensive	OK	Little
1. Rapport-building, check in on past week, and challenge/assess progress	☐	☐	☐
2. Orient patient to session agenda	☐	☐	☐
3. Complete PTSD screening if indicated	☐	☐	☐
4. Review and summarize the results of PRS and PTSD screen as part of reflective discussion	☐	☐	☐
5. If indicated, seek further evaluation	☐	☐	☐
6. Summarize session and elicit between-session challenge	☐	☐	☐
7. Conclude session	☐	☐	☐

MI Skills and Strategies Practiced

	Extensive	OK	Little
8. OARS	☐	☐	☐
9. Personalized reflective discussion	☐	☐	☐
10. Express empathy, develop discrepancy, awareness of ambivalence, roll with sustain talk/discord, support self-efficacy	☐	☐	☐
11. Ratio of clinician-to-patient talk	70/30	50/50	30/70

Comments_____

Name_____

Reviewer_____ Date_____

ICT Session 15-2
Adherence and Competence Checklist

PT ID _____ DATE_____

	Extensive	OK	Little
1. Rapport-building, check in on past week, and challenge/assess progress	☐	☐	☐
2. Orient patient to session agenda	☐	☐	☐
3. Educate patient on the effects of trauma	☐	☐	☐
4. Elicit Personal discussion with patient on trauma and substance use	☐	☐	☐
5. Introduce safety plan and rationale	☐	☐	☐
6. Screen for past suicidal history (Suicidal Behaviors Questionnaire, Revised —SBQ-R)	☐	☐	☐
7. Complete safety plan	☐	☐	☐
8. Introduce, train, and practice deep-breathing relaxation	☐	☐	☐
9. Distribute PTSD information sheet	☐	☐	☐
10. Conclude session with between-session challenge	☐	☐	☐

MI Skills and Strategies Practiced

	Extensive	OK	Little
11. OARS	☐	☐	☐
12. Personalized reflective discussion	☐	☐	☐
13. Express empathy, develop discrepancy, awareness of ambivalence, roll with sustain talk/discord, support self-efficacy	☐	☐	☐
14. Ratio of clinician-to-patient talk	70/30	50/50	30/70

Comments_____

Name_____

Reviewer_____ Date_____

ICT Session 15-3
Adherence and Competence Checklist

PT ID _____ DATE_____

	Extensive	OK	Little
1. Rapport-building, check in on past week, and challenge/assess progress	☐	☐	☐
2. Orient patient to session agenda	☐	☐	☐
3. Introduce and ask patient to complete trauma/substance use awareness handout	☐	☐	☐
4. Discuss and elicit three to five situations triggering trauma affects/symptoms and/or substance use	☐	☐	☐
5. Discuss situations to gain full understanding using personalized reflective discussion	☐	☐	☐
6. Identify and prioritize skills and strategies to address trauma symptoms and associated ICT sessions/activities	☐	☐	☐
7. Summarize the session	☐	☐	☐
8. Assign a between-session challenge	☐	☐	☐
9. Conclude session	☐	☐	☐

MI Skills and Strategies Practiced

	Extensive	OK	Little
10. OARS	☐	☐	☐
11. Personalized reflective discussion and functional analysis	☐	☐	☐
12. Express empathy, support self-efficacy	☐	☐	☐
13. Ratio of clinician-to-patient talk	70/30	50/50	30/70

Comments_____

Name_____

Reviewer_____ Date_____

ICT Session 1. Rapport, Collaboration, and Personal Reflections Handouts

Clinician's Quick Reference to Session 1

1. Welcome the patient and build rapport
    - Explore patient's passion, interests, strengths
    - Review Welcome sheet
2. Assess the patient's readiness to proceed
    - Ask patient for his or her feelings and thoughts about the assessment session
    - Ask whether any changes have occurred since the last meeting
    - Reinforce expressions of motivation
3. Review the Personalized Reflective Summary (PRS) (share or give patient a copy)
    - Review the PRS
    - Elicit the patient's "most personal and important" benefits of continued use
    - Elicit any problems caused by use
    - Discuss the current identified risk factors
    - Discuss current reasons for reductions in use and /or quitting
    - Confidence in efforts to reduce use and/or quit
4. Summarize the PRS review
5. Elicit and reinforce patient's readiness to change
6. Assist the patient in preparing for change
    - If appropriate, discuss and help patient develop a specific reduction target, "sampling sobriety period" or a stop date (if the patient has not already stopped using)
    - Elicit
        - Intentions toward use
        - What the patient will do with current supply of alcohol or other substances and paraphernalia
        - How the patient will disclose plans to family and friends
        - How the patient will address problems in maintaining abstinence

7. Help the patient identify specific behavior change strategies
    - Discuss *Learning New Coping Strategies*
    - Discuss barriers to quitting and vulnerabilities to slipping
        - Managing general stress (HALT)
        - People, situations, and thoughts that increase vulnerability
        - Significant life changes likely to produce stress
        - Supportive people who will provide help
    - Review previous successful experiences at quitting to identify useful strategies
8. Assign appropriate life work practice
9. Review and conclude session

Eight Questions Essential To Creating a Personalized Reflective Summary Report

1. Based on your use and the problems it has caused, list the main substances (alcohol or drugs) that you want to discuss today?

   Examples:

   - ☐ Alcohol
   - ☐ Marijuana
   - ☐ Prescription drugs
   - ☐ Cocaine/crack
   - ☐ Other Illicit drugs

2. Where do you typically engage in this behavior?

   - ☐ At home
   - ☐ At a party
   - ☐ At someone else's house
   - ☐ At school

3. What types of situations cause you to use?
4. In the past month, how much money have you spent on alcohol and other drugs?
5. What do you like about using the substance, and what good things have come from using it?
6. What are some reasons you have for changing this behavior? What good things could happen if you tried to change this behavior?
7. How motivated are you to try to change the behavior right now?

   Choose one:

   - ☐ No motivation to change
   - ☐ Thinking about changing
   - ☐ Preparing to change
   - ☐ Planning to change
   - ☐ Already changing

8. How confident are you in your ability to change the behavior?

   Choose one:

   - ☐ No confidence
   - ☐ Worried, but will try soon
   - ☐ Trying, but now uncertain
   - ☐ Building confidence
   - ☐ Very confident

A Bridge to Well-Being

Directions: At the beginning of this session, a brief one-page personalized reflective summary of the intake interview and screening and assessment information is provided to the patient. This simple type of feedback form is used to develop discrepancy, enhance motivation, and elicit change talk. Whenever possible, the clinician, prior to the session, fills out the overall risk level and the four questions that emphasize the most critical areas of the results.

Substance Use Risk Based on Screening

You are here

Moderate | High | Very High

Moderate: You run the risk of having health and other problems because of your current substance use.

High: Your risk of having serious problems from your substance use is high. These may be health, social, money, legal, and relationship problems. You may become dependent.

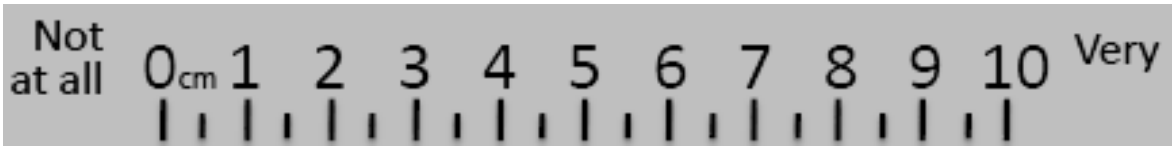
Very High: It is likely you are having serious problems because of your substance use. These may be health, social, money, legal, and relationship problems. You may be dependent or addicted.

1. The primary reasons you identified for using are:
2. The most troublesome problem (s) of using are:
3. The most important reason (s) you would stop or decrease your use is:
4. Your present level of motivation on a scale from 1 to 5 for you to act now, work in treatment to reduce substances and increase your health and psychological and social well-being:

1 ... 10

Not at all ready | Almost ready | Somewhat ready | Very ready | Extremely ready

Readiness Ruler



A Bridge to Well-Being (expanded)

Directions: If possible, prior to the session, this longer version of the personal reflective summary report is used to enhance motivation to change by filling in blanks and checking boxes to capture the patient intake results.

Welcome! My name is [_____] and I am looking forward to working with you over the next few months to help you with the goals you may have. You recently met with an assessment counselor and provided a lot of information about your life and use of alcohol and other substances. Thank you for sharing this information as I believe it will be helpful to us as we begin to discuss how you see your current situation and what direction you would like to move in, including any changes you might like to make. I am here to help you figure out what you think would be best for you and your overall health and well-being

This report provides a summary of some of the questions you answered during your assessment meeting and I was hoping we could start with this information as a starting point for our work together, to make sure the information is accurate, and to see how you feel when we review this material together. Let me know if you have any questions as we go along, if you feel any information is incorrect, or if anything strikes you in a particular way that you want us to discuss further.

Alcohol/Substance Use

Substance	Screening Results or Assessment Findings	Risk Level
Tobacco		
Alcohol		
Marijuana		
Cocaine		
Amphetamine		
Inhalants		
Sedatives		
Hallucinogens		
Pain Medications and Opioids		
Other; Specify		

Definitions Low Risk. You are at low risk of health and other problems from your current pattern of use of the following:

Moderate Risk. You are at risk of health and other problems from your current pattern of use of the following:

High Risk. You are at high risk of experiencing severe problems (health, social, financial, legal, relationship) as a result of your current pattern of use and are likely to be dependent on the following:

Note: Include information about the substance or substance for which the patient evidences moderate or high risk; for example, the following information taken from this Web site could be incorporated into the PRS: *http://www.drugabuse.gov/infofacts/cocaine.html*

As part of your screening (or your assessment), you indicated that using [____] has been problematic for you in the following areas*:*

- ☐ Work or school
- ☐ Relationships
- ☐ Physical health, describe
- ☐ Self-care
- ☐ Emotional health, describe
- ☐ Energy/vitality
- ☐ Self-esteem, confidence
- ☐ Legal
- ☐ Financial
- ☐ Other, describe

You also said it was important to you to make a change in your current use of [____] for the following reasons:

- ☐ To show myself that I can quit if I want to
- ☐ Because I will like myself better if I quit
- ☐ Because I won't have to leave social functions or other people's houses to use
- ☐ So I can feel in control of my life
- ☐ Because my family and friends will stop nagging me if I quit
- ☐ To get praise from people I'm close to
- ☐ Because using does not fit in with my self-image
- ☐ Because using is becoming less socially acceptable
- ☐ Because someone has told me to quit or else
- ☐ Because I will receive a special gift if I quit
- ☐ Because of potential health problems
- ☐ Because people I am close to will be upset if I don't quit
- ☐ So that I can get more things done
- ☐ Because I have noticed that using is hurting my health
- ☐ Because I want to save the money I spend on using
- ☐ To prove that I'm not addicted to
- ☐ Because there is a drug-testing policy at work
- ☐ Because I know others with health problems caused by using
- ☐ Because I am concerned that using will shorten my life
- ☐ Because of legal problems related to using
- ☐ Because I don't want to be a bad example for children
- ☐ Because I want to have more energy
- ☐ So my hair and clothes won't smell from my using substances
- ☐ So I won't burn holes in clothes or furniture
- ☐ Because my memory will improve
- ☐ So that I will be able to think more clearly

You listed these reasons because they have personal significance for you. Do you have any other important reasons for quitting that you would like to add?

_____

_____

Your indicated your current motivation for making these changes:

☐ Low ☐ Moderate ☐ High

How does this compare to how you are feeling now (today)?

_____

_____

What you would need to make the changes you desire (e.g., support from significant others; more resources such as time, money, energy, beliefs/confidence level/attitude)?

_____

_____

What keeps you from being able to accomplish what you would like? You predicted your most difficult situations for maintaining abstinence. These high-risk situations include—

- ☐ Doing monotonous work
- ☐ Wanting to feel more confident
- ☐ Vacationing
- ☐ Seeing someone else using and enjoying it
- ☐ Feeling depressed or worried
- ☐ Drinking alcohol
- ☐ Feeling like celebrating good news or an accomplishment
- ☐ Feeling frustrated
- ☐ Wanting to feel better about myself
- ☐ Feeling angry about something or someone
- ☐ Enjoying a pleasant social situation
- ☐ Having some time to myself, free of responsibilities
- ☐ Using other drugs recreationally
- ☐ Being at a party with people who are using or drinking
- ☐ Feeling embarrassed
- ☐ Being with a spouse or close friend who is using
- ☐ Being in an uncomfortable social situation
- ☐ Being offered alcohol or other substances by someone
- ☐ Being bored, with nothing to do
- ☐ Feeling stressed out and needing to calm down

As you think about highly tempting situations? Are there situations that you'd like to add?

_____

_____

Brief Treatment: Information Sheet

I hope this summary has been useful and sheds some light upon areas that may be critical as we embark on this journey of self-discovery and positive growth. Over the next 2–3 months we will be meeting together (individually or as part of a group) and developing some goals that are important to you and that seem reasonable for you to achieve in this amount of time. You can set the pace of our work together and let me know if, at any point, I am moving too quickly or slowly. I have some ideas for how we can work together on the goals that you have identified already and hope to share these ideas and help you develop effective skills, or build upon abilities you already have but may not recognize or be using to your best advantage. Following are some general guidelines:

1. **Regular meetings**. It seems most helpful if we can meet on a regular basis, such as weekly. If you need to cancel or are running late, I would appreciate your letting me know with as much advance notice as possible.
2. **Commitment to treatment**. Change is difficult for everyone. I ask that you make every effort to participate fully in the treatment by coming to sessions, sharing your thoughts and feelings and frustrations, and staying the course, even if you feel at times our work is not helping as quickly as you would like.
3. **Therapy process**. I will do my best to help you feel comfortable, and my hope is that we can work as a collaborative team. Therapy can be uncomfortable at times because different thoughts and feelings may come up. This doesn't mean that treatment isn't working. However, if at any point you find yourself upset with something that has happened, or something I have said or done, I encourage you to bring this up and let me know so that we can continue with a positive connection.
4. **Substance use**. I ask that you refrain from using alcohol or substances on days or at times when we will be meeting together. I think our discussions together can be most productive and helpful to you if you are not under the influence of any substances.
5. **Structure of meetings and practice exercises**. We will meet together for about an hour each time. I will usually want to hear about how things have been going the previous week and anything you want to share about events in your life. Then we will spend some time on a particular topic area or skill that I hope will be helpful to you in accomplishing your goals. I may ask you to do some writing or thinking about what we have discussed between sessions. It is up to you whether you do this and the goal is not to make you feel pressured or burdened. You will never be graded or judged on what you write. The purpose is to keep the material alive between the times we meet and encourage you to practice or apply some of the new ideas and skills in your real life, as opposed to merely discussing them. If I ask you to write or practice something that you are not comfortable with, please let me know so we can come up with an exercise that is more suitable to you.
6. **Questions** you may have regarding treatment, what is involved, my background and role.
7. **I look forward to working together with you.**

Learning New Coping Strategies in Support of Change

Developing Alternatives…

You can do many things to stop using. Some may work better than others. Some help you resist the urge to use or avoid tempting situations or satisfy your needs in more constructive ways than using. Expect to try several new strategies and add any that may be helpful for you. Think about what worked when you gave up (e.g., drinking, smoking, using substances) before or when you made other changes in your life. Be kind to yourself as you begin this change process—you're doing something to take care of yourself, and you deserve all the comfort and self-acceptance you can get! Remind yourself that learning and changing inevitably mean giving up old ways and that, in time, you will feel more comfortable. Remember the changes your body and mind went through when you learned to drive, got to know a new person, started a new job, or learned a new skill. Chances are you felt awkward, uncomfortable, silly, dumb, nervous, frustrated, impatient, or anxious, in addition to hopeful, excited, and challenged. What helped you then? How long did it take you to feel relaxed? Did you learn all at once, or were improvement and progress gradual?

First Actions

Avoid or escape from situations that make you want to use; sometimes this is the easiest and most effective way to resist temptation, especially at the beginning.

Delay decisions to give in to urges; for example, you could make a decision to wait 15 minutes. Take several deep breaths. Focus on the fresh air entering your lungs, cleansing and nourishing your body. Let out tension with each exhalation.

Change your physical position. Stand up and stretch, walk around the room, or step outside.

Carry things to put in your mouth: toothpicks, gum, mints, plastic straws, low-calorie snacks.

Carry objects to fiddle with: a rubber ball to squeeze, a small puzzle, a pebble, worry beads.

Have a distracting activity available: a phone call, a crossword puzzle, magazine, book, a postcard to write.

New Thoughts

Self-talk. Give yourself a pep talk; remind yourself of your reasons for quitting; remind yourself of the consequences of using; challenge any wavering in your commitment to quit.

Imagery and visualization. Visualize yourself as a nonsmoker, happy, healthy, and in control; imagine your lungs getting pink and healthy; or focus on negative imagery and imagine yourself with cancer, emphysema, unable to breathe, needing constant care. Visualize yourself in a jail made of alcohol or substances, symbolizing the way it controls your life.

Thought-stopping. Tell yourself loudly to STOP; get up and do something else.

Distraction. Focus on something different: the task at hand, a daydream, a fantasy, counting

Exercise or take a brisk daily walk. Get your body used to moving; use stairs instead of elevators; park farther away from your destination; walk instead of drive.

Practice relaxation or meditation techniques regularly (we will have opportunity to learn and practice these techniques later in our work together).

Take up a hobby or pick up an old hobby you used to enjoy.

Drink less coffee; switch to decaf; drink herbal teas.

Engage in an enjoyable activity that is not related to work several times a week.

Change routines associated with using, at least temporarily; for example, don't turn on the TV when you get home from work; don't spend time with friends who smoke.

Social Interactions and Environment

Remove paraphernalia (pipes, papers, bongs, ashtrays, matches, lighters,etc) from your home and car.

Go to places where it's difficult to get high, such as a library, theater, swimming pool, sauna, steam bath, restaurant, and public gatherings (not rock concerts).

Spend time with friends who don't smoke. Enlist support from family and friends. Announce that you've quit; ask people not to offer you alcohol or other substances, to praise you for stopping, to provide emotional support, and not to smoke around you.

Learn to be appropriately assertive; learn to handle frustration or anger directly instead of by using.

Specific Suggestions for Some Common High-Risk Situations

Below are several high-risk situations that people who use confront, along with suggestions for coping without using.

Tension Relief and Negative Emotions (e.g., depression, anxiety, nervousness, irritability): Develop relaxation techniques, exercise, write down your feelings or talk to a friend or counselor, do something enjoyable that requires little effort, figure out what you're feeling and whether you can do anything about it.

Anger, Frustration, and Interpersonal Conflict: Try to handle the situation directly rather than hiding your feelings; if appropriate, be assertive; get some release by squeezing a rubber ball, pounding a pillow, or doing some physical activity; write down your feelings or tell them to someone; take deep breaths.

Fatigue and Low Energy: Do muscle relaxations; take a brisk walk; do something enjoyable; eat properly and get enough sleep.

Insomnia: Don't fight being unable to sleep. Get up and do something constructive or relaxing. Read a book, watch TV, or do muscle relaxations until you feel sleepy. Remember that no one dies from losing a night's sleep.

Time-Out: Read, do a crossword puzzle, prepare a healthy snack, take up a hobby, knit or do other needlework (things you can carry with you for easy access).

Self-Image: Try a new image: get a new haircut or buy new clothes.

Social Pressure: Be aware when others are using. Remember your commitment not to use. Be assertive and request that people not offer you alcohol or substances. If appropriate, ask that they not use around you for a while. If necessary, be prepared to leave the situation, especially when you've recently quit.

Cravings and Urges: The only way to interrupt cravings is to break the chain of responding to them. That is, don't give in. Eventually they will decrease. Do something to distract yourself; use the techniques listed under Thoughts; breathe deeply; call a friend; go for a walk; move around; time the urge, and you'll find that it will disappear like a wave breaking.

This handout is optional and offered to patients ready to think about immediate ways of changing. This will be reviewed with patients during the next session.

ICT Session 2. The Change Plan and Supporter Involvement Handouts

Clinician's Quick Reference to Session 2

1. Continue Building Rapport
    - Welcome the patient, and if present, the support person.
    - Quickly check in on the past week.
    - Ask about any positive experiences.
    - Share the session agenda; invite items from the patient.
2. Assess the patient's progress and readiness to proceed
    - Ask the patient how he or she feels about continuing therapy.
    - Address patient comments and questions about session 1 handouts.
    - Review the patient's work regarding the Change Plan, Quit Agreement, and Learning New Coping Strategies.
3. Welcome the supporter (if in attendance)
    - Reinforce the importance of the supporter's participation.
    - Provide basic information and orientation about ICT.
    - Offer optional supportive session as part of the process.
    - Answer questions.
4. Examine the patient's recent experiences (supporter attendance optional)
    - Did the patient make an effort to stop? cut down?
    - Did he or she experience any high-risk or tempting situations?
    - Did the patient use any strategies from *Learning New Coping Strategies*?
    - Were the strategies successful?
    - Have the patient describe three to five incidents of use in recent history (functional analysis).
5. Identify internal and external factors/triggers associated with use
    - Discuss associated skills and associated treatment sessions
    - Establish a change plan
    - Suggest interim goals if the patient is not ready for abstinence.
    - Encourage the patient to set general and specific goals.
6. Involve the supporter and review supporter strategies and the supporter agreement
7. Elicit the supporter's concerns and hopes for the patient.
8. Give the patient and the supporter the *I Promise To Support* handout.
9. Complete the supporter agreement.
10. Review the supporter agreement.
11. Help the patient and the supporter decide which items they can agree to.

12. Review the supporter agreement with patient, even if no supporter attends.
13. Review daily trust discussion, asking for support, and role-play.
14. Assign a between-session challenge and elicit a specific commitment for completion
15. Review and conclude session

Alcohol/Substance Use Awareness Record

As a way to increase awareness about your patterns of use, we'll use this form to identify the kinds of situations, thoughts, feelings, and consequences that are associated with your alcohol/substance use. It may be difficult initially, but once you get accustomed to paying more attention, you will become skilled at discovering the ways in which you typically use alcohol/substances.

Trigger (What types of events tend to make you want to use? For example, an argument, disappointment, loss, or frustration; spending time with friends who use; having alcohol/substances easily available to you; recalling positive memories of past use.)

1._____

2._____

Thoughts, Feelings, and Beliefs (What were you thinking or how were you feeling in relation to the triggers you have identified? For example, thinking you were incompetent or stupid or that you could never achieve a particular goal; feeling angry, sad, frightened, or glad.)

1._____

2._____

Behavior (What did you actually do when you were thinking and feeling in these ways? For example, used [____], went out to dinner, isolated yourself from people.)

1._____

2._____

Positive Consequence*s* (What good came out of your response to the situation? For example, I felt much better for a short period.)

1._____

2._____

Negative Consequences (What negative things happened as a result of your response? For example, I felt bad about myself for using; I couldn't complete the work I needed to finish.)

1._____

2. _____

Quit Agreement

I,_____, am quitting [____] because [fill in reasons for quitting]

_____

_____

_____

_____

_____

_____

_____

_____

_____

As of [date], I intend to stop using [____] and to refrain from use in the future by [fill in strategies to be used]

_____

_____

_____

_____

_____

_____

_____

_____

_____

Personal Signature _____

Supporter Signature_____

A Change Plan

Once commitment is solidified, it is important to move on and help the individual create a plan for making the changes they have committed to make. The change plan should be expressed verbally at a minimum but can also be in writing. Ideally, the patient/patient should actually write the plan or complete the form. Responses to the following questions will create a simple but powerful plan for change.

Change Plan

Person's Name _____

1. The changes I want to make are— (specifics)

_____

_____

2. The most important reasons I want to make these changes are—

a._____

b._____

c._____

3. The steps I plan to make in changing are—

a._____

b._____

c._____

4. The ways people can help me are—

a._____

b._____

c._____

5. I will know that my plan is working if—

a._____

b._____

c._____

6. The things that could interfere with my plan are—

a._____

b._____

c._____

Planning To Feel Good

I am doing this right now.	I used to do this and I want to try again.	I have never done this and I want to try.

I Promise To Support…

In this document, [_____] will be referred to as the supporter and [_____] will be referred to as the participant. To maintain [_____]'s success in quitting [_____], we agree to the following arrangements.

Types of Support: Supporter and participant initial all conditions that apply to agreement. Whenever possible, a daily eye-to-eye check-in is requested so that there is a building of consistent communication and trust. Supporter and participant agree to a time/place and to keeping a record of the daily check-ins.

Initials

_____ Supporter will let participant know how pleased he or she is with the participant's success at not using.

_____ Supporter will ask participant about his or her motivation for remaining abstinent if supporter notices that motivation may be decreasing.

_____ Participant will let supporter know that he or she appreciates the support received.

_____ Supporter will remind participant of his or her reasons for quitting and of the consequences that [_____] caused, if motivation seems to lag.

_____ Participant will review the Reasons for Quitting Questionnaire or the Quit Agreement with the supporter if they agree that motivation needs a boost.

_____ Supporter will discuss and participate with participant in lifestyle changes that will reduce the need for using.

_____ Supporter will ask participant about upcoming high-risk situations that supporter anticipates but is not sure whether the participant anticipates. In addition, supporter will help participant plan to cope with high-risk situations.

_____ Supporter will help participant cope with a slip and return to abstinence by asking about participant's motivation and the circumstances of the slip.

_____ Supporter will help restore motivation and develop a coping plan for future situations that led to the slip.

_____ Participant will negotiate rewards for supporter's continued support and involvement.

_____ Supporter will avoid being critical of participant in communicating concerns about motivation, high-risk situations, and slips.

_____ Supporter will focus on questioning participant's motives and coping plans and on challenging rationalizations for using.

_____ Participant will listen to what supporter has to say about observations of lagging motivation, upcoming high-risk situations, or rationalizations for using.

_____ Supporter may express disappointment if participant fails to accept supporter's input.

_____ Participant will suggest another time (within 24 hours) to discuss supporter's observations or concerns if participant's current mood/situation doesn't allow them to be open to supporter's comments at the moment.

Specific conditions or support agreements: List additional conditions on back of sheet.

Signatures: _____ _____

Supporter Participant

ICT Session 3. Making Important Life Decisions Handouts

Clinician's Quick Reference to Session 3

1. Welcome the patient and continue to build rapport; address any obstacles to the therapeutic alliance.
    - Share the session agenda.
    - Ask if any changes have occurred since the last meeting.
    - Discuss the decision of concern, the benefits, and any consequences.
    - Review the between-session challenge(s).
    - Review the daily check-in and supporter plan completion.
2. Introduce motivational strategy involving readiness for change.
    - Reintroduce the readiness ruler.
    - Elicit the patient's readiness score regarding specific concern.
    - Seek elaboration and outcomes.
    - Discuss the history of patient's life prior to use or in relationship to current concern.
    - Discuss real and potential future for patient without change and with change.
3. Introduce and teach decisionmaking steps:
    - Discuss concept of decisionmaking, normalizing ambivalence as part of the process.
    - Provide a rationale for focusing on decisionmaking.
    - Introduce idea that certain steps can make the decisionmaking process less overwhelming and potentially more clear.
    - Emphasize that while these steps can be used for any decision, today's session focus will be on the decision whether to continue to use.
    - Give patient Decisionmaking Guide and review steps 1 through 5.
4. Complete steps 1 through 3 of the Decisionmaking Guide for decision regarding use.
    - Elicit from patient what the decision topic is and from which options the patient can choose.
    - Using Decisionmaking Guide, explore pros and cons of each choice, including how the choice relates to patient's short- and long-term goals and what feelings each decision evokes.
    - Review relevant history of patient's life.
    - Discuss real and potential future for patient without change and with change.
    - Elicit the patient's top three statements in each category; end with the benefits of changing.
5. Using the readiness ruler in the Decisionmaking Guide, ask the patient to reassess his or her readiness.
    - Summarize the change talk discussions, emphasizing any change in readiness: Illustrate any increased readiness or continued ambivalence.
    - Have patient complete step 5 of the Decisionmaking Guide.
    - If appropriate, assign a between-session challenge and elicit a specific commitment to complete the challenge:

- If appropriate, discuss and help patient develop a specific plan such as: reduction target, “sampling sobriety period,” or stop date (if the patient has not already stopped using).
- If the patient is not ready to make changes but is willing to engage in continued exploration: If change is substance specific, suggest committing to accurately monitoring use to identify any possibility of change or reduction.
- If the patient has made decision, affirm the patient’s efforts to date and end in a positive fashion. It may be useful to ask the patient to think it over, talk about it with a significant other, and then call with a final decision in a day or two.

6. Conclude the session.

MI Skills and Strategies

Motivational Interviewing (MI) Spirit
- **I**nterviewing
- **C**ollaboration
- **G**uiding

MI Principles
- Express empathy
- Develop discrepancy
- Roll with resistance
- Support self-efficacy

Fundamental Skills
- Open-ended questions
- Affirmations
- Reflections
- Summarizations

Change Talk
- Desire to change
- Ability
- Reason
- Need
- Commitment

Eliciting Change Talk
- Importance/confidence ruler
- Querying extremes
- Looking back; looking forward
- Evocative questions
- Decisional balance
- Goals/values exploration
- Elaboration

Responding to Change Talk
- **R**eflection
- **E**laboration questions
- **S**ummary
- **A**ffirmation

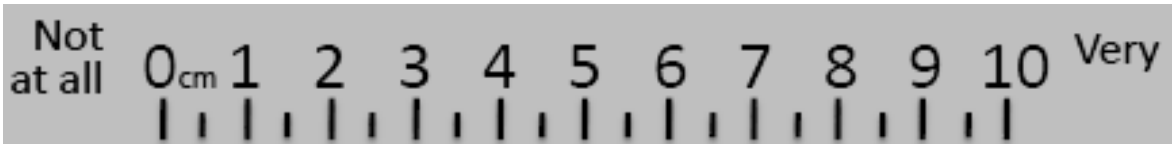
Elicit-**P**rovide-**E**licit

Menu **o**f **O**ptions

Dealing With Resistance
- Simple reflections
- Amplified reflections
- Double-sided reflections and shifting focus
- Agreement with a twist
- Coming alongside
- Reframing
- Emphasizing personal control
- Disclosing feelings

Traps
- Premature focus
- Labeling
- Question/answer
- Confrontation/denial
- Expert
- Blaming

Readiness-To-Change Ruler



The Readiness-To-Change Ruler is used to assess a person's willingness or readiness to change, determine where they are on the continuum between "not prepared to change" and "already changing," and promote identification and discussion of perceived barriers to change. The ruler represents a continuum from "not prepared to change" on the left to "already changing" on the right.

The Readiness-To-Change Ruler may be used as a quick assessment of a person's present motivational state relative to changing a specific behavior and serve as the basis for motivation-based interventions to elicit behavior change. Readiness to change should be assessed regarding a specific activity, such as reducing use of alcohol, since persons may differ in their stages of readiness to change for different behaviors.

Administration

1. Indicate the specific behavior to be assessed on the Readiness-To-Change Ruler form. Ask the person to mark on a linear scale from 0 to 10 his or her current position in the change process. A 0 on the left side of the scale indicates "not prepared for change," and a 10 on the right side of the scale indicates "already changing."
2. Question the person about why he or she did not place the mark further to the left, which elicits motivational statements.
3. Question the person about why he or she did not place the mark further to the right, which elicits perceived barriers.
4. Ask the person for suggestions about ways to overcome identified barriers and actions that might be taken.

Interview Questions

"Could we talk for a few minutes about your interest in making a change?"

"On a scale from 1 to 10, with 1 being not ready at all and 10 being completely ready, how ready are you to make any changes in your alcohol use?"

"You marked (or said) [____]. That's great. That means you are [____] percent ready to make change."

"Why did you choose that number and not a lower one such as a 1 or a 2? Sounds like you have some important reasons for change."

Decisionmaking Guide

Why create this decisionmaking guide?

This will help you think about the choices you are being presented with so you can calmly and logically identify and consider the ***Good Things*** and the ***Not-so-Good Things*** about each choice. While you are being asked to complete this sheet around your choice as to whether to continue using or abstain, it can be a helpful strategy when making other important life decisions. Weighing the ***Good Things*** and the ***Not-so-Good Things*** helps people make decisions. For example, while drinking may sometimes help people relax, it could also cause problems with family or work. Ask yourself, "What are the good things and the not-so-good things about my current use?" "What are the good things and the not-so-good things about changing my use?"

STEP 1: Define what decision you have to make, including options.	Decision Topic:
STEP 2: Brainstorm the good and not-so-good things about **continuing** the behavior.	Option 1 (continuing behavior):
STEP 3: Brainstorm the good and not-so-good things about **changing** the behavior.	Option 2 (changing behavior):

Continuing Behavior	
Cost	Benefits
1.	1.
2.	2.
3.	3.
4.	4.

Changing Behavior	
Cost	Benefits
1.	1.
2.	2.
3.	3.
4.	4.

Decisionmaking Guide (continued)

Consider….

How will continuing the behavior help me reach my goals?	How will changing the behavior help me reach my goals?

STEP 4: Assess how ready you are to make a change in your behavior using the readiness ruler below.

STEP 5: Write down your decision below, including how you are going to act on your decision and when you want to look back and consider how well it is working

I intend to:

I will do this by:

I will evaluate my decision and how it is working in *(time frame)*:

Decisionmaking Guide Example

Why create this decisionmaking guide?

This will help you think about the choices you are being presented with so you can calmly and logically identify and consider the ***Good Things*** and the ***Not-so-Good Things*** about each choice. While you are being asked to complete this sheet around your choice as to whether to continue using or abstain, it can be a helpful strategy when making other important life decisions. Weighing the ***Good Things*** and the ***Not-so-Good Things*** helps people make decisions. For example, while drinking may sometimes help people relax, it could also cause problems with family or work. Ask yourself, "What are the good things and the not-so-good things about my current use?" "What are the good things and the not-so-good things about changing my use?"

Here's an example from another individual. Remember, every person has different reasons for wanting to change use.

STEP 1: Define what decision you have to make, including options.	Decision Topic: My alcohol use
STEP 2: Brainstorm the good and not-so-good things about **continuing** the behavior.	Option 1 (continuing behavior): Keep drinking the way I have been—5 days a week, three to four 4 drinks per day.
STEP 3: Brainstorm the good and not-so-good things about **changing** the behavior.	Option 2 (changing behavior): Stop drinking alcohol altogether.

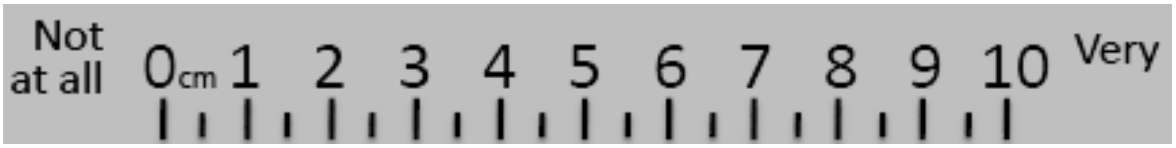
Good things about my use	Good things about changing my use
More relaxed Will not have to think about my problems for a while More comfortable with drinking friends	More control over my life Support from family and friends Less legal trouble Better health
Not-so-good things about my use	**Not-so-good things about changing my use**
Disapproval from family and friends Can't get as much work done Costs too much money I'm late for class I argue with my roommate	More stress or anxiety Feel more depressed Feel inhibited with people I don't know Harder to socialize at parties

Decisionmaking Guide Example (continued)

Consider….

How will continuing the behavior help me reach my goals?	How will changing the behavior help me reach my goals?
Helps me handle my problems in the moment so I can keep going and get through the day.	Maybe my problems will get better, so I won't feel so stressed out and down all the time. I will have more money and do better at work and school, which will help me to stay independent.

STEP 4: Assess how ready you are to make a change in your behavior using the readiness ruler below.



STEP 5: Write down your decision below, including how you are going to act on your decision and when you want to look back and consider how well it is working

I intend to:

I intend to stop drinking entirely.

I will do this by:

I will do this by not going to the bar, asking my friends and family for support, coming to treatment, and reminding myself why I am doing this.

I will evaluate my decision and how it is working in *(time frame)*:

I will evaluate my decision and how it is working in 1 week.

Thinking About My Use Option 3

Use this page to complete your own thinking exercise about alcohol/drug use. Remember, everyone is different, and your exercise will be uniquely yours.

Good things about my use	Good things about changing my use
Not-so-good things about my use	**Not-so-good things about changing my use**

ICT Session 4. Enhancing Self-Awareness Handouts

Clinician's Quick Reference to Session 4

1. Building Rapport and Review
    - Welcome the patient; check in about the week in general.
    - Review the patient's cravings, recent use experiences, and successes.
    - Review the between-session challenge.
    - Attend to the therapeutic alliance and address any obstacles, concerns.
    - Assess motivational factors and change readiness.
2. Explore the Development of Addictive Patterns
    - Provide rationale, such as the learned or associative nature of addiction (pairing with alterations in thinking and feeling).
    - Using the patient's own experiences, illustrate how using alcohol or other substances can change one's feelings; if the patient has not stated any examples, provide examples that are appropriate to his or her situation.
    - From the patient's stated use situations, identify examples of environmental triggers for use; ask the patient for other triggers he or she has experienced.
    - Elicit examples of feelings, beliefs, or automatic thoughts people may have about substances; use examples provided by the patient, and ask the patient for more examples.
    - Suggest that the patient start the process of change by understanding his or her behavior; ask, "Does this make sense to you?"
3. Empowerment Though Self-Knowledge: Understanding High-Risk Situations and Triggers
    - Explore with the patient—
        - Typical use situations (places, people, activities, time, days)
        - Triggers for use
        - A recent use situation
        - Thoughts and feelings at use times (tense, bored, stressed, etc.)
        - Complete *Knowledge Is Power* and summarize the list
4. Putting the Pieces Together: Draw Connections, Consider New Roads, and Build Coping Strategies
    - Emphasize the importance of coping strategies.
    - Reintroduce Learning New Coping Strategies.
    - Introduce a drawing connection exercise and identify new pathways toward desired outcomes.
    - Ask patient to identify strategies he or she has tried and those that might work best.
5. Develop or Elicit a Specific Between-Session Challenge That Incorporates Material From the Session

Alcohol/Substance Use Awareness Record

As a way to increase awareness about your patterns of use, we'll use this form to identify the kinds of situations, thoughts, feelings, and consequences that are associated with your alcohol/substance use. It may be difficult initially, but once you get accustomed to paying more attention, you will become skilled at discovering the ways in which you typically use alcohol/substances.

Trigger (What types of events tend to make you want to use? For example, an argument, disappointment, loss, or frustration; spending time with friends who use; having alcohol/substances easily available to you; recalling positive memories of past use.)

1._____

2._____

Thoughts, Feelings, and Beliefs (What were you thinking or how were you feeling in relation to the triggers you have identified? For example, thinking you were incompetent or stupid or that you could never achieve a particular goal; feeling angry, sad, frightened, or glad.)

1._____

2._____

Behavior (What did you actually do when you were thinking and feeling in these ways? For example, used [____], went out to dinner, isolated yourself from people.)

1._____

2._____

Positive Consequence*s* (What good came out of your response to the situation? For example, I felt much better for a short period.)

1._____

2._____

Negative Consequences (What negative things happened as a result of your response? For example, I felt bad about myself for using; I couldn't complete the work I needed to finish.)

1._____

2. _____

Future Self Letter

Sometime during the next week, imagine that a year has passed and that you haven't used alcohol/substances for a year. Making believe that it's next year, write a letter to yourself (the old you). Write about your life as it has become. Include the reasons why you stopped a year earlier, what your lifestyle is like in the new year, and the benefits you enjoy from not using. Mention in your letter any problems you faced during the past year in giving up alcohol/substance use. Describe yourself without alcohol/substances as clearly as you can. As you visualize yourself in the future without alcohol/substances, it may help to think about friendships, self-esteem, health, employment, recreational activities, and general lifestyle satisfaction. If you prefer, draw, sketch, or paint a picture of this image of yourself in the future, rather than depicting it in writing. Choose a medium that will allow you to see another possibility for yourself.

This exercise is extremely useful. It helps you visualize your journey and your goal. Having a clear picture of where you're going, why, and how you're going to get there will be useful in the months ahead. At our next session, we'll talk about the future you foresee for yourself.

Relaxation Practice Exercise

Arrange to spend some quiet time in a room where you will not be interrupted. Try to practice this relaxation technique at least three times during the next week. Proceed through the eight groups of muscles in the list below, first tensing each for 5 seconds and then relaxing each for 15 to 20 seconds. Settle back as comfortably as you can, take a deep breath, and exhale very slowly. You may feel most comfortable if you close your eyes. Notice the sensations in your body; you will soon be able to control those sensations. Begin by focusing your attention on your hands and forearms.

- Squeeze both hands into fists, with arms straight. Then relax hands.
- Flex both arms at the elbows. Then relax arms.
- Shrug shoulders toward head. Tilt chin toward chest. Then relax shoulders and neck.
- Clench jaw, gritting your teeth together. Then relax jaw.
- Close your eyes tightly. Then relax eyes.
- Wrinkle up your forehead and brow. Then relax these muscles.
- Harden your stomach muscles, as if expecting someone to punch you there (continue to breathe slowly as you tense your stomach). Then relax stomach.
- Stretch out both legs, point your toes toward your head, and press your legs together. Then relax legs.

Self-Rating Task

Each day that you engage in this exercise, rate your relaxation level before and after, using the following guide: ***0 = highly tense; 100 = fully relaxed***.

Day	Time	Before	After

ICT Session 5. Handling Urges, Cravings, and Discomfort Handouts

Clinician's Quick Reference to Session 5

1. Provide reasons for focusing on cravings.
   - Provide basic information about the nature of cravings.
     - Cravings are experienced most often early in abstinence but can occur weeks, months, even years later.
     - Cravings may feel very uncomfortable but are a common experience.
     - An urge to use does not mean something is wrong.
   - Give patient the Coping With Cravings and Urges handout.
   - Provide a framework for understanding craving as a subset of the universal experience of longing or desire.
2. Identify cues or triggers for cravings.
   - Give the patient examples of common cues
     - Exposure to alcohol, substances, or paraphernalia
     - Seeing other people using substances
     - Contact with people, places, times of day, or situations associated with using
     - Particular emotions and physical feelings
   - Distinguish external or environmental triggers from internal states.
   - Review the patient's experience of cravings or urges.
3. Discuss strategies for coping with triggers.
   - Avoidance
   - Escape
   - Distraction
   - Embrace
4. Complete exercises.
   - Make a list of craving triggers
   - Make a plan for managing craving
5. Assign between-session exercises.
   - Encourage the patient to review the handouts before the next session
   - Encourage the patient to practice urge surfing
   - Complete the Daily Record of Urges To Use Alcohol or Other Substances
6. Review and Conclude the Session

Coping With Cravings and Discomfort

- Urges are common in the recovery process. Do not regard them as signs of failure. Instead, use your urges to help you understand what triggers your cravings.
- Urges are like ocean waves. They get stronger only to a point; then they start to subside.
- You win every time you defeat an urge to use. Urges get stronger the next time if you give in and "feed" them. However, if you don't feed it, an urge eventually will weaken and die.

Practice Exercise

For the next week, make a daily record of urges to use alcohol or substances, the intensity of those urges, and the coping behaviors you used.

Fill out the Daily Record of Urges to Use Alcohol or Substances:

- Date
- Situation: Include anything about the situation and your thoughts or feelings that seemed to trigger the urge to use.
- Intensity of cravings: Rate your craving; **1 = none at all, 100 = worst ever**.
- Coping behaviors used: Note how you attempted to cope with the urge to use alcohol or substances. If it helps, note the effectiveness of your coping technique.

Urge Surfing

Many people try to cope with their urges by gritting their teeth and toughing it out. Some urges, especially when you first return to your old using environment, are too strong to ignore. When this happens, it can be useful to stay with your urge to use until it passes. This technique is called urge surfing.

Urges are like ocean waves. They are small when they start, grow in size, and then break up and dissipate. You can imagine yourself as a surfer who will ride the wave, staying on top of it until it crests, breaks, and turns into less powerful, foamy surf. The basis of urge surfing is similar to that of many martial arts. In judo, one overpowers an opponent 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. This type of technique of gaining control by first going with the opponent allows one to take control while expending a minimum of energy. Urge surfing is similar. You can join with an urge (rather than meet it with a strong opposing force) as a way of taking control of your urge to use. After you have read and become familiar with the instructions for urge surfing, you may find this a useful technique when you have a strong urge to use.

Urge surfing has three basic steps:

1. Take an inventory of how you experience the craving. Do this by sitting in a comfortable chair with your feet flat on the floor and your hands in a comfortable position. Take a few deep breaths and focus 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 tell yourself what you are experiencing. For example, "Let me see—my craving is in my mouth and nose and in my stomach."
2. 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, or numb? Are your muscles tense or relaxed? How large an area is involved? Notice the sensations and describe them to yourself. Notice the changes that occur in the sensation. "Well, my mouth feels dry and parched. There is tension in my lips and tongue. I keep swallowing. As I exhale, I can imagine the smell and taste of [____]."
3. Refocus on each part of your body that experiences the craving. Don't try to escape from or avoid the experience of craving. Accept its presence. Pay attention to and describe to yourself the changes that occur in the sensations. Notice how the urge comes and goes.

Many people notice that after a few minutes of urge surfing, the craving vanishes. The purpose of this exercise, however, is not to make the craving go away but to experience the craving in a new way. If you practice urge surfing, you will become familiar with your cravings and learn how to ride them out until they go away easily.

Personal Awareness Form: What Happens Before and After I Use Alcohol and Drugs?

As a way to increase awareness about your patterns of use, use this form to identify the kinds of situations, thoughts, feelings, and consequences that are associated with your alcohol/substance use.

Trigger	Thoughts. Feelings and Beliefs	Intensity of Craving	Behavior	Positive Results	Negative Results
(What sets me up to be more likely to use alcohol or drugs?)	(What was I thinking? What was I feeling? What did I tell myself?)	Low–high, 1–10	(What did I do then?)	(What good things happened?)	(What bad things happened?)

Date and Time:_____

Personal Awareness Form Example: What Happens Before and After I Use Alcohol and Drugs?

As a way to increase awareness about your patterns of use, use this form to identify the kinds of situations, thoughts, feelings, and consequences that are associated with your alcohol/substance use. Below is an example of how the form might be used.

Trigger	Thoughts. Feelings and Beliefs	Intensity of Craving	Behavior	Positive Results	Negative Results
(What sets me up to be more likely to use alcohol or drugs?)	(What was I thinking? What was I feeling? What did I tell myself?)	Low–high, 1–10	(What did I do then?)	(What good things happened?)	(What bad things happened?)
Friend called and invited me to get high with him. Nothing else to do.	"I want to reward myself." "I'm bored." "Felt good about going 15 days without using, so felt OK about getting high today."		Went out with friend and used.	Had fun. Felt good to get high, having gone 15 days without.	Broke the 15-day abstinence (although wasn't too worried about this). Didn't get as much done. Didn't feel as healthy.

Daily Record of Urges To Use

Date	Situation (Include Thoughts and Feelings)	Intensity of Cravings (1–100)*	Coping Behaviors Used

*Intensity of cravings scale: 1 = none at all, 100 = worst ever

Learning New Coping Strategies

Developing Alternatives

You can do many things to stop using. Some may work better than others. Some help you resist the urge to use or avoid tempting situations or satisfy your needs in more constructive ways than using. Expect to try several and add any that may be helpful. Think about what worked when you gave up something before (e.g., drinking, smoking, using substances) or when you made other changes in your life. Be kind to yourself as you begin this change process—you're doing something to take care of yourself, and you deserve all the comfort and self-acceptance you can get! Remind yourself that learning and changing inevitably mean giving up old ways and that, in time, you will feel more comfortable. Remember the changes your body and mind went through when you learned to drive, got to know a new person, started a new job, or learned a new skill. Chances are you felt awkward, uncomfortable, silly, dumb, scared, frustrated, impatient, or anxious, in addition to hopeful, excited, and challenged. What helped you then? How long did it take you to feel relaxed? Did you learn all at once, or were improvement and progress gradual?

Actions

- Avoid or escape from situations that make you want to use. Sometimes this is the easiest and most effective way to resist temptation, especially at the beginning.
- Delay decisions to give in to temptation; for example, you could wait 15 minutes. Take several deep breaths. Focus on the fresh air entering your lungs, cleansing and nourishing your body. Let out tension with each exhalation.
- Change your physical position. Stand up and stretch, walk around the room, or step outside.
- Carry things to put in your mouth: toothpicks, gum, mints, plastic straws, low-calorie snacks.
- Carry objects to fiddle with: a rubber ball to squeeze, a small puzzle, a pebble, worry beads.
- Have a distracting activity available: a crossword puzzle, magazine, book, a postcard to write.

Thoughts

- ***Self-talk.*** Give yourself a pep talk; remind yourself of your reasons for quitting; remind yourself of the consequences of using; challenge any wavering in your commitment to quit.
- ***Imagery and visualization.*** Visualize yourself as a nonsmoker, happy, healthy, and in control; imagine your lungs getting pink and healthy; or focus on negative imagery and imagine yourself with cancer, emphysema, unable to breathe, needing constant care. Visualize yourself in a jail made of alcohol or substances, symbolizing the way it controls your life.
- ***Thought-stopping.*** Tell yourself loudly to STOP; get up and do something else.
- ***Distraction.*** Focus on something different: the task at hand, a daydream, a fantasy, counting.
- ***Exercise or take a brisk daily walk.*** Get your body used to moving; use stairs instead of elevators; park farther away from your destination; walk instead of drive.
- Practice relaxation or meditation techniques regularly (we will have the opportunity to learn and practice these techniques later in our work together).
- Take up a hobby or pick up an old hobby you used to enjoy.
- Drink less coffee; switch to decaf; drink herbal teas.

- Engage in an enjoyable activity that is not work related several times a week.
- Change routines associated with using, at least temporarily; for example, don't turn on the TV when you get home from work; don't spend time with friends who smoke.

Social Interactions and Environment

- Remove paraphernalia (pipes, papers, bongs, ashtrays, matches, lighters, [____]) from your home and car.
- Go to places where it's difficult to get high, such as a library, theater, swimming pool, sauna, steam bath, restaurant, and public gatherings (not rock concerts).
- Spend time with friends who don't smoke. Enlist support from family and friends. Announce that you've quit; ask people not to offer you alcohol or other substances, to praise you for stopping, to provide emotional support, and not to smoke around you.
- Learn to be appropriately assertive; learn to handle frustration or anger directly instead of by using.

Specific Suggestions for Some Common High-Risk Situations

Below are several high-risk situations that people who use confront, along with suggestions for coping without using.

- ***Tension Relief and Negative Emotions (e.g., depression, anxiety, nervousness, irritability):*** Develop relaxation techniques, exercise, write down your feelings or talk to a friend or clinician, do something enjoyable that requires little effort, figure out what you're feeling and whether you can do anything about it.
- ***Anger, Frustration, and Interpersonal Conflict:*** Try to handle the situation directly rather than hide your feelings; if appropriate, be assertive; get some release by squeezing a rubber ball, pounding a pillow, or doing some physical activity; write down your feelings or tell them to someone; take deep breaths.
- ***Fatigue and Low Energy:*** Do muscle relaxations; take a brisk walk; do something enjoyable; eat properly and get enough sleep.
- ***Insomnia:*** Don't fight being unable to sleep. Get up and do something constructive or relaxing. Read a book, watch TV, or do muscle relaxations until you feel sleepy. Remember that no one dies from losing a night's sleep.
- ***Timeout:*** Read, do a crossword puzzle, prepare a healthy snack, take up a hobby, knit or do other needlework (things you can carry with you for easy access).
- ***Self-Image:*** Try a new image: get a new haircut or buy new clothes.
- ***Social Pressure:*** Be aware when others are using. Remember your commitment not to use. Be assertive and request that people not offer you alcohol or substances. If appropriate, ask that they not use around you for a while. If necessary, be prepared to leave the situation, especially when you've recently quit.
- ***Cravings and Urges:*** The only way to interrupt cravings is to break the chain of responding to them. That is, don't give in. Eventually they will decrease. Do something to distract yourself; use the techniques listed under Thoughts; breathe deeply; call a friend; go for a walk; move around; time the urge, and you'll find that it will disappear like a wave breaking.

ICT Session 6. Supporting Recovery Through Enhanced Social Supports and Activities
Handouts

Clinician's Quick Reference to Session 6

1. Welcome the patient and build rapport:
    - Review the patient's past week.
    - Use it as an opportunity to continue to explore patient's passions, interests, strengths.
2. Examine the patient's recent experiences; review life work practice:
    - Did the patient make an effort to stop? Cut down? Maintain abstinence?
    - Did the patient experience any high-risk or tempting situations?
    - Did the patient use any strategies from *Learning New Coping Strategies in Support of Change*?
        - Were the strategies successful?
    - Did the patient complete the between-session challenge? How did it go?
    - If the patient did not complete the between-session challenge, explore what got in the way and potentially problem-solve in anticipation of this week's challenge.
3. Introduce increasing pleasant activities:
    - Explain the rationale that often one of the reasons people use alcohol and/or other drugs is because of the pleasure they get from the experience or because they alleviate boredom.
    - Over time, it can be difficult to have fun or enjoy oneself without using.
    - Related to this is the idea that drugs operate on specific reward centers in the brain.
    - Those reward centers are also affected by other, exciting, nonsubstance-related activities such as running or playing basketball.
    - Finding sober activities that are rewarding, challenging, and stimulating can help increase long-term abstinence.
4. Explore the patient's interests and passions regarding sober activities:
    - Have the patient complete the top part of the *Increasing Pleasant Activities* handout.
    - Discuss the types of activities the patient selected, including the differences between mastery and pleasure.
    - Brainstorm additional activities if needed.
5. Elicit commitment from the patient to engage in one activity two times between sessions:
    - Patient completes the bottom portion of the *Increasing Pleasant Activities* handout.
    - Explore with the patient what could get in the way or pose a barrier to engaging in the chosen activities.
    - Have the patient problem-solve to resolve any challenges to completing the task.
6. Introduce increasing social support:
    - Explain rationale for building the patient's social support networks (see *Social Support* handout)
    - Elicit a discussion about what types of support the patient is currently receiving or has received in the past: Who provided it? What did it look like? In what ways was it helpful? Unhelpful? What type of support does the patient feel is most needed? Why?

7. Discuss the different types of social support:
    - Continue reviewing the different types of support from the *Social Support* handout.
    - Elicit examples from the patient for each type
    - Ask the patient to consider supports not used in the past but which he or she might be willing to consider.
8. Develop a plan for enhancing social support:
    - Continue reviewing the different types of support from the *Social Support* handout.
    - Elicit examples from the patient for each type.
    - Ask the patient to consider supports he or she has not used in the past but might be willing to consider.
    - Have the patient complete the *Plan for Seeking Support* handout.
9. Review tips on how to ask for support and address potential obstacles:
    - Continue reviewing the tips on how to ask for support (*Social Support* handout).
    - Discuss any potential barriers to getting the support identified in the patient's plans and engage the patient in group problem solving
10. Assign second life work practice:
    - Elicit commitment from the patient to seek out one support identified in the plan during the next week.
    - Have the patient define specifically when he or she will seek out the support and how.

Increasing Pleasant Activities

Following is a list of activities that people find pleasurable. Please check those that seem appealing to you, either because you know you like them, or you imagine you would like them if you tried. Also check any items that you're not sure about but might be willing to consider if you had some support or encouragement to try it out. There are no grades on this exercise. Check as many as you wish. If there are things that are not listed that you want to include, please add them. Thanks.

- ☐ Reading a book
- ☐ Going to the movies
- ☐ Going out to a meal
- ☐ Exercising
- ☐ Listening to music
- ☐ Writing or journaling
- ☐ Dancing
- ☐ Singing
- ☐ Computer/Internet
- ☐ Photography
- ☐ Drawing
- ☐ Writing/calling friend
- ☐ Making jewelry
- ☐ Baking/cooking
- ☐ Shopping
- ☐ Painting
- ☐ Swimming
- ☐ Boating
- ☐ Ice skating
- ☐ Knitting/crocheting
- ☐ Taking a bath
- ☐ Gardening/lawn
- ☐ Fixing things
- ☐ Refinishing furniture
- ☐ Going to live theater
- ☐ Library
- ☐ Visiting park, garden
- ☐ Skydiving
- ☐ Running
- ☐ Organizing
- ☐ Party/social event
- ☐ Hiking
- ☐ Fishing
- ☐ Skiing
- ☐ Playing competitive sports
- ☐ Antiquing
- ☐ Spending time with friends/family

Other activities: _____

Commitment:

I will do the following activity,_____

_____number of times in the next week. I will do the activity on _____

(list specific dates) at _____(list specific times).

Engaging in Replacement Activities

Why?

When we reduce immediate pleasure/reward, it is important to replace it.

Both immediate PLEASURE type activities and more skill-based MASTERY activities are needed.

They produce the same brain chemicals.

They tap into life passions and keep us feeling better.

What types of immediate pleasure activities do you like to do?

_____

_____

_____

Which are you willing to commit to doing this week? _____

What types of skill-based MASTERY activities would you like to do?

_____

_____

_____

Which are you willing to commit to doing this week?

_____

_____

_____

Social Support

Why is social support important?

We all need support at different times in our lives. Having people in our lives to support us can help us reach our goals and deal successfully with any challenges that come our way. When trying to quit alcohol and/or drug use, you may experience the following:

- Continuing to interact with family and friends that use alcohol or drugs
- Missing out on social interactions that involve alcohol or drug use
- Feeling anxious about socializing without alcohol or drug use
- Facing a diminished social network of people who do not engage in alcohol or drug use

Having a network of people who understand and support your efforts to change can be extremely helpful.

What types of support is out there?

- Self-help groups
- Professional help
- Spiritual or religious affiliations
- Personal relationships
- Coworkers
- Community service agencies

How to ask for support

- Be specific about what type of support you need
- Show appreciation for the person's support if it was helpful
- Give feedback to the person if he or she is giving support that was not helpful
- Find a way to support the other person

Plan for Seeking Support

Support	How this support will help	Plan for getting this support
Support	How this support will help	Plan for getting this support
Support	How this support will help	Plan for getting this support

ICT Session 7. Problem Solving Handouts

Clinician's Quick Reference to Session 7

1. Discuss the importance of recognizing problems as opportunities to learn.
    - Explain the rationale that everyone has problems (the rich, the famous, the not so famous), and provide relevant examples.
    - Provide the rationale that we often cannot control much of what happens in life, so we say problems are not the problem; rather, how we react to problems is important. Problems can be seen as opportunities rather than roadblocks.
    - For patients, problem situations result in alcohol or substance use when people feel they have no effective coping responses to handle them or their range of abilities is narrow or constricted. However, these same situations can be managed by practicing effective problem-solving skills so the choices diminish the negative consequences of the situations and even sometimes create opportunities.
2. Provide examples of problem-solving practice and how it is effective.
    - Explain how firemen practice setting fires to be prepared for the real fire, similar to other emergency workers who develop response routines so that the incidents do not become overwhelming when they occur. This is similar to learning to do CPR or the Heimlich maneuver, gaining needed skills to respond to problem situations.
3. Brainstorm problems and describe problem-solving skills.
    - Recognize the problem.
    - Identify or elaborate on the problem.
    - Consider various approaches.
    - Select the most promising approach.
    - Evaluate effectiveness.
4. Practice problem-solving skills.
    - Work through the process, identifying and applying problem-solving skills.
    - Role-play solutions and evaluate effectiveness.
5. Review and conclude the session.
6. Assign a between-session challenge.

Problem Solving

Here is a brief list of the steps in the problem-solving process:

I = Identify. Is there a problem? Recognize that a problem exists. We get clues from our bodies, our thoughts and feelings, our behaviors, our responses to other people, and the ways that other people respond to us.

S = State. What is the problem? Identify the problem. Describe the problem as accurately as you can using an "I" statement where the outcome is in your control. Break it into manageable parts.

O = Options. What can I do? Consider various approaches to solving the problem. Brainstorm to think of as many solutions as you can. Consider acting to change the situation; consider changing the way you think about the situation.

L = Look. What will happen if . . . ? Select the most promising approach. Consider all the positive and negative aspects of each approach.

V = Vote. Select the one most likely to solve the problem.

E = Evaluate. How did it work? Assess the effectiveness of the selected approach. After you have given the approach a fair trial, determine whether it worked. If it did not, consider what you can do to improve the plan, or give it up and try one of the other approaches.

Practice Exercise

Select a problem that does not have an obvious solution. Describe it accurately. Brainstorm a list of possible solutions. Evaluate the possibilities, and number them in order of your preference.

Identify the problem:

_____

_____

_____

List brainstorming solutions:

_____

_____

_____

Examine the (+, -, 0) long-term and short-term results.

Select the achievable option that has the most benefits.

Commit to using.

Evaluate outcome.

Source: Kadden, Litt, & Cooney, 1994.

ICT Session 8. Learning Assertiveness
Handouts

Clinician's Quick Reference to Session 8

1. Enhance rapport, review the week in general (pros and cons) and progress toward recovery goals, review the weekly challenge.
2. Provide the rationale for assertive communication in general and assertive refusal skills.
3. Engage and elicit patient communication style:
    - Make an offer to the patient to reveal the patient's communication style.
    - Example: Offer the patient a food you know he or she dislikes or even despises.
4. Define aggressive, passive, passive-aggressive, and assertive communication.
5. Discuss benefits of assertiveness:
    - Increases likelihood person will achieve goal or objective
    - Increases chance the person will feel more satisfied with a situation
6. Demonstrations:
    - Model different styles of communication
    - Identify scenarios exemplifying these styles
    - Develop role-play exercise of relevance for patient
    - Practice assertiveness in the context of role-play
    - Identify obstacles and barriers
7. Summarize and elicit a between session challenge commitment.
    - Review the patient's communication style and the skill of assertiveness.
    - Hand out *Between-Session Challenge: Assertiveness*, and ask the patient to commit to a weekly between-session challenge using assertive communication in several upcoming situations**.**

Communication Styles

Passive-Aggressive

With passive-aggressive communication or behavior, someone may appear to agree or go along with a plan of action but engage in other behavior that conveys their true feelings. Passive-aggressive communication can be difficult to identify because often people are not aware they are doing it.

Example: A woman asks her husband to attend a family gathering. He is not enthusiastic about family events and has somewhat conflicted relationships with some of his wife's family members. He would prefer to stay home and watch a tennis match on television. Instead of telling his wife his feelings, he agrees to go to the family party and arranges to meet her there after he completes some errands. He ends up being "held up" with some of his chores and arrives at the party 2 hours late. This would be considered "passive-aggressive" because on the surface he seemed willing to go along with his wife's wishes, but by arriving late he conveyed indirectly his preference to be elsewhere.

Aggressive

When someone behaves or communicates in an aggressive manner, they tend to ignore the rights or feelings of another person. They prioritize their own experience and needs over and above others involved. They may communicate through loud tones, yelling, threatening, and/or intimidating. They may be insensitive to how their message is coming across to others. They also may not be willing to hear how someone else feels or what they want in a particular situation.

Example: A group of friends goes out to dinner and begins talking about their children. One member of the group comments and gives unsolicited advice to the parents about all the mistakes they are making and how their behavior is damaging their children.

Passive

This style occurs when someone feels unable to or fearful of expressing themselves or their feelings directly. They tend to acquiesce, or go along with, what the other person wants. They may not feel entitled to their opinions, or believe the other person will not listen or care.

Example: Someone is asked to attend an event for work that is really inconvenient, but rather than asking to be excused or reschedule the person agrees immediately. With this form of communication an individual does not express their needs and wants in a clear way.

Assertive Communication

With assertive communication, a person expresses their thoughts, feelings, or needs directly and clearly, but is respectful and sensitive to the rights and feelings of others. They do not yell or intimidate, but they also do not sugarcoat their message to the point of meaninglessness.

Benefits of being assertive—

- Most effective way to let others know what is going on or what effect their behavior has
- Resolve uncomfortable feelings that otherwise build up
- Can lead to feeling more in control of life
- Increases the chances that goals will be met
- Makes people feel better about their role in the situation

Between-Session Challenge

Assertiveness

Remember the following points in practicing assertiveness—

- Take a moment to think before you speak.
- Be specific and direct in what you say.
- Pay attention to your body language (use direct eye contact; face the person you are addressing).
- Be willing to compromise.
- Restate your assertion if you feel that you are not being heard.

Practice Exercise

The following exercises will help you become aware of your style of handling various social situations. The four common response styles are **passive, aggressive, passive–aggressive, and assertive**.

Pick **two** different social situations. Write brief descriptions of them and of your responses to them. Then decide which of the four common response styles best describes each response.

Situation 1 (describe)—

_____

_____

Your response—

_____

Circle response style**:* ***passive ***aggressive*** ***passive–aggressive*** ***assertive***

If your response was not assertive, think of an assertive response and write it down here:

_____

_____

Situation 2 (describe)—

_____

_____

Your response—

_____

Circle response style**:* ***passive ***aggressive*** ***passive–aggressive*** ***assertive***

If your response was not assertive, think of an assertive response and write it down here:

_____

_____

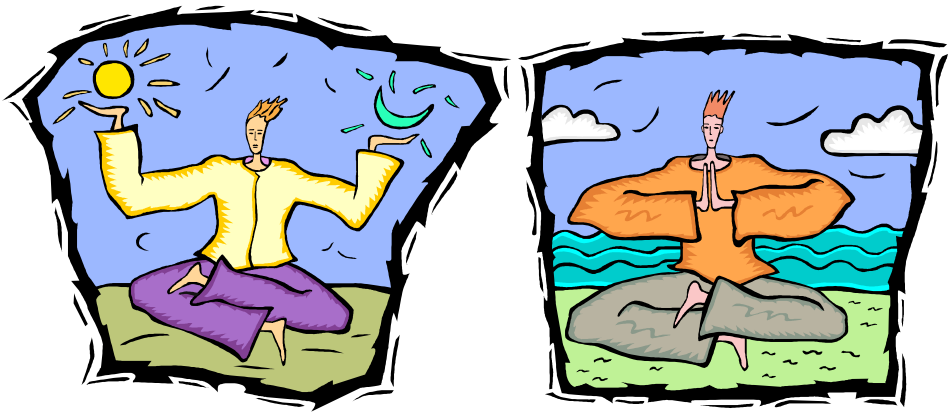
Source: Monti, Abrams, Kadden, & Cooney, 1989.

ICT Session 9. Mindfulness, Meditation, and Stepping Back Handouts

Clinician's Quick Reference to Session 9

1. Build rapport and review
    - Check in with the patient on recent experiences
    - Attend to the therapeutic alliance and address any obstacles, concerns
    - Assess motivational factors, change readiness
2. Clinician introduces concept of mindfulness
    - Awareness and acceptance of present moment
    - Connection to alcohol/substance use
    - Role of mindfulness in regulating internal states
3. Clinician conducts experiential exercises demonstrating mindfulness
    - Mindfulness exercise (e.g., eating raisin)
    - Process patient's experience and reaction
4. Clinician discusses meditation
    - Can be part of religious practice, but also incorporated into nonreligious health practices
    - Strategy for increasing mindfulness
    - Strategy for managing difficult emotions and thoughts
    - Approach for coping with alcohol/substance use
5. Clinician conducts experiential meditation exercise
    - Breathing meditation
    - Clinician processes patient's experience
6. Clinician provides the following to the patient
    - Provides meditation instructions
    - Provides alternate meditation exercise (*On the Riverbank*)
    - Encourages daily practice
7. Clinician closes session

Mindfulness Meditation Instructions



1. Find a quiet, comfortable location, with few distractions.
2. Choose a time of day that increases the chance you will be able to sit quietly with few distractions.
3. Sit on a cushion (cross-legged if not difficult) or chair. Try to keep back straight, but do not hold tension there to do this (i.e., do not try too hard).
4. Maintain a soft gaze.
5. Have a timer and signal for starting and stopping.
6. Choose a single point of focus (e.g., the breath, a word or phrase, a nonmeaningful word, an image or picture).
7. Sit quietly for 10 minutes and maintain focus.
8. Observe distracting sounds, thoughts, and feelings with mild disinterest and attempt to return to focus. This may happen many times during one sitting. Try not to be discouraged but, rather, recognize this is how our minds are.
9. Try to practice this daily, and journal or record in a log.

Source: Steinberg Gallucci, Damon, & McRee, 2012

Meditation Exercise: On the Riverbank

For this variation on a standard meditation, find a quiet place with few distractions. Begin by focusing on your breathing and trying to slow it down to increase a sense of peace and relaxation. Count slowly with each inhalation and exhalation, increasing from 1 to 10 so your breathing rate slows considerably. Imagine yourself sitting on a riverbank on a beautiful, sunny day, watching the water flow by. You may notice fish, stream currents; a small boat may sail by from time to time. Imagine that as you sit at the bank, observing what is happening, these objects passing by are your thoughts, feelings, and sensations that arise in the course of your meditation. Consider that with each object, each representing an experience of yours, you may choose how to relate to it.

For example, you can get into a boat of "worry" and ride downstream for a while. Or you can decide to let that boat pass you by. Perhaps you see a school of fish representing your thoughts that you will never be able to accomplish this or that. Do you decide to swim with those fish, or sit back and take notice saying, "Ah….doubt?"

For each thought, feeling, or interpretation that threatens to derail or take you off track, recognize you have the capacity to swim, sail, or sit back and watch it come and go. They are "just thoughts" or "just feelings." They are not necessarily true, good, or bad. They just are. Perhaps they do not even belong to you but are merely finding a host, temporarily, to attach to. You can become attached to them and their "stories," own them, hide from them, and live in fear of them. Or you can simply take notice as you might a sailboat passing by on a summer's day, but not go for a ride. And simply wait for the next interesting entity to pass your way. Keep your focus…

Source: Steinberg Gallucci, Damon, & McRee, 2012

ICT Session 10. Working With Thoughts Handouts

Clinician's Quick Reference to Session 10

1. Maintain rapport and review
2. The clinician normalizes thoughts about alcohol or substance
3. Identify thought patterns associated with use
4. Discuss automatic thoughts and strategies for coping
    - Describe situations likely to trigger automatic thoughts
5. Explore conceptual difficulties
    - Review material and probe for the patient's understanding of basic concepts
    - Use illustrations and examples
    - Walk patient through a using episode to understand thought processes
6. Develop skills for coping with automatic thoughts
    - Explain general principles for coping with thoughts about using
    - Describe specific strategies for managing thoughts about using; review *Managing Thoughts About Alcohol or Substances* form
7. Practice skills for coping with automatic thoughts
    - Demonstrate self-talk
    - Have patient practice with one of his or her using thoughts
8. Assign between-session exercises
9. Review and conclude session

Managing Thoughts About Alcohol and Substances

When trying to stop using alcohol or other substances, it is common to struggle with thoughts about using, and for these thoughts to act as triggers for potential lapses. There are a variety of approaches which may be helpful to you as you are faced with these thoughts.

1. Recognize that they are "just thoughts."
    a. Having a thought does not make it true or mean one must act on it.
    b. One thought does not have to take on more significance or have more salience than any other thought—that is, one need not become "attached" to a particular thought or story.
    c. See the thought as a necessary part of recovery.
2. Use mindfulness or meditation practice to work with challenging thoughts.
    a. Observe with mild disinterest "oh, a thought" or "craving" or "discomfort."
    b. See the thought as "separate" from you; step back from it.
    c. Imagine the thought is just passing through, as if stopping temporarily at a hotel, and is not "owned" by you.
3. Use creative visualization or imagery to work with challenging thoughts.
    a. Imagine you are sitting in a theater and watching a movie about the situation. You have special controls at your seat to control the action of the performance—rewind, fast-forward, rewrite the script, change the ending, and give your character special powers.
    b. Imagine you are able to take a magic carpet ride to a special, peaceful, magical land. The difficult thought(s) are symbolized by dragons (or other objects) that are defeated or tricked by a benevolent wizard.
4. See where the thought fits into your puzzle or story.
    a. Is it an insistent visitor/unwelcome guest?
    b. Can it be viewed with perspective?
    c. What are the meanings attached to the thought?
5. Use self-talk to challenge the thought or thoughts.
    a. What is the evidence (e.g., I cannot make it if I do not use)?
    b. What is the likelihood (e.g., if I use this one time, I will be able to stop right away)?
    c. How helpful is the thought?
    d. Is there another thought that would move me in a different direction?
6. Create your list

Remind yourself of the reasons and benefits of not using alcohol or other substances, the negative aspects of using, and obstacles to keeping on your path of change.

Positive benefits of not using—

_____

_____

Negative aspects of using—

_____

_____

_____

_____

Obstacles to staying on your path—

_____

_____

_____

_____

Source: Steinberg Gallucci, Damon, & McRee, 2012

ICT Session 11. Working With Emotions Fostering Some, Dissolving Others Handouts

Clinician's Quick Reference to Session 11

1. Maintain rapport and review previous week.
2. Introduce the concept of "working with" emotions.
3. Discuss the evolutionary value and/or the role of various emotions in day-to-day life.
4. Explore the patient's experience with different emotions, his or her connection with alcohol or other drug use, and how the patient tends to regulate his or her emotional state.
5. Provide a rationale for fostering positive emotions, which can be constructive and healing.
6. Review a list of pleasant activities and develop a plan for increasing opportunities for positive emotion.
7. Assign practice exercises involving pleasant activities.
8. Provide a rationale for decreasing or dissolving the effects of negative emotions.
9. Discuss thinking patterns or cognitive distortions that tend to dampen or depress one's mood.
    - Review *Cognitive Distortions That Dampen One's Mood.*
    - Explain "cognitive distortions."
    - Explore automatic thought patterns that appear to lead to negative mood states.
    - Ask the patient to identify which automatic negative thoughts he or she may engage in before or during depressed, anxious, or irritable moods.
10. Build internal resources for handling automatic thoughts.
    - Discuss with the patient guidelines for evaluating these thoughts.
    - Give the patient the *Managing Negative Moods and Depression* handout.
    - Engage the patient in problem solving to address problems contributing to his or her negative moods.
11. Link negative moods with alcohol or substance use.
    - Explore the relationship between the patient's alcohol or substance use and his or her experience of negative moods.
    - Explore methods of changing the patient's automatic thoughts that can lead to alcohol or substance use.

Focus on Emotion: Roles of Positive and Negative Emotions

All emotions have some role or function, and an evolutionary value.

Negative or "withdrawal" emotions tend to narrow our thinking and constrict our ability when approaching new situations and challenges. Examples include fear, grief, and anger. These emotions can be helpful when we are facing an acute threat and need to act quickly.

Positive or "approach" emotions tend to help us feel more capable, creative, optimistic, and connected with others. Examples include joy, contentment, curiosity, empathy, and enthusiasm. Positive emotions may be healing, have positive effects on our immune system, and counteract the effects of stress. Engaging in activities which promote positive feelings and experience can have both immediate and far-reaching benefits through building internal resources. Increasing positive emotions may have the benefit of undermining or diminishing negative emotions.

Emotion and Substance Use

Many people who use alcohol or other substances experience negative emotions both as triggers for, and consequences of, excessive use. Substances become a way of "regulating" emotional states. Increasing positive emotions through activities and experiences that enhance well-being may remove emotional triggers for substance use.

Describe a recent situation where you felt negatively, discouraged, angry, fearful, or sad. How did you cope with the situation and/or the feelings you had? In retrospect, could you have handled things differently? How might you rewrite or replay events if you could?

_____

_____

_____

Describe a time when you felt really positively, content, or hopeful. What happened or what were you doing? What contributed to your positive feelings or outlook? Could you recreate this experience through your thoughts or actions?

_____

_____

_____

What types of experiences are likely to result in positive emotions for you?

_____

_____

_____

Can any of these experiences serve as replacements for alcohol or substance use?

_____

_____

_____

Focus on Emotion: Pleasant Activities

Following is a list of activities that people find pleasurable to engage in. Please check those that seem appealing to you, either because you know you like them or you imagine you would like them if you tried. Also, check any items you are not sure about but might be willing to consider if you had some support or encouragement to try them out. There are no grades for this exercise. Check as many as you wish. If there are things not listed that you want to include, please add them.

- ☐ Reading a book
- ☐ Going to the movies
- ☐ Going out to a meal
- ☐ Exercising
- ☐ Listening to music
- ☐ Writing or journaling
- ☐ Dancing
- ☐ Singing
- ☐ Computer/Internet
- ☐ Photography
- ☐ Drawing
- ☐ Writing/Calling friend
- ☐ Making jewelry
- ☐ Baking/Cooking
- ☐ Shopping
- ☐ Painting
- ☐ Swimming
- ☐ Boating
- ☐ Ice Skating
- ☐ Knitting/Crocheting
- ☐ Taking a bath
- ☐ Gardening/Lawn
- ☐ Fixing things
- ☐ Refinishing furniture
- ☐ Going to live theater
- ☐ Library
- ☐ Visiting park, garden
- ☐ Skydiving
- ☐ Running
- ☐ Organizing
- ☐ Party/social event
- ☐ Hiking
- ☐ Fishing
- ☐ Skiing
- ☐ Antiquing
- ☐ Playing competitive sports
- ☐ Spending time with friends/family

Other activities _____

Cognitive Distortions That Dampen One's Mood

Type of Distortion	Example
Personalizing	Thinking all situations and events revolve around you "Everyone was looking at me."
Magnifying	Blowing negative events out of proportion "This is the worst thing that could happen to me."
Minimizing	Downplaying the positives "I got the job, but probably no one else applied."
Either/or thinking	Not taking into account the full continuum "I'm either a loser or a winner."
Taking events out of contex	After a successful experience, focusing on one or two rough points "I may have gotten the job, but I blew that one question in the interview."
Jumping to conclusion	Making a premature conclusion without enough data "I have a swollen gland. It must be cancer."
Overgeneralizing	Making a sweeping judgment based on one event "I failed this time; I fail at everything I ever try."
Self-blame	Blaming oneself rather than specific behaviors that can be changed "I'm no good."
Mindreading	Believing you know what everyone else is thinking "Everyone there thought I was fat and ugly."
Comparing	Comparing yourself unfavorably with someone else "That supermodel has a better figure than I do."
Catastrophizing	Focusing on the worst possible outcome or explanation. "He didn't call, and I know something terrible has happened to him."

Managing Negative Moods and Depression

Use the **three "A"s** to overcome negative feelings:

1. Be **aware** of signs of depression and negative states.
    a. Reflect on your moods and situations that influence them.
    b. Notice automatic negative thoughts that increase negative emotions.
    c. Observe experiences and situations that narrow or constrict your overall outlook.
2. **Answer** or respond to the automatic thoughts OR observe them with mild disinterest.
    a. Challenge the assumptions of the thoughts.
    b. Transform negative thoughts and feelings into constructive/healing emotions.
3. **Act** differently.
    a. Increase activities that promote positive emotions.
    b. Engage in pleasant activities.
    c. Reduce involvement with unpleasant and unnecessary activities and with people who have a negative effect on your outlook.
    d. Reward yourself for positive steps along the way and the process of change.

In the space below, take notes for each of the three areas above as they relate to your own struggles with negative moods.

Patient Health Questionnaire–9 (PHQ-9)

Nine-Symptom Checklist

Patient Name _____ Date_____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

   a. Little interest or pleasure in doing things
   b. Feeling down, depressed, or hopeless
   c. Trouble falling/staying asleep, sleeping too much
   d. Feeling tired or having little energy
   e. Poor appetite or overeating
   f. Feeling bad about yourself, or that you are a failure or have let yourself or your family down
   g. Trouble concentrating on things, such as reading the newspaper or watching television
   h. Moving or speaking so slowly that other people have noticed, or the opposite—being so fidgety or restless that you have been moving around a lot more than usual
   i. Thoughts that you would be better off dead or of hurting yourself in some way

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Total Score Depression Severity

1–4	Minimal depression
5–9	Mild depression
10–14	Moderate depression
15–19	Moderately severe depression
20–27	Severe depression

Generalized Anxiety Disorder 7-Item Scale (GAD-7)

Patient Name _____ Date_____

Choose the one description for each item that best describes how many days you have been bothered by the following over the past 2 weeks:

	None	Several	Seven or more	Nearly every day
Feeling nervous, anxious, or on edge				
Unable to stop worrying				
Worrying too much about different things				
Problems relaxing				
Feeling restless or unable to sit still				
Feeling irritable or easily annoyed				
Being afraid something awful might happen				

Scoring

Sum scores from each question:

None = 0

Several = 1

Seven or more = 2

Nearly every day = 3

Total score: _____

A total score of 5–9 suggests mild anxiety.

A total score of ≥ 10 suggests moderate to severe anxiety.

PDF available at http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B . A brief measure for assessing generalized anxiety disorder. Archives of Internal Medicine. 2006;166:1092-1097.

ICT Session 12. The Next Chapter
Wellness Planning, Writing the Story
Handouts

Clinician's Quick Reference to Session 12

1. Review treatment
    - Elicit the patient's experience of engaging in the treatment process.
    - Review areas of progress and strength and continued challenges.
2. Explain the effects of major life changes
    - Identify life changes the patient has or will experience.
3. Present a personal care plan: high-risk situation
4. Present a personal care plan: lapse
5. Review previous skill topics
    - Review strategies from previous skill topics the patient found helpful.
6. Encourage the patient to write or record his or her story
    - Highlight the courage and effort the patient demonstrated.
    - Encourage the patient to develop a creative project.
    - Identify a format the patient might enjoy (e.g., writing narrative, journal, expressive art, collage, dream box).

Personal Care Plan: High-Risk Safety Planning

If I encounter a high-risk situation—

- I will leave or change the situation or environment.
- I will put off the decision to use for 15 minutes. I will remember that most cravings are time limited and that I can wait it out and not use.
- I will challenge my thoughts about using. *Do I really need to use* _____*?* I will remind myself that my only true needs are for air, water, food, shelter, and connections with others.
- I will think of something unrelated to using.
- I will remind myself of my successes to this point.
- I will call people on my list of emergency numbers:

	Names	Phone Numbers
1.		
2.		
3.		
4.		
5.		
6.		

Remember—Riding out this crisis will strengthen my program.

Source: Monti, Abrams, Kadden, & Cooney, 1989.

Personal Care Plan: Coping With a Lapse or Slip

A lapse can represent a crisis in recovery. Returning to abstinence requires an all-out effort. Here are some things you can do.

If I do experience a lapse—

- I will get rid of alcohol or substances and get away from the setting where I lapsed.
- I will realize that a little substance use or even 1 day of use does not have to result in a full-blown relapse. I will not give in to feelings of guilt or blame myself because I know these feelings will pass in time.
- I will call someone for help.

Remember—This lapse is only a temporary detour on the road to abstinence.

Write a detailed emergency plan for coping with high-risk lapse situations.

1._____

_____

2._____

_____

3._____

_____

4._____

_____

5._____

_____

6._____

_____

My Story

When one has undertaken a process of personal growth or change, it can be very helpful to capture this in some way, through writing, creative expression, or some other means as a way of further integrating what has been learned and accomplished. It can also just be an enjoyable way of highlighting the important work that has taken place. The following are some ideas to consider as you continue to progress along your journey of healing and self-discovery.

1. Write a story, journal/diary, or poem, or find existing poetry or inspirational literature and make it your own somehow (e.g., print on a small card or form that you laminate and carry easily).

2. Create a picture in some form, such as a drawing, painting (abstract is great—it only needs to be meaningful to you!), or collage.

3. Create an object, such as a dream box, containing "fortunes" that describe your most important wishes for the future.

4. Find music that expresses important feelings or values to you and create a "healing CD."

ICT Session 13. Use of Medication in Support of Treatment and Recovery Handouts

Clinician's Quick Reference to Session 13

1. Enhance rapport, review the week in general (pros and cons) and progress toward recovery goals, review the weekly challenge.
2. Ask permission to discuss treatment options and provide the rationale for medication in support of recovery goals.
3. Explore patients thoughts, feelings, beliefs and prior experiences (if any) with medications
4. Provide information as necessary
5. Addressing negative perceptions
6. Facilitating patient reflection on risks and benefits
7. Facilitate decisional balance discussion
8. Negotiate plan for next steps
9. Following up on a decision for a medication evaluation (when indicated)
10. Review, summarize, and conclude session

Medications To Treat Opioid Dependence

The most common medications used in the treatment of opioid addiction are methadone and buprenorphine. Sometimes another medication, called naltrexone, is used. Cost varies for the different medications. This may need to be taken into account when considering treatment options.

Methadone and buprenorphine bind with the brain opioid (Mu) receptor sites. The person taking the medication feels normal, not high, and withdrawal does not occur. Methadone and buprenorphine also reduce cravings.

Naltrexone helps overcome addiction in a different way. It blocks the effect of opioid drugs. This takes away the feeling of getting high if the problem drug is used again. This feature makes naltrexone a good choice to prevent relapse (falling back into problem drug use).

These three medications have the same positive effect—they reduce problem addiction behavior. All three medications come in pill form. Methadone also comes as a liquid and a wafer. Methadone is taken daily. The other two medications are taken daily at first. After time, buprenorphine is taken daily or every other day, and doses of naltrexone are taken up to 3 days apart.

Methadone to treat addiction is dispensed only at specially licensed treatment centers. Buprenorphine and naltrexone are dispensed at treatment centers or prescribed by doctors. A doctor must have special approval to prescribe buprenorphine. Some people go to the treatment center or doctor's office every time they need to take their medication. People who are stable in recovery may be prescribed a supply of medication to take at home.

***Sources*:** Excerpted from Center for Substance Abuse Treatment. (2011). *Medication-assisted treatment for opioid addiction*. HHS Publication No. (SMA) 09-4443. Prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by the Knowledge Application Program, a joint venture of the CDM Group, Inc., and JBS International, Inc., under contract number 270-04-7049 with SAMHSA, U.S. Department of Health and Human Services.

Medications To Treat Alcohol Dependence

Currently, there are four medications approved by the FDA to treat alcohol dependence:

- Acamprosate
- Oral naltrexone
- Injectable naltrexone
- Disulfiram

Research has demonstrated that including approved medications for the treatment of alcohol dependence, in conjunction with treatment, improves treatment outcomes. These medications have been found to—

- Reduce persisting symptoms of withdrawal that can prompt relapse (acamprosate)
- Help minimize alcohol cravings
- Help to avoid relapse
- Prolong intervals between slips or relapses
- Increase the benefits of counseling or other alcohol treatments

Acamprosate (Campral)

Acamprosate helps restore brain function damaged by alcoholism.

Alcohol causes intense but relatively brief withdrawal symptoms, and much longer lasting but milder symptoms of withdrawal. Although milder, these enduring withdrawal symptoms (such as difficulty sleeping, irritability, and anxiety) can lead to alcohol relapse.

Acamprosate helps motivated patients maintain abstinence by reducing the severity of these longer lasting withdrawal symptoms. Acamprosate is thought to reduce glutamate activity, but its exact means of action remains poorly understood.

Advantages of Acamprosate—

- Acamprosate is not metabolized in the liver, and so can be used by patients with liver damage or cirrhosis.
- It can be used by patients taking methadone or Suboxone, and by those requiring opiates for pain control (unlike naltrexone).
- It causes no withdrawal symptoms and can be stopped suddenly, if needed. It can also be taken safely with benzodiazepines.
- It cannot be abused and it is not dangerous, even at overdose quantities.
- Side effects are generally minimal, and those that occur are well tolerated.

Acamprosate becomes fully effective between 5 and 8 days after treatment initiation.

Oral Naltrexone (ReVia)

Patients taking oral naltrexone experience reduced cravings for alcohol, and while taking the medication, drinking alcohol will not produce as much pleasure. Since drinking does not make people on naltrexone feel as good, people who slip while taking the medication tend to drink lesser amounts.

Oral naltrexone is effective at helping people maintain abstinence or drink less. Studies of oral naltrexone have shown that, compared to people taking a placebo, people taking the medication—

- Have lower rates of relapse
- If they do drink, drink less often and drink less in a sitting

Advantages of oral naltrexone—

- It works well, particularly for people who experience heavy alcohol cravings and who are motivated to maintain abstinence.
- It is well tolerated, causing few side effects (the most common side effect is nausea).
- It has no abuse potential and causes no withdrawal symptoms.

Disadvantages of oral naltrexone—

- It cannot be used by some people with liver problems.
- It cannot be used by anyone using methadone, Suboxone, or requiring opiate pain medications.
- It may increase a person's vulnerability to opiate overdose by decreasing opiate tolerance.

Injectable Naltrexone (Vivitrol)

Injectable naltrexone works in the same way as oral naltrexone to reduce alcohol cravings and decrease the pleasures of alcohol consumption. While oral naltrexone needs to be taken daily, intramuscularly injected naltrexone works for a continuous month. With a monthly injectable dose, everyday compliance is not an issue.

Studies that have examined the efficacy of naltrexone as a treatment for alcoholism have consistently encountered patient noncompliance as a barrier to successful treatment.

The advantages and disadvantages of injectable naltrexone treatment closely mimic those of oral naltrexone treatment. The main benefit of injectable naltrexone is increased patient compliance. Some points of concern include—

- There is a possibility of an injection site reaction.
- The duration of effectiveness means that any adverse reactions experienced will be experienced for 30 days.

Disulfiram (Antabuse)

Patients talking disulfiram cannot consume alcohol without becoming ill. Patients taking this medication know this and so avoid drinking alcohol while taking the medication. Normally, alcohol is metabolized by the body into acetaldehyde and then into acetic acid. Disulfiram disrupts the final stage of this process (the metabolization of acetaldehyde into acetic acid), causing a much higher level of acetaldehyde in the body after any alcohol consumption.

High levels of acetaldehyde in the bloodstream lead to very uncomfortable reactions, such as the following:

- Hyperventilation
- Thirst
- Nausea and vomiting
- Chest pains
- Dizziness
- Confusion
- Muscle weakness

At higher doses, the combination of disulfiram and alcohol can lead to serious reactions that can include symptoms such as the following:

- Seizures
- Heart failure

- Respiratory depression
- Death

Does Disulfiram Work?

Studies have shown that disulfiram helps to reduce drinking days among those actively drinking but does not seem to work better than placebo in supporting abstinence. Patients who are supervised while taking their medication (to ensure compliance) seem to do better than those who are left unsupervised.

Disulfiram is not an appropriate medication for people with any of the following—

- Mental illness
- Poor impulse control
- Cognitive impairments

Medications To Treat Anxiety Disorders

Antidepressants, antianxiety medications, and beta-blockers are the most common medications used for anxiety disorders.

Anxiety disorders include—

- Obsessive-compulsive disorder (OCD)
- Posttraumatic stress disorder (PTSD)
- Generalized anxiety disorder (GAD)
- Panic disorder
- Social phobia

Antidepressants

Antidepressants were developed to treat depression, but they also help people with anxiety disorders. Selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine (Prozac), sertraline (Zoloft), escitalopram (Lexapro), paroxetine (Paxil), and citalopram (Celexa) are commonly prescribed for panic disorder, OCD, PTSD, and social phobia. The serotonin-norepinephrin reuptake inhibitor (SNRI) venlafaxine (Effexor) is commonly used to treat GAD. The antidepressant bupropion (Wellbutrin) is also sometimes used. When treating anxiety disorders, antidepressants generally are started at low doses and increased over time.

Some tricyclic antidepressants work well for anxiety. For example, imipramine (Tofranil) is prescribed for panic disorder and GAD. Clomipramine (Anafranil) is used to treat OCD. Tricyclics are also started at low doses and increased over time.

Monoamine oxidase inhibitors (MAOIs) are also used for anxiety disorders. Doctors sometimes prescribe phenelzine (Nardil), tranylcypromine (Parnate), and isocarboxazid (Marplan). People who take MAOIs must avoid certain foods and medicines that can interact with their MAOI and cause dangerous increases in blood pressure. For more information, see the section on medications used to treat depression.

Benzodiazepines (antianxiety medications)

The antianxiety medications called benzodiazepines can start working more quickly than antidepressants. The ones used to treat anxiety disorders include—

- Clonazepam (Klonopin) is used for social phobia and GAD.
- Lorazepam (Ativan) is used for panic disorder.
- Alprazolam (Xanax) is used for panic disorder and GAD.
- Buspirone (Buspar) is an antianxiety medication used to treat GAD. Unlike benzodiazepines, however, it takes at least 2 weeks for buspirone to begin working.
- Clonazepam, listed above, is an anticonvulsant medication.

Beta-Blockers

Beta-blockers control some of the physical symptoms of anxiety, such as trembling and sweating. Propranolol (Inderal) is a beta-blocker usually used to treat heart conditions and high blood pressure. The medicine also helps people who have physical problems related to anxiety. For example, when a person with social phobia must face a stressful situation, such as giving a speech or attending an important meeting, a doctor may prescribe a beta-blocker. Taking the medicine for a short period of time can help the person keep physical symptoms under control.

What are the side effects?

See the section on antidepressants for a discussion on side effects. The most common side effects for benzodiazepines are drowsiness and dizziness. Other possible side effects include—

- Upset stomach
- Blurred vision
- Headache
- Confusion
- Grogginess
- Nightmares

Possible side effects from buspirone (BuSpar) include—

- Dizziness
- Headaches
- Nausea
- Nervousness
- Lightheadedness
- Excitement
- Trouble sleeping

Common side effects from beta-blockers include—

- Fatigue
- Cold hands
- Dizziness
- Weakness

In addition, beta-blockers generally are not recommended for people with asthma or diabetes because they may worsen symptoms.

Medications To Treat Depression

Depression is commonly treated with antidepressant medications. Antidepressants work to balance some of the natural chemicals in our brains. These chemicals are called neurotransmitters, and they affect our mood and emotional responses. Antidepressants work on neurotransmitters such as serotonin, norepinephrine, and dopamine.

The most popular types of antidepressants are SSRIs. These include—

- Fluoxetine (Prozac)
- Citalopram (Celexa)
- Sertraline (Zoloft)
- Paroxetine (Paxil)
- Escitalopram (Lexapro)

Other types of antidepressants are SNRIs. SNRIs are similar to SSRIs and include venlafaxine (Effexor) and duloxetine (Cymbalta). Another antidepressant that is commonly used is bupropion (Wellbutrin). Bupropion, which works on the neurotransmitter dopamine, is unique in that it does not fit into any specific drug type.

SSRIs and SNRIs are popular because they do not cause as many side effects as older classes of antidepressants. Older antidepressant medications include tricyclics, tetracyclics, and MAOIs. For some people, tricyclics, tetracyclics, or MAOIs may be the best medications.

What are the side effects?

Antidepressants may cause mild side effects that usually do not last long. ***Any unusual reactions or side effects should be reported to a doctor immediately***.

The most common side effects associated with SSRIs and SNRIs include—

- Headache, which usually goes away within a few days
- Nausea (feeling sick to your stomach), which usually goes away within a few days
- Sleeplessness or drowsiness, which may happen during the first few weeks but then goes away—Sometimes the medication dose needs to be reduced, or the time of day it is taken needs to be adjusted to help lessen these side effects.
- Agitation (feeling jittery)

- Sexual problems, which can affect both men and women and may include reduced sex drive and problems having and enjoying sex

Tricyclic antidepressants can cause side effects, including—

- Dry mouth
- Constipation
- Bladder problems—It may be hard to empty the bladder, or the urine stream may not be as strong as usual. Older men with enlarged prostate conditions may be more affected.
- Sexual problems, which can affect both men and women and may include reduced sex drive and problems having and enjoying sex
- Blurred vision, which usually goes away quickly
- Drowsiness—Usually, antidepressants that make you drowsy are taken at bedtime.

People taking MAOIs need to be careful about the foods they eat and the medicines they take. Foods and medicines that contain high levels of a chemical called tyramine are dangerous for people taking MAOIs. Tyramine is found in some cheeses, wines, and pickles. The chemical is also in some medications, including decongestants and over-the-counter cold medicine.

Mixing MAOIs and tyramine can cause a sharp increase in blood pressure, which can lead to stroke. People taking MAOIs should ask their doctors for a complete list of foods, medicines, and other substances to avoid. An MAOI skin patch has recently been developed and may help reduce some of these risks. A doctor can help a person figure out if a patch or a pill will work for him or her.

***Source**:* National Institute of Mental Health. (2012). *Mental health medications*. NIH Publication No. 12–3929. Bethesda, MD: National Institutes of Health, Department of Health and Human Services.

ICT Session 14. Engagement With Self-Help Handouts

Clinician's Quick Reference to Session 14

1. Ask permission to discuss this topic.
2. Link attendance in self-help meetings with enhancing patient need for improved social supports.
3. Discuss the patient's previous experience, knowledge, and beliefs regarding AA and NA.
4. Using MI skills, process patient ambivalence regarding participation in self-help.
5. Negotiate an agreement to attend a certain number of meetings to learn more.
6. Agree upon a concrete plan of activity in the coming week regarding patient attendance.
7. Close the session.

What Happens in an Alcoholics Anonymous Meeting?

Most meetings take place in public buildings with defined dates and times. As a meeting begins, the chairperson usually asks if anyone is attending Alcoholics Anonymous (AA) for the first, second, or third time ever. The chair may then ask if there are any out-of-town visitors. The purpose is to welcome guests and newcomers. Individuals who are at their first AA meeting or have less than 30 days of sobriety may be welcomed with a hug and awarded a "keep coming back" coin or chip. The chair may talk for a few minutes and then call on meeting participants to talk or "share" and may request they limit their comments to 3 to 5 minutes and restrict their discussion to issues relating to alcoholism and recovery.

Sometime during the meeting, the chair may open the meeting to anyone who has not been called on who really needs to talk, frequently referred to as a "burning desire to share." People who are called upon to speak usually do so by identifying themselves, for instance, "My name is Michael, and I am an alcoholic." The group usually responds with "Hi, Michael," and then the individual speaks for a few minutes. If a person is called upon and does not wish to talk, he or she has only to say, "I think I will just listen today," or, "I'll pass." Another safety feature of the meetings is the absence of crosstalk or interruption. Unlike group therapy, AA members share their own experience, strength, and hope with each other, rather than telling one another what to do.

At some point, the meeting pauses for announcements and to collect funds for AA's Seventh Tradition, which states that AA groups are self-supporting through their own contributions. Cash donations of a dollar or two are usual, although newcomers are not required to contribute until they understand what AA is about.

Most meetings last 1–1½ hours. At the end of the meeting, the group members stand, join hands, and recite the Lord's Prayer or the Serenity Prayer, for those who care to join. With slight variations, this basic meeting format is the same throughout the world, varying only in language. An AA member can walk into a meeting anywhere and feel at home. If you are interested in attending an AA meeting or any of the other 12-step programs, please call your local central service committee for information about a meeting near you.

At meetings, you may witness a lot of laughter and joking. People in AA are not a glum lot, and they insist on having a good time. The humor shows itself in an AA meeting, and newcomers are frequently surprised to hear members laughing about an incident that might seem grim or unfortunate. Usually, the laughter is based on identification with the speaker, as well as relief that sober people are no longer getting arrested, crashing automobiles, or engaging in unmanageable drunken behavior.

Some people who have never attended an AA meeting express unease with 12-step programs because of "all the talk about God." In AA, "God" is to be understood as "a higher power"—interpreted in any way that works for you. Therefore, a "Group of Drunks" (GOD) providing "Good, Orderly Direction" (GOD) can be the higher power for the alcoholic if he or she so decides. AA is a spiritual program, not a religious one, and takes no position on political issues or controversy.

The success enjoyed by AA has been so great that many other groups use the AA model for meetings and the 12-step format. There are Gamblers Anonymous (GA), Overeaters Anonymous (OA), Cocaine Anonymous (CA), Narcotics Anonymous (NA), Sex Addicts Anonymous (SAA), Co-Dependents Anonymous (CODA), and Adult Children of Alcoholics (ACOA), just to name a few. Of course, there is Al-Anon for the spouses, family members, and friends of alcoholics. For the purpose of simplicity, this article talks about AA, but the word cocaine, sex, emotions, gambling, and so on, can be substituted for the word "alcohol" in the 12 steps of Alcoholics Anonymous, and other 12-step programs follow similar formats.

Research also indicates that participation in 12-step programs increases an individual's chances for sustained recovery. A 1999 study at the University of California, Los Angeles, found that patients who completed treatment and participated in 12-step meetings had twice the abstinence rate compared to those who completed treatment and did not go to

meetings. In a 1994 study of 65,000 patients who attended AA after treatment, those who attended AA weekly for 1 year had a 73 percent rate of staying sober. Of those who attended AA only occasionally, 53 percent stayed sober. In contrast, those who never went to 12-step meetings or stopped going had a 43 percent rate of sobriety.

The 12 Steps

1. Admitted that we were powerless over alcohol (and/or drugs) and that our lives had become unmanageable
2. Came to believe that a power greater than ourselves could restore us to sanity
3. Made a decision to turn our will and our lives over to the care of God as we understood Him
4. Made a searching and fearless moral inventory of ourselves
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs
6. Were entirely ready to have God remove all these defects of character
7. Humbly asked Him to remove our shortcomings
8. Made a list of all persons we had harmed and became willing to make amends to them all
9. Made direct amends to such people wherever possible, except when to do so would injure them or others
10. Continued to take personal inventory, and when we were wrong, promptly admitted it
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out
12. Having had a spiritual awakening as a result of the steps, tried to carry this message to alcoholics and practice these principles in all our affairs

The 12 Traditions of Alcoholics Anonymous

1. Our common welfare should come first; personal recovery depends upon AA unity.
2. For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.
5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An AA group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every AA group ought to be fully self-supporting, declining outside contributions.
8. AA should remain forever nonprofessional, but our service centers may employ special workers.
9. AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. AA has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

ICT Session 15. A MET/CBT Approach for Traumatic Stress and Substance Use Handouts

Clinician's Quick Reference to Session 15-1

1. Rapport building
    - Check in on past week.
    - Follow up on between-session challenge.
    - Assess progress.
2. Orient the patient to the session agenda.
    - Personalized reflective discussion addressing trauma and substance use.
3. Describe model/approach for trauma sessions.
    - Personalized reflective discussion addressing trauma and substance use, safety planning
    - Learning a (stress-reducing) relaxation technique
    - Psychoeducation about trauma
    - Identifying, understanding, and monitoring for internal and external triggers
    - Developing skills for working with feelings/thoughts
4. Complete PTSD screening if indicated.
5. Review and summarize the results of the personalized reflective discussion (substance use) and PTSD screen as part of reflective discussion.
6. If indicated, seek further evaluation.
7. Summarize session and elicit between-session challenge.
8. Conclude session.

Clinician's Quick Reference to Session 15-2

1. Rapport building
    - Check in on past week.
    - Follow up on between-session challenge.
    - Assess progress.
2. Orient patient to session agenda.
    - Safety planning, deep breathing relaxation, and psychoeducation
    - Educate on effects of trauma
3. Educate patient on effects of trauma.
4. Elicit personal discussion with patient on trauma and substance use.
    - Ask patient what he or she knows about the effects of trauma experiences in general, and how the trauma is affecting him or her (and others).
    - Ask how he or she believes the use of alcohol/drugs is affecting his or her feelings and behaviors.
    - Describe the ICT session activities that can address those feelings and behaviors.
5. Introduce safety plan and rationale.
6. Screen for past suicidal history (SBQ-R handout).
7. Complete safety plan (handout).
8. Introduce, train, and practice deep-breathing relaxation.
9. Distribute PTSD information sheet.
10. Conclude session with between-session challenge.

Clinician's Quick Reference to Session 15-3

1. Rapport building
    - Check in on past week.
    - Follow up on between-session challenge.
    - Assess progress.
2. Orient patient to session agenda.
    - Enhancing self-awareness and introducing cognitive restructuring (skills training).
3. Introduce and ask patient to complete trauma/substance use awareness handout.
4. Discuss and elicit three to five situation that trigger trauma symptoms and/or substance use.
5. Discuss situations to gain full understanding using personalized reflective discussion.
6. Identify and prioritize skills and strategies to address trauma symptoms and associated ICT sessions/activities.
7. Individualize plan by negotiating specific skills sessions and other indicated supports.
8. Summarize the session.
9. Assign a between-session challenge.
10. Conclude session.

PTSD Checklist, Civilian Version (PCL-C)

Patient's Name:_____

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each item carefully, and put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut* off from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD. Behavioral Science Division
This is a Government document in the public domain

The PCL is a standardized self-report rating scale for PTSD composed of 17 items that correspond to the key symptoms of PTSD. Two versions of the PCL exist: (1) PCL-M is specific to PTSD caused by military experiences, and (2) PCL-C is applied generally to any traumatic event.

The PCL can be easily modified to fit specific time frames or events. For example, instead of asking about "the past month," questions may ask about "the past week" or be modified to focus on events specific to a deployment.

How is the PCL completed?

- The PCL is self-administered
- Respondents indicate how much they have been bothered by a symptom over the past month using a 5-point (1–5) scale, circling their responses. Responses range from **1** *Not at All to* **5** *Extremely*

How is the PCL Scored?

1. Add up all items for a total severity score

or

2. Treat response categories **3–5** (*Moderately* or above) as symptomatic and responses

   1–2 (below *Moderately*) as nonsymptomatic, then use the following DSM criteria for a diagnosis:

   - Symptomatic response to at least 1 "B" item (Questions 1–5)
   - Symptomatic response to at least 3 "C" items (Questions 6–12)
   - Symptomatic response to at least 2 "D" items (Questions 13–17)

Are Results Valid and Reliable?

- Two studies of both Vietnam and Persian Gulf theater veterans show that the PCL is both valid and reliable (additional references are available from the DHCC)

What Additional Followup Is Available?

- All military health system beneficiaries with health concerns they believe are deployment-related are encouraged to seek medical care
- Patients should be asked, **"Is your health concern today related to a deployment?"** during all primary care visits.

- If the patient replies "**yes**," the provider should follow the Post-Deployment Health Clinical Practice Guideline (PDH-CPG) and supporting guidelines available through the DHCC and www.PDHealth.mil

DHCC Clinicians Helpline: 1 (866) 559-1627 DSN: 662-6563 www.PDHealth.mil

PDH-CPG Tool Kit Pocket Cards Version 1.0 December 2003

PTSD CheckList, Military Version (PCL-M)

Name:_____Unit:_____

Best contact number and/or email: _____

Deployed location: _____

Instructions: Below is a list of problems and complaints that veterans sometimes have in response to a stressful military experience. Please read each one carefully, put an "X" in the box.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful military experience?					
2.	Repeated, disturbing *dreams* of a stressful military experience?					
3.	Suddenly *acting* or *feeling* as if a stressful military experience *were happening again* (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful military experience?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful military experience?					
6.	Avoid *thinking about* or *talking about* a stressful military experience or avoid *having feelings* related to it?					
7.	Avoid *activities* or *talking about* a stressful military experience or avoid *having feelings* related to it?					
8.	Trouble *remembering important parts* of a stressful military experience?					
9.	Loss of *interest* in things that you used to enjoy?					
10.	Feeling *distant* or *cut off* from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short?*					

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

Has anyone indicated that you've changed since the stressful military experience? Yes ___ No___

Primary Care PTSD Screen (PC-PTSD)

Description

The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

Scale

Instructions

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that in the past month, you—

1. Have had nightmares about it or thought about it when you did not want to?

   Yes/No

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

   Yes/No

3. Were constantly on guard, watchful, or easily startled?

   Yes/No

4. Felt numb or detached from others, activities, or your surroundings?

   Yes/No

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any 3 items.

Prins, Ouimette, & Kimerling, 2003

Sample Safety Plan

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing

1. _____

2. _____

3. _____

Step 2: Internal coping strategies: Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity)

1. _____

2. _____

3. _____

Step 3: People and social settings that provide distraction

1. Name _____ Phone _____

2. Name _____ Phone _____

3. Place _____ 4. Place _____

Step 4: People whom I can ask for help

1. Name _____ Phone _____

2. Name _____ Phone _____

3. Name _____ Phone _____

Step 5: Professionals or agencies I can contact during a crisis

1. Clinician Name _____ Phone _____

   Clinician Pager or Emergency Contact Number_____

2. Clinician Name _____ Phone _____

   Clinician Pager or Emergency Contact Number_____

3. Local Urgent Care Services _____

   Urgent Care Services Address _____

   Urgent Care Services Phone _____

4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe

1. _____

2. _____

The one thing that is most important to me and worth living for is:

_____

Deep-Breathing Relaxation

Deep-Breathing Relaxation	
Key Aspects	Deep-breathing relaxation is a well-known and widely used stress reduction technique. The essential elements include the following: a. Provide the rationale: relieves stress, can replace the need for substances, balances body chemistry, helps calm and focus the mind. There are two parts: 1. Centering helps you reach a state of feeling present and stable. 2. The breathing technique helps you balance the breath for full inhalations and exhalations. b. After you have given rationale, demonstrate centering and deep-breathing, emphasizing the centering position and the enlarged abdomen, then chest expansion. c. Next, ask the patient to center himself or herself. Have the patient get in a comfortable position with both feet on the ground and focus the mind on the core between the spine and belly button. d. Next, have the patient take a normal breath in through the nose and extend the exhalation out through the mouth. e. Coach the skill acquisition; repeat in through nose, longer out through mouth, 10–15 times. f. Talk with the patient about how it feels. g. Assign life work suggesting the patient practice twice a day so the relaxation technique becomes automatic when needed. In the following scene, the clinician delivers the relaxation technique and coaches the attempts by the patient to adopt and practice the skill.
Relaxation Discussion	
Clinician	*"You've told me you are most tempted to drink when there is a lot of stress, and alcohol almost immediately helps you stay calm."*
Patient	*"Yes, but it has its down side. I do not get as much done so the pressures are actually worse."*
Provider	*"Other students tell me that too. May I suggest another way of dealing with your stress that other people have found particularly helpful?"*
Patient	*"Like taking some Xanax? It makes me groggy. I just fall asleep and still get nothing done."*
Clinician	*"Actually an even more effective way to relax is called deep-relaxation breathing. There are no negative side effects, and it can change and reduce your body's cortisol levels. Cortisol is one of the main stress hormones. If you want, we could take a moment now for you to learn and practice the technique."*
Patient	*"Sure, why not."*
Clinician	*"Ok. First notice your breathing. Is it shallow? Is it quick?"*

Deep-Breathing Relaxation	
Patient	*"Both shallow and quick."*
Clinician	*"Watch as I demonstrate [puts hands on stomach]. I breathe deeply through the nose and into my stomach, which gets larger, then to release the air, I simply let it flow out from my mouth."* *"To begin, I need you to begin to focus your mind and sit in a relaxing, but well-supported position."*
Patient	*"Okay. I'll try."*
Clinician	*"Try to sit with both feet firmly on the ground Then, begin to breathe normally, focusing your mind on your core—the place between the belly button and spine. Let all your other thoughts go, as you focus on your core.* *Now just inhale through your nose, and as you exhale, extend your breath out through your mouth."*
Patient	*"What should I think about?"*
Clinician	*"Just prior to breathing out, it helps to think of a calming word such as "relax" or picture yourself relaxing." scene – like the beach or woods.*
Patient	*"So, all I really need to do is just breathe air through my nose, into my stomach. It expands and then I release by slowly exhaling through my mouth. And do this 10–15 times."*
Clinician	*[Observing] "Yes, that's right."*
Patient	*"Okay, but it's weird to have you watch me breath."*
Clinician	*"Understandably, but I'll just get you started so you can do this on your own. Try to focus your mind on your core and relax. If you need to, place your hands on your stomach do so you can make sure it expands when you breathe in and contracts when you breath out."* *"Many people express it is harder at first but always worth the effort."* *"It is best to practice twice a day for 10–15 breaths, so it becomes more automatic when you begin to feel stress or experience a lot of pressure.* *What do you say you try this for the next few months, and we revisit this the next time you come in?"*
Patient	*"This is bit stressful for me now, but I could see how it could help."*

The Suicide Behaviors Questionnaire-Revised (SBQ-R) Overview

The SBQ-R has four items, each tapping a different dimension of suicidality[1]

- Item 1 taps into lifetime ideation and/or suicide attempt.
- Item 2 assesses the frequency of suicidal ideation over the past 12.
- Item 3 assesses the threat of suicide attempt.
- Item 4 evaluates self-reported likelihood of suicidal behavior in the future.

Clinical Utility

Due to the wording of the four SBQ-R items, a broad range of information is obtained in a very brief administration. Reponses can be used to identify at-risk individual and specific risk behaviors.

Scoring

See scoring guideline on following page.

Psychometric Properties[1]	Cutoff score	Sensitivity	Specificity
Adult General Population	≥7	90%	95%
Adult Psychiatric Inpatients	≥8	80%	91%

SBQ-R Scoring

Item 1: Taps into lifetime suicide ideation and/or suicide attempts			
Selected response 1	Nonsuicidal subgroup	1 point	Total Points _____
Selected response 2	Suicide risk ideation subgroup	2 points	
Selected response 3a or 3b	Suicide plan subgroup	3 points	
Selected response 4a or 4b	Suicide attempt subgroup	4 points	

Item 2: Assesses the frequency of suicidal ideation over the past 12 months			
Selected Responses	Never	1 point	Total Points _____
	Rarely (1 time)	2 points	
	Sometimes (2 times)	3 points	
	Often (3–4 times)	4 points	
	Very Often (5 or more times)	5 points	

[1] Osman A., Bagge, C. L., Guitierrez, P. M., Kooper, B. A., & Barrios, F. X. (2001). The Suicidal Behaviors Questionnaire, Revised (SBQ-R): Validation with clinical and nonclinical samples. *Assessment, 5*, 443–454.

Item 3: Taps into the threat of suicide attempt		
Selected response 1	1 point	Total Points _____
Selected response 2a or 2b	2 points	
Selected response 3a or 3b	3 points	

Item4: Evaluates self-reported likelihood of suicidal behavior in the future			
Selected Responses	Never	0 points	Total Points _____
	No chance at all	1 point	
	Rather unlikely	2 points	
	Likely	3 points	
	Unlikely	4 points	
	Rather unlikely	5 points	
	Very unlikely	6 points	
Sum all the scores circled/checked by the respondents. The total score should range from 3 to 18.			Total Points _____

AUC = Area Under the Receiver Operating Characteristics Curve; the area measures discrimination; that is, the ability of the test to correctly classify those with and without the risk (.90–1.0 = Excellent; .80–.90 = Good; .70–.80 = Fair, .60–.70 = Poor)

	Sensitivity	Specificity	PPV	AUC
Item 1: A cutoff score of ≥ 2				
Validation Reference: Adult Inpatient	0.80	0.97	0.95	0.92
Validation Reference: Undergraduate College	1.00	1.00	1.00	1.00
Total SBQ-R: A cutoff score of ≥ 7				
Validation Reference: Undergraduate College	0.93	0.95	0.70	0.96
Total SBQ-R: A cutoff score of ≥ 8				
Validation Reference: Adult Inpatient	.080	0.91	0.89	0.89

SBQ-R: The Suicide Behaviors Questionnaire, Revised

Patient Name _____ Date of Visit _____

Instructions: Please check the number beside the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself? (check one only)

- ☐ 1. Never
- ☐ 2. It was just a brief passing thought
- ☐ 3a. I have had a plan at least once to kill myself but did not try to do it
- ☐ 3b. I have had a plan at least once to kill myself and really wanted to die
- ☐ 4a. I have attempted to kill myself but did not want to die
- ☐ 4b. I have attempted to kill myself and really hoped to die

2. Have you ever thought about or attempted to kill yourself? (check one only)

- ☐ 1. Never
- ☐ 2. Rarely (1 time)
- ☐ 3. Sometimes (2 times)
- ☐ 4. Often (3–4 times)
- ☐ 5. Very often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it? (check one only)

- ☐ 1. No
- ☐ 2a. Yes, at one time but did not really want to die
- ☐ 2b. Yes, at one time and really wanted to die
- ☐ 4a. Yes, more than once but did not want to do it
- ☐ 4b. Yes, more than once and really wanted to do it

4. How likely is it that you will attempt suicide some day? (check one only)

- ☐ 0. Never
- ☐ 1. No chance at all
- ☐ 2. Rather unlikely
- ☐ 3. Unlikely
- ☐ 4. Likely
- ☐ 5. Rather likely
- ☐ 6. Very likely

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