✓Treatments That Work™

A Cognitive-Behavioral Treatment Program for Overcoming Alcohol Problems

Therapist Guide

Elizabeth E. Epstein
Barbara S. McCrady

A Cognitive-Behavioral Treatment Program for Overcoming Alcohol Problems

✓Treatments *That Work*™

A Cognitive-Behavioral Treatment Program for Overcoming Alcohol Problems

Therapist Guide

Elizabeth E. Epstein • Barbara S. McCrady

OXFORD
UNIVERSITY PRESS

2009

OXFORD
UNIVERSITY PRESS

Oxford University Press, Inc., publishes works that further
Oxford University's objective of excellence
in research, scholarship, and education.

Oxford New York
Auckland Cape Town Dar es Salaam Hong Kong Karachi
Kuala Lumpur Madrid Melbourne Mexico City Nairobi
New Delhi Shanghai Taipei Toronto

With offices in
Argentina Austria Brazil Chile Czech Republic France Greece
Guatemala Hungary Italy Japan Poland Portugal Singapore
South Korea Switzerland Thailand Turkey Ukraine Vietnam

Published by Oxford University Press, Inc.
198 Madison Avenue, New York, New York 10016

www.oup.com

Oxford is a registered trademark of Oxford University Press

Library of Congress Cataloging-in-Publication Data
Epstein, Elizabeth E.
A cognitive-behavioral treatment program for overcoming alcohol problems :
therapist guide / Elizabeth E. Epstein, Barbara S. McCrady.
p. cm. — (Treatments that work)
Includes bibliographical references.
ISBN 978-0-19-532281-1 (pbk. : alk. paper)
1. Alcoholism—Treatment. 2. Cognitive therapy. I. McCrady, Barbara S. II. Title.
RC565.E67 2009
362.292—dc22

2008047103

9 8 7 6 5 4 3 2 1

Printed in the United States of America
on acid-free paper

About Treatments *ThatWork*™

Stunning developments in healthcare have taken place over the last several years, but many of our widely accepted interventions and strategies in mental health and behavioral medicine have been brought into question by research evidence as not only lacking benefit, but perhaps, inducing harm. Other strategies have been proven effective using the best current standards of evidence, resulting in broad-based recommendations to make these practices more available to the public. Several recent developments are behind this revolution. First, we have arrived at a much deeper understanding of pathology, both psychological and physical, which has led to the development of new, more precisely targeted interventions. Second, our research methodologies have improved substantially, such that we have reduced threats to internal and external validity, making the outcomes more directly applicable to clinical situations. Third, governments around the world and healthcare systems and policymakers have decided that the quality of care should improve, that it should be evidence based, and that it is in the public's interest to ensure that this happens (Barlow, 2004; Institute of Medicine, 2001).

Of course, the major stumbling block for clinicians everywhere is the accessibility of newly developed evidence-based psychological interventions. Workshops and books can go only so far in acquainting responsible and conscientious practitioners with the latest behavioral healthcare practices and their applicability to individual patients. This new series, Treatments *ThatWork*™, is devoted to communicating these exciting new interventions to clinicians on the frontlines of practice.

The manuals and workbooks in this series contain step-by-step detailed procedures for assessing and treating specific problems and diagnoses. But this series also goes beyond the books and manuals by providing

ancillary materials that will approximate the supervisory process in assisting practitioners in the implementation of these procedures in their practice.

In our emerging healthcare system, the growing consensus is that evidence-based practice offers the most responsible course of action for the mental health professional. All behavioral healthcare clinicians deeply desire to provide the best possible care for their patients. In this series, our aim is to close the dissemination and information gap and make that possible.

This therapist guide outlines a cognitive-behavioral treatment program for alcohol use disorder (AUD). Problems with alcohol use are common and can have significant social, medical, and interpersonal consequences. Interventions over the course of 12 sessions help the client achieve the primary goal of abstinence from drinking. Through self-recording, the client identifies his or her drinking patterns and triggers. With the therapist's assistance, the client anticipates high-risk situations and plans for dealing with urges to drink. Additional treatment components include coping with anxiety and depression, building social support, assertiveness training, anger management, and problem solving. Extensive relapse prevention helps the client maintain gains and prepares the client for handling slips and relapses. Clinicians will find this a complete guide to implementing an effective and comprehensive program for those clients who wish to overcome alcohol problems.

David H. Barlow, Editor-in-Chief,
Treatments *That Work*™
Boston, MA

References

Barlow, D. H. (2004). Psychological treatments. *American Psychologist, 59*, 869–878.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.

Dedication

To my mentors—Dr. Stein, Ruth and Louie Guttman, Benson Ginsburg, Victor Hesselbrock, Erich Labouvie, and Barbara McCrady, whose guidance led me here, and to my patients, whose guidance keeps me here—EEE

To my wonderful colleagues—at Butler Hospital, Rutgers University, and now the University of New Mexico—for your wisdom, support, and friendship—BSM

This page intentionally left blank

Acknowledgments

This therapist guide is the culmination of almost 30 years of work, close to 60 years of accumulated clinical experience, and the contributions of countless colleagues, staff, and students. It is impossible to acknowledge them all by name, but we want especially to thank those who contributed to developing our treatment manuals and client worksheets, including Larry Dean, Ed Dubreuil, Sue Swanson, William Hay, David Abrams, Charles Neighbors, Barbara Niles, Sadi Irvine Delaney, Helen Raytek, and Melissa Mitchell. Staff and colleagues who have been key to the long-term success of our research program include Nora Noel, Hilary Fisher-Nelson, Bob Stout, Sandy Hoffmann, Noelle Jensen, Sharon Cook, Jean Schellhorn, and Thomas Morgan. We are deeply grateful to them and to all who have contributed to our research program. Our families, Denny, Kari, Eric, Sam, Eve, and Jeremy, keep us going and motivated to be the best we can be. We would also like to acknowledge the careful and intelligent editing by Julia TerMaat of Oxford University Press.

This page intentionally left blank

Contents

Chapter 1 *Introductory Information for Therapists*

Background Information and Purpose of This Program

This manual includes 12 therapy sessions to be delivered in individual therapy modality and covers (1) core cognitive-behavioral therapy (CBT) elements for alcohol use disorders (AUDs), including self-recording, functional analysis, dealing with heavy drinkers in the social network, self-management planning, coping with craving and alcohol-related thoughts, drink refusal, making sober social connections, and relapse prevention; (2) management of negative affects (e.g., anxiety, depression, and anger); and (3) general coping skills including assertiveness training and problem solving. The session-by-session outline for this manual is shown in Table 1.1, found at the end of this chapter, with interventions broken down into categories of: (1) routine interventions, (2) alcohol-specific coping skills interventions, and (3) general coping skills interventions.

The treatment manual was designed and tested for clients with a goal of abstinence from alcohol; to date, there have been no studies regarding adaptations for clients who wish to moderate their drinking.

Alcohol Use Disorders

Alcohol use disorders are among the most common psychiatric diagnoses in the United States, with 1-year prevalence estimates of 8.5% among adults (Grant et al., 2004). The health, economic, and social costs of AUDs are considerable. For example, estimated alcohol-related traffic fatalities in the United States were 16,919 (39.5% of all fatalities)

in 2004 (Yi, Chen, & Williams, 2006); almost one in four violent offenders had been drinking at the time of the crime (U.S. Department of Health and Human Services, 2001); the economic costs of AUDs were estimated at 184.6 billion dollars in 1998 (Harwood, 2000), and an estimated 50% of American adults have a family member with an AUDs (U.S. Department of Health and Human Services, 2001).

It is common for persons with AUDs to have other psychological and social problems as well. A high percentage of those with AUDs experience other psychological problems that may be antecedent to, concurrent with, or consequent to their drinking (Rosenthal & Westreich, 1999). Other substance use disorders, depression, and anxiety disorders are most common and are found in as many as 60% of males in treatment. The most common Axis II disorder in men with an AUD is antisocial personality disorder, with rates ranging from 15% to 50%. Females are more likely than men to have mood disorders, and one-quarter to a third of women with AUDs have a mood disorder prior to the onset of their alcoholism. The most common Axis II diagnosis among alcohol-dependent women is borderline personality disorder.

Cognitive deficits and medical problems are common among individuals with AUDs. These individuals may also have problems with their employment, their interpersonal relationships, and the criminal justice system. Cognitive deficits in the areas of abstract reasoning, memory, and problem solving are most common (Bates, Bowden, & Barry, 2002). However, since verbal functioning typically is unimpaired, these cognitive problems are not immediately apparent. Heavy drinking may cause a variety of health problems in the cardiovascular, digestive, and neurological systems. Even without active medical problems, heavy drinking may result in nutritional deficits, poor energy, and a general feeling and appearance of poor health. Mortality rates are elevated for persons of all ages who have AUDs.

Interpersonal relationships also may be disrupted. The rates of separation and divorce are elevated, spousal violence is higher in both men and women with AUDs (Drapkin, McCrady, Swingle, & Epstein, 2005), and their spouses and children are more likely to have physical or emotional problems (Moos & Billings, 1982; Moos, Finney, & Gamble, 1982).

Involvement with the legal system also may complicate treatment because of charges related to driving while intoxicated (DWI), other alcohol-related offenses such as assault, or involvement with the child welfare system because of child abuse or neglect. Drug-related charges also may bring a client to treatment.

Knowledge about the efficacy of treatment for AUDs has increased substantially in the past 30 years. In an analysis of seven major, multisite treatment studies, Miller, Walters, and Bennett (2001) reported that, on average, 25% of clients maintained abstinence during the first year after treatment, and 10% were drinking moderately and without problems. Mortality was less than 2%, the percentage of days that clients abstained from alcohol was 75%, and the amount that clients drank on drinking days decreased by 87%. Comparisons of treated and untreated alcohol-dependent community samples suggest that remission rates with treatment are higher than natural recovery rates (approximately 4.8% per year vs. 3%) (Finney, Moos, & Timko, 1999). Comprehensive reviews of the efficacy of different treatment approaches suggest that there are good efficacy data for brief interventions, social skills training, the community reinforcement approach, behavioral contracting, behavioral couple therapy, case management, opiate antagonists such as naltrexone and nalmefene, and acamprosate (Miller & Wilbourne, 2002).

Given the complexity of AUDs (see Epstein, 2001), assessment is central to treatment planning and is an integral part of the treatment process described in this therapist guide. Chapter 3 provides a brief overview of the necessary components of assessment for the treatment.

Diagnostic Criteria for Alcohol Use Disorders (*DSM-IV-TR*, American Psychiatric Association, 2000)

The following is a list of the criteria for AUDs (alcohol abuse and alcohol dependence):

Alcohol Abuse Criteria: *DSM-IV-TR*

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one

(or more) or the following, occurring within a 12-month period:

(1) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household);
(2) Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);
(3) Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct);
(4) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

B. The symptoms have never met the criteria for Alcohol Dependence.

Alcohol Dependence Criteria: *DSM-IV-TR*

A. A maladaptive pattern of substance use, leading to clinically significant impairment or distress as manifested by three or more of the following occurring at any time in the same 12-month period:

(1) Tolerance, as defined by either of the following:
    (a) need for markedly increased amounts of a substance to achieve intoxication or desired effect; or
    (b) markedly diminished effect with continued use of the same amount of the substance;
(2) Withdrawal, as manifested by either of the following:
    (a) the characteristic withdrawal syndrome for the substance, or
    (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms;
(3) The substance is often taken in larger amounts or over a longer period than was intended;

(4) There is a persistent desire or unsuccessful efforts to cut down or control substance use;
(5) A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects;
(6) Important social, occupational, or recreational activities are given up or reduced because of substance use;
(7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Specifiers:

* With physiological dependence: Evidence of tolerance or withdrawal (i.e., either Item 1 or 2 is present)
* Without physiological dependence: No evidence of tolerance or withdrawal (i.e., neither Item 1 nor 2 is present)

Development of This Treatment Program and Evidence Base

Practitioners encounter AUDs in all practice settings. Depending on the facility, it is estimated that at least 20% (in private, community-based hospitals) and as much as 60% (in Veterans Administration Hospitals) of medically hospitalized patients have medical problems either caused or exacerbated by their drinking, and an estimated 25% of patients in mental health settings have either a primary or a secondary AUD (reviewed in McCrady, Richter, Morgan, Slade, & Pfeifer, 1996). Generally, mental health practitioners receive limited training in the treatment of AUDs and may have misconceptions about appropriate ways to manage clients with these problems and limited knowledge or experience with effective treatment approaches.

Practitioners who wish to provide evidence-based treatment for their clients with AUDs are faced with a variety of challenges. Clinicians experience a tension between the desire to provide effective treatments supported by research and the realities of busy schedules, the heterogeneity among clients (Epstein, Labouvie, McCrady, Jensen, & Hayaki, 2002; Epstein, 2001), and the paucity of treatment manuals that provide appropriate guidance for a practice setting.

This manual includes a step-by-step cognitive-behavioral approach for individuals, as well as suggestions for adaptation to the unique problems that women present. The treatment manual is the outgrowth of 30 years of research to develop and test evidence-based approaches to AUDs.

Research Evidence

Research evidence coming from several sources supports the effectiveness of the treatment detailed in this volume. A brief review provided here focuses on research findings from the labs of Drs. McCrady and Epstein. Three major research threads are important:

The Problem Drinkers Project (PDP): In the late 1970s, Dr. McCrady created one of the first substance abuse treatment programs based on CBT principles. The program used a functional analytic and skills training approach, delivered in a group setting, first in an inpatient and later in a partial hospital treatment setting. The outpatient PDP model was developed as part of a randomized clinical trial of inpatient versus intensive outpatient treatment. The results, published in a series of papers (Fink et al., 1985; Longabaugh et al., 1983; McCrady, Longabaugh et al., 1986), established the effectiveness of ambulatory CBT treatment for individuals with AUDs. Patients were followed for 2 years after treatment, and results suggested that patients improved significantly from pretreatment, that outcomes were comparable between the inpatient and intensive outpatient settings, and that costs favored the intensive outpatient setting. Patients were abstinent about 85% of the days during the first year of follow-up. A client manual, written by Dr. McCrady and her colleagues at Butler Hospital in Rhode Island, was developed and used in the treatment program.

Iterations of the original PDP manual were then used over the subsequent 10 years to develop and test CBT in various modalities such as couples therapy, relapse prevention focused therapy, and integration of couples therapy with 12-step treatment (Epstein et al., 2007a; Epstein et al., 2007b; McCrady, Epstein, & Hirsch, 1996; McCrady, Epstein, & Kahler, 2004; McCrady, Noel, et al., 1986; McCrady et al., 1991). The CBT model adapted for couples therapy continued to show good results—participants on average reduced pretreatment drinking frequency from approximately 61% of days to approximately 20% of the

days in the 18 months post-treatment. Drinking quantity also decreased substantially, and rates of continuous abstinence hovered around 40% of the sample at 6 months after treatment.

In 1998, we updated older versions of the CBT manuals to develop an individual CBT manual used in our 5-year National Institute on Alcohol Abuse and Alcoholism (NIAAA)-funded randomized trial to test alcohol behavioral couples therapy (ABCT) and alcohol behavioral individual therapy (ABIT). A 20-session protocol was provided to 102 alcohol-dependent females in committed relationships. Couples received an intensive pretreatment assessment and were followed for 18 months from the original baseline interview (12 months from the projected end of treatment) (McCrady, Epstein, Hildebrandt, Cook, & Jensen, in press). Overall, the women in CBT individual treatment (n=52) increased the frequency of alcohol abstinence from 32% of the 90 days prior to treatment to 74% of the days during the 6 months of treatment and 63% of the days in the 12 months post-treatment. Percent days of heavy drinking reduced substantially from 57% pretreatment to 19% at the end of treatment and 23% during the 12 months post-treatment. Approximately 62% of the sample was completely abstinent by week 6 of treatment. Generalizability of results from this study is limited by the inclusion criteria of all female clients with a male partner who was willing and able to attend therapy with her. Findings on the efficacy of CBT from our research are consistent with the larger body of research showing that CBT for AUDs is among the efficacious treatments (Miller & Wilbourne, 2002), and, as reviewed by Donovan in Longabaugh et al. (2005), CBT yields outcomes comparable to or better than comparison treatments and can be taught to frontline clinicians (Longabaugh et al., 2005).

In 2003, we began another 5-year NIAAA-funded randomized trial allowing alcohol-dependent females to choose either couples therapy or individual therapy, using either our couples CBT protocol or our individual CBT protocol. For this study, the CBT individual manual was further modified to become the current, 12-session, published version. Women treated with this manual reduced drinking frequency from 71% of days pretreatment to 39% of days during treatment, and reduced frequency of heavy drinking (>3 standard drinks) from 54% days pretreatment to 21% days post-treatment.

Manual Development

In addition to being based on a well-studied and empirically supported base of CBT(Anton et al., 2006; Carroll, 1999; Miller & Wilbourne, 2002; Miller et al., 2001; Project MATCH, 1997), the current manual is unique in that it is the result of a process of development that began 30 years ago and has undergone repeated "product testing" and improvement over the course of five NIAAA-funded randomized clinical trials and a total of over 350 client participants. Over the years, the manual has become uniquely user-friendly to clinicians who learn and administer the treatment protocol. Clear, explicit directions, logical rationales, clear homework assignments, session structure, and sample dialogue all help the therapist absorb and deliver the manual material in a clinically meaningful way. Likewise, clients appreciate the comprehensive assessment, useful skills, relevant examples, clear worksheets, and step-wise progression toward abstinence, as well as attention to issues important to people struggling to become and remain sober. Affect, life after alcohol, and social support, for example, all play a major role in these struggles, and this manual provides help to cope with these issues in addition to directly alcohol-related skills. In short, this manual grows out of a combined 58 years of clinical experience treating substance abusers, as well as that of countless collaborators, students, clinicians, and clients.

What is Cognitive-Behavioral Treatment for Alcohol Use Disorders?

As described above, this manual is based on a cognitive-behavioral approach to treatment and has been developed as part of our randomized clinical trials of various treatment modalities of the model over the past 30 years. CBT derives from classical behavioral theories such as classical and operant conditioning and social modeling (see Carroll, 1999, or Epstein & McCrady, 2002). In CBT, we see substance use disorders as multiply determined, complex behaviors (Hesselbrok, Hesselbrock, & Epstein, 1999), but CBT approaches focus primarily on factors maintaining the alcohol-use problems. Specifically, excessive drinking is treated as a habit, an overlearned behavior that can be unlearned. Classic CBT interventions are explicated in this manual and are organized around three major elements: motivational enhancement, functional

analysis as a guiding framework for behavior change, and relapse prevention. CBT approaches to alcohol-use problems have strong empirical support for their effectiveness (Carroll, 1999). Specific components of CBT delivered in this manual are discussed in greater detail here.

Motivational Enhancement

It is almost axiomatic that therapy cannot occur without a client, and a client with low motivation will not continue in treatment. The manual is structured to include several major approaches to enhancing and maintaining motivation:

1. **General therapeutic stance**. The therapist should treat the client with respect and as a person of value. Expressing interest in the client's emotional experiences and welfare, as well as the details of the client's daily life, is part of valuing the client. The use of some motivational interviewing strategies (see Miller & Rollnick, 2002 for details) is appropriate, particularly reflective listening, empathy, and "rolling with resistance," but the therapy is skills-based rather than motivationally based, so these basic therapeutic skills are combined with specific, structured aspects of the therapy.

2. **Feedback**. In the session, after assessment, the therapist provides feedback to the client about the extent and severity of her drinking. Such feedback has been demonstrated to enhance motivation to change (e.g., Miller, Sovereign, & Krege, 1988).

3. **Decisional balance**. In Session 4, the therapist and the client begin a decisional matrix exercise, which continues in subsequent sessions. This exercise helps the client to be more aware of the decision she has made to change, acknowledges the losses associated with stopping drinking, and enables the therapist to be empathic about the loss as well as noting the potential gains from abstinence.

4. **Functional analysis**. In the functional analysis, the client examines the negative consequences of drinking in a variety of situations. This repeated focus on the reasons to stop should also reinforce the client's motivation to change.

Functional Analysis

The functional analysis is central to individualized CBT planning. Through the functional analysis and related exercises, the therapist and the client identify situations that place the client at high risk for drinking, as well as the cognitive and affective responses that follow. Therapy then progresses by systematically helping the client learn ways to modify high-risk situations, learn different cognitive responses to high-risk situations, learn new behaviors to use in response to high-risk situations, use insight about the positive consequences of drinking to learn new ways to obtain similar positive reinforcers through means other than drinking, and learn to focus on the negative consequences of drinking in high-risk situations. Specifics include the following:

1. **Identifying triggers or high-risk situations** is accomplished through interviewing, client recording of triggers on the daily self-recording cards, and through completion of the Drinking Patterns Questionnaire found in the appendix (DPQ, Zitter & McCrady, 1979; Zweig, McCrady, & Epstein, in press; Menges, McCrady, Epstein, & Beem, 2008). Worksheets help the client think of triggers in different areas of her life.

2. **Identifying dysfunctional thoughts** is accomplished primarily through careful interviewing, as well as completing specific behavior chains with the client. The therapist helps the client identify dysfunctional thoughts about self and others, as well as identifying positive expectancies about the effects that are anticipated from drinking.

3. **Identifying dysfunctional emotions** is also accomplished primarily through careful interviewing, completing specific behavior chains with the client, as well as through the DPQ.

4. **Identifying consequences of drinking** is accomplished through interviewing and completion of specific behavior chains. The therapist often has to help the client become more aware of the consequences, either positive or negative, of drinking in specific situations.

5. **Changing triggers**. From the list of triggers, the therapist then works with the client to develop strategies to change the most important triggers on the client's list of high-risk situations. Triggers that relate to environmental and habitual aspects of drinking are best handled through the self-management planning exercise.

6. **Changing thoughts and feelings**. The therapist needs to think carefully about the client's behavior chains to identify commonalities in the client's thinking about alcohol that can be addressed through specific interventions. Interventions targeted to changing thoughts and feelings include urge coping, dealing with alcohol-related thoughts, and, to some degree, the decisional matrix exercise described above under motivational interventions.

7. **Changing behavior**. The therapist also needs to think carefully about specific behavior chains to identify coping skills that the client may lack. In a generic CBT treatment, coping skills training focuses specifically on alcohol-related skills. These skills included drink refusal, anticipating high-risk situations, and problem solving.

8. **Changing consequences**. The functional analysis helps the client become aware of positive consequences from drinking and helps her identify alternative ways to obtain these same reinforcers.

Relapse Prevention

The treatment has drawn on several of Marlatt's original concepts of relapse prevention (Marlatt & Gordon, 1985), and the full course of treatment incorporates, in some respects, a relapse prevention approach as it focuses on identification and anticipation of high-risk situations and use of alternative coping skills. The last part of the treatment focuses more explicitly on relapse prevention, introducing the notion that clients do relapse and developing a set of strategies to both avoid relapses and cope with relapses that may occur.

Risks and Benefits of This Treatment Program

Benefits of CBT have been shown in many research studies to be multifaceted. Reductions in frequency and quantity of alcohol consumed, increased rates of abstinence, and maintenance of change sustained after therapy have been typical research findings. In addition, reduction of depression, anxiety, and other comorbid drug use has been reported. CBT is a noninvasive treatment and does not involve medication or any type of physiological intervention, though it can be delivered in conjunction with adjunctive pharmacotherapy. It can also be integrated into a primarily 12-step program to help patients develop specific coping skills. The individual CBT protocol is flexible in that it can be integrated into various modalities such as family or group therapy. Risks of this treatment approach are minimal. One potential risk as in any outpatient program is experience of withdrawal symptoms, especially in the beginning of treatment, when the patient is reducing or stopping drinking, but the clinician is trained to use a detailed assessment of level of care indicated at the beginning of treatment to help the patient avoid problems related to withdrawal.

Alternative Treatments

There is good empirical evidence to support three outpatient approaches to treatment for persons with AUDs. Twelve-step facilitation counseling (TSF) uses counseling procedures to help a client become integrated with Alcoholics Anonymous (AA), and research suggests that clients who participate in TSF have a greater likelihood of maintaining complete abstinence from alcohol than clients receiving other forms of outpatient counseling (Project MATCH Research Group, 1997a). Additionally, clients whose social network strongly encourages them to drink do particularly well with TSF (Longabaugh, Wirtz, Zweben, & Stout, 1998). Motivational enhancement therapy (MET) uses motivational techniques to help clients recognize their drinking problems and develop the motivation to change (Miller, Zweben, DiClemente, & Rychtarik, 1994). MET appears to be particularly effective with clients who enter treatment angry and resentful of the treatment process (Project MATCH Research Group, 1997b). In contrast, CBT, such as

the model in this manual, helps clients identify high-risk situations for drinking and develop cognitive, affective, and behavioral skills to cope with these situations (Kadden et al., 1995). More recently, aspects of all three treatments have been combined into one treatment package (Miller, 2004), but research evidence for the combined approach is limited.

There are three medications with evidence supporting their use in the treatment of AUDs. Disulfiram (Antabuse®) blocks the metabolic breakdown of alcohol, leading the patient to become ill if she drinks while on the medication (Barber & O'Brien, 1999). Naltrexone (Revia®) is an opiate antagonist that appears to help clients who experience strong cravings to drink; evidence suggests that naltrexone results in less drinking among patients who relapse (O'Malley et al., 1992; Volpicelli, Alterman, Hayashida, & O'Brien, 1992). In a series of European trials (Paille et al., 1995), acamprosate (Campral®) appeared to increase the probability that patients would maintain complete abstinence while on the medication. Findings from a recent U.S. trial did not support the effectiveness of acamprosate (Anton et al., 2006).

The Role of Medications

There are no contraindications to using medications for depression, anxiety, other comorbid disorders, or for reduction of craving and/or aversion therapy for alcohol in combination with CBT for an AUD. In the context of careful diagnosis, use of antidepressants for someone with a concurrent AUD is now widely acceptable, but it is generally best that the therapist refer the patient an addictions psychiatrist or an Addiction Society on Addictions Medicine (ASAM)-certified physician, rather than a general psychiatrist or a family doctor, if such a specialist is available. There are ongoing developments in the use of medications to aid in achieving and maintaining abstinence, with which an expert in addictions is more likely to be familiar. Certain medications for short-term alleviation of anxiety and depression, such as benzodiazepines, should generally not be prescribed to patients who have a current or past AUD. Therapists who treat patients with comorbid depression and AUDs must familiarize themselves with medication options that are

appropriate to treat this population in order to make well-informed recommendations and to help the patient participate in decisions about medications prescribed.

Outline of This Treatment Program

Each session follows the same format of 50–60 min, to be roughly divided into three segments. First, the routine interventions are part of every session, and include check in, review of homework, and graphing of daily monitoring data. Then, the therapist presents the rationale for and clients practice in session one or two new skills. The worksheets are used for working in session and for assignments of completion of work started in session. For the last 10 minutes of the session, the therapist assigns homework for the week and the therapist and client review and plan strategies for upcoming high-risk drinking situations. A session-by-session outline of the manual is provided in Table 1.1. For application of this treatment specifically to women, see Chapter 2.

Use of the Client Workbook

The client workbook is designed to be used in conjunction with each therapy session. The workbook is organized into chapters that correspond to each of the 12 therapy sessions and includes a summary of the major concepts introduced in the session. The workbook includes worksheets that the therapist should complete with the client during the session and also provides additional worksheets for homework assignments between sessions. Instruct clients to bring the workbook to each therapy session. Therapists are advised to have extra, loose copies of the in-session worksheets to use with clients who forget the workbook for a particular session. The workbook also includes a place to graph the client's weekly drinking and drinking urges, and the therapist should update the graph each week during the session to provide immediate feedback to the client on her progress.

Table 1.1 Outline of Sessions

Routine Interventions	Alcohol-Related Interventions	General Coping Skills
Session 1: Introduction / Rationale / Self-Recording		
A. BAL 2 🕒	E. Feedback from baseline and clinical screen 15 🕒	
B. Opening statements; building rapport 5 🕒	F. Introduction to self-recording 10 🕒	
C. Treatment rationale psychoeducation 3 🕒	G. Abstinence plan (optional) *and/or* Possible problem areas (optional) 5 🕒	
D. Treatment requirements 5 🕒	H. Anticipating high-risk situations 5 🕒	
I. Homework 10 🕒		
Session 2: Functional Analysis		
A. BAL 2 🕒	E. Functional analysis 30 🕒	
B. Overview of session 5 🕒	F. Anticipating high-risk situations 5 🕒	
C. Review of self-recording and homework 5 🕒		
D. Check in 10 🕒		
G. Homework 5 🕒		
Session 3: High-Risk Hierarchy / Social Network Triggers / Self-Management Plans		
A. BAL 2 🕒	E. High-Risk Hierarchy 15 🕒	F. Problem-solving for presence of heavy drinkers in social network 20 🕒
B. Overview of session 3 🕒	G. Self-management planning 20 🕒	
C. Review of self-recording and homework 5 🕒	H. Anticipating high-risk situations 5 🕒	
D. Check in 5 🕒		
I. Homework 2 🕒		
Session 4: Enhancing Motivation to Change		
A. BAL 2 🕒	E. More self-emanagement planning 10 🕒	
B. Overview of session 5 🕒	F. Decisional matrix and motivation enhancement 25 🕒	
C. Review of self-recording and homework 5 🕒	G. Use of negative consequences cards 5 🕒	
D. Check in 5 🕒	H. Anticipating high-risk situations this week 5 🕒	
I. Homework 5 🕒		

continued

Table 1.1 Outline of Sessions *continued*

Routine Interventions	Alcohol-Related Interventions	General Coping Skills
Session 5: Assessing Anxiety and Depression / Dealing With Urges		
A. BAL 2	G. Dealing with urges 15	E. Coping with anxiety 10
B. Overview of session 5	I. Anticipating high-risk situations 5	F. Coping with depression 10
C. Review self-recording and homework 5		H. Review of skills and progress (optional) 20
D. Check in 5		
J. Homework 5		
Session 6: Affect and Mood Management / Rearranging Behavioral Consequences		
A. BAL 2	F. Rearranging behavioral consequences for drinking 5	E. Management of emotions and moods 40
B. Overview of session 2	G. Identifying alternatives to drinking 20	
C. Review self-recording and homework 5	H. Anticipating high-risk situations 5	
D. Check in 5		
I. Homework 3		
Session 7: Connecting With Others / Dealing With Alcohol-Related Thoughts		
A. BAL 2	F. Dealing with alcohol-related thoughts 15	E. Connecting with others: Improving social support for abstinence 20
B. Overview of session 2	G. Anticipating high-risk situations 3	
C. Review self-recording and homework 15		
D. Check in 3		
H. Homework 2		
Session 8: Assertiveness Training / Drink Refusal		
A. BAL 2	F. Drink-refusal training 15	E. Assertiveness training 20
B. Overview of session 3	G. Anticipating high-risk situations 5	
C. Review self-recording and homework 5		
D. Check in 5		
H. Homework 5		

continued

Routine Interventions	Alcohol-Related Interventions	General Coping Skills

Session 9: Anger Management Part I / Relapse Prevention Part I: Seemingly Irrelevant Decisions

Routine Interventions	Alcohol-Related Interventions	General Coping Skills
A. BAL 2 ◷	F. Relapse Prevention I: Seemingly irrelevant decisions 20 ◷	E. Anger Management I 15 ◷
B. Overview of session 5 ◷	G. Anticipating high-risk situations 5 ◷	
C. Review self-recording and homework 5 ◷		
D. Check in 5 ◷		
H. Homework 5 ◷		

Session 10: Anger Management Part II / Problem Solving / Relapse Prevention Part II

Routine Interventions	Alcohol-Related Interventions	General Coping Skills
A. BAL 2 ◷	G. Relapse Prevention II: Identifying and managing warning signs of relapse 25 ◷	E. Anger Management II: Time-Outs 20 ◷
B. Overview of session 2 ◷	H. Anticipating high-risk situations 3 ◷	F. Problem-solving introduction and exercises 20 ◷
C. Review self-recording and homework 3 ◷		
D. Check in 5 ◷		
I. Homework 2 ◷		

Session 11: Relapse Prevention Part III

Routine Interventions	Alcohol-Related Interventions	General Coping Skills
A. BAL 2 ◷	E. Handling slips and relapses 35 ◷	
B. Overview of session 5 ◷	F. Anticipating high-risk situations 5 ◷	
C. Review self-recording and homework 5 ◷		
D. Check in 5 ◷		
G. Homework 5 ◷		

Session 12: Review / Relapse Prevention Part IV: Maintenance Planning and Relapse Contract

Routine Interventions	Alcohol-Related Interventions	General Coping Skills
A. BAL 2 ◷	E. Final review and maintenance planning 30 ◷	
B. Overview of session 5 ◷	F. Relapse contract 10 ◷	
C. Review self-recording and homework 5 ◷		
D. Check in 5 ◷		
G. Treatment termination 15 ◷		

Note: Time estimates are approximate and do not always add up to 60 min per session. Therapists may administer particular interventions in the session and not others depending on the case.

This page intentionally left blank

Chapter 2 *Clinical Issues*

Continued Drinking and Ambivalence About Abstinence

At the initial intake (clinical screen), the client answers a written "drinking goal" question, for instance, that he has decided to remain abstinent forever, or wants to have a drink occasionally, or has some other drinking goal (see Chapter 3). Despite this question, it is important to make it clear to the client at the initial intake interview that this is an abstinence-based program and that you expect the client to commit to trying to become abstinent. We don't expect each client to become abstinent right away; in fact, we work with each client individually to create abstinence plans starting in Session 1. This manual is geared toward achieving abstinence by Session 5. Therapists in clinical practice may take a different approach to clients with non-abstinent goals (see, e.g., Hester, 2003), but our CBT program has been tested using the approach described here.

Ambivalence

You should be aware of the client's answer to the drinking goal question and should take the client's level of ambivalence about abstinence into account when devising the abstinence plan in Session 1. Some clients continue to drink through a number of sessions. If the client continues to drink past Session 5, it is important to address this issue and to explore the continued drinking until both you and the client understand why it is still occurring. At each session up to Session 5, you should review the abstinence plan and revise it if the client is not making progress toward his quit date. In all cases, if a client is continuing to drink by Session 5,

we suggest a case review with a colleague or a clinical supervisor. Some of the most common reasons clients continue to drink are listed here with suggested interventions.

Some comments that may be helpful in addressing ambivalence are as follows:

> *It's very common for people to have mixed feelings about abstinence, and many people who come to treatment for alcohol problems say that they would like to have a drink now and then, or do "controlled drinking" or "social drinking." Our program is abstinence-based, and while we haven't asked you to commit to remaining abstinent your whole life, we do ask that you make a commitment to be abstinent during the 3 months you're in treatment with us. I'd like you to have a stretch of time with alcohol out of your life so that you can get used to it a bit, and see what it's like. Often people don't realize how much alcohol plays a role in their lives until it's gone for a while, and they don't realize how much better they feel without alcohol until they've gotten used to living without it for a while. While you're in this program, you might as well take advantage of the time to learn the skills to be abstinent, so that you will always have those skills should you want to use them.*
>
> *The second reason we are an abstinence-based program is that abstinence is the safest choice. You won't have alcohol-related problems if you're not drinking. And it's too easy to start out with a drink here and there and then work your way up over time to problem drinking again.*

At this point, you can review the client's relapse history.

> *Third, "controlled drinking" is not the same as "social drinking." Social drinkers can have a drink here and there, but they don't think about drinking otherwise. They can take it or leave it. Controlled or "moderated" drinking means continuing to keep alcohol in your life, but always working to control it, count drinks, not lose self-control, and be aware and deliberate about your drinking. Moderated drinking means limiting your drinking to a certain number of drinks per week and per drinking occasion and requires that you spend quite a bit of energy and thinking on alcohol in order to keep your drinking*

contained. For many people, it turns out that abstinence is easier in the long run than "controlled drinking," which requires a whole different focus in treatment and in your life. What are your thoughts?

Sometimes the client voices commitment to abstinence but continues to drink at reduced levels and is clearly ambivalent about stopping drinking completely. In this case, you can use some of the strategies just discussed for the client who has changed his mind or you can keep working toward the abstinence goal without really directly addressing the choice of moderated drinking. For instance, while graphing the client's drinking patterns, you can remind the client that *x* number of weeks are left in therapy and it is desirable for him to have some weeks of sobriety while still in treatment to discuss with you how abstinence feels. As this process is ongoing, use a motivational interviewing style in therapy sessions to highlight ambivalence and positive reasons to stop drinking. Or, frame the client's drinking pattern as an initial drastic reduction (which is common) and then a plateau, which also is common, and then let the client know that he needs to work toward the next plateau and the next, until the drinking is at 0. Thus, after the initial reduction, drinking during subsequent weeks can be treated as relapses, or slips, in the process of attaining abstinence.

Inability to Follow the Plan

The client is struggling with the drinking reduction plan and is unable to follow it; he may reduce the level of drinking to some degree but not substantially. In other words, the client is not really getting better despite genuine efforts. In this case, both therapist and client generally know by Session 2 or 3 that the drinking-reduction plan will be unlikely to work for him. Thus, an alternative abstinence plan must be devised. If by Sessions 2–5 (depending on the case) the client is not abstinent or at least on a steep drinking reduction trajectory, it may be time to discuss the need for a higher level of care, such as an intensive outpatient or inpatient treatment, or an alternative, more definitive means to stopping drinking, such as a detoxification program.

Change of Mind

The client has reconsidered the commitment to abstinence during treatment and informs you that he no longer intends to work toward complete abstinence. In this case, you may decide to continue to use CBT to let the client "test" his ability to consistently meet a weekly goal of moderated drinking, may decide to refer the client to a therapist with expertise in moderation approaches (if you do not have this expertise), or may decide to try to encourage the client to reconsider an abstinence drinking goal. It is usually best not to directly confront the client about his desire to continue drinking. Rather, use a motivational interviewing style. Revisit the decisional matrix to try to help the client remember what negative consequences of drinking led to his initial decision to seek help, and use motivational interviewing techniques to help the client explore his ambivalence about abstinence in an effort to enhance a commitment to be abstinent for the treatment duration.

Domestic Violence

Domestic violence is highly prevalent in households where one or both partners in a relationship drink heavily. If domestic violence is present, immediately assess the current severity or frequency and make a referral for treatment if necessary. Consultation with a peer or supervisor also is advisable. You should also do the following:

- Determine if there are weapons in the home. Make a plan to get them out of the home or render them unusable.
- Identify interactional sequences leading up to violent episodes. Problem solve with the client to modify his role in the sequences. Work on relevant communication skills.
- Emphasize that it is the responsibility of the person who has the impulse to be violent to refrain from violent behavior, but it is the responsibility of the abused partner to keep himself safe by not provoking the abuser and by creating an individualized safety plan.
- Discuss legal options such as a restraining order.
- Identify a safe place for the abused partner to go.

- Give the abused partner phone numbers for shelters and hotlines.
- Help the abused partner to plan how to save money and if necessary, prepare for a quick departure by having a packed bag ready.
- Identify barriers to leaving the home and problem solve.

Child Abuse or Neglect

If a client makes reference to child abuse or neglect, or if your client drinks heavily and/or drives during the time he is responsible for caring for young children, you need to assess the situation further. Ask specific questions of the client that will provide a clearer view of the nature of the abuse or neglect. Examples of possible questions are, *"When you hit your child, do you use your hand or an object?"; "Do you leave marks when you hit your child?"; "For how long a time do you leave your child unsupervised?" "Based on what you said about your drinking pattern, you are sometimes intoxicated throughout the day—who is watching the baby during this time?"*

Therapists are legally bound to report cases of suspected child abuse or neglect, and the informed consent for treatment should indicate this limitation on confidentiality. If the situation is unclear bring it up immediately with a peer consultant or supervisor to get feedback on the next steps to take. Typically, our procedure is to discuss the situation with the client to inform him that we are legally obligated to report the incident to the state's child protective services (CPS) unit and that the first steps CPS will take will be to investigate the need for further action on their part. We inform the clients that our goal is to work with them to ensure that their children are safe. Be sure that you have contact information for your state's CPS.

Arrival to Treatment With Elevated BAL

At the beginning of each session, the client is given a Breathalyzer to determine the presence of alcohol in his system. Do not proceed if the

blood alcohol level (BAL) is .05 or greater. There may be instances when the client has a positive alcohol screen but adamantly denies being under the influence. No matter what he says, nothing but alcohol will result in an actual BAL of .01 or more, although smoking a cigarette or using mouthwash within 15 min of the breath test can result in a spurious reading. However, if the BAL still is positive after 15 min then you can rule out these proximal causes.

In any case where you have to terminate the session early because of an elevated BAL, you must determine an immediate plan to assure the safety of the client, determine whether the pattern of drinking prior to the session warrants a higher level of care, and develop a short-term plan. If it seems appropriate for the client to continue in outpatient treatment, schedule another session as soon as is feasible.

Do not engage the client in confrontational interchanges around the use of alcohol or not. Simply inform him that there is alcohol in his system currently above the .05 level, that your policy is to reschedule the session, and that you do not make any exceptions to this policy. If the BAL is a bit over .05, it is worth waiting 15–20 min to retake a Breathalyzer reading to see if the BAL is on the descending limb (i.e., going down). If it decreases to below .05, you can hold the session.

If the client's BAL is above the legal driving limit (.08), the client will need to make arrangements to get home safely without operating a vehicle. The client can wait in your office until his BAL is below the legal driving limit, *if* his BAL is on the descending limb and is close enough to the limit. If the intoxicated client refuses to wait or call for alternative transportation, our general policy is to inform the client that we must call the police to inform them that an intoxicated person is leaving the building and is planning to drive. Check with a local attorney to determine best practices in your own state. If an underage client has an elevated BAL, he should not be allowed to drive home, as any BAL is considered over the legal limit for underage drinkers, and parents should be called to inform them of the situation and to help arrange a ride home for the client.

If the client's BAL is high enough to potentially be dangerous (.40 and above, roughly) there are additional considerations. At these levels, alcohol poisoning can occur, and the client needs medical attention. The

client can arrange for a taxi to the nearest emergency room and arrange to have a friend or his partner come pick up his car, or the client can take a taxi back to the therapist's office to get the car later.

In some cases, if the client agrees to go directly to a detoxification or inpatient rehabilitation unit, you can help the client contact his insurance company to determine which facilities are in the client's network and to get pre-authorization for admission. Then, arrangements will need to be made to transport the client to the treatment facility. Some treatment facilities provide pick-up services.

Difficulties in Developing a Therapeutic Alliance

In treatment, there are times when the therapist has difficulty connecting with a specific client. Additionally, there are times when clients will have a negative, hostile attitude toward their therapist. When this occurs, attrition is common. In other instances, the client will remain in treatment but express his negative and hostile attitude. When faced with this attitude, it is common for therapists to feel frustrated, angry, and unsure of themselves. If you run into this problem, it is important that you do not react with anger or act defensively. Instead, adopt the motivational interviewing style of "rolling with the resistance," listening reflectively, and responding empathically (see Miller & Rollnick, 2002). Genuinely attempt to understand the client's negativity and what "kernel of truth" the client is responding to (*do you* have a negative attitude toward the client?). Openly addressing problems in the therapeutic relationship often will be enough to resolve it satisfactorily. However, if there are continued strains in the therapy alliance, bring this up with a peer consultant or supervisor for feedback and suggestions, and consider referral to another therapist.

Homework

Compliance with homework requirements is a marker of motivation, good rapport with the therapist, effort to practice skills learned in session, and treatment retention as well as positive treatment outcome.

Homework is an important and unique aspect of CBT and is especially important in helping drinkers practice and consolidate skills discussed in session to make successful changes.

Highlight the importance of homework explicitly by reviewing the rationale for it. You may say something like the following:

> *I only have you for 1 h per week—the rest of your life has you for the other 167! For us to make progress, it's important that you take what we discuss in here and apply it during the week. Changing a habit is hard work, and that's where the homework comes in. If you hang in there and keep trying, eventually it will work and it will also become easier.*

Highlight the importance of homework implicitly by always remembering to review assigned and completed homework carefully and in a clinically meaningful way so that clients feel reinforced for completing their homework and also so that they understand how it can be meaningful for them.

Homework Noncompliance

Address the issue of homework noncompletion directly by commenting that you notice that the client doesn't seem to like doing at-home assignments and you're wondering what's behind that. Use reflective listening and a motivational interviewing style to try to understand and help the client understand his ambivalence about doing homework.

Be aware that not completing homework may be indicative of a deeper ambivalence toward therapy or stopping drinking. Begin to explore this from a position of concern for the client's anxiety about giving up drinking, of desiring to understand his experience of the therapy, and of acknowledging that changes often are unsettling to an intimate relationship. Not addressing homework noncompliance can result in therapy attrition.

Some people have personalities, comorbid conditions such as attention deficit disorder or depression, or hectic life contexts that make it difficult to complete homework. For instance, impulsive, nonverbal,

action-oriented people often find it difficult to focus and complete CBT homework. These people can be told that one of the points of CBT and also CBT homework is in fact to help the client "slow down the process of automatic behavior, or habits" so that they become easier to identify and control. Thus, though especially difficult for them, these clients need to make the extra effort to try to complete the homework as best as they can to get the most out of therapy.

Some people say, "When I do the homework it just reminds me of drinking and is a trigger for me. It's easier for me to stay sober if I just don't think about it." For these people, it's important to tell them that if simply thinking about homework is a trigger for them it may indicate that they need to work even harder on their abstinence coping skills. Suggest to the client that he might want to try to do the homework and get through the associated cravings to further consolidate his abstinence and to acquire new skills the client may want to use one day.

Presence of an Axis I Disorder

Many clients with AUDs show signs of an Axis I disorder (mood, anxiety, eating disorders, etc.; see Epstein, Green, & Drapkin, in press). It is important to be familiar with the *DSM-IV* criteria for Axis I clinical syndromes so that you can assess the severity of the problem and refer for additional treatment, if necessary. During the assessment (see Chapter 3), the therapist should use some structured means to assess for Axis I disorders.

In assessing the severity of the Axis I disorder, include the following:

Assess suicidality. If a client is suicidal, discuss your concerns and options with the client. When assessing suicidality, you should assess thoughts, means, plans, and history of attempts. If the client presents as a suicide risk, you may have to ensure that he is evaluated at a psychiatric emergency service. Or, you may call the police to have them come to help you to transport the client to a local emergency room. Keep in mind that most suicides are attempted and committed during periods of intoxication, so you should be extra cautious in evaluating

the safety of an addictions patient who is exhibiting indications of suicidality.

Explain to the client that many symptoms of depression and anxiety will diminish once he achieves and maintains sobriety for several weeks. Monitor the level of depression and anxiety over the course of treatment. In the first month of abstinence, it is common for clients to experience increased levels of anxious and depressed feelings. If these persist for longer than 2 weeks post-abstinence, concerns and questions should be brought to clinical supervision. When indicated, the therapist should make appropriate clinical referrals. These might include referrals to mental heath counseling and/or a psychiatric assessment for medication.

Presence of an Axis II Disorder

Many of our clients meet criteria for an Axis II disorder. In populations with substance use disorders, antisocial personality and borderline personality disorders are the most prevalent Axis II diagnoses; however, a broad range of personality disorders is common. Most often, individuals with Axis II disorders do not perceive the need for their behavior to change and are not receptive to referrals for psychiatric treatment. Clear structure and consistent adherence to boundaries are important for the therapist when working with individuals with Axis II disorders. Therapists should use peer consultation or supervision as a way to get feedback on using various interventions as well as to discuss their own reactions to working with individuals with Axis II disorders.

Need for Additional Services or Higher Level of Care

Reasons for additional or more intensive treatment might be continued heavy drinking, lack of progress toward an abstinence goal, increased drinking or other drug use, depression, or simply a desire to attend additional treatment and get more support for abstinence. Consult with your colleagues if necessary, and maintain a list of referrals for treatments at higher levels of care.

Differences Between Female and Male Drinkers

A fairly substantial literature on women and alcohol suggests that women with alcohol use disorders (AUDs) differ from men on a variety of individual and relational dimensions. Women with AUDs differ from men in their drinking patterns, reasons for use, psychological and medical sequelae, and comorbid disorders. Women are more likely than men to drink alone (Braiker, 1984). Reasons for alcohol use often are related to relationship or affective issues (Mays, Beckman, Oranchak, & Harper, 1994). For example, married women with drinking problems report that they drink to continue to function in the relationship, to be more assertive, and to deal with sexual "demands" from their partners (Lammers, Schippers, & van der Staak, 1995). Women also report that their relationships contribute to their drinking. Women also may be more likely to drink in response to negative moods than men. A study of reactivity in response to alcohol cues found greater cue reactivity to negative mood inductions for female than male subjects (Rubonis et al., 1994).

Psychological and medical correlates of alcohol abuse or dependence also differ for women and men (Epstein, Fischer-Elber, & Al Otaiba, 2007). High rates of histories of sexual abuse (between 55% and 60%) and post-traumatic stress disorder (PTSD) (44–56% lifetime; 15–40% current) have been reported in both probability samples and clinical samples of women with alcohol abuse or dependence (e.g., Dansky, Saladin, Brady, Kilpatrick, & Resnick, 1995). Women with AUDs show lower levels of self-esteem than women or men who are not alcohol dependent (Beckman, 1978) and generally show higher rates of medical and psychological problems (Schneider, Kviz, Isola, & Filstead, 1995). Women with AUDs have more medical problems (Smith & Weisner, 2000), a more rapid rate of development of alcohol-related morbidity and mortality, and greater cognitive and somatic deficits than males with alcohol problems (Diehl et al., 2007). Death rates are estimated to be 50–100% higher among women with AUDs than those of males with AUDs (Smith & Weisner, 2000).

Rates of comorbidity with other psychiatric disorders are high, particularly comorbidity with benzodiazepine abuse, agoraphobia, dysthymia

anorexia, or bulimia (Wilcox & Yates, 1993), with as many as half the women with AUDs fitting criteria for another psychiatric disorder (Helzer & Pryzbeck, 1988). In treatment samples, as many as 65% of women with AUDs meet lifetime criteria for another psychiatric disorder (Mann, Hintz, & Jung, 2004). Depression and anxiety disorders are particularly common, with comorbidity rates of approximately 49% versus 24% in men (Grant & Harford, 1995; Hesselbrock, Meyer, & Keener, 1985; Regier et al., 1990). It is unclear to what degree symptoms are primary or secondary to the AUD (Epstein, Green, & Drapkin, in press).

The intimate relationships of women with AUDs also show certain notable features. Studies suggest that about 50% of partners of women with AUDs also have drug abuse/dependence and that many of these women report poor or conflicted marriages (reports range from 34% to 80%), and sexual problems (reviewed in McCrady, 1988). High rates of domestic violence also characterize many of these relationships. After treatment, women are more likely to relapse with either a romantic partner (Connors, Maisto, & Zywiak, 1998) or a friend; men are more likely to relapse when alone (Rubin, Stout, & Longabaugh, 1996).

Just as women's reasons for using alcohol differ from men's, women cite different reasons for stopping drinking and seeking help for their drinking. In population samples, women cite dislike of alcohol, reductions in social activities, alcohol making them sick, and familial alcoholism as reasons to stop (Dawson, 1994). Women enter treatment because of familial and interpersonal problems, criticisms from others about their drinking, marital instability, and physical or emotional problems (Duckert, 1987). However, notable barriers make it difficult for some women to receive treatment, including lack of childcare, the perceived stigma associated with female drunkenness, opposition from family/friends (particularly men), or negative attitudes from physicians (Mays et al., 1994).

Treatment Effectiveness and Outcome for Women

Despite several reviews encouraging research on treatment for women (e.g., Vannicelli, 1984), there continues to be a paucity of research to identify effective treatments for women with AUDs. In a review

of treatment studies published between 1980 and 1989 (McCrady & Raytek, 1993), only 10.3% used female-only samples, and 17.9% reported analyses of outcomes by gender. Most studies that included males and females had insufficient females in the sample to analyze outcomes separately by gender. The limited number of studies on women in treatment suggest that there is some evidence for superior outcomes for women compared to men (e.g., Alford, 1980; Alford, Koehler, & Leonard, 1991; Filstead, 1990), but assessment of outcomes often is contaminated by lack of gender-differentiated definitions of successful outcomes in terms of drinking quantities. However, even in studies that use gender-linked definitions of heavy drinking, women have tended to be more successful than males in reducing heavy drinking and overall post-treatment alcohol-related problems when provided with brief behavioral treatment for heavy drinking (Sanchez-Craig, Leigh, Spivak, & Lei, 1989). Two studies have examined the value of providing specialized, gender-segregated treatment programs for women. Although one randomized clinical trial found better outcomes for the women in the gender-segregated treatment (Dahlgren & Willander, 1989), a later nonrandomized study did not find similar results (Copeland, Hall, Didcott, & Biggs, 1993).

Data on predictors of outcome also portray a complex, gender-differentiated picture. Psychological problems are strongly related to relapse in women but not men (Schneider et al., 1995). Women but not men with comorbid depression have better outcomes of treatment (Rounsaville, Dolinsky, Babor, & Meyer, 1987). Diagnoses of antisocial personality disorder or other drug abuse predict poorer outcomes for both men and women (Rounsaville et al., 1987). For men, being married predicts a better outcome (Schneider et al., 1995). Data about the relationship of marital status to outcomes in women are mixed, with some studies suggesting that being married predicts a better outcome for women (Smith & Cloninger, 1984), while others report that being married contributes to relapse risk for women (Schneider et al., 1995), or that being *un*married predicts better outcome for women (Cronkite & Moos, 1984). Marital problems prior to treatment and a dysfunctional relationship with an important person predict poor outcome (MacDonald, 1987). Since most treatments to date were developed using exclusively male samples or not paying particular attention

to gender differences, next are suggestions for applying aspects of this manual that based on the scientific literature are more likely to come up for women than men with AUDs. However, keep in mind that all interventions and themes should be used as necessary—for both female and male patients.

Overview of Specific Gender Issues in Delivery of This Treatment

Application to treatment of general knowledge about women and AUDs can be accomplished through several ways.

Core Thematic Women's Issues

Women-specific treatment may address two core therapeutic issues related to women's lives: the woman as an active agent in her own life, and the woman's right to self-care versus other-care. These themes are to be integrated into the treatment structure and content throughout the 12 sessions, through specific examples, discussion, and illustrative material guided by these themes.

1. **The woman as an active agent in her own life**.
   One goal of the women-specific therapy is to create and/or enhance a sense of autonomy and self-confidence for each woman. The therapist should work with the client to begin or continue to view herself as a competent person capable of managing her life and creating meaning and happiness for herself.

2. **The woman's right to self-care versus other-care**.
   A second goal of the women-specific therapy is to strengthen the woman client's belief that she is a lovable person worthy of the respect and love of others, as well as worthy of her own self-respect and self-care. She should learn that she deserves the same level of attention to herself that she gives to others. The importance and quality of relationships in her life should be balanced with her ability to take her own needs into account. Likewise, responsibilities in a woman's life should be balanced with self-care and enjoyable activities.

Psychoeducation

Psychoeducational material can be covered to educate the patient about the ways in which women uniquely use, process, and suffer from heavy use of alcohol.

High-Risk Situations

The treatment addresses high-risk situations generated by seven areas of concern often raised for individuals with AUDs, but typically with difference in the content based on gender (see Epstein, Fischer-Elber, & Al Otaiba, 2007).

1. **Managing presence of heavy drinkers in the social network**
   For women, heavy drinkers often are intimate partners, close family, close friends, or partner's friends (Manuel, McCrady, Epstein, Cook, & Tonigan, 2007). For men, heavy drinkers might also include business associates as well as acquaintances. For men and women, discussions of heavy drinkers in the social network of necessity also focus on the unique challenges of handling these different types of relationships.

2. **Coping with anxiety**

   a. How to recognize anxiety problems
   b. How to recognize anxious thinking
      This topic is useful for women in terms of multiple role stress, PTSD, or low self-esteem. For both genders, the topic is useful in terms of the need for perfection (e.g., obsessive-compulsive traits and generalized anxiety disorder), insecurity, and uncertainty.

3. **Coping with depression**

   a. How to recognize clinical depression
      Though rates of comorbid depression are typically higher among alcohol-dependent women, alcohol-dependent men

also have elevated rates relative to the general population and also may benefit from this aspect of the manual.

b. How to recognize depressive thinking

4. **Coping with stress and strong emotions**
5. **Improving social network support for abstinence and life**
6. **Anger management**
7. **Assertiveness**

Other high-risk situations and drinking antecedents particularly relevant for women with AUDs can be highlighted by using situations relevant to each client in the various skills training interventions. These may include use of alcohol in response to sexual dysfunction as a trigger, parenting issues, "sandwich generation" issues (i.e., caretaking of elderly parents), menopause, multiple role stress, and physiological triggers such as premenstrual dysphoria and craving (Epstein et al., 2006). For men, typical high-risk situations might involve worries about financial issues, work-related events, social events, and sports.

Chapter 3 *Assessing Alcohol Use and Problems*

Materials Needed

- Breathalyzer or other alcohol breath test
- Onsite urine or saliva screens for drugs
- Clinical Intake Semi-Structured Interview Form
- Semi-Structured Clinical Interview for *DSM-IV* Axis I Diagnoses (SCID-I) Alcohol and Drug Sections
- Form-90 manual
- Timeline Followback Interview
- Personal Drinking Goal form
- Short Inventory of Problems (SIP) or Drinkers Inventory of Consequences (DrInC)
- Beck Depression Inventory (BDI)
- Beck Anxiety Inventory (BAI)

Outline

- Conduct a semi-structured clinical intake interview with the client
- Have the client complete self-report questionnaires
- Interpret assessment data to establish diagnosis, severity of problem, and level of care determination
- Provide feedback to the client regarding recommendations for treatment

Overview of Assessment

This chapter provides an assessment protocol for use with clients, including both semi-structured clinical interviews and self-report measures.

The assessment data will yield screening, diagnostic, and severity information for the alcohol use, as well as the history and consequences of the alcohol use, quantity/frequency and drinking pattern, typical and peak levels of blood alcohol level (BAL), level of care determination, level of motivation to change drinking behavior, and associated psychiatric problems.

The chapter first briefly reviews areas of assessment that are important, and then guides you through administration of the battery, as well as interpretation of results.

The assessment has four purposes: The data are used (1) as an overall evaluation of problems to determine appropriate level of care and services needed; (2) to help with abstinence planning; (3) as a basis for treatment interventions such as motivational enhancement and functional analysis, and (4) to generate feedback to enhance motivation. Feedback collected regarding the assessment data is given to the client in Session 1. Session 1 of this therapist manual provides information necessary to calculate BAL and interpret quantity of alcohol use vis-à-vis normative data and to allow for interpretation of the assessment data. In the CBT model, continued assessment and a feedback loop throughout treatment are important aspects of the treatment. These are accomplished through daily drinking logs completed by clients throughout the program that are reviewed each week at the beginning of the session. These monitoring forms are presented in Session 1. Assessment to complete a functional analysis of the client's drinking occurs as part of the treatment itself and is accomplished in the first two to three sessions.

Assessment Plan

Assessment typically requires one to three sessions, depending on the severity of the alcohol problem and complications such as comorbid

psychopathology and/or drug use. If possible, allot 90–120 min for the first assessment session so that much of the assessment can be done in this one extended session.

In this treatment model, assessment is considered part of the therapy protocol; it is important to keep in mind that this may be the first time the drinker is speaking candidly, or speaking at all about the alcohol use. The assessment sessions are thus often quite difficult and emotional for the client, and it is important for you to establish rapport and to communicate accurate empathy with the client's perspective, while moving the interview forward and gathering all necessary information. Table 3.1 lists topics to cover in the initial clinical interview. Each aspect of the table will then be described (see Epstein & McCrady, 2002, and McCrady, 2008 for more detail).

Table 3.1 Topics to Cover in Initial Assessment

1. Initial Orientation
   a. Introductions
   b. Breath alcohol test, drug screen
   c. Brief questionnaires
2. Initial Assessment
   a. Presenting problems
   b. Role of alcohol in presenting problems
   c. Other concerns
3. Drinking or Drug-Use Assessment
   a. Last alcohol consumption
   b. Length of drinking or drug-use problem
   c. Quantity, frequency, pattern of drinking
   d. Negative consequences of drinking or drug-use problem
   e. *DSM-IV-TR* symptoms
   f. Assessment of need for detoxification
4. Assessment of Other Problems
   a. Psychotic symptoms
   b. Depression
   c. Anxiety
   d. Cognitive impairment
   e. Health status
   f. Medications
   g. Other drug use
5. Assessment of Domestic Violence

Establishing Rapport

You should spend a few minutes establishing general rapport to help the client feel comfortable through small talk. Then describe what will happen in the intake by saying something like the following:

> *In the initial 1–3 sessions, I'll be asking you lots of questions, and you'll fill out some questionnaires. I'll give you feedback about whether or not I think this treatment is the best choice for you at this time. Please ask me as many questions as you want.*

Breath Alcohol Test

During the intake, and at the beginning of all subsequent sessions, you will test the client's BAL using a Breathalyzer. You can purchase a hand-held Breathalyzer from any of several companies online, such as Alcopro.com. There are other methods to test BAL on site, such as saliva sticks and other types of single-wrapped devices for saliva, urine, and breath testing.

Introduce the breath test as follows:

> *My policy is to use a Breathalyzer to check for alcohol in your system. It is important to have a clear head during our meetings together. This means you should not drink alcohol or use any drugs on the day of a scheduled therapy appointment. We will start each session by using this machine to measure your blood alcohol level. It is easy to use. I will hold it up to your mouth and you simply take a deep breath and blow through the tube for a few seconds until I tell you to stop.*

If deemed helpful, you may demonstrate how the Breathalyzer is used.

If the client has a positive BAL, ask about her drinking that day, and explain the relationship between amount of drinking and BAL. If BAL is above .05, further assess the client's drinking pattern and consider a detoxification program; if this does not seem indicated, you should reschedule the interview (see clinical issues in chapter 2).

Brief Questionnaires

The client should be given a set of questionnaires to complete. It is most efficient to have clients do this before the beginning of the assessment session, either by asking them to come 30 minutes early to the session and completing the forms in the waiting room or by sending the paperwork to clients at home to complete beforehand.

The client should complete a general demographics survey including name, address, age, date of birth, employment status, occupation, children's names and ages, ethnicity, religion, marital status, and years married or in a committed relationship.

Recommended instruments include the following:

- *Personal Drinking Goal form*. This one-item questionnaire assesses the client's motivation for changing her drinking patterns. The client rates her drinking goal on a 6-point scale ranging from "no change" to "lifelong abstinence" (adapted from Hall, Havassy, & Wasserman, 1991) on the form in this chapter. If you need additional copies of this form, you may photocopy it from the book.
- *The Beck Depression Inventory (BDI)* is a 21-item self-report instrument used to assess depression (Beck, Steer, & Garbin, 1988). BDI scores of 14–19 indicate mild depression, 20–28 indicates moderate depression, and 29–63 is suggestive of severe depression.
- *The Beck Anxiety Inventory (BAI)* is 21-item self-report instrument that measures symptoms of anxiety using a 4-point Likert-type scale (Beck, Epstein, Brown, & Steer, 1988). BAI score thresholds are: 0–7 indicates "mild anxiety"; 16–25 "moderate"; and 26–63 "severe."

Personal Drinking Goal

Please read the goals listed below and choose the one that best represents your thoughts about drinking at this time by circling the number that corresponds to your goal.

1. I have decided not to change my pattern of drinking.
2. I have decided to cut down on my drinking and drink in a more controlled manner—to be in control of how often I drink and how much I drink. I would like to limit myself to no more than ___ drinks per _____ (days or weeks or months).
3. I have decided to stop drinking completely for a period of time, after which I will make a new decision about whether I will drink again. For me, the period of time I want to stop drinking is _____ (days, weeks, months, years).
4. I have decided to stop drinking regularly, but would like to have an occasional drink when I really have the urge.
5. I have decided to quit drinking once and for all, even though I realize I may slip up and drink once in a while.
6. I have decided to quit drinking once and for all, to be totally abstinent, and never drink alcohol ever again for the rest of my life.
7. None of this applies exactly to me. My own goal is:

_____

Use the following worksheet to gather information on the client's problems (alcohol-related or otherwise). Since you will likely use this form with more than one client, you may photocopy it from the book as needed.

1. *I'd like to get an idea of the sort of problems that have been troubling you. Can you tell me about them*? (If not clear): *How has the use of alcohol contributed to these problems*?

2. *What have been the main difficulties that led you to seek help*?

3. *Are there any additional problems that concern you*?

Last use, length of problem, and quantity and frequency of alcohol use can be assessed through questions and instruments administered by the clinician. For instance, you can start off by asking the client the following:

- *When did you last have a drink of alcohol?* (month, day, time of day)
- *What and how much did you drink at that time?*
- *When and what did you drink the time before that (and the time before that, etc.)?*
- *When did you have your first alcoholic drink when not under the supervision of your parents?*
- *When was the first time you became intoxicated?*
- *How many years has drinking been a problem for you?*

Then, you can move on to asking the client about the quantity and frequency of alcohol consumed over the past month or so. You may ask the following questions:

- *Over the past month or so, how many days per week have you had any alcohol to drink?*
- *What do you like to drink?*
- *Approximately how much do you usually drink?*
- *How long have you been drinking in this pattern?* (Get typical pattern of quantity/frequency in standard drinks—briefly)

Therapist Note

- *If client has not had a drink in the past month or has been trying to cut down and therefore drinking at a lower level than usual, ask about the pattern of the last month and then ask again for the most recent pattern of problematic drinking. You may use the following questions:*

- *How many months/years did you drink in this general pattern?*

- *And what was your drinking pattern before that and how long did it last?*

This line of questioning will allow you to ascertain general patterns of drinking for recent and past history. Please note that questions regarding alcohol *must be extremely detailed*, in that you need to assess what *specific type* of alcoholic beverage the client drank (e.g., domestic beer, ice beer, foreign beer, or light beer), *what proof* the beverage was, *how many ounces, the time the client began and stopped drinking for typical drinking occasions*, and *how much the client weighed at the time.* This is the information you need in order to calculate number of standard drinks consumed, as well as approximate BAL. See Chapter 4 of this guide for a chart of standard drink conversion and a chart to calculate BAL. *All alcohol consumption assessed is translated into standard drinks.*

To get even more detailed information about a client's typical drinking pattern, use the Steady Pattern Grid in the Form-90 manual (Miller, 1996) to ascertain the pattern for a typical week. A copy of the Steady Pattern Grid is provided here. If you need additional copies, you may photocopy the form from the book. For an assessment of a longer period of time, for instance, over the 3 months prior to treatment entry, use the *Timeline Followback Interview (TLFB)* (Sobell & Sobell, 1996), which is a calendar method to obtain daily drinking data. In the Form-90 manual (Miller, 1996), there are instructions for using the pattern grid in conjunction with the Timeline Followback Interview.

Steady Pattern Grid From the Form-90

Please describe for me a usual or typical (heavy) week of drinking. In a typical week, let's start with weekdays—Monday through Friday—what did you normally drink in the morning, from the time you got up until lunchtime? (Do not include what was drank with lunch) (Record on Steady Pattern Chart)

Now how about weekday afternoons, including what you drank with lunch, up through the afternoon until (right before) dinner time—what did you normally drink on weekday afternoons, Monday through Friday? (Record on chart)

And how about weekday evenings? What did you normally drink with dinner, up through the rest of the evening until the time you went to sleep? (Record on chart)

Repeat these same instructions for weekend days, and record on the chart.

Remember: Obtain specific, detailed information on ounces consumed, proof of the alcohol, time began/time ended, and type of alcohol.

Steady Pattern Chart

Day	Morning	Afternoon	Evening	Total standard drinks
MON	0	0	10 ounces red wine 5–6 p.m.	2
TUE	0	2 light beers 12 ounces both 1–2 p.m.	16 ounces red wine 6–8 p.m.	4.5
WED	0	0	8 ounces red wine 6–7 p.m.	1.5
THU	0	0	8 ounces red wine 3 ounces vodka 6–11 p.m.	3.5
FRI	0	Happy Hour 2 mixed drinks 3 ounces rum 4–5 p.m.	12 ounces light beer 4.5 ounce vodka 8–11 p.m.	5.75
SAT	0	0	5 regular shots vodka 9 p.m.–12 a.m.	5
SUN	Mimosa 5 ounces champagne 11 a.m.–12 p.m.	5 light beers, 12 ounces each 2–5 p.m.	0	4.75
Total Weekly Standard Drinks				27.00

Steady Pattern Chart

Day	Morning	Afternoon	Evening	Total standard drinks
MON				_____
TUE				_____
WED				_____
THU				_____
FRI				_____
SAT				_____
SUN				_____

The *Structured Clinical Interview for DSM-IV (SCID), Alcohol Disorders Module* (First, Spitzer, Gibbon, & Williams, 2002), yields lifetime and current alcohol abuse/dependence diagnoses. *DSM-IV-TR* criteria for Alcohol Abuse and Alcohol Dependence are listed in Chapter 1 of this guide.

Negative consequences of use can be assessed via paper and pencil questionnaires such as the *Short Inventory of Problems (SIP)* or the *Drinker's Inventory of Consequences (DrInC)*, both of which are public domain and can be accessed via this Web site: http://casaa.unm.edu/inst.htm. The SIP is a 15-item condensed version of the Drinker Inventory of Consequences (DrInC), which has 50 items. Three items that are intended to assess lifetime problems with alcohol were taken from each of the DrInC subscales to comprise the SIP, including Physical, Intrapersonal, Social Responsibility, Interpersonal, and Impulse Control. The internal consistency and reliability for the SIP are high ($\alpha = .81$, $r = .94$; Miller, Tonigan, & Longabaugh, 1995).

To assess for need for detoxification and level of care determination, after the withdrawal question in the SCID-I, take into account the last time the client had an alcoholic drink (queried above) and ask: "*Are you currently feeling any of these withdrawal symptoms that I just listed? If so, which ones*?"

Determination of need for detoxification is complex and based on multiple criteria. Some useful guidelines: (1) daily drinkers are more likely to need detoxification than episodic drinkers; (2) morning drinking (or drug use) or morning withdrawal symptoms suggest need for detoxification; (3) persons who drink on and off throughout the day are more likely to need detoxification than those who drink only in the evening; (4) high-volume drinkers, who achieve a BAL above 200–250 mg, are likely to need detoxification; (5) persons with a history of withdrawal symptoms who are drinking regularly are likely to need detoxification; (6) persons with a history of withdrawal seizures or major withdrawal syndrome (disorientation, hallucinations) **must** get a medically supervised detoxification; (7) regular drinkers who have other medical problems (e.g., history of stroke, high-blood pressure, and liver disease) should have a medically supervised detoxification. If the clinician concludes that the client will need to be detoxified, this must be addressed at the conclusion of the interview. See Session 1 (Chapter 4)

for an overview of abstinence plans, including consideration of level of care.

Assessment of Other Problems

Psychotic symptoms can be briefly assessed with the *SCID Psychotic Screen*. Should a screen be positive, the psychotic section from the SCID-I (First et al., 2002) can be administered. Depression and anxiety can be assessed using the BDI and BAI (see previous sections) or the SCID-I (First et al., 2002). Personality disorders can be assessed by the SCID II (First, Gibbon, Spitzer, & Williams, 1997). Cognitive impairment, if suspected, can be assessed briefly using the *Mini-Mental State Exam (MMSE)* (Folstein, Folstein, & McHugh, 1975). Health status and medications can be queried about in an open-ended way.

Use of illicit drugs can be assessed in brief using sections from the Brief or Comprehensive Drinker's Profile (Miller & Marlatt, 1984). Then, if the client has used drugs in the past year, the SCID drug section can be used to get more detailed information and diagnostic criteria for each class of drug used.

Determining Level of Care

Level of care determination depends on several variables, including need for medically supervised detoxification (see previous information) based on severity of recent alcohol problem, medical history, and history of withdrawal symptoms, psychiatric problems, past treatment experiences, support network, insurance considerations, and client preference (see Kadden & Skerker, 1999). In general, the treatment model in this guide is appropriate (1) as an aftercare program for clients who need a medically supervised detoxification initially to safely eliminate alcohol from their system, or (2) for clients who do not need or refuse a detoxification program but meet criteria for alcohol abuse or dependence *or* who are considered to be heavy drinkers because they drink more than 14 (for women) and 21 (for men) standard drinks per week (U.S. Department of Health and Human Services, National Institute of

Health, 2003), or (3) for clients who do not need inpatient or intensive outpatient treatment. In all three cases, clients should not have uncontrolled current psychiatric symptoms such as psychosis, mania, or suicidal ideation with intent or plan and should not have recent history of non–alcohol-related domestic violence. Use the results of the assessment to determine the appropriate initial level of care for the client. Options for initial abstinence plans (including levels of care) are described in Session 1.

Giving Recommendations to the Client

After the initial sessions and at the end of the assessment, be sure to give the client some feedback. After the initial session, feedback could be phrased as follows:

> *You clearly have concerns about your drinking, and I think these concerns are appropriate. I think you've made a good decision to look for some help. And, I'm confident that you'd benefit from the program. What are your thoughts at this point about getting involved with our program?*

Need for Detoxification

If you determined that the drinker needs detoxification, give feedback about the need for detoxification, tailoring the specific content to the drinker's situation. A general suggested approach is as follows:

> *A little earlier, I asked you a number of questions about your drinking pattern. From what you told me, it seems likely that you are physically dependent on alcohol and that you may need the help of a physician to stop drinking. This is called detoxification. It would be best for you to get some help to stop drinking before the treatment starts. There are two basic approaches to detoxification—inpatient or outpatient. In either case, you would receive medication for a few days to make it easier for you to get off the alcohol. You can do this either through a detoxification facility or as an outpatient.*

You should recommend inpatient detoxification as the only option if the client has a history of withdrawal seizures, major withdrawal syndrome, or has significant medical problems.

You and the client should then discuss options (see Session 1) and develop a specific plan. Chapter 1 discusses abstinence versus moderate drinking goals for this treatment approach and gives suggestions for how you can present the advantages of abstinence.

Summary

Assessment is considered a pivotal and integral part of CBT for alcohol-use problems. This chapter has provided an assessment plan that includes suggestions of areas to evaluate that are relevant to the treatment of alcohol misuse, as well as specific questions to ask in a clinical interview, and recommendations for self-report measures. Suggestions for providing feedback to the client are provided here, and more detailed feedback using the assessment data is outlined in Session 1 of this manual. This assessment should allow you to get a detailed alcohol and drug history and a clear picture of current use and negative consequences of that use. The information obtained will allow you to determine level of care and services needed, as well as to develop an abstinence plan. We find that clients often find the assessment phase of the treatment to be a valuable and therapeutic way to begin to examine their maladaptive drinking habits.

Chapter 4 *Session 1: Introduction / Rationale / Self-Recording*

(Corresponds to chapter 1 of the workbook)

Materials Needed

- Copy of client workbook
- Breathalyzer and tube
- Treatment Contract
- Feedback Sheet
- Client self-recording cards
- Abstinence Plan worksheet
- High-Risk Situations worksheet
- Drinking Patterns Questionnaire (DPQ)

Outline

- Determine blood alcohol level (BAL) of the client
- Make opening statements and build rapport
- Provide treatment rationale
- Discuss treatment requirements
- Review data collected during intake assessment and complete Feedback Sheet
- Introduce the concept of self-recording

- Work with client to draft an abstinence plan (optional) *and/or* address possible problem areas (optional)
- Discuss ways to handle high-risk situations
- Assign homework

Therapist Note

■ *If the client is still drinking and needs an abstinence plan, leave more time in Session 1 for creating a plan.* ■

Before Session 1, review all data collected at the intake assessment. Extract specific information about the client's drinking patterns. Use the Short Inventory of Problems (SIP), Timeline Followback Interview, Form-90, and the intake interview.

Also make sure that the client has a copy of the workbook, and remind him to bring the workbook to all sessions.

Blood Alcohol Level Determination

If the client's BAL is greater than .05, review treatment agreement and reschedule the session (see Chapter 2 for instructions to administer the Breathalyzer test).

Introductions: Opening Statements, Building Rapport

Begin the session by providing an overview of the agenda and purpose of today's meeting. The focus of Session 1 is a discussion of the client's drinking patterns to enhance motivation, as well as the rationale for treatment and what the sessions will be like.

The rapport-building process should include asking the client about his experiences with the assessment phase, any ways that he was influenced by the assessment, problems he is concerned about, and his goals for treatment.

Therapist Note

- *You should check possible urgent issues such as:*
- *Domestic violence and child safety*
- *Mood or anxiety disorders*

If the client reports an urgent issue, be sure to address the issue to the level that appears to be clinically appropriate. Check guidelines for dealing with the specific urgent issue provided in Chapter 2. If you have a supervisor or consultant, discuss with him how to deal with the particular issue. ■

Treatment Rationale

When providing the treatment rationale, be sure to have an interactive discussion. Ask for the client's reactions and thoughts as you cover each point. The major points to discuss are (1) reasons for entering treatment and (2) goals of treatment.

You may use the following sample dialogue to present the rationale for treatment. The same dialogue also appears in the client workbook.

> *Together in this therapy, we are starting a journey. The most successful and ambitious journeys all start with a road map (a plan) and a destination (a goal). This therapy is part of the road map. The goal is sobriety. I will show you ways of quitting drinking and improving your life. We will work on identifying high-risk situations—those that may lead to drinking. Some of these situations will involve places, people, and things that you come across. Some of these situations will involve thoughts and emotions that are connected to your use. Some of these situations may come from your relationships. We will develop a plan and skills to get through these tough situations. This journey will require dedication. In each session, we will provide a new skill or technique for dealing with high-risk situations.*
>
> *The road will get bumpy at times. Sometimes things may be so rough that you will wonder if you've made a wrong turn. Many people who decide to quit drinking have a rough time in the beginning. Some people get discouraged by the tough times. Other people see these rough*

times as a chance to learn more about themselves. Whatever happens, we will look at these rough times as chances to learn more about what kinds of situations are risky and what it takes to get through them. When learning to ride a bicycle, most people will fall a few times. Most everyone gets back on the bicycle and eventually succeeds in learning to ride. You may go down the wrong path during our journey. If you do, recognizing this will be important so you can get back on the right road.

One very important part of this therapy is your commitment to working with me. Each week I will ask you to do things during the week. It is very important that you work hard at home. Work outside sessions is as important as work during sessions. Many individuals have succeeded with this program. The things taught in this program help people stop drinking and build better lifestyles.

Refer the client to the description of the plan for treatment in the workbook. A copy for your use is provided here.

The Plan

Over the course of this program you will:

1. Study your drinking habits. Figure out what leads to drinking and what keeps it going.
2. Change habits and things around you that lead to or encourage drinking.
3. Learn positive alternatives to drinking alcohol.

Your therapist will help you through these phases during the next 12 weeks. In the first three sessions, the focus will be on phase one. As part of phase one, you will look at what people, places, and things lead to drinking. You will also look at what happens because of drinking.

The following is a list of some important points about the treatment program you are about to begin.

- People with problems similar to yours have learned to stop drinking.
- Drinking is something you have learned to do. Habits can be changed. Right now, it does not matter how the drinking got started; it is important to figure out how to change.
- The goal is to be totally abstinent—to stop drinking altogether. Drinking should stop early on in the treatment. Sometimes people will have slips, but successful people learn from mistakes and get back with the program.
- Work in between sessions is as important as work during sessions. There will be things that you will be asked to do to learn and practice new skills. Practice is the only way to get this right. Often it is not possible to learn everything well during the session. If you do not complete the tasks required, your therapist reserves the right to reschedule your session in order to give you an opportunity to make up the work.

Continue the discussion of the treatment rationale:

> *Together we will help you to stop drinking (if you are not abstinent already) and help you to stay abstinent to the very best of your ability. This will be challenging for both of us, and I expect some difficulties. This is where I will give you the help you need. I will help you in understanding your drinking and give you alternatives to control your drinking better. You will get homework and it is* ***essential*** *that you practice these new skills between therapy sessions. It is very hard to break old habits unless you do this.* (Ask the client how he feels about this. Respond to issues such as denial, minimization, misconceptions about etiology, and lack of taking responsibility for behavior in a nonjudgmental way.)
>
> *If you have any questions or are having a hard time please let me know, that's what I am here for.*

Rationale for Female-Specific Alcohol Treatment Program

If conducting a female-specific program, explain that this treatment is particularly suited for women. Inform the patient that the more we know about alcohol, the more we know about the differences between male and female problem drinking. Give patient the "Unique Aspects of Women's Drinking" handout and briefly review it in session.

Try to generate some discussion about this information with the client and make the psychoeducational material meaningful by stimulating an interactive exchange. Ask the client for her reactions, opinions, or any personal experience with any of these topics.

Unique Aspects of Women's Drinking

Women process alcohol differently than men.

- For instance, women have less body water than men of similar weight, so the concentration of alcohol is higher in a woman's body than in a man's after drinking the same amounts of alcohol.
- Women also have less of the enzyme that breaks down alcohol in the stomach, resulting in a higher concentration of alcohol being transmitted directly into the system.

Also, women seem to be more at risk than men to suffer from several negative consequences of alcohol.

- Women experience a "telescoping effect" of alcohol—that is, women have a later onset of age of problem drinking than men, but develop a host of problems more quickly than do men. So, if a woman starts drinking heavily at age 35, versus 25 in a man, they may have similar amounts of alcohol-related damage to their internal organs by the time they reach the age of 40.
- Women are more vulnerable to liver, heart, and brain damage than are men. In terms of brain damage, alcohol has particularly adverse effects on women's attention skills and memory.
- Heavy alcohol consumption increases the risk for breast cancer.
- Women are also at an increased risk for violent victimization and alcohol-related traffic fatalities when drinking.
- Women in general, and particularly problem-drinking women, are more at risk to develop problems like depression and anxiety than are men.
- Women are also typically more concerned than men with issues related to relationships, self-esteem, and caretaking.
- Women differ from men in terms of triggers to drink, as well as in terms of where they drink, their emotions, and their relationships with others.
- Following treatment, women who relapse tend to relapse for different reasons than men.

Tell the client that he should attend all sessions and arrive on time, call if he has to reschedule, refrain from drinking before sessions, and complete all homework assignments. Emphasize that the client is responsible for cooperating with treatment and dealing with his drinking. Stress to the client that completing self-recording forms, questionnaires, and other homework assignments is critical for treatment success.

Have the client read and sign a brief treatment contract at this time. A copy of the treatment contract is provided on the following page, as well as in the workbook. You may make photocopies as necessary.

Treatment Contract

1. I understand that this treatment will include 12 sessions over 3 months, and I agree to participate for that length of time. If I want to withdraw from the program, I agree to discuss this decision with my therapist prior to taking this action.
2. I agree to attend all sessions and to be prompt. If it is absolutely necessary that I cancel a session, I will call at least 24 hours in advance to reschedule. I also agree to call in advance if I will be late to a session.
3. I understand that this treatment is intended for people who want to abstain from alcohol. I understand that I must work on remaining clean and sober.
4. I agree that it is essential for me to come to the session alcohol-free. I understand that I will be asked to leave any session to which I come with a blood alcohol level of over .05. I will be required to arrange safe transportation home.
5. I understand that I will be given a breath test for alcohol use each session.
6. I understand that I will be expected to practice some of the skills I discuss in treatment. I agree to bring in the workbook with the completed homework each week to discuss with my therapist.
7. I understand that I will be expected to attend all scheduled weekly session as research has shown that this type of treatment is effective only if clients attend scheduled appointments on a regular basis.

I have reviewed the above statements with my therapist and I agree to abide by them.

_____ _____

Client Date

_____ _____

Therapist Date

Explain to the client that you, as the therapist, also have several responsibilities. You will be at all scheduled sessions on time, will call if you have to reschedule, and will provide coverage when away.

Encourage the client to call you during the week if any problems arise and provide your contact information.

Feedback From Intake Assessment

Explain to the client that the feedback helps him to understand where he is beginning and then allows him to see how the drinking progresses during treatment. During the feedback session, be sure to occasionally ask the client if he has any questions.

Exercise—Feedback

Use the information garnered during the intake assessment to complete a Feedback Sheet for the client in session. We have included a blank sheet for your use at the end of this chapter. You may photocopy the sheet from the book and distribute to the client. We have also included a blank Feedback Sheet in the corresponding workbook. If you wish, you may provide the client with data and have him fill out the sheet on his own.

Review this form with the client. Briefly review how to calculate standard drinks, using the information provided, and how to calculate BAL and percentile using the Alcohol Information table (Table 4.1), the Blood Alcohol Level Estimation Charts (Table 4.2), and Percentile Table for Alcohol Use (Table 4.3).

Table 4.1 Alcohol Information

Beer	Standard drinks			
Ounces	Light	Regular	European	Ice
12	.75	1	1.25	1.5
16	1	1.33	1.66	–

Wine 5 ounces = 1 standard drink

Amount	Ounces	Standard Drinks
750 ml	25.6	5
1.5 L	51	10

Hard Liquor
1.5 ounces of 80 proof liquor = 1 standard drink

Liquor			Equivalent number of standard drinks		
Amount	Street Name	Ounces	80 proof	100 proof	190 proof
	"Shot"	1.5	1	1.25	2.38
200 ml	"Half pint"	6.8	4.5	5.67	10.77
375 ml	"Pint"	12.75	8.5	10.63	20.19
750 ml	"Fifth"	25.5	17	21.25	40.38
1.75 L	"Half Gallon"	59.5	40	49.58	94.21

A sample completed Feedback Sheet is shown in Figure 4.1.

Summarize and provide feedback for the client using the Feedback Sheet. This sheet addresses quantity of alcohol consumed and frequency of drinking, percentile of alcohol consumption, estimated peak BAL in a typical week, estimated average blood alcohol concentration (BAC) in a typical week, and severity of the alcohol use disorder (AUD) as determined by the SIP and SCID measures administered during intake assessment. Also describe to the client 3–6 negative consequences he reported during pretreatment assessment. This review will begin to set the stage for functional analysis, self-awareness, and change.

Table 4.2 Blood Alcohol Level Estimation Charts

Men

Approximate Blood Alcohol Percentage

Drinks	Body Weight in Pounds								Sample Behavioral Effects
	100	120	140	160	180	200	220	240	
0	.00	.00	.00	.00	.00	.00	.00	.00	Only completely safe limit
1	.04	.03	.03	.02	.02	.02	.02	.02	Impairment begins
2	.08	.06	.05	.05	.04	.04	.03	.03	Driving skills significantly affected; Information processing altered
3	.11	.09	.08	.07	.06	.06	.05	.05	
4	.15	.12	.11	.09	.08	.08	.07	.06	
5	.19	.16	.13	.12	.11	.09	.09	.08	
6	.23	.19	.16	.14	.13	.11	.10	.09	Legally intoxicated; Criminal penalties; Reaction time slowed; Loss of balance; Impaired movement; Slurred speech
7	.26	.22	.19	.16	.15	.13	.12	.11	
8	.30	.25	.21	.19	.17	.15	.14	.13	
9	.34	.28	.24	.21	.19	.17	.15	.14	
10	.38	.31	.27	.23	.21	.19	.17	.16	

One drink is 1.5 oz. shot of hard liquor, 12 oz. of beer, or 5 oz. of table wine.

Women

Approximate Blood Alcohol Percentage

Drinks	Body Weight in Pounds								Sample Behavioral Effects
	90	100	120	140	160	180	200	220	240	
0	.00	.00	.00	.00	.00	.00	.00	.00	.00	Only completely safe limit
1	.05	.05	.04	.03	.03	.03	.02	.02	.02	Impairment begins
2	.10	.09	.08	.07	.06	.05	.05	.04	.04	Driving skills significantly affected; Information processing altered
3	.15	.14	.11	.10	.09	.08	.07	.06	.06	
4	.20	.18	.15	.13	.11	.10	.09	.08	.08	
5	.25	.23	.19	.16	.14	.13	.11	.10	.09	
6	.30	.27	.23	.19	.17	.15	.14	.12	.11	Legally intoxicated; Criminal penalties; Reaction time slowed; Loss of balance; Impaired movement; Slurred speech
7	.35	.32	.27	.23	.20	.18	.16	.14	.13	
8	.40	.36	.30	.26	.23	.20	.18	.17	.15	
9	.45	.41	.34	.29	.26	.23	.20	.19	.17	
10	.51	.45	.38	.32	.28	.25	.23	.21	.19	

One drink is 1.5 oz. shot of hard liquor, 12 oz. of beer or 5 oz. of table wine.

Subtract .015 for each hour that you take to consume the number of drinks listed in the table. For example, if you are a 160 pound woman and have two drinks in two hours, your BAC would be $.06 - (2 \times .015) = .03$

NOTE: Blood Alcohol Level (BAL) charts do not take into consideration a wide range of additional variables that contribute to the determination of BAL's achieved and the behavioral effects experienced at a given BAL. These additional variables include: age, water-to-body-mass ratio, ethanol metabolism, tolerance level, drugs or medications taken, amount and type of food in the stomach during consumption, speed of consumption, and general physical condition. Thus, BAL charts only provide extremely rough estimates and should never be used alone to determine any individual's safe level of drinking.

Adapted from BAC Charts produced by the National Clearinghouse for Alcohol and Drug Information.

Table 4.3 Percentile Table for Alcohol Use

Drinks per week	Total	Men	Women
0	35	29	41
1	58	46	68
2	66	54	77
3	68	57	78
4	71	61	82
5	77	67	86
6	78	68	87
7	80	70	89
8	81	71	89
9	82	73	90
10	83	75	91
11	84	75	91
12	85	77	92
13	86	77	93
14	87	79	94
15	87	80	94
16	88	81	94
17	89	82	95
18	90	84	96
19	91	85	96
20	91	86	96
21	92	88	96
22	92	88	97
23–24	93	88	97
25	93	89	98
26–27	94	89	98
28	94	90	98
29	95	91	98
30–33	95	92	98
34–35	95	93	98
36	96	93	98
37–39	96	94	98
40	96	94	99
41–46	97	95	99
47–48	97	96	99
49–50	98	97	99
51–62	98	97	99
63–64	99	97	>99.5
65–84	99	98	>99.6
85–101	99	99	>99.9
102–159	>99.5	99	>99.9
160+	>99.8	>99.5	>99.9

Source: 1990 National Alcohol Survey, Alcohol Research Group, Berkeley. Courtesy of Dr. Robin Room.

Feedback Sheet

1. Based on the information I obtained during the assessment, I calculated the number of "standard drinks" you consumed in a typical week during the last 3 months before you came in:

   Total number of standard drinks per *week* 143

   Average number of standard drinks per *drinking day* 20.4

2. When we look at everyone who drinks in the United States, you have been drinking more than approximately 99 percent of the population in the country.

3. I also estimated your highest and average blood alcohol level (BAL) in the past 3 months. Your BAL is based on how many standard drinks you consume, the length of time over which you drink that much, whether you are a man or a woman, and how much you weigh. So,

   Your estimated *peak BAL* in the past 3 months was .50
   Your estimated *typical BAL* in an average week was .27

4. You have experienced many negative consequences from drinking. Here are some of the most important:

Blackouts	Physical violence
Hospitalization	Depression
Making people afraid	Missing work

Figure 4.1
Example of Completed Feedback Sheet

You may use the following sample dialogue:

> *Based on the information we obtained at the assessment session, I calculated the number of "standard drinks" you consume in a typical week, during the 3 months before you came here. You have been drinking an average of ____ standard drinks per week and an average of ____ standard drinks per drinking day. This places you in the ____ percentile of men/women in America, in terms of drinking. In other words, you have been drinking more than approximately ____ percent of the population of men/women in America, and more than ____ percent of the population of adults in America.* (Refer to Table 4.3)
>
> *I also estimated your peak and typical Blood Alcohol Concentration (BAC) in the last 3 months. Your BAC is based on how many standard*

drinks you consume, the length of time over which you drink that many standard drinks, whether you are a male or female, and how much you weigh. So, for instance, if we use these tables for the amount of alcohol you typically drink per drinking occasion, at your weight, and over the amount of time it typically takes you to consume this amount of alcohol, your peak (highest) BAC for the past 3 months or so was ____. Your typical BAC for the past 3 months or so has been ____. This is a measure of how intoxicated you typically become. There is a table in your workbook outlining the impairment people suffer based on different BACs. In New Jersey, legal intoxication is considered .08 % or higher BAC for adults over the age of 21. For underage drinkers, legal intoxication is considered to be any positive BAC at all. (Refer the client to Table 4.4, which is also found in the workbook.)

You have told us about several negative consequences you experience from drinking (discuss the negative consequences the client identified during the pretreatment assessment phase).

Ask the client to comment on the feedback provided. Listen attentively, convey understanding verbally and nonverbally, and indicate that clients with similar drinking problems have successfully utilized this treatment (*establish positive expectancy*).

Table 4.4 Common Effects of Different Levels of Intoxication

.02–.06%	This is the "normal" social drinking range. Driving, even at these levels, is unsafe.
.08%	Memory, judgment, and perception are impaired. Legally intoxicated in most states.
.1%	Reaction time and coordination of movement are affected. Legally intoxicated in all states.
.15%	Vomiting may occur in normal drinkers; balance is often impaired.
.2%	Memory "blackout" may occur, causing loss of recall for events occurring while intoxicated.
.3%	Unconsciousness in a normal person, though some remain conscious at levels in excess of .6% if tolerance is very high.
.4–.5%	Fatal dose for a normal person, though some survive higher levels if tolerance is very high.

Therapist Note

■ *Inform the client that it's always a good idea to see his physician for a checkup and to get a blood test to check on liver function, since alcohol is a toxin and heavy drinking can affect the liver and other vital organs. A list of specific hepatic function tests is included in the workbook. Ask the client to bring lab results to the session to show you. See Allen and Litten (2001) for information on how to interpret lab tests.*

Tell the client to specifically request the following tests:

Gamma glutamic transpeptidase (GGTP)

Aspartate aminotransferase (AST)

Alanine aminotransferase (ALT)

Mean corpuscular volume (MCV)

Bilirubin

Uric acid ■

Self-Recording

Self-monitoring is when the drinker writes down what he does on a daily basis. Explain to the client that recording drinking and urges to drink will help everyone get a better idea of what is going on. Monitoring will help the client identify patterns in his life and figure out different chains of behaviors that lead to drinking. You may use the following sample dialogue to further explain the importance of self-monitoring:

> *An important part of treatment is to work with facts, with accurate information. In our case, we want to learn about what happens during your day. The best way to collect facts is to write them down as they happen. Trying to recall things later is difficult. Everyone makes mistakes when they try to figure out what happened some time back, whether it was a few days ago or yesterday.*
>
> *With self-monitoring, drinkers are surprised with how much they are drinking and that their drinking falls into patterns that happen over and over. It also helps us to realize how often you are getting urges or*

desires to drink and what leads to these urges. We will learn how you are able to beat back some urges already. Some urges will be tougher than others. We will learn more about which triggers are easier than others. The self-monitoring will help us see your progress as we go through this program.

On the cards provided in your workbook, you should write down your urges to drink and any drinks or drugs you may have had.

You will need to do this everyday. I will help you figure out a way to remember to record every day. One suggestion is to keep the cards in a place with other things that you always have with you. When you have a drink or have an urge, write it down as soon as possible. Don't rely on your memory later.

An appendix of self-recording cards is included in the corresponding workbook. Since clients will need to carry their self-recording cards with them at all times, they have been placed on perforated sheets enabling the client to tear them out of the workbook.

The client will be asked to keep:

- A daily record of drinking behavior;
- A daily record of urges or thoughts of drinking (both quantity and strength);

Self-recording responses should be taught through modeling and role-playing with feedback in order to ensure that the procedures are clearly understood.

Tell the client to carry the self-recording cards at all times, 1 per day. If the client drinks, he should record before each drink (i.e., record each drink separately). Instruct the client to include details about what type of drink (e.g., "Bud Light" or "white wine"), how much (ounces), and the situation in which the drinking occurred. Also, the client should record each thought or urge immediately and its intensity on a 1–7 scale (7 = most intense). Tell the client that urges may occur for months after cessation of drinking. This is normal and to be expected.

Provide the client with the following instructions for completing the card. These same instructions can be found in the workbook as well.

Make sure to write in the date that you are filling in the card. You should fill in a card for every day of the week. We will use this information to look at patterns that happen across the week.

Under "Urges," I would like you to write down at what time the urge happened and how intense it was. For intensity, put down a number between 1 and 7 to describe how strong the urge was. Number 1 would mean that the urge was very weak. Number 7 would mean that the urge was one of the strongest ones that you have ever felt. If the urge was somewhere in the middle, then give it a number in between. Write down what triggered the urge.

If you drink, under the "Drinks" column I want you to put in some information about what you drank, how much, and what was the amount of alcohol in the drink. In the column labeled "Time," write down what time you started drinking. Record the type of drink you had in the column labeled "Type of Drink." In the column labeled "Amount," write down how many drinks you had and what the number of ounces was for each drink. One way to do this is to know the size of the glass and how much liquid it holds. We often tell people to measure their drinks, so they can understand how much they are drinking. In the column labeled "% Alcohol," write down the alcohol content of the drink you are having. Drinks will have this on the bottle or can.

An example of a completed self-recording card is shown in Figure 4.2.

Exercise—Self-Recording

Model self-recording responses, then ask the client for a typical drinking situation and have him role-play self-recording. Role-play problem situations and alternative responses, such as the following:

- "What if someone asks me what I'm doing?"—Sample alternatives: Tell them straight; or say, "I am on a diet," etc.
- "This is an abstinence program. What if I drink?"—Inform the client that you do not encourage drinking and will not hold sessions when the client's BAL is greater than .05; however, you want the client to be honest when recording so that you can teach skills for abstaining in situations that are difficult.

Self-Recording Card

Daily monitoring							Date *10/8/08*
Urges			Drinks				
Time	How strong? (1–7)	Trigger	Time	Type of drink	Amount (in ounces)	% Alcohol	Trigger
8:00 a.m.	4	Traffic during commute					
5:30 p.m.	7	Irritated when I came home	6:00 p.m.	Wine	1 bottle 25 oz.	12%	Fight with John

Figure 4.2
Example of Completed Self-Recording Card

Emphasize the fact that self-recording has been found to increase self-awareness and its important role in self-control. Self-recording is also part of treatment, that is, becoming aware of chains of triggers, behaviors, and consequences that were hidden before.

Abstinence Plan for Client Still Drinking and/or Possible Problem Areas

If clinically indicated, present the following rationale to the client:

> *The first phase in treatment is helping you to actually stop drinking. Then we will move on, throughout the treatment, to teaching you skills to stay sober, prevent relapse, cope better with problems, etc. Let's talk about the first phase.*
>
> *There are several options for stopping your use of alcohol. Let me review the options and then we can discuss the ones that appeal to you most.*

Discuss the following options for stopping drinking with your client: (1) inpatient detoxification, (2) outpatient detoxification, (3) going "cold turkey," and (4) stopping on your own, with the help of the therapist.

Inpatient Detoxification

> *One option is inpatient detoxification. There are hospitals in the area that do this. This means that you would go to a hospital detoxification or a rehabilitation unit and stay there between 3 and 7 days. They would probably give you some medicine during this time to relieve withdrawal symptoms. The advantage of an inpatient detoxification is that you are medically supervised, will avoid most withdrawal symptoms since you'll be medicated, and it's a quick way to get the alcohol out of your system and "start fresh" in this program as your aftercare. I will help you stay clean and prevent relapse. The disadvantage to inpatient detoxification is that some people don't want to stay in a hospital for a few days, and some people don't have insurance to cover this. I strongly recommend inpatient detoxification*

for patients who are very heavy drinkers and those who are unable to stop drinking on their own. Also, it is essential for anyone who is at risk for medical complications during withdrawal (personal or family history of seizures, stroke, high-blood pressure, cardiac problems, etc.).

Outpatient Detoxification

Another option is outpatient detoxification. This is where you would go see a physician—either your family doctor or a doctor who specializes in outpatient detoxification—on an outpatient basis. Each doctor may do an outpatient detoxification in his or her own way; typically, doctors who do outpatient detoxification will prescribe enough medication to last a couple of days, and then have you come back for an evaluation and determine whether medication is needed for a few more days, depending on the severity of your withdrawal symptoms. The advantage to an outpatient detoxification is that, similar to inpatient detoxification, you get it over with quickly. Within a week, you will have stopped using alcohol and passed through the initial more severe withdrawal symptoms with medication to help ease them. Another advantage is that you are under a physician's care, in case there are medical complications. A disadvantage to outpatient detoxification is that you must not drink alcohol while you are taking the medication that the doctor prescribes, and some patients end up using both, which is extremely dangerous.

Going "Cold Turkey"

A third option is for you to stop on your own, or go "cold turkey." I recommend this option only for people who drink episodically rather than daily, who have no history of withdrawal symptoms when they stopped drinking in the past, who are not at risk medically (high-blood pressure, history of stroke, etc.), and who are not extremely heavy drinkers. For heavy, regular drinkers, going cold turkey with no medical supervision can result in uncomfortable withdrawal symptoms at best, and, at worst, serious medical complications such as seizures. Also, withdrawal symptoms are often triggers for relapse.

A fourth option for certain individuals is to wind down yourself, with my help. We would work together and agree on a schedule for you to gradually stop your use of alcohol over the next few weeks. We would set a quit date, and then work toward that date. Gradual reduction in your alcohol consumption will reduce, but probably not eliminate, withdrawal symptoms you will experience. So, for instance, we will take out a calendar and plan for how much you can drink each day, and we'll make sure that it is always either a plateau or a reduction from 1 day to the next—otherwise you'll have withdrawal if you cut back a lot 1 day and then use more the next, and you'll have to go through withdrawal all over again. The advantage to this method is that you don't have to go somewhere inpatient or see a physician. It is gradual, so you will be able to avoid major withdrawal symptoms, but you must be prepared to experience some withdrawal problems since you won't be medicated. You'd be at less risk for the medical dangers of stopping cold turkey, if you're a daily heavy user. A disadvantage of this approach is that since it is gradual, it does take some time, and some people feel they would rather just get it over with quickly than spread out the reduction and associated withdrawal symptoms over a few weeks. Another disadvantage is that this approach takes a lot of planning and willpower on your part, especially in the beginning. I will help you, but you have to expect some challenges.

Engage the client in the decision about how to achieve abstinence. See Figure 4.3 for a sample abstinence plan.

Abstinence Plan

I will check myself into a detox center this weekend and do what they tell me to do. I will not stop "cold turkey" because that will put me at risk for major withdrawal symptoms if I am not in a hospital at the time.

If I cannot get a bed in a detoxification facility, I will go with "Plan B" discussed with Dr. Epstein—I will reduce my drinking over the week as we mapped out toward quit date in two weeks, first reducing quantity and then reducing frequency.

Today (Monday): No hard liquor, and drink 3 beers instead of five. Start with a diet soda and food, then a beer, then a water, then a beer, then water, then a beer.

Tomorrow: Same, but substitute light beer instead of regular beer. Go to home depot to buy materials for phase one of my backyard paver project.

Wednesday: Same—during high-risk drinking time work on deck pavers.

Thursday: same.

Friday: two light beers.

Saturday: two light beers—take day off from work and take family to beach.

Sunday: two light beers—catch up on bills and paperwork, then take kids to swim club and movie.

Monday—see Dr. Epstein, review status of abstinence plan. If going well, reduce to one light beer. Go to home depot after work and pick up pavers for next phase of project.

Tuesday: one light beer. Start on next phase of project.

Wednesday: no alcohol. At trigger time after work meet Sandy and kids at diner for dinner, then home and work on next phase of project.

Thursday: no alcohol. After work get massage at Sandy's spa. Then watch a TV show with her that night.

Friday: no alcohol. After work finish phase two of paver project.

Saturday: no alcohol. take day off and bring kids to great adventure for the day.

Sunday: no alcohol. Go to church in am with kids and then home depot to buy new deck chairs. Pick up new novel at from the bookstore and sit on new paved deck and read. Grill fish for dinner.

Figure 4.3

Example of Completed Abstinence Plan

Some clients believe that all they need is "willpower" in order to change. Respond to this by telling the client that he needs to develop ways to carry out his will.

Some clients may ask, "What if I start drinking or binge?" In all probability, this question will arise at some point during treatment. A possible response may be:

> *Breaking a problem drinking habit is a difficult undertaking that necessitates a commitment to change on the part of the client. This treatment program is designed to help you remain abstinent, teaching you the skills of self-control. If you feel that you are losing control or are about to drink, the rule of thumb is "to leave fast" then use your self-recording as a ways to analyze your thoughts or urges. If you drink, remember, "One drink does not mean drunk." We have treated people who have had one drink and stopped, have binged 3 days and then been abstinent, even people who have had to be hospitalized but who subsequently have remained sober. The majority of our clients remain abstinent. If you are committed to the treatment, you will succeed.*

The idea is to communicate the fact that the treatment goal is abstinence but that "slips" do not equal treatment failure. It has been documented that one factor affecting relapse rate is client expectancy. If the client feels that having one drink means "loss of control," he will probably keep drinking. Convey to the client that "loss of control" is partly "in the head." Remind the client that he can always call you (before drinking) if other alternatives have been exhausted and drinking seems inevitable. It is important for you to convey a nonjudgmental attitude and openness when discussing drinking. If the client can discuss drinking freely, then appropriate intervention measures can be implemented.

Clients may also ask, "Should I go to AA/NA meetings?" A possible response may be:

If you are already going to Twelve-step meetings, you can continue to go if you find it helpful. If you are interested in a support group, some individuals find Alcoholics Anonymous helpful. There are also support groups based on the same principles of cognitive-behavioral therapy that we are using in this program. One such group is called SMART Recovery®, and I can help you find meetings if you are interested. Both types of groups are worth trying. Neither is incompatible with the work we will do here.

Anticipating High-Risk Situations This Week

You may use the following sample dialogue to discuss high-risk situations with the client:

At the end of each session, we will spend a bit of time discussing any problem situations that you think might come up around drinking this week. As you progress through therapy, you will get better and better at anticipating and handling these. A "high-risk situation" is a situation in which you would find it very difficult not to drink. Today, I'd like us to spend a few minutes together thinking about the upcoming week. Are there any situations that you might encounter this week that would tempt you to drink?

Exercise—High-Risk Situations

Work with the client to identify at least one high-risk situation coming up in the next week. Instruct the client to write down ideas about how to handle this situation on the High-Risk Situations worksheet in the workbook. Also ask the client to write down on the back of a self-recording card how he actually handled the anticipated situation and to write down any other situations that were not anticipated. An example of a completed high-risk situations worksheet is given in Figure 4.4.

High-Risk Situations

What high-risk situations do you think you may experience this week?

Situation 1: Friday—end of the work week—will want a reward for working hard

How can you handle this situation?

- Tell myself that being sober is a gift
- Go to the gym instead of the bar
- Take a bubble bath and read new book I buy

Situation 2: Have to get child support payment to my ex-wife

How can you handle this situation?

- Put the check in her mailbox when she's not home
- Get a pizza after I drop off the check and bring it home to eat
- Ask my brother to drop off the check for me

Situation 3: Neighbors' son's sweet 16 at a dance hall

How can you handle this situation?

- Skip cocktail hour and arrive for dinner
- Eat something as soon as I sit down at table and ask wife to get me a soda
- Put my hand over my wine glass when waiter comes by with wine and then put my wine glass on another table

Figure 4.4
Example of Completed High-Risk Situations Worksheet

Homework

- ✎ Instruct the client to record alcohol use and urges (intensity, frequency) on a daily basis using the self-recording cards.
- ✎ Ask the client to record the occurrence of high-risk situations, and how he handled those that were discussed in session.
- ✎ Have the client complete the Drinking Patterns Questionnaire (DPQ) and bring it to the next session. The DPQ can be found at the end of the book. You may photocopy and distribute as necessary.
- ✎ Instruct the client to read Chapter 1 of the workbook.
- ✎ Have the client make an appointment with his general practitioner to have a physical and to get blood tests to check liver function (see page 66 for a list of specific tests).

Feedback Sheet 1

1. Based on the information I obtained during the assessment, I calculated the number of "standard drinks" you consumed in a typical week during the last 3 months before you came in :

Total number of standard drinks per *week* _____

Average number of standard drinks per *drinking day* _____

2. When we look at everyone who drinks in the United States, you have been drinking more than approximately _____ percent of the population in the country.

3. I also estimated your highest and average blood alcohol level (BAL) in the past 3 months. Your BAL is based on how many standard drinks you consume, the length of time over which you drink that much, whether you are a man or a woman, and how much you weigh. So,

Your estimated *peak BAL* in the past 3 months was _____

Your estimated *typical BAL* in an average week was _____

4. You have experienced many negative consequences from drinking. Here are some of the most important:

_____ _____

_____ _____

_____ _____

Chapter 5 *Session 2: Functional Analysis*

(Corresponds to chapter 2 of the workbook)

Materials Needed

- Copy of client workbook
- Breathalyzer and tube
- Client self-recording cards
- Alcohol Use and Urges Graph
- List of Triggers worksheet
- Behavior Chain worksheet
- High-Risk Situations worksheet

Outline

- Determine blood alcohol level (BAL)
- Provide overview of session
- Review self-recording and homework
- Check in
- Perform a functional analysis with the client to determine triggers for drinking
- Identify potential upcoming high-risk situations, and plan for how to cope with them
- Assign homework

Blood Alcohol Level Determination

If the client's BAL is greater than .05, reschedule the session.

Overview of Session and Setting the Agenda

Explain to the client what will be covered in this session. Ask her if there is anything pressing she would like to discuss today in addition to the planned material.

Review of Self-Recording and Homework

In the beginning of this and subsequent sessions, review and collect completed self-recording cards from the client. If homework is not done, ask what made it difficult to complete. Completion of homework should be discussed and clarified, and a firm commitment for the future should be stressed in a nonjudgmental way. You should then reconstruct the urge and drinking data for the week (see section "Graphing Progress" in the workbook). This includes daily drinking and urges. Reinforce self-recording behavior, screen for questions or problems, and help the client develop solutions for difficulties related to self-recording. The following conversations between client (C) and therapist (T) provide examples.

Example 1

C: I thought about drinking the whole morning. Is that one urge thought or more than one?

T: You had the urge continually?

C: Not every minute.

T: Well, each time you think about having a specific type of drink or a drink in a particular situation that counts as a separate urge. Can you give me some specific situations you thought about?

Example 2

C: My husband asked to see my cards but I think he'll get mad when he sees them.

T: It's common for spouses to be curious about what you do in therapy. But you have the right to choose what you want to share with him. You have the right to calmly but firmly say, "I'm glad you're taking an interest in what I'm doing in therapy. For now, though, it would be better for me to not show you my work. I'll make more progress that way, and you and I will both benefit—but thanks for asking."

C: Well, I don't want my kids to see it either and they don't exactly respect my privacy.

T: Remember, you have the right to keep your workbook and papers in a private, protected place! And you have the right to set a rule in your household that certain areas or objects in the house are off-limits to the children.

At this point in the session, review the client's recording of high-risk situations and how she handled them.

Collect the completed Drinking Patterns Questionnaires (DPQs) from the client. Check each item for completeness, and have her fill in any missing items. Tell her that you'll be using the DPQs later in the session.

Graphing Progress of Alcohol Use and Urges

Use the blank Alcohol Use and Urges Graph in the client workbook to graph data from the client's self-recording cards. You may photocopy the graph from the book if necessary. The client can also complete her own blank graph in the workbook.

The following three data points should be graphed immediately on a graph where the *x*-axis is time (the pretreatment baseline and 12 sessions):

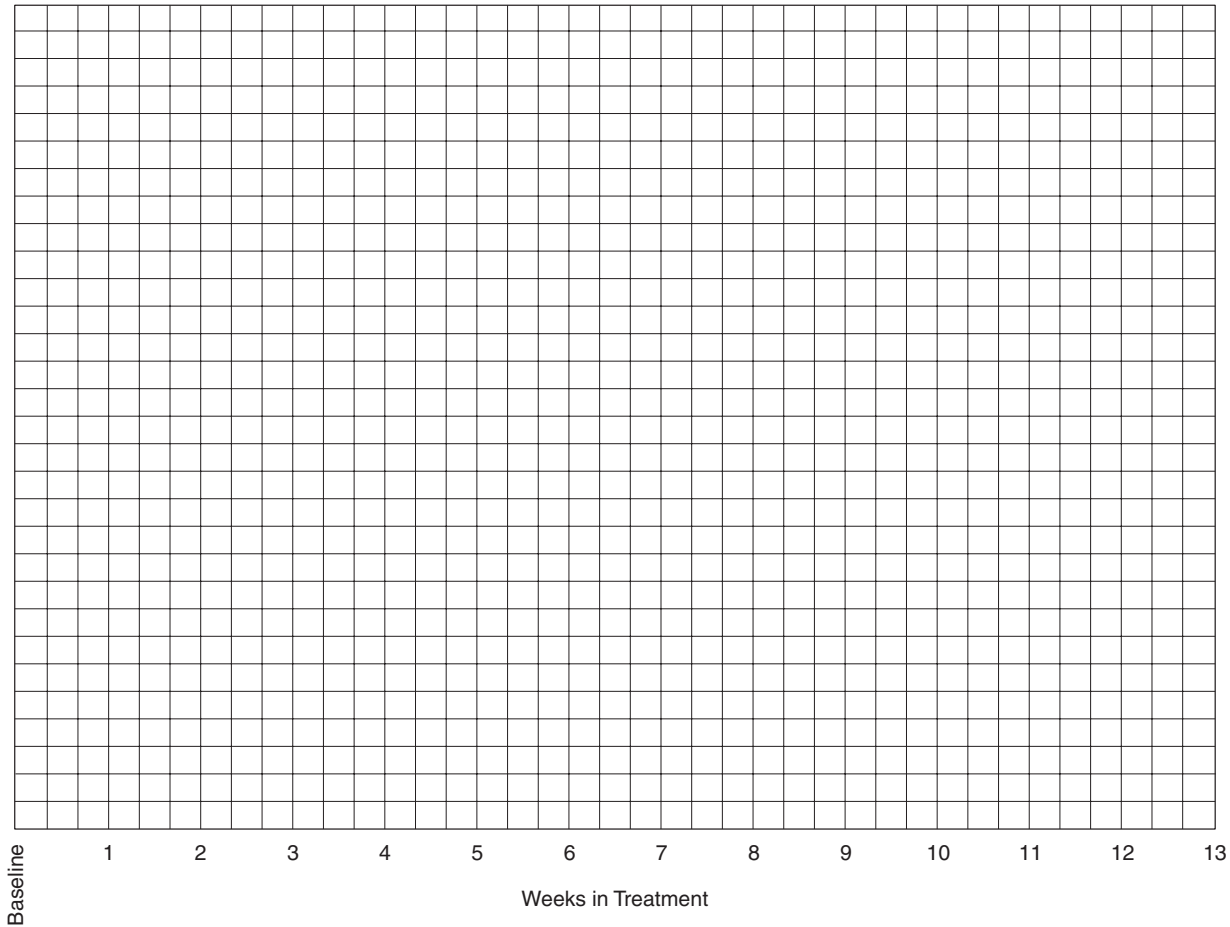
1. Total number of standard drinks consumed for the week (add up the number of drinks)

2. Total number of urges during the week (urge frequency) (count up the number of urges)

3. Average strength of urges during the week (1–7) (add up the ratings for all the urges during the week and divide by the total number of urges)

An example of a completed Alcohol Use and Urges Graph is shown in Figure 5.1.

Alcohol Use and Urges Graph



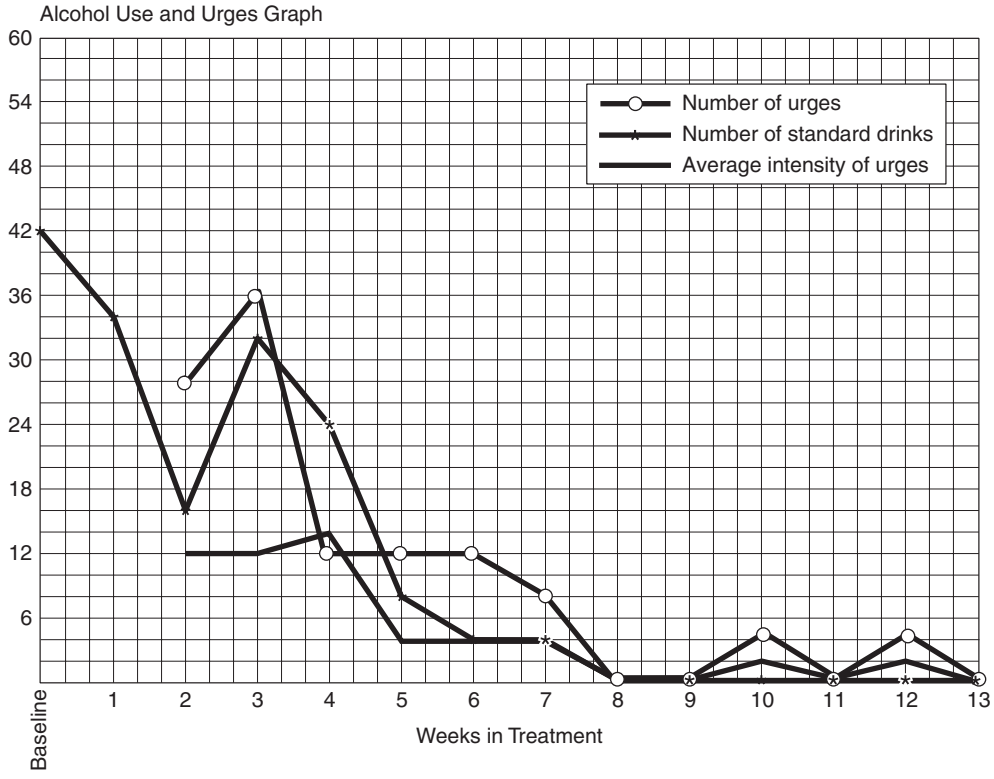


Figure 5.1
Example of Completed Alcohol Use and Urges Graph

Check In

Ask the client how her week was in general and acknowledge her concerns. Use information from this discussion for specific topics in the rest of the session. Review with the client the basic format of each session. Point out that we cannot cover everything at once, that treatment will go step-by-step, that treatment is a process, and that by the end of the 12 sessions she will have acquired a whole new set of skills to become and remain abstinent from drinking.

Check in on and discuss progress of abstinence plan. Update the plan if necessary.

Explain to the client that learning to identify situations that trigger drinking and learning to cope with them will help her stay sober. Discuss functional analysis (habit analysis) as the first step in understanding and gaining self-control over "out-of-control" drinking. Tell the client that problem drinking is a habit triggered by certain cues and maintained by both long- and short-term "maintainers" or consequences.

Present the following rationale to the client:

> *The first step in achieving abstinence is understanding more about your drinking. Together we will carefully identify and analyze all the factors that seem to be high-risk situations for drinking. Then we will put it all together to come up with a plan that will work for you. This is called a* ***functional analysis*** *or a habit analysis. A functional analysis can be broken down into different steps. Let's look at each step of the behavior chain* (review the steps as outlined in Table 5.1).

Refer the client to Chapter 2 of the workbook for more information on functional analysis. Also refer the client to the sample behavior chain in the workbook, and discuss using the following dialogue:

> *For example, say it's 5 p.m. on Friday and you've had a long week at work. Your coworkers are going out to Happy Hour at a sports bar that you pass on the way home. They've asked you to join them. You figure you might as well stop for a quick drink and you'll still be home in time for dinner, since you've had such a tough week and you deserve a short break. At the bar, you get involved with conversation; your coworkers order you a second and then a third drink, and by the time you arrive home it's 9 p.m., you've had five drinks, missed dinner, and your spouse is pretty angry.*
>
> *In this example,* **first**, *its being Friday afternoon and your coworkers inviting you out—after a tough week that left you tense—happened* ***before*** *you drank and "set the stage" for drinking. We call these* ***"triggers"****—risky situations, places, people, times, or feelings that lead up to your drinking. They happen before you drink—they trigger or create a desire to drink.* (Ask if client understands or has questions.)

Table 5.1 Steps to Functional Analysis

Triggers	People, places, and things will be associated with drinking. A trigger is something that usually occurs before drinking. A trigger can be something easy to see or something sneaky. Often the drinker is not aware of the triggers. Triggers don't make people drink; they just set up thoughts and feelings connected to drinking.
Thoughts and Feelings	Triggers set up thoughts and feelings. The triggers bring up feelings and ideas that are connected to drinking. These thoughts and feelings can be nice or unpleasant. Some examples are "I need to drink to be more sociable," "People will think I am weak if I don't drink," "Drinking will help me relax," or "Drinking will make me happy."
Drink	Drinking is something you do. It is a behavior that is a part of the chain.
Positive Consequences	Very often something nice happens when someone drinks. The alcohol will often cause pleasant feelings. People learn to expect that alcohol will make them more relaxed, more sociable, or happier. These pleasant effects help keep people stuck on alcohol.
Negative Consequences	The trouble that comes with alcohol often comes later. The trouble comes in many forms: arguments in the family, problems with a boss, financial difficulties, poor health, etc. Because the trouble comes later on, many people don't always make the connection between the trouble and their drinking. Many times, the possible trouble is out of your mind when thoughts of the pleasant parts of drinking are on your mind.

Triggers are like yellow or red traffic lights; they signal "Danger—trouble coming up ahead unless you stop." Triggers don't make people drink; they just set up thoughts and feelings connected with drinking.

Second, *triggers are usually associated with certain thoughts and feelings. Feelings at work on Friday afternoon might be tension, fatigue, and anticipation of relaxing. Examples of thoughts are, "I had a really hard week—I deserve a short break from my routine. I'll just stop for one drink and stay 30 minutes. I need to forget my troubles and unwind for just a bit."*

Third, *the drinking you do is in response to the thoughts and feelings. Despite intentions of having "just one," you end up drinking 2*

domestic beers and 3 shots of vodka (for a total of 5 standard drinks over 4 h, or a BAL of .075, assuming weight of 160).

Fourth, *starting to drink and beginning to feel relaxed from a few drinks all happen during or just after drinking. This is an important and immediate, or short-term,* ***positive consequence****. Positive consequences can also be long term, but these are typically fewer and harder to identify. This is one reason it is so difficult to change a drinking habit; the short-term positive consequences of drinking are immediate and strong, while the* ***negative*** *consequences of drinking (see below) usually become apparent* ***after*** *the short-term* ***positive*** *consequences of drinking. That is, drinking is a form of immediate gratification with delayed negative consequences.*

Fifth, *staying late and missing dinner at home, which causes your spouse to be angry, and driving home with a BAL of .075 are* ***negative consequences*** *of drinking; they happen as a result of drinking. These can be short- or long-term.* (Ask if the client has any questions or comments.)

This whole series of events is called a ***behavior chain*** *(of triggers, thoughts and feelings, drinking behaviors, and consequences* : see Figure 5.2)

Figure 5.2

Drinking Behavior Chain

Review the following steps for completing a functional analysis based on the preceding example.

1. *First you write in the "Drink" column when and where the drinking happened. In our example, the person had five standard drinks at the sports bar Friday evening between 5:30 p.m. and 8:30 p.m. for a BAL of .075.*
2. *Then think back to what happened before the drinking happened. What were the people, places, or things that set up the drinking? Write these things in the "Trigger" column. In this example, the person had had a tough week and coworkers invited him out to a sports bar. Friday at 5 p.m. was also a trigger.*

3. *After writing the triggers, think back to those thoughts and feelings that made drinking more likely. In this example, the person thinks about being tired and tense after the work week, feels he deserves a break, and anticipates relaxation and fun at the bar. He thinks "I will have **a** beer."*

4. *After this, think about what happened after drinking. Remember the good things, the positive consequences. It is realistic to say that good things will happen, in the short term, to people when they drink. In our example, the person feels more relaxed, enjoys the initial euphoria from the alcohol, and enjoys socializing with his friends from work.*

5. *Now think about the things that happened later—the negative consequences. The problems created by drinking often come later on. In this example, the person had an argument with his wife, missed seeing his kids before bedtime, his driving was impaired, he risked getting a DUI, and he had a hangover the next day.*

Figure 5.3 shows how the completed behavior chain for the preceding example would look. Figure 5.4 shows an example of a completed behavior chain for a different trigger.

Trigger	Thoughts and feelings	Response	Positive consequences	Negative consequences
Friday 5 p.m., invitation from coworkers to go to sports bar →	Tired and tense. "I deserve a break. I'll just have one quick drink and go home" →	At sports bar Friday evening—stayed 2 1/2 hours, had 4 drinks instead of 1. Drank 4/16 ounce bud ice, or 7.5 standard drinks over 2 hours. →	Relaxation, initial euphoria from alcohol, socialize with friends, fun →	Stayed too long, drank too much, spouse angry (argument followed), didn't see kids, drove under influence, had a hangover the next day

Figure 5.3
Example 1 of Completed Behavior Chain

Trigger	Thoughts and feelings	Response	Positive consequences	Negative consequences
Home from work— house is a mess, laundry piled up, time to cook dinner. →	How in the world am I going to get everything done? I'm tired. This isn't fair. I'll have a glass of wine to calm down. Tired, angry, overwhelmed. →	Have 8 oz. glass of wine with ice. Then have 2 more. (24 ounces total = about 5 standard drinks) →	Relaxed. Not angry anymore. Don't care temporarily. →	Fell asleep. No dinner made, house still a mess. Husband angry, kids neglected. Work piling up, no resolution to problem. Hangover next morning. Call in sick.

Figure 5.4

Example 2 of Completed Behavior Chain

As with most people, the person in this example falls into a pattern. Some triggers will set off thoughts and emotions that lead to drinking. The drinking leads to some nice things happening. These nice things encourage the drinker to keep using alcohol.

The functional analysis helps us learn about patterns. Most people are not aware of the patterns and habits that happen in their lives, and it takes some detective work to identify these patterns.

Exercise—List of Triggers

*We will look at each part of the chain and find out what **your** patterns are and how to change them. That is what a functional analysis of your drinking patterns is all about. Now perhaps you can begin to see why I ask such detailed questions; I need to know precisely and exactly what your particular drinking patterns are like. Every individual is different. This is all part of the treatment.*

The first part of gaining self-control of your drinking will be to analyze your drinking habits; the second part will be to learn ways to rearrange your environment (your triggers, drinking behaviors, and maintainers or consequences); the third part will be to learn positive alternatives to alcohol use (give examples of assertion or lifestyle

balance); *and the fourth part will be to learn how to maintain these changes. These four steps will help you gain self-control and maintain long-term abstinence.*

By understanding your behavior chains for drinking, you are taking the next step to feeling in charge. Instead of being at the mercy of your triggers, you will be able to take control—analyze the situation and figure out how to deal with each trigger instead of just reacting to it by

List of Triggers

Environmental (places, things)	5 p.m. on weeknight, preparing dinner at home
	Saturday evening
	Restaurant
	Messy house
	Dinner party or barbecue
	10 p.m., home
	Working in yard on hot day
Interpersonal (people)	Eating out with spouse
	Night out with friends
	5:00 on Friday and office buddies going to happy hour after work
	When my mother is bossy
	Argument with partner
	Kids are loud and boisterous
	Boss criticizing me at a meeting
Emotions/Thoughts	Anxiety
	Depression, sadness
	Anger, frustration
	Loneliness
	Stressed out, tense
Physical	Back pain
	Headache
	Can't sleep

Figure 5.5
Example of Completed List of Triggers

drinking. The choice to suffer or not to suffer negative consequences of drinking will be yours!

Now let's start a list of all of your triggers (ask the client to turn to the sample List of Triggers worksheet in the workbook). *As you can see on the sample worksheet, triggers can be environmental, interpersonal, emotional, etc.* (Review common types of triggers—see Figure 5.5.) *Let's try to think of what some of your triggers are.*

Help the client list her triggers on the blank worksheet, using her DPQ, self-recording cards, intake information, as well as any triggers you might have noticed in her drinking pattern as guides. Look for the types of situations rated most highly on the DPQ as well as individual items.

Exercise—Behavior Chains

After the client has completed the List of Triggers worksheet, help her complete the Behavior Chain worksheet in the workbook. Introduce as in the following therapist–client script:

T: Let's pick one of the triggers you listed on your trigger sheet—perhaps one that came up this previous week, and work through a behavior chain together on the Behavior Chain worksheet in your workbook. Which trigger do you want to use? . . .It helps to be as specific as possible.

C: How about after the kids are home and wild and I start making dinner? Wednesday is the hardest day because I know my husband won't be home to help.

T: Or to see you drinking. . . .

C: Well, yes, that too.

T: Okay, in the "triggers box" put 5:00 p.m. when you begin to make dinner for the family. Now think back to this previous Wednesday when you drank in response to that trigger—can you remember what thoughts were going through your mind?

C: I was really tired, and didn't feel like making dinner.

T: Those are feelings—what were your thoughts?

C: If I have a glass of red wine I can enjoy while cooking, I can get through this.

T: Good. So write that in the "thoughts" box, and also write for feelings, "tired" and—you said you didn't feel like making dinner—so what was that feeling like? Dread? Annoyance? Overwhelmed?

C: Dread, I guess—I felt—heavy.

T: Now for response to your thought "If I have *a* glass of red wine"—you ended up pouring another, and then another, 8 ounce glass of wine. Technically, that's 24 ounces of red wine, which is 5 standard drinks, or one full bottle of wine. So write that in the "response" box. Now let's calculate your BAL and put it in that box as well. . . . That would be a BAL of about .115 after five standard drinks over 3 h at your weight of 140. Remember, women get a higher BAL because they don't metabolize alcohol as efficiently as men, so you have to be careful.

C: Wow—that's certainly not what I had in mind when I figured I'd have one drink!

T: Yes, alcohol can be tricky like that. Now, let's continue with the behavior chain and look at the positive consequences. What was good about having that wine?

C: The first glass was great. I liked the taste, and I almost immediately felt more relaxed, sort of happy, energized and started humming and cooking.

T: Okay, so write in, for short-term positive consequences, euphoria, relaxed, energized, okay with cooking. What about long-term positive consequences of drinking?

C: Longer term? I can't think of any.

T: Yes, it's typical to have few long-term positive consequences of drinking. This brings us to negative consequences of drinking—what can you write in here for short-term negative consequences?

C: By 8:00 I was so tired I could barely move off the couch. Thank goodness none of the kids needed a ride somewhere. I was too tired and drunk to drive safely.

T: Good point. Also, if you did drive with a BAL of .115, it would be above the legal limit and aside from being impaired and putting yourself and your kids in danger, you might have gotten a DUI and lost your license for 6 months. What would you do if that happened?

C: My goodness—that would be awful. I wouldn't be able to get the kids to their activities or shop, or do anything! We live in a town where the closest food store is 5 miles away!

T: Any other short-term negative consequences?

C: Well, the kids saw me like that again, and my husband was really angry when he got home and knew I had been drinking. That bottle of wine cost $15 and was supposed to last a week. Plus, I must have had—how many calories in that bottle?

T: Probably about 750 empty calories. 150 per 5 ounces of red wine.

C: At night I was so passed out that I didn't hear my 5-year-old calling for me—he told me in the morning I just mumbled and went back to sleep. And the next morning, I had a headache and overslept. The kids missed their bus and I had to drive them, and they were late too.

T: Any other longer-term negative consequences?

C: Well, my husband can't take much more of this. He's so angry and disgusted with me sometimes he won't even look at me all day. And the kids—they shouldn't grow up with memories of their mother like this. The money adds up . . . so do the calories. And I know I'm damaging my body.

T: Good—the point here is that you learn to think about this chain from trigger to negative consequence, so that you can then figure out how to use a healthier response, learn to react to triggers differently, change the way you think and feel about alcohol. Let's do another behavior chain together for a different trigger and then you can complete two more on your own for homework this week.

When you and the client have worked out two behavior chains on the sheet, ask the client how she felt about the exercise, what stood out, and any surprise reactions. Review the client's completed behavior chains to help her understand the various parts of the drinking chain triggers and consequences. Point out that there are both positive and negative consequences (give examples). Remember that a client is likely to feel some shame and embarrassment while constructing alcohol behavior chains with you. Be sure to take a supportive, nonjudgemental, validating therapeutic stance while helping the client explore the reality of her drinking behavior. Do *not* take a confrontational or judgemental tone or approach.

Choose several situations from the list of triggers and have the client work out at least two more behavior chains as homework for this week, using the Behavior Chain worksheet.

Anticipating High-Risk Situations This Week

Work with the client to identify at least one high-risk situation coming up in the next week (see sample dialogue in Session 1). Have the client write out ideas for handling the situation on the High-Risk Situations worksheet in the workbook.

Homework

- ✎ Instruct the client to continue self-recording and record coping with high-risk situations on the back of the self-recording card.
- ✎ Ask the client to complete List of Triggers worksheet and fill out two or more behavior chains on the Behavior Chain worksheet in the workbook.
- ✎ Have the client read Chapter 2 of the workbook.

Chapter 6 *Session 3: High-Risk Hierarchy / Social Network Triggers / Self-Management Plans*

(Corresponds to chapter 3 of the workbook)

Materials Needed

- Copy of client workbook
- Breathalyzer and tube
- Self-recording cards
- Alcohol Use and Urges Graph in progress
- High-Risk Hierarchy worksheet
- Your Social Network worksheet
- Heavy Drinkers in Your Social Network worksheet
- Self-Management Planning Sheet
- High-Risk Situations worksheet

Outline

- Determine blood alcohol level (BAL) of the client
- Provide overview of session
- Review self-recording and homework
- Check in
- Work with client to develop a hierarchy of high-risk situations
- Discuss how heavy drinkers in social network act as triggers

- Assess client's social network
- Problem solve for presence of heavy drinkers in the social network
- Teach client how to create self-management plans for dealing with high-risk situations
- Identify potential upcoming high-risk situations and plan for how to cope with them
- Assign homework

Blood Alcohol Level Determination

If the client's BAL is greater than .05, reschedule the session. If the client is still drinking, remind client of the abstinence plan and revise if necessary.

Setting the Agenda

Present today's topics and ask the client if there are any additional issues he would like to discuss.

Review of Self-Recording and Homework

1. Collect and review the client's self-recording cards and discuss any questions and/or problems the client may be having. Reinforce the client for completing homework and making progress. Review and update the Alcohol Use and Urges Graph. Discuss trends and patterns in triggers, thoughts, urges, and alcohol use (if any). For example:

   T: I see that your strongest urges tend to cluster on Saturday night and Wednesday night—what was going on those nights?

   C: Yes, on Saturdays we typically go out and have a bottle of wine with our pasta. And Wednesday is the night my husband has his bowling league so I'm home alone.

T: I also see that weekdays at about 4:00 p.m. can be tough for you.

C: Yes, that's when all the kids come home from school hungry and loud!

T: I notice on your card that you had one glass of wine on Saturday, which is far less than the 3 glasses you were drinking before you came in. And on Wednesday you didn't drink at all, despite the cravings—how did you manage that?

C: On Wednesday I took a bath, read my new novel for a while and then went to sleep early.

2. Be sure to review the client's completed High-Risk Situations worksheet and discuss how she handled the situations.

3. Check the client's completed functional analysis homework (Behavior Chain worksheet) and review both positive and negative consequences of the drinking in each situation recorded. For homework, ask the client to choose two times during the week when she experiences a "strong urge" and then develop all the triggers and thoughts about consequences around these two specific real-life events; that is, have the client develop two more complete behavior chains around actual urges recorded on her self-recording card. If client is not having "strong urges" have her use any two urges that seem important during the week.

Check In

Ask client how his week was in general and acknowledge his concerns. Use information from this discussion for specific topics in the rest of the session.

Developing a Hierarchy of High-Risk Situations

In the previous session, you discussed triggers and high-risk situations. Today, you will work with the client to plan for these difficulties. To make planning easier, ask the client to list potential problem situations

in order from least difficult to handle to most difficult to handle. Present the following rationale to the client:

> *In the previous session, we identified some of the major situations, feelings, people, behaviors that are associated with your drinking. Doing this tells us what may make attaining or maintaining abstinence difficult for you. We need to plan for those difficulties. To make your planning easier, we recommend that you put your list of difficulties in order so that you can plan to tackle some of the easier problems and situations first.*

Refer the client to the section in Chapter 3 of the workbook entitled "Looking Ahead for Trouble." Review the information with the client using the copy provided on the following page.

Looking Ahead for Trouble

Smart travelers look ahead for possible trouble. By looking ahead for rough spots in the road, they can handle tough situations better. Travelers who see the trouble ahead on the road can make changes to steer around the problem. In the same way, people who quit drinking can look ahead for difficult situations. Smart people plan for the rough spots.

Everybody who has stopped drinking has faced people, places, or things that made it difficult to stay sober. Some situations are more difficult than others. For you, some situations will be easier to handle. Other situations will be more difficult to manage.

What are your rough spots? What people, places, emotions, or things can be trouble for you? Think of what goes with drinking:

- People
- Places
- Emotions, like sadness, anger, boredom, and happiness
- Events, like parties
- Things you see, like bottles
- Problems with your partner
- Problems with your children
- Good times

Some rough spots are harder and others are easier to handle. You can usually tell ahead of time how hard something will be. By thinking about how hard different situations can be, you can be ready for the tougher ones.

We want you to write down all your difficult situations. Try to think of anything that could get you feeling like drinking. Try to write them down in order, from the hardest to the easiest.

Then we want you to rate how hard each situation is for you. The easiest way to do this is by using numbers. Use numbers between 0 and 100 to describe each situation. Larger numbers mean that the situation is harder to handle. Smaller numbers mean that the situation is easier. Something that is no trouble at all would get a number 0. Something that would be very hard for you to handle would get a higher number. The number 100 would mean that the particular situation was the most difficult one for you to handle without drinking.

Exercise—High-Risk Hierarchy

Use the client's completed List of Triggers worksheet (add any new triggers to the list as necessary) from Session 2 to create a hierarchy of high-risk situations. Introduce the Hierarchy of High-Risk Situations worksheet in the workbook.

Ask the client if he believes that there are differences in how difficult these situations are to cope with without drinking. If the client says no, pick the most extreme ones, and ask if they are equally difficult. The client most likely will be able to identify some differences in difficulty. Suggest that each situation can be rated for difficulty, on a 0–100 scale, where 0 = extremely easy to cope with without alcohol, and 100 = extremely difficult to deal with without drinking. Using the High-Risk Situations worksheet, write down three triggers and ask the client to assign ratings to them. For homework, ask the client to put the situations in order from least to most difficult, and assign a difficulty rating to each. Figure 6.1 shows a sample High-Risk Hierarchy.

High-Risk Hierarchy

Difficult Situation	**How Hard?**
	very easy — very hard
	0 - - - - - - - 100
1. Being angry after an argument with my partner	95
2. Being at a party with alcohol	85
3. Working on the yard	85
4. Co-workers going out for drinks invite me	80
5. My partner yelling at me for drinking	75
6. Being at a professional meeting	65
7. Watching TV	55

Figure 6.1
Example of Completed High-Risk Hierarchy

Heavy Drinkers in Social Network as Triggers

Explain that heavy drinkers in one's social network can act as triggers for drinking. Tell the client that you want to help her learn to manage this set of triggers, so that she can make her own choice to stay sober whether or not heavy drinkers in her social circle are drinking. She should think of herself as an independent operator, able to decide that her sobriety is a priority regardless of how other people see it.

Information on Heavy Drinkers in Social Network as Triggers

We know from research (McCrady et al., in press) on female problem drinkers that almost 50% of their spouses/partners drink at moderate to heavy levels, and about 1/3 of the spouses/partners have themselves had a lifetime, or have a current, drinking problem. Also, an average of 17% of the drinkers in their social networks are heavy drinkers. Men are less likely than women to have partners who drink heavily or who also have drinking problems, but men often drink with their wives or female partners. However, men have more drinkers among their friends (e.g., 26% vs. 19%; Mohr, Averne, Kenny, & Delboca, 2001). Lesbian, gay, and bisexual individuals are more likely than heterosexuals to drink, often meet others in gay bars, and therefore typically have social networks with a greater concentration of drinkers (Hughes & Eliason, 2002).

Share the handout Who's in Your Circle? Who's in Your Corner? There are two versions of the handout: Facts for Women and Facts for Men. A copy of both of these is provided in the workbook.

Who's in Your Circle? Who's in Your Corner?

Facts for Women

fact: Social networks are extremely important to women. Men tend to think in terms of hierarchies (who has more power), while women tend to think in circles (who is in my inner circle of friends; who is more distant).

fact: Among women in the United States in 1990, 41% didn't drink at all. As a woman, if you drink more than 1 drink per week, you're drinking more than 68% of the women in the United States—that is, only 32% of women in the United States drink more than one drink per week. Only 23% of women in the United States drink more than 2 drinks per week.

fact: Among 102 female problem drinkers, the average number of drinkers in their social networks was 6, or almost three-quarters of their social networks.

fact: Among those 102 female problem drinkers, the more drinkers in the social network and the more heavy drinkers in the social network, the more often the woman drank herself.

fact: Among female problem drinkers, approximately 42% reported that their spouses were moderate or heavy drinkers; 29% of their male partners had a current or lifetime drinking problem.

fact: Emotional situations and social situations are among the strongest drinking triggers for women.

fact: Heavy drinking spouses can serve as an interpersonal trigger for women to drink.

Who's in Your Circle? Who's in Your Corner?

Facts for Men

fact: Social networks are extremely important to men. Men have a higher proportion of drinkers in their social networks than women.

fact: Among men in the United States in 1990, 29% didn't drink at all. If you drink more 1 drink per week, you're drinking more than 46% of the men in the United States—that is, only 54% of men in the United States drink more than one drink per week. Only 33% of men in the United States drink more than 4 drinks per week.

fact: Among men with drinking problems, many of their closest and most important friends are drinkers.

fact: Having more people in the social network who support continued drinking predicts a poorer outcome, but finding more people who support abstinence is associated with treatment success.

fact: Environmental situations and work-related stress are among the strongest drinking triggers for men.

fact: Social pressure to drink and interpersonal conflicts may be triggers for relapse.

Have the client turn to the Your Social Network worksheet in the workbook to make a picture of her social network as she experiences it (see Figure 6.2). Give the following instructions (also found in the workbook):

> *You see there are circles within circles, with your name in the middle. Write the name(s) of the person/people you consider closest to you in the inner circle, and then move out from there in terms of placement. So the people in the outermost circle would be less close to you than those in the inner circles. This is a picture of your social network.*

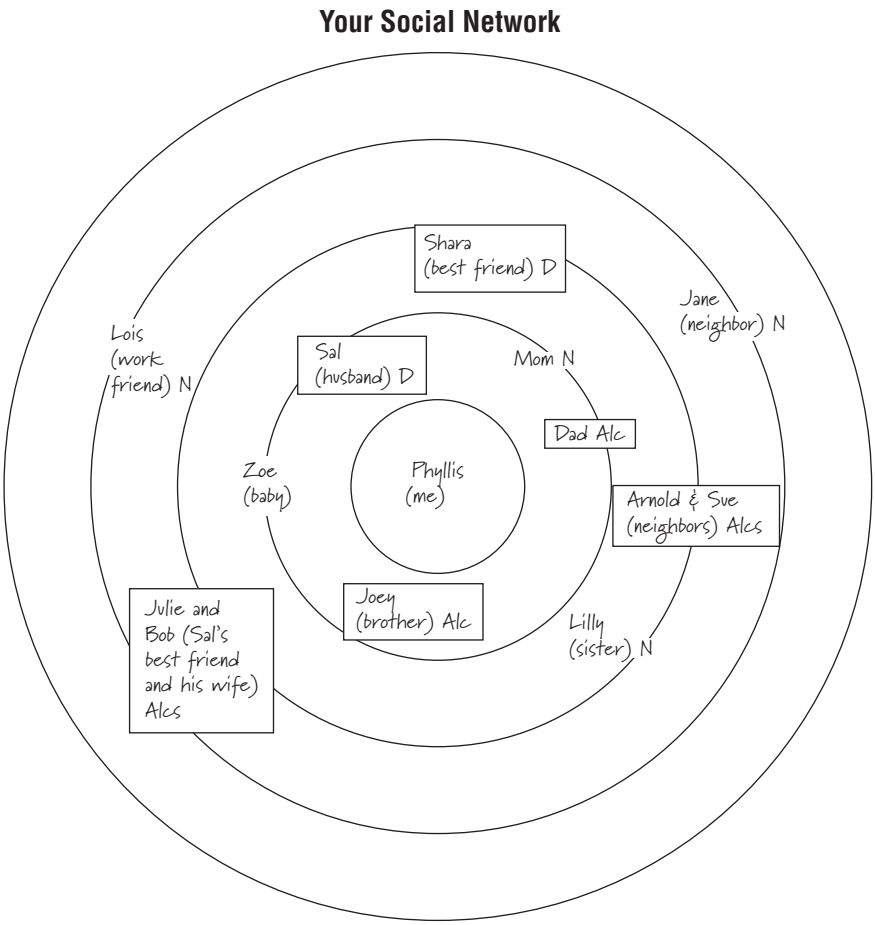


Figure 6.2
Example of Completed Your Social Network Worksheet

Now, let's draw a box around those who drink at all. Put a "D," for Heavy Drinker, next to names of people who you think are heavy drinkers. Put an "Alc" (for alcohol problem) next to names of people you think have an alcohol problem. Put an "N" next to people in the network who are nondrinkers.

Exercise—Heavy Drinkers in Your Social Network

Next, have the client complete the Dealing with Heavy Drinkers in Your Social Network worksheet in the workbook (see Figure 6.3). She should list the people in her social network who might be considered "interpersonal triggers" for her to drink, along with a sentence or two about how their drinking may impact her efforts to stay sober.

Therapist Note

■ *If the patient has no heavy drinkers in her social network, still complete the exercise, and have her add people who may be outside of her intimate social network but still may be triggers for her. Then use self-management planning for those.* ■

Also, be sure to discuss people in the social network who do not drink; these are the people the client may wish to consider spending more time with, even perhaps with the goal of moving some nondrinkers into the "inner circles." Tell the client that we will revisit this idea in Session 7, when we will further brainstorm about how to develop additional nondrinking social connections.

Dealing With Heavy Drinkers in Your Social Network

Name of heavy drinker Sal

How might this person's drinking affect your efforts to stop drinking and stay sober?

1. Sal keeps vodka in the house and that's a temptation for me.
2. We have a nightcap together—I will miss that.
3. When we socialize we usually drink.

Name of heavy drinker Dad

How might this person's drinking affect your efforts to stop drinking and stay sober?

1. Dad keeps telling me I don't have a problem and that is nonsense.
2. When Dad and Mom come over he expects to be served drinks.

Name of heavy drinker Shara

How might this person's drinking affect your efforts to stop drinking and stay sober?

1. I love Shara but we usually do drink when we get together. We drink and giggle, and that's so much fun.

Name of heavy drinker

How might this person's drinking affect your efforts to stop drinking and stay sober?

Figure 6.3
Example of Completed Heavy Drinkers in Your Social Network Worksheet

Present the following rationale to the client:

> *We have discussed your drinking as a habit triggered by certain cues and maintained by certain consequences, but knowing about triggers isn't enough. We need a plan! Developing a good plan takes patience and a lot of thinking. We have a step-by-step method that makes planning much easier.*
>
> *Self-management planning is a problem-solving technique to help you figure out ways to deal with specific triggers to make your life less risky for drinking. Today we'll practice self-management planning for triggers related to heavy drinkers in your social network.*

Training in "stimulus control" procedures is aimed at teaching the client to alter the antecedent triggers for drinking that have been identified, with the result of decreasing the likelihood of drinking in response to these cues. This means thinking of ways to rearrange those environmental events that used to trigger drinking or replacing them with non-risky situations. The antecedents were identified through the DPQ, self-recording, functional analysis, and high-risk hierarchy exercises. Focus on settings or situations, times, and people. Naturally, these categories are related to each other and several can be going on at the same time. For some clients only a subset of these antecedents will be applicable.

Explain that external environmental events often can trigger drinking. Divide environmental events into categories (time of day/week, settings, persons, situations). Give examples and relate these to the DPQ and functional analysis (after work, weekends, watching TV advertisements, when others are drinking). There are three basic ways of handling these environmental antecedents differently to reduce the risk of drinking. Discuss them with the client using the following dialogue:

> *One way is to remove yourself from the environment (e.g., not going out with your friends or your partner to a party or a bar). This may involve coming up with alternative things to do or places to be to avoid those times, places, people that are problematic.*
>
> *Another way is to rearrange the environment (e.g., don't keep alcohol in the house in a highly visible place; don't carry money with you if you have to walk right past your favorite liquor store).*

A third way is to behave differently in the same environment, by using different coping skills.

In deciding how to handle these situations, the client may want to consider how to change his overall lifestyle to facilitate, maintain, and enjoy a sober lifestyle—does he want to work longer (or fewer) hours, spend more time with his family, begin to exercise, pursue a hobby, learn something to further his career or just for pleasure, etc. Although most clients will not yet have a clear idea of what they want, they should be encouraged to think about an overall sober lifestyle when developing self-management plans. Say to the client:

Self-management is a great skill to use because it enables you to take charge of your situation and be active and "planful" in coming up with solutions that work for you. You are not a victim of circumstance. Of course, you can't control if certain triggers happen or exist. But you can control how you respond to those triggers, and you can control your actions. I want you to stop using triggers as "excuses to drink" and to stop feeling bad about triggers you can't control. I want you to put your energies into your reactions, which you can control!

Exercise—Self-Management Planning

Review and explain the sample Self-Management Planning Sheet in Chapter 3 of the workbook. When the client understands the exercise, integrate the self-management planning and social network triggers just covered and pick a salient interpersonal trigger from his completed social network form and develop a self-management plan for the particular trigger. This will continue to solidify skills for dealing with heavy drinkers in his social network while also providing an introduction and practice for the self-management skill. Next session the self-management planning will be expanded to practice with other types of triggers.

Review the following instructions from the workbook with the client. Use them to help the client develop a plan for managing triggers.

1. Pick out triggers that you will come across soon. Start with an easier trigger. As you get more practice at this, you can plan for harder triggers.

2. Write down as many ideas as possible for handling the trigger. Be creative and brainstorm! Do not worry about being silly or unrealistic. The best ideas often come when you let ideas fly without stopping to think about what is good or bad about each one. The evaluation will come later. There are three kinds of strategies for handling triggers:
    - Remove yourself from the situation to avoid trouble.
    - Change things around you to avoid the trigger. For example, get rid of alcohol around the house or do not walk past the liquor store.
    - Think or act in different ways when you are faced with the trigger. For example, someone may avoid drinking by remembering the consequences that will come later.
3. *After* coming up with several ideas, think and write down what is good and bad about each one. Now is the time to think about what you need to do for each one of the ideas. Remember, some consequences of your plan will happen quickly and others will happen later. Try to think them through. The goal here is to think about the pros and cons of each idea.
4. Think about how easy or hard each idea would be to carry out instead of drinking. Some will be hard to do, others will be easy. For each idea or plan, give it a number between 1 and 10 that shows how hard it would be to do compared to just drinking in response to that trigger. For example, the easiest plan that you can do would get a 1, and the hardest would get a 10. Write down how hard each idea would be for you. That is, how difficult would it be to carry out the new plan in place of old behavior that involved drinking in response to the same trigger?
5. Pick a plan. Choose the plan or plans that have the best balance between positive and negative consequences. Try to pick ones that will not be too hard for you.
6. After putting a plan to work, check to see how it is working. If a plan is not working, do not be afraid to make changes or to pick another idea.

If time in session is short, work with the client to choose at least two of his triggers and complete steps 1–4 for each. Figure 6.4 shows a sample Self-Management Planning Sheet.

Self-Management Planning Sheet			
Trigger	**Plan**	**+/− Consequences**	**Difficulty (1–10)**
Husband invites heavy drinking neighbors over for impromptu barbecue at our house; they are drinking frozen daiquiris and beer. In fact, your husband asks you to keep the daiquiris coming while he tends the grill.	a. Abandon efforts to stay sober and join them.	a. + Have fun, fit in + Not embarrassed that not drinking + No need to deal with cravings − Let self down − Cravings intensify next week, harder to stay sober − Later resentful of husband − Lose control, drink too much	a. 4
	b. Leave home until the party is over.	b. + Avoid trigger + Avoid drinking − No one sober is watching the kids at home − Husband annoyed, neighbors baffled − Resentful of husband	b. 8
	c. Make myself frozen virgin coladas and stay busy at the grill and in the kitchen.	c. + Socialize + Enjoy a non alcoholic drink + Husband not annoyed − Still a high-risk situation, high cravings − Resentment toward husband	c. 5
	d. Approach husband the following week and discuss this and similar situations with him.	d. + Express feelings, be assertive + Possibly avoid future similar situations + Plan ahead − Husband may not wish to talk about it − May be frustrating	d. 10
	e. Remain pleasant to neighbors but don't join the barbecue—stay inside. Tell your husband you won't be able to make the daiquiris.	e. + Avoid trigger + Protecting right to self-care − Bored, resentful of husband − Neighbors think I'm rude	e. 10

Figure 6.4

Example of Completed Self-Management Planning Sheet for Heavy Drinkers in Social Network

Anticipating High-Risk Situations This Week

Work with the client to identify at least one high-risk situation coming up in the next week (see sample dialogue in Session 1). Have the client write out ideas for handling the situation on the High-Risk Situations worksheet in the workbook.

Homework

- ✎ Instruct the client to continue self-recording and record coping with high-risk situations on the back of his self-recording card.
- ✎ Instruct the client to create a hierarchy of high-risk situations, with ratings of difficulty in handling.
- ✎ Have client finish Your Social Network worksheet started in session.
- ✎ Have client finish Heavy Drinkers in Your Social Network worksheet started in session.
- ✎ Have client complete Self-Management Planning sheets for two trigger situations for heavy drinkers in his social network.
- ✎ Ask the client to identify two times during the week when he experiences a "strong urge" to drink and complete a behavior chain for each one. If the client is not having "strong urges" have him use any two urges that seem important during the week.
- ✎ Have the client read Chapter 3 of the workbook.

Chapter 7 *Session 4: Enhancing Motivation to Change*

(Corresponds to chapter 4 of the workbook)

Materials Needed

- Copy of client workbook
- Breathalyzer and tube
- Self-recording cards
- Alcohol Use and Urges Graph in progress
- Self-Management Planning Sheet
- Decisional Matrix worksheet
- 3 × 5 index cards
- High-Risk Situations worksheet

Outline

- Determine blood alcohol level (BAL) of the client
- Provide overview of session
- Review self-recording and homework
- Check in
- Continue discussion of self-management planning
- Introduce the Decisional Matrix and work with the client to enhance her motivation for treatment

- Introduce the use of negative consequences cards
- Identify potential upcoming high-risk situations and plan for how to cope with them
- Assign homework

Blood Alcohol Level Determination

If the client's BAL is greater than .05, reschedule the session. If the client is still drinking, remind client of the abstinence plan and revise if necessary.

Overview of Session and Setting the Agenda

Present today's topics and ask the client if there are any additional issues she would like to discuss.

Review of Self-Recording and Homework

1. Collect and review completed recording cards from the client and use the data to update the Alcohol Use and Urges Graph. Reinforce the client for compliance. Add any relevant information (i.e., antecedent–consequent conditions) to functional analysis sheet.
2. Consider questions, problems regarding client functional analysis homework.
3. Review and discuss client's high-risk hierarchies. Discuss any situations which she did not rate. Evaluate client's ratings to see whether there appear to be any major discrepancies between what you believe are the client's difficulties with coping and her ratings. Explain to the client that she will continue to select problems from these hierarchies to work on.
4. Review Dealing With Heavy Drinkers in Social Network worksheet.

5. Briefly review the self-management planning for heavy drinkers in the social network homework and put it aside to use later in the session.

Check In

Ask the client how her week was in general and acknowledge her concerns. Use information from this discussion for specific topics in the rest of the session.

If introduced in Session 1, check in with the client on the success of the abstinence plan. If the client is still drinking, update the plan.

Continuation of Self-Management Planning

At this point in the session, you will review the client's completed Self-Management Planning Sheet in more detail.

Exercise—More Self-Management Planning

Continue with self-management planning focused on triggers related to heavy drinkers in one's social network. Discuss with the client how she dealt with her triggers that were related to her social network during this past week.

Next focus on self-management planning using other types of triggers, such as environmental, emotions/thoughts, or physical. See the two examples on the sample Self-Management Planning Sheet. Then help the client choose an example from the High-Risk Hierarchy that is of moderate difficulty to deal with without drinking and is not an interpersonal trigger, and use a blank self-management planning sheet to work out a self-management plan in session with the client. For homework, assign one more plan to work out for any type of trigger of greater difficulty as rated on the High-Risk Hierarchy. Figure 7.1 shows a sample self-management planning sheet.

Self-Management Planning Sheet

Trigger	Plan	+/– Consequences	Difficulty (1–10)
Going to a restaurant for lunch	1. Don't eat lunch	+ Avoid trigger – Will be hungry	9
	2. Eat lunch at work	+ Avoid trigger + Won't be hungry + Will save money – Boring	5
	3. Go to a restaurant that doesn't serve liquor	+ Avoid trigger – Coworkers may not agree – Loss of privacy	3
	4. Learn to refuse when coworkers urge you to order a drink	+ Don't need to switch restaurants – May feel uncomfortable – Loss of privacy – Still faced with difficult trigger	8
Keeping liquor in the house	1. Never buy liquor	+ Save money + Avoid trigger – Partner can't drink at home – Company can't drink	5
	2. Hide the liquor	+ Avoid trigger – Inconvenient – I can find it	9
	3. Don't invite people over who drink	+ Avoid trigger – Lose friends	8
	4. Don't serve liquor to guests	+ Save money + Put myself first – Some people may be offended	7
	5. Buy liquor right before guests arrive and throw out the extra after they leave	+ Avoid offending guests + Minimize exposure to trigger – May waste money	2

Figure 7.1

Example of Completed Self-Management Planning Sheet

Present the following rationale to the client:

> *Even though you have entered treatment, you probably have some mixed feelings about being in therapy and about actually making major changes in your life. This is a common feeling. You don't know what things will be like in the future, and that makes it somewhat frightening. In contrast, you do know what things are like now. Sometimes the familiar is comforting, even if it is unhappy. You are also giving up something that has provided good things in your life. Most people get pleasure from drinking—they enjoy the taste, like the sensations, and associate it with many good things in their lives. Giving it up is like saying good-bye to a friend you will miss, even though we both know that alcohol is not a friend with your best interests in mind. Having mixed feelings about giving up alcohol is perfectly natural.*
>
> *You may also have mixed feelings about abstinence. Some people feel that it's impossible to have fun without alcohol, or feel that it's the only way they can relax.*

Exercise—Decisional Matrix

Introduce the Decisional Matrix exercise using the following dialogue:

> *I'd like to help you think out some of the pros and cons of drinking and not drinking. In thinking about the pros and cons, it may be helpful to think about short-term consequences and long-term consequences.*

Review the following information from the workbook with the client.

The Good, the Bad, and the Ugly of Drinking

Think about what things happen when you drink. We call these things consequences. Some consequences are good, others are bad. Most of the time, the good consequences happen right as you are drinking. The bad consequences come later.

There are reasons why you drink. These come from the good things that happen, even if the good things only happen sometimes. Your mind and body remember these things.

The bad consequences can come right when you are drinking (like getting sick or having a fight) or can come later (like not being able to get up the next morning or having your children upset with you).

It will be easier to quit if you have a list of the bad things about drinking. The more you remember the bad things, the easier it is to say no when you have an urge to drink.

Also think about what will be good and bad about quitting drinking. Some people don't think ahead when they make a change in their life. You will be more successful if you look ahead to see the good and bad about making a change. Thinking about what you lost and what you get makes it easier to stay motivated.

Take a moment and start writing down the things that happen to you when you drink. Write down the things that happen right away and the things that happen later. Some kinds of consequences are:

- Physical things: body sensations or effects like getting sick
- Negative feelings
- Depressing thoughts
- Things that happen with other people, such as family or friends
- Money or legal trouble
- Work problems

On the Decisional Matrix sheet, write down the good and bad things that happen right away (immediate consequences) when you drink. Also write down the good and bad things that happen later (delayed consequences) after drinking. Write these in the section marked "Continued Alcohol Use."

Do the same thing for quitting drinking. Write down the good and bad things that will happen right away when you stop drinking. Then, write down the good and bad things that will come later. Write these in the section marked "Abstinence."

Be realistic! It is important to be honest. The more we understand the reasons why you drink, the easier it will be to find a solution. When we are done, we want to have more good reasons for stopping drinking than for keeping things the way they are.

Ask the client whether or not she can relate to these comments, and encourage discussion. After some general discussion, ask the client if she can identify some good and bad things about drinking. Have the client write these down on the Decisional Matrix in the workbook. Also ask the client if she can think of some pros and cons of abstinence. Have the client write these down on the worksheet as well. In addition to what the client generates, you can help her by pointing out pros and cons of drinking or abstinence that she hasn't thought of. For instance:

> *Also, I've noticed that the time you spent drinking at night was the only "down" time you allowed yourself to have, as if you couldn't allow yourself to have any "alone time" or "me time" unless it was to drink. So in this way, a "pro" of drinking was that it provided some "me time." However, if we can think of a healthier way for you to have some "alone time "—which you certainly deserve—it could become a pro of abstinence. For example, you could spend former drinking time at the gym, or working out at home, or taking a walk, or taking a bath, or watching a favorite T.V. show, or reading a novel, or even getting a babysitter and going to a movie with your friend.*

For homework, ask the client to spend more time on this exercise and fill out the worksheet as completely as possible. A sample Decisional Matrix is shown in Figure 7.2.

Decisional Matrix

Abstinence	
Pros (short- and long-term)	**Cons (short- and long-term)**
Stay alive	Hard to be in my skin
Get along with my partner better	Will miss drinking
My children will respect me more	May experience withdrawal symptoms
I will respect myself	Have to face negative emotions without
Save money	alcohol

Continued alcohol use	
Pros (short- and long-term)	**Cons (short- and long-term)**
Makes me feel better, bad feelings go away	I could lose my job
Good way to get even with my partner	I could lose visitation with my children
when we're fighting	I could become physically violent
Allows me to let loose and have a good time	I will probably fight with my partner more
Don't need to fight cravings	I may experience blackouts
	I could end up in the hospital

Figure 7.2
Example of Completed Decisional Matrix

Rearranging Behavioral Consequences: Negative Consequences Cards

Use the following dialogue to introduce the use of negative consequences cards:

> *I'd like you to practice* ***thinking*** *about the negative consequences of drinking before you take a drink. That is, just before you take a drink, you probably have been thinking mostly about the short-term pros of drinking, such as* (point out the short-term positive consequences

of drinking from the client's completed decisional matrix). *This exercise will help you start getting used to thinking about the cons of drinking, rather than the pros. This is one way of controlling your thoughts to help you avoid drinking. In other words, we want to make the negative consequences of drinking more salient than the positive consequences of drinking when you are faced with a trigger, so that the negative consequences are what you think of first.*

List negative consequences of drinking on a 3×5 index card, and then devise ways to increase the amount of time the client thinks about these consequences—the client must learn a new thinking habit. Have client read the 3×5 card prior to high-frequency activities (hang card on mirror in bathroom, put near coffee pot, etc.).

Anticipating High-Risk Situations This Week

Work with the client to identify at least one high-risk situation coming up in the next week (see sample dialogue in Session 1). Have the client write out ideas for handling the situation on the High-Risk Situations worksheet in the workbook.

Homework

- ✎ Instruct the client to continue self-recording and record coping with high-risk situations on the back of the self-recording cards.
- ✎ Have the client complete self-management plans for triggers not yet done.
- ✎ Have the client complete the Decisional Matrix.
- ✎ Have the client implement self-management plans and write on back of self-recording cards how triggers were dealt with.
- ✎ Have the client read Chapter 4 of the workbook.

This page intentionally left blank

Chapter 8 *Session 5: Assessing Anxiety and Depression / Dealing With Urges*

(Corresponds to chapter 5 of the workbook)

Materials Needed

- Copy of client workbook
- Breathalyzer and tube
- Self-recording cards
- Alcohol Use and Urges Graph in progress
- What Do You Get Anxious About? worksheet
- Log of Anxiety Situations and Thoughts
- What Do You Get Depressed About? worksheet
- Log of Depressing Situations and Thoughts
- Dealing With Urges worksheet
- High-Risk Situations worksheet

Outline

- Determine blood alcohol level (BAL) of the client
- Provide overview of session
- Review self-recording and homework
- Check in
- Provide psychoeducation about anxiety and assess client's anxiety

- Provide psychoeducation about depression and assess client's depression
- Discuss the relationship between alcohol and mood
- Discuss ways of dealing with urges to drink
- Review skills and progress made thus far (optional)
- Identify potential upcoming high-risk situations and plan for how to cope with them
- Assign homework

Therapist Note

■ *Before this session, check the client's SCID I—Mood Disorders section, the Beck Anxiety Inventory and the Beck Depression Inventory to get a sense of lifetime and current anxiety and depression problems and diagnoses. Choose to spend time on the problems that are most relevant for your particular client. You may also want to spend more than one session on the material in this chapter.* ■

Blood Alcohol Level Determination

If the client's BAL is greater than .05, reschedule the session. If the client is still drinking, remind client of the abstinence plan and revise if necessary.

Overview of Session and Setting the Agenda

Inform client of topics that will be covered in the session. Ask the client if there are any additional issues he would like to discuss today.

Review of Self-Recording and Homework

1. Collect and review completed recording cards from the client, and use the data to update the Alcohol Use and Urges Graph.

Reinforce the client for compliance. Continue to discuss patterns and trends in cravings, triggers, and how the client dealt with them.

2. Review the client's completed High-Risk Situations worksheet. Determine if there were any situations that the client did not anticipate, and see whether he could have anticipated these ahead of time. Reinforce successful coping.
3. Review decisional matrix homework. Ask the client to discuss his reactions to the decisional matrix homework and whether or not it had an impact on his desire to be in treatment or to change.
4. Check that the client has completed self-management plans for two more triggers from the High-Risk Hierarchy. Assign two more for the week from higher-risk situations on the hierarchy.
5. Review implementation of ongoing self-management plans.

Check In

Ask client how his week was in general and acknowledge his concerns. Use information from this for specific topics in the rest of the session.

By Session 5, the client should be completely abstinent from drinking. If not, we suggest the following interventions:

1. Check client's motivation for abstinence by revisiting his decisional matrix and reasons for seeking treatment (see Session 4).
2. Remind client that this is an abstinence-based treatment and revise the abstinence plan.
3. Identify the situations in which the client is drinking.
4. Identify what is getting in the way of quitting.
5. Help client choose a target quit date.
6. Help client identify ways to prepare for the target quit date.
7. Assess the level of physical dependence. Does the client need a supervised detoxification or higher level of care?

8. If the client is ambivalent about abstinence, refer to the relevant section in Chapter 2.

Assessing Anxiety

You may want to use the following dialogue to start off the discussion about anxiety:

> *Many problem drinkers (women in particular) tend to struggle with sadness and anxiety in their lives. Today, we will discuss these two emotions and determine if and how they affect you, and how they might relate to your alcohol use. Next week we'll follow up on this discussion with some tips for helping you to calm yourself so that you feel less need to use alcohol for that job.*
>
> *Let's talk first about anxiety. Most people experience some level of anxiety at some points in their lives. It's a normal human emotion that is designed to warn you of danger. In some situations, low levels of anxiety can actually improve your performance. For instance, when taking a test in school, a bit of anxiety can help you to concentrate on the test. High levels of anxiety, however, are usually counterproductive, making it harder to focus.*
>
> *High levels of anxiety are uncomfortable and can be disabling. If you suspect you suffer from anxiety more than the average person, we should discuss it. If you feel that anxiety is not a big problem for you, I think you will still benefit from learning how to manage everyday feelings of anxiety.*

Generate discussion using the section of the workbook titled "Taking Stock of Anxiety" and the worksheet titled "What Do You Get Anxious About?" as guides. Discuss the client's experience of anxiety and what types of situations generate anxiety for him, using the following psychoeducational method:

1. Review common anxiety symptoms that go with each anxiety disorder (as listed in the worksheet Taking Stock of Your Anxiety). Panic attacks usually involve breathing, skin, and heart-related symptoms, and can happen during the course of any anxiety disorder. Panic *disorder* is when the panic attacks come out of the blue and are not associated

with any particular situation or context, and when the content of the patient's fear is fear of another panic attack. Generalized anxiety disorder (uncontrollable worry about everyday matters and safety of loved ones) is associated with intestinal and muscular symptoms, worrying, as well as irritability. Obsessive-compulsive disorder is most often associated with scary intrusive thoughts that the person recognizes as bizarre, and repeated behaviors that the person feels compelled to do that don't seem to make much sense. Social anxiety disorder can include panic-like and cognitive symptoms. Most anxiety disorders involve avoidance on some level.

1. Using the Taking Stock of Your Anxiety worksheet, ask the following questions:

- *Which of these symptoms have you noticed and when*?
- *What have you done to try to get relief* ?

2. Review the content of worry typically associated with each anxiety disorder by discussing the worksheet What Do You Get Anxious About? See Figure 8.1 for a completed example.

(Adapted in part from *How to Control Your Anxiety before it Controls You*, by Albert Ellis)

These are some common anxiety symptoms. Put a checkmark next to the ones you have experienced

Breathing/Chest Symptoms
Shortness of breath
Rapid or shallow breathing
Pressure on chest
Lump in throat
Choking sensations

Skin-Related Symptoms
Sweating
Hot and cold spells
Itching

Heart/Blood Pressure Symptoms
Heart Racing
Palpitations
Faintness
Increased/decreased blood pressure

Intestinal Symptoms
Loss of appetite
Nausea or vomiting
Stomach discomfort

Muscular Symptoms
Shaking, tremors
Eyelid twitching
Startle reactions
Fidgeting
Pacing
Insomnia

Cognitive/Emotional Symptoms
Intrusive thoughts
Nightmares
Depersonalization (feeling outside of yourself)
Brief hallucinations
Paranoia and fear
Obsessing with no relief
Consistent worry about everyday events

Behavioral Symptoms
Avoidance
Irritability
Compulsive, repetitive acts

What Do You Get Anxious About?

Social Anxiety:
Socializing
Public speaking
Job-related things
Being the center of attention

Post-Traumatic Stress:
Memories of traumatic events

Generalized Anxiety:
Thinking about things that could go wrong
Thoughts about not being able to pay the bills
Thoughts about people I love getting hurt

Panic Attacks:
Being nervous about having a panic attack
Fear of dying from a panic attack

Specific Phobias:
Open places
Closed places
Heights
Trains, planes
cars, bridges, tunnels
Animals

Obsessions/Compulsions:
Intrusive thoughts
Feeling very detached
Fear of germs
Fear of hurting others
Fear of being bad
Checking for safety

What types of things do I get anxious about?

Meeting new people, speaking up in meetings at work, eating alone in restaurants, going to parties, making small talk with people I don't know well.

How do I feel when I'm anxious?

Sweaty, heart racing, hard to swallow, mouth gets dry

What works to make me less anxious?

Leaving the room, taking a deep breath, having a glass of wine.

Figure 8.1
Example of Completed What Do You Get Anxious About Worksheet?

Log of Anxiety Situations and Thoughts

Keep a log this week of situations or thoughts that make you feel anxious. Rate each one from 0 to 10.

Date	Time	Situation	Thought	Anxiety level 0–10
8/2/08	5 a.m.	Wake up, laying in bed	Why can't I sleep? What if I never get a full night's sleep again?	7
8/2/08	5 a.m.	Same	I'm so tired. What if I nod off at work?	6
8/2/08	5 a.m.	Same	What if they say I need to work late tonight? I'll never wake up in time for my trip tomorrow.	7
8/3/08	6 a.m.	Wake up, lay in bed	Up again. What if I'm so anxious on the plane that I freak out?	7
8/4/08	4 p.m.	Getting ready to go out for dinner	What if I'm so nervous at dinner I freeze and lose my train of thought? What if they all think I'm a loser? I'll look so stupid and nerdy.	9
8/6/08	8 a.m.	Driving to work	I acted like such an idiot yesterday—they will all know I don't know what I'm talking about. What if I lose my job over this?	8

Figure 8.2
Example of Completed Log of Anxiety Situations and Thoughts

If the client reports recent experience of anxiety, assign homework for the coming week to keep a daily log of anxiety triggers and thoughts. Explain that thoughts written down should be the actual thought, and often start with "I." The client can photocopy the Log of Anxiety Situations and Thoughts worksheet provided in the workbook. Next week you will review the log with him and discuss ways to cope with anxiety. Figure 8.2 provides an example of completed log of anxiety situations and thoughts.

Another common problem among problem drinkers (again, more often for women but for men as well) is depression and sadness. Look now at whether sadness and depression have been problematic in the client's life; next week you will follow up with some tips on how to manage negative moods. You may want to use the following dialogue to begin:

> *We all feel sad from time to time. Passing feelings of sadness or depression are normal and common. Like anxiety, feelings of sadness and depression can be triggers to drink excessively, and, like anxiety, depression is usually made worse in the long run by excessive drinking. So, it's important for problem drinkers to keep aware of their moods and to be able to change their moods through methods that do not involve alcohol.*

Use the sample worksheet titled "What Do You Get Depressed About?" (Figure 8.3) to guide your discussion. On the client's blank worksheet in the workbook, have client identify and circle the symptoms of depression he may have been experiencing recently. Discuss types of situations that have made the client feel depressed in the past in order to figure out how he can cope with these situations without drinking.

You may also want to use the following dialogue:

> *Remember, drinking may be a short-term solution to escape feelings of sadness and depression, but in the long run, it makes the depression worse and also creates a new set of problems that themselves can cause you to get depressed. Let's find a way out of the vicious cycle!*

The client can finish filling out the worksheet titled "What Do You Get Depressed About?" for homework this week. Also, if the client has been struggling with depression, have him fill in the Log of Depressing Situations and Thoughts during the week (see Figure 8.4). A blank copy is provided in the workbook for photocopying. Next session you will review the log and discuss ways to cope with depression.

These are some common symptoms of depression:

- Depressed mood
- Sadness
- Apathy
- Tearful
- Feeling empty
- Thoughts of death, thoughts of suicide
- Decreased interest in things you used to enjoy
- Sleeping more than usual or unable to sleep
- Feeling worthless, low self-esteem
- Fatigue or loss of energy
- Feelings of hopelessness
- Waking up at 4 or 5 a.m.
- Difficulty concentrating
- Change in appetite
- Moving slowly

What situations tend to make you feel depressed?

I get depressed when I get ready for work because I hate my job and feel like I ruined my life. I get depressed about my marriage—I get depressed when I think of how old I'm getting and how life is passing me by.

What thoughts tend to make you feel depressed?

I should have stayed in school longer.
I miss my family in Ohio and never should have moved to New Jersey.
I am afraid to talk to my husband about my real feelings.
I am already almost 40 and life is passing me by.

How do you feel when you are depressed?

Sad, really tired, tearful, apathetic about everything. Even small chores feel overwhelming, just want to sleep

What works to make you feel less depressed?

Talk to my therapist, talk to my sister, take a walk, Force myself to exercise, challenge my thoughts

Figure 8.3
Example of Completed What Do You Get Depressed About?

Log of Depressing Situations and Thoughts

Keep a log this week of situations or thoughts that make you feel sad or depressed. Rate each one from 0 to 10. We'll go over it next week.

Date	Time	Situation	Thought	Depression level 0–10
9/6/08	4 a.m.	Can't sleep, lay in bed	Oh my. I feel awful. So depressed. I don't want to go to work today. I can't sleep what's wrong with me?	9
9/6/08	5:30 a.m.	Get out of bed	Oh man—what's the point of showering. Too tired. Will call in sick. Can't face work today. Work is stupid and I don't contribute anyway.	9
9/6/08	7 a.m.	Driving to work	Dragged myself through the morning routine. I feel awful. I will end up an old lady alone all the time. Will die alone in a bare room. What's the point. My life is not where it was supposed to be at this age.	7
9/7/08	6 a.m.	In shower	I'm so tired. Who cares about work. I can't take this feeling much longer. Ugh—have to choke down some breakfast or will get a headache. Ah—who cares, don't feel like eating. Who cares if I get a headache	9
9/9/08	6 p.m.	Get home from work	Alone again. I've managed to alienate or isolate from everyone in my life who used to love me. Now no one calls or cares. Serves me right. What a loser.	7

Figure 8.4

Example of Completed Log of Depressing Situations and Thoughts

Explain the relationship between anxiety, depression, and alcohol with the following dialogue, while the client follows along using "The Relationship Between Anxiety, Depression, and Alcohol" section in his workbook.

Alcohol depresses (slows down) your central nervous system, but it tricks you first!

In the short run, alcohol makes you feel euphoric, happy, and relaxed. In this way, it feels at first like a stimulant, but this is because it is suppressing ("depressing") the parts of your brain that make you feel inhibited or anxious.

When the alcohol increases in your system to a certain point, it can make you feel depressed, irritable, or angry.

When the alcohol leaves your system, the withdrawal effects are opposite those of the initial effects of relaxation and happiness. That is, you feel a "rebound effect" of anxiety—even more anxious!! You may also feel depressed, irritable, or restless.

In other words, the use of alcohol temporarily (and artificially) erases the negative feelings (anxiety, depression) that made you want to drink in the first place, but then actually magnifies (increases) the very same anxiety and depressive symptoms that made you want to drink. Now you feel even more anxious and depressed—which makes you feel like you need to drink again, to get rid of those feelings again.

It's a vicious cycle. When experiencing the increased anxiety or depression withdrawal symptoms after alcohol, it's common for people to think, "Wow, I must be really anxious (depressed)—even more than I thought. If I don't have alcohol in my system, I feel REALLY anxious. I'd better have a drink to calm my nerves again and get rid of this awful anxiety (prevent another panic attack, stop these obsessive thoughts)."

Many people don't realize that it's actually the alcohol itself that is causing an increase in the anxiety or depression!

The only way to stop this vicious cycle is to get off the roller coaster—to stop drinking and learn to cope with the anxiety and depression that led you to drink in the first place. Longer-term solutions take time to learn and practice. You have to tolerate a certain amount of discomfort while you are learning to control your anxiety and depression without alcohol.

There are nonaddictive antidepressant medications available to help as well. If appropriate, have the client discuss this option with a physician. Ideally, the therapist should refer the client to an American Society of Addictions Medicine (ASAM) physician or a psychiatrist with additional accreditation from the American Academy of Addiction Psychiatry—these physicians are best equipped to treat alcohol-dependent patients for psychiatric problems. If physicians with these credentials are not available, keep a referral list of psychiatrists with expertise and experience in the treatment of alcohol and other substance use disorders that practice in your geographic area.

Dealing With Urges

Explain to the client that as he tries to cut down or stop drinking, he will experience urges to drink. In this section, you will offer the client some ways to handle these urges.

Ask the following questions to help the client articulate his own beliefs about urges, and counter these beliefs where appropriate. You may use the following sample dialogue:

I'd like to discuss your understanding of urges to drink by asking you some questions, and then we'll work on ways to help you cope with urges. First—where do you think that urges come from?

Try to help the client view urges *as responses to external situations that are difficult to cope with (i.e., triggers)*. Probe for the belief that urges are physiologically based or are caused by lack of motivation to change, and help the client understand the relapse prevention model of urges, which emphasizes situational cues and coping deficits.

Second—what do you think it means if you are experiencing urges?

Try to help the client view urges as signs of the need to cope with a situation differently, not a sign of addiction.

Finally—what has your experience been with urges? When you do experience an urge to drink, how long does it last? What happens to the intensity? Does it keep getting worse and worse, or does it get better over time?

Elicit the client's beliefs about the time course of urges. Does he view them as time-limited or as something that will continuously increase in intensity over time unless he drinks?

Continue the discussion by reviewing with the client the important points to remember about urges and triggers.

Urges are reactions to triggers. Your body has learned to connect certain people, places, and things to drinking. The triggers can even be thoughts or emotions.

Urges are a sign that you have to do something different. Something in the situations is making it difficult for you. The way you handle the situation has to change.

Urges to drink don't last forever! They are like waves in the ocean—they peak, they crest, and they subside. They usually go away in a short time. Even though the few minutes can seem very long, remember that the desire to drink will go away if you give it time.

To summarize, emphasize to the client that urges can be seen as

1. triggered by external events;
2. a natural experience associated with change;
3. an indication of the need to cope differently with a trigger;
4. time-limited;
5. not an indicator of motivation or prognosis—almost everyone has urges when they stop drinking.

Exercise—Ways to Deal With Urges

Discuss with the client the various ways of effectively coping with urges to drink. You may use the following sample dialogue:

> *There are many effective ways to cope with urges. Some people cope best through thinking, some through action, and some through contact with other people. Let's talk about some of these options.*
>
> *You might find that the use of imagery is a helpful way to deal with urges. We have found that different clients experience urges differently and that different images help them. For some clients, the best way to deal with urges is to "go with the flow"—that is, to recognize and accept the urge and just ride it out. Other people find that they want to use active imagery to deal with urges. Which of these views seems more like your feelings about urges?*

Ask carefully about the client's views here, in order to develop the best imagery. Select imagery consistent with the client's preferred mode of thinking about urges. For clients who select the mode of actively dealing with urges, an image that Marlatt and Gordon (1985) suggest is that of the Samurai—viewing the urge as an enemy, that, as soon as recognized, is "beheaded."

Other images are of a wine glass filled with bleach, or a wine glass with a dead spider floating at the bottom, or an older woman or man sitting alone at a bar, drunk, face weathered and lined, eyes glazed, or any other negative image that is meaningful. These images are only examples. The client might come up with another image that he finds more compatible.

Explain to the client that some people prefer to deal with urges through activity. Ask the client to identify a couple of other approaches to handling urges that may be useful. The client may think that getting involved in a distracting activity can help him deal with urges to drink. Reading, working on a hobby, going to a movie, and exercising (jogging, biking) are all good examples of distracting activities. Once the client gets interested in something else, he will find that the urges go away in no time. Another effective response to craving is eating before

beginning to drink alcohol, as most people don't feel like drinking after eating a meal or something sweet. Also instead of an alcoholic drink, the client can have a sugarless hard candy and a glass of iced tea or iced seltzer with juice. Or, when attending a buffet or function where there is an open bar, the client can begin immediately with some hors d'oeuvres and a glass of soda with ice.

Explain to the client that some people cope best with urges by reaching out to other people. Ask the client if there are people he could call who would distract from an urge (i.e., someone the client likes to talk to) or who could help him deal with an urge (i.e., someone who understands what the client is trying to do). Summarize the discussion for the client using the following sample dialogue:

> *In summary, here are some ways of dealing with urges to drink. Pick one or more that will work for you.*
>
> - *Remind yourself that the urge is a temporary thing. No matter how bad it is, it will not last forever.*
> - *If possible, get away from the situations that created the trigger.*
> - *Go through the list of reasons why you decided to stop drinking. Remind yourself about the bad parts of drinking. Remind yourself about the good things about not drinking.*
> - *Find something to do that will get your mind off the urge to drink. A fun activity that does not involve drinking will help distract you from the struggle.*
> - *Talk with somebody who will be understanding and supportive. Often just talking about the urge will take some pressure off you.*
> - *Say encouraging things to yourself that will make you feel good about not drinking.*
> - *Use your imagination. Imagine yourself in a pleasant place where you are peaceful and happy.*
> - *Another way to use your imagination is to have a picture in your head of the urge looking like an ugly monster. Think of yourself as a ninja or a samurai fighting back and beating the monster. Or picture bleach poured in a wineglass.*

- *Imagine that you are in a boat and the urge is a big wave that comes and rocks the boat, but then passes you by.*
- *Tell yourself you can't always control when an urge comes, but you can just accept that "there's that urge again," and let it stay until it evaporates. Don't try to get rid of it, just notice it, distract yourself, and let it go away when it's ready.*
- *Pray.*
- *Read through your workbook and do exercises you find helpful, such as a behavior chain for that particular urge.*
- *Journal.*
- *Talk to a qualified physician (preferably accredited by the American Academy of Addiction Psychiatry or an ASAM-Certified Physician) about the option of medication to help reduce cravings for alcohol. Research has supported the usefulness of these medicines: naltrexone (ReVia®) and acamprosate (Campral®). Other medications are currently in various stages of research and development.*

Have the client write down ideas for dealing with urges on the worksheet provided in the workbook.

Review of Skills and Progress (Optional)

If time in session allows, take this chance to catch up on interventions not delivered yet, and/or to provide a time for you and the client to review and reflect on material covered thus far, evaluate the client's progress toward the goal of abstinence, reflect on positive aspects of the client's participation, and reflect on positive consequences of his behavior change. Also, ask about areas that are still difficult and problematic for the client and discuss those as challenges to address during the rest of the therapy.

Refer the client to the section "Look How Far You've Come" in Chapter 5 of the workbook, and review the skills covered in treatment up to this point. The section highlights skills already learned as well as

upcoming treatment topics. A copy for your use is provided on page 139. Use this discussion to point out how much progress has been made.

> *Let's review this handout together to highlight your progress over the past few weeks, as well as the new skills you've learned. The handout also lists the topics we have yet to cover as part of the treatment program. This is to give you the "big picture" of the treatment plan and to help you see how much progress you've made here and how many new skills you now have under your belt.*

Look How Far You've Come

You have already learned a great deal in treatment. You have been practicing many skills to help keep you from drinking. You understand alcohol better, in terms of standard drinks, blood alcohol level, and problem levels of drinking. You have been doing self-recording, learning to recognize your triggers, and gaining insight into the behavior chain that leads to drinking after you encounter one of your triggers.

You've learned what cues in the world around you may start you feeling and thinking your way toward drinking. You've figured out which risky situations are going to be the toughest for you—and since forewarned is forearmed, now you can be prepared. And you have learned to see well ahead of time that these situations are coming up, so now you can plan accordingly. You'll see the trouble before you are right on top of it! You've analyzed your social network and identified people who may be triggers for drinking as well as nondrinkers who may be potential buffers for you against drinking. You've learned to generate plans for dealing with triggers, so that you are prepared with a specific way to deal with each one.

You have considered the pros and cons of drinking and of abstinence, so that you may feel more strongly that the pros of abstinence outweigh the pros of drinking. You are also clearer on the cons of drinking.

You have some new tools to deal with urges and cravings.

You have learned to identify types of negative emotions and symptoms.

You're on your way! Stay tuned . . . you'll be learning to:

- Calm yourself when anxious or sad
- Speak assertively
- Create more rewards for sobriety to replace the positive consequences of drinking
- Recognize the negative consequences of drinking
- Challenge thoughts about alcohol that get you into trouble
- Deal effectively with situations where alcohol is present
- Make less risky decisions
- Solve problems effectively
- Manage angry thoughts, feelings, and behavior better
- Identify warning signs that could lead to relapses
- Avoid relapses and deal with any slips

Anticipating High-Risk Situations This Week

Work with the client to identify at least one high-risk situation coming up in the next week (see sample dialogue in Session 1). Have the client write out ideas for handling the situation on the High-Risk Situations worksheet in the workbook.

Homework

- ✎ Instruct the client to continue self-recording and record coping with high-risk situations on the back of the self-recording cards.
- ✎ Have the client finish What Do You Get Anxious About? worksheet started in session.
- ✎ If relevant, have the client keep a Log of Anxiety Situations and Thoughts.
- ✎ Have the client finish What Do You Get Depressed About? worksheet started in session.
- ✎ If relevant, have the client keep a Log of Depressing Situations and Thoughts.
- ✎ Instruct the client to complete two more self-management plans for more difficult items on the High-Risk Hierarchy.
- ✎ The client should use urge coping twice during the week in a high-risk situation or another time when experiencing an urge.
- ✎ Have the client read Chapter 5 of the workbook.

Chapter 9 *Session 6: Affect and Mood Management / Rearranging Behavioral Consequences*

(Corresponds to chapter 6 of the workbook)

Materials Needed

- Copy of client workbook
- Breathalyzer and tube
- Self-recording cards
- Alcohol Use and Urges Graph in progress
- Challenging Negative Thoughts worksheet
- Tips to Manage Strong Negative Emotions
- Decisional Matrix from Session 4
- Alternatives to Drinking worksheet
- High-Risk Situations worksheet

Outline

- Determine blood alcohol level (BAL) of the client
- Provide overview of session
- Review self-recording and homework
- Check in
- Introduce the management of negative emotions and moods
- Help the client challenge negative thoughts

- Review tips to manage strong negative emotions
- Summarize and discuss ways to cope with anxiety and depression
- Help the client rearrange behavioral consequences for drinking
- Help the client identify alternatives to drinking that can replace some of the prior positive consequences of drinking
- Identify potential upcoming high-risk situations and plan for how to cope with them
- Assign homework

Therapist Note

■ *The material in this chapter may take up to several sessions, depending on the needs of the particular client.* ■

Blood Alcohol Level Determination

Reschedule if BAL of client is greater than .05. Check on compliance with homework and abstinence goal.

Overview of Session and Setting the Agenda

Inform client of topics that will be covered in the session. Ask the client if there are any additional issues she would like to discuss today.

Review of Self-Recording and Homework

1. Collect completed self-recording cards from the client, and use the data to update the Alcohol Use and Urges Graph. Reinforce the client for compliance and for coping well with triggers. Continue to discuss patterns and trends in urges, drinking, and triggers.
2. Review self-management homework. The client should have rearranged/avoided at least 2 triggers. For homework, have the

client complete two more self-management plans, selecting items that are rated higher (50–75) on the high-risk hierarchy.

3. Review worksheets and logs on anxiety and assign log of anxious thoughts again this week if relevant. Use thought logs in current session.

4. Briefly review worksheets and logs on depression. Assign log of depressing thoughts again this week if relevant. Use thought logs in current session.

5. Review urge coping homework and ask the client if she found it helpful. Ask client if there are other skills to deal with urges that she thinks could be helpful. Instruct client to use these skills twice this week in urge or high-risk situations.

Check In

Ask client how her week was and acknowledge her concerns. Use this information for specific topics in the rest of the session.

If client is not abstinent at this point, discuss possible need for higher level of care. (See abstinence plan options in Session 1.)

Introduction to the Management of Negative Emotions and Moods

Last session assessed the client's anxiety and depression; this session will focus on how to cope with that anxiety and depression. Introduce the management of negative emotions and mood with the following dialogue:

> *In today's session, we will use some of the information we covered last week to teach you new ways to calm down and feel better. The goal is to train yourself to stop reacting to people and situations in ways that increase your negative emotions and decrease your self-confidence. By recognizing when you're starting to become anxious or depressed, you can stop yourself from spiraling downward into uncontrolled anxiety or sadness.*

Ask the client if any of this rings a bell, or bring in examples from her own life to illustrate the concepts.

Review and summarize with the client the worksheets and homework from last week, to discuss which types of emotions and moods seem most problematic for her. Focus on those in this session. Remind the client of the idea of triggers:

> *You have more control over whether you feel sad or anxious in response to a situation than you think! Similar to triggers to drink, there are triggers for anxiety and sadness. It's not always possible or desirable to avoid triggers for strong emotions, so today we will focus on how to change your thoughts and responses to such triggers.*

To help the patient deal with anxiety and depression, you will cover the following methods: challenging negative thoughts and learning to relax. You will also review some general tips to manage negative emotions.

Challenging Negative Thoughts

You may want to begin with the following dialogue:

> *Negative events can be thought of as emotion triggers. They lead to negative thoughts, which then lead to negative feelings and behavior. If you can learn to identify, challenge, and replace negative thoughts, you can avoid or alleviate anxious and depressed feelings and behaviors.*

Use the example of a completed Challenging Negative Thoughts worksheet (Figure 9.1) to introduce the client to the process of identifying, challenging, and replacing negative thoughts. Use this example to explain the process of identifying and writing down the negative thoughts and what emotions they generate, then challenging them, and then replacing them with more constructive, adaptive thoughts.

Types of Negative Emotion Thoughts

Next have the client look at the section "Types of Negative Emotion Thoughts" of the workbook. Introduce the idea of classifying negative emotion thoughts into types. Explain to the client that it is easier to challenge and replace a negative thought after identifying and figuring out which type of negative thought it is, and we will now discuss different types of thoughts so that she can learn to classify hers. Refer

Challenging Negative Thoughts

Situation:

Jane has been sober for 2 months now, thanks to hard work on her part. She is feeling particularly proud of herself this weekend. She managed to attend a wedding on Saturday and didn't have a slip even though there was an open bar. On Sunday morning she is thinking that maybe she and her boyfriend, with his two kids, will take a ride to the beach. But when he wakes up he announces that he forgot to tell her that he promised his kids that he would take them on a fishing boat that day. He tells her that she's welcome to come with them if she wants. Jane feels herself getting upset. She thinks, "I get nauseous on those boats so I don't want to go. Now I'll be stuck here all day alone, with nothing to do. My life is empty. I don't have my own kids. I probably would have been a bad mother anyway. I'm such a loser, of course John doesn't want to spend the day with me." In past similar situations, she might have stayed quiet, cried when they left, and then stayed home watching TV and feeling sad. Today instead she challenged and replaced her negative thoughts:

Negative Thought (emotion generated: sadness):
Now I'll be stuck here all day alone, with nothing to do. My life is empty.

Challenge and Replace Thought (emotions generated: relief, excitement):
Wait a minute—I'm not stuck. I can still go to the beach—I'll create my own fun day.

Negative Thought (emotion generated: sadness)
I don't have my own kids. I probably would have been a bad mother anyway.

Challenge and Replace (emotions generated: relief, contentment):
I didn't want to have children with my first husband, and that was an excellent decision. I love John and I love his kids, so we decided not to have kids of our own. I've been happy with that decision too. It's just at times like this that I regret my decisions, but I know they were the right decisions for me at the time. And John's kids and I have a nice relationship.

Negative Thought (emotion generated: depression)
I'm such a loser. Of course John doesn't want to spend the day with me.

Challenge and Replace (emotions generated: confidence, positive anticipation)
Loser schmoozer. John asked me to go with them, silly!! It's a beautiful day out and I'm not going to waste my time feeling sorry for myself. I'll call my girlfriend and see if she wants to spend the day at the beach. Maybe I'll make us a banana bread to snack on . . .

Figure 9.1

Example of Completed Challenging Negative Thoughts Worksheet

the client to the section in her workbook listing types of negative emotion thoughts. Review the different types of negative emotion thoughts, especially those types that seem most relevant to the client. Ask the client which types ring a bell for her. Use the client's anxious and depressing thought logs completed for homework as examples of some of these types of negative thinking.

All or Nothing Thinking: This type of thinking ignores the possibility that some things are between all good and all bad. Example: *"I must always do a perfect job."*

Overgeneralization: Overgeneralization happens when people see one bad experience as evidence of everything being bad. Example: *"I lost that account; I am a crummy account executive."*

Mental Filter: A negative mental filter keeps out positive thoughts and focuses on negative things. People who always see "the glass as half empty" have a negative mental filter. Example: *"I am extremely unattractive—just look at that fly-away hair."*

Disqualifying the Positive: This problem thinking happens when a person believes that good things that happen are unusual or somehow do not count. Example: *"I got a good grade on that test because it was so easy. Anyone could have gotten an A."*

Jumping to Conclusions: People often jump to conclusions without having evidence to support their negative interpretations. For instance, **Mind Reading** is jumping to the conclusion that you know what the other person is thinking. Example: *"My husband looked at me funny. He hates this new outfit I bought and is mad that I spent money on it."*

Catastrophizing: *Catastrophizing* happens when a person exaggerates the importance of things. A key to this type of thinking is someone thinking about how something is **awful, terrible**, or **horrible**. Example: *"Here I am, stuck in traffic. This is the third time this year I'll be late to the meeting. My boss is probably ready to fire me. I can't believe I let myself be late again."*

Depression Filter: When people are depressed, they typically have thoughts that are quite negative, but this is because depression tends to distort the thinking process to result in an onslaught of negative

self-talk. Example: *"I am really not where I should be at this stage of my life. At this rate, I have very little hope for improving my future."*

Should Statements: Some people set such high standards for themselves that they set themselves up for failure if they do not meet their standards of perfection. The key to catching this kind of thinking is the word *should*. Example: *"I should cook a full meal with a protein and vegetable every night and the whole family should sit down and eat it together, because I'm a good mother and that's what good mothers do."*

What If: This is a special type of anxiety thought that relates to worrying:

People worry about inability to do common everyday things:

"What if I run out of money this month and can't pay my rent?"

Or they worry about being or going crazy:

"What if I'm really nuts and I end up in a mental hospital?"

Or they worry about rare events:

"What if my doctor tells me I have cancer?"

Or about having anxiety:

"What if I have another panic attack while I'm driving the car?"

[Adapted in part from David Burns (1980). *Feeling good: the new mood therapy*. New York: New American Library.]

Exercise—Challenging Negative Thoughts

Categorize some of the thoughts the client listed on her homework thought logs. Use the sample Challenging Negative Thoughts worksheet (Figure 9.1) to illustrate how to identify, challenge, and replace negative thoughts, as well as to identify which type of thought each of the negative thoughts is. Then have the client practice identifying, challenging, and replacing her own thoughts on the blank Challenging Negative Thoughts worksheet in the workbook in session with you. She can finish it up for homework this week. Emphasize to the client that

our thoughts are not always accurate, and we can decide how to respond to them:

> *Remember! Your thoughts are not facts! You can choose to go with negative thoughts or to leave them behind!*

Tips to Manage Strong Negative Emotions

Next discuss some skills to help the client manage strong negative emotions. Have the client follow along using the worksheet titled "Tips to Manage Strong Negative Emotions." Have the client circle the coping skills that seem most helpful and add her own. Introduce and discuss these following strategies to manage negative strong emotion:

1. **Retain your calm and cool**. One of the destructive effects of strong emotion is mental confusion and its effect on judgment. As long as you can retain your cool, you will be in control of the situation. Here are some phrases you can say to yourself to help you cool off in a crisis:
   - *Time out.*
   - *I can handle this.*
   - *Take it easy.*
   - *Take a few deep breaths.*
   - *Hold it—don't do or say anything I'll regret later.*
   - *Easy does it.*
   - *Chill out.*
   - *Relax.*
   - *Count to ten.*
   - *Cool it.*
2. **Take a "time-out**." If you cannot immediately calm down use the "time-out" procedure to allow yourself time to get back in control of your anger and avoid "acting-out" your emotions and repeating past destructive behaviors. (See "Time-Out" handout for Session 9.)
3. **Slow down** and assess the situation. Identify and challenge negative thoughts.

4. **Stop catastrophizing**. Take a deep breath from the bottom of your stomach, and tell yourself you'll be fine. Remember, you are a good coper—you can cope with whatever comes your way, you just have to slow down and figure out the best way to proceed. Acting emotional will only make matters worse.

5. **Figure out what you can control** in this situation, and what is out of your control. Let go of what you can't control.

   You may find that you cannot resolve the situation and you still feel sad. Remember that you can't fix everything. Let yourself feel sad—it's a natural feeling and will go away after a while. Don't punish yourself for feeling sad.

6. **Congratulate yourself** for handling a difficult situation in a nonreactive way. You behaved in a self-respectful way, and did not let others or your own emotion get the better of you. You also have prevented yourself from spiraling downward into deeper anxiety or depression.

Summary of Coping With Anxiety and Depression

Summarize and discuss three basic ways covered to cope with anxiety and depression. The client should follow along using the section Coping With Anxiety and Depression in the workbook.

You might explain this material as follows:

Here are three ways to cope with anxiety and depression—(1) learning how to relax, (2) challenging and replacing negative thoughts with the method that we've just reviewed, and (3) learning to let things go:

1. Learning How to Relax

Most people experience anxiety or tension in their everyday lives: real problems occur, we worry about problems that might happen, and we worry about ourselves. All these worries create tension and anxiety.

Some people use alcohol to cope with feelings of tension, anxiety, or sadness. Alcohol may provide temporary relief, but the problems and

worries don't go away. In fact, alcohol creates its own sets of problems and usually makes the anxiety and sadness worse in the long run. Instead of drinking, learning how to relax can help.

Having a few simple, quick ways to relax such as the following can come in handy when you start to feel anxious or depressed.

- *Exercise*
- *Take a hot bath*
- *Get a massage*
- *Take a long walk or swim*
- *Use relaxation breathing to help to relieve tension—it's quick and simple to learn.*

An easy type of relaxation breathing is to take a deep breath from the abdomen (hold your hand on your stomach to make sure it's moving up and down with the breath) every 4–10 seconds Inhale to a slow count of 6, and exhale to a slow count of 4. Do this for 5–10 min before or during an anxious situation to regulate your breathing and reduce anxiety, and/or every day for 20 min to have more long-lasting effects.

Remember, you can use relaxation breathing anywhere—all anyone might notice is how calm you are!

2. Identifying, Classifying, and Challenging Negative Thoughts

Use the skills you learned for identifying, classifying, challenging, and replacing negative affect thoughts. (See section "Types of Negative Emotion Thoughts" for types of thoughts.)

3. Letting Things Go

You can't control whether or not you'll have anxiety or depression thoughts. But you can control whether you let yourself get caught up in them, worry about them, obsess about them, and get even more anxious or depressed. Anxious and depressed thoughts are like a snowball rolling down a hill. They pick up speed, size, and strength as

they go, if you let yourself get caught up. Let the negative thought float in one ear, recognize it, identify it, and classify it, and then let it float out the other ear. Tell yourself: "It can't hurt me. I am safe. I'm fine."

Go over examples of letting go with the client. For instance:

Anxious Thought ("what if" thought):

"What if I lose my job and I can't pay my bills?":

To let go of that "what if" thought, observe that you've had that thought and that it made you feel anxious, then try thinking something like this next:

"There's that 'what if' thought again. I don't have time or energy to worry about that now—it would be a waste of time. Let it go when it's ready. Now where's that CD I like to listen to . . ."

Depressing Thought

"I've wasted so much time in my life drinking—I'll never get on track."

Again, notice that you've had this depressing thought and that it made you feel sad. Then try an alternative thought:

"I'm only 35 and I have plenty of time left, no sense wasting any more of it thinking depressing thoughts. I'm going to make the most of my time today. I think I'll go for a walk. Just because I had this thought doesn't make it true."

Notes for the Therapist

1. If the client has a diagnosable anxiety or mood disorder and needs additional help, be sure to discuss in clinical supervision. It may be necessary to refer that client for a psychiatric evaluation or additional psychological care.
2. If at any point a client displays suicidal ideation, do a standard clinical suicide risk assessment and discuss with the client's treatment team (if there is a treatment team available) and/or seek peer consultation if you need to. Take appropriate steps to ensure the client's safety.

3. Be sure to communicate the following to clients who are considering medication to help with anxiety or depression:

> *Sometimes people experiencing anxiety and depression seek help from their family physician and are prescribed medications to help them. You should be careful that the medications prescribed are not addictive, such as benzodiazepines (Valium®, Xanax®, Ativan®). These medications, like alcohol, are addictive and often will create a new set of addiction problems for you. There are several medications to treat anxiety and depression which are not addictive. It's important to seek help for anxiety or depression from a qualified psychiatrist, preferably an addictions psychiatrist, if you feel you need additional help to get relief from anxiety and depression. Let us help you find a qualified addiction psychiatrist.*

Rearranging Behavioral Consequences

Present the following rationale to the client:

> *Today, we will talk about ways to increase the positive rewards you experience from staying sober. We are also going to discuss other ways to increase the positive thoughts that you have about staying sober and to increase the negative thoughts that you have right now about drinking.*

Remind client of the decisional matrix developed in Session 4. Turn back to the client's completed matrix in the workbook (or use a photocopy), and look at it together.

Now that the client has been in treatment 2 more weeks it makes sense to update and change the matrix in any ways necessary. Ask the client to think of any additions that she would make to any parts of the matrix (short- or long-term consequences of drinking or of sobriety). The goal of this exercise is to teach the client how to rearrange the consequences so that she thinks more clearly and convincingly about the negative consequences of drinking and learns how to find rewarding nonalcohol replacements for the positive consequences of alcohol so that sobriety becomes more rewarding.

Now that we have reviewed some of the pros and cons of stopping versus continuing to drink, let's talk about two ways you can use this decisional matrix to help you stay (become) sober.

Increasing the Salience of Negative Consequences of Drinking

Introduce this section with the following dialogue:

You have already been practicing thinking about the negative consequences of drinking several times a day when you read your 3×5 negative consequences card. Now, I'd like to extend that to have you keep the card with you in your wallet and take it out to read before you drink. Be sure to use these cards when specific situations that may lead to drinking come up.

Have the patient consider the following example:

Some friends call and invite you to join them and a few other people at a club to relax and socialize. Your first thoughts will most probably be related to the positive consequences (don't be surprised, you have had a long time to develop that thinking habit). Delay accepting their offer ("I need to check my schedule, let me get back to you in an hour") and review your 3×5 card; practice your new thinking habit. Then call back and decline, using these suggestions:

Be firm but polite—make it clear that you mean what you say when you decline.

Suggest an alternative—Even though you aren't going to go to the club, say you'd like to see them and you wonder if they would they like to come over for dinner on Sunday.

We'll look at how to refuse drinks and drinking opportunities like this in depth in Session 8 in a couple of weeks.

Replacing the Positive Consequences of Drinking With Positive Rewards of Sobriety

Look over the positive consequences of drinking that the client listed on the decisional matrix and present the following rationale.

Despite the negative consequences of drinking, we have to remember that the positive consequences are what kept you drinking and giving up those positive aspects of drinking is difficult. When people develop a drinking problem, they experience the "funneling effect": many resources—time, money, energy, attention—are directed toward alcohol, including thinking about alcohol, getting alcohol, drinking, being drunk, and recovering from alcohol's effects.

When people leave drinking behind, they often experience a frightening emptiness in their lives—the time and energy that drinking took has to be filled with something rewarding, to keep you from going back to drinking. Try to think of it like this: One advantage of not drinking is that you have newfound freedom to use your time and resources in new ways, in whatever ways you choose. Let's make that a conscious choice. Let's think of ways to replace some of the positive consequences of drinking with rewarding activities that will be fun, positive, and healthy. To help you with that we've listed some activities in your workbook that many people enjoy.

Refer client to the list of activities in the workbook. A copy for your use is provided here (see Table 9.1).

Alternatives to Drinking to Get Similar Positive Rewards

Discuss with client the notion that some of the positive consequences of drinking, such as euphoria and relaxation induced by alcohol are not easily replaced, but that these consequences were artificial and temporary, followed by the negative consequences.

Review the client's list of positive consequences of drinking as outlined on her decisional matrix, and develop a list of responses that serve as positive, rewarding alternatives to drinking (e.g., relaxation, social activities, enjoying nature). Go slowly and have the client record alternatives on the Alternatives to Drinking worksheet in the workbook. Remind the client to select alternatives that fit with her long-term goals. For example, the client might decide to go running or to engage in another form of exercise to relax instead of reading or listening to

Table 9.1 What Do Other People Do?

Read a book	On a rainy day, clean the house while dancing to loud music	Play basketball or tennis with your kids at the park
Go to the gym and work out	Sort through old photos and start a scrapbook	Take a long walk on the boardwalk
Go out for a nice meal	Surf the Web	Go to a meeting and out for coffee after
Do volunteer work	Go "treasure hunting" at garage sales on the weekends	Go to a free lecture at the local community college
Go to a county fair	Work backstage or build sets for your local community theater group	Do yard work and enjoy the fresh air
Play cards or board games	Get a massage, manicure or pedicure, or all three!	Take your dog to the park or for a brisk walk around the neighborhood
Wander the mall to find bargains	Call an old friend who lives far away	Paint a room in your home
Begin a knitting or carpentry project	Go to a sporting event	Sign up for a cooking class or art course
Go to a concert or play	Go to a museum or art gallery	Visit the zoo or aquarium
Go on a picnic at a park or take your picnic to the beach on a summer day	Lounge by the pool, or swim indoors at the YMCA	Go on a camping trip
Take a bike ride	Order in and watch a DVD	Go horseback riding
Go to Home Depot and buy materials for a new do-it-yourself home repair project	Run errands	Play basketball at the park
Take a dance or martial arts class	Go into the city and window shop	Go to services at your house of worship
Plant a vegetable garden or flowers	Catch fireflies	Buy new fancy bodywash and take a shower or bath
Call or visit your grandchildren, or a favorite niece or nephew	Make a nice dinner	Plan a trip someplace new
Join a book club or go to the library or book store to find a great novel to read	Go rollerblading	Volunteer at your local place of worship

Alternatives to Drinking	
Trigger situation and positive consequences of alcohol	**Alternative activity with similar positive consequences**
Saturday night at restaurant with my partner Positive consequences of alcohol—relaxation, wine goes with dinner, euphoria, festive atmosphere	Get my favorite takeout food, eat at home, and then go to a movie
Tuesday night, partner working late, and no one is home Positive consequences of alcohol—reduce lonliness, special time alone, relaxation	Join a gym and go swimming Tuesday night. On way home, stop at coffee shop or local bookstore
Friday, after work, doing yard work Positive consequences of alcohol—relaxation	Stop at gym after work for an exercise class. Do the yard work Saturday morning instead
Neighborhood picnic, 4th of July Positive consequences of alcohol—festive atmosphere, chance to be social, euphoria	Go to the gym before the picnic. Bring my own soda to the party. If there are too many tempting triggers at the picnic, leave and go to the beach.

Figure 9.2
Example of Completed Alternatives to Drinking Worksheet

music, if one of her long-term goals is to get into better shape. An example of completed Alternatives to Drinking worksheet is shown in Figure 9.2.

Anticipating High-Risk Situations This Week

Work with the client to identify at least one high-risk situation coming up in the next week (see sample dialogue in Session 1). Have the client write out ideas for handling the situation on the High-Risk Situations worksheet in the workbook.

Homework

- ✎ Instruct the client to continue self-recording and record coping with high-risk situations on the back of the self-recording cards.
- ✎ Have client continue keeping Log of Anxiety Thoughts and/or Log of Depressing Thoughts if useful for the client.
- ✎ Have client finish worksheet Challenging Negative Thoughts. This week, the client should try to catch herself with anxious or sad thoughts, challenge them, and replace them.
- ✎ Instruct the client to use relaxation skills two times this week, and write down on back of self-recording card when she does.
- ✎ The client should continue to implement self-management plans.
- ✎ Ask the client to complete the Alternatives to Drinking worksheet in the workbook and practice two alternatives this week.
- ✎ Instruct the client to hang a 3×5 card listing negative consequences of drinking in at least one spot this week and read it on a daily basis.
- ✎ Have the client read Chapter 6 of the workbook.

This page intentionally left blank

Chapter 10 *Session 7: Connecting With Others / Dealing With Alcohol-Related Thoughts*

(Corresponds to chapter 7 of the workbook)

Materials Needed

- Copy of client workbook
- Breathalyzer and tube
- Self-recording cards
- Alcohol Use and Urges graph in progress
- I Want to Connect With People Who worksheet
- Making Connections worksheet
- Dealing With Alcohol-Rlated Thoughts worksheet
- High-Risk Situations worksheet

Outline

- Determine blood alcohol level (BAL) of the client
- Provide overview of session
- Review self-recording and homework
- Check in
- Discuss improving social support for abstinence
- Discuss dealing with alcohol-related thoughts

- Identify potential upcoming high-risk situations and plan for how to cope with them
- Assign homework

Blood Alcohol Level Determination

Reschedule if BAL of client is greater than .05. Check on compliance with homework and abstinence goal.

Overview of Session and Setting the Agenda

Present today's topics and ask the client if there are any additional issues he would like to discuss.

Review of Self-Recording and Homework

1. Collect completed self-recording cards from the client, and use the data to update the Alcohol Use and Urges Gaph. Reinforce the client for compliance. Continue to discuss patterns and trends of triggers and cravings.
2. Review status of self-management planning. Client should select and implement two more plans for homework.
3. Review decisional matrix status and review negative consequences card.
4. Review alternatives to drinking; identify two more positive activities and assign.

Check In

Ask client how his week was in general and acknowledge his concerns. Use information from this discussion for specific topics in the rest of the session.

If client is not abstinent at this point, discuss possible need for higher level of care, augmentation of treatment with anti-craving medications or aversion-based medication disulfiram (Antabuse®).

Connecting With Others: Improving Social Support for Abstinence

Discuss the importance of social support for abstinence. You can introduce the topic with the following dialogue:

> *In Session 3, we discussed how to manage heavy drinkers in your social support network, as a way to help you become and stay abstinent. Today, I would like to introduce a related topic. As an abstinent person, you need to know how to manage heavy drinkers in your social network, but it's also very important to develop a stable personal support network of nondrinkers or other people who support your abstinence, and whom you can enjoy, spend time with, turn to when you have troubles, and who need you. (Women in particular thrive better in general when they have a web of healthy connection with others.) You have been learning to cope well, be autonomous, and know how to take care of yourself, that is, be your own best friend. In addition to this, a nice sober social support network will enrich your life, provide you with opportunities for growth, warmth, and happiness, and be there when you need a shoulder.*
>
> *In today's session, we will reevaluate the social network support you have now versus when you began treatment. Then, we will discuss what you are looking for in members of your network. Third, we will discuss ways to reach out and develop a richer social network if that's what you feel you want to do. Part of taking care of yourself is providing yourself with a rich, healthy network of connections and knowing when and how to reach out to people who want to help you—people who have your best interest in mind and who treat you well. You don't need to do this alone.*

Social Support Network Exercise

Update the client's Your Social Network worksheet from Session 3 (make changes, add any new members). Ask the client how he perceives his social network as having changed over the past weeks since he stopped drinking. Discuss his feelings about whether he is content with his current sober support network or not and whether he feels "connected" or not.

Making Connections

Have the client look at the I Want to Connect With People Who worksheet to help identify what he is looking for in members of his network. Discuss the notion that he deserves to be around people who treat him well and to *not* be with people who treat him poorly or do not have his best interest in mind. Point out that this worksheet is *not* for the purpose of thinking about the characteristics of a "perfect mate," but rather is designed to help him think of *how he wants to be treated* by people in his current or new social network.

Next use the Making Connections worksheet to brainstorm ways to find and develop a social network. (See Figure 10.1 for a completed example.) You may want to introduce the worksheet with the following dialogue:

> *Some people are lucky enough to have great social networks "built in" to their families—supportive siblings, for example—or their neighborhoods—a circle of friendly neighbors, for instance. Others have to make more of an effort to develop a social network that they value. Remember, social networks can consist of different types of "friends"—romantic partners, children, relatives, friends, AA members, professional counselors, community-based networks, etc.*

Point out that in completing the worksheet, the client can use any term he feels comfortable with—friend, significant other, social support person, etc. Discuss barriers he might experience to developing new friendships and how to overcome them.

Making Connections

Brainstorm by category ways for you to connect with others to establish a strong, healthy social network.

How can you . . .

- **Connect with friends**?
  (Volunteer organizations, classes, reconnecting with old friends)

  I will attend my high school reunion and reconnect with some people I miss.

  I will dig up the numbers of two women I used to be friendly with—they are only 30–40 minutes away.

  I will take a baking class at the local community college.

- **Connect with community-based networks?**

  (AA, professional counselors, clubs, religious affiliations, special interest groups)

  I will go to 4 AA meetings a week—women's meetings.

  I will volunteer at my church and start attending services.

  I will go on the Web to see if there are biking clubs in my town.

- **Connect with children and relatives as part of your social support network?**

  I will call my sisters each once per week to say hi.

  I start a vegetable garden and perennial plant garden project with my kid.

  I will visit my Mom and Dad at least once a month even though it's a 90 min ride.

- **Connect with a romantic partner as part of your social support network?**

  I will join a dating website to see what it's like.

  I will remind my friends that I am available if they know anyone for a blind date.

Figure 10.1
Example of Completed Making Connections Worksheet

So far, treatment has focused on the development and rearrangement of external triggers and the development of ways to focus on negative consequences of drinking and generate positive alternatives. The emphasis in this section is on further expansion of cognitive control, teaching the client to modify what he says to himself—the rearrangement of internal or cognitive events. This will be done in two ways:

- Identifying and challenging dangerous thoughts about alcohol (there are three types)
- Learning to "think through the drink"—to stop and think through the behavior chain

Identifying and Challenging Dangerous Thoughts About Alcohol

Refer the client to the section "Dealing with Thinking about Alcohol" in Chapter 7 of the workbook. Explain the 3 types of thoughts that can trigger drinking:

1. Thoughts or images about alcohol can create urges. Some examples are images of bars, thoughts about a favorite drink, and smells and sounds of alcohol. These thoughts directly trigger urges.
2. Thoughts about the enjoyable effects of alcohol can trigger urges. Some examples are thoughts such as "Just one won't hurt"; "It will calm my nerves"; "My friends will think I'm strange if I don't drink"; "It will help me sleep"; "I can have just one." These thoughts are generally about the short-term benefits of drinking, but ignore the long-term problems it can cause.
3. Negative thinking can lead to drinking. Unpleasant thoughts and emotions can also lead to drinking. Some of these thoughts are about hopelessness or about negative self-worth. Examples are self-doubt, guilt, and anger. Negative thoughts are indirect triggers. They set up a chain of events that lead to drinking.

Figure 10.2
Thoughts That Can Trigger Drinking

Figure 10.2 shows the three different types of thoughts that can lead to drinking.

Thinking Through the Drink

Inform the client that our thoughts and what we do in a particular situation are chained. You may use the following sample dialogue:

> *Your thoughts lead to actions. Sometimes those thoughts go through your head so quickly that people believe they are acting without thinking. The idea of this skill is to slow down the whole process so that you have more control over your thoughts and your actions. An important step in interrupting drinking chains is to recognize your thoughts in trigger situations. You have already listed many of your own triggers. Among these triggers, you will find some dangerous thoughts. Be alert for these dangerous thoughts. When you identify a dangerous thought, challenge it and replace with a healthy thought. Imagine your dangerous thoughts as tripping off an alarm—a blinking red light in your head, indicating that it's time to deal with the trigger in a way that will avoid drinking.*

Exercise—Dealing With Alcohol-Related Thoughts

Have the client use the Dealing With Alcohol-Related Thoughts worksheet in the workbook to write down at least one personal example of each type of thought he has or has experienced that has led to drinking.

(See Figure 10.3 for a completed example.) Provide instructions as follows:

1. a) *You feel the "urge" to drink. Write down the positive thoughts you have about alcohol when you experience this urge (e.g., "ummm . . . a cold beer is so inviting!").*

   b) *Challenge the positive thoughts about alcohol with a replacement thought (e.g., "Beer is a toxin. I can't have just one.")*

2. a) *You feel the "urge" to drink. Write down a thought about positive consequences of drinking (e.g., "A cold wine spritzer would quench my thirst").*

   b) *Challenge and replace: "Think through the drink" (e.g., "Yes, it might taste good and quench my thirst at first, but I can't have just one, and so I will get drunk, neglect the kids, my husband will get angry, I will end up passed out on the couch and tomorrow I will feel ashamed and the kids will have this role model and a memory they don't deserve. And besides, alcohol only seems to quench thirst—it actually makes people even thirstier.")*

3. a) *You feel the "urge" to drink. Write down a negative thought that leads you to drink (e.g., "I've already been such a bad wife that my husband's family hates me. I might as well drink, what the hell. What's done is done.")*

   b) *Challenge and replace (e.g., "Yes, I have alienated my in-laws, but the truth is I don't really like them anyway and I won't let them have this much power over me. I won't drink because of them. The only way to clean up my act is to start by stopping drinking. My in-laws have nothing to do with this. I'm just using them as an excuse.")*

Therapist Note

■ *The client should be taught procedures to modify this category of thoughts through cognitive restructuring. The rationale for these procedures should stress their use as self-control skills. Encourage a high level of client involvement in the formulation of the dangerous thoughts that may lead to drinking, as well as more healthy, replacement thoughts. Emphasize that better control of thoughts will make it easier for the client to control drinking behavior.* ■

Dealing With Alcohol-Related Thoughts

1. Direct, positive thoughts about alcohol:
(for example, an image of a cold glass of beer)

I love that first swallow of frostly beer.

Challenge and replace:

One beer tastes good. Twelve beers make me sick. I can never stop after just one so there's no point in thinking about it. Beer actually doesn't quench thirst. I'm better off with water and lemon.

2. Thoughts about positive consequences of alcohol:
(for example, "A glass of wine will taste good")

I won't feel so lonely if I drink a lot.

Challenge and replace:

In the long run, I'll be even lonelier because I'll end up alienating those people close to me with my drinking.

3. Negative thinking:
(for example, "I'm such a loser, I might as well drink too")

I have hurt so many people. They'll never forgive me. There's no point in even trying.

Challenge and replace:

Drinking will definitely make things worse. At least I have a chance of making things right if I stay sober and am willing to try.

Figure 10.3
Example of Completed Dealing With Alcohol-Related Thoughts worksheet

Anticipating High-Risk Situations This Week

Work with the client to identify at least one high-risk situation coming up in the next week (see sample dialogue in Session 1). Have the client write out ideas for handling the situation on the High-Risk Situations worksheet in the workbook.

Homework

- ✎ Instruct the client to continue self-recording and record coping with high-risk situations on the back of the self-recording cards.
- ✎ The client should continue to rehearse negative consequences from the 3 × 5 card in high-risk situations this week.
- ✎ Have the client finish I Want to Connect With People Who worksheet started in session.
- ✎ Have the client finish Making Connections worksheet started in session and implement new ways to begin connecting with others.
- ✎ Have the client start to develop new thinking habits and finish completing the Dealing With Alcohol-Related Thoughts worksheet.
- ✎ Instruct the client to implement two more stimulus-control alternative plans.
- ✎ Have the client read Chapter 7 of the workbook.

Chapter 11 *Session 8: Assertiveness Training / Drink Refusal*

(Corresponds to chapter 8 of the workbook)

Materials Needed

- Copy of the client workbook
- Breathalyzer and tube
- Self-recording cards
- Alcohol Use and Urges Graph in progress
- Assertiveness worksheet
- High-Risk Situations worksheet

Outline

- Determine blood alcohol level (BAL) of the client
- Provide overview of session
- Review self-recording and homework
- Check in
- Conduct assertiveness training
- Teach client how to refuse a drink
- Identify potential upcoming high-risk situations and plan for how to cope with them
- Assign homework

Blood Alcohol Level Determination

Reschedule if BAL of client is greater than.05. Check on compliance with homework and abstinence goal.

Overview of Session and Setting the Agenda

Inform client of topics that will be covered in the session. Ask the client if there are any additional issues she would like to discuss today.

Review of Self-Recording and Homework

1. Review self-recording, update graph, and reinforce client.
2. Review use of 3×5 card in high-risk situations.
3. Review worksheets on connecting with others—encourage implementation of 2 ways to improve social network.
4. Review application of all past exercises and self-management plans: Problems? Questions? Determine if any new situations have occurred requiring a plan; reinforce increased self-control, new thinking patterns, and rehearsal.
5. Review Dealing With Alcohol-Related Thoughts homework.

Check In

Ask client how her week was in general and acknowledge her concerns. Use information from this discussion for specific topics in the rest of the session.

Assertiveness Training

Tell the client that each person should be able to choose for herself how she will act in a given circumstance. This session will teach the

client how to act more effectively; there are several situations in which assertiveness may be helpful:

- dealing with frustrating and anger-inducing situations
- making requests
- refusing requests
- giving criticism
- receiving criticism

Which Do You Do?

You may begin with the following dialogue:

> *Many people have interpersonal interactions that lead to unpleasant emotions. These bad emotions may then lead to drinking. Often, people have difficulty letting others know what they want. Few people learn the basics of speaking assertively. It seems obvious but it's not. Assertiveness means recognizing that each person has rights. It means that understanding that both you and the other person have rights. Assertiveness means that you are able to show respect to both the other person AND YOURSELF!*

Review these rights with the client as follows:

- People have the right to make their feelings known in a way that does not hurt others.
- People have the right to make their opinions known to others.
- People have the right to request that another person change a behavior that is affecting others.
- People have the right to accept or reject anything that someone else says to them or requests of them.

Explain that people have three different styles of asking something from others: passive, aggressive, and assertive. Present each of these to the client while the client follows along in the workbook section "Speaking Assertively."

Passive behavior *is usually based on an underlying belief that you do not have the right to ask for what you want or that you do not deserve to have what you want. A person who consistently chooses a passive response and puts others' rights before hers most of the time may end up being "passive-aggressive," which can be considered a fourth way of responding. This means that she is angry but does not outwardly express anger. Instead, she may begin to talk maliciously behind someone's back instead of figuring out how to communicate directly with that person to get what she needs, or take on a project she doesn't think is fair, but somehow mess the project up by procrastinating, for instance—this is called being "passive-aggressive." Sometimes a person can be passive for a while, building up resentment, and then eventually explode in an aggressive act.*

Aggressive behavior *is often associated with "losing your temper" and acting in an angry, mean way to bully someone into giving you want you want. Typically it does not result in your getting what you want, and often in fact has the opposite effect.*

Assertive behavior *is the "gold standard" and involves thinking about what you believe both you and the other party deserves and has a right to and then thinking about how best to choose an effective communication style to obtain what you want. Usually after an assertive response, you feel better about yourself and you haven't hurt anyone in the process.*

Review the chart entitled Which Do You Do (Table 11.1), and highlight examples of each type of behavior so that the client understands the three categories. Then have the client identify and discuss responses she typically uses.

Table 11.1 Which Do You Do?

Passive Behavior	Aggressive Behavior	Assertive Behavior
Self-denying ("Let him go first, even though I've been waiting longer") **Inhibited** ("I can't ask that—it may sound silly.") **Hurt, anxious** ("What if they don't like me?") **Allows others to choose for self** **Does not achieve desired goal** ("Oh well . . .") **Does not feel worthy of desired goal** ("Oh well . . .") **Resentment grows** ("Why doesn't anybody see how hard I work?") **Often results in explosive aggression** ("I'VE HAD ENOUGH!!!") **Talks behind others' backs** (passive-aggressive) **Gossips** (passive-aggressive) **Complains a lot** (passive-aggressive) **Whines about unfair situation** (passive-aggressive) **Does not take responsibility** ("They are so unfair . . . no one sees that . . .") **Feels helpless and depressed** **Does not command respect**	**Loses control of anger** ("These idiots had better give me what I want!!") **Chooses for others** ("Just do it my way and shut up") **Feels ashamed after losing control** ("I can never come back to this store") **Does not achieve desired goal** ("I stomped out and now I still can't return this stained shirt") **Does not consider others' rights** ("Just give me what I want!") **Hurts others** **Is quite unpopular** **Feels out of control and stressed**	**Feels good about self** ("I stayed in control and I feel good about that") **Chooses for self** ("I am an adult; I can remain calm and ask for this.") **Considers rights of self and others** ("I don't think I'm taking advantage. I have every right to ask this. It's fair to both of us.") **Usually achieves desired goal** ("Yes!!") **Takes responsibility** ("It doesn't matter if life is unfair – I'm the one who loses if I don't try to take care of myself.") **Feels worthy of her own rights** ("I do deserve this!") **Thinks about how to word things** ("Let's see, getting angry won't help. Take a deep breath and figure out how to say this in an effective way . . .") **Expressive** **Feels calmer and in control**

Speaking Assertively

Discuss the section of the workbook entitled Speaking Assertively. Review the following tips, guidelines, and steps to communicating assertively.

Guidelines for Speaking Assertively

Your Thoughts

- Think about how you want the situation to turn out.
- Remind yourself that getting angry will not achieve desired goals and you will feel ashamed after.
- Remind yourself that doing nothing also will not achieve your goals, and you'll feel frustrated.
- Try to think about the situation from the other person's position.
- Recognize the other person's rights. If the person feels respected, she will be more likely to respect you.
- Think about how to word your request.
- Talk yourself through it.

Your Feelings

- Understand what you are feeling.
- You are allowed to feel as angry as you want, but you acting on those feelings impulsively without the filter of assertiveness will probably backfire.
- Take a deep cleansing breath, or use relaxation breathing skills (from Session 6) to focus and be calm.
- When you feel really angry, take a time out.

Your Actions

- Take action before you are too afraid to act, or so angry you can barely contain yourself.
- Don't go in looking for a fight—assume the person wants to help resolve the issue and approach the issue in a calm, problem-solving way, not in an emotional, adversarial way.
- Begin with a positive statement and balance the negative with positive, so that the other person does not feel attacked.
- Speak up clearly and in a respectful but clear tone. Don't apologize.
- Look the other person in the eye, but keep your nonverbals relaxed and not aggressive. This tells the other person that you are confident but respectful.
- Use guidelines for good communication:
  - Be polite
  - Avoid blaming and sentences that begin with "you"—that make the other person feel attacked.
  - Keep your voice tone pleasant
- Clearly state what you want and why.
- Request a specific change. Vague requests do not work because the other person is not clear about what you want.
- Be firm but polite in your answers to requests made by the other person.

Steps to Communicating Assertively

1. Start with something nice.
2. Calmly explain your position without blaming others.

   Instead of, "*Your store sold me a defective shirt with a stain on it and your return policy is ridiculous*" say, "*I bought this shirt here a few weeks ago and didn't notice until I went to wear it yesterday for the first time that it has a stain on it which must have been there when I*

bought it. Unfortunately, it's past the return date according to the policy but since I haven't worn it I would like to exchange it for a similar shirt with no stain."

3. Start with an "I" statement whenever possible.
4. Explain calmly what you are upset about.
5. Make a specific request for change.
6. No Grand Slam plays. Instead of storming out, be politely persistent. (*"I see you're busy. May I speak with the manager, please?"*)

Assertiveness Exercise

Ask the client to generate examples of situations in which she thinks it would be helpful for her to be more assertive. You can help her to come up with situations if needed. Use the Assertiveness worksheet to list the situations and to help the client identify whether she was using a passive, aggressive, or assertive response in each situation.

Next have client choose an example from this list, and role-play an assertive response in that situation, using the Guidelines for Speaking Assertively. First, you should role-play the client and model an assertive response to a situation the client presents. Then the client should role-play an assertive response to a situation you present. Please note that clients often are uncomfortable (self-conscious) about role-play in session and may not want to participate. Acknowledge that role-play may seem a bit forced at first but thought to be one of the most helpful ways to use therapy time and that as soon as they begin they will get past the awkwardness. You should be encouraging and persistent in finding a way to start to role-play. Sometimes, clients are more comfortable at first if they are not "on the spot"—having the therapist take the client role, and the client take the other role can ease them into a role play. Then, the therapist can suggest switching roles. For homework, have client identify two situations during the coming week in which she can practice using assertiveness skills. Have her write down these situations on the back of her self-recording card.

Inform the client that the ability to refuse drinks is a special case of assertiveness, however, one-third of alcoholic patients relapse as a direct result of social pressure from "friends" to drink.

> *The ability to refuse drinks is much more difficult than it appears. It is another weapon in your arsenal of self-control skills. We are going to practice ways of refusing/turning down drinks so that you can gain control in these tough situations.*

Expect resistance during this exercise. The client may say, "Refusing drinks is not a problem," to which you can reply, *"Yes, but it's a good skill to have anyway."*

Exercise—How to Refuse a Drink

Introduce the drink-refusal exercise using the following dialogue. Have the client follow along with the "How to Refuse a Drink" section in the workbook.

> *Use this rule of thumb: Remember that individuals who offer you drinks are "pushers" and must be discouraged politely but firmly.*
>
> *Refusing offers of drinks is harder than most people think. It takes special skills to say no to drinks.*
>
> *Offers of drinks come in many forms. Sometimes friends or coworkers put pressure on you to join in their drinking. Other times the pressure comes from family members. Sometimes you may be concerned about what others will think if you refuse a drink.*
>
> *Some people are easier to refuse than others. Some will politely accept your first refusal. Others may get pushy.*
>
> *Drink refusal is an important assertiveness skill. The foundation of assertiveness skills is a respect for your own needs. Be firm without getting aggressive. By using the following skills you can refuse a drink without coming on too strong.*

- *"No" or "no thank you" should be the first thing you say. Starting with "no" makes it tougher for the pusher to try to manipulate you.*
- *Look the person in the eye when you speak. Eye contact makes you come across as firm. Not looking the other person in the eye tells her that you are not sure about what you are saying.*
- *Speak clearly and in a serious tone. Your manner should say that you mean business.*
- *You have a right to say no. You want to stay sober. It is your life that you are protecting. Do not feel guilty. You have a right to say no and be in control.*
- *Suggest alternatives. If someone is offering a drink, ask for something nonalcoholic. If someone is asking you to get into a risky situation, suggest something else that is not risky.*
- *Change the subject to a new topic of conversation.*
- *Ask the person not to continue offering you a drink. Someone who is pushing you to drink is not respecting your rights. Ask her to leave you alone.*
- *Know your bottom line. You are saying no out of respect for yourself. If the person keeps pushing, use your problem-solving skills. Remember, you can leave, get the person to leave, or you can get help from others.*
- *And finally, remember to practice, practice, practice!*

Drink-Refusal Case Examples

Refer the client to the drink-refusal examples in the workbook and go over them as follows:

> *You're at your brother's house Christmas Day. It's a special occasion; you're with family and friends. He says, "How about a beer?" You say, "No thanks, I'd like a soda, though."*

A group of your friends approach you at a party and offer you a drink. They say, "Hey Jill, how about a glass of wine?" You say, "No thanks, I'm not drinking." They say, "Oh come on, one drink won't hurt you. What kind of friend are you?" or "What's the matter? Are you too good to drink with us?" You say, "I'll just take a selzer with lemon, thanks."

Exercise—Role-Play

Construct at least three typical scenes in which the client has had difficulty refusing a drink or has been encouraged to drink (use functional analysis and DPQ for examples).

Now pick an example from the client's life and practice drink-refusal role-play in session. You will play the part of the client while the client plays the part of the pusher. Then, you will switch roles.

Therapist Note

■ *Most clients will have trouble just saying no. A good procedure is to teach the components of refusal one at a time (i.e., have the client say no, then practice changing the topic). After each role-play, have the client evaluate the effectiveness of her response. Role reversal where the client plays the part of the pusher and you play the part of the client saying no is a helpful technique. In addition, the client should be asked to refuse three separate times in each scene.* ■

Anticipating High-Risk Situations This Week

Work with the client to identify at least one high-risk situation coming up in the next week (see sample dialogue in Session 1). Have the client write out ideas for handling the situation on the High-Risk Situations worksheet in the workbook. Also ask the client to write down on the back of the client self-recording card how she actually handled the anticipated situation and to write down any other situations that she had not anticipated.

Homework

- ✎ Instruct the client to continue self-recording and record coping with high-risk situations on the back of the self-recording cards.
- ✎ Determine a situation during the next week in which the client will be offered alcohol. Contract with the client to practice her refusal scenes twice daily.
- ✎ Instruct the client to continue employing self-control procedures.
- ✎ Have client implement two strategies to connect with others (see Making Connections worksheet in Session 7).
- ✎ Have client identify two situations during the week to use her assertiveness skills. Write on back of self-monitoring card what happened.
- ✎ Have the client read Chapter 8 of the workbook.

Chapter 12 *Session 9: Anger Management Part I / Relapse Prevention Part I: Seemingly Irrelevant Decisions*

(Corresponds to chapter 9 of the workbook)

Materials Needed

- Copy of workbook
- Breathalyzer and tube
- Self-recording cards
- Alcohol Use and Urges Graph in progress
- Anger Triggers worksheet
- Anger Behavior Chain worksheet
- Seemingly Irrelevant Decisions worksheet
- High-Risk Situations worksheet

Outline

- Determine blood alcohol level (BAL) of the client
- Provide overview of session
- Review self-recording and homework
- Check in
- Introduce anger management
- Introduce the concept of "seemingly irrelevant decisions" and how certain actions that may have nothing to do with drinking can lead the client to drink

- Identify potential upcoming high-risk situations and plan for how to cope with them
- Assign homework

Blood Alcohol Level Determination

Reschedule if BAL of client is greater than .05. Check on compliance with homework and abstinence goal.

Overview of Session and Setting the Agenda

Inform client of topics that will be covered in the session. Ask the client if there are any additional issues he would like to discuss today.

Check In

Ask client how his week was in general and acknowledge client's concerns. Use information from this discussion for specific topics in the rest of the session.

Review of Self-Recording and Homework

1. Review self-recording, update graphs, and reinforce client for recording behavior.
2. Review week regarding problem situations encountered and application of self-control procedures.
3. Review drink-refusal training homework assignment: Problems? Questions?
4. Review assertiveness homework.

Tell the client the following:

> *Today, we will take a closer look at aggressive responses. Sometimes we find ourselves "flying off the handle"—losing our temper when someone or an unfair situation makes us mad. Some people tend to be "reactive" rather than "proactive."*
>
> *For instance, imagine a State Department negotiator losing his temper at what he perceives as an unfair decision. Does he start to scream and cry? Does he yell and throw things? No, typically he remains "cool headed" and not reactive. He still feels angry, of course, but he doesn't act on his anger in a destructive way.*
>
> *Now imagine a person in front of you in line at the department store. He has lost his temper because the cashier won't accept a return without a receipt. He starts to scream and swear at the cashier, then stomps out of the store yelling, "That's the last time I shop here!" Everyone on line just shakes their heads and goes on with their business. The man did not get what he wanted and for the rest of the day he felt embarrassed and ashamed about his behavior in the store.*
>
> *Which way do you want to behave? Which way do you think commands more respect from others, and more importantly, more self-respect? Losing your temper is usually not productive. Just because someone may try to provoke you into anger or into an argument doesn't mean you have to accept! You have the choice and the right to not get angry!*

Tell the client that the goal for this part of the session is to understand that he can choose to handle anything that comes his way in a self-respecting, nonreactive way, using problem-focused (rather than emotion-focused) coping (see Session 10).

Exercise—Anger Triggers

Use the Anger Triggers worksheet (see Figure 12.1) to identify what types of situations are anger triggers for the client by each category (environmental, interpersonal, thoughts and feelings, and physical). Then, use the sample Anger Behavior Chain (Figure 12.2) to explain the

Anger Triggers

Environmental (places, things)

stuck in traffic not moving on highway for an hour

Interpersonal (people)

spouse interrupting during an argument, won't let me finish a sentence, and just keeps repeating same thing over and over

Emotions/Thoughts

anxious about being late for work when stuck in traffic

"this stupid stalled bus is making us all sit here—what is it doing in the middle of the road? Why can't the traffic police resolve this?"

Physical

In withdrawal from alcohol

Figure 12.1

Example of Completed Anger Triggers Worksheet

Anger Behavior Chain

Anger Trigger	Thoughts/feelings	Response	Positive Consequences	Negative consequences
Received a child support check 1 week late and I notice that he deducted a toy he bought for our child.	"What a jerk! He is not allowed to do that!" "Now he'll start deducting whatever he buys and I won't have enough to pay the bills" "I need to give him a piece of my mind!" Anger, rage, burning up	Call ex-husband, leave screaming message	Momentarily relieved	Children say, "Mom, you're crazy" Ex-husband plays taped message for the judge as evidence that kids are right Feel ashamed Situation not resolved Still angry
Same trigger	"What a jerk! He is not allowed to do that!" "Now he'll start deducting whatever he buys and I won't have enough to pay the bills" "If I call him I'll just leave a screaming message and I know he keeps those tapes to use against me" "Of course I'm angry, he's an expert at pressing my buttons. I won't let myself suffer anger because of him" "I'll call my lawyer in the morning, so this doesn't happen again because it's not fair." "The toy only cost $25—I can afford that and it's for Jimmy" "I feel sorry for him—doesn't he have anything better to think about in life, than trying to push my buttons" "I'm angry and I know that's normal but I don't want to feel angry. I'm going to swim some laps until I feel better"	Swim laps Take a walk	Feel less angry Proud of self—didn't lose control No screaming message taped to use against me Ex doesn't have satisfaction of having gotten to me Lawyer will help resolve situation Got some exercise	Still feel a bit like screaming at him, frustrating

Figure 12.2

Example of Completed Anger Behavior Chain, illustrating an ineffective response versus a more effective response to the same anger trigger

anger behavior chain as you explained the drinking behavior chain. The anger behavior chain format is quite similar to the drinking behavior chain, except that it focuses on angry thoughts, feelings, and behavior rather than for drinking. Then complete one Anger Behavior Chain worksheet with the client, after listing the client's triggers for anger on the Anger Triggers worksheet. Talk about methods he can use to calm himself down. Alcohol probably used to be one of those methods, or maybe even the primary method. Now he needs to develop new ways of dealing with those triggers, challenging angry thoughts, and calming down.

Exercise—Anger Behavior Chain

Use the following dialogue to begin the exercise:

> *Let's use the blank anger behavior chain in your workbook to complete one chain together, then you can do two more for homework this week. Which anger trigger from the Anger Triggers Worksheet we just filled in do you want to use as the trigger in the behavior chain we'll do together?*

In a way similar to how you walked the patient through the drinking behavior chain exercise in Session 2, you will collaborate with the client in completing one behavior chain here. Help him identify a trigger to use, then help him pinpoint what thoughts were going through his head when he was faced with that trigger and what feelings he experienced. (Be specific—"angry" is good but not enough—you should have the client describe what the angry feeling is like for him: Is it a physical sensation, a tightening sensation in his chest, a feeling that his heart is pounding, or a "tense" feeling all over?) The more specific the client is about how he experiences anger in each trigger situation, the better able he will be to identify and control these emotions when faced with that trigger. Then discuss what "response" the patient typically has in response to that trigger and those thoughts/feelings—you can discuss a real situation, for example, the last time the client responded to that particular trigger. (Did he scream? Did his voice shake? Did he have "road rage" and try to cut off another driver or roll down the window and yell? Did he become violent—if so, what

exactly did he do? Did he roll his eyes, walk away, and then later take his anger out on someone else?) Once the response is detailed (again, be specific), discuss what the short-term positive consequences were of his response (typically this would involve release of anger and temporary satisfaction or relief of tension) and few long-term positive consequences, then discuss what the short- and long-term negative consequences of his response were. Typical short-term negative consequences would be the following: feeling embarrassed after screaming, feeling regret about reacting so strongly, possibly getting into a car accident, not achieving desired goal, others thinking he's "crazy," feeling out of control, having uncomfortable physical sensations, etc. Long-term negative consequences of an angry response might include the following: cumulative damage to a relationship after repeated angry episodes, eroded lack of trust by others, and medical problems in cardiovascular and vasculatory system due to chronic release of excess stress hormones.

You will discuss how to use "time-outs" next week, as an option for a response that is an alternative to the angry responses used in the past. Also alternative responses to angry responses can be found in the sections on assertiveness training (Session 8), how to manage strong negative emotions (Session 6), and calming down before proceeding with problem solving (Session 10).

Relapse Prevention Part I: Seemingly Irrelevant Decisions

Present the following rationale to the client:

> *Many of the ordinary, mundane choices that are made every day seem to have nothing at all to do with drinking. Although they may not involve making a direct choice of whether to drink, they may move you, one small step at a time, closer to being confronted with that choice. Through a series of minor decisions, you may gradually work your way closer to the point at which drinking becomes very likely. These seemingly unimportant decisions that may in fact put you on the road to drinking are called "seemingly irrelevant decisions."*

To illustrate this process, consider the following story about a drinker explaining his most recent relapse—where are the seemingly irrelevant decisions?

Exercise—Jeff's Seemingly Irrelevant Decisions

Present the following story to the client and have him follow along with "Jeff's Seemingly Irrelevant Decisions" section in the workbook:

Jeff is on his way home from work and hasn't had a drink in 5 months. He's gotten to the point where he catches himself not thinking about alcohol for 2 to 3 days at a time. It's hot outside and he wants to get home, but today there's a 10 million dollar lottery and he wants to stop to buy a couple of lottery tickets on the way home. He pulls into the liquor store/bar he used to frequent; he knows they sell lottery tickets there. He buys the tickets and is about to turn around and walk out when he hears his name being called. He looks behind him and sees Rich, an old drinking buddy, waving him over to the bar. He walks over to say hi and finds an ice-cold beer that Rich has ordered for him, waiting at the counter. Before he can stop himself, he downs the beer and orders another.

Process the story with the client using the following sample dialogue:

Now that you've heard the story, you may be able to see that Jeff made a series of decisions that led up to his final decision to drink some beer. In your workbook, underline each one of the choice points where Jeff could have made a different decision that would have taken him away from a risky situation. (Did he really have to stop at a bar? Couldn't he have gone to a convenience store? Did he have to walk over to his old drinking buddy, or could he have waved hello to him?)

So you can see that Jeff made a series of decisions, each of which contributed in some way to his finally having some beer.

Continue the discussion with the following:

People often think of themselves as victims: "Things just seemed to happen in such a way that I ended up in a situation and then had a drink—I couldn't help it." They don't recognize how perhaps dozens of

their "little" decisions, over a period of time, gradually brought them closer and closer to their predicament. That is because many choices don't actually seem to involve drinking at the time. Each choice you make may only take you just a little bit closer to having to make that big choice. But after you've been sober for a while, it's hard to make the connection between a choice that doesn't seem related to alcohol at the moment and later trouble.

The best solution is to think about every choice you have to make, no matter how seemingly irrelevant it is to drinking. By thinking ahead about each possible option you have and where each of them may lead, you can anticipate dangers that may lie along certain paths. It may feel awkward at first to have to consider everything so carefully, but after awhile, it becomes second nature and happens automatically, without much effort.

By paying more attention to the decision-making process, you'll have a greater chance to interrupt the chain of decisions that could lead to a relapse. This is important because it's much easier to stop the process early, before you wind up in a high-risk situation, than later, when you're in a situation that's harder to handle and where you may be exposed to a number of triggers.

Also, by paying attention to your decision-making process, you'll be able to recognize certain kinds of thoughts that can lead to making risky decisions, such as the thought Jeff had that he "had to stop at a bar" for lottery tickets in the example above. Thoughts like "I have to" go to a party, "have to" see a certain drinking friend, or "have to" drive by a particular place often occur at the beginning of a "Seemingly Irrelevant Decision" and should be treated as a warning or "red flag." Other "red flag" thoughts often start with "It doesn't matter if I . . ." or "I can handle . . ."

Exercise—Georgia's Seemingly Irrelevant Decisions

Here is another example of a seemingly irrelevant decision:

> *Georgia decided to make a gourmet dinner for her and her husband and invited another couple to join them. She felt good about being abstinent from alcohol in the last 2 months and did not want to drink with dinner. However, she knew that the other couple both liked wine and that red wine would go well with the menu she had planned. She also felt it would not be fair of her to deprive the others of alcohol. Therefore, she asked her husband to buy a couple of bottles of good red wine for the company. During the dinner, she felt comfortable not drinking. Her husband and their friends finished one bottle of wine and started the second. When Georgia was cleaning up in the kitchen after her friends had left, she looked at the almost full bottle of wine and decided it would feel good to have one glass and that she would then stop drinking. She had a glass of wine and then went on to have several more glasses, finishing the bottle.*

Run through the exercise again in which the client underlines all risky choices that Georgia makes and discuss safer ones.

Discuss low-risk and high-risk options as follows:

> *When faced with a decision, you should generally choose a low-risk option, to avoid putting yourself in a risky situation. On the other hand, you may for some reason decide to select a high-risk option. If you make this choice, you must also plan how to protect yourself while in the high-risk situation. It is usually much easier to decide to avoid a high-risk situation before you get too close to it than it is to resist temptation once you are in it.*

Exercise—Discussion

Ask the client to think about the most recent time he drank. Help the client trace back through the decision-making chain. What was the starting point? (Exposure to a trigger? Certain thoughts?) Can the client recognize the choice points where he chose to make a risky decision?

Ask the client to suggest a low-risk option for the following "seemingly irrelevant decisions" situations:

- whether to keep liquor in the house
- whether to offer an ex-drinking friend a ride home
- whether to go to a bar to see old drinking friends
- where to go to get a snack/cigarettes
- whether to tell a friend that you have quit drinking or keep it a secret
- what route to take when driving (i.e., to go past or take a detour to avoid a favorite bar, liquor store, etc.)

For homework, have the client think about a decision he has made recently or is about to make. The decision could involve any aspect of the client's life, such as his job, recreational activities, friends, or family. Identify safe choices and choices that might increase the client's risk for relapse. Have the client complete the Seemingly Irrelevant Decisions worksheet. Also have him read the section "Small Things Count" in the workbook.

Anticipating High-Risk Situations This Week

Work with the client to identify at least one high-risk situation coming up in the next week (see sample dialogue in Session 1). Have the client write out ideas for handling the situation on the High-Risk Situations worksheet in the workbook. Also ask the client to write down on the back of the client self-recording card how he actually handled the anticipated situation and to write down any other situations that he had not anticipated.

Homework

- ✎ Instruct client to continue self-recording and record coping with high-risk situations on the back of the self-recording cards.
- ✎ Have client continue implementing strategies for connecting with others.
- ✎ Have client finish Anger Triggers worksheet.
- ✎ Have client complete Anger Behavior Chain worksheet.
- ✎ Have client use new skills on anger management this week if situation arises and write on back of self-recording card what happened.
- ✎ Have client underline Georgia's Seemingly Irrelevant Decisions for extra practice.
- ✎ Have the client complete the Seemingly Irrelevant Decisions worksheet in the workbook using a decision he had made recently or is about to make.
- ✎ Have the client read Chapter 9 of the workbook.

Chapter 13 *Session 10: Anger Management Part II / Problem Solving / Relapse Prevention Part II*

(Corresponds to chapter 10 of the workbook)

Materials Needed

- Copy of client workbook
- Breathalyzer and tube
- Self-recording cards
- Alcohol Use and Urges Graph in progress
- Problem-Solving worksheet
- Identifying and Managing Relapse Warning Signs worksheet
- High-Risk Situations worksheet

Outline

- Determine blood alcohol level (BAL) of the client
- Provide overview of session
- Review self-recording and homework
- Check in
- Discuss anger management
- Teach the client problem solving as a general coping strategy
- Discuss ways of identifying and managing warning signs of relapse
- Start to discuss termination if you plan to stop therapy after Session 12

- Identify potential upcoming high-risk situations and plan for how to cope with them
- Assign homework

Blood Alcohol Level Determination

Reschedule if BAL of client is greater than .05. Check on compliance with homework and abstinence goal.

Overview of Session and Setting the Agenda

Inform client of topics that will be covered in the session. Ask the client if there are any additional issues she would like to discuss today.

Review of Self-Recording and Homework

1. Review self-recording (drinking, urges), update graph, and provide feedback and reinforcement to the client.
2. Review skills covered thus far, including self-management, rehearsal of negatives of drinking, drink refusal, etc. Highlight strategies that the client is now using automatically to stay sober. Highlight positive consequences of abstinence, and ask if client has noticed any unanticipated benefits of sobriety.
3. Review Anger Triggers and Anger Behavior Chain worksheets.
4. Discuss anger management responses to situations during the week, if relevant.
5. Review completed Seemingly Irrelevant Decisions worksheet.

Check In

Ask client how her week was in general and acknowledge her concerns. Use information from this discussion for specific topics in the rest of the session.

Introduce this part of anger management with the following dialogue. Client can follow along with the section "Time-Out" in the workbook.

> *Last week we started talking about how to deal with feeling angry. One good strategy is to use a "time-out" to help you calm down. "Time-out" means taking a break from a situation where you are getting angry or tense. You can also use this method if you are starting to feel anxious or depressed. Use a time-out to relax, think, cool down, and avoid being unreasonable or violent. Remember, it takes two people to make an argument. Just because someone else is angry, doesn't mean you have to be. You are a separate person. It is your choice to engage in arguments; it is your choice how to react to an unfair situation.*

Review the following tips for time-outs with the client.

Things to Tell the Other Person

If you are with someone when you choose to take a time-out, you need to tell the other person:

1. What you are going to do
2. Where you are going (e.g., next room, to a friend's house)
3. When you will return (certain number of minutes/hours)

Example: "I'm going to take a walk to cool off and I'll be back in an hour."

Steps to Taking a Time-Out

Tell the other person that you are feeling tense and need some time to relax and think. It is important to communicate that you are not trying to avoid the problems and that you will be willing to talk about them later when you feel more relaxed and reasonable.

Get away from the person and the situation. It is best to leave the area altogether.

Do not drive a vehicle, use drugs, use a gun, or drink alcohol during a "time-out."

Calm yourself physically and mentally. Use a combination of physical and mental exercises that are nonaggressive. Concentrate on your breathing. Identify negative affect thoughts. Practice challenging and replacing them with positive self-talk.

Give yourself time to relax and get control of yourself. When we get angry or anxious, our heart rate increases, blood pressure rises, blood sugar level rises, and certain other chemicals increase in our bodies. It takes time for our body to get back to normal. Give yourself at least 20 min and preferably, 45 min to an hour before returning to the situation.

Repeat, if necessary, the time-out procedure until there is no risk of getting out of control.

Once you're calm, you can use your assertiveness skills to handle the upsetting situation.

Time-Out Do's and Don'ts

Client can follow along in the workbook, section "Time-Out Do's and Don'ts."

Some Things to Do During a Time Out

Do: Practice positive self-talk.

For example:

- *As long as I keep my cool, I'm in control of myself.*
- *I'm the only person who can make myself angry or calm myself down.*
- *It's time to relax and slow things down.*

- *It's impossible to control other people and situations. The only thing I can control is myself and how I express my feelings.*
- *It's nice to have other people's love and approval, but even without it, I can still accept and like myself.*

Do: Go for a walk, jog, run, or swim to help work off some of the energy.

Do: Think of constructive solutions to the problem.

Do: Make use of your positive social connections—talk to a good friend.

Do: Check in when you return home.

Do: Let yourself have a good cry if you want to.

Do: Let yourself feel sad if you need to. Then, let it go and allow yourself to feel hopeful.

Some Things to Avoid During a Time-Out

Do not . . . use alcohol. You will just create a new set of problems, and alcohol increases hostility, anxiety, and depression. Alcohol makes it impossible to gain self-control and self-respect.

Do not . . . talk with people who will feed your anger.

Do not . . . go to places where you have used alcohol in the past.

Do not . . . drive while angry. It is not only self-destructive, but dangerous to others as well.

Do not . . . use any weapons.

Do not . . . justify your anger or think about how wrong the other person is.

Do not . . . think about ways to control aspects of the situation you can't.

Do not . . . let yourself get sucked in to anxious thoughts—let them come and go.

Do not . . . tell yourself you're crazy for feeling this way. You're not.

Point out to the client that problem-solving skills are a very important part of changing behavior and learning to negotiate changes:

> *We will focus in this session on using problem solving as a general coping skill. First, I'll describe what problem solving is and how to do it. Then, we'll apply problem solving to a problem that you are concerned about.*

Types of Coping Strategies

Explain that there are at least two types of coping strategies that people tend to use.

Emotion-focused coping is when one gets caught up in the negative emotions associated with a life problem. Anger, sadness, frustration are common emotions that one focuses on and then often feels the need to escape from (i.e., by drinking to "feel numb" or "make the problem go away"). This type of coping is often not effective and can in fact increase distress and make things worse.

Problem-focused coping is when one acknowledges and tolerates difficult emotions, but puts them aside in order to deal with the actual problem in a relatively nonemotional, rational way. This type of coping is generally much more effective in resolving difficult situations and in defusing distress.

The client first needs to learn how to acknowledge her strong emotions in response to a situation and how to calm herself so that she can then proceed with the problem-solving steps. This preparation to problem-solving is introduced first to the client as a "self-calming" skill.

Self-Calming

Explain to the client that in order to problem solve effectively, he will need to be in a calm and rational state. If he feels overwhelmed by

emotion in response to a particular problem, he will need to calm himself down before attempting problem solving. Strategies for self-calming include:

- using relaxation breathing (introduced in Session 6)—taking a deep breath from your stomach every 6–10 seconds or so for 20 minutes
- taking a walk outside for 20 min breathing deeply
- counting to ten, taking a deep breath, and telling yourself that acting on these emotions will be counterproductive
- meditating

Ask the client if he can identify other strategies for calming himself down.

Problem-Solving Method

Emphasis should be placed on training problem-solving *techniques*, rather than only trying to solve a specific problem, in order to increase generalization. Review the general outline of problem-solving procedures. After the preparation of self-calming (if necessary), problem solving consists of seven steps (tell the client to follow along in the workbook section "Problem Solving Method and Example").

1. *Gather information*: Think about the problem situation. Who is involved? When does it happen? Exactly what takes place? What effect does this have on you? What happens before the problem (the antecedents)? What keeps the problem going (the consequences)? Where does it occur? How does the problem affect you?
2. *Define the problem*: What is the goal that you would like to achieve? Be clear and specific. Many people get into trouble at this step because they select very vague goals. Define your goal as something that can be counted. The more specific and real you make the problem, the easier it will be to solve.
3. *Brainstorm for alternatives*: This can be a fun step. The goal of this step is to build a long list of possible solutions. The first rule of

brainstorming is that no idea is too silly or dumb. Try to think about any and every possible solution to the problem. Do not think about how good or bad each idea is—that will come later. By not evaluating the ideas as they come, you will be more creative in thinking of solutions. Make as long a list as you can. The number of ideas is more important than their quality.

4. *Now, consider the consequences of each*: For each of your alternatives, list the positive and negative consequences. Think about the short-term and long-term results of each solution. Ask yourself: What things can you reasonably expect to happen? What will be the positive consequences? What will be the negative consequences? Which consequences will happen right away? Which consequences will happen later? How can you combine different alternatives?

5. *Decide*: Which of the alternatives is the most likely to achieve the goal you set in Step 2? Look for the solution (or solutions) that have the best balance of consequences.

6. *Do it!* The best plan in the world is useless if you do not put into action. Try it out.

7. *Evaluate*: Check out how the plan is working. Which parts work best? Which parts can you improve? Fix what can be fixed.

Problem-Solving Example

Problem definition:

- Background: *Susan's live-in boyfriend is less responsible with money than she is, and she often finds herself paying the household bills. She is developing resentment toward her boyfriend, since he regularly promises to pay but then uses his money on his personal expenses instead.*
- Specific problem situation: *Susan wants to find a different way to deal with this situation.*

Brainstorming for alternatives:

- *Keep trying to ask him for money when she needs it to pay bills and hope he changes*
- *Open a joint checking account, and plan for each of them to have certain amount of paycheck direct deposited into that joint account, which Susan will use for the household bills*
- *Ask boyfriend to take over the bill paying*
- *Hire an accountant or bookkeeper to handle all household finances*

Decision making (choosing the most effective alternative):

- Evaluate the positive and negative consequences of each possible alternative (see Figure 13.1).

Problem-Solving Worksheet

	Pros	Cons
a. Keep doing the same	+ Familiar + Boyfriend not mad	– Resentment grows – Possible break-up of relationship – Unfair to Susan
b. Open joint checking	+ Fair to both + Susan doesn't have to ask boyfriend for money + Reduced resentment	– Need to deal with paperwork for direct deposit change – Need to open bank account – Susan still paying the bills
c. Ask boyfriend to take over bills	+ Susan reduces resentment + Susan doesn't have to ask for money	– Boyfriend probably not capable – Damage to credit history – Bills not paid – Resentment eventually increased on both sides
d. Hire accountant	+ Less burden for Susan + Less resentment of boyfriend	– Expensive – Someone else knows all personal business

Figure 13.1
Example of Completed Problem-Solving Worksheet

- Choose the alternative with the best payoff, solving the problem while maximizing positive consequences and minimizing negatives.

Exercise—Problem Solving

Explain to the client that problem-solving techniques can be applied to almost any problematic situation in her life. Together, choose a problem that has come up over the sessions for the client.

1. Ask the client to imagine that the situation is occurring and have her describe how she views or defines the problem. Help the client conceptualize the essence of the problem.
2. Define the problem, in specific terms.
3. Ask the client to generate alternative ways of responding to the situation (e.g., one alternative would be the typical response the client would have to the situation). Remind the client that brainstorming for alternatives means not evaluating too soon. ("Let your mind go; the more ideas the merrier.")
4. Determine with the client the full range of consequences that would result from each proposed alternative (i.e., positive and negative, both long and short term).
5. Help the client select the most viable alternative (highest probability of gaining desired result).
6. Have the client make a commitment to implementing a solution.
7. Have client evaluate how it went.

Review the sample Problem-Solving worksheet shown in Figure 13.1, and use the blank worksheet in the workbook to practice problem solving with the client in session. Pick a problem that has come up in the course of treatment so far.

Introduce the concept of relapses and relapse prevention at this time.

Ask the client to turn to the section on warning signs in Chapter 10 of the workbook and paraphrase the following:

> *The focus of our treatment has been on helping you achieve abstinence and then developing the skills you need to maintain abstinence in the long run. So far, you have been pretty successful with the treatment.* (Adjust your introduction as necessary. If the client has had many slips, then refer to those. If the client has not had any slips, then introduce the possibility of future slips.)
>
> *However, we do know that many people who want to stay sober still have difficulties at times and may experience a slip or relapse. We have two more sessions after today, and we want to help you be prepared for situations you may face after treatment is over.*
>
> *It may seem pessimistic to discuss drinking when you're not, but we like to think about relapse prevention the way we think about fire prevention. For fire prevention, we look at possible dangers in our homes, schools, and workplaces. We remain aware of possible trouble: something flammable near a heat source, or strange smoke. And though we don't want or expect a fire, we make sure to have a plan in place to minimize the damage and/or escape if a fire occurs. We know where the fire extinguishers are and how to contact the fire department, and we have an evacuation plan established. Similarly, we should remain aware of signs of trouble about possible drinking, which we call warning signs for relapse. We will generate a plan to deal with these warning signs to help prevent relapse. Next session, we will generate a plan to deal with slips and relapses to use in the event that they occur.*

Ask the client for her reactions to this discussion.

Identifying Warning Signs

After this introduction to relapse prevention, introduce the concept that there usually are "warning signs" that a relapse might be coming. These

warning signs might be changes in the way the client is thinking or changes in behavior or habits.

> *Warning signs might be changes in the way you think and interact or changes in habits. You have learned many new behaviors. Through dedication, these behaviors can become everyday habits. Changes in these new habits may signal trouble. Look out for old habits, especially ones that led to trouble in the past. Look for changes in mood, people you associate with, places you go to, ways you handle problems, and routines. Be alert for changes in the way you think about alcohol, yourself, or things around you. All these things could signal the possibility of a slip.*

Exercise—Identifying Warning Signs

Ask the client to think back to the last lapse or relapse that she experienced.

> *What kinds of thoughts, feelings, or behaviors occurred before the lapse that you now think were warning signs that a relapse might be coming?*

Ask the client to think about the period of time (several days) before the relapse, and identify any changes in the her usual habits that she noticed, as well as her moods, people with whom she was spending time, places that she went, ways that she handled problems or stressors, etc. Help the client record the warning signs on the Identifying and Managing Relapse worksheet in the workbook.

After the client has listed all warning signs, ask if there are any other experiences associated with past relapses that she thinks would be warning signs for future lapses or relapses.

Also point out that the client has learned new ways of coping during therapy and any changes away from the new behaviors might be warning signs. For homework, have the client think about the new patterns she has established during therapy and what changes in these might be warning signs for relapse.

For example, the client might have initiated a regular exercise program after work at a time when she previously drank. Stopping the exercise program or beginning to skip workouts might be a subtle warning sign for impending relapse because the client would be beginning to fall back into old patterns.

Refer to the notion of "seemingly irrelevant decisions" (see Session 9) and remind the client that any changes in patterns that *seem* to have nothing to do with drinking may in fact set the client up to drink.

Managing Warning Signs for Relapse

Present the following rationale to the client:

> *We are going to continue to help you prepare to face situations that will occur after our treatment ends. Having a list of warning signs for relapses does not necessarily mean that you will be aware of them as warning signs when they actually occur—remember seemingly irrelevant decisions.* (Use the example of a client who stopped exercising, saying that she had hurt her back and couldn't do her usual workout, so she was going to wait until her back healed.)

Exercise—Managing Warnings Signs for Relapse

Go over the relapse warning signs that the client identified on the completed Identifying and Managing Relapse Warning Signs worksheet. For one warning sign in each category, discuss a *plan* for what to do if that relapse warning sign should occur. Write down the plan in the space provided on the worksheet. For homework, ask the client to develop plans for the remaining warning signs listed.

Anticipating High-Risk Situations This Week

Work with the client to identify at least one high-risk situation coming up in the next week (see sample dialogue in Session 1). Have the client write out ideas for handling the situation on the High-Risk Situations

worksheet in the workbook. Also ask the client to write down on the back of the client self-recording card how she actually handled the anticipated situation and to write down any other situations that she had not anticipated.

Homework

- ✎ Instruct the client to continue self-recording and record coping with high-risk situations on the back of the self-recording cards.
- ✎ Encourage the client to practice self-calming strategies.
- ✎ Ask the client to complete one problem-solving exercise at home.
- ✎ Have the client complete the Identifying and Managing Relapse Warning Signs worksheet.
- ✎ Have the client read Chapter 10 of the workbook.

Chapter 14 *Session 11: Relapse Prevention Part III*

(Corresponds to chapter 11 of the workbook)

Materials Needed

- Copy of client workbook
- Breathalyzer and tube
- Self-recording cards
- Alcohol Use and Urges Graph in progress
- Plan for Handling Slips or Relapses worksheet
- High-Risk Situations worksheet

Outline

- Determine blood alcohol level (BAL) of the client
- Provide overview of session
- Review self-recording and homework
- Check in
- Help the client develop a plan for handling slips and relapses
- (If applicable) discuss termination and how client feels about it
- Identify potential upcoming high-risk situations and plan for how to cope with them
- Assign homework

Blood Alcohol Level Determination

Reschedule if BAL of client is greater than .05. Check on compliance with homework and abstinence goal.

Overview of Session and Setting the Agenda

Inform client of topics that will be covered in the session. Ask the client if there are any additional issues he would like to discuss today.

Review of Self-Recording and Homework

1. Review self-recording, update graph, and give feedback and reinforcement.
2. Review application of other self-control procedures: Questions? Problems?
3. Review client's problem-solving homework.
4. Review client's warning signs homework.
5. Review client's use of "time-out."

Check In

Ask client how his week was in general and acknowledge his concerns. Use information from this discussion for specific topics in the rest of the session.

Handling Slips and Relapses

Offer the following rationale to the client:

> *Sometimes discussions of warning signs aren't enough—even using your best skills you may still have difficulties. It will be easier for you*

in the long run if you don't, but it is possible that you will eventually take a drink, despite your best efforts. If drinking occurs, it is important to realize that one drink does not have to inevitably lead to a full-blown relapse.

A person who slips can think of it in three ways:

1. *The slip is a mistake which should never be repeated. This is considered a lapse if the person does not continue drinking.*
2. *The slip is an opportunity to learn about something risky. The person should think of different ways to handle the situation in the future. This is considered a prolapse if the person does not continue drinking, but learns a lesson for the future.*
3. *The slip is a disaster that shows that the person is hopeless. People who see the slip in this way think "I have blown it. I will never succeed. I will just give up."*

The third way of thinking is the worst choice. Slips are like falling off a bicycle. The fall may hurt, but you should get back on the bicycle and keep riding. You may feel rotten about the slip, but you should get back to remaining sober. The slip may even be an opportunity to learn about a difficult situation.

Review the following information from the workbook with the client.

Handling Slips and Relapses

Looking for and thinking about warning signs help to prevent a slip. However, even people who work hard to remain abstinent may find themselves in an overwhelming situation. While you should work hard and expect to not take another drink, we believe you should be prepared for the possibility of a slip.

If you should take a drink, you have choices. As discussed previously, there are three different ways to think about the drink. You could think of it as a mistake (a slip), a mistake from which you learn something (a prolapse), or as a hopeless disaster (a relapse). The goal is never to have a relapse.

A drink does not have to become a relapse. If you ever have a drink, you should try to make it turn out to be a slip or prolapse. If you have a drink, remember the following:

1. **Don't panic**. One drink does not have to lead to an extended binge or a return to uncontrolled drinking.

2. **Stop, look, and listen**. Stop the ongoing flow of events and look and listen to what is happening. The lapse should be seen as a warning signal that you are in trouble. The lapse is like a flat tire—it is time to pull off the road to deal with the situation.

3. **Be aware of the abstinence violation effect**. Once you have a drink, you may have thoughts such as "I blew it," or "All our efforts were a waste," or "As long as I've blown it, I might as well keep drinking," or "My willpower has failed, I have no control," or "I'm addicted, and once I drink my body will take over." These thoughts might be accompanied by feelings of anger or guilt. It is crucial to dispute these thoughts immediately.

4. **Renew your commitment**. After a lapse, it is easy to feel discouraged and to want to give up. Think back over the reasons why you decided to change your drinking in the first place; look at your decisional matrix and think about all the positive long-term benefits of abstinence and the long-term problems associated with continued drinking.

5. **Decide on a course of action**. At a minimum, this should include:

   - Getting out of the drinking situation.
   - Waiting at least 2 h before having a second drink.
   - Engaging in some activity during those 2 h that would help avoid continued drinking. The activity might be a pleasurable one, or reviewing materials from treatment, or talking over the lapse with someone who could be helpful, or calling your therapist.

6. **Review the situation leading up to the lapse**. Don't blame yourself for what happened. By focusing on your own failings, you will feel guiltier and blame yourself more. Ask yourself, what events led up to the slip? What were the main triggers? Were there any early warning signs? Did you try to deal with these constructively? If not, why not? Was your motivation weakened by fatigue, social pressure, or depression? Once you have analyzed the slip, think about what changes you need to make to avoid future slips.

7. **Ask for help**. Make it easier on yourself by asking someone to help you either by encouraging you, giving you advice, distracting you, or engaging in some alternative activity with you. If you had a flat tire and your spare tire was also flat, you'd have to get help—a slip is the same situation.

Exercise—Handling Slips and Relapses

Using the Plan for Handling Slips and Relapses worksheet in the workbook, discuss and have the client write down some plans for handling slips or relapses, should they occur. Use real-life examples of previously discussed high-risk situations, as well as possible anticipated, problematic situations that the client thinks might generate strong cravings and use of alcohol (i.e., accident or death in the family, loss of job, etc.).

This worksheet should be thought of as a "tool" the client can turn to and read in the event of a slip. A sample plan for Handling Slips and Relapse worksheet is shown in Figure 14.1.

Plan for Handling Slips and Relapses

Immediate plans to prevent the slip from becoming a relapse:

Get out of the situation where I'm drinking. Pour what's left (if anything) down the drain or ask my boyfriend to get rid of it.

Look over my treatment workbook to get refocused

Ask myself, "what was the trigger for my drinking in this particular situation?"

How I will get support to handle the relapse?

Tell my boyfriend, talk to my sister

Call someone in AA or SMART Recovery

Call my therapist

The next day . . .

Review the information in my workbook.

Look at my negative consequences card.

Identify my triggers and deal with them.

Figure 14.1
Example of Completed Plan for Handling Slips and Relapses

Anticipating High-Risk Situations This Week

Work with the client to identify at least one high-risk situation coming up in the next week (see sample dialogue in Session 1). Have the client write out ideas for handling the situation on the High-Risk Situations worksheet in the workbook. Also ask the client to write down on the back of the client self-recording card how he actually handled the anticipated situation and to write down any other situations that he had not anticipated.

Homework

- ✎ Instruct the client to continue self-recording and record coping with high-risk situations on the back of the self-recording cards.
- ✎ Have the client draft plans for slips or relapses by situation.
- ✎ Have the client read Chapter 11 of the workbook.

Chapter 15 *Session 12: Review / Relapse Prevention Part IV: Maintenance Planning and Relapse Contract*

(Corresponds to chapter 12 of the workbook)

Materials Needed

- Copy of client workbook
- Breathalyzer and tube
- Alcohol Use and Urges Graph in progress
- Relapse Contract

Outline

- Determine blood alcohol level (BAL) of the client
- Provide overview of session
- Review self-recording and homework
- Check in
- Review techniques and plan for maintaining treatment gains
- Develop a relapse prevention contract
- Wrap-up treatment

Blood Alcohol Level Determination

Reschedule if BAL of client is greater than .05. Check on compliance with homework and abstinence goal.

Overview of Session and Setting the Agenda

Inform client of topics that will be covered in the session. Ask the client if there are any additional issues she would like to discuss today.

Review of Self-Recording and Homework

After setting today's agenda, review the client's completed self-recording cards, update progress graph, and provide feedback and reinforcement to client. Spend a few minutes reviewing and discussing the trajectory of the graph. Give positive feedback to the client for reducing the frequency and intensity of cravings, as well as drinking. Show the client how the graph reflects how much different her drinking habits are now versus what they were at the beginning of treatment. Remind the client of how difficult it was in the first few weeks of treatment when cravings were frequent and strong. The client can look to this graph for encouragement in the future, if and when cravings occur.

Check In

Ask client how her week was in general. Acknowledge client's concerns. Use information from this discussion for specific topics in the rest of the session. Check in to see how the client feels about this being the final session.

Final Review and Maintenance Planning

The goal of this session is to give the client a positive set or expectancy that she now has the skills to remain abstinent. In addition, the goal is to let the client know that she has learned a set of skills that can be applied in the day-to-day environment to deal with high-risk situations and that relapse-prevention techniques will help the client maintain gains made during treatment. The learning of these skills has placed control

back into the clients' hands. Review the following skills the client has learned:

Alcohol-Related Skills

1. Understanding alcohol in a different way (standard drinks, blood alcohol level, as a toxin that affects you medically, etc.)
2. Self-recording cravings and drinking, linking to triggers
3. Identifying and becoming more aware of triggers
4. Drinking behavior chains: thinking through the drink
5. Self-management planning to cope with triggers, including heavy drinkers in your social network
6. Self-control procedures using your thoughts: thinking about negative consequence of drinking, challenging and replacing positive thoughts about alcohol
7. Positive alternatives to drinking: using your former drinking time to do fun things without the use of alcohol and making sober life fun and satisfying
8. Drink-refusal skills
9. Relapse-prevention strategies: identifying seemingly irrelevant decisions, anticipating and planning for upcoming high-risk situations, identifying and managing warning signs for relapse, coping with slips or relapses

General Coping Skills

1. Understanding and coping with sadness and anxiety
2. Challenging and replacing negative thoughts to better control your emotions
3. Connecting with others

4. Assertiveness
5. Anger management
6. Problem solving

Have the client identify the skills that she thinks have been most important to the changes made during therapy. Explore the strategies and techniques that the client will continue to try to implement in order to maintain progress, now that treatment is ending. If the client wants to continue therapy or feels the need to come back in the future, discuss her options.

Inform the client that she will most probably continue to experience urges to drink periodically. Daily self-recording should be continued. Remind the client that relapses most often occur in the type of situations she is now prepared to handle.

Relapse Contract

Using the template provided, work with the client to create a relapse contract. Include ways to address the possible relapse warning signs and ways of handling those that have been identified. Review in detail the emergency plan for relapse, including actions to be taken. Have the client sign the contract.

Sample Relapse Contract

1. If I drink alcohol at all, in any amount, I will leave the situation as soon as possible. I will sit down the following day and review what to do in the event of a relapse. I will use my trigger sheets to figure out what happened. I will tell my partner (or best friend, sibling, etc.) and ask for his or her support.

2. If I drink again within a month, I will call my therapist with the goal of getting a referral or getting back into treatment, or coming back in for a "booster session."

3. If I drink even once in a binge (out of control) fashion, I will call, with the goal of getting back into treatment.

4. My goal is to remain abstinent for at least _____. At that time I will reevaluate this contract and write a new one.

_____ _____

Client Signature Date

_____ _____

_____ _____

Congratulate the client on the work she has done, encourage her to maintain changes, and tell her to give you a call if she has questions or concerns in the future.

Drinking Patterns Questionnaire

We have found that each person has a unique or different pattern of drinking alcohol. People drink more at certain times of the day, in particular moods, with certain people, in specific places, and so forth. It is very common for people to drink more under various stresses, before or after difficult interactions, and when they are experiencing particular feelings. It may sometimes seem that there are no circumstances that relate to your drinking, that is, "I just drink." However, after some thought, every person can identify at least some important factors.

This questionnaire will help you to think about different aspects of your life and how each might relate to your drinking. You will find instructions at the beginning of each section. Please give each item careful consideration. You will benefit most from this questionnaire if you are honest and open with your responses.

For each item, mark with an "X" whether or not you drank in this situation in the *PAST 6 MONTHS.*

Use the following options to answer each of the questions:

- Mark "X" under **Did not drink** if you did not drink in this situation in the past 6 months.
- Mark "X" under **Sometimes drank** if you did drink in this situation in the past 6 months.
- Mark "X" under **Major drinking**, if you drank often in this situation in the past 6 months.

Various locations, times, people, activities, and events are associated with every person's drinking. The items in this section will help you to think about these factors. Read each item carefully as some are divided into more than one part.

Location

Put an "X" in one box next to each of the following items to indicate the frequency with which you drank in each of the following locations during the *PAST 6 MONTHS*. If the location does not apply to you, answer "Did not drink in this location."

	Drinking locations	Did not drink in this location	Sometimes drank in this location	Major drinking location
1.	Home			
2.	Bar			
3.	Club			
4.	Private club			
5.	Automobile			
6.	Outdoors			
7.	Church or temple			
8.	Work			
9.	Restaurant			
10.	Other's home			

After you have answered each of the above questions, go back and put a circle around the number of the location where you drank *most* often during the *past 6 months.*

Time

Put an "X" in one box next to each of the following items to indicate the frequency with which you drank at each of the following times during the *PAST 6 MONTHS*. If the time does not apply to you, answer "Did not drink at this time."

	Drinking times	Did not drink at this time	Sometimes drank at this time	Major drinking time
11.	During the morning			
12.	Lunchtime			
13.	Afternoon			
14.	After work (if employed)			
15.	During supper			
16.	During the evening			
17.	At bedtime			
18.	During the night			

After you have answered each of the above questions, go back and put a circle around the number of the time during which you drank *most* often during the *past 6 months*.

Companions

Put an "X" in one box next to each of the following items to indicate the frequency with which you drank with each of the following people during the *PAST 6 MONTHS*. If a particular person does not apply to you, answer "Did not drink with this person."

	Drinking companions	Did not drink with this person	Sometimes drank with this person	Major drinking companion
19.	Spouse/Partner			
20.	Relative			
21.	Child			
22.	Male friend(s)			
23.	Female friend(s)			
24.	Male and female friend(s)			
25.	Alone			
26.	Strangers			
27.	Business acquaintances			

After you have answered each of the above questions, go back and put a circle around the number of the person with whom you drank *most* often during the *past 6 months*.

Activities

Put an "X" in one box next to each of the following items to indicate the frequency with which you drank during each of the following activities during the *PAST 6 MONTHS*. If a particular activity does not apply to you, answer "Did not drink during this activity."

	Drinking activities	Did not drink during this activity	Sometimes drank during this activity	Major drinking activity
28.	Cooking			
29.	Chores			
30.	Shopping			
31.	Smoking			
32.	Watching television			
33.	Eating			
34.	Reading			
35.	Resting			
36.	Doing crafts or hobby			
37.	Talking			
38.	Playing pool			
39.	Playing games (cards, pinball, etc.)			
40.	Gambling (horses, dogs)			
41.	Entertaining			
42.	Listening to entertainment			

continued

continued

	Drinking activities	Did not drink during this activity	Sometimes drank during this activity	Major drinking activity
43.	Attending a meeting			
44.	Partying			
45.	Driving			
46.	Playing sports			
47.	Attending sporting event			
48.	Sunbathing			
49.	Cooking out			
50.	Walking or hiking			
51.	Recreational activities (fishing, swimming, etc.)			
52.	In sexual activities			
53.	Fighting (arguing)			

After you have answered each of the above questions, go back and put a circle around the number of the activity during which you drank *most* often during the *past 6 months*.

Urges

Put an "X" in one box next to each of the following items that best describes your drinking or urges to drink during the *PAST 6 MONTHS.* If a particular situation does not apply to you, answer "Did not drink in this situation."

	Drinking urges	Did not drink in this situation	Sometimes drank in this situation	Major drinking situation
54.	I sometimes drink when I see or hear an advertisement for alcohol (TV commercial, magazine ad, billboard, etc.)			
55.	I sometimes drink when passing a particular bar or restaurant			
56.	I sometimes drink when I see someone else drinking			
57.	I sometimes drink when I hear people talking about drinking			
58.	I seem to drink more on particular days of the week			
59.	I seem to drink more during certain times of the month			
60.	I seem to drink more at certain times of the year (holidays, vacations, etc.)			

continued

continued

	Drinking urges	Did not drink in this situation	Sometimes drank in this situation	Major drinking situation
61.	I sometimes like to have a drink with certain foods, snacks, or meals			
62.	When I drink at home, I usually drink only in certain parts of the house			
63.	I sometimes drink more frequently in certain types of weather (hot day, cold day, etc.)			

After you have answered each of the above questions, go back and put a circle around the number of the situation during which you drank *most* often during the *past 6 months*.

Put an "X" in one box next to each of the following items to indicate *YES* or *NO*, whether each of the following three items applied to you in the *PAST 6 MONTHS.*

		YES	NO
A	I have been employed at some time in the PAST 6 MONTHS		
B	I have done volunteer work in the PAST 6 MONTHS		
C	I have looked for work in the PAST 6 MONTHS		

If you did *not* answer "Yes" to A, B, or C above, skip the entire "Work" section (questions 64–76).

If you *did* answer "Yes" to either item A, B, or C, please complete the entire "Work" section.

It is not unusual at times for people to drink because of work-related events or difficulties. This can happen in both paying jobs and volunteer work. The stress of looking for a job may also relate to drinking. Put an "X" in the box next to each of the following items that best describes your drinking in the *PAST 6 MONTHS*.

continued

		Did not drink in this situation	Sometimes drank in this situation	Major drinking situation
64.	I sometimes drink before I go to work			
65.	I sometimes drink on the job			
66.	I sometimes drink during work breaks			
67.	I sometimes go drinking with friends straight from work before stopping home			
68.	I sometimes drink after work to help relieve some of the pressure from the job			
69.	I sometimes drink with business associates at meetings, conventions, cocktail parties, etc.			
70.	I sometimes drink when I have problems with my coworkers or boss			
71.	I sometimes drink when I get nervous at work			
72.	I sometimes drink when I feel that I'm not getting anywhere in my job or career			
73.	I sometimes drink when I am happy with the way work is going			
74.	I sometimes drink more on payday after cashing my check			
75.	I sometimes drink after a job interview			
76.	I sometimes drink when I feel that finding a new job is hopeless			

continued

After you have answered each of the above questions, go back and put a circle around the number of the situation during which you drank *most* often during the *past 6 months*.

Often, people drink as a response to financial difficulties. For each of the following items put an "X" in the box that best describes your drinking in the *PAST 6 MONTHS.* If a particular situation does not apply to you, put an "X" under "Did not drink in this situation."

		Did not drink in this situation	Sometimes drank in this situation	Major drinking situation
77.	I sometimes drink when I attempt to pay my bills and I get frustrated			
78.	I sometimes drink when I worry about my finances			
79.	I sometimes drink when I feel bad or guilty about not being a good provider			
80.	I sometimes drink when I can't buy something that a family member requests			
81.	I sometimes drink when I can't afford something that I want very much			
82.	I sometimes drink when a family member makes a purchase that I know we can't afford			
83.	I sometimes drink after I spend too much money			

continued

continued

		Did not drink in this situation	Sometimes drank in this situation	Major drinking situation
84.	I sometimes drink when I think that my spouse doesn't make enough money			
85.	I sometimes feel like drinking because of arguments over how to spend money			
86.	I sometimes drink when I get angry over who controls the money			
87.	I am sometimes more tempted to drink when my finances are going well and/or I have caught up with all of my bills			
88.	I am sometimes more tempted to drink when I have a lot of money in my pocket			

After you have answered each of the above questions, go back and put a circle around the number of the situation during which you drank *most* often during the *past 6 months*.

Put an "X" in one box next to each of the following items that best describes your drinking behavior during the *PAST 6 MONTHS.* If a particular situation does not apply to you, put an "X" in the box that indicates "Did not drink in this situation."

		Did not drink in this situation	Sometimes drank in this situation	Major drinking situation
89.	I sometimes feel shaky and drink to stop it			
90.	I sometimes drink when I feel tired or fatigued			
91.	I sometimes drink when I get restless			
92.	I sometimes drink when I'm experiencing physical pain (back pain, headache, etc.)			
93.	I sometimes take a drink if I have trouble falling asleep			
94.	I sometimes wake up during the night and take a drink to get back to sleep			
95.	I sometimes drink alcohol when I am thirsty			
96.	I sometimes drink before my menstrual period			

After you have answered each of the above questions, go back and put a circle around the number of the situation during which you drank *most* often during the *past 6 months*.

People drink in social situations, that is, with other people, for many reasons. Put an "X" in one box next to each of the following items that best describes your drinking in the *PAST 6 MONTHS.* If a particular situation does not apply to you, put an "X" under "Did not drink in this situation."

		Did not drink in this situation	Sometimes drank in this situation	Major drinking situation
97.	It is sometimes difficult for me not to drink when people around me are drinking			
98.	I sometimes find it hard to resist if someone buys me a drink or offers to do so			
99.	I sometimes drink to be part of the group			
100.	I sometimes drink as a way to meet people or be with others			
101.	I sometimes drink to feel more comfortable with others			
102.	I sometimes think that I don't relate well to others and drinking helps me do so			
103.	I sometimes feel that I'm not as good as other people and drinking helps me feel better			

continued

continued

		Did not drink in this situation	Sometimes drank in this situation	Major drinking situation
104.	I sometimes find that I drink after I become angry at someone			
105.	I sometimes drink after feeling hurt by someone			
106.	I sometimes drink when I want to hurt or get back at someone			
107.	I sometimes drink when I am angry at myself for not speaking my mind to someone			
108.	I sometimes drink to help me express my feelings toward someone (anger, love, etc.)			
109.	I sometimes drink when I feel lonely			
110.	I sometimes drink because I think it's the only way to have fun			
111.	I sometimes drink when I'm bored and have nothing to do			
112.	I sometimes drink when I think that nobody cares about me			

continued

continued

		Did not drink in this situation	Sometimes drank in this situation	Major drinking situation
113.	I sometimes drink when I want someone to pay attention to me			
114.	I sometimes drink when I feel that people have put too much responsibility on me			
115.	I sometimes drink when I think about past relationships			

After you have answered each of the above questions, go back and put a circle around the number of the situation during which you drank *most* often during the *past 6 months*.

Put an "X" in the *YES* or *NO* box to indicate whether you have been married or involved in a romantic relationship in the *PAST 6 MONTHS*:

	YES	NO
I have been married or involved in a romantic relationship in the past 6 months		

If you answered "NO" to this question, skip the entire "Marital/Relationship" section (questions 116–142).

If you answered "Yes" to this question, please complete the entire "Marital/Relationship" section.

Although sometimes hard to discuss, it is quite common for relationship issues to be related to drinking. Put an "X" in the box after each of the following items that best describes your drinking in the *PAST 6 MONTHS*. If a particular situation does not apply to you, put an "X" under "Did not drink in this situation."

		Did not drink in this situation	Sometimes drank in this situation	Major drinking situation
116.	I sometimes drink when I anticipate an argument with my partner			
117.	I sometimes drink after having an argument with my partner			
118.	I sometimes drink after my partner nags me about something			

continued

continued

		Did not drink in this situation	Sometimes drank in this situation	Major drinking situation
119.	I sometimes drink after my partner criticizes me			
120.	I sometimes drink when my partner is drinking or offers me a drink			
121.	I sometimes drink to help me express my feelings toward my partner			
122.	I sometimes drink when my partner and I are celebrating something			
123.	I sometimes drink after my partner and I disagree about sexual relations			
124.	I sometimes drink or get an urge to drink when I want to avoid sexual relations with my partner			
125.	I sometimes drink when I'm concerned about my sexual adequacy			
126.	I sometimes drink when I want to enjoy sexual relations more			
127.	I sometimes drink after physical violence occurs in the family or when I have concerns about it			

continued

		Did not drink in this situation	Sometimes drank in this situation	Major drinking situation
128.	I sometimes drink when I think my partner or family doesn't care about me			
129.	I sometimes drink when I feel that my partner doesn't understand my needs or desires			
130.	I sometimes drink when my partner doesn't spend enough time with me			
131.	I sometimes drink when I feel "trapped" in my relationship			
132.	I sometimes drink when I'm frustrated that my partner and I can't resolve a conflict			
133.	I sometimes drink after my partner embarrasses me in public			
134.	I sometimes drink at times when I am jealous			
135.	I sometimes drink when my partner and I have conflict on how to deal with our child(ren)			
136.	I sometimes drink when I am not happy with my role in the family			
137.	I sometimes drink when it seems that my partner is not treating my like an adult			

continued

continued

		Did not drink in this situation	Sometimes drank in this situation	Major drinking situation
138.	I sometimes drink when I think my partner is too involved with my affairs			
139.	I sometimes drink when I feel that my partner doesn't meet his or her responsibilities			
140.	I sometimes drink when I feel that I don't meet my responsibilities			
141.	I sometimes drink to "get back" at my partner			
142.	I sometimes drink more when my partner tries to stop my drinking			

After you have answered each of the above questions, go back and put a circle around the number of the situation during which you drank *most* often during the *past 6 months.*

Put an "X" in the YES or NO box to indicate whether at least one of your parents and/or in-laws are still living:

		YES	NO
A	My parents are still living		
B	My in-laws are still living		

If you answered "No" to both A and B, skip the entire "Parents" section (questions 143–154).

If you answered "Yes" to either A or B, please complete the entire "Parents" section.

Put an "X" in one box that best describes your drinking in the *PAST 6 MONTHS*. If a particular situation does not apply to you, put an "X" under "Did not drink in this situation."

		Did not drink in this situation	Sometimes drank in this situation	Major drinking situation
143.	I sometimes drink with my parents or in-laws			
144.	I sometimes drink after spending time with my parents or in-laws			
145.	I sometimes drink to help me express my feelings toward my parents or in-laws			
146.	I sometimes drink when I'm upset with my parents or in-laws			

continued

continued

		Did not drink in this situation	Sometimes drank in this situation	Major drinking situation
147.	I sometimes drink when I feel that my parents or in-laws don't respect me as an adult			
148.	I sometimes drink when I feel guilty about something related to my parents or in-laws			
149.	I sometimes drink when I hurt or embarrass my parents or in-laws			
150.	I sometimes drink when I feel that my parents or in-laws are too demanding or interfering			
151.	I sometimes drink after my parents or in-laws and I disagree about something			
152.	I sometimes drink when I think about things that my parents did to me when I was younger			
153.	I sometimes drink when I see that my parents or in-laws are getting older			
154.	I sometimes drink when I think about the death of one or both of my parents or in-laws			

After you have answered each of the above questions, go back and put a circle around the number of the situation during which you drank *most* often during the *past 6 months*.

If you have children, interactions with your children can lead you to certain feelings or moods related to your drinking. Put an "X" under the *YES* or *NO* box to indicate whether you have any children.

YES	NO

If you do *not* have any children, skip the remainder of this section (questions 155–171).

Please complete this section even if children from your present or previous marriage are not currently living with you. Put an "X" after each of the following items for the *PAST 6 MONTHS.* If a particular situation does not apply to you, put an "X" under "Did not drink in this situation."

		Did not drink in this situation	Sometimes drank in this situation	Major drinking situation
155.	I sometimes drink after interacting with my children			
156.	I sometimes drink when my spouse and I have a disagreement about our children			
157.	I sometimes drink to help me express my feelings toward my children			

continued

continued

		Did not drink in this situation	Sometimes drank in this situation	Major drinking situation
158.	I sometimes drink when I'm annoyed with my children			
159.	I sometimes drink when I feel that my children don't respect me			
160.	I sometimes drink when I feel that my children are ashamed of me			
161.	I sometimes drink after my children get in trouble at school or with legal authorities			
162.	I sometimes drink after my children do not follow my orders or wishes			
163.	I sometimes drink when I feel that my children are too much responsibility			
164.	I sometimes drink when I feel that I cannot control my children			
165.	I sometimes drink when I feel guilty about something related to my children			
166.	I sometimes drink when I can't give my children something they want			

continued

		Did not drink in this situation	Sometimes drank in this situation	Major drinking situation
167.	I sometimes drink after punishing my children too harshly or losing my temper			
168.	I sometimes drink after my children manipulate my spouse/partner into doing something with which I'm not pleased			
169.	I sometimes drink when I want to see my children but I can't do so			
170.	I sometimes drink when my children talk back to me			
171.	I sometimes drink when I feel that my children don't need me any longer			

After you have answered each of the above questions, go back and put a circle around the number of the situation during which you drank *most* often during the *past 6 months*.

People often drink when they are experiencing some type of emotion, either negative or positive. Put an "X" next to each emotion on the following list to describe the emotions you have or haven't experienced before drinking in the *PAST 6 MONTHS.* If a particular emotion does not apply to you, put an "X" under "Did not drink with this emotion."

		Did not drink with this emotion	Sometimes drank in this situation	Major drinking-related emotion
172.	Angry			
173.	Sad			
174.	Depressed			
175.	Hurt			
176.	Spiteful			
177.	Lonely			
178.	Hopeless			
179.	Frustrated			
180.	Guilty			
181.	Fearful			
182.	Nervous			

continued

continued

		Did not drink with this emotion	Sometimes drank in this situation	Major drinking-related emotion
183	Restless			
184	Insecure			
185	Fatigued			
186	Happy			
187	Relaxed			
188	Self-confident			
189.	Loving			

After you have answered each of the above questions, go back and put a circle around the number of the feeling with which you drank *most* often during the *past 6 months*.

Review

You have now finished the sections of the questionnaire dealing with events, people, and feelings that come before your drinking or urges to drink. We would like you to look back over the questionnaire and think about the relative importance of each of these sections as it applies to your drinking, that is, how important each section is compared to the other sections.

The different sections of the questionnaire that you have just completed are listed below. Think about the section that is most important, out of all nine sections, in relation to your drinking or urges to drink. Put an "X" under "1" next to that section. Then think about the section that is second most important to your drinking, and put an "X" under "2" next to that section. Then think about the section that is third most important to your drinking, and put an "X" under "3" next to that section. Continue to do that until you have ranked each of the nine sections listed below. Each number should be used only once. The sections marked "8" and "9" should be least important related to your drinking, compared to the other sections.

Most Important- -Least Important

		1	2	3	4	5	6	7	8	9
Section 1	Environmental (p. 220)									
Section 2	Work (p. 227)									
Section 3	Financial (p. 229)									
Section 4	Physiological (p. 231)									
Section 5	Interpersonal (p. 232)									
Section 6	Marital/ Relationship (p. 235)									
Section 7	Parents (p. 239)									
Section 8	Children (p. 241)									
Section 9	Emotional (p. 244)									

References

Alford, G. S. (1980). Alcoholics Anonymous: An empirical outcome study. Addictive *Behaviors, 5*, 359–370.

Alford, G. S., Koehler, R. A., & Leonard, J. (1991). Alcoholics Anonymous-Narcotics Anonymous model inpatient treatment of chemically dependent adolescents: A 2-year outcome study. *Journal of Studies on Alcohol, 52*, 118–126.

Allen, J. P. & Litten, R. Z. (2001). The role of laboratory tests in alcoholism treatment. *Journal of Substance Abuse Treatment, 20*, 81–85.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Rev.). Washington D.C: Author.

American Psychiatric Association. (2004). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR* (4th ed., Text Rev.). Washington, DC: Author.

Anton, R. F., O'Malley, S. S., Ciraulo, D. A., Cisler, R. A., Couper, D., Donovan, D. M., et al. COMBINE Study Research Group. (2006). Combined pharmacotherapies and behavioral interventions for alcohol dependence: The COMBINE study: A randomized controlled trial. *The Journal of the American Medical Association, 295*(17), 2003–2017.

Barber, W. S., & O'Brien, C. P. (1999). Pharmacotherapies. In: B. S. McCrady & E. E. Epstein (Eds.), *Addictions: A comprehensive guidebook* (pp. 347–369). New York, NY: Oxford University Press.

Bates, M. E., Bowden, S. C., & Barry, D. (2002). Neurocognitive impairment associated with alcohol use disorders: Implications for treatment. *Experimental and Clinical Psychopharmacology, 10*, 193–212.

Beck, A. T., Epstein, N., Brown, G., & Steer, R. A. (1988). An inventory for measuring clinical anxiety: Psychometric properties. *Journal of Consulting and Clinical Psychology, 56*(6), 893–889.

Beck, A. T., Steer, R. A., & Garbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review, 8*(1), 77–100.

Beckman, L. J. (1978). Self-esteem of women alcoholics. *Journal of Studies on Alcohol, 39*, 491–498.

Braiker, H. B. (1984). Therapeutic issues in the treatment of alcoholic women. In S. C. Wilsnack & L. J. Beckman (Eds.), *Alcohol problems in women* (pp. 349–368). New York: Guilford Press.

Carroll, K. (1999). Behavioral and cognitive behavioral treatments. In: B. S. McCrady & E. E. Epstein (Eds.), *Addictions: A comprehensive guidebook* (pp. 250–267). New York: Oxford University Press.

Connors, G. J., Maisto, S. A., & Zywiak, W. H. (1998). Male and female alcoholics' attributions regarding onset and termination of relapses and the maintenance of abstinence. *Journal of Substance Abuse, 10*, 27–42.

Copeland, J., Hall, W., Didcott, P., & Biggs, V. (1993). A comparison of a specialist women's alcohol and other durg treatment service with two traditional mixed-sex services: Client characteristics and treatment outcome. *Drug and Alcohol Dependence, 32*, 81–92.

Cronkite, R. C., & Moos, R. H. (1984). Sex and marital status in relation to the treatment and outcome of alcoholic patients. *Sex Roles, 11*, 93–112.

Dahlgren, L., & Willander, A. (1989). Are special treatment facilities for female alcoholics needed? A controlled 2-year study from a specialized female unit (EWA) versus a mixed male/female treatment facility. *Alcoholism: Clinical and Experimental Research, 13*, 499–504.

Dansky, B. S., Saladin, M. E., Brady, K. T., Kilpatrick, D. G., & Resnick, H. S. (1995). Prevalence of victimization and posttraumatic stress disorder among women with substance use disorders: Comparison of telephone and in-person assessment samples. *International Journal of the Addictions, 30*, 1079–1099.

Dawson, D. A. (1994). Are men and women more likely to stop drinking because of alcohol problems? *Drug and Alcohol Dependence, 36*, 57–64.

Diehl, A., Croissant, B., Batra, A., Mundle, G., Nakovics, H., & Mann, K. (2007). Alcoholism in women: is it different in onset and outcome compared to men? *European Archives of Psychiatry and Clinical Neuroscience, 257*, 344–351.

Drapkin, M. L., McCrady, B. S., Swingle, J., Epstein, E. E., & Cook, S. M. (2005). Exploring bidirectional couple violence in a clinical sample of female alcoholics. *Journal of Studies on Alcohol, 66*, 213–219.

Duckert, F. (1987). Recruitment into treatment and effects of treatment for female problem drinkers. *Addictive Behaviors, 12*, 137–150.

Epstein, E. E. (2001). Classification of alcohol related problems and dependence. In N. Heather, T. J. Peters, & T. Stockwell (Eds.). *Handbook*

of Alcohol Dependence and Related Problems. Britain: John Wiley. pp. 47–70.

Epstein, E. E., Fischer-Elber, K., & Al Otaiba, Z. (2007). Women, Aging, and Alcohol Use Disorders. *Journal of Women & Aging*, 19(1/2), 31–48.

Epstein, E. E., Green, K., & Drapkin, M. (in press). Relapse Prevention of depression and Substance Abuse. In C. S. Richards & M.G. Perri (Eds.) *Relapse Prevention for Depression*. Washington D.C.: American Psychological Association.

Epstein, E. E., Labouvie, E. W., McCrady, B. S., Jensen, N. , & Hayaki, J. (2002). A multisite study of alcohol subtypes: Classification and Overlap of Unidimensional and Multidimensional Typologies. *Addiction*, 97, 1041–1053.

Epstein, E. E., & McCrady, B. S. (2002). Couple therapy in the treatment of alcoholism. In A. S. Gurman and N. Jacobson (Eds.) *Clinical Handbook of Marital Therapy, 3nd Edition*. New York: Guilford Publications (pps. 597–628).

Epstein, E. E., McCrady, B. S., Morgan, T. J., Cook, S. M., Kugler, G., & Ziedonis, D. (2007). The successive cohort design: A model for developing new behavioral therapies for drug use disorders, and application to behavioral couple treatment. *Addictive Disorders & Their Treatment* 6(1), 1–19.

Epstein, E. E., McCrady, B. S., Morgan, T. J., Cook, S. M., Kugler, G., & Ziedonis, D. (2007). Couples Treatment for drug-dependent males. *Addictive Disorders & Their Treatment* 6(1), 21–37.

Epstein, E. E., Rhines, K. C., Cook, S. M., Zdep-Mattocks, B., Jensen, N. K., & McCrady, B. S. (2006). Changes in alcohol craving and consumption by phase of menstrual cycle in alcohol dependent women.

Filstead, W. J. (1990). Treatment outcome: An evaluation of adult and youth treatment services. Park Ridge, IL: Parkside Medical Services Corporation.

Fink, E. B., Longabaugh, R., McCrady, B. S., Stout, R. L., Beattie, M., Ruggieri-Authelet, A., et al. (1985). Effectiveness of alcoholism treatment in partial versus inpatient settings: Twenty-four month outcomes. *Addictive Behaviors, 10*, 235–248.

Finney, J. W., Moos, R. H., & Timko, C. (1999). The course of treated and untreated substance use disorders: Remission and resolution, relapse and mortality (pp. 30–49). In: B. S. McCrady & E. E. Epstein (Eds.), *Addictions: A comprehensive guidebook*. New York: Oxford University Press.

First, M. B., Gibbon, M., Spitzer, R. L, & Williams, J. B. W. (1997). *The Structured Clinical Interview for DSM-IV: Axis II Personality Disorders (SCID-II)*. Washington, DC: American Psychiatric Press.

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (2002). *Structured Clinical Interview for the DSM-IV-TR Axis I Disorders, Research Version, Patient Edition (SCID-I/P)*. New York: Biometrics Research, New York State Psychiatric Institute.

Folstein, M. F., Folstein, S. E., & McHugh, P. R. (1975). Mini-mental state: A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research, 12*, 189–198.

Grant, B. F., Dawson, D. A., Stinson, F. S., Chou, S. P., Dufour, M. C., & Pickering, R. P. (2004). The 12-month prevalence and trends in DSM-IV alcohol abuse and dependence: United States, 1991–1992 and 2001–2002. *Drug and Alcohol Dependence, 74*, 223–234.

Grant, B. F., & Harford, T. C. (1995). Comorbidity between DSM-IV alcohol use disorders and major depression: Results of a national survey. *Drug and Alcohol Dependence, 39*, 197–206.

Hall, S. M., Havassy, B. E., & Wasserman, D. A. (1991). Effects of commitment to abstinence, positive moods, stress, and coping on relapse to cocaine use. *Journal of Consulting and Clinical Psychology, 59*, 526–532.

Harwood, H. (2000). *Updating estimates of the economic costs of alcohol abuse in the United States: Estimates, update methods, and data*. Report prepared by The Lewin Group for the National Institute on Alcohol Abuse and Alcoholism.

Helzer, J. E., & Pryzbeck, T. R. (1988). The co-occurrence of alcoholism with other psychiatric disorders in the general population with its impact on treatment. *Journal of Studies on Alcohol, 49*, 219–224.

Hesselbrock, M., Meyer, R., & Keener, J. J. (1985). Psychopathology in hospitalized alcoholics. *Archives of General Psychiatry, 42*, 1050–1055.

Hesselbrock, M., Hesselbrock, V., & Epstein, E.E. (1999). Etiology of alcohol and drug use disorders. In B. S. McCrady and E. E. Epstein (Eds.). *Addictions: A Comprehensive Guidebook*. NY: Oxford University Press.

Hester, R. K. (2003). Behavioral self-control training. In: R. K. Hester & W. R. Miller (Eds.), *Handbook of alcoholism treatment approaches. Effective alternatives* (3rd ed., pp. 152–164). Boston, MA: Allyn & Bacon.

Hughes, T. L., & Eliason, M. (2002). Substance use and abuse in lesbian, gay, bisexual and transgender populations. *Journal of Primary Prevention, 22*, 263–298.

Kadden, R., Carroll, K., Donovan, D., Cooney, N., Monti, P., Abrams, D., et al. (1995). *Cognitive-behavioral coping skills therapy manual*. NIH Pub. No. 94-3724. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Kadden, R. M., & Skerker, P. M. (1999). Treatment decision making and goal setting. In B. S. McCrady & E. E. Epstein (Eds.), *Addictions: A comprehensive guidebook* (pp. 216–231). New York: Oxford University Press.

Lammers, S. M. M., Schippers, G. M., & van der Staak, C. P. F. (1995, June). *Submission and rebellion. Excessive drinking of women in problematic heterosexual partner relationships*. Paper presented at the International Conference on Treatment of Addictive Behaviors, The Netherlands.

Longabaugh, R., Donovan, D. M., Karno, M. P., McCrady, B. S., Morgenstern, J., & Tonigan, J. S. (2005). Active ingredients: How and why evidence-based alcohol behavioral treatment interventions work. *Alcoholism: Clinical and Experimental Research, 29*, 235–247.

Longabaugh, R., McCrady, B., Fink, E., Stout, R., McAuley, T., & McNeill, D. (1983). Cost-effectiveness of alcoholism treatment in inpatient versus partial hospital settings: Six-month outcomes. *Journal of Studies on Alcohol, 44*, 1049–1071.

Longabaugh, R., Wirtz, P. W., Zweben, A., & Stout, R. L. (1998). Network support for drinking, Alcoholics Anonymous and long-term matching effects. *Addiction, 93*, 1313–1333.

MacDonald, J. G. (1987). Predictors of treatment outcome for alcoholic women. *International Journal of the Addictions, 22*, 235–248.

Mann, K., Hintz, T., & Jung, M. (2004). Does psychiatric comorbidity in alcohol-dependent patients affect treatment outcome? *European Archives of Psychiatry & Clinical Neuroscience, 254*(3), 172–181.

Manuel, J. K., McCrady, B. S., Epstein, E. E., Cook, S., & Tonigan, J. S. (2007). The pretreatment social networks of females with alcohol dependence. *Journal of Studies on Alcohol and Drugs*, *68*(6), 871–878.

Marlatt, G. A., & Gordon, J. (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors*. New York: Guilford Press.

Mays, V. M., Beckman, L. J., Oranchak, E., & Harper, B. (1994). Perceived social support for help-seeking behaviors of black heterosexual and homosexually active women alcoholics. *Psychology of Addictive Behaviors, 8*(4), 235–242.

McCrady, B. S. (1988). Alcoholism. In E. A. Blechman & K. D. Brownell (Eds.), *Handbook of behavioral medicine for women* (pp. 357–368). New York: Pergamon Press.

McCrady, B. S., Epstein, E. E., Hildebrandt, T., Cook, S. C., & Jensen, N. (in press). A randomized trial of individual and couple behavioral alcohol treatment for women. *Journal of Consulting and Clinical Psychology*.

McCrady, B. S. (2008). Alcohol use disorders. In: D. H. Barlow (Ed.), Clinical handbook of psychological disorders, Fourth edition (pp. 492–546). New York: Guilford Press.

McCrady, B. S., Epstein, E. E., & Hirsch, L. S. (1996). Issues in the implementation of a randomized clinical trial that includes Alcoholics Anonymous: Studying AA-related behaviors during treatment. *Journal of Studies on Alcohol, 57*, 604–612.

McCrady, B. S., Epstein, E. E., & Kahler, C. W. (2004). AA and relapse prevention as maintenance strategies after conjoint behavioral alcohol treatment for men: 18 month outcomes. *Journal of Consulting and Clinical Psychology, 72*, 870–878.

McCrady, B. S., Longabaugh, R., Fink, E., Stout, R., Beattie, M., Ruggieri-Authelet, A., et al. (1986). Cost effectiveness of alcoholism treatment in partial hospital versus inpatient settings after brief inpatient treatment: Twelve month outcomes. *Journal of Consulting and Clinical Psychology, 54*, 708–713.

McCrady, B. S., Noel, N. E., Stout, R. L., Abrams, D. B., Fisher-Nelson, H., & Hay, W. (1986). Comparative effectiveness of three types of spouse involvement in outpatient behavioral alcoholism treatment. *Journal of Studies on Alcohol, 47*, 459–467.

McCrady, B. S., Noel, N. E., Stout, R. L., Abrams, D. B., & Nelson, H. F. (1991). Effectiveness of three types of spouse-involved behavioral alcoholism treatment: Outcome 18 months after treatment. *British Journal of Addictions, 86*, 1415–1424.

McCrady, B. S., & Raytek, H. (1993). Women and substance abuse: Treatment modalities and outcomes. In E. S. L. Gomberg & T. D. Nirenberg (Eds.), *Women and substance abuse* (pp. 314–338). Norwood, NJ: Ablex Publishing.

McCrady, B. S., Richter, S., Morgan, T. J., Slade, J., & Pfeifer, C. (1996). Involving health care workers in screening for alcohol problems. *Journal of Addictive Diseases, 15*, 45–58.

Menges, D., McCrady, B. S., Epstein, E. E., & Beem, C. (2008). Psychometric properties of the Drinking Patterns Questionnaire. *Addictive Disorders and Their Treatment*, 33(8), 1061–1066.

Miller, W. R. (1996). Form 90. A Structured Assessment Interview for Drinking and Related Behaviors. In M. E. Mattson & L. A. Marshall

(Eds.), *Project MATCH Monograph Series*, Volume 5. National Institute on Alcohol Abuse and Alcoholism, U.S. Department of Health and Human Services, Bethesda, MD.

Miller, W. R. (2004). *Combined behavioral intervention manual: A clinical research guide for therapists treating people with alcohol abuse and dependence*. NIH Pub. No. 04-5288. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Miller, W. R., & Marlatt, G. A. (1984). *Comprehensive Drinker Profile*. Odessa, FL: Psychological Assessment Resources.

Miller, W. R. & Rollnick, S. (2002). *Motivational interviewing* (2nd ed.). New York: Guilford Press.

Miller, W. R., Sovereign, R. G., & Krege, B. (1988). Motivational interviewing with problem drinkers: 2. The Drinker's Check-up as a preventive intervention. *Behavioural Psychotherapy, 16*, 251–268.

Miller, W. R., Tonigan, J. S., & Longabaugh, R. (1995). *The Drinker Inventory of Consequences (DrInC): An instrument for assessing Adverse Consequences of Alcohol Abuse (Project Match Monograph Series)* (NIH Publication No. 95-3911). Vol. 4. US Department of Health and Human Services, Public Health Service, Notional Institutes of Health, National Institute on Alcohol Abuse and Alcoholism, Rockville, MD.

Miller, W. R., Walters, S. T., & Bennett, M. E. (2001). How effective is alcoholism treatment in the United States? *Journal of Studies on Alcohol, 62*, 211–220.

Miller, W. R., & Wilbourne, P. L. (2002). Mesa Grande: A methodological analysis of clinical trials of treatment for alcohol use disorders. *Addiction, 97*, 265–277.

Miller, W. R., Zweben, A., DiClemente, C. C., & Rychtarik, R. G. (1994). *Motivational enhancement therapy manual*. NIH Pub. No. 94-3723. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism.

Mohr, C. D., Averne, S., Kenny, D. A., & Delboca, F. (2001). "Getting by (or getting high) with a little help from my friends": An examination of adult alcoholics friendships. *Journal of Studies on Alcohol, 62*, 637–645.

Moos, R. H., & Billings, A. (1982). Children of alcoholics during the recovery process: Alcoholic and matched control families. *Addictive Behaviors, 7*, 155–163.

Moos, R. H., Finney, J. W., & Gamble, W. (1982). The process of recovery from alcoholism: II. Comparing spouses of alcoholic patients and matched community controls. *Journal of Studies on Alcohol, 43*, 888–909.

O'Malley, S. S., Jaffe, A. J., Change, G., Schottenfeld, R. S., Meyer, R. E., & Rounsaville, B. (1992). Natrexone and coping skills therapy for alcohol dependence: A controlled study. *Archives of General Psychiatry, 49*, 881–887.

Paille, F. M., Guelfi, J. D., Perkins, A. C., Royer, R. J., Steru, L., & Parot, P. (1995). Double-blind randomized multicentre trial of acamprosate in maintaining abstinence from alcohol. *Alcohol and Alcoholism, 30(2)*, 239–247.

Project MATCH Research Group. (1997a). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol, 58*, 7–29.

Project MATCH Research Group. (1997b). Project MATCH secondary a priori hypotheses. *Addiction, 92*, 1671–1698.

Regier, C. A., Boyd, J. H., Burke, J. D., Rae, D. S., Myers, J. K., Kramer, M., et al. (1990). Comorbidity of mental disorder with alcohol and other drug abuse: Results from the Epidemiologic Catchment Area (ECA) Study. *Journal of the American Medical Association, 264*, 2511–2518.

Rosenthal, R. N., & Westreich, L. (1999). Treatment of persons with dual diagnoses of substance use disorder and other psychological problems. (pp. 439–476). In: B. S. McCrady & E. E. Epstein (Eds.), *Addictions: A comprehensive guidebook*. New York: Oxford University Press.

Rubin, A., Stout, R. L., & Longabaugh, R. (1996). Gender differences in relapse situations. *Addiction, 91*(Supplement), S111–S120.

Rubonis, A. V., Colby, S. M., Monti, P. M., Rohsenow, D. J., Gulliver, S. B., & Sirota, A. D. (1994). Alcohol cue reactivity and mood induction in male and female alcoholics. *Journal of Studies on Alcohol, 55*, 487–494.

Rounsaville, B. J., Dolinsky, Z. S., Babor, T. F., & Meyer, R. E. (1987). Psychopathology as a predictor of treatment outcome in alcoholics. *Archives of General Psychiatry, 44*, 505–513.

Sanchez-Craig, M., Leigh, G., Spivak, K., & Lei, H. (1989). Superior outcome of females over males after brief treatment for the reduction of heavy drinking. *British Journal of Addiction, 84*, 395–404.

Schneider, K. M., Kviz, F. J., Isola, M. L., & Filstead, W. J. (1995). Evaluating multiple outcomes and gender differences in alcoholism treatment. *Addictive Behaviors, 20*(1), 1–21.

Smith, E. M., & Cloninger, R. (1984). A prospective twelve-year follow-up of alcoholic women: A prognostic scale for long-term outcome. *National Institute of Drug Abuse Research Monograph Series, 55*, 245–251.

Smith, W. B., & Weisner, C. (2000, June). Alcohol problems in women: Making the case for gender-specific research. *Front Lines: Linking Alcohol Services Research and Practice*, 1–2.

Sobell, L. C., & Sobell, M. B. (1996). *Timeline follow back: A calendar method for assessing alcohol and drug use (Users Guide)*. Toronto: Addiction Research Foundation.

U.S. Department of Health and Human Services. (2001). *10th Special Report to the U.S. Congress on Alcohol and Health from the Secretary of Health and Human Services 2000*. Washington, DC: Department of Health and Human Services, National Institute on Alcohol Abuse and Alcoholism.

U.S. Department of Health and Human Services, National Institutes of Health. (2003). *Alcohol: A woman's health issue*. NIH Publication number 03-4956. Washington, DC: Department of Health and Human Services, National Institute on Alcohol Abuse and Alcoholism.

Vannicelli, M. (1984). Treatment outcome of alcoholic women: The state of the art in relation to sex bias and expectancy effects. In S. C. Wilsnack & L. Beckman (Eds.), *Alcohol problems in women*. New York: Guilford Press.

Volpicelli, J. R., Alterman, A. I., Hayashida, M., & O'Brien, C. P. (1992). Naltrexone in the treatment of alcohol dependence. *Archives of General Psychiatry, 49*, 876–880.

Wilcox, J. A., & Yates, W. R. (1993). Gender and psychiatric comorbidity in substance-abusing individuals. *American Journal on Addictions, 2*, 202–206.

Yi, H.-y., Chen, C. M., & Williams, G. D. (2006). *Surveillance Report #76: Trends in alcohol-related fatal traffic crashes, United States, 1982–2004*. Bethesda, MD: US Department of Health and Human Services.

Zitter, R., & McCrady, B. S. (1979). *The Drinking Patterns Questionnaire*. Unpublished manuscript.

Zweig, R. S., McCrady, B. S., & Epstein, E. E. (in press). Investigation of the psychometric properties of the Drinking Patterns Questionnaire. *Addictive Disorders and Their Treatment*.

Zweig, R. D., McCrady, B. S., & Epstein, E.E. (in press) Investigation of the Psychometric Properties of the Drinking Patterns Questionnaire. *Addictive Disorders and their Treatment.*

This page intentionally left blank

About the Authors

Elizabeth E. Epstein received her PhD in Clinical Psychology from the University of Connecticut in 1989. She is a licensed psychologist, and an Associate Research Professor in the Clinical Division at the Center of Alcohol Studies, Rutgers University. She holds joint appointments with the Graduate School of Applied and Professional Psychology (GSAPP), the Graduate Faculty in the Department of Psychology at Rutgers, and the University of Medicine and Dentistry of New Jersey/Robert Wood Johnson Medical School Department of Psychiatry Addictions Psychiatry Division. In addition to her academic and research activities, Dr. Epstein treats patients part time. Dr. Epstein also directs the Program for Addictions, Consultation, and Treatment (PACT), jointly run by the Rutgers Center of Alcohol Studies and GSAPP. PACT is an outpatient clinic for treatment of substance abuse, providing individual, group, couples, or family therapy for substance abusers and their family members. Dr. Epstein is an expert in cognitive-behavioral (CBT) individual- and couples-therapy development for alcohol and drug abuse and dependence. She has lectured widely, presenting research findings at both scientific conferences and training workshops in CBT for addictions. Dr. Epstein is a member of the Research Society on Alcoholism, Association for Behavioral and Cognitive Therapies, and the APA. She serves as ad hoc grant reviewer for NIAAA and NIDA and reviews manuscripts for many scientific journals. She is also a member of the editorial board of the *Journal of Studies on Alcohol and Drugs*. Dr. Epstein is recipient of NIAAA- and NIDA-funded grants to develop and test couples, group, and individual CBT models and mechanisms of treatment for alcohol- and drug-dependent men and women, as well as to study individual differences among substance abusers in comorbidity, family history, and other potential indicators of heterogeneity in clinical presentation and response to treatment for addictions. Dr. Epstein has been published extensively in scientific journals on the addictions.

Barbara S. McCrady received her BS in Biological Sciences from Purdue University in 1969 and her PhD in Psychology from the University of Rhode Island in 1975. She is currently Distinguished Professor of Psychology and Director of the Center on Alcoholism, Substance Abuse, and Addictions at the University of New Mexico. Previously, she was the chair of the Department of Psychology and Clinical Director of the Center of Alcohol Studies at Rutgers University.

Dr. McCrady is an internationally known expert in empirically supported treatments for persons with substance use disorders, with a particular focus on conjoint therapy, cognitive-behavioral therapy (CBT), mutual help groups, and therapies for women. She is a fellow of the Clinical Psychology and Addictions divisions of the American Psychological Association (APA). She is a past president of Division 50 (Addictions) of the APA, past member of the Board of Directors of the Research Society on Alcoholism, and past secretary-treasurer of the Association for Behavioral and Cognitive Therapies. She also served on the Research Advisory Board of the Hazelden Foundation and the Board of Directors of the Pacific Institute for Research and Evaluation. She has served on a National Institute on Alcohol Abuse and Alcoholism (NIAAA) study section and has also served on advisory panels for NIAAA, the National Institute on Drug Abuse, and the Institute of Medicine. Her work has been funded by the National Institutes of Health (NIH) since 1979, and was funded under the NIAAA MERIT program for 10 years. Dr. McCrady has published close to 200 refereed papers, chapters, and books on her work.

Dr. McCrady is the 1999 recipient of the AMERSA Betty Ford award and the 2007 recipient of the outstanding educator award from Division 50 of the APA.