Cognitive Behavioral Therapy for Substance Use Disorders Among Veterans

Therapist Manual

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Acknowledgements

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This manual was influenced by the work of Marlatt and Gordon (1985) and Monti and colleagues (Monti, Abrams, Kadden, & Cooney, 1989; Monti, Kadden, Rohsenow, Cooney, & Abrams, 2002). Portions of this manual were drawn from work by Wenzel, Brown, and Karlin (2011). Some material used in this manual was derived from previously published treatment manuals that are in the public domain. Material presented in this manual, particularly the section on cognitive behavioral strategies, draws extensively from the following manuals developed and/or evaluated with funding provided by the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse, the Center for Substance Abuse Treatment, and/or the Substance Abuse and Mental Health Services Administration:

Carroll, K. M., (1998). *A cognitive-behavioral approach: Treating cocaine addiction. Therapy manuals for drug addiction.* Rockville, MD: National Institute of Drug Abuse.

Miller, W. R. (Ed.) (2004). *Combined Behavioral Intervention manual: A clinical research guide for therapists treating people with alcohol abuse and dependence.* COMBINE Monograph Series, (Vol.1). Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism. DHHS No. 04-5288.

Kadden, R., Carroll, K. M., Donovan, D., Cooney, N., Monti, P., Abrams, D., . . . Hester, R. (1995). *Cognitive-behavioral coping skills therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence.* Project MATCH Monograph Series, (Vol. 3). Rockville, MD: National Institute on Alcohol Abuse and Alcoholism: DHHS No. 94-3724.

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

Preface

In an effort to bridge the gap between research and clinical practice, the U.S. Department of Veterans Affairs (VA) has developed national initiatives to disseminate and implement evidence-based psychotherapies for substance use disorders, depression, posttraumatic stress disorder, insomnia, chronic pain, serious mental illness, and other conditions throughout the Veterans Health Administration (VHA; Karlin & Cross, 2014). Initial program evaluation results have shown that training and implementation efforts have significantly enhanced therapist skills and client outcomes (e.g., Eftekhari et al., 2013; Karlin et al., 2012; Karlin, Trockel, Taylor, Gimeno, & Manber, 2013; Trockel, Karlin, Taylor, & Manber, 2014; Walser, Karlin, Trockel, Mazina, & Taylor, 2013).

VA has developed national staff training programs in several evidence-based psychotherapies focused on the treatment of problematic substance use, including Motivational Enhancement Therapy, Behavioral Couples Therapy, and Cognitive Behavioral Therapy (CBT). The overall goal of the CBT for Substance Use Disorders Training Program is to provide competency-based training to VA mental health clinicians, which includes experientially-based workshop training followed by ongoing consultation with an expert in CBT for substance use disorders (SUD).

The VA CBT for Substance Use Disorders Training Program focuses on both the theory and application of CBT based on the protocol described in this manual. The program is designed to provide state of the art, evidence-based treatment for problematic substance use that has been adapted specifically for Veterans. This manual is designed to serve as a training resource for therapists completing the training program, as well as for others inside and outside of VHA who are interested in further developing their CBT-SUD skills, particularly as they are applied to the treatment of problematic substance use. This CBT treatment strongly emphasizes the therapeutic relationship and therapeutic strategies in CBT and differs from approaches to CBT that are primarily psycho-educational or solely skills-based. This protocol also places primary importance on case conceptualization, as in other CBT protocols being implemented in VHA (e.g., Wenzel, Brown, & Karlin, 2011). The conceptualization guides the direction of this individualized therapy as it takes place within the context of a collaborative and supportive therapeutic relationship.

This manual is designed primarily for clinicians who are already providing treatment for substance use disorders. Three fictitious case examples that represent composites of Veterans the authors have treated for substance use disorders are used throughout the manual to illustrate the process of case conceptualization and the implementation of CBT strategies.

Part 1: Background, Theory, Case Conceptualization, and Treatment Structure

Introduction

What is Cognitive Behavioral Therapy?

Cognitive Behavioral Therapy (CBT) is a well-researched, efficacious, and time-limited psychotherapeutic approach that has been used to treat a number of mental and behavioral health conditions. CBT involves a structured approach that focuses on the relationships among cognitions (or thoughts), emotions (or feelings), and behavior. As the name suggests, CBT is guided by an integration of cognitive and behavioral theories. Cognitive behavioral theory has informed treatment for a variety of different mental health conditions. Treatments based on cognitive behavioral theory have been successfully applied to problematic substance use (Budney, Roffman, Stephens, & Walker, 2007; Dutra, Stathopoulou, Basden, Leyro, Powers, & Otto, 2008; McHugh, Hearon, & Otto, 2010; Project Match Research Group, 1997).

About the Manual

This manual is divided into two parts. The first part focuses on cognitive behavioral theory, CBT intervention technique, the therapeutic alliance, and the structure of treatment. The second part of the manual focuses on the implementation of CBT for substance use disorders and contains several sections, including: a) preparing and planning for change, b) cognitive behavioral strategies, c) termination and maintaining gains, and d) pull-out procedures, or information that will be useful for a subset of Veterans.

It is important to note that for clinicians new to CBT for substance use disorders, the role of consultation and/or supervision is critical. This manual provides a common conceptual framework for clinicians, consultants, and supervisors to use when discussing the implementation of CBT for substance use disorders. It is a tool that provides a foundation on which to base subsequent discussions about implementation.

Often times, CBT for substance use disorders will not be a stand-alone treatment. As a part of comprehensive care, the Veteran should also be made aware of treatment options related to pharmacotherapy and, if the Veteran is interested, referred for an evaluation for medication to assist with achieving and maintaining abstinence.

A Word about Language

Sometimes, unintentionally, the language that is used when describing substance use or individuals who use substances can be judgmental or contain moralistic overtones. The way that substance use related conditions are described can perpetuate associated stigma or attenuate it. For example, when a person is referred to as a substance "abuser" it may evoke more blaming and punitive attitudes toward the person than if that same individual is described as "having a substance use disorder" (Kelly, Dow, & Westerhoff, 2010). This manual strives to avoid potentially harmful language and instead focuses on describing the behavior. For instance, "resumed alcohol use" or "resumed cocaine use" are used to describe a person who abstained for a period of time and then used a substance. Changes in the quantity or frequency of substance use are described as "increased use" or "decreased use." Describing behaviors in this way also addresses the problems inherent in dichotomous terms such as clean/dirty, drunk/sober and so forth. The word "relapse" is used only when the term is in a specific model as described by the original author.

Case Examples

Throughout the manual the three case examples below are used to illustrate CBT including case conceptualization, the therapeutic relationship, and application of cognitive behavioral intervention strategies.

Matt

Matt is a 25-year-old, male Veteran who recently returned from his second deployment to Afghanistan. Matt is married and has a two-year-old son. He came to the VA at the urging of a friend and fellow Veteran who told him he needed to get help for his alcohol and cannabis use. Matt reported that he has been spending more time alone and has been less interested in spending time with his friends. Matt reported that he gets along well with his wife and son, but that he is having trouble connecting with other people both at work and outside of work. He has been getting angry more easily than he used to and has broken some things at the house. His wife expressed concern about his anger and unsafe driving. Matt has used alcohol and cannabis since he was 15-years-old, but during the past year his use has increased and he has been drinking every evening. He works full-time for a landscaping company and he and his co-workers use cannabis throughout the work day.

Jim

Jim is a 70-year-old, retired male Veteran who has used multiple substances in the past and has an extensive history of problematic alcohol, cocaine, and cannabis use. It has been more than 10 years since he used cocaine or cannabis. Five years ago, he completed an intensive outpatient treatment program and following that episode of care he remained abstinent from alcohol for four years. During the past year, he began using alcohol again and his use has become problematic. He is married for the third time and has informed his treatment providers that his wife is saying she will leave if he continues to drink. He has one adult daughter he is close with and speaks with regularly. He also has two grandchildren, ages three and five, but his daughter will not allow him to see them because of his alcohol use. Jim has been diagnosed with diabetes and he was recently informed that his liver enzymes are elevated.

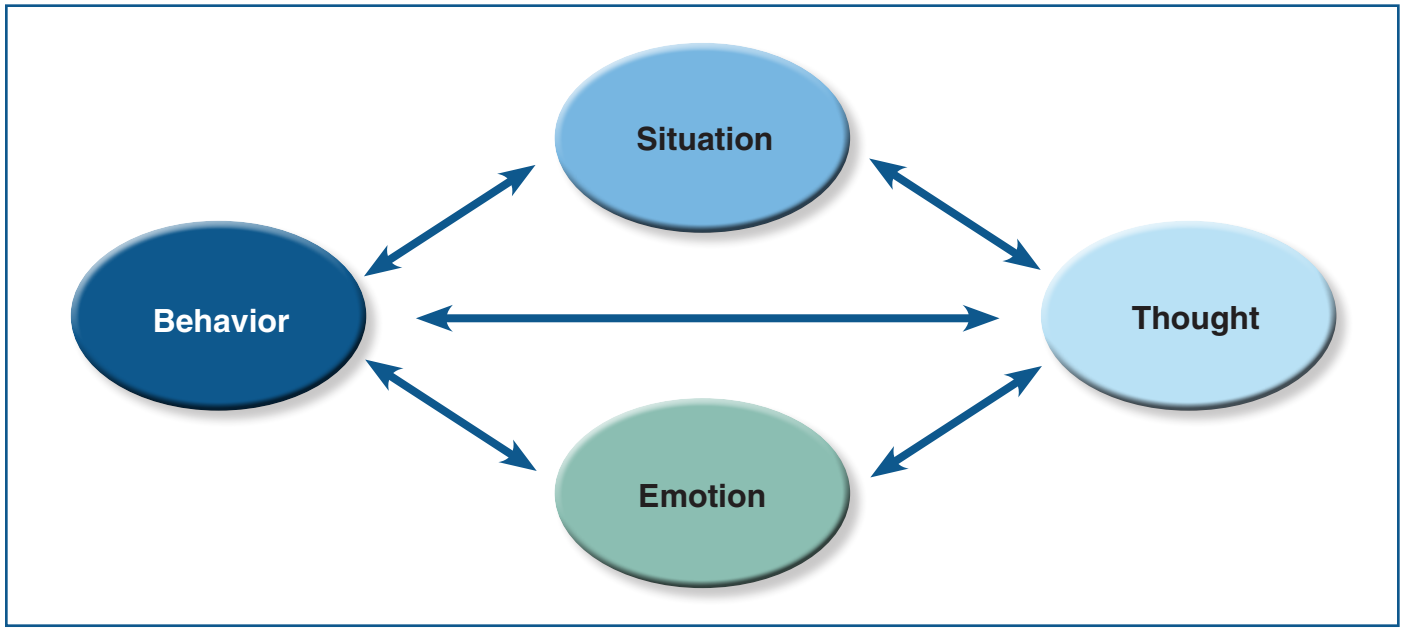
Laura

Laura is a 30-year-old, single female Veteran who returned from deployment in Iraq five years ago. She was referred by her primary therapist who has been providing treatment for posttraumatic stress disorder. Her primary therapist expressed concern that Laura's alcohol intake is increasing. The therapist said Laura is using alcohol as a form of avoidance and is drinking to cope with uncomfortable emotions. Laura has said that she does not see her alcohol use as problematic, but acknowledged she does not want her use of alcohol to increase. Laura is employed full-time at a local newspaper and has expressed concern about taking more time away from work for treatment.

Cognitive Behavioral Theory of Substance Use Disorders

Psychotherapy benefits from an understanding of an underlying theory or framework. Theory guides the therapist in forming a conceptualization of each individual, and in turn, the conceptualization provides a roadmap for treatment planning. From a cognitive behavioral perspective, thoughts, emotions, and behaviors are all closely connected and influence one another. The following is a visual description of the relationship among thoughts, emotions, behaviors, and situations.[1]

Figure 1. Relationship Among Thoughts, Emotions, Behaviors, and Situations



Informed by a social learning perspective, cognitive behavioral theorists have developed comprehensive models of how problematic substance use develops. It is thought that problematic substance use results from maladaptive coping strategies that have developed over time as a result of poor coping skills interacting with certain types of beliefs and expectancies (or thoughts) surrounding substance use (Marlatt & Gordon, 1985; Longabaugh & Morgenstern, 1999; Monti, Kadden, Rohsenow, Cooney, & Abrams, 2002).

A central tenet of social learning explanations of the development of substance use disorders is that the immediate reinforcing effects of substance use interact with psychological or behavioral coping deficits in certain individuals to produce escalation of substance use (Maisto, Carey, & Bradizza, 1999). For example, if a person struggles with anxiety and experiences a decrease in anxiety after consuming alcohol, the person may be more likely to consume alcohol in an attempt to reduce anxiety in the future. Each time alcohol is consumed and anxiety is reduced, the use of alcohol is reinforced.

[1] Adapted from Wenzel, A., Brown, G. K., & Karlin, B. E. (2011). *Cognitive Behavioral Therapy for Depression in Veterans and Military Servicemembers: Therapist Manual.* Washington, DC: U.S. Department of Veterans Affairs.

In contrast to the immediate reinforcing effects of substance use, the negative consequences of the substance use may be delayed and therefore not immediately experienced by the person using the substance. For instance, an individual who uses alcohol to cope with anxiety may go years without experiencing negative consequences related to alcohol use and then later develop alcohol-related social, occupational, and/or health problems.

In contrast to the immediate reinforcing effects of substance use, the negative consequences of substance use may be delayed.

Different beliefs and expectancies about the effects of substance use develop over time as a result of what an individual observes in the social environment and experiences firsthand. Individuals who have low confidence in their ability to cope adaptively may be more likely to engage in substance use as a way of coping. If a person has used alcohol to cope with anxiety for many years, the person may not have experience with alternative, adaptive ways of coping with anxiety. The person may have developed the belief that alcohol is the only way to cope.

Cognitive behavioral theory also informs intervention strategies used during treatment. Cognitive behavioral theory postulates that the acquisition of adaptive coping skills provides the individual with ways to manage maladaptive thoughts, mood states, and behaviors. New adaptive coping skills can be learned and implemented, resulting in an increase in self-efficacy (defined as the level of confidence one has in his or her ability to perform a specific behavior (Bandura, 1977)) for implementing adaptive coping behaviors in the future. For example, a person who has used alcohol in an attempt to manage or cope with panic attacks might learn and practice an alternative coping strategy such as diaphragmatic breathing during treatment. If the person finds that diaphragmatic breathing is as effective as or more effective than alcohol use then the use of that more adaptive coping strategy is reinforced. The more times that the person implements diaphragmatic breathing successfully, the higher the person's self-efficacy will be for implementing the new coping strategy when experiencing symptoms of panic in the future.

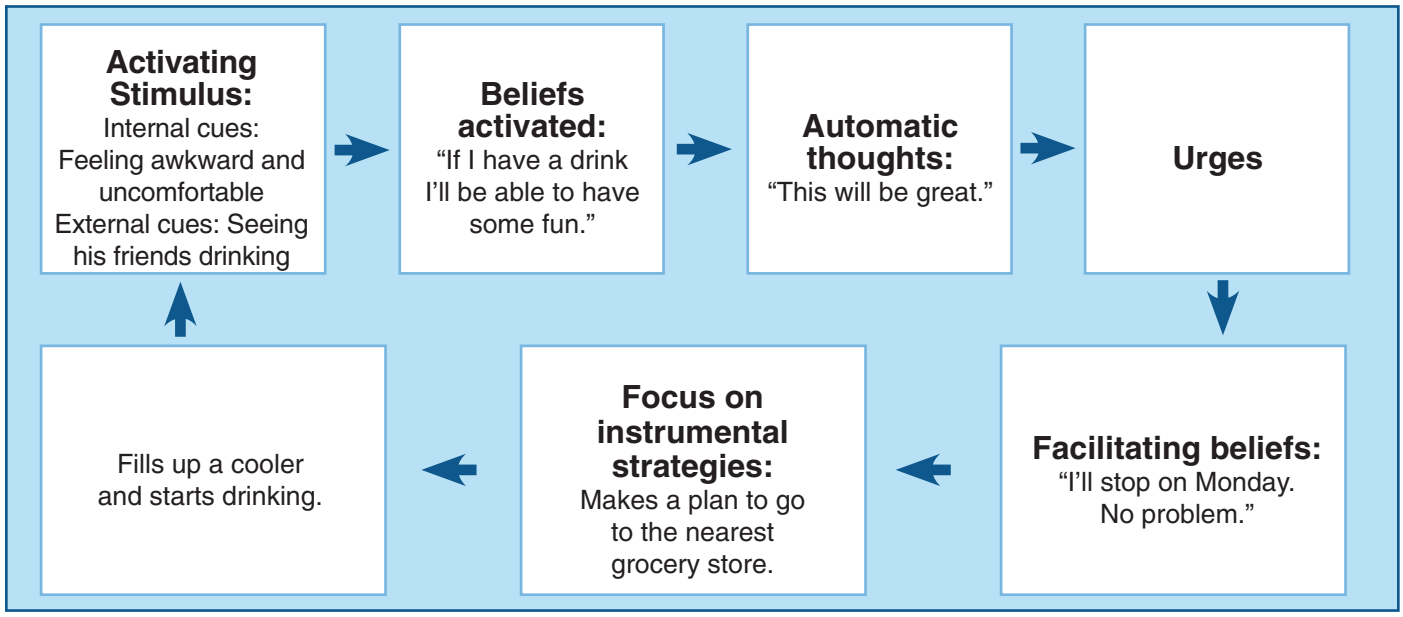
Another way of thinking about the development of problematic substance use has been offered by Beck and colleagues (Beck et al., 1993). The model they developed is described next and then illustrated using the case example of "Jim." The model begins with a situation or "activating stimulus." An activating stimulus can be an event external to the individual, such as passing by a bar, or it can be internal to the individual, such as a craving or urge, a memory, or a feeling. Situations or activating stimuli are capable of activating thoughts (often referred to as "automatic thoughts" in CBT). Automatic thoughts include expectations about self-efficacy and an example of that would be, "I can't make it through this party without drinking." A person may also have beliefs that minimize the potential harmful impact that using alcohol or other drugs will have, such as, "It's not a big deal. It's not like I get high every day." Beliefs about the anticipated effects of substance use, often referred to as outcome expectancies, are activated by certain internal and external stimuli and contribute to cravings. An example of such a thought might be, "One hit and I'll feel good."

According to cognitive behavioral theory, automatic thoughts stem from core beliefs that have developed as a result of the person's life experiences. For instance, certain types of core beliefs (e.g., "I am unlovable." or "I am inadequate.") are associated with problematic substance use and other mental health conditions. Taken together, the activating stimulus and beliefs that result in automatic thoughts set the stage for instrumental strategies, or behaviors that are focused on obtaining or using a substance.

Case example: Jim

Jim used to really enjoy hunting and fishing. He looked forward to an annual three-day weekend event where he and some of his buddies would set up camp on property that belonged to one of the men. He always used to drink during these events and people described him as "the life of the party" because he was always making jokes and laughing loudly. After completing an intensive outpatient program and quitting drinking, Jim decided not to go to this event for several years in a row. This past year, Jim felt confident in his ability to continue to abstain from alcohol and he decided he wanted to go. Once he arrived, he saw that everyone was drinking. He felt more awkward than he had anticipated he would.

Figure 2. Cognitive Model of Substance Use Applied to Jim[2]



[2] Cognitive Therapy of Substance Abuse, Aaron T. Beck, Fred D. Wright, Cory F. Newman & Bruce S. Liese. 1993. Copyright Guilford Press. Adapted with permission of The Guilford Press.

CBT Intervention Technique

Socratic questioning and guided discovery are terms frequently associated with CBT. Socratic questioning is an indirect method of questioning by the therapist that aids Veterans in examining whether automatic thoughts are accurate, valid, or helpful and if not to develop more realistic and helpful alternative ways of thinking. The goal of Socratic questioning is to elicit information from within the client, rather than the therapist attempting to provide answers that may or may not prove to be helpful. According to Beck and colleagues Socratic questions "should be phrased in such a way that they stimulate thought and increase awareness, rather than requiring a correct answer" (Beck Wright, Newman, & Liese, 1993, p. 103).

Socratic questioning and guided discovery are terms frequently associated with CBT.

Socratic questioning, when executed well, occurs in the context of a strong therapeutic working relationship in which the therapist expresses understanding, warmth, genuineness, and a non-judgmental stance. The goal is to convey to Veterans that their perspectives are appreciated, taken into consideration, and not critically disputed by the therapist. The therapist is not trying to change the mind of the Veteran, but rather guide the process of discovery.

Cognitive behavioral therapists often use the term *guided discovery* to describe the process in which the therapist uses Socratic questioning to help guide the client in making unique realizations. The process of discovery is far more powerful than the therapist simply providing information to the Veteran. It is part of helping the client to adopt an experimental approach to evaluating thoughts, behaviors, and emotions, and an inquisitive style to draw their own conclusions. Guided discovery requires a high degree of competency, as the therapist must be able to ask questions to uncover relevant information outside of the client's current awareness. It requires accurate listening and reflection and shaping questions that will help the client explore and come to new realizations. The therapist uses questions, often open-ended questions, to help the client think about situations from multiple new perspectives. The therapist expresses genuine curiosity about potential alternative ways to view situations. The hope is that through repeated practice with a therapist in session, clients will learn to ask themselves similar questions when they identify their own inaccurate automatic thoughts.

Building Rapport and the Therapeutic Alliance

A strong therapeutic alliance is essential to effective treatment. Often when clients present for treatment they are ambivalent about whether they want to make any change or if they even want to be there. Clients will observe closely and attempt to determine if their therapist is trustworthy, capable, and genuine. Early drop-out is not uncommon in CBT for substance use disorders and is more likely in the absence of a strong therapeutic alliance (Meier, Barrowclough, & Donmall, 2005).

A strong therapeutic alliance is essential to effective treatment.

Some therapists view CBT for substance use disorders as synonymous with coping skills training. This is a misperception because CBT emphasizes that change occurs in the context of a safe, accepting therapeutic relationship. In order to make meaningful change, Veterans should feel comfortable sharing private information such as their thoughts, feelings, and experiences. Delivering CBT effectively is not just a matter of completing a checklist of required tasks. Therapists bring unique qualities to the therapeutic relationship including their individual timing, style, personality, and creativity. These qualities can make the difference between treatment delivery that is adequate and treatment delivery that is outstanding. It's like a professional bicyclist racing for the win, deciding when to speed up or slow down or how to take a curve. The road is the same but how they navigate the course can make all the difference in the race. While there are clearly tasks to complete in CBT, it is the delivery of the treatment within the context of a strong therapeutic alliance that allows and encourages meaningful change to take place with greater likelihood of a lasting impact.

Alliance in the therapeutic relationship is fostered when the therapist is warm, genuine, and communicates empathy. Depending on the case conceptualization for an individual, more or less time may need to be devoted to empathic understanding and the therapeutic relationship. Communicating empathy requires that the therapist (a) attentively listen to what the Veteran is saying, (b) understand what the Veteran is expressing, and (c) convey that understanding to the Veteran. Treatment outcomes improve when therapists communicate high levels of empathy (Moyers & Miller, 2013).

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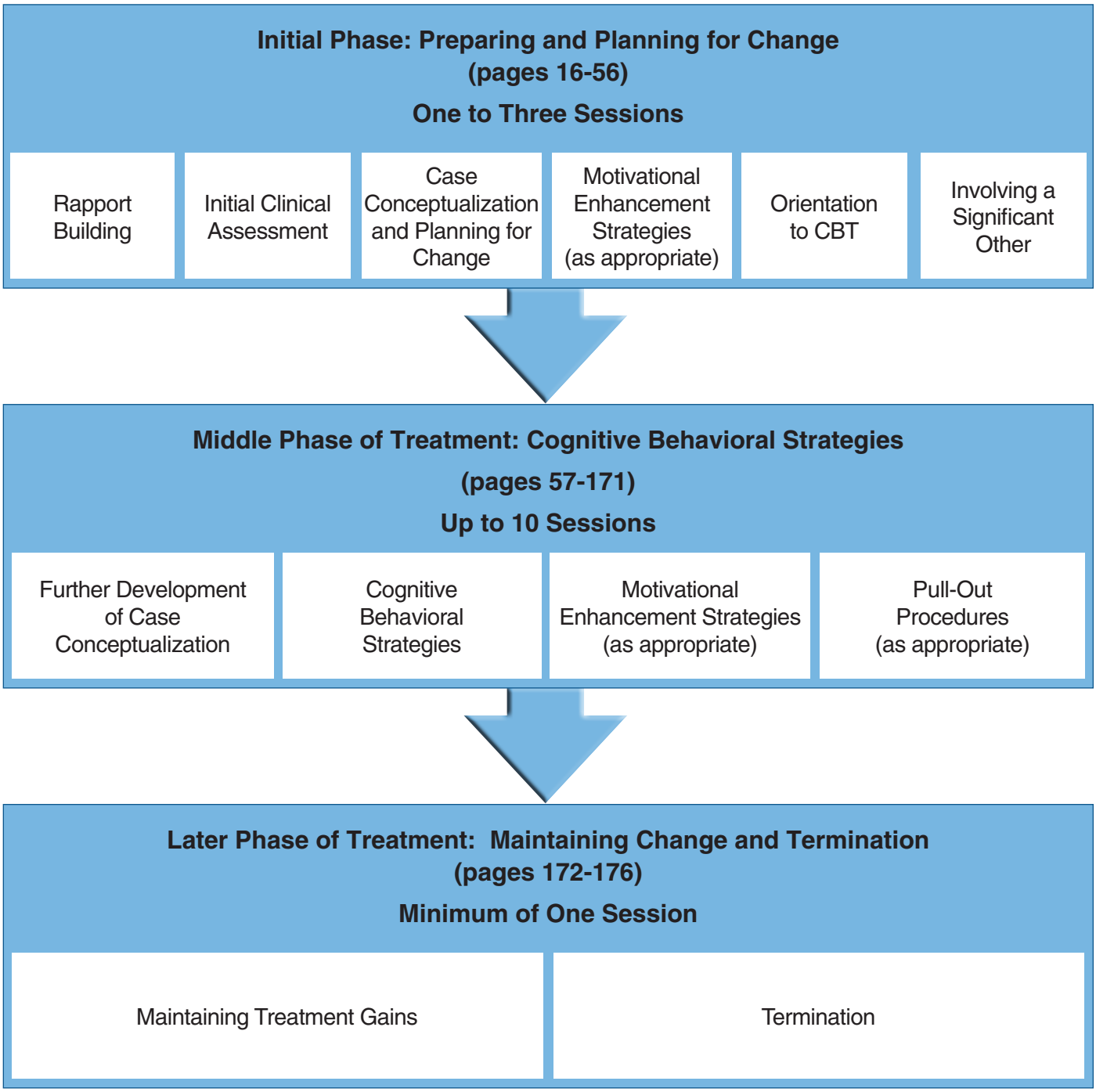
During the course of this treatment, therapists will work with clients to help them learn to identify and challenge inaccurate and unhelpful thoughts. If difficulties occur in the therapeutic relationship, the therapist is encouraged to examine his or her own thoughts and consider whether some may be unhelpful, inaccurate, or otherwise interfering with the therapeutic relationship.

Structure of Treatment

Overview of Treatment Structure

This treatment is designed to be flexible and individualized. Approximately 12 sessions will be delivered during a 16-week period. These individual sessions are designed to last 45 minutes to one hour. Not all tasks within treatment phases (e.g., rapport building, case conceptualization, motivational enhancement strategies) are intended to take place in sequential order or all at one time. Rather the intent is to engage in the tasks as clinically indicated. Some of the tasks, such as case conceptualization, will likely evolve throughout the course of treatment. A depiction of the structure of this treatment follows:



Treatment Considerations

Because this treatment is flexible and individualized it can be challenging to know when to progress from one cognitive behavioral strategy to the next. Exposure to a skill and mastery of a skill are two very different things. Almost always, mastery of a cognitive behavioral skill will take more than one session. It may require multiple sessions and a great deal of practice by the Veteran between sessions. One way to assess a Veteran's level of understanding of a skill is to ask the Veteran to summarize information not only about the skill but also about how and when to implement it. Role-play or in session practice of skills also provide information about a Veteran's level of mastery. If receiving supervision or engaged in consultation, this is a useful topic to bring up and discuss throughout the course of treatment.

It is not unusual for individuals seeking treatment for substance use disorders to return to use or increase their use during the course of treatment. The structure of treatment is altered for these individuals. The behavior is not viewed as a treatment failure, but rather part of the treatment process for some individuals. At times, treatment may look like taking two steps forward and one back. If the individual seeking treatment continues to have the goal of making changes in use and is open to attending psychotherapy sessions, this treatment continues (unless a higher level of treatment is indicated). One of the pull out procedures, *Addressing Resumed/Increased Use,* addresses managing resumed or increased use. It is placed in the pull out procedures section because the material will likely not apply to every Veteran in treatment. However, often this information will be applicable. Become familiar with the content in that section as well as the content of the other two pull out procedures that address safety concerns and managing acute intoxication. Returning to use or increasing use can happen at any time during the course of treatment and for some Veterans it may be a prominent issue in treatment.

General Session Structure

Each session of CBT for substance use disorders follows a structure in order to make efficient use of time, ensure that goals are achieved in each session, and maintain a thread across sessions so that progress is made toward longer-term goals. CBT session structure includes the following:

- ✓ Bridge from previous session
- ✓ Functional analysis (as indicated)
- ✓ Agenda setting
- ✓ Discussion of agenda items/Cognitive behavioral strategies
- ✓ Closing the session/Planning the home assignment

Of course, sound clinical judgment might point to an alternative course of action during a session in specific situations, such as in response to crises, or when Veterans report or display behaviors that suggest a specific action should be taken to assess or address potential safety concerns.

CBT is fundamentally a collaborative enterprise between the therapist and client.

In cognitive behavioral therapy it is important to be cognizant of the therapeutic relationship while structuring the session. CBT is

fundamentally a *collaborative* enterprise between the therapist and client. Veterans are active participants in all aspects of therapy and contribute to the structure of therapy as much as is possible.

Many clients welcome session structure so that expectations for what will be accomplished and their roles in treatment are clear. The structure models a systematic approach to addressing problems. In addition, implementation of session structure has the potential to enhance the therapeutic relationship, in that it communicates to clients that their therapist wants to ensure that they thoroughly cover the issues that are important to them.

Some clients would prefer to "vent" or "chat" rather than stick to a preset agenda. For this reason, early orientation to CBT and discussion of the therapy process are important. Furthermore, in some instances, it is necessary to be creative in modifying session structure in order to respond to the preferences of Veterans. This can foster a strong, collaborative therapeutic relationship, which should always take precedence. One way of doing this is agreeing to allow 5 to 10 minutes of the session to be consistent with the stated, non-structured, preference of the Veteran with the knowledge that the structured session will follow.

When a topic is delivered in more than one session, discuss and practice the more basic skills first and the more challenging skills in the second (and sometimes third sessions). Allowing more than one session for each topic provides the therapist and Veteran the opportunity to individualize the treatment based on the case conceptualization. Spending more than one session on a topic also provides the Veteran with additional opportunity to practice the skill or skills in between sessions.

Bridge from previous session. The bridge from the previous session may be as brief as one to two minutes or may take somewhat longer depending on what the Veteran brings to the session. The bridge ensures that the Veteran remembers the work completed in the previous session and also involves a review of the home assignment. It provides an opportunity to follow up on relevant issues. It is helpful to bridge from the previous session so that coherent themes across the course of treatment will be evident, and goals established at the beginning of treatment are met. It also provides an opportunity to identify any negative reactions that the Veteran might have had to the previous session. It is often a good time to discuss items from the *Working Alliance Inventory* (see page 34 for guidance on using this measure in session).

Below are examples of questions to help bridge from the previous session. It is not recommended to use all, or even necessarily more than one of the following questions to bridge from the previous session. Rather, the intent of providing the following questions is to give some ideas for questions that might aid in this task.

Sample Questions for Bridging from the Previous Session

- What did we cover in the previous session that you found helpful?
- What did we cover in the previous session that you did not find helpful?
- What did you learn from the previous session?
- What stood out for you about our last session?
- What message did you take home from the previous session?
- Are there things from the previous session that we need to follow up on?
- Was there anything that bothered you from our previous session?

Review of home assignments also provides a way to bridge from the previous session. Always inquire about home assignments and positively reinforce any efforts related to treatment that were made by the Veteran between sessions. Reviewing the home assignment every time conveys to the client the importance of the task.

On occasion, clients present for a treatment session without having completed the home assignment. This may be frustrating, but it is important for therapists to monitor their own reactions, which could lead to counterproductive therapeutic responses. There are many potential reasons a client may present to therapy without having completed a home assignment. It is possible that the Veteran has had a traumatic brain injury, or has memory and concentration problems as a result of past substance use. It is also possible that the Veteran may not be fully invested in treatment and may benefit from additional motivational enhancement strategies.

Although home assignment review is referenced in the section on bridging from the previous session, in reality it can occur at many different points in the session. If the home assignment has not been reviewed by the time an agenda is set for the session, then, in most cases, encourage the Veteran to put it on the agenda. If it is clear that discussion of the home assignment will be lengthy, then it is best to put it on the agenda, rather than reviewing the home assignment before setting the agenda.

When reviewing the home assignment it is often helpful to inquire about what the client learned from it and how completion of the assignment was applicable to daily life. Also inquire about ways that the Veteran can envision using the skill that was practiced in the future.

Functional analysis. This is a useful tool throughout treatment. It takes place during the initial assessment, and again whenever there is an instance of cravings or urges to use, resumed use, or increased use. The purpose of functional analysis is to increase understanding of specific behaviors. Examining the chain of events that occur surrounding a behavior provides information on what is maintaining the particular behavior. A thorough understanding of a behavior provides information about potential targets for cognitive behavioral strategies. Detailed instructions on conducting a functional analysis are provided in the section that covers the initial clinical assessment (see pages 27-32).

Examining the chain of events that occur surrounding a behavior provides information on what is maintaining the particular behavior.

Agenda setting. This is a collaborative process in which topics to be addressed during the therapy session are identified. Functional analysis also informs what topics will be placed on the agenda each session. Another function of agenda setting is that it facilitates the prioritization of the most important problems, which are usually related to the treatment goals. It also provides the opportunity to check in with Veterans about safety concerns and general concerns since the previous session.

Some clients find that the agenda setting process is quite different than the usual manner in which they address problems in their lives. Thus, it is important to orient clients to the agenda setting process early in the course of treatment. In the first session, clients are educated about what agenda setting involves and its purpose, as well as the expectation that both parties will contribute to agenda setting at the beginning of each subsequent session. Take care to follow through on what was agreed. Not only work with the client to identify the items to place on the agenda, also indicate the relative priority of each item. In addition, work with the Veteran to identify an approximate amount of time to devote to each agenda item. Many therapists

have found it helpful to write down the agenda and keep it in a location so that it can be referred throughout the session.

It is important to strike a balance between ensuring that items on the agenda will help Veterans achieve the goals they established at the beginning of treatment and the items that they deem important (whether or not they are related to treatment goals) are given attention. Flexibility is encouraged during agenda setting. It may be necessary to deviate from what is believed most important in order to maintain the therapeutic alliance and to help the Veteran with immediate issues that may have arisen in the time since the previous session.

A straightforward manner to commence agenda setting is to ask the Veteran, "What items would you like to place on the agenda for today's session?" However, some clients find the use of the term "agenda" aversive. In these cases, ask, "What do you think is important for us to discuss today?" or "What would you like to have accomplished by the end of today's session?" to obtain the same information. Some clients find more informal language easier to digest, such as using the term "game plan" rather than "agenda."

Discussion of agenda items/cognitive behavioral strategies. CBT views the development of problematic substance use as occurring through learning processes. The same learning processes can be used to assist individuals in reducing or stopping substance use. Two steps are essential to the process of unlearning. First, individuals need to learn to *identify* triggers for substance use. Next, they need to learn to *cope* with triggers. In CBT there are core cognitive behavioral skills that individuals learn and practice in order to effectively cope with urges and cravings to use. Some skills are behavioral, some are cognitive, and some blend cognitive and behavioral strategies.

Two topics are considered core in this manual: *Coping with Cravings and Urges* and *Refusal Skills*. Every Veteran who engages in this treatment will begin with these two topics. The strategies covered in these two topics include behavioral aspects of coping, such as avoiding, and cognitive strategies, such as cognitive restructuring, both of which are viewed as essential components for CBT for SUD. The skills covered in these two topics tend to be applicable to all individuals beginning treatment for problematic substance use and provide strategies to help individuals achieve abstinence or reduce use early on. Once the individual has developed the basic skills contained in *Coping with Cravings and Urges* and *Refusal Skills*, the therapist and client will choose additional topics based on the case conceptualization. The skills covered in the later topics frequently include more complex cognitive behavior skills or specific applications of the skills covered in the core topics.

As each item on the agenda is discussed, remain cognizant of cognitive behavioral principles underlying the identified issue and begin to identify ways to use the problem as a means for advancing the case conceptualization and/or skill building. In other words, regardless of the specific content of the problem introduced by the Veteran, encourage the application of strategies that balance empathic understanding and cognitive behavioral change to resolve it. Frequently cognitive behavioral strategies that become the focus of sessions have been identified, at least in part, during the change planning session(s). Other times, the situation requires a strategy that has not yet been considered in the course of treatment, and this becomes the opportunity to introduce it. On occasion, it may be decided together to return to an intervention strategy that was covered previously in order to practice generalizing the strategy to a new problem or issue. Throughout the discussion of agenda items, work to understand the Veteran's symptoms and problems in light of the therapeutic relationship and cognitive behavioral theory, and then strategically selects specific intervention strategies from this manual to address those symptoms and problems.

This manual contains five different elective categories of cognitive behavioral strategies (e.g., Problem Solving). Again, the case conceptualization will be a guide to the therapist and client in making decisions about which strategies will be most useful and how many sessions will be spent on a particular set of strategies. For each topic, a section titled "Therapist Information" is provided with useful background and theoretical information. Following that is guidance on "Implementing the Session(s)." This information includes a list of the different strategies covered within the broader topic, a list of materials to consider having available during the session(s), and a reminder of what the structure of each session is. Other information provided includes guidance for conducting the session and examples of dialogue that illustrate how particular topics and strategies might be approached.

Closing the session/planning the home assignment. At the end of session, conduct a final summary or, alternatively, have the Veteran summarize the most important lessons gleaned from the session. In addition to summarizing content, consider including an affirmation of the Veteran's efforts or strengths. Ask questions such as, "What was the most helpful thing that we discussed in today's session?" or "What will you take away from this session?" Asking for feedback in this manner helps to gain a better understanding of the specific points that resonated most with the Veteran. Also ask about how the Veteran felt about the session, especially if a particularly upsetting or sensitive topic was discussed. This is an important question to ask because clients may avoid future sessions if they leave sessions feeling distressed and do not have a plan for dealing with this distress. Also assess whether clients think they were understood correctly and whether they want to do anything differently in the next session. Items not discussed in this session could be identified at this point and established as agenda items for the following week. Write down the information and be sure to introduce the items identified by the Veteran in the next session. Many of the questions used to bridge from the previous session can be modified to obtain a final summary and feedback from Veterans.

Home assignments are an essential component of CBT. Home assignments provide an opportunity for clients to test out cognitive behavioral skills in their own environment. In practice, home assignments can be developed at any point during the session when it is logical to devise one following the discussion of an agenda item. It is more likely that clients will actually complete the home assignment if the assignment is determined through a collaborative process rather than it being assigned. Ideally, Veterans will take ownership of assignments and be invested such that they will follow through with the completion of the task.

For the cognitive behavioral intervention strategies, described in the following sections of this manual, options for assignments are provided. The role of the therapist is to assist clients to shape the home assignment to best meet their needs or goals.

When relevant and time-permitting, begin home assignments in session so that Veterans have a model when they attempt to complete it on their own. When the home assignment discussion is saved until the last few minutes of the session, it runs the risk that it will not be developed fully, clients will not fully understand the rationale for it, and will not fully understand how to carry it out.

As much as possible, the home assignment should set the Veteran up for success and minimize the possibility of falling short. In most instances, there should be no more than two components of the home assignment so that clients do not become overwhelmed or discouraged by their magnitude. Home assignments *should always be written down during the session,* and both the Veteran and the therapist should retain a copy of the assignment. It is also helpful to write down the date and time of the next treatment session and give the client that information along with the home assignment.

Part 2: Cognitive Behavioral Treatment for Substance Use Disorders

Initial Phase of Treatment: Preparing and Planning for Change

Initial Phase of Treatment: Preparing and Planning for Change (pages 16-56) 1-3 Sessions					
Rapport Building	Initial Clinical Assessment	Case Conceptualization and Planning for Change	Motivational Enhancement Strategies (as appropriate)	Orientation to CBT	Involving a Signficant Other

Addressing Motivation

Clients present with varying degrees of motivation for treatment and varying degrees of motivation to make changes in substance use. It is also common for motivation levels to fluctuate during the course of treatment. Because the level of motivation changes over time it is important to regularly assess motivational levels. Motivational work is important at the outset of treatment and is often important during the other parts of treatment as well.

The issue of client motivation is an important one. In some cases, it may be the primary issue. Some clients may present with minimal coping skill deficits, and instead may be struggling more with motivation to change. If Veterans are not ready to make changes when they present for treatment, more time should be allotted to the use of motivational enhancement strategies described later in this section. Similarly, if motivation begins to wane during the course of treatment, it will be necessary to return to the use of motivational enhancement strategies.

Problems can occur in the therapeutic relationship if therapists assume clients are more or less motivated to make changes than they actually are. For example, therapists may expect to begin teaching and practicing cognitive behavioral strategies when clients are not yet sure that they even want to make a change in substance use (or even be in treatment). This can result in the client feeling not heard or understood, which in turn can lead to undesirable outcomes (e.g., the Veteran terminating therapy prematurely).

Problems can occur in the therapeutic relationship if therapists assume clients are more or less motivated to make changes than they actually are.

Motivational interviewing/clinical style. The VA and the Department of Defense developed the VA/DoD Clinical Practice Guideline for Management of Substance Use Disorders (2009). The guideline recommends the use of a motivational interviewing (MI) style during therapeutic encounters with Veterans, regardless of the particular psychosocial intervention being used. MI has been defined in the following way:

> Motivational interviewing is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and

commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion (Miller & Rollnick, 2013, p. 29).

While comprehensive training in MI is beyond the scope of this manual, it is important to have background information on MI as well as knowledge of techniques used to enhance motivation. A motivational interviewing style will be used throughout this CBT-SUD protocol. Sometimes there is confusion about what motivational interviewing is. In that case it may be useful to read Miller and Rollnick's article that provides information and clarification about what does and does not constitute MI (2009).

A motivational interviewing style will be used throughout this CBT-SUD protocol.

At the outset of treatment, MI will be used to help establish a strong therapeutic alliance and to engage the Veteran in the treatment process. Miller and Rollnick (2013) describe an ongoing process of "engagement" in which the client and therapist establish a helpful connection and working relationship. Veterans are more likely to "engage" when they feel respected, listened to, and understood. Engagement is a crucial component of the therapeutic process and impacts all that will follow in treatment.

During the course of treatment, Veterans may express ambivalence about being in treatment, making changes in substance use, or completing home assignments. MI is used to explore and address ambivalence that arises about these specific behaviors.

In order to use a MI style, an understanding of the spirit of MI is necessary. Miller and Rollnick (2013) describe this as involving four interrelated elements: partnership, acceptance, compassion, and evocation.

Partnership	Treatment is done in partnership with the Veteran. Treatment is not done to the Veteran, but with the Veteran. The Veteran is treated with respect at all times. Veterans are viewed as the experts on themselves.
Acceptance	The therapist does not need to approve of what a Veteran might bring to the table, but the therapist does need to accept the Veteran.
Compassion	The therapist makes the Veteran's needs a priority and actively works to promote the Veteran's welfare.
Evocation	The therapist's role is to evoke the Veteran's goals, strengths, resources, and ideas about how to go about change. Rather than telling the Veteran what to do and how to do it, the therapist works to elicit that information from the Veteran.

In addition to the style and spirit that underlies MI, there are core skills that the therapist uses when interacting with the Veteran. Open questions, affirmations, reflections, and summaries are used both to explore the Veteran's circumstances and to guide the conversation in a way that facilitates change. These communication skills will be used throughout treatment.

Open questions facilitate the communication process and allow clients to share information they deem important with the therapist. The information that the Veteran provides in response to open questions allows the therapist to better understand the Veteran. Closed questions can make it more difficult to obtain important information. It can also result in a dynamic where the therapist is seen as being in the "expert" role, rather than a collaborator. Below are some examples of open and closed questions.

Open questions, affirmations, reflections, and summaries are used both to explore the Veteran's circumstances and to guide the conversation in a way that facilitates change.

Open Questions	Closed Questions
What was that like for you?	Was that scary?
How does the alcohol affect you?	Do you want to stop drinking?
Why do you want to make this change?	Do you want to have better health?
What is the next step for you?	Are you going to stop before our next session?

Affirmations are used by the therapist to acknowledge the Veteran's personal strengths, accomplishments, and efforts. Affirmations are most meaningful when they are delivered in a genuine and sincere manner.

Reflections are used in motivational interviewing for multiple purposes. Accurate reflections let clients know that the therapist is listening and attempting to understand them. They can be used as a way to encourage Veterans to elaborate on something they have said. Reflections can also be a way for the therapist to test a hypothesis. The client then has the opportunity to respond to the hypothesis by confirming it or providing clarifying information.

In MI, the therapist strives to reflect more often than inquire. At times, the content of a reflection might be the same as that of a question, but the inflection is different. The boxes below illustrate how the different inflection influences whether a question or a reflection is formed.

Questions	Reflections
You have never thought about making a change?	You have never thought about making a change.
Change is scary?	Change is scary.
You're concerned about your health?	You're concerned about your health.
You don't think your wife will understand?	You don't think your wife will understand.

Summaries are one form of reflection. They are unique in that the therapist is reflecting back several of pieces of information. Again, one of the therapist's goals is to let clients know that they have been heard. The therapist can strategically decide what to include in a summary as a way of linking information together, or to guide the conversation in a particular direction.

Example dialogue. Throughout the remainder of this section and the following section on the initial clinical assessment, whenever core motivational interviewing skills are used in dialogue the type of skill is labeled in *red italics.*

Following is an example of dialogue between a therapist and Laura, a 30-year-old Veteran who is not motivated to engage in treatment for substance use. The therapist uses a non-judgmental, motivational approach to gather information. Notice the therapist's use of reflections throughout the exchange. The therapist also uses a summary at the end of this exchange.

Therapist: Thank you for agreeing to meet with me today Laura. Your therapist contacted me and said she is concerned about you. I'm interested to hear from you what has been happening *(open question)*.

Laura: Sure. Dr. Smith thinks I'm drinking too much. I really like working with her and she has helped me a lot. That's why I agreed to come in and see you – not because I think I have a problem with alcohol.

Therapist: You don't share her concern about the alcohol *(reflection)*.

Laura: Right. I don't drink every day and it doesn't get in the way of anything. There are plenty of people out there drinking a lot more than I am.

Therapist: You don't have any concerns about your drinking *(reflection)*.

Laura: Well, like I said, I do really like working with Dr. Smith. It bothers me that she is concerned. I have PTSD and I'm really making progress with her. In a lot of ways I'm feeling better than I have in years.

Therapist: You are having a positive experience in therapy *(reflection)*.

Laura: Yes. I am able to do a lot of things that I had stopped doing because of all my anxiety. I'm being more social. That's part of the increase in the drinking, I think. I'm spending more time with other people.

Therapist: That's great. You have been working hard and you're seeing progress *(affirmation)*. You said that your drinking has increased some. I'm interested to hear more about your use of alcohol. Tell me about your drinking *(open question)*?

Laura: It used to be that I rarely drank at all. Alcohol has never been my thing. Recently I have been drinking more.

Therapist: More than you used to *(reflection)*.

Laura: Yes, but still not too much. I drink 3-4 times a week and usually I just have a couple of drinks. Occasionally I will drink quite a bit more. And like I said, it hasn't caused me any problems.

Therapist: Every now and then you find that you're drinking more than you had planned to *(reflection)*.

Laura: Every now and then. I never set out to get drunk. It's usually the mixed drinks that get me. I don't always know how much alcohol is in a drink. And once I get going-I keep going.

Therapist: Let me see if I've got this right. You're not so sure the alcohol is a big deal and at the same time Dr. Smith is concerned about your alcohol. You really just came in to see me out of respect for Dr. Smith. Also, you didn't used to drink much at all and recently you find yourself drinking more frequently and sometimes drinking more than you meant to *(summary)*.

Change talk, sustain talk, and discord. One central component of MI involves eliciting *change talk* from clients. Change talk is about the target behavior (e.g., substance use, therapy attendance) and is language clients use when they are indicating they have a desire to change, believe they have the ability to change, state they have reasons to change, express a need to change, or talk about a change they are starting to make or have already made.

Another key component of MI involves the effective management of *sustain talk* and *discord*. Sustain talk is the opposite of change talk. Clients are engaging in sustain talk when they argue for the status quo. Discord is when there is a problem in the therapeutic relationship.

Following are some examples of different ways to manage sustain talk, illustrated in dialogue between Matt, one of the case examples, and his CBT-SUD therapist. As a reminder, Matt is a 25-year-old, male Veteran who recently returned from his second deployment to Afghanistan.

In the example below, the therapist uses a reflection when the Veteran makes a statement containing sustain talk.

Matt: I've been using alcohol and pot since I was a teenager. They've helped me in a lot of ways.
Therapist: Alcohol and marijuana have made some things better *(reflection)*.
Matt: They have. They've also made a lot of things worse. Once in the military I tested positive for pot and I was dropped an entire rank.

Another type of reflection is an amplified refection. For this type of reflection, the therapist reflects back the sustain talk with added intensity.

Matt: I've been using alcohol and pot since I was a teenager. They've helped me in a lot of ways.
Therapist: Alcohol and marijuana have helped you a great deal *(reflection)*.
Matt: Well, I don't know about that. My wife has been great. So has my son.

Double-sided reflections are another option. In the following example, the therapist acknowledges the sustain talk, but also integrates a piece of change talk.

Matt: I've been using alcohol and pot since I was a teenager. They've helped me in a lot of ways.
Therapist: The alcohol and marijuana have helped with some things and at the same time they have cause you some problems *(reflection)*.

Emphasizing autonomy is another strategy for managing sustain talk. People make their own decisions. When the therapist emphasizes the Veteran's autonomy, the therapist is simply making a statement to that effect.

Matt: I'm not sure that a treatment program is right for me.
Therapist: Matt, you are the only one who can decide whether you want to enter treatment. No one else can make that decision for you.
Matt: Yeah. I'm not sure yet. I'm thinking about it.

Motivational enhancement strategies. The motivational enhancement strategies described in this section are not intended to be used all in one session, but rather woven throughout treatment, as clinically appropriate. These strategies can be used at the beginning of treatment to enhance (a) motivation to make changes in substance use, and/or (b) motivation for treatment. These strategies can also be used later in treatment if it appears that the Veteran's motivation is not as strong as it once was. In addition, these strategies help to strengthen and consolidate motivation. Deciding which of the strategies to implement and when to implement them will depend on the client's situation. Depending on familiarity with motivational

enhancement, determining when the use of such strategies is appropriate and which strategies to select may be an important topic to discuss with training program consultants.

When addressing the issue of motivation in treatment, always consider the following question: "Motivation for what?" The *target behavior* needs to be identified before motivational enhancement strategies can be put to use. Because this is treatment for substance use disorders, it is likely that the target behavior will be alcohol and/or other drugs. However, the target behavior could also be treatment attendance or completion of home assignments.

The *target behavior* needs to be identified before motivational enhancement strategies can be put to use.

While not an exhaustive list, information is provided on several strategies aimed at enhancing motivation:

1. Exploring Importance and Confidence
2. Looking Forward
3. Querying Extremes
4. Identifying Strengths and Resources
5. Examining Short-Term Goals
6. Identifying Substance Use Related Consequences
7. Identifying Benefits of Stopping or Reducing Substance Use

Exploring importance and confidence. The rulers that follow are tools that are used strategically to elicit change talk. While using the rulers, use of open questions, affirmations, reflections, and summaries are encouraged. Often times a therapist may wish to use both the importance and confidence rulers within one session. However, there may be times when it makes sense to use one type of ruler or the other. Below are six steps for each ruler to use as a guide.

Importance

1. Ask about importance: *How important would you say it is for you to [target behavior]? On a scale from 1 to 10, where 1 is not at all important and 10 is extremely important, where would you say you are?*

1	2	3	4	5	6	7	8	9	10
NOT AT ALL IMPORTANT									EXTREMELY IMPORTANT

2. Backwards question: *Why did you pick a 4 and not a 1?* This question is used strategically to elicit change talk from the Veteran. The number that the Veteran chooses is not important. It is the direction of the question that is important. If the question were to asked differently *(i.e., Why did you pick a 1 and not a 4?)* it would likely elicit sustain talk.
3. Reflect back any change talk the Veteran has offered. The reflection may or may not be in the form of a summary.
4. Forwards question: *What would need to happen for you to get from a 4 to an 8?*

5. Reflect back any change talk the Veteran has offered. The reflection may or may not be in the form of a summary.
6. Ask: *What would you add?* or *What else?*

Confidence

1. Ask about confidence: *Let's say you decided to make this change. How confident are you that you could do it? On the same scale from 1 to 10, where 1 is not at all confident and 10 is extremely confident, where would you say you are?"*

1	2	3	4	5	6	7	8	9	10
NOT AT ALL CONFIDENT									EXTREMELY CONFIDENT

2. Backwards question: *Why did you pick a 6 and not a 2?* This question is used strategically to elicit change talk from the Veteran. The number that the Veteran chooses is not important. It is the direction of the question that is important. If the question were asked differently *(i.e., Why did you pick a 1 and not a 4?)* it would likely elicit sustain talk.
3. Reflect back any change talk the Veteran has offered. The reflection may or may not be in the form of a summary.
4. Forwards question: *What would need to happen for you to get from a 6 to a 9?*
5. Reflect back any change talk the Veteran has offered. The reflection may or may not be in the form of a summary.
6. Ask: *What would you add? or What else?*

After going through the above steps for one or both of the rulers, ask the Veteran about next steps:

- *Where does that leave you now?*
- *I wonder what you're thinking about _____ at this point.*
- *What's the next step?*
- *How does _____fit into your future?*

Looking forward. Thinking about the future can increase motivation for change. The following exchange between Jim (70-year-old, Vietnam combat Veteran) and his therapist illustrates this:

Therapist: Jim, I'm curious about what your hopes for the future are *(open question)*. What do you want things to look like 10 years down the road *(open question)*?

Jim: Well, I hope to be around, for one. I'd like to be healthy enough to do things on my own. My granddaughters will be in high school then. I'd like to see them play sports.

Therapist: You'd like to be healthy and you would like to be involved with your granddaughters *(reflection)*.

Jim: Yes. The doctors recently gave me some news about my health that is pretty bad. I'm hoping to turn that around. And my granddaughters are very important to me.

Therapist: I'm wondering what role, if any, alcohol might have in making those things happen *(open question)*?

Jim: Alcohol needs to be out of the picture. If I keep drinking my future will be pretty bleak. I'd probably be dead in less than 10 years. My body can't take much more of this.

Another way to elicit change talk involves asking clients to imagine how their life would be different if they decided to stop using alcohol or other drugs. An exchange between Laura (the 30-year-old, single female Veteran, who returned from deployment in Iraq five years ago) and her CBT-SUD therapist follows.

Therapist: Let's say that you stop drinking. How would things be different *(open question)*?
Laura: I don't know that they would be very different. I guess I would have more money. Dr. Smith could stop worrying about me.
Therapist: What else *(open question)*?
Laura: No more headaches in the morning. I might lose a couple of pounds.

In addition to asking the Veterans how things would be different if they stopped using, the therapist can also ask about what they think life will be like in the future if they do not make a change.

Therapist: Let's say that you keep on drinking. What do you think things will look like down the road *(open question)*?
Laura: I don't know. I really don't see my drinking as an issue. I will say that I don't want to drink any more than I already am.
Therapist: It's possible that your use will increase over time *(reflection)*.
Laura: Yes. It has increased in the last year or so. I don't want it to keep going in the direction.
Therapist: You're OK with what you're doing now, but you're afraid of what might happen if your drinking continues to increase *(reflection)*.

Querying extremes. Querying extremes involves the strategic use of questions to elicit change talk. Below is an exchange between Matt, a 25-year old Veteran who recently returned from his second deployment to Afghanistan, and his therapist. The therapist asks three different questions that address extremes.

Therapist: What worries you the most about your alcohol and cannabis use *(open question)*?
Matt: I worry that it's going to start causing me problems. My wife doesn't like it.
Therapist: You don't want to make her unhappy *(reflection)*. If you don't stop using, what's the worst thing that might happen *(open question)*?
Matt: Worst case scenario would be that my family would leave. I don't think my wife would take the kids and go, but that would be the worst possible outcome.
Therapist: You don't want to lose them *(reflection)*. Your family is very important to you *(reflection)*. What's the one thing you'd really like to see improve if you decide to stop drinking and smoking pot *(open question)*?
Matt: I'd like things to go back to the way they were before I was deployed. I want to feel comfortable around people again.

Identifying strengths and resources. Another motivational enhancement strategy involves identifying strengths and resources. This information will be useful during the treatment process and the identification of strengths and resources by the Veteran can aid in increasing self-efficacy. Assessing strengths and weaknesses can be done through conversation alone or with the assistance of a structured activity. Either way, the therapist will provide a transitional statement such as the following:

Therapist: Now I'd like to turn to talking about some of your strengths. I'm interested to hear about the things you have going for you, things that have helped to achieve difficult goals in the past *(open question)*.

One way to structure this conversation is to ask the Veteran to share some of his or her past successes. Successes can vary widely. Some examples might be graduating from high school, being a good parent, completing basic training, keeping a fellow service member safe, or quitting smoking. Elicit several examples of past successes and for each one, ask the Veteran to identify personal strengths, skills, and resources that made the success possible. Ask how those same strengths, skills, and resources could be applied to the current goal of making changes in substance use.

Examining short-term goals. For some, the identification of short-term goals that are important to them may also increase motivation for treatment and to make changes in substance use. Ask Veterans to identify goals in areas of their lives that are important to them including physical health, emotional health, family, employment, finances, and interpersonal relationships. Assisting Veterans in identifying goals that are truly short-term as well as achievable and specific is encouraged. Discussing how treatment will focus on helping achieve identified goals can increase clients' hope and optimism about treatment.

The following is an example of a therapist assisting Jim in the identification of his short-term goals. As a reminder, Jim is the 70-year-old, retired male Veteran. Following a period of abstinence, he began using alcohol during the past year. His alcohol use has contributed to some difficulties with his wife and daughter. In addition, his use of alcohol is likely exacerbating some of his medical conditions.

Therapist: Jim, we've been talking a lot about the things in your life that haven't been going the way you'd like them to. If it's alright with you, I'd like to spend some time today talking about some of the things you would like to see change. It can often be helpful to identify what you would like to see change in the upcoming weeks or months. Then I'd like to hear about some of the things you're doing to make those changes happen. Does that make sense?

Jim: Makes sense. There's a lot I'd like to see change for the better. I'm not sure where to start.

Therapist: Well, sometimes it's helpful to look at specific areas one at a time. Some examples of different areas are family, finances, spirituality, and health. What area or areas are important to you *(open question)*? Something you really care about and would like to see a change.

Jim: My health is a really important area for me right now. I'd like to get my blood sugar under control. When I've stopped drinking in the past I was able to get it back under control. I'd like to see that happen again.

Therapist: What else *(open question)?*

Jim: Well, I don't know how long it takes, but the doctor told me that my liver enzymes are up. I'll like to see those go back to normal.

Therapist: So for physical health short-term goals, you'd like to see your blood sugar back under control and your liver enzymes back in the normal range *(reflection)*. Regarding these goals, what do you see as the difference between where you are now and where you'd like to be in the near future *(open question)*?

Jim: Well, my numbers are up now and I just want to see them come down. I think that will happen if I manage to stay away from the alcohol. It's worked for me in the past anyway.

Therapist: So based on your past experience you believe you can reach your health goals as long as alcohol is not in the picture *(reflection)*. You've already taken a big step coming to treatment and we'll be spending quite a bit of time talking about strategies to help you remain abstinent. By being in treatment you're already taking steps to help you succeed in making the changes you're identifying. How about at home? What changes would you like to see there in the upcoming weeks *(open question)*?

Jim: I'd like things to go back to how they were before I started drinking again. My wife and I got along better then.
Therapist: You'd like to see your relationship with your wife improve *(reflection)*.
Jim: Yeah, but that's easier said than done.
Therapist: You're right. It may not be easy. At the same time, it's a perfect example of something the two of us can work on together in treatment. We can put our heads together and develop strategies to help you stay abstinent. We can also discuss strategies to help you communicate better with your wife. How does that sound *(open question)*?
Jim: I could use the help. I really dug myself into a hole this time. And it's not the first time.
Therapist: You're doing great, Jim. You've identified some specific goals you have for your health and for your home life *(summary)*.

At this point, the therapist may continue to assess Jim's goals in other areas of his life. Notice how the therapist asked Jim what the difference was between where he is now and where he would like to be. The therapist also linked his goals back to treatment, informing him that treatment will involve learning strategies that will help him achieve his short-term goals.

Identifying substance use related consequences. Another motivational enhancement strategy involves asking the client to identify negative consequences that have resulted from substance use. Some clients may not have made connections between their use and the difficulties they're having at home, at work, with finances, or with their physical or emotional health. Sometimes this can be a difficult conversation to have and some clients may experience painful emotions when identifying and/or talking about substance use related consequences. At the same time, it often motivates them to stick with treatment and/or make changes in their substance use because they no longer want to experience the negative consequences. Below is a list of example questions that may be helpful to ask when identifying substance use related consequences. Notice they are all open-ended questions.

Sample Questions for Identifying Substance Related Negative Consequences

- What concerns do your family members or friends have about your use?
- What problems, if any, has your use of alcohol and/or other drugs caused?
- What effect has your use had on your health? Your family? Your finances? Your work? Your spirituality?
- What types of things have you given up because of your use of alcohol and/or other drugs?
- How does your use affect your mood?
- How would things be different if you had not experienced [insert negative consequence] because of your use?

Identifying benefits of stopping or reducing substance use. Identifying the benefits of stopping or reducing use is a motivational enhancement strategy that is often combined with identifying substance use related consequences. When clients begin to envision how their lives might change and improve it

can provide motivation and hope for the future. Notice that both *stopping* and *reducing* substance use are mentioned. Using language that is congruent with the stated goal of the Veteran is encouraged. That said, it is still acceptable to ask how life would be different if they stopped using altogether, even if the stated goal was not to stop using substances completely.

Below is a list of sample questions that may be helpful to ask when identifying benefits of stopping or reducing substance use. Again, notice they are all open-ended question.

Sample Questions for Identifying Benefits of Stopping or Reducing Substance Use

- How would your life be different if you stopped using substances altogether?
- If you stop (or reduce) your use, what change would you be most excited to see happen?
- How do you think stopping (or reducing) your use would affect your health? Your mental health? Your sleep?
- How would your relationships change if you stopped using (or reduced your use)?
- In what ways would stopping (or reducing) your use impact your ability to reach your goals?

Initial Clinical Assessment

The initial CBT-SUD session includes a clinical interview and the completion of assessment measures described in this section. In addition, information contained in the Veteran's electronic medical record should be reviewed. Strategically gather information that aids in the development of case conceptualization from a CBT perspective.

Remember that addressing motivation, the initial clinical assessment, and planning for change will involve 1 to 3 sessions depending on the individual Veteran. More or less time may be spent on any of those areas depending on what is clinically indicated.

Clinical interview. Local procedures may dictate who conducts the initial clinical interview and it may not be the same person who provides CBT. Because the information gathered during the clinical interview contributes to the development of the case conceptualization, it is preferable to have the clinical interview conducted by the same person who will provide treatment. If this is not possible, the therapist who will provide CBT should carefully review any information that may have been previously gathered during an initial intake evaluation or interview. Ask the Veteran to elaborate on certain areas or ask questions that may not have been covered. Regardless of who completes the initial clinical interview, the initial sessions should involve gathering information from the Veteran.

…the therapist who will provide CBT should carefully review any information that may have been previously gathered during an initial intake evaluation or interview.

In addition to the relevance to case conceptualization, this type of exchange of information between the therapist and client is often an important aspect of the rapport building process. For example, it provides the therapist an opportunity to express interest in the Veteran and to use reflections to convey empathic understanding. The clinical interview is not intended to be a series of close-ended questions asked one after

the other, but rather an opportunity to gain an understanding of the Veteran and begin to build the foundation for a strong working relationship.

A motivational interviewing style (described previously) should be used throughout the clinical interview. One way to do this is to create an *assessment sandwich* in which the first third of the session is spent using open-ended questions and reflections to gather information, the second third of the session may involve close-ended questions aimed at ensuring that required information is gathered, and the final third of the session returns to the use of client centered communication skills consistent with motivational interviewing.

Information gathered during the initial sessions is similar to that which is gathered prior to any type of psychotherapy and should include the following:

- presenting problems
- a biopsychosocial assessment (including family/medical/social history)
- a safety assessment
- military history
- substance use history
- history of abuse or neglect
- co-occurring mental health issues
- history of mental health treatment (including treatment for substance use)

Particular attention should be paid to substance use history, as problematic substance use is the target of treatment. Substance use histories vary widely and may be extensive. The goal of the substance use assessment is not to gather every detail about the Veteran's use, but to ensure assessment is detailed enough to fully inform case conceptualization and treatment. It is recommended that detailed information on recent use (e.g., past month, past year) be collected including substances used, patterns of use, and last date of use for each substance. Negative consequences of use and DSM-5 symptoms should be assessed. In addition, gather information about the more distant past including: (a) family history of problematic substance use, (b) the age the Veteran began using substances, (c) substances the Veteran has used, and (d) whether or not the Veteran (or others) viewed the use as problematic.

As noted in the section about obstacles to treatment (page 36) it is also important to discuss the Veteran's past treatment experiences and views on treatment. Some individuals may have had negative experiences with treatment in the past and if that is the case it is important to discuss these early on and provide information about what can be expected during this treatment (e.g., a collaborative approach that is respectful of each individual's autonomy).

Conducting a functional analysis. A functional analysis is also part of the initial clinical assessment that takes place during the initial sessions (up to 3 sessions). Below are guidelines for completing a functional analysis using the ***Exploring Triggers*** worksheet. A copy of the worksheet is located at the end of this section and in Appendix A.

The first task is to ask clients to identify times when they have been most likely to use in the past. These types of situations may be referred to as high-risk situations or triggers. Carroll (1998) recommends that the therapist inquire about at least five general domains: (a) social, (b) environmental, (c) emotional, (d) cognitive, and (e) physical. It is often helpful to identify triggers and high-risk situations by learning about the client's typical use pattern and examining more closely specific instances of use. While not an

exhaustive list, examples of questions to ask a Veteran during a functional analysis follow. Some of the questions are aimed at examining typical use situations, while some of the questions are about specific instances of use.

EXAMPLE QUESTIONS

Social

- Who did you use with last?
- Who do you typically use with?
- Do you live with someone who uses?

Environmental

- Where do you typically use?
- What type of cues or triggers are present in the environment where you use?
- How often are you in this environment?

Emotional

- What mood are you typically in prior to using (e.g., angry, depressed, happy, anxious)?

Cognitive

- What thoughts do you typically have before using?

Physical

- Were you experiencing withdrawal symptoms?
- Were you experiencing physical pain??

Use the ***Exploring Triggers*** worksheet (provided in Appendix A and the end of this section) to make notes on situations the Veteran identifies. If the Veteran has previously shared any other situations that seem relevant, inquire about those and add them to the worksheet if the Veteran agrees that they are situations that tend to trigger use. Throughout the conversation, prompt for additional information from the five domains listed above to ensure adequate detail has been obtained about the trigger situation. Not all of the information needs to be recorded on the worksheet, just enough to be able to use it together in a meaningful way. Also ask the Veteran to describe both the positive and negative consequences of the substance use.

Following is an example of a therapist beginning a functional analysis with Matt, one of the case examples described earlier. The therapist begins by providing a rationale for the activity and then works collaboratively with the Veteran to identify triggers for use. Notice the therapist using reflective listening

skills during the interaction. An example of what the ***Exploring Triggers*** worksheet will look like follows the dialogue below.

Therapist: If it is OK with you, what I would like to do next is take a closer look at your use.
Matt: Sure.
Therapist: Great. Together we'll talk about what's been happening for you. I'll be writing down some of the things you say so we can look at the information together. The reason I'd like to do this is because taking a close look at your use will help us figure out what will be most useful for us to focus on in treatment. Before we begin, what questions do you have *(open-ended question)*?
Matt: No questions.
Therapist: Just let me know if any questions come up along the way. I'm curious about the types of situations where you've typically found yourself using alcohol or pot *(open-ended question)*. I'm also interested to hear about situations where you found yourself using more than was typical for you *(open-ended question)*.
Matt: Okay. Well, I usually start drinking at night after my son has gone to bed. I'll have a few beers and then right before I go to bed I'll do a few shots.
Therapist: You find yourself drinking pretty consistently in the evenings *(reflection)*.
Matt: Yes. Pretty much the same thing every night. Otherwise I have trouble sleeping.
Therapist: Okay. We will come back to your difficulty sleeping. That's important. What else is going on when this is happening *(open-ended question)*?
Matt: My wife is at the house, but I'm not drinking in front of her. A lot of times I'm just sitting at my computer.
Therapist: And would you describe what you're thinking about and how you're feeling *(open-ended question)*?
Matt: I guess I'm thinking that I just want to get some sleep.
Therapist: And when you're having that thought how are you feeling *(open-ended question)*?
Matt: I'm worried, and sometimes pretty angry, because I don't think it's going to happen.
Therapist: Okay. I'm starting to get a picture of what the situation looks like. Tell me a little about how the alcohol has been working for you *(open-ended question)*. What have you been getting out of it *(open-ended question)*? I'm curious about both things you like about it and things you don't. To start with, you said you often drink to help you sleep. How has that been working *(open-ended question)*?
Matt: I pass out instead of just being in bed for hours unable to sleep. It's also a good thing when I don't remember my dreams.
Therapist: So sometimes the alcohol does have the effect you would like it to have *(reflection)*.
Matt: Yes, sometimes but not always. There are also things I don't like. I'm sure my wife would like it better if I didn't come to bed smelling like liquor.
Therapist: She would prefer you come to bed without alcohol on your breath *(reflection)*. What else *(open question)*?
Matt: That's pretty much all I can think of.
Therapist: Okay. You're a really thoughtful person – you are providing a lot of good information *(affirmation)*. Let's take a look at another situation. What's another situation you find yourself using in *(open question)*?
Matt: At work. I tend to smoke pot at work. It seems like everyone who works there smokes pot.
Therapist: Smoking pot is the norm there *(reflection)*.
Matt: It always has been.
Therapist: Okay. When you're getting ready to smoke pot, what's happening around you *(open question)*?

Matt: Well all the people who work there like to get high. I pretty much walk in the door and someone wants to smoke.

Therapist: So it could be any of your co-workers *(reflection)*. What's going through your head when this is happening *(open question)*? What thoughts are you having *(open question)*?

Matt: I'm not really sure. I've been smoking pot there pretty much every day since I started working there and now it's just a normal part of the day.

Therapist: It's become a habit *(reflection)*. Take a moment to think about it and put yourself in the situation in your mind. What are you thinking about *(open question)*?

Matt: I guess I do think it makes the day go faster. Maybe I'm thinking it makes work less boring too.

Therapist: When you smoke pot you find your work to be more interesting *(reflection)*. What else *(open question)*?

Matt: I think that if I didn't smoke at work, the other guys would think there is something wrong with me, maybe think I'm a cop or something.

Therapist: You think that everyone expects you to smoke pot *(reflection)*.

Matt: It's just part of the culture there. By smoking pot, I don't rock the boat.

Therapist: You'd prefer to be under the radar *(reflection)*. So for you, that's a positive *(reflection)*.

Matt: Yeah. I get kind of nervous when I think I'm drawing attention to myself. I can't think of any other positives. I'm not sure I'm getting a lot out of smoking pot. It's really expensive and I feel guilty spending money on pot when I have a family to think about. I said that I smoke because it makes me less bored, but I'm not so sure that's even true.

Therapist: You're not so sure the pot is doing what you want it to do *(reflection)*.

Matt: Not really. Maybe I've smoked too much for too long.

Therapist: You're pretty sure that smoking pot at work isn't what you want for yourself right now *(reflection)*.

While the Veteran is providing information, the therapist is recording it on the ***Exploring Triggers*** worksheet. An example of what the ***Exploring Triggers*** worksheet might look like at this point follows.

Exploring Triggers				
Triggers What sets me up to use?	**Thoughts and Feelings** What was I thinking? What was I feeling?	**Behavior** What did I do then?	**Positive Consequences** What positive things happened?	**Negative Consequences** What negative things happened?
Before bed- hard to sleep	Fall asleep, no dreams	Drank beer, took shots	Fall asleep right away, sometimes no dreams	Wife doesn't like it, often have a headache in the morning
At work where coworkers are smoking pot	Reduce anxiety and boredom	Smoked a joint with co-worker	Didn't rock the boat	Expensive, bad for health, potential legal issues

Once the ***Exploring Triggers*** worksheet has been completed, the therapist and the Veteran spend time discussing the connections between the "Triggers" and "Thoughts and Feelings" columns.

Therapist: As we've been talking, I've been taking some notes on this worksheet. I'm guessing you won't be surprised that people frequently report using substances as a way to cope with what's happening here (point to "Triggers" column) The hope is that the alcohol or the pot will get you from a place you don't necessarily want to be (point to "Triggers" column") to someplace better (points to "Positive Consequences") column.

Matt: Makes sense.

Therapist: Sometimes, people feel like the only way they can get from the trigger situation to the outcome they want is by using alcohol or other drugs. As we can see from the sheet, sometimes you do get the positive consequences you were hoping for, but other times it gets consequences you don't like.

Matt: Yes. I listed more negatives than positives.

Therapist: As part of this treatment we want to increase your options for getting the outcome you want. Rather than only having alcohol or pot to get you there, you'll develop skills that result in having other options. The new options won't involve alcohol or drugs, so it cuts down on those negative consequences you identified.

Matt: That's what I want. I don't want to feel like I need a drink every time I can't sleep. I also don't want to spend the rest of my life smoking pot.

Therapist: Okay. Let's start with the smoking pot at work situation and use it as an example. What other ways might there be to not "rock the boat", other than smoking pot *(open question)*?

As the conversation continues, the therapist reflects and reinforces the Veteran's ideas about how to manage a situation without alcohol or other drugs. The goal is for the therapist to elicit ideas from the Veteran. If they appear stuck or ask for ideas from the therapist, it is acceptable to provide them. However, the therapist will first want to encourage clients to share their own ideas. For example, if the Veteran is asking for the therapist's ideas about how change should happen the therapist might say something like the following:

Therapist: I do have some ideas and I know some things that other people in a similar situation have tried and have said worked well for them. I'll share those with you in just a bit, but first I'm curious to hear from you what you think would work best for you *(open question)*.

As the discussion continues, it will provide the therapist and Veteran with important information on what cognitive behavioral strategies from this manual will likely be most useful. For example, if Matt discusses how difficult it is for him to say no to his co-workers and says he feels a lot of pressure to use when he is around them, the therapist would suggest focusing on interventions related to refusal and social pressure skills.

Exploring Triggers				
Triggers What sets me up to use?	**Thoughts and Feelings** What was I thinking? What was I feeling?	**Behavior** What did I do then?	**Positive Consequences** What positive things happened?	**Negative Consequences** What negative things happened?

Clinical assessment measures. Below is a brief description of the clinical assessment measures that are incorporated into the protocol as a way to inform treatment and potential adjustments to the individualized treatment plan. Some of these measures are available in the Mental Health Assistant in Computerized Patient Record System (CPRS). Entering the assessment information into CPRS so that the information is available to other mental health providers who may work with the Veteran is encouraged. Interpretative guidelines for the measures are included in the Clinical Assessment Guide.

The recommended timing of administration follows the description of the measures (see Figure 3, Suggested Timing for Administration of Clinical Assessment Measures). One way to facilitate the completion of assessment measures is to have Veterans arrive 5 to 10 minutes before the scheduled sessions, particularly on days when there are more measures to complete. One exception is that the Working Alliance Inventory should be administered at the end of the session, not prior to the session starting.

Occasionally, a Veteran might find the completion of assessment measures aversive, or may have difficulty organizing their lives in order to arrive to their sessions early enough to complete the forms. In these cases, discuss with Veterans any thoughts or concerns they may have about completing the assessment measures. Consider brainstorming together ideas for how to overcome any potential barriers to completing measures. It is also often helpful to provide a rationale for the measures. For instance, inform the Veteran that the information gathered from the assessment measure(s) serves a purpose similar to that of measuring vital signs at their primary care appointments. They provide clinically useful information and prompt follow-up questions about areas that show improvement or decline. Assessment measures also provide a way to monitor the Veteran's progress. As information is collected over time, affirm progress that is being made. If the Veteran is unable or unwilling to complete the written measures, then complete whatever possible based on verbal information provided by the Veteran. By making an adjustment such as this, it demonstrates that CBT is a collaborative enterprise and that the opinions and wishes of the Veteran are important.

Brief Addiction Monitor (BAM; Cacciola et al., 2013). At each session the Veteran will be asked to complete a version of the BAM. At the beginning, middle, and end of treatment the Veteran will be asked to complete the full 17-item version of the BAM. This version of the BAM will provide information about the Veteran's strengths as well as problem areas. Strengths identified by the BAM may include high self-efficacy, religious or spiritual beliefs, vocational involvements, financial stability, and social supports for recovery. Problem areas identified by the BAM include family and social problems, mood and sleep difficulties, and physical health problems. At each of the remaining sessions, the Veteran will be asked to complete the Brief Addiction Monitor-Consumption (BAM-C). The original BAM-C assessed substance use during the past 30 days, however, for the purpose of this treatment protocol it has been modified to assess substance use since the previous session. Information on scoring the BAM is available at https://vaww.portal.va.gov/sites/OMHS/SUD/BAM_Scoring/Forms/AllItems.aspx.

Short Inventory of Problems-Alcohol and Drugs (SIP-AD; Blanchard, Morgenstern, Morgan, Lobouvie & Bux, 2003). The SIP-AD contains 15 items that assess adverse consequences of alcohol and drug use. There are two versions of this measure included in the appendix. One is a lifetime version and the other asks the Veteran to answer the questions based on the previous 30 days. The lifetime version should be used for the initial administration to provide an overall picture of the types of substance-related consequences the client has experienced. After that, the version that asks about the previous 30 days should be administered. Information on scoring the SIP is provided by Miller, Tonigan & Longabaugh (1995) and can be accessed

at http://pubs.niaaa.nih.gov/publications/ProjectMatch/match04.pdf (pages 25-26 and 50-51). It is recommended that this measure be administered at sessions 1, 6, and 12.

Rulers. The rulers are tools that assess motivation. Veterans are asked to identify what their substance use-related goal is and then to indicate, on a scale of 1 to 10, how important that goal is to them and how confident they are that they will be able to reach the goal. Detailed information on how to use the rulers clinically is provided in the section of the manual that addressed motivational enhancement strategies. It is recommended that this measure be administered at sessions 1, 6, and 12.

World Health Organization Quality of Life-Brief (WHOQOL-BREF; World Health Organization Quality of Life (WHOQOL) Group, 1998). The WHOQOL-BREF (26-items) is the short form of the WHOQOL-100 (100-items; Bonomi, Patrick, Bushnell, & Martin, 2000). This tool was developed by the World Health Organization (WHO) [see http://www.who.int/mental_health/media/en/76.pdf] to assess quality of life across many cultures. Items are grouped into four domains: Physical Health, Psychological Health, Social Relationships, and Environment; it also contains two global items (questions 1 and 2) that assess an individual's overall perception of their quality of life and health. This measure provides the therapist and Veteran with information about changes in quality of life and health over the course of a treatment. It is recommended that this measure be administered at sessions 1, 6, and 12.

Working Alliance Inventory–Short Revised (WAI-SR; Hatcher & Gillaspy, 2006). As part of this treatment, an abbreviated version of the *Working Alliance Inventory* (WAI; Horvath & Greenberg, 1989) will be used as a clinical tool to aid in the assessment of and discussion about the therapeutic relationship. The WAI was derived from Bordin's (1979) theory of change-inducing relationships, which specifies key components of the working alliance as (a) agreement on the treatment goals, (b) agreement on how to achieve the goals (task agreement), and (c) development of a personal bond between client and therapist. It is recommended that the WAI-SR be administered at the end of the sessions indicated in Figure 3 (i.e., sessions 1, 3, 7, 11) and then discussed with the Veteran during the following session. Interpretative guidelines for this measure are provided in the *Clinical Assessment Guide,* however, keep in mind that there is no true cut-off for what is considered a "good" or "bad" alliance.

Inquiring about the therapeutic alliance is beneficial for assessing the strength or degree of collaboration of the therapeutic relationship.

Inquiring about the therapeutic alliance is beneficial for assessing the strength or degree of collaboration of the therapeutic relationship. It can also help identify any potential strains in the therapeutic relationship earlier rather than later so that issues may be discussed with the intent to resolve them. Use the WAI-SR in therapy by reviewing individual items and discussing them qualitatively, particularly any of the Veteran's responses that point to potential problems in the therapeutic alliance. For instance, if a Veteran responds to the item, "My therapist and I respect each other" with "Sometimes," it is an opportunity to ask the Veteran more about this. The therapist might say something similar to the following, "I noticed that you responded to item number five by indicating that you and I sometimes respect each other. Would you be open to telling me more about what you mean by that? My intention is to always treat you with respect and it would be very helpful for me to understand your perspective. Would you be willing to provide me with some examples of when you have felt I treated you with respect and when you have felt that I did not?"

Breathalyzers and Urine Drug Screens. The standard of care in the treatment of substance use disorders includes the use of breathalyzers and urine drug screens at the time that treatment is initiated. Breathalyzers and urine drug screens help promote candid self-reporting of substance use. Become familiar with local policies, standards, and protocols related to the administration of breathalyzers and drug screens. For some individuals, breathalyzers and urine drug screens may be clinically indicated at each session. For other individuals, the tests may not be clinically indicated as frequently or at all. In addition, depending on the site, it may not be possible to regularly administer breathalyzers and drug screens.

Figure 3. Suggested Timing for Administration of Clinical Assessment Measures

Session 1 *(Baseline)*	BAM	UDS	BAL	WAI-SR	SIP-AD (Lifetime/ 30 Days)	Ruler	WHOQOL-BREF
Session 2	BAM-C	*	*				
Session 3	BAM-C	*	*	WAI-SR			
Session 4	BAM-C	*	*				
Session 5	BAM-C	*	*				
Session 6 *(Mid-Point)*	BAM	UDS	BAL		SIP-AD (30 Days)	Ruler	WHOQOL-BREF
Session 7	BAM-C	*	*	WAI-SR			
Session 8	BAM-C	*	*				
Session 9	BAM-C	*	*				
Session 10	BAM-C	*	*				
Session 11	BAM-C	*	*	WAI-SR			
Session 12 *(Final)*	BAM	UDS	BAL		SIP-AD (30 Days)	Ruler	WHOQOL-BREF
Administrative Note		If CBT-SUD is terminated prior to Session 12, please have Veteran complete the BAM, UDS, BAL, WAI-SR, SIP-AD, Ruler, and WHOQOL-BREF at the (earlier) termination session.					

* Administer as clinically indicated.

Obstacles to Treatment

Assessing any obstacles to treatment is an important early task. Obstacles can takes many forms, some logistical in nature and some linked to negative cognitions surrounding treatment. Obstacles that are logistical in nature can often be addressed by modeling a problem-solving approach. When obstacles are related to negative attitudes and cognitions about treatment, explore this with the client. It will be important to ask Veterans about any prior history of treatment for substance use and responses to such experiences. Some individuals have had negative experiences in past treatment and this will be important to address. Others may have expectations based on what they have seen in the media or been told by people they know. Eliciting Veteran expectations for treatment and attempting to correct any misinformation can contribute to building a strong therapeutic alliance. The focus here is on gaining an understanding of what Veterans are thinking and how they feel about treatment. Use open-ended questions to explore Veteran's attitudes toward treatment. Use reflections and summaries to communicate actively listening to the Veteran and attempting to fully understand the Veteran's point of view. The decision to participate in treatment is always up to the client. Respect the autonomy of the Veteran at all times. At the same time, work collaboratively to address any concerns about participating in treatment. In some cases a client may be willing to commit to "trying treatment out" but may not be willing to commit to the entire course of treatment. In these cases, a strong therapeutic alliance may make all the difference in whether or not a Veteran is willing to give treatment a try.

Some individuals have had negative experiences in treatment in the past and this will be important to address.

Orientation to CBT

It is important to orient the Veteran to both the structure and process of CBT. This may include information about CBT and how it differs from other types of therapy. The goal is to provide the Veteran with a roadmap for what can be expected during treatment and to make clear expectations for both the therapist and the Veteran.

Orientation to CBT involves providing the following types of information:

Orientation to CBT
The structure of treatment and expectations for attendance and participation.
Role of the therapist.
An overview of the CBT model and how it relates to the identified goals for treatment.
Evidence for the effectiveness of CBT-SUD.
Rationale for in-session practice, in-session role-plays, and home assignments.
Responses to any questions about CBT that the Veteran has.

Begin orienting the Veteran to CBT during the first session. While all of the above information is important, and should be provided to the Veteran during the first few sessions (1 to 3), be sure to provide the following information at the *initial* session:

- The structure of treatment (see page 9):
  - A brief overview of treatment, including information about the effectiveness of CBT-SUD.
  - The length and frequency of sessions (12 weekly individual sessions delivered during a 16 week period).
- Expectations for attendance and participation:
  - Regular attendance.
  - Completion of home assignments.
  - In order to gain maximum benefit from the treatment, the client will not present for treatment under the influence of alcohol or other drugs.
- The role of the therapist including:
  - The collaborative nature of this treatment.

Check with the Veteran to ensure understanding and elicit feedback and questions from the Veteran throughout the orientation process.

While much of the orientation to CBT will occur early on in treatment, it will continue throughout the course of therapy as the client is provided with strong rationales for cognitive behavioral intervention strategies.

Involving a Supportive Significant Other[3]

Every Veteran who participates in this treatment is *encouraged* to invite a supportive significant other (SSO) to participate in the treatment. Of course, this is entirely voluntary and may be more appropriate for some Veterans than others. The SSO is invited to attend certain sessions to learn more about the individual's difficulties with alcohol and/or other drugs, offer constructive feedback about the treatment plans, provide ongoing support for sobriety, and become an important motivator for change.

The SSO is not involved in the first 1 to 3 sessions so that the therapist has an opportunity to develop rapport and an understanding of the Veteran's current circumstances. The SSO selection process should be completed as early as possible in treatment if the Veteran is not opposed to the idea. SSO involvement is encouraged and supported but not imposed upon the Veteran. Be prepared to provide a strong rationale for SSO involvement.

Introduce the idea of identifying someone from the Veteran's social network to engage in the treatment process. Veterans need to be given the opportunity to explore underlying ambivalence and uncertainty about SSO involvement before a decision is made to involve the SSO. Pay careful attention to the Veteran's verbal and non-verbal behavior in response to open-ended questions. Explore the Veteran's thinking about SSO involvement. This includes bringing out concerns. Responding to uncertainty and ambivalence with acceptance and respect may help to minimize resistance to involving SSOs in treatment.

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[3] Much of this section was adapted from Miller, W. R. (Ed.) (2004). *Combined Behavioral Intervention manual: A clinical research guide for therapists treating people with alcohol abuse and dependence.* COMBINE Monograph Series, (Vol.1). Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism. DHHS No. 04-5288.

If Veterans remain opposed to bringing an SSO after exploring in this manner, a decision may be made to delay any further discussion of SSO participation to protect the therapeutic alliance and reduce discord. Veterans who decline to have an SSO participate at this stage should be asked again when sessions begin to focus on the cognitive behavioral strategies.

Explore all potential candidates with the Veteran in the event his or her first choice for SSO is unable or unavailable to participate. This will diminish the possibility that part of another session would need to be dedicated to this task.

Guidelines for selecting a SSO:

1. Is helpful and supportive of the treatment, of the Veteran as a person, and is available..
2. Lives nearby and has transportation.
3. Is willing to commit to attend regularly.

If the Veteran agrees to involve a SSO, the simplest way to initiate this is to encourage the Veteran to ask the SSO to come. It might be useful to rehearse how the Veteran would approach and ask the SSO. It is also permissible for the Veteran to telephone the SSO from the office during the session. If the Veteran prefers, or if the Veteran's own invitation does not get the SSO to come on the first try, then offer to make the contact. This requires the completion of a Release of Information Form (use VA Form 10-5345).

Explain that the letter defines a role for the SSO, and provides important information on how the SSO can contribute to the therapeutic process. Review the letter with the Veteran and ask if there are any specific concerns about the contents. If the Veteran has serious reservations, postpone providing the letter until there has been a chance to resolve the concerns. Otherwise, ask the Veteran to give the letter to the identified SSO. Here is suggested language for the letter:

> Dear [SSO]:
>
> This letter is to invite you to support [Veteran] by participating in the treatment program [he/she] has begun. We find that this treatment works best when a supportive person participates in the treatment sessions and [Veteran] has identified you as someone [he/she] believes could be particularly helpful. If you agree to participate, your role will be strictly to support [Veteran]. You are not being asked to enter treatment yourself. You are being asked to attend [Veteran's] treatment sessions so that you may offer [him/her] support.
>
> [His/Her] treatment will involve 9 to 10 future sessions over a period of about three months. We can discuss the amount of your participation, and reach a decision that is acceptable to all involved. The treatment sessions last about an hour and are scheduled at everyone's convenience. They are held at [location].
>
> As we work together, [Veteran] will be developing specific plans for change. If you agree to participate, you could be helpful to [Veteran] by giving encouragement, offering helpful ideas, and supporting [his/her] own efforts toward treatment goals. You would not be on your own. We will discuss in-session how best you can support [Veteran] toward positive change.
>
> I hope that you will agree to come to at least one session to explore how you might support [Veteran's] efforts toward change. If you have any questions, please feel free to call me at the

number listed above. Otherwise, [Veteran] can just tell you the date and time of [his/her] next appointment so that you may attend.

Thank you for considering taking part in [Veteran's] treatment. Your support could make a big difference.

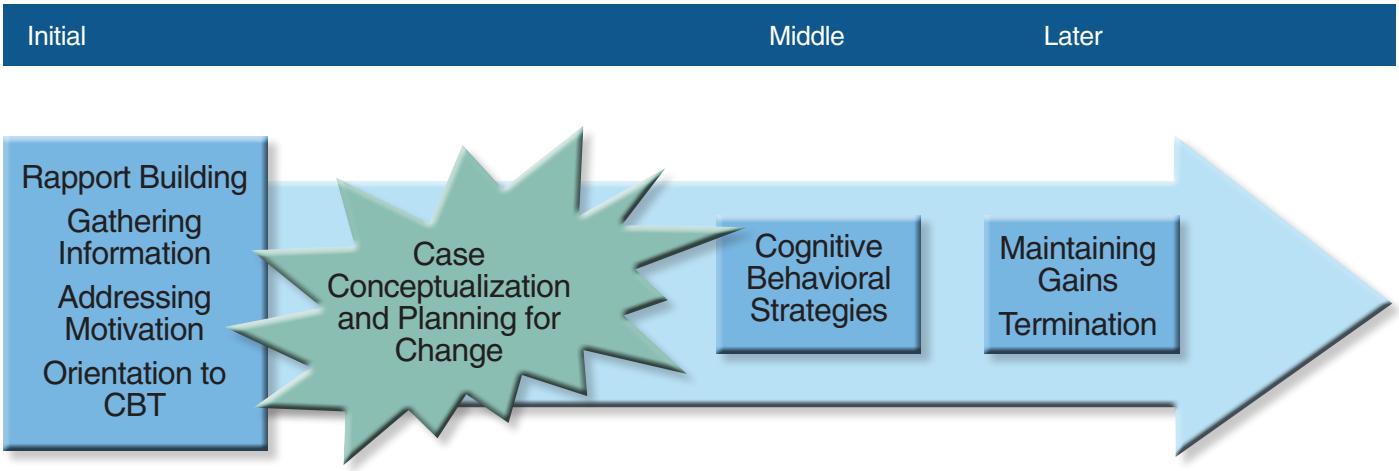
Sincerely,

[Therapist name]
[Therapist contact information]

Case Conceptualization and Planning for Change

This section contains information on the purpose of case conceptualization, provides a tool to aid in the process, and uses the examples of Matt and Laura to illustrate how case conceptualization guides treatment. As illustrated in Figure 4, case conceptualization begins during the initial phase of treatment and influences the remaining phases.

Figure 4. Timeline of CBT-SUD: Case Conceptualization and Treatment Planning



Case conceptualization. Case conceptualization is an on-going, empirical process that involves the integration of information obtained through clinical interview, chart review, assessment measures, behavioral observations, and the Veteran's family members and/or other providers. Use this information to formulate hypotheses about the Veteran's presenting problems, how they originated, and what is maintaining them. The conceptualization evolves over time as new information is gathered. It may be that hypotheses are confirmed or disconfirmed and new hypotheses formed. While avoiding the use of technical jargon, share the case conceptualization with the Veteran as part of the treatment process.

Persons (2008) describes the case conceptualization process as forming hypotheses about the (a) mechanisms that have caused the individual's problems, (b) the precipitants that are activating the mechanisms, and (c) the origins of those mechanisms. This information, taken together, provides

information to consider together with the Veteran when making decisions about which strategies to focus on during the course of treatment. The conceptualization is essential for treatment to be tailored appropriately to the individual. This is where CBT differs from coping skills training or using a pre-planned treatment package to treat all individuals with a certain diagnosis (e.g., alcohol use disorders) or category of diagnoses (e.g., substance use disorders).

One tool for case conceptualization was developed by Beck (1995) and is titled the Cognitive Conceptualization Diagram. Several terms used in the Cognitive Conceptualization Diagram are described next, followed by the diagram itself.

Relevant childhood data includes early childhood experiences, and for the purpose of this manual, formative experiences in adulthood that contribute to the development of core beliefs, intermediate beliefs, and compensatory strategies that impact the Veteran's present-day cognitive, emotional, and/or behavioral functioning. Examples of relevant childhood data include parental divorce, abuse or neglect, conflict in the home, or a parent with problematic substance use. A military experience that impacts core beliefs is an example of a formative experience in adulthood.

Core beliefs are the most central and important beliefs a person has. These beliefs reflect how people view themselves. They are global and rigid in nature. An example of a core belief is, "I'm incompetent."

Conditional assumptions, beliefs, and rules are used to cope with core beliefs. An example is: "If I pretend that everything is normal, then people will continue to love me."

Compensatory strategies are behaviors aimed at coping with core beliefs. Often they are not effective. The use of substances to cope with negative core beliefs frequently falls into this category.

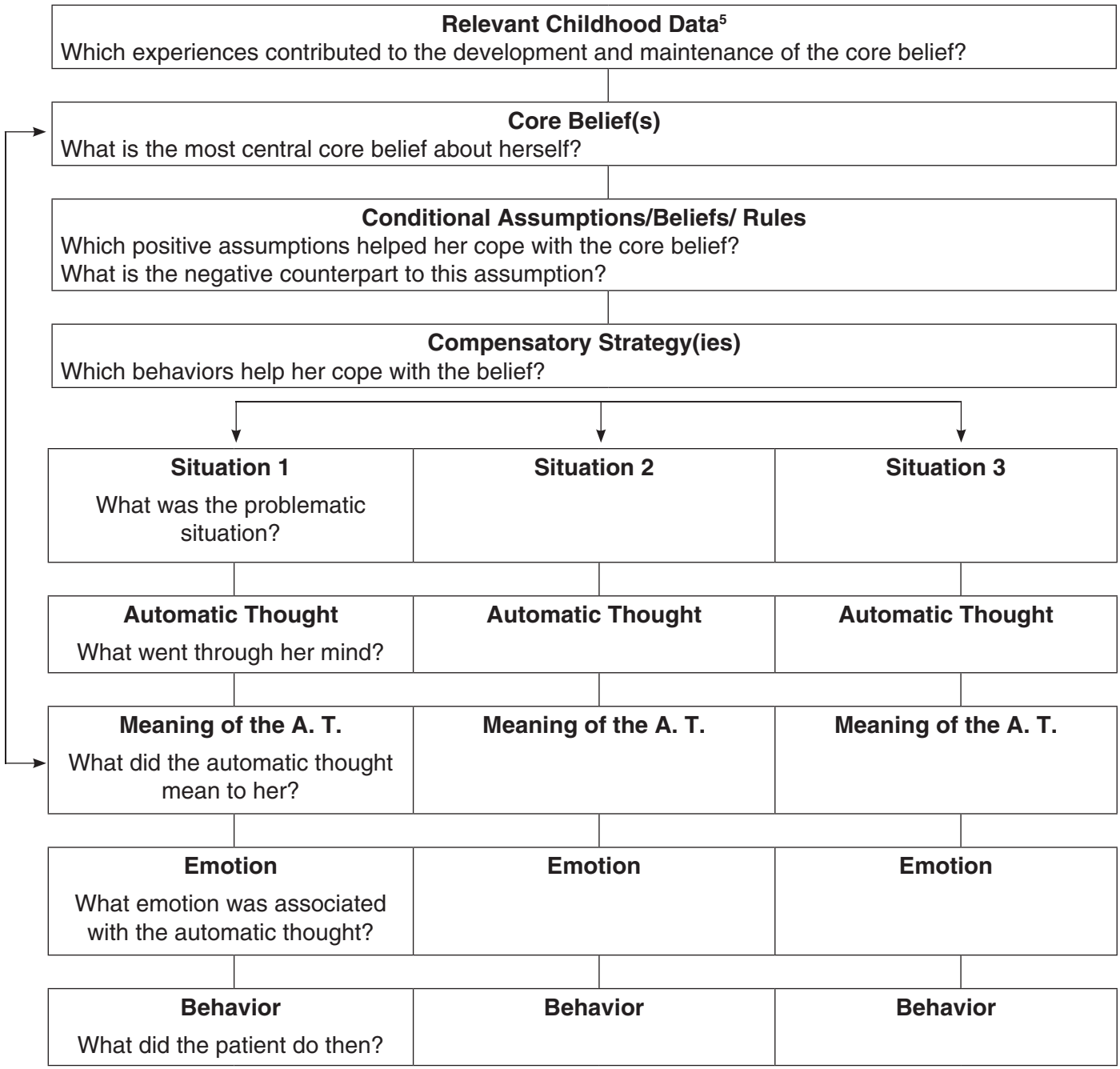
Situations include circumstances that activate core beliefs and/or substance-related beliefs. Situations can vary greatly from person to person. For one individual, attending a work function could be a situation. For another person, any situation that increases anxiety might activate core beliefs and/or substance-related beliefs.

Automatic thoughts result from the activation of core, conditional, and substance-related beliefs. Automatic thoughts vary greatly depending on the core belief. If a person has the core belief, "I am incompetent," examples of automatic thoughts related to that belief are, "I don't know why I bother" and "I know I won't be able to do it right."

Emotions result from a particular automatic thought. These may include anger, anxiety, depression, or other emotions.

Behaviors are the end results. Substance use is an example of a behavior that may result from the activation of the above beliefs, thoughts, and emotions.

Figure 5. Cognitive Conceptualization Diagram[4]



A blank version of the diagram is also included in Appendix A. Use this form to organize information about the Veteran. The form is meant to be filled out as the information is gathered. Early in therapy not all boxes will be completed. Add to and revise the form as additional information is gathered.

[4] © J. Beck, 1996. Reprinted from *Cognitive Therapy Worksheet Packet* and used with permission.

[5] For the purpose of this manual, formative experiences in adulthood that impact the Veteran's present-day cognitive, emotional, and/or behavioral functioning are also included.

At the first CBT-SUD session, Veterans are asked to complete several assessment measures. Clinical assessment measures contain important information. Reviewing the information will help inform case conceptualization.

Planning for change. Next, the process of planning for change based on the case conceptualization is described. First, general information on the process of planning for change is provided. Following that, the case examples of Matt and Laura will be used to illustrate how the case conceptualization guides the treatment planning process. A type of information exchange termed "Elicit-Provide-Elicit" (EPE) is introduced and the use of two change planning tools is illustrated.

Planning for change is the link between preparing for change and the cognitive behavioral strategies. It is important to remember that planning for change is a collaborative effort on the part of the client and therapist. The case conceptualization serves as a guide in making decisions about which cognitive behavioral strategies will be most useful in treatment. Strategies are chosen such that the treatment is tailored to each individual.

The case conceptualization serves as a guide in making decisions about which cognitive behavioral strategies will be most useful in treatment.

Begin by asking Veterans what areas they know they would like to address in treatment. While clients are providing a list of areas they would like to focus on, use reflective listening skills. Also use open questions to encourage Veterans to identify multiple areas that are important to them.

Take the opportunity to provide additional ideas once the client has identified their areas of concern,. These should be based on the case conceptualization. For instance, bring up key triggers that have been identified and how they might be addressed in treatment. Information or ideas should be offered in a non-judgmental manner.

Elicit-Provide-Elicit. During the planning for change process it is recommended to engage the Veteran in a particular type of information exchange termed "Elicit-Provide-Elicit" (EPE). EPE is a process of providing and eliciting using a motivational interviewing style. Throughout an EPE exchange use reflective listening skills and make statements that are supportive of client autonomy. The first task of an EPE exchange is to "elicit." According to Miller and Rollnick (2013), eliciting serves three general functions:

During the planning for change process it is recommended to engage the Veteran in a particular type of information exchange termed "Elicit-Provide-Elicit."

1. Asking permission.
2. Exploring clients' prior knowledge. During the planning for change process it is recommended to engage the Veteran in a particular type of information exchange termed "Elicit-Provide-Elicit."
3. Querying their interest in whatever information the therapist may be able to provide.

Another piece of EPE involves providing information or advice to the client. If there are areas that have come up previously that the Veteran does not list, ask the client if these are areas that should be added to the form. Additionally, based on the case conceptualization, ideas about what will be helpful for the client may arise. EPE is a useful way to approach these topics with the Veteran. This is an opportunity to offer recommendations for areas to focus on in treatment. Prioritization of recommendations is encouraged.

Share the top one or two. The "provide" in EPE is not an opportunity to provide a laundry list of what might be helpful, but rather an opportunity to share whatever, based on the case conceptualization, is seen as the most important areas that the Veteran did not identify independently. Whenever therapists "provide" information, they will then "elicit" again. A therapist wants to find out what the Veteran thinks about the information that was provided. Pages 47 and 52 contain sample EPE dialogue.

Change planning tools. At the same time EPE is used to discuss change planning, also begin entering the relevant information into the circles on the ***Options*** handout. This handout is a tool to assist in brainstorming possible areas to focus on in treatment. Issues the Veteran would like to address and areas the therapist views as important are all written down on the ***Options*** handout. A blank copy of this handout is provided at the end of this section and in Appendix A. This tool can be particularly useful when a client has complex presenting concerns. Each circle does not need to be filled, but elicit several areas that the Veteran would like to work on.

Because the overall focus of this treatment is substance use disorders, work with the Veteran to ensure that substance use is listed as an area to focus on. Orient the client to the handout by saying something similar to the following:

Therapist: This page with the circles is one way for us to lay out the concerns that you are experiencing, the goals that you have, and the things that we can talk about in our work together.

Because the overall focus of this treatment is substance use disorders, work with the Veteran to ensure that substance use is listed as an area to focus on.

Once the handout has been filled out, review the various areas listed to see which of them can be addressed by this particular treatment. Let the Veteran know which of the areas are possible for this particular treatment. It may be that there are areas listed that will require a referral or there may be items that the Veteran will be able to work on independently.

Once the areas that will be a focus of treatment are agreed on together, a treatment plan with goals and objectives is completed. A blank ***Change Plan*** worksheet is provided at the end of this section and Appendix A.

In the first column, broad areas to be addressed are recorded. Note that alcohol and/or other drug use will always be a primary target for this treatment. Some Veterans will clearly state that they have a goal to abstain from all substances. Others may wish to abstain from a particular substance and reduce the use of another one. If clients say they are not ready to make changes in substance use, interim areas to focus on may include improving skills that will help them quit or reduce in the future. Areas to be addressed may include improving communication skills, learning to manage urges and cravings, participating in new social activities, or starting to attend mutual-support groups.

The areas that will be focused on will be listed in the first column.

In the second column, goals and objectives will be listed. For the objectives, assist the Veteran in listing goals that are achievable. The objectives should be stated in observable or measureable terms.

In the third column, specify how the Veteran plans to address the area identified in a way that accomplishes the goals and objectives that were listed in the second column. Identify cognitive behavioral strategies or topic areas from this manual to focus on during treatment.

Note that as treatment progresses, there may be a reason to modify the original treatment plan.

Case conceptualization and planning for change: case example 1. Next, the case example of "Matt" will be used to illustrate case conceptualization and treatment planning.

Case example: Matt

Based on an initial intake interview Matt was assigned diagnoses of alcohol use disorder, moderate, and cannabis use disorder, moderate. He was also diagnosed with other specified trauma- and stressor-related disorder, adjustment like disorder with prolonged duration of more than 6 months without prolonged duration of stressor because he endorsed several symptoms related to posttraumatic stress disorder, but did not meet all diagnostic criteria for the condition. He also endorsed a long history of experiencing anxiety in social situations.

During the clinical interview, Matt shared that several male members of his family, including his father, had been in the military. Matt said that while growing up his parents were rarely around. While his physical needs were met, his emotional needs were neglected. He said that he wished his father had been around more and that he tried different ways to make his father proud, including joining the military himself.

Matt said that until high school, he had few friends. He said that he was shy and nervous around people. At age 15, he developed a close group of friends. That group of friends regularly used alcohol and cannabis and he started doing the same. He said he felt much more comfortable around people if he used alcohol or cannabis. Matt said he used socially and never viewed it as a problem. Matt denied any history of mental health concerns or treatment.

Matt had a very successful military career, but said that things have not been the same for him since his most recent deployment. He said he would like to be deployed again and that in many ways he feels more comfortable while deployed. He said he thinks his father is proud of him for joining the military and that when they speak to one another, the military is always the topic of conversation.

For the purpose of this example, the therapist who will provide CBT-SUD is not the person who conducted the initial intake interview. However, the therapist who will provide CBT-SUD reviewed Matt's medical record, including the information from the intake summarized above, prior to meeting with Matt. While the therapist does not have enough information for a complete conceptualization, the information that was collected at the initial interview will allow the therapist to form hypotheses about how the childhood experience of being neglected and adult military experiences may have impacted Matt's core beliefs, intermediate beliefs and compensatory strategies. For instance, the therapist might hypothesize that due to the neglect Matt experienced as a child, he may have a core belief about not being wanted or about not being lovable.

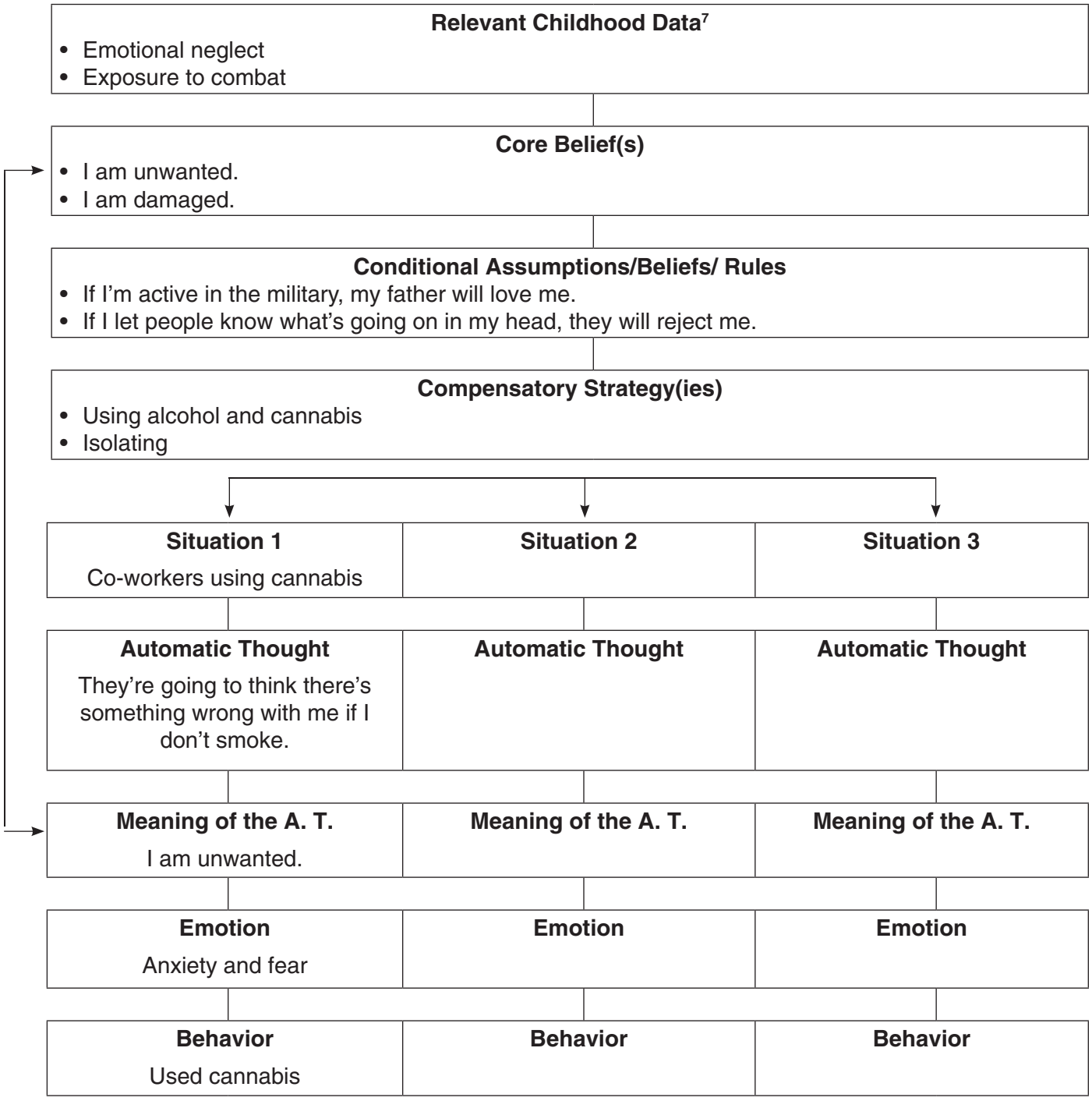
Following the first session, Matt's therapist also reviewed the information provided by Matt on the clinical assessment measures. That information will be valuable in the conceptualization process.

The following interaction between Matt and his CBT-SUD therapist, occurring early in treatment (i.e., during sessions 1, 2, or 3) illustrates the therapist gathering additional useful information for the conceptualization process.

Therapist: Matt, when you get to work and your co-workers are smoking pot and offer it to you, what are some of the thoughts that you have?
Matt: That I might as well smoke. That they're going to think there's something wrong with me if I don't smoke.
Therapist: So you have the thought, "They will think something is wrong with me if I don't smoke." And if they think there is something wrong with you then…
Matt: They won't want to work with me anymore.
Therapist: If you tell them you've decided to quit smoking pot, no one there will want to work with you. What would that mean to you?
Matt: It might mean I would have to find a new place to work. I don't want to do that. I have a hard time being around people, especially new people. The last thing I want to do is have to get a new job with people I don't know. Even though my current job isn't perfect, at least they already know me, know that I'm different.
Therapist: Different. Tell me more about what you mean.
Matt: [long pause]
Therapist: A lot of this stuff is really hard for people to talk about. I really appreciate your willingness to share as much as you have with me.
Matt: It is hard. I mean, I was always shy, but since I got back from being deployed it's gotten worse. Sometimes I think I'm crazy. Some of the things that go through my head aren't normal. I guess that's one reason I was smoking pot at work. When I'm high, I don't worry so much about people noticing that I'm different.
Therapist: You think that you're the only one having the kinds of thoughts you're having. And that makes you pretty uncomfortable.
Matt: Yes.
Therapist: And you're afraid that if you do let people in on what you're thinking about, they won't want anything to do with you.
Matt: I'm sure of it.

In the above example, the therapist uses questions and reflections to gather additional information on core beliefs, intermediate beliefs, and compensatory strategies. The therapist begins to record relevant information on the Cognitive Conceptualization Diagram. Some of the information included in the diagram has been provided directly by Matt, while some of the information is based on hypotheses the therapist has formed.

Figure 6. Cognitive Conceptualization Diagram for Matt [6]



The therapist continues to gather additional information about situations, automatic thoughts, emotions, and behaviors, and completes the initial version of the diagram.

[6] © J. Beck, 1996. Adapted from *Cognitive Therapy Worksheet Packet* and used with permission.

[7] For the purpose of this manual, formative experiences in adulthood that impact the Veteran's present-day cognitive, emotional, and/or behavioral functioning are also included.

Continuing with the case example of Matt, below is an example of dialogue illustrating the therapist's use of EPE during the process of planning for change.

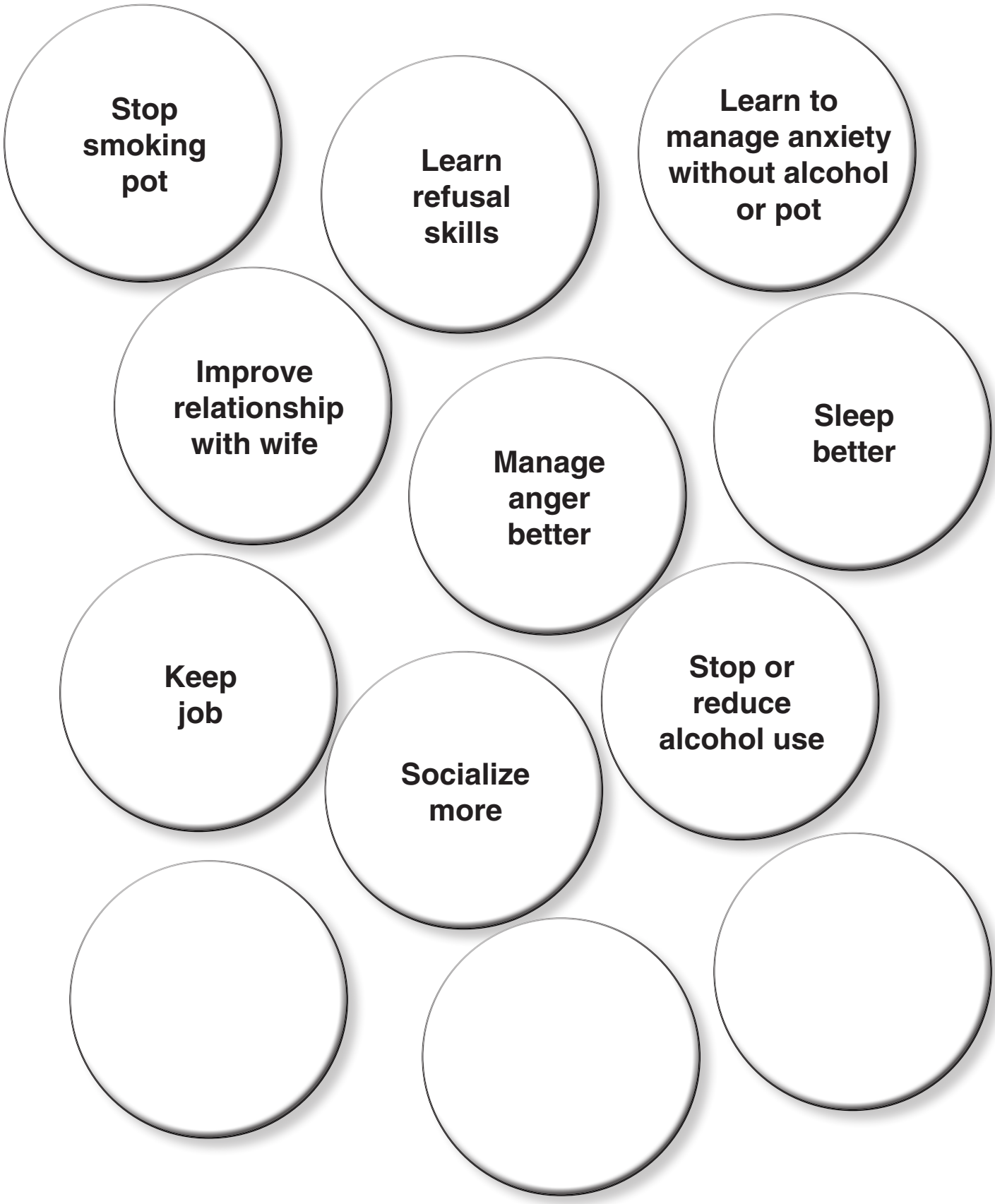
Therapist: What are the areas you know you would like to focus on during our time together? *[Elicit]*
Matt: In a perfect world I'd quit smoking pot and drink a lot less.
Therapist: You'd like to make changes in your substance use for sure. What else? *[Elicit]*
Matt: I'd like to be more comfortable at work.
Therapist: Okay. Here's what I'm thinking. You've said you have a really tough time not smoking pot with your co-workers because you're not quite sure how to tell them you're not interested. One way we could address this is by spending some time focusing on refusal skills. *[Provide]* What do you think of that? *[Elicit]*

Following is another example of what EPE might sound like.

Therapist: Is it okay with you if I share some concerns? *[Elicit]*
Matt: Sure.
Therapist: You've mentioned that you feel anxious around a lot of people and that feeling anxious is a big trigger for you. I'm concerned that if we don't spend some time focusing on how to cope with the anxiety, you may continue to struggle at work and continue to keep avoiding social activities. This is an area we can work on together. *[Provide]* What thoughts do you have about that? *[Elicit]*

The following page illustrates what the ***Options*** handout might look like for Matt. Notice that not all of the circles are filled. What is important is that issues identified as important by the Veteran and issues identified as important by the therapist are all written down.

Options



An example change plan for Matt follows on the next page. The treatment plan is developed by the therapist and client together in a collaborative manner.

Change Plan

Areas to be addressed by treatment or referral	Broad goals and specific objectives to be achieved	Treatment plan (how)
#1 Substance use	Quit smoking pot • Report no use of canna bis during treatment Stop or reduce alcohol use • Report no use of alcohol as a sleep aid during treatment	• Attend weekly treatment sessions • Urge monitoring • Cognitive restructuring • Referral for evaluation for medication to help with cravings for alcohol
#2 Communication	Increase assertiveness • Let co-workers know you're making a change • Turn down co-worker's offers to use • Participate in a minimum of five role plays	• Refusal Skills section
#3 Anxiety	Reduce anxiety • Self-report decreased anxiety	• Cognitive restructuring • Mood Management
#4 Anger	Reduce anger • Self-report no destruction of property • Self-report engaging in safe driving practices	• Mood Management

Case conceptualization and planning for change: case example 2. The following example of "Laura" is used to provide a second example of the use of the case conceptualization diagram and how case conceptualization informs the treatment planning process.

Case example: Laura

Laura was diagnosed with posttraumatic stress disorder (PTSD) and alcohol use disorder, mild. She endorsed two of the diagnostic criteria for an alcohol use disorder: (a) craving, or a strong desire or urge to use alcohol, and (b) alcohol is often taken in larger amounts or over a longer period than was intended. Laura's primary therapist, Dr. Smith, included in her initial intake that she also believed that Laura's use of alcohol was contributing to the maintenance of PTSD symptoms and therefore causing significant impairment. Dr. Smith also noted that Laura did not agree that her use of alcohol was resulting in significant impairment.

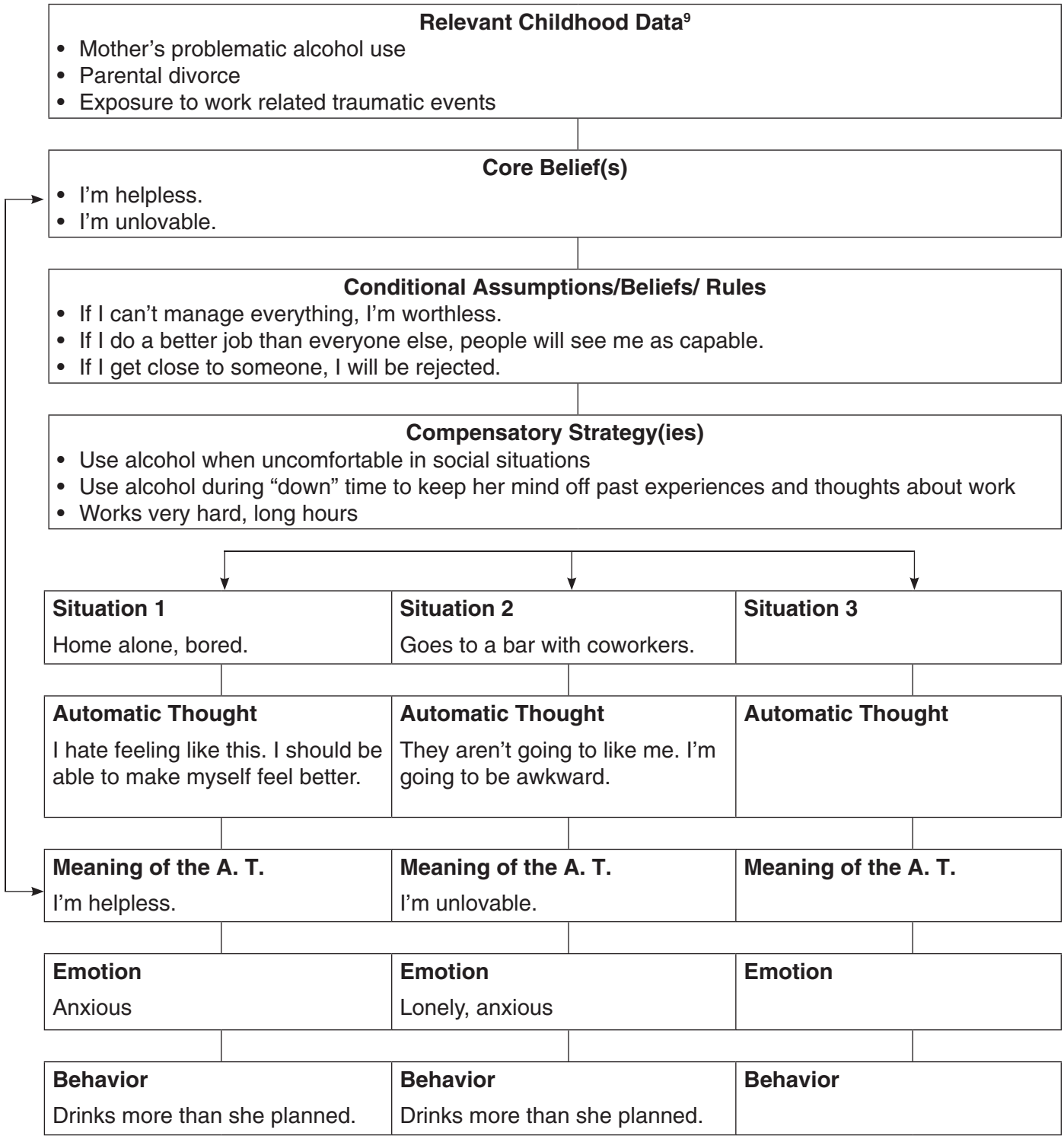
Laura grew up with a mother who used alcohol problematically. Day after day she saw her mother come home from work in a terrible mood. The first thing her mother did was pour a drink. Her mother was inconsistent and unpredictable in her treatment of Laura, sometimes providing a lot of praise and encouragement while at other times being overly-critical, even hostile. Laura's mother and father fought frequently when she was young and divorced when she was 7 years old. Laura continued living with her mother while her father remarried and had two additional children. Laura said she was not close with her father following the divorce.

While in the military, Laura worked as a journalist. As part of her duties, she was exposed multiple times to the aftermath of traumatic events.

Laura is a hard worker. She tends to be a perfectionist. Her primary focus is on her job.

Even without meeting with Laura, the CBT-SUD therapist has enough information to begin to form hypotheses. On the next page is an example of a Cognitive Conceptualization Diagram partially completed based on the information the therapist gathered from Laura's medical record and primary therapist. As the therapist works with Laura, information is added and the conceptualization is revised as appropriate.

Figure 7. Cognitive Conceptualization Diagram for Laura [8]



[8] © J. Beck, 1996. Reprinted from *Cognitive Therapy Worksheet Packet* and used with permission.

[9] For the purpose of this manual, formative experiences in adulthood that impact the Veteran's present-day cognitive, emotional, and/or behavioral functioning are also included.

During the early CBT-SUD sessions (i.e., sessions 1, 2, and possibly 3) the therapist will continue to gather information that will contribute to the case conceptualization. The therapist will also review the clinical assessment measures that Laura completes at the first session appointment and integrate that information into the conceptualization that will guide the planning for change process.

Below is an example of dialogue illustrating the therapist's use of EPE with Laura during the change planning process.

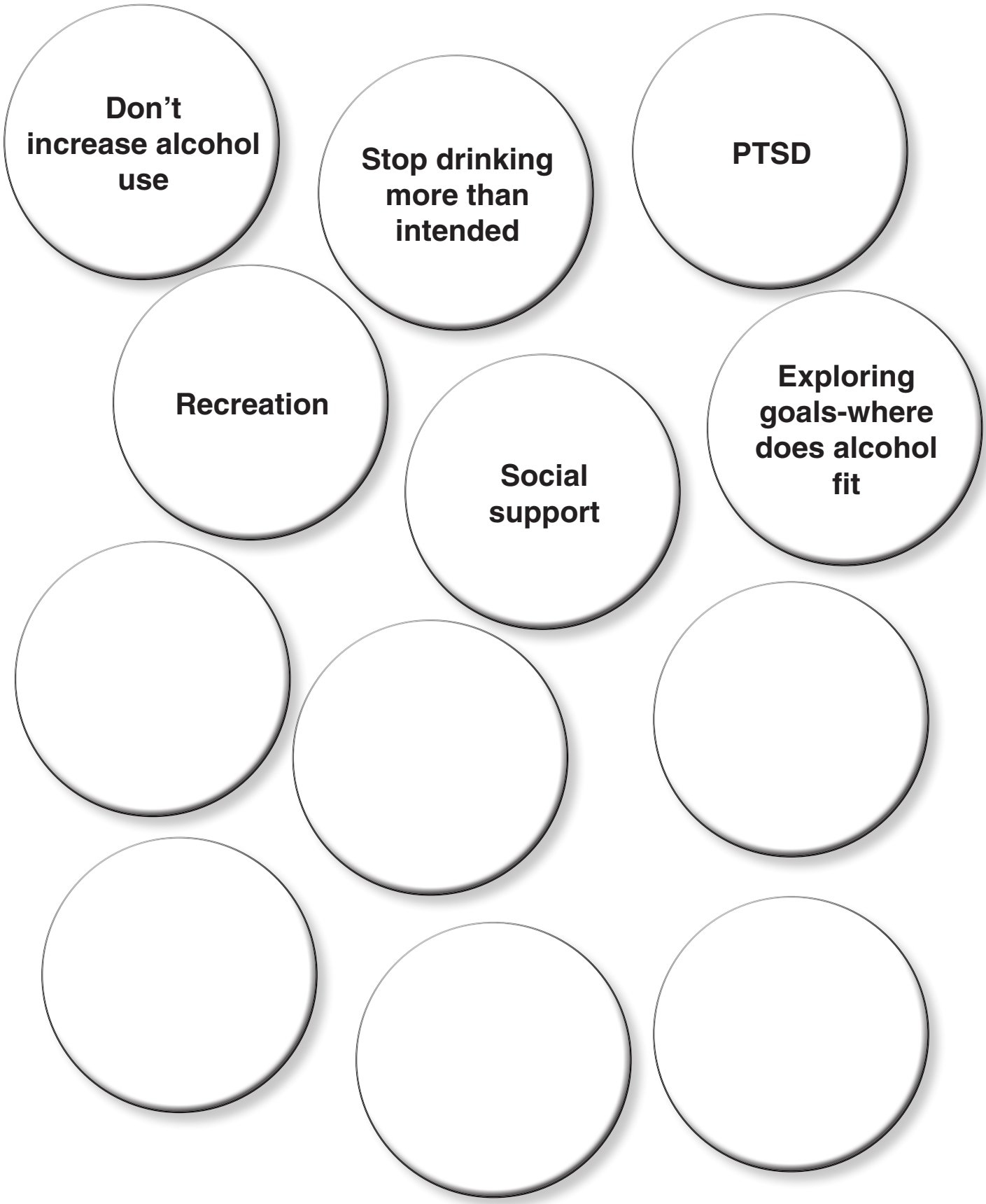
Therapist: What do you think would be most helpful for us to work on during our time together? [Elicit]
Laura: Like I said earlier, I'm not so sure I need to make changes in my drinking. I would like to make sure it doesn't increase. Maybe we can talk about that. I'm most concerned with my anxiety symptoms.
Therapist: We will definitely be able to talk more about the alcohol use. I think that's a great idea. I'm going to put that down in one of these circles. I know you've been working on the anxiety with Dr. Smith and you're happy with the results. We will write that down in one of the circles too, however, it won't be a primary focus of our work together because that's something you and Dr. Smith will be getting back to. Does that make sense?
Laura: Yes. That makes sense.
Therapist: Okay. What else would be helpful for us to focus on? [Elicit]
Laura: I'd just like to get back to having more fun again.
Therapist: Let's put that down too. One of the areas we can focus on has to do with increasing social activities. We could also look at ways to help increase the social support you have. [Provide] I'm interested to hear your thoughts on those possibilities? [Elicit]

Following is another example of what EPE might sound like.

Therapist: If it's okay with you, I'd like to share a thought I have? [Elicit]
Laura: Yes. Please.
Therapist: One thing we've talked about is how you aren't sure whether you want to make significant changes in your alcohol use or not. I'd like to spend some time exploring that more. I'd like to spend some time talking about your short term goals and how alcohol use fits in with them. [Provide] How does that sound? [Elicit]

The following page illustrates what the ***Options*** handout might look like for Laura.

Options

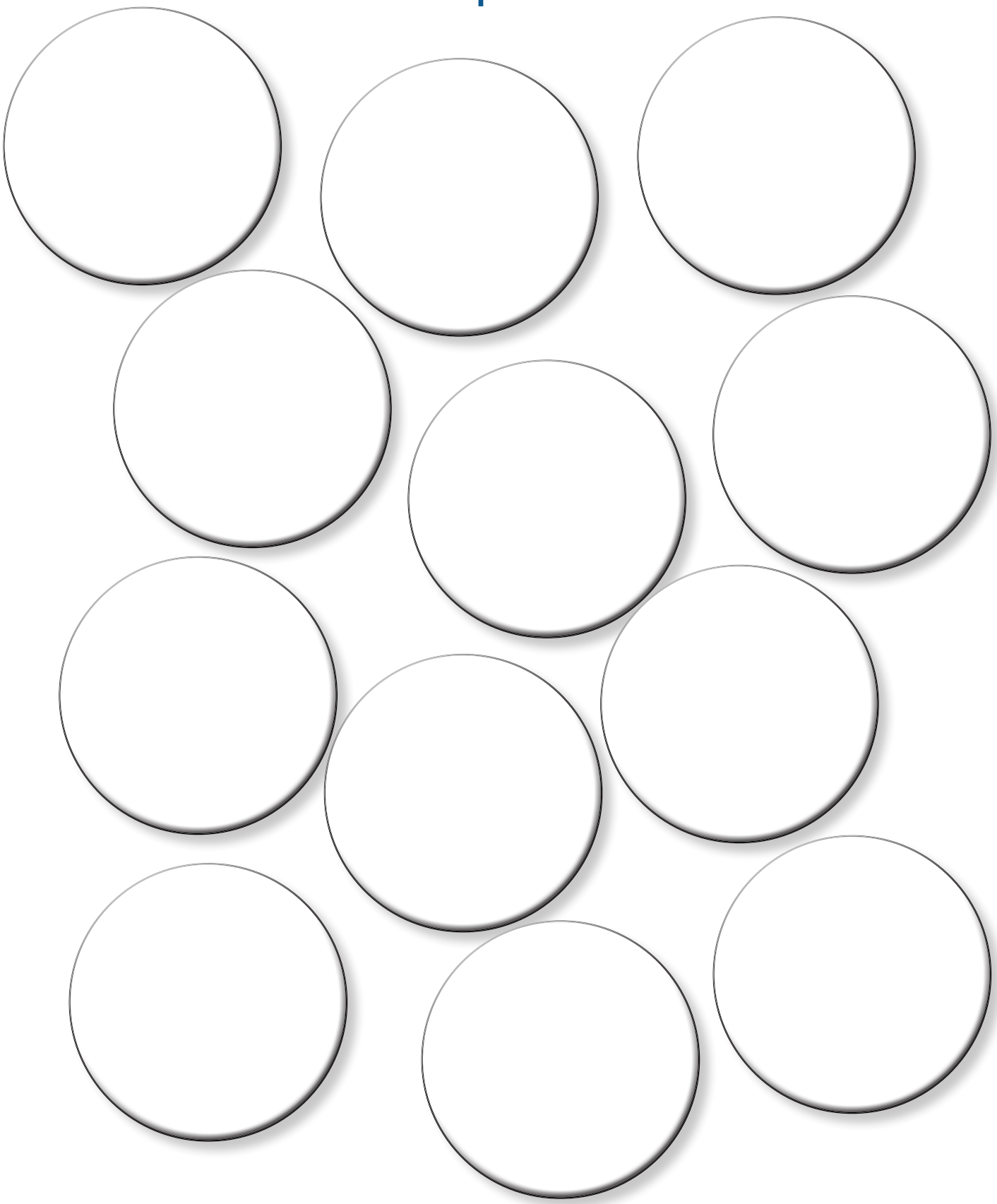


An example change plan for Laura follows on the next page. The treatment plan was developed by the therapist and client in a collaborative manner.

Change Plan

Areas to be addressed by treatment or referral	Broad goals and specific objectives to be achieved	Treatment plan (how)
#1 Alcohol	No increase in use • Track and report alcohol use at weekly sessions No heavy drinking days • Track number of standard drinks per drinking day	• Attend weekly treatment sessions • Complete section on urges and cravings • Read information on pharmacotherapy
#2 PTSD	Maintain gains made in PTSD treatment	• Dr. Smith will continue to be involved
#3 Recreation	Increase participation in recreational activities • Participate in one recreational activity per week	• Complete Social and Recreational Counseling
#4 Motivation	Explore motivation for treatment/motivation for making changes in alcohol use • Engage in three or four specific activities aimed at exploring motivation	• Examine short term goals • Looking forward exercise • Rulers • Benefits of not using/consequences of using exercise

Options



Change Plan

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

Middle Phase of Treatment: Cognitive Behavioral Strategies

Middle Phase of Treatment: Cognitive Behavioral Strategies (pages 57-171) Up to 10 Sessions			
Further Development of Case Conceptualization	Cognitive Behavioral Strategies: Core and Elective Strategies	Motivational Enhancement Strategies (as appropriate)	Pull-Out Procedures (as appropriate)

Core Components

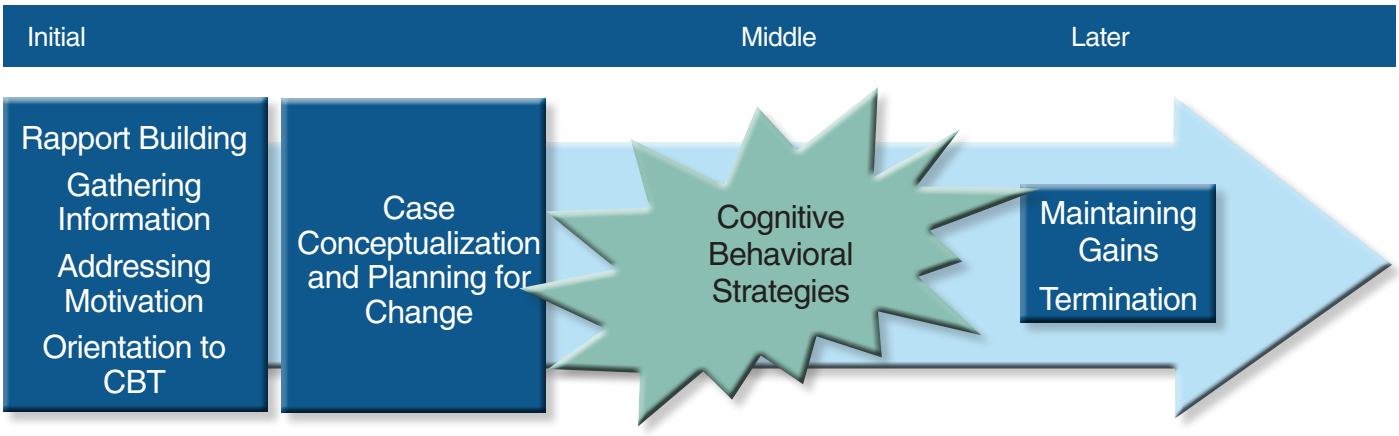
In this section of the manual, a number of core cognitive behavioral strategies for managing substance use are described. Cover this material with Veterans prior to moving to the section titled *Elective Components*. Core components include:

- Cravings and Urges Part 1: Recognizing Cravings, Urges, and Triggers
- Cravings and Urges Part 2: Coping with Cravings and Urges
- Refusal Skills

The core components include skills intended to help the Veteran make changes early on that will be reinforced quickly. The elective cognitive behavioral strategies described later in the section titled *Elective Components* will build on many of the basic core strategies covered in these initial sessions. For instance, the section on coping with cravings and urges introduces the Veteran to cognitive restructuring while the elective component on mood management builds on the cognitive restructuring skills developed in these initial core sessions.

The core components include skills intended to help the Veteran make changes early on that will be reinforced quickly.

Figure 8. Timeline of CBT-SUD: Cognitive Behavioral Strategies



Cravings and Urges Parts 1 and 2

Cravings and Urges Parts 1 and 2: Therapist Information Sheet

Recommended session content

In this manual, essential cognitive behavioral skills are introduced within the context of addressing cravings and urges. Difficulties with cravings and urges are common. It is therefore helpful to begin discussion about them early on and work to assist the Veteran in developing skills to manage them effectively.

The section on cravings and urges is divided into two parts. Because of the amount of content covered, it is recommended to take 1 to 2 sessions with each part as needed. In other words, this topic may take four sessions.

In Part 1: Recognizing Cravings, Urges and Triggers, urge monitoring is introduced. In Part 2: Cognitive Restructuring for Cravings and Urges, cognitive restructuring is introduced. These cognitive behavioral skills are viewed as essential to this treatment and adequate time should be allotted for covering the material. The amount of content covered in a session will depend on many factors such as the cognitive ability of the client, other pressing issues that need to be the focus of clinical attention, and whether the Veteran presents for the session on time. While urge monitoring and cognitive restructuring are addressed specifically within the context of the section on cravings and urges, it is likely that clients will benefit from practicing these cognitive behavioral skills throughout the course of treatment. Therapists and clients may jointly decide that it will be beneficial to continue practicing these skills between sessions after the content of this section has been completed.

Below are some suggested guidelines for covering the topic content.

Part 1: Recognizing Cravings, Urges and Triggers

Session 1: Trigger /Cue Identification
Session 2: Urge Monitoring

Part 2: Coping with Cravings and Urges

Session 1: Introducing Cognitive Restructuring and Identifying Automatic Thoughts
Session 2: Evaluating Automatic Thoughts and Other Strategies for Coping with Urges and Cravings

Background

For those with substance use disorders, the experience of stopping or modifying substance use is usually marked by repeated challenges in the form of cravings or urges of varying intensity. The terms craving and urge have been broadly defined and will be used interchangeably here when referring to motivational states in which a person experiences a strong desire to engage in substance use. Linked by clinical evidence with resumed or increased use, drug-seeking behavior, or maintenance of abstinence (e.g., Paliwal, Hyman, & Sinha, 2008; Rohsenow, Martin, Eaton & Monti 2007), cravings and urges are important constructs in the neurobiology and treatment of substance use disorders. For the majority of clients who present for treatment, learning to cope effectively with these experiences will be an important treatment goal. Cravings commonly occur with greater intensity and frequency early in treatment. They vary from person to person and may persist for weeks or months after modifying or stopping use. As there can be wide variability in the

subjective experience, for some, coping effectively with cravings could remain a prominent treatment goal for several weeks.

Substances may be used in a wide variety of circumstances with a frequency that over time leads to repeated pairings of the substance use and circumstances across a multitude of stimuli. Those stimuli begin as social, situational, emotional, cognitive, and physical antecedents of use and then become triggers or cues for cravings through classical and operant conditioning. In other words, cravings result from the desire to experience the positive reinforcing effects associated with substance use. Cravings then may occur in the presence of stimuli or situations previously associated with use. Cravings can also result from the desire to avoid negative or aversive experiences resulting from physiological changes involved in conditioned tolerance. From a cognitive behavioral perspective, craving is considered a subjective state that occurs because of the expectation that substance use will have positive effects or will improve an existing negative mood state. Cravings occur particularly in situations in which individuals who use substances have little confidence in their ability to resist using (Anton, 1999; Singleton & Gorelick, 1998).

The intervention strategies described in this section on cravings and urges aim to help individuals recognize and understand the experience of urges and cravings, identify the cues or triggers that increase risk for use, and develop ways of managing them. As Veterans begin to effectively manage urges and cravings, self-efficacy is increased and the cravings lose their power. By coping with the cravings and forgoing use, over time the bond between the conditioned stimulus and the conditioned response weakens.

Part 1 of Cravings and Urges involves learning to identify triggers and how to self-monitor urges. Working with Veterans to identify particular cues or triggers that result in urges or cravings to use is an important first step. Some may become overwhelmed when asked to identify cues. When one Veteran was asked, for example, he stated that for him, every waking moment was a trigger. Help explore with Veterans the various ways they might experience an urge or craving. Recognizing these experiences is important before moving to the actual coping strategies.

Working with Veterans to identify particular cues or triggers that result in urges or cravings to use is an important first step.

Part 2 of Cravings and Urges introduces cognitive restructuring. Cognitive restructuring is a powerful and fundamental cognitive behavioral skill. It is a skill that helps clients (a) learn to identify unrealistic and unhelpful thoughts and beliefs, (b) distance themselves from those unhelpful thoughts before they act upon them, and (c) evaluate the accuracy of those thoughts. When a thought is identified as being inaccurate or unrealistic, cognitive restructuring provides the Veteran with a way of developing alternative thoughts that are more realistic. It is introduced in this section because it is often an effective way to cope with urges and cravings. The elective component on mood management training also focuses on the skill of cognitive restructuring and extends the use of the skill to managing mood states such as depression and anxiety which can contribute to urges and cravings to use.

Cravings and Urges: Parts 1

Recognizing Cravings, Urges, and Triggers: Implementing the Session(s)

Overall Goals

- Assist the Veteran in identifying triggers.
- Assist the Veteran in learning how to monitor cravings and urges.

Cognitive Behavioral Strategies

- Trigger Identification
- Urge Monitoring and Urge Surfing

Materials

- BAM or BAM-C (consult Figure 3)
- Other assessment measures (consult Figure 3)
- Breathalyzer and urine drug screen (consult Figure 3 and as clinically indicated)
- Exploring Triggers handout (for the functional analysis)
- Urge Monitoring Instructions
- Urge Monitoring cards

Structure of Session(s)

✓	Bridge from previous session
✓	Functional analysis (as indicated)
✓	Agenda setting
✓	Discussion of agenda items/Cognitive behavioral strategies: Cravings and Urges Part 1
✓	Planning the home assignment

Beginning the Session(s)

As with each session, begin with a bridge from the previous session, followed by a functional analysis (as indicated), and set the agenda. Detailed instructions for each of these tasks are provided on pages 11-13 in the section titled “General Session Structure.” If the Veteran is also receiving pharmacotherapy, this is a good time to check in about how that is going and whether or not the Veteran is using medications as prescribed.

Discussion of Agenda Items/Cognitive Behavioral Strategies

Provide a Rationale

Always preface the discussion and practice of cognitive behavioral strategies by providing a rationale. Read the information provided in the Therapist Information Sheet and substitute words that provide a rationale in a way that the Veteran will understand. Check in with the Veteran to determine if the rationale is understood.

Trigger Identification

Begin by assessing what the Veteran already knows about triggers, urges, and cravings. Ask the Veteran to describe what their experiences with urges and cravings have been. To help identify and recognize different ways cravings can be experienced, ask the Veteran to focus on a few recent situations in which they experienced craving or an urge to use.

It is important to use terminology that is comfortable for the Veteran. Some may be more at ease with the word *urge* while others may be more comfortable with the word *craving*. One Veteran for example stated he had never experienced craving but shared that he would have urges to smoke from the time he got out of work until he went to sleep for the night.

It is important to use terminology that is comfortable for the Veteran. Some may be more at ease with the word *urge* while others may be more comfortable the with word *craving*.

It is important to cover some general information about characteristics of urges and cravings. Specifically point out that they are *common, predictable, time-limited* and *controllable*. This can serve to impart a sense of hopefulness. Also provide the Veteran with the ***Facts about Cravings*** handout.

Common. It is normal in the course of substance use behavior change to experience cravings or urges. They should not be viewed as a signal indicating that something is wrong. They should be expected and viewed as learning opportunities.

Predictable. Cravings and urges tend to occur in certain situations that are expectable such as exposure to others using substances, or at certain times of day. They can also be triggered by affective or internal stimuli such as feeling tense, shaky, or angry.

Time-Limited. Urges are short-lived. They can last a few minutes or at most a few hours. They act like waves in that they start off low, peak after a short time, and then die down and dissipate often within minutes. Cravings and urges cannot harm the client.

Controllable. They are manageable. Each time a Veteran successfully "rides out" an urge the probability of succeeding in facing future urges increases. An individual is not helpless in the face of cravings or urges, there are things a person can do.

Then ask how the above information relates to the Veteran's experiences.

Below is an example of what to say to introduce the topic and begin exploring the Veteran's experiences with urges and cravings.

Therapist: When we talked earlier, you indicated that one thing you wanted to work on was learning how to more effectively manage urges to use. You indicated that you have had these before and have found them quite uncomfortable at times. Today we can talk about what it feels like for you when you have urges to drink. From there we can think about what triggers the urges and begin to talk about how you might be able to manage them. How do you think that sounds?

Laura: Sounds good. When I do have an urge, it's pretty intense. I'm not really able to ignore it. I find that sometimes it is so overwhelming I just end up giving in.

Therapist: So for you, urges can seem very powerful. I want to get an even better sense of your experiences. Describe a recent time when you had a strong urge, a time that you would be comfortable talking with me about.

Laura: Oh yeah, after my last therapy session.

Therapist: Okay. Let's start with that. What specifically was the experience like for you?

Laura: The last therapy session with my primary was really hard for me. I thought I was doing well but then afterwards, when I got home, I really wanted to have a drink. I know that I am not supposed to do that right after a session but I mean I really wanted it. I needed a break.

Use open questions to get a better understanding of the experience as well as overall awareness of the symptoms of an urge. Reflect back what the Veteran says. Ask permission to provide additional information on cravings. Below is a list of some example questions that may be helpful in getting a good understanding of the client's experience.

What *specifically* was the experience like?	How did you know you were having a urge to use or were craving? Was it a thought, a physical sensation, an emotion?
What was happening *just before* and *during* the experience?	What was going on? What did you see, hear, smell, taste, feel?
What happened *after* the experience of urge or craving?	Did you use? If not, how did you succeed in not using? What did you think afterward? How did you feel afterward?

It is important to note that urges or cravings can be triggered simply by talking in detail about a craving or use experience. If this occurs it can actually present as a useful therapeutic opportunity providing rich material to focus on in the session. Because talking about a specific urge or use experience can lead to such an occurrence, it is important to start the identification process early in the session so that there is ample time to discuss and debrief the material. Starting this too close to the end of a session is not a good idea. Make a point to check-in with the Veteran periodically during the sessions throughout treatment. It's important to explore and identify if cravings are experienced during the session.

It is important to note that urges or cravings can be triggered simply by talking in detail about a craving or use experience. … it is important to start the identification process early in the session so there is ample time to discuss and debrief the material.

The following chart provides information about different ways urges and cravings may be experienced. Depending on the individual, it may be useful to review some or all of this information. If the Veteran appears to have a solid understanding of urges and cravings, this may not be necessary.

Thoughts	Physical Sensations	Positive Expectancies	Emotions	Behaviors
"Wouldn't it be nice to have a drink."	Racing heart	I'd feel better with just a few hits.	Anxiety	Pausing when passing the wine isle in the store.
	Shakiness		Depression	
"I'd rather be out watching the game and getting high with buddies."	Sweating	A couple of drinks and I am more sociable.	Irritability	Holding onto the phone number of a dealer.
	Muscle aches	I've been good. I deserve one.	Anger	
			Elation	Keeping a pipe around.
			Happiness	

If sharing the information in the above chart, then it is also encouraged to ask clients what they think of the information that has been provided. Then reflect or summarize what the Veteran has said. Summaries also provide an opportunity to transition to the topic of identifying triggers.

When transitioning to the topic of trigger identification, begin by explaining that starting to identify urge triggers sets the ground work for planning coping strategies for them. It is important to establish the link between triggers and urges. Triggers are often situations previously associated with alcohol and/or other drug use. Due to past repeated associations between these situations and alcohol and/or other drug use, such situations can trigger urges. If the Veteran understands this connection it can help with making urges more predictable and thus more manageable.

Work with the Veteran in session to begin creating a comprehensive list of the triggers. The best initial source for this is likely to be the Veteran's own recollections of situations in which cravings or urges were experienced. Even so, the Veteran may not initially recognize what aspects of a situation triggered the desire to use. The ***Exploring Triggers*** worksheet used to complete the initial functional analysis (Triggers column) may provide useful material here. After the explanation, ask the Veteran to begin to list personal triggers. Once again, use open questions and inquire about their understanding of these triggers. Then, if information about various types of triggers is not elicited, follow with more directive questioning. Below is a list of some of the more commonly reported triggers that may be explored. Be sure to cover that the triggers can be external (something that occurs outside the person) or internal (something that happens inside the person).

COMMON TRIGGERS

External Triggers	• Exposure to substances (alcohol and/or other drugs) • Smells, sights and sounds of others drinking and/or using other drugs • Contact with people, places and things previously associated with using such as using buddies, parties, bars, crack pipes, medicine bottles, watching football on TV, or fishing • Particular times of day commonly associated with use (getting off work, weekends, payday, sunset, between activities) • Stimuli previously associated with withdrawal (hospital, aspirin, morning)
Internal Triggers	• Negative emotions (anger, anxiety, frustration, sadness, feeling lonely, fatigue, feeling "stressed out") • Positive emotions (elation, excitement, feelings of accomplishment) • "Normal" feelings (bored, tired, hungry) • Physical feelings (sick, tense, headachy, in pain) • Thoughts about use ("I can have just one hit," or "Ill feel better if I have a drink").

For some clients, this may be a good stopping point for the session. If that's the case, this is a good opportunity to offer a summary and transition to planning the home assignment. (If time still remains in the session, move on to introducing urge monitoring). Below is example dialogue that provides a summary and transitions to planning the home assignment.

Therapist: So, at this point you've given me a good idea of what the experience of urges and cravings are like for you. You've also done a nice job identifying different triggers including (review the individual triggers identified). We have some idea of where, when and why you might have an urge. It is possible that there are other triggers for you that we did not think of and that we did not put on the list. We often find that when a person starts to really pay attention to when they want to drink/use they start to become aware of triggers that they hadn't previously recognized. Sometimes people find it helpful to identify triggers as their home assignment. Now is a good time for us to talk about your home assignment for next time. The home assignment is something we decide on together.

Urge Monitoring and Urge Surfing

Self-monitoring can be an effective tool for change. Having Veteran's monitor their urges is important to this treatment. Urge monitoring involves collecting accurate data about urges. Many clients report not knowing why they used, just that they did. Monitoring the occurrence of urges allows the individual to then think about what was happening prior to the urge occurring. Identifying the triggers that lead to urges provides information about what types of circumstances the Veteran will need to avoid or learn other ways to cope with. Recording what happens following an urge also provides valuable information.

Identifying the triggers that lead to urges provides information about what types of circumstances the Veteran will need to either avoid or cope with.

Urge monitoring also provides baseline data about what the client is experiencing. It requires that, in the time between sessions, clients write down every urge to use, regardless of intensity.

As always, begin by providing a rationale for urge monitoring. Describe benefits that are likely to mean something to the client (e.g., better self-awareness, greater self-control, feedback on improvement, and so on). Also elicit potential benefits from the Veteran directly.

Explain that it can be helpful to monitor urges outside of session to get more information on the experience of the urges and triggers as well as information on any coping skills that are being used to manage the urges and triggers.

Give the Veteran ***Urge Monitoring*** cards to make this process easier. Instructions and ***Urge Monitoring*** cards are included at the end of this section and in Appendix A. Have a copy of instructions to give the Veteran along with the supply of blank ***Urge Monitoring*** cards.

Below is an example of a therapist discussing urge monitoring with Laura.

Therapist: I'm going to provide you with some urge monitoring cards that you can use to keep track of your urges or cravings over the next week. I also have some written instructions that I'm going to go over with you. Before I do that, I'm wondering what you think might be helpful about monitoring and keeping records of your urges or cravings?

Laura: I would think that knowing I have to write about it will help to reduce them.

Therapist: You know, that can actually happen. Just the fact that you are tracking or observing and writing about it raises the cost of the behavior. The higher cost can reduce its likelihood. What else might you learn from this exercise?

Laura: Well, I am guessing that there are some things I haven't really thought of and keeping records could help me identify more of them.

Therapist: Yes, and that could result in you becoming more self-aware and more likely recognize when you are having urges.

Laura: I could also see when the urges get better and see how I improve.

Therapist: Exactly. And you will be taking more control through the process by finding out what is likely to trigger your urges. The process can seem automatic and seem to happen so quickly that at times it may feel as if the urge is just suddenly there. In reality a series of thoughts and reactions occur between the trigger and the urges to use. By becoming more aware, you put yourself in a better position to be able to cope. If you are okay with it, I would like you to track the urges and cravings for the next week or two. We can evaluate how it's going and make changes accordingly. What do you think?

In session, use an ***Urge Monitoring*** card to work through an example. If possible use a recent experience described by the Veteran. An example of what a completed ***Urge Monitoring*** card might look like follows.

A Sample Completed Urge Monitoring Card

Date/Time	Situation	Rating (0-100%)	How I responded
7/11 @ 4pm	Arrived at home after a meeting. Wanted to relax and forget about everything for a while.	80%	I ran a hot bath and did some relaxation exercises.
7/11 @ 7pm	Feeling anxious and antsy at bedtime. Unable to get to sleep. Had the thought, "A drink would really help."	60%	Got up, had a cup of herbal tea and read.
7/12 @ 11am	Went to meet friend for lunch. Angry that I cannot have a glass of wine.	75%	Ordered club soda with lime.
7/13 @ 4:30pm	Been watching the clock. Time to get dinner ready soon. I keep seeing myself walking to the liquor store on the corner.	85%	Really focused and pictured myself walking right by the store. Didn't drink. Started the dinner planning.
7/20 @5:30pm	Pay Day - Had money in my pocket and a friend coming by that also knows it's pay-day and will want to go party.	95%	Suggested we go for coffee instead.

Urge Surfing. Introduce urge surfing by explaining that urges are a lot like ocean waves. They start small, grow in size and peak, and then break-up and dissipate. It can also be helpful to explain that the idea behind urge surfing is similar to the idea behind many martial arts. In judo, an individual overpowers by first going with the force of the attack. By joining with the opponent's force, a person can take control of it and redirect it to their advantage. It's a lot easier to swim with a wave than to stand up against it.

Explain to clients that they can initially join with an urge (as an alternative to meeting it with a strong opposite force) as a way of keeping balance. What the Veteran is "going with" here, of course, is not using but the experience of the urge itself.

If a client experiences craving during a treatment session it can be beneficial to practice urge surfing in vivo. In such a case, consider asking the Veteran to sit in a comfortable position. Then provide the instructions described below. There is also an ***Urge Surfing*** handout located at the end of this section and in the Appendix to provide for the Veteran to reference and use outside of session.

If a client experiences craving during a treatment session it can be beneficial to practice urge surfing in vivo.

Therapist: Take a few deep breaths and focus your attention inward. Allow your attention to wander through your body. Notice where in your body you experience the craving and what the sensations are like. Notice each area where you experience the urge, and say what you are experiencing. For example, "I have a jumpy feeling in my chest and I feel antsy in my arms and legs."

Focus on one area where you are experiencing the urge. Notice the exact sensations in that area. For example, do you feel hot, cold, tingly, numb? Are your muscles tense or relaxed? How large an area is involved? Notice the sensations and describe them to yourself. Notice the changes that occur in the sensation. For example, "Well, my heart is beating rather hard in my chest. There is tension all over and I feel like I could jump out of my skin." As I focus, I can imagine the warming sensation and mellow feelings from smoking a joint."

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

Closing the Session/Planning the Home Assignment

As always, at the end of session, conduct a final summary or, alternatively, have the Veteran summarize the most important lessons gleaned from the session. In addition to summarizing content, possibly include an affirmation of the Veteran's efforts or strengths. Be sure to also ask about how the client felt about the session, especially if a particularly upsetting or sensitive topic was discussed. When relevant, and with time-permitting, consider beginning home assignments in session so that Veterans have a model when they attempt to complete it on their own. See the section titled General Structure (pages 10-11) for additional guidance on closing a session and planning a home assignment.

Below are home assignments relevant to this topic. Remember that therapist and Veteran collaboratively choose home assignments. It may be that more than one home assignment is agreed upon.

1. Continue to identify triggers. The Veteran is asked to continue to identify more subtle cues that arise and develop a comprehensive list of triggers to plan for.
2. Self-monitor urges and cravings using the ***Urge Monitoring*** cards.
3. Practice urge surfing.

Explore potential barriers that may prevent the Veteran from keeping good records outside of session. What might the Veteran do to keep good records? Might there be any problems the Veteran foresees? Attempt to understand and convey understanding of what the Veteran is expressing.

Facts about Cravings

Cravings are a common occurrence when stopping or reducing alcohol and/or drug use. Understanding cravings helps people to overcome them, so here are some simple facts.

1. Cravings are the result of long-term alcohol and/or other drug use and can continue for some time after the use has stopped. People with a history of heavier use might experience stronger or more frequent urges. These are *common*.

2. Cravings can be triggered by people, places, things, feelings, situations, or anything associated with past use. Cravings are *predictable*.

3. A craving is just like a wave at the beach. Every wave in a set starts off small, builds up to its highest point, and then breaks and flows away to shore. Each individual wave never lasts more than a few minutes. A craving is just the same. It starts off small and then builds up. But it peaks, just like a wave, and will eventually break and disappear. This whole process usually doesn't last more than minutes. Cravings are *time-limited***.**

4. Cravings will lose their power if force is not given to them by using or drinking in response. Even if use occurs only once in a while, it will still keep those cravings alive. Cravings are like a stray animal – keep feeding them and they will keep coming back. So in a very real sense these cravings are *controllable*.

5. Cravings tend to be stronger earlier on, then weaken, and eventually fade over time.

6. Each time a person does something other than drink and/or use others drugs, the craving loses power.

7. Stopping alcohol and other drug use completely is the quickest way to get rid of the cravings.

8. There are medications that help people manage cravings for alcohol and some other drugs.

Urge Monitoring Instructions

1. Keep a couple of cards of forms and a pen or pencil with you all the time. (Discuss how the Veteran can do this - where to carry the cards, etc. Elicit the Veteran's own ideas.)
2. Whenever you feel an urge to drink or use, write it down as soon as possible. Records are much less accurate and useful if they are made later. Do not, for example, wait until the end of the day and then try to reconstruct your day. Still - better late than never, though.
3. Write down the following four things with each entry:
   - The date and time of day.
   - The situation: Where you were, whom you were with, what you were doing or thinking.
   - Rate how strong the urge was, from 0 (no urge at all) to 100 (strongest you've ever felt).
   - What you did – how you responded to the urge. If you do use, write that down. If you don't, write down what you did instead.

Urge Monitoring Card Sample

Date/Time	Situation	Rating (0-100%)	How I responded
Sept 12 2:10	Talking about what it was like using with friends. Started to feel a little antsy.	40%	Practiced riding out the urge and using the surfing instructions. Did not use.

Urge Monitoring Card

Date/Time	Situation	Rating (0-100%)	How I responded

Urge Monitoring Card

Date/Time	Situation	Rating (0-100%)	How I responded

Urge Surfing

Many people try to cope with their urges by gritting their teeth and toughing it out. Some urges may be too strong to ignore. When this happens, it can be useful to stay with your urge to use until it passes. This technique is called *urge surfing*.

Urges are like ocean waves. They start out small, grow to a peak then break and fade off. You can imagine yourself riding the wave, staying on top of it until it crests, breaks, and turns into less powerful, foamy surf. The basis of urge surfing is similar to that of many martial arts. In judo, it is possible to overpower an opponent by first *going with* the force of the attack. By joining with the opponent's force, control is taken and redirected to obtain the advantage. To practice this type of technique, of gaining control by first going with the opponent, take the following steps:

1. Take inventory of your craving experience. Sit in a comfortable chair with your feet flat on the floor and your hands in a comfortable position. Take a few deep breaths and focus inward. Allow your attention to wander through your body. Notice where in your body you experience the craving and what the sensations are like. Notice each area where you experience the urge and tell yourself what you are experiencing. For example, "Let me see. My craving is in my mouth and nose and in my stomach."

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

3. Refocus on each part of your body that experiences the craving. Pay attention to and describe to yourself the changes that occur in the sensations. Notice how the urge comes and goes.

Many people notice that after a few minutes of urge surfing the craving vanishes. The purpose of this exercise, however, is not to make the craving go away but to experience the craving in a new way. If you practice urge surfing, you will become familiar with your cravings and learn how to ride them out until they easily go away.

Cravings and Urges: Part 2

Coping with Cravings and Urges: Implementing the Session(s)

Overall Goal

- Assist the Veteran in learning how to effectively manage cravings and urges

Cognitive Behavioral Strategies

- Cognitive restructuring
- Other cognitive behavioral strategies for coping with cravings and urges

Materials

- BAM or BAM-C (consult Figure 3)
- Other assessment measures (consult Figure 3)
- Breathalyzer and urine drug screen (consult Figure 3 & as clinically indicated)
- Exploring Triggers handout (for the functional analysis and planning)
- Situations, Thoughts, and Feelings handout
- Feelings From A to Z handout
- Three-Column Thought Record
- Five-Column Thought Record-Urges
- Coping Plan handout

Structure of Session(s)

✓	Bridge from previous session
✓	Functional analysis (as indicated)
✓	Agenda setting
✓	Discussion of agenda items/Cognitive behavioral strategies: Cravings and Urges Part 2
✓	Planning the home assignment

Beginning the Session(s)

As with each session, begin with a bridge from the previous session, followed by a functional analysis (as indicated), and set the agenda. Detailed instructions for each of these tasks are provided on pages 11-13 in the section titled “General Session Structure.” If the Veteran is also receiving pharmacotherapy, this is a good time to check in about how that is going and whether or not the Veteran is using medications as prescribed.

It is important to review the client's ***Urge Monitoring*** card from the previous session. This should be a collaborative endeavor. Ask questions to supplement the information on the form. Discuss the Veteran's experience with monitoring.

A major goal of reviewing the ***Urge Monitoring*** cards is to help the Veteran recognize the link between triggers and urges. Special attention should be paid to instances in which the client wrote that they responded to the urge by coping effectively without using substances. This is an opportunity to affirm the Veteran's efforts and successes. Also, when reviewing the cards note any triggers that were not identified in the previous sessions. If triggers are identified that were not previously discussed, add them to the ***Exploring Triggers*** worksheet.

Discussion of Agenda Items/Cognitive Behavioral Strategies

Provide a Rationale

Always preface the discussion and practice of cognitive behavioral strategies by providing a rationale. Read the information provided in the Therapist Information Sheet and substitute words that provide a rationale in a way that the Veteran will understand. Check in with the Veteran to determine if the rationale is understood. Below is an example of a therapist providing a rationale for this session.

Therapist: Last time we talked about how urges and cravings are normal. How you respond to the urges and cravings is key. The way to break the chain is not to use in response to the urge. You mentioned in our prior session that you would like to learn new ways to manage your urges without using. Today I think it would be helpful to take a look at what you've done in response to urges or cravings in the past and ways you could manage in the future. How does that sound to you?

Cognitive Restructuring/Re-thinking

Introducing Cognitive Restructuring. Cognitive restructuring is also often referred to as *re-thinking*. Some Veterans may relate to this term and it may help them understand what cognitive restructuring is intended to do. If clients have been involved in treatment for substance use in the past, they may already be familiar with the term *cognitive restructuring* or the term *re-thinking*. Some treatments for substance use disorders refer to the unrealistic and unhelpful thoughts that are targeted in cognitive restructuring as *"stinking thinking."* Use whatever language makes the most sense to the Veteran. Begin by asking clients what they already know about cognitive restructuring. If the client is unfamiliar with the skill then the therapist will need to describe how cognitive restructuring is a skill aimed at addressing unrealistic and unhelpful thinking. It may help some Veterans to think of thoughts as *self-talk*. Sometimes automatic thoughts, or self-talk, can be unrealistic and unhelpful. The goal is to help the Veteran learn to change self-talk to be more realistic. Following are some examples of unrealistic and realistic self-talk.

The goal is to help the Veteran learn to change their self-talk to be more realistic.

Self-Talk/ Unrealistic	"This urge is more intense than I can take." "I will never get through this." "I can't handle this."
Self-Talk Realistic	"This urge feels overwhelming right now. I also know it won't last forever." "I know if I just hang in there it will pass." "I will try my best and see what happens."

Cognitive restructuring (or re-thinking) is a skill that takes practice. It takes practice to be able to identify unrealistic thoughts (or self-talk) and it takes practice to become effective at developing alternative thoughts. Provide plans to work through multiple examples of cognitive restructuring in session with the client. Ask the Veteran to explain the process of cognitive restructuring in their own words. Use this explanation to evaluate the client's understanding and correct any errors or misconceptions. Ask Veterans to complete homework assignments that involve identifying unrealistic negative thoughts and developing alternative thoughts between sessions.

The ultimate goal is for Veterans to be able to engage in the cognitive restructuring process in the moment, as they are faced with situations that elicit strong affect. Through this process, they learn how to be their own therapist by applying the practiced skills to situations that arise in their daily lives. Teaching Veterans to become their own therapist is an important goal of CBT and greatly helps to extend treatment gains following the termination of regular treatment sessions.

For cognitive restructuring to be effective, clients need to understand how thoughts and beliefs often have a significant influence on emotions, behaviors, and physiological responses. Assist Veterans in learning how to evaluate whether their thoughts are realistic. If thoughts are unrealistic and unhelpful, assist them in learning how to evaluate available evidence and then identify alternative, realistic thoughts and beliefs that will impact their feelings and behaviors.

Urges and cravings do not occur or continue in a vacuum. Urges and cravings are part of a sequence of events occurring within a particular context. It is important to educate Veterans about the CBT model, specifically information on the relationship among situations, thoughts, and feelings. Provide the Veteran with a copy of ***Situations, Thoughts, and Feelings*** handout. This is located both at the end of this section and in the appendix. It will be important to convey the following information and ask Veterans to explain the relationship among these factors in their own words.

Situation. The situation refers to the persons, places and things that surround the Veteran at a particular point in time. People often attribute their moods to these external sources. It is important to explain that the situation is only one part of the story. Certain kinds of situational factors do seem to increase the probability that a person will experience urges or cravings to use. To be sure, individuals differ in their susceptibility to such situational influence.

Thoughts. Automatic thoughts are evaluative thoughts that arise very quickly. It is often a person's interpretation of events rather than the events themselves that influence how an individual will feel. No situation affects an individual until they *interpret* it. Different thoughts or interpretations lead to different feelings. For example, encountering a rattlesnake along a wilderness trail might evoke considerable

arousal for a person who recognizes it for what it is but could result in little more than curiosity for a person who had no idea of the danger it poses.

Feelings. Feelings often occur in response to automatic thoughts. Feelings may include being happy, excited, agitated, angry, upset, afraid, and so on. Some people may have difficulty identifying feelings and/or differentiating them from thoughts. In this case, provide the Veteran with a copy of the ***Feelings from A to Z*** handout.

Next, two steps in cognitive restructuring are described: identifying automatic thoughts and evaluating automatic thoughts.

Identifying Automatic Thoughts. As discussed in the section on case conceptualization, identifying inaccurate and harmful thought patterns provides targets for treatment. Teach the Veteran to identify, challenge, and change those patterns to promote healthier functioning.

The first step in working with automatic thoughts is to help individuals learn how to identify them. In session, ask clients to describe situations associated with a noticeable urge or craving to use. As Veterans provide details about the situation, use *guided discovery* (see pages 7) to identify the thoughts that were activated during that situation. When the client reports a notable urge or craving to use, ask, "What were you thinking at that moment?"

The first step in working with automatic thoughts is to help individuals learn how to identify them.

In some cases, Veterans do not know what ran through their minds, focusing exclusively on the urges or cravings to use. In these instances, it can be helpful to use *imagery techniques* for clients to first develop a vivid image of the situation, and then to identify the thoughts that were running through their minds at that time. Others confuse thoughts and feelings. To help the Veteran grasp cognitive restructuring, explain that it's one way to *slow down* what may have happened (as in an instant replay shown in slow motion). Assist the Veteran in breaking down the sequence of thoughts and feelings. The client learns to observe, for example, that a tense interaction with a coworker may lead to thoughts about not being good enough (e.g., smart, competent, or skilled enough) and/or thoughts about wanting to use and feelings of frustration.

To help the Veteran grasp cognitive restructuring explain that it's one way to *slow down* what may have happened.

A thought record is a tool for clients to systematically record descriptions of situations associated with cravings or urges to use, their automatic thoughts, and their feelings. It is a tool to aid them in collecting "data" on their automatic thoughts and further examine the notion of the interrelatedness between thoughts, feelings, and behavior. Suggest to clients that their thought record is a "test" to see if their thoughts and emotions are truly linked. The most basic thought record consists of three columns: (a) situation, (b) thought, and (c) feeling. Illustrate the use of a thought record using a whiteboard, blackboard, pad of paper on an easel, or a sheet of paper. On the next page is an example of a blank ***Three-Column Thought*** Record. Blank copies of this can be found at the end of this section and in Appendix A.

Situation Describe the people, place, or thing that triggered the urge/craving.	**Thought** Write down any automatic thoughts (or self-talk) you had about using.	**Feeling** What feeling(s) did you experience?

Entries on the ***Three-Column Thought*** Record can be completed in session, and if the Veteran agrees that the identification of automatic thoughts is valuable, keeping a thought record can be assigned as homework.

Not all clients respond favorably to completing thought records. For example, some may have limited educational, language, or English-speaking skills, and find the completion of thought records to be overly difficult. In these instances, take the lead in completing the thought record in session, listing the situation, thoughts, and feelings; and visually demonstrating the link between them using a diagram similar to the one below. The letters A, B, and C represent the situations, thoughts, and feelings respectively.

Figure 9. The Link Among Situations, Thoughts, and Feelings

Once the Veteran can analyze the series of thoughts and feelings that preceded previous substance use, the idea of identifying and modifying thought processes can be introduced.

Evaluating Automatic Thoughts. There are a number of strategies that can be implemented when automatic thoughts are identified so that more realistic, adaptive interpretations can be constructed. The strategies require consistent practice. Remind Veterans that they have had a substantial amount of time to practice responding to the world in a way that elicits their current automatic thoughts. Therefore, it makes sense that it will take a commitment along with some work and practice to develop a new way of responding to the world, which will then become a habit. In other words, previous cognitive styles have been over learned, and most of the time people do not put a great deal of effort into addressing the logic of their thoughts—they just trust them to be sound and reliable. With practice, they will learn a new way of evaluating information from their environment, and eventually it will become as automatic as the automatic thoughts. For military personnel, this can be likened to learning to march at Basic Training. At first, the commands sounded foreign, and they had to think about how and where they stepped. However, after practicing it enough times, they knew exactly what to do when they heard, “Column Left, March!” In fact, they eventually did it instinctively.

As previously stated, a common method to help clients evaluate their automatic thoughts is to use Socratic questioning. As a reminder, this involves asking questions that stimulate critical thinking and accurate examination of these cognitions. Refrain from directly challenging the accuracy of the Veteran's automatic thoughts. In fact, there is often a "grain of truth" in these thoughts, and it would damage the therapeutic relationship to overlook that. The goal of Socratic questioning is for the client and therapist to work collaboratively to evaluate the automatic thought's validity or usefulness and to develop an alternative, realistic response that follows logically from the evaluation. Below is a list of sample questions that might assist in the process of evaluating accuracy of automatic thoughts.

Refrain from directly challenging the accuracy of the Veteran's automatic thoughts.

Sample Questions for Evaluation of Automatic Thoughts

- What is the evidence that if you don't use cannabis in the next 10 minutes, you'll die?
- Has anyone ever died from not using cocaine?
- What's the evidence that people recovering from difficulties with substance use don't have the feelings you're having?
- What's the evidence that you'll never improve?
- What's so awful about feeling bad?
- What's so bad about being irritable for a while?

A useful tool for helping clients evaluate their automatic thoughts is an expansion of the ***Three-Column Thought*** Record described previously—the ***Five-Column Thought Record-Urges***. The first three columns of this thought record are the same as the thought record described previously—Veterans record the situation associated with the urges or cravings, the automatic thoughts, and the associated emotions.

However, the ***Five-Column Thought Record-Urges*** requires that clients supply two additional pieces of information. In the fourth column, Veterans record alternative responses to the automatic thoughts listed in the third column. They arrive upon the alternative response by asking themselves questions that assist in evaluating the accuracy of the automatic thought. In the fifth column, they record the outcome associated with the alternative response. The outcome may be an adaptive behavioral response that the Veteran engages in as a result of the more realistic alternative response. The outcome might be a decision not to use substances. It is critical for clients to complete the outcome column in order to provide evidence that the cognitive restructuring process is facilitating positive changes in their lives. On the next page is an example of a ***Five-Column Thought Record-Urges.***

Situation Describe the people, place, or thing that triggered the urge/craving.	**Thought** Write down any automatic thoughts (or self-talk) you had about using.	**Feeling** What feeling(s) did you experience?	**Alternative, Realistic Thought** Use the questions to come up with a more balanced, realistic thought.	**Outcome** What feeling or behavior might result from the alternative, realistic thought?

It is important to continue to promote regular practice of cognitive restructuring outside of session. Learning the skill of cognitive restructuring takes time and practice. Focusing on the skill for two sessions alone is not likely to result in much benefit.

As Veterans begin to identify their unrealistic/unhelpful thoughts, they may begin to notice specific patterns in both the types of thoughts and the situations that are difficult for them. They may even begin to notice that they have a particular style of interpreting events and situations. These styles are referred to as types of *cognitive distortions*. Cognitive distortions are addressed in the section on mood management which extends many of the cognitive restructuring techniques introduced in this section.

Possible Reasons for Unsuccessful Cognitive Restructuring

- The Veteran has difficulty identifying automatic thoughts.
- The Veteran has difficulty distinguishing thoughts from emotions and/or situations/stimuli.
- There are more important or central automatic thoughts that were not identified or evaluated.
- The evaluation was implausible, superficial, or inadequate.
- The Veteran did not fully articulate the evidence that supported the automatic thought.
- The Veteran understood at an intellectual level that the thought was distorted, but did not believe it at an emotional level.
- The Veteran discounted the evaluation.

Other Cognitive Behavioral Strategies for Coping with Cravings and Urges

No one strategy works for every situation so it is important for a client to have options for coping. Ask clients how they think they will best cope with triggers. Elicit thoughts and ideas from them prior to offering information. Ask if they are interested in learning about any or all of the strategies covered in the remainder of this section.

Avoid, Escape, Distract

Avoid	• Avoid those triggers that can be avoided. Those who successfully modify substance use typically avoid the triggers they can, especially early in the process. • Get rid of substances at home and in other common places (e.g., car, boat, worksite). • Stay away from parties or places where use occurs. • Reduce contact with friends who use and meet them only in substance free contexts.
Escape	• Have a plan for getting out of a situation as quickly as possible if strong urges occur. • Have the means for escape ready – do not get stranded. • Plan for what to say.
Distract	• Prepare a list of reliable distracting activities so that when confronted with triggers there is a line of defense (e.g., walking, running, biking, reading, calling someone, making something, going to a movie).

Develop an Individual Coping Plan. Develop with the Veteran a specific plan to cope with future urges or craving. A handout that may be helpful entitled ***Coping Plan*** is located at the end of this section and in Appendix A. After reviewing the general strategies that they can use, ask Veterans to select two or three that seem to fit best and that seem most realistic for use in the course of their daily life. Develop those strategies in detail. For example, if getting involved in a distracting activity seems helpful, which activities would be best? Are they reliably available? Which of these might take some preparation? For strategies amenable to practice (as most of these are), use in-session role-play or home assignments.

Closing the Session/Planning the Home Assignment

As always, at the end of session, conduct a final summary or, alternatively, have the Veteran summarize the most important lessons gleaned from the session. In addition to summarizing content, include an affirmation of the Veteran's efforts or strengths. Also ask about how the Veteran felt about the session, especially if a particularly upsetting or sensitive topic was discussed. When relevant and time-permitting, begin home assignments in session so that clients have a model when they attempt to complete it on their own. See the section titled General Structure (pages 10-11) for additional guidance on closing a session and planning a home assignment.

Below is an example of a therapist providing a summary that also highlights accomplishments from the session. The therapist ends by asking the Veteran for feedback.

Therapist: We've gone over a fair amount of material today. The time and effort that you put into filling out your Urge Monitoring cards shows you're commitment to change. Our session today has been focused on getting a plan together for how to cope with the urges that are triggered in your daily routine. You had some good ideas about how to cope with urges when we began this work; with some new strategies added to what you already know and some really detailed plans, you may be

better prepared to get through some of these triggers. You seem more confident in your ability to recognize and manage an urge when it occurs. What are your thoughts about our work today?

Discuss together whether it makes sense to continue with the craving and urges topic for another session or plan to move to another topic. Regardless of the decision, there should be a discussion about what the focus will be and how it relates to what has been accomplished thus far.

Below are several home assignment options that directly relate to coping with urges and cravings. Collaboratively choose home assignments.

1. Continue to identify triggers ideally begun last session and continued between sessions.
2. Continue to self-monitor urges and cravings using the ***Urge Monitoring*** cards.
3. Create a straightforward checklist of the Veteran's automatic thoughts identified in each session and ask the Veteran to make a checkmark each time they catch themselves thinking the automatic thought in the time between sessions.
4. Complete the ***Three-Column Thought*** Record.
5. Complete the ***Five-Column Thought Record-Urges***.
6. Complete an individual coping plan.

Situations, Thoughts, and Feelings

Situations

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

Thoughts

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

Feelings

Your Feelings: Feelings may include being happy, excited, agitated, angry, upset, afraid, and so on.

Feelings from A to Z

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

Three-Column Thought Record

Situation Describe the people, place, or thing that triggered the urge/craving.	**Thought** Write down any automatic thoughts (or self-talk) you had about using.	**Feeling** What feeling(s) did you experience?

Five-Column Thought Record-Urges

Situation Describe the people, place, or thing that triggered the urge/craving.	**Thought** Write down any automatic thoughts (or self-talk) you had about using.	**Feeling** What feeling(s) did you experience?	**Alternative, Realistic Thought** Use the questions to come up with a more balanced, realistic thought.	**Outcome** What feeling or behavior might result from the alternative, realistic thought?

Coping Plan

It is not always possible to avoid triggers. Be prepared with some different coping strategies when you are confronted with an urge.

If I run into a trigger situation:

1. **I will escape/leave or change the situation.**

   Safe place I can go: _____

2. **I will delay/put off the decision to use or drink for 15 minutes. I'll remember that my craving usually goes away in ___ minutes and I have dealt with cravings successfully in the past.**

3. **I'll distract myself with something to do.**

   Good distracters: _____

4. **I'll call my list of emergency numbers.**

   Name: _____

   Name: _____

   Name: _____

5. **I'll remind myself of my success to this point.**

6. **I'll think of the positives of not using and/or the negative consequences of using.**

7. **I will reward myself for taking positive actions based on the warning signs by (list rewards below):**

_____

_____

_____

_____

_____

_____

Refusal Skills

Refusal Skills: Therapist Information Sheet

Recommended session content

Research has shown that improving skills for managing different types of social pressure, such as improving drink or drug refusal skills, is associated with increased self-efficacy and with improved treatment outcome (Witkiewitz, Donovan & Hartzler, 2012).

Below are some suggested guidelines for covering the content.

Session 1: Assess Social Pressure/Develop Skills for Coping with Social Pressure
Session 2: Engage in Role-Plays/Behavioral Rehearsal
Session 3: Identifying Situations that Call for Assertive Communication/Practice Assertive Communication.[10]

Background

Dealing with social pressure can be quite challenging for those attempting to modify substance use (Marlatt & Gordon, 1985; Ramo & Brown, 2008). There are two types of social pressure exerted by contact with other people that can pose a high risk: *indirect and direct.* Careful preparation and learning to cope with, resist or manage both types of social pressure can help a person to stay on track with his or her goals.

Indirect Social Pressure. Indirect social pressures are those that can trigger urges or craving in the absence of a direct offer of a drink or drug. Those diagnosed with substance use disorders tend to report experiencing a high degree of craving in situations in which they are exposed to contextual drinking or drug use cues (Monti et al., 1987; Veilleux, Conrad, & Kassel, 2013). Some individuals may feel uncomfortable and/or fear they could lose friends, status, or even business contacts if they do not drink or use in certain situations where substance use is the norm, even though no actual offer is made.

Direct Social Pressure. The experience of *direct social pressure* occurs in situations in which increased temptation to use results from an offer of drugs or alcohol. Working with a Veteran to improve his or her substance refusal skills can reduce susceptibility to the direct social pressures and increase self-efficacy.

Role-plays. Practicing substance refusal responses is important especially if the Veteran has difficulties with assertiveness or responding effectively. When clients practice a refusal in the context of treatment via behavioral role-play, they receive feedback from the therapist about the effectiveness of specific refusal responses, acquire some mastery over refusal skills, and thereby increase overall confidence in facing direct social pressure.

How a person responds to social pressure is likely to be influenced by relationships with people who are using or offering the opportunity to use. Therefore, it is important to examine a Veteran's ability to cope with social pressure in response to specific people and practice refusal skills for a variety of personal relationship contexts. For example, it may be more difficult for the Veteran to avoid family gatherings than a drug dealer's corner, or the Veteran may find it more difficult to refuse an offer from a close friend, who is insulted by the refusal, than to refuse an offer from a casual acquaintance.

[10] The content suggested for session 3 should be considered elective material.

The importance of actively rehearsing coping behaviors is highlighted by research findings which suggest that being placed in situations with use-related cues can lead to the deterioration of those coping skills (Lee et al., 1008; Monti et al, 1987). Talking about different coping strategies is likely not adequate. Rehearsing social situations, to ensure that the Veteran can articulate effective responses, offers more effective protection against substance use that is triggered by social pressure (Zywiak et al., 2006).

Types of Communication. In order to prepare for this topic, review the passive, assertive, and aggressive communication provided below. It is also important to note that what constitutes assertive communication (as distinct from aggressive or passive communication) varies widely across cultures and subcultures. What is regarded as normal assertive behavior in New York City may be extremely aggressive and inappropriate behavior in a Scandinavian or Native American social context. The basic principle of finding a socially appropriate middle ground (between aggression and passivity) crosses cultures reasonably well, but cultural sensitivity is needed to determine what constitutes appropriate assertive behavior in the Veteran's social contexts.

Passive communication. Passive communicators give up their rights whenever it appears there might be a conflict between what they want and what someone else wants. Speakers who engage in passive communication keep silent, downplay how they feel about something, or try to get a message across though indirect means such as withdrawing, pouting, or isolating from others. Because the speaker does not express directly to the listener thoughts or feelings that might create conflict, the other person may not know about them. This can result in the passive communicator bottling up of feelings out of habit, even when the situation doesn't require it, and a consequence can be anxiety or resentment. Alternatively, people who engage in passive communication sometimes suffer from depressive symptoms because they may feel a great deal of self-blame. Passive communicators often defer their own rights and feelings to those of others.

Furthermore, passive communication is often misinterpreted. A client might state, for example, "I wasn't speaking to her – she knew what I wanted, because I was so quiet, and that's just how I am." The person believes that their not communicating is correctly understood by others (mind reading), and may resent that their rights and feelings are respected. The person who relies on passive communication seldom gets what they want. In addition, other people may come to resent the passive style of communication, and by association, the person, for not communicating in a direct and assertive manner.

Assertive communication. Assertive speakers express themselves directly and in a manner that also honors the rights and feelings of others. There is a planned-out element in assertiveness: speakers are clear about their own material (feelings, needs, goals), thinks through the most appropriate way to express these to the people involved, and then acts on the plan. Usually, the most effective plan of action is to openly and directly state feelings and opinions, or make specific requests for the change desired. In different situations, however, the assertive communicator may decide that a more passive response is the safest approach (e.g., not responding verbally to a threat from a stranger), or that a more aggressive response is called for (e.g., when appropriately assertive requests have been ignored). Assertive communication is flexible in that it takes into account the unique aspects of each communication challenge and tailors responses accordingly. The middle way is not the only way, but it is usually the one that yields the best long-term results. People who reliably use assertive communication techniques usually feel good about their own actions and are well thought of by others.

Assertive communication is a skill that takes practice and becomes more comfortable with time. It is very important that assertive expression is practiced during the session(s).

Interpersonal conflicts, and the resulting anger and negative feelings, are common high-risk situations for using alcohol and/or other drugs. Assertive communication skills can help Veterans deal effectively with differences or conflicts with other people.

Aggressive communication. Aggressive speakers press their rights while disregarding the rights and feelings of others. An aggressive, coercive style often satisfies immediate short-term goals (get it "off my chest," get what I want), but the long-term consequences of this type of communication are often quite negative. The aggressive communicator earns the ill will of other people, who in the long run may not want to be involved with the person anymore, or thwart his or her long-term goals. Examples of aggressive communication extend, but are by no means limited, to violence and threatened violence. Shouting, blaming, name-calling, insulting, shaming, demanding, derisive humor, and ordering are direct verbal forms of aggressive communication.

Refusal Skills: Implementing the Session(s)

Overall Goal

Assist Veterans in learning assertiveness skills to cope with *indirect* and *direct social pressure.*

Cognitive Behavioral Strategies

- Assess Social Pressure
- Develop Skills for Coping with Social Pressure
- Engage in Role-Plays/Behavioral Rehearsal
- Identifying Situations that Call for Assertive Communication
- Practice Assertive Communication

Materials

- BAM or BAM-C (consult Figure 3)
- Other assessment measures (consult Figure 3)
- Breathalyzer and urine drug screen (consult Figure 3 & as clinically indicated)
- Exploring Triggers handout (for the functional analysis)
- Identifying Social Pressure Situations and Coping Responses
- Checklist of Social Pressure Situations
- Examples of Situations Where Assertive Communication Is Needed handout
- Basic Tips for Assertive Communication

Structure of Session(s)

✓	Bridge from previous session
✓	Functional analysis (as indicated)
✓	Agenda setting
✓	Discussion of agenda items/Cognitive behavioral strategies: Refusal Skills
✓	Planning the home assignment

Beginning the Session(s)

As with each session, begin with a bridge from the previous session, followed by a functional analysis (as indicated), and set the agenda. Detailed instructions for each of these tasks are provided on pages 11-13 in the section titled "General Session Structure." If the Veteran is also receiving pharmacotherapy, this is a good time to check in about how that is going and whether or not the Veteran is using medications as prescribed.

Discussion of Agenda Items/Cognitive Behavioral Strategies

Provide a Rationale

Always preface the discussion and practice of cognitive behavioral strategies by providing a rationale. Read the information provided in the Therapist Information Sheet and substitute words that provide a

rationale in a way that the Veteran will understand. Check in with the Veteran to determine if the rationale is understood.

Assessing Social Pressure

A first step is to ask Veterans to describe the types of social pressure that cause them to be more tempted to use. Then explain the types of social pressure that can increase the temptation to use: indirect and direct.

Explain to Veterans that *indirect social pressure* is related to observing other people using, even if no one is directly encouraging them to drink or use or offering a drink or other drug. *Direct social pressure* is when other people directly offer a drink or drug, encourage use, or give the Veteran a hard time for not using.

Following are some examples of situations that could lead to the temptation to use due to indirect social pressures:

- Situations in which use is customary and/or expected (e.g., when dining with potential work associates or clients, at a wedding or party).
- In the company of using companions.
- In situations or places encouraging use (e.g., at a dealer's house).
- In a situation in which a person lacks confidence in his or her ability to cope without using (e.g., when socially anxious).

First help the Veteran generate a list of potential indirect social pressure situations (i.e., those in which the Veteran will feel tempted to return to using as a result of being around other people who are using or under the influence of a substance). To generate this list, ask Veterans to think about situations from the past in which they have felt tempted to use primarily as a result of just being around other people who were using, such as attending weddings, anniversaries, or holiday parties; hanging out with friends who use; working with people who use on the job; facing family members who show up at home under the influence; or going to a drinking or drugging establishment with friends. Ask clients to think about new situations in which they might encounter other people using and would be likely to feel a temptation to use (e.g., a wedding or a holiday party). Record these situations in the left-hand column "Situations" of the ***Identifying Social Pressure Situations*** worksheet.

Next ask the Veteran to think about direct social pressure situations. Direct social pressure can vary from mild to more extreme in which another person really tries hard to exert influence and get the person to use. Offers of a drink or drug can come from people who may or may not know that the Veteran is trying to stop using, may make the offer with varied levels of insistence, and may not accept the Veteran's first attempt at refusal. For example, the following situations are quite variable and illustrate how different factors can impact the degree of pressure.

At a restaurant a waitress provides a wine list and asks what you would like to drink this evening.

Cousin comes to town and calls you saying, "Hey, a group of us cousins are meeting at a local bar for happy hour and some pool. Come down and join us."

You are catching a ride with a co-worker who pulls out and lights a joint. He offers it to you and says, "Come on you can have a couple of hits!"

While one offer to use might be benign another could involve significant pressure and persistence. For example, the coworker who offers the joint might go on after an initial refusal to say, "Hey, come on now. What's up when a couple of old friends can't share a joint? You're killing me. Here just take a hit."

In direct social pressure situations being prepared with strong *refusal skills* can help a person feel more confident, cope effectively, and avoid returning to or increasing use. Such preparation requires practice. Practicing in session can result in the development of effective refusal skills and knowledge of ways to cope with offers from different people. Learning about and practicing a variety of responses for a host of different refusal situations is best. The response can vary with who it is that makes the offer, the intensity of the offer, the response to the refusal, and various situational nuances. The response in the case of a casual offer from a waitress will likely be very different than in the case of insistence from a former using buddy. There are, however, some general guidelines that the Veteran can learn for a skillful refusal.

Learning about and practicing a variety of responses for a host of different refusal situations is best.

Determine what types of social pressure the Veteran believes could increase temptation to resume or increase use. Explore both indirect and direct social pressure situations. Throughout this intervention use the ***Identifying Social Pressure Situations and Coping Responses*** worksheet to record specific risk situations and possible coping responses. Blank copies of the form are located at the end of this topic and in the Appendix. For some Veterans, only one type of social pressure may seem important. If this is the case, it may not be necessary to prepare for both direct and indirect social pressure.

Remember that the focus here is not only on the actual offer to use, but also more generally on direct invitations, encouragement, cajoling, shaming, and other forms of direct social pressure. Again ask for experiences from the past and also anticipate situations when this might occur in the future. Examples of people who might offer the Veteran a drink or drug would include friends, neighbors, relatives, coworkers, an employer, and former drinking or drugging companions. Clients may have mentioned some of the people who would offer them alcohol or other drugs in the indirect social pressure situations described above. Examples of situations in which this might be likely to occur include those where alcohol or drugs are readily available, using is, or other people with problematic substance use are present. Again, record these on the worksheet in the "Situations" column.

There is also the option of asking the Veteran to complete the ***Checklist of Social Pressure Situations*** worksheet (located at the end of this topic and in the Appendix). This tool can be used as a basis for further discussion and may lead to identification of potentially problematic situations. The Veteran is also asked to estimate how much of a problem each situation is likely to be.

Develop Skills for Coping with Social Pressure

While making the transition from assessing to focusing on coping skills, it is important to elicit from the Veteran reasons why it would be helpful to practice ways to cope with the situations just discussed. Discuss how the Veteran will likely encounter unanticipated situations and that the more preparation work ahead of time the better. Highlight the importance of rehearsing a variety of different coping strategies to enhance the ability to cope with the unexpected. It will be important to ensure that the Veteran understands that being prepared can help facilitate achievement of the overall treatment

It is important to practice and not just talk about coping strategies.

goals. This section helps the client develop several skills for coping with social pressure. It is important to practice and not just talk about coping strategies.

There are two ways of coping with social pressure:

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

The first of these involves conscious decision-making and is a strategy that people who are successful at making changes in their use often use early on. Using the ***Identifying Social Pressure Situations and Coping Responses*** worksheet, ask the Veteran to identify which situations would be best to avoid altogether to reduce the temptation to use. Write "avoid" as one coping response in the "Coping Strategies" column for each situation the Veteran plans to avoid. Anticipate and explore thoughts, feelings, and problems that could occur when the Veteran tries to avoid these situations or that could interfere with the appropriate use of avoidance as a coping strategy for these situations. Does the Veteran anticipate any negative consequences as a result of avoidance? For example, does the Veteran feel guilty about avoiding friends or family or worry about how avoiding a situation might appear to other people? Does the Veteran feel it shows weakness to need to avoid a situation where there will be a temptation to use?

Of course, people cannot avoid all situations where other people are drinking or using, or when they will experience direct pressure to use. Even if the Veteran's intent has been to avoid certain situations, exposure to them may occur by accident or choice. This raises the issue of what other coping responses the Veteran will have and use to avoid using. Emphasize the need to develop several possible strategies for situations that may be unavoidable. It is both acceptable and a good idea to record two or more possible strategies in the right-hand column for risk situations.

The primary approach for developing coping strategies should be one of asking the Veteran more than telling. While there is nothing wrong with giving clients good ideas for possible coping strategies it is always best to first ask them to suggest ways they could cope with the social pressure situations. This includes exploring examples when the Veteran successfully refused alcohol or drugs in the past. Clients usually have very good ideas about what would work, that are often better and more appropriate than the ideas a therapist might prescribe for them. It is important for the Veteran to "own" and accept the strategies that are developed collaboratively.

Clients usually have very good ideas about what would work for them, often better and more appropriate than the ideas a therapist might prescribe for them.

For situations when the Veteran believes there may be temptation to drink or use as a result of direct or indirect social pressure, ask the Veteran what coping strategies might help. Below is a list of coping strategies that could be suggested:

- Bring along a sober or supportive friend.
- Plan an escape if the temptation gets too great.
- Ask others to help by refraining from pressuring you or using in your presence.
- Practice effective "I don't drink" or "I don't use" responses.

Remember to not only draw on the Veteran's expertise, but also to use plenty of reflective listening and affirmations.

In the example below, the therapist and Veteran are discussing social pressure and how to cope with it. The situation involves both indirect and direct social pressure, but the initial focus of the discussion is on how it will feel to be around other people drinking.

Therapist: Now that we've talked about the two types of social pressure that can lead to temptation, and some of the general strategies that you might use to decrease the risk of drinking in these situations, I'd like to get a better idea of how you are affected by social pressure. I think you mentioned that you feel particularly tempted around other people who are drinking. Is that right?

Jim: Yes.

Therapist: Okay. So if we can identify all the different types of social pressure situations that you are likely to encounter, we can do some planning to help you better cope with those situations when they occur. How does this sound?

Jim: It makes sense to me.

Therapist: Tell me more about being tempted around others drinking – would you be willing to describe some of the situations in which you might find yourself around other people who are drinking?

Jim: I've been drinking on and off for many years. There are a lot of them.

Therapist: Even though there have been some significant periods that you were not drinking, with the number of years you have, it is likely you would have many examples. Perhaps it would be most useful to start with a situation that you are likely to encounter sometime in the near future. What might a situation look like for you?

Jim: Actually, I have a few Veteran friends. The wives arranged for us to play cards as couples once a month. We rotate houses and this month it's our turn to host it. In fact, it's coming up this Wednesday. Because it's my house I provide the snacks and the drinks. The guys drink plenty of beer and the wives have either wine or mixed drinks. I know there will be plenty of drinking. It's kind of a heavy drinking crowd.

Therapist: That is a good example. What concerns do you have about the evening?

Jim: I can't drink and in addition to that, I have been trying to watch my diet to control the diabetes. So, it is not going to be a whole lot of fun and I am not sure I can manage it. I've never been to one of these evenings without drinking. You know how it is – everyone's drinking and snacking on all kinds of good foods that I am not supposed to eat.

Therapist: With all that you will be trying to manage just in that one evening it is understandable that you would feel it's a challenge and have some concerns. So, do I understand that this is the first time you would be attending one of these evenings without drinking and also with having to watch what you eat?

Jim: Right. I've tried to cut down on my drinking a few times when we've played because it can get pretty crazy, but you know how it is once you get started.

Therapist: Then your experience has been that trying to cut down won't work for you in this situation. What is your goal for the game this coming week?

Jim: Well I haven't had anything to drink since I got the ultimatum from my wife. With her plan to leave me if I do drink I really don't want to start up again. I want to stay alcohol free but I don't know if that's possible.

Therapist: So are you unsure about even having the game?

Jim: With so much riding on it I would have to say yes.

Therapist: That is understandable. If you had to guess right now, what do you think it would feel like to be at the game this Wednesday without drinking?

Jim: Very strange. All I can picture is everyone laughing and talking and I would probably be miserable watching them, feeling like I was missing out on something.

Therapist: And that would tempt you to drink.

Jim: Absolutely. And it would definitely create some attention I don't want.

Therapist: So it's hard to imagine having as good a time at the game without drinking, and you also think people would pay attention to your not drinking.

Jim: I don't really know, but I think I'd feel like the oddball who can't even handle a few lousy beers.

Therapist: They would judge you, you think, for not drinking.

Jim: Well, I don't know. I've never been in this situation before. I just think I'd stick out if I'm not drinking.

Therapist: Is anyone likely to offer you a drink?

Jim: With the game being at my house, it is more likely that someone will ask why I am not drinking. Someone might also just grab a beer for me when they go to the fridge for one.

Therapist: So you'd have to be ready from the moment the evening starts to refuse drinks gracefully. How comfortable would you be in turning down a beer?

Jim: Really uncomfortable. I'm sure the other people would probably feel uncomfortable, too. I guess I'm the first one in this particular crowd to stop drinking. I'm not the only one who has a problem with alcohol.

Therapist: I see. So you're also worried that other people might feel judged or criticized personally, maybe threatened by the fact that you're not drinking. That's very considerate of you. Is there anyone in the group that does not drink?

Jim: Maybe. I've never really noticed. Well actually, now that I think of it, one of the guys didn't drink when he was going to be having a surgery. Most of the time they all seem to drink.

Therapist: So it's possible that there have been other people there not drinking and you just didn't notice.

Veteran: I don't pay much attention to what other people are drinking. No one makes a big deal out of the drinking, really, but it seems like they all drink. It's just part of the deal – snacks and beer.

Therapist: So it's not like everyone is *required* to drink. It's more like it's just *assumed*, or at least pretty available. Would you consider the people involved to be pretty good friends?

Jim: I guess. One of the guys was in the same unit I was. We all attend the same church and we have been on retreats together. One couple goes hunting with us. So, I would have to say they are pretty good friends.

Therapist: Anyone attending who already knows that you've stopped drinking?

Jim: No. It's not really something I've been ready to tell people. I suppose they'll find out eventually but I don't know. I am not really ready to let anyone know. I guess a couple of them would think it's a good idea because in the past they've told me they thought I needed to slow down my drinking.

Therapist: So at least some of your friends who attend might think it's a good idea you stopped drinking, and might even support your effort to do this?

Jim: Well, I don't know how it would go over if I announced at the beginning of the evening that I totally stopped drinking. They probably thought I just needed to cut back a bit.

Therapist: You're not sure how they might react.

Jim: They might think it's a total drag to be around me, especially when they're drinking.

Therapist: So I wonder how you're going to handle this situation.

Jim: I guess I may have to cancel the night altogether. I know if we hold it, there's a good chance I'll drink, and I just don't want to blow it.

Therapist: Would that be okay? How would you feel about cancelling?

Jim: It really would not be okay. It wouldn't be good at all. We are the hosts. You know, it really ticks me off to even have to think of cancelling. I just know I'm not feeling ready to go through a night like this without drinking at all.

Therapist: Okay. I'm writing down on this worksheet the situations that we talk about that create some social pressure. I'll give you the list when we're done. I'm also going to write down your ideas for how you're going to handle these situations to avoid drinking. So for this one I'll write down "Don't go" under this situation. Is that okay?

Jim: If I have to avoid everyone who drinks I'll never be able to socialize again.

Therapist: That must seem pretty discouraging, even lonely.

Jim: In reality, alcohol is everywhere. You can't avoid it forever unless you live in a cave.

Therapist: You're right about that. In fact, as we were discussing this situation I was already thinking about how you might in the future be able to be in a situation like this and not drink – how it will get easier for you. But right now I respect your decision that avoiding the card game this month is the best choice. In fact, people who successfully stop drinking often avoid temptation situations at first and then gradually ease themselves into some of the situations when they are more confident of their coping skills. So I don't think you're talking about "forever" here. In fact, part of our work together here is to help you prepare for dealing with situations like this in the future when you choose not to avoid them. Are there any others coming up soon?

Jim: The group of Veterans I volunteer with is being honored for the efforts made in a ceremony next month. There's going to be a lot of drinking.

Therapist: That sounds like a really special occasion – one you wouldn't want to miss.

Jim: Yeah. We really have worked hard and collected a lot of donations for local homeless Veterans and their families. We presented a sizable check to a local shelter and brought hundreds of pounds of canned goods to the food pantry. It's incredible how things have come together this past year. I want to be there.

Therapist: That's a celebration you want to be part of. Are you worried at all about how you'll handle not drinking if you go?

Jim: Definitely. I think I'll probably feel tempted to drink, but I have to go or I'll be tempted to drink because of how much it will eat away at me.

Therapist: You know one thing I hear in your words is that you are feeling a little trapped. A while ago you said that it makes you angry that you "can't" go to events with alcohol, and now that you "have to" go to this event. It sounds like you feel like your choices are really limited here.

Jim: Well, aren't they?

Therapist: No, I don't think so. At least not quite in the way I'm hearing. You *can* go to an event if you choose. You *can* decide not to go. What you're really talking about here is consequences - what you want, how you'd like things to be. Does that make sense?

Jim: Well, I guess so. But still I'm someone who can't drink.

Therapist: And you're angry about that. But what does that mean, really?

Jim: I can't drink without losing it, without screwing up.

Therapist: Exactly. You know that if you do drink, the consequences are likely to be bad – not how you want your life to be. You always *can* choose to drink and have those consequences – there's no one else stopping you. That choice is yours. What you're saying, in a way, when you say that you "can't" drink is that you *choose* not to drink.

Jim: Because of what happens when I do.

Therapist: Right. I'm sure it doesn't seem fair to you that that's how it is – that when you drink sooner or later it's a nightmare for you – but you do seem to be recognizing, even accepting that that's how it is, even if it's not fair. I really admire that – it's not an easy thing to do.

Jim: No.

Therapist: So if you do choose to go to the celebration, what do you think could create the most temptation for you at this event?

Jim: Just seeing other people laughing and talking and having a good time. I'll be able to tell they're feeling pretty good from drinking.

Therapist: And it's not possible, really, to have a good time without drinking.

Jim: I was able to enjoy myself when I was alcohol and drug free over the 4 year period. In the last year I've always been drinking when I've had a good time, though.

Therapist: So what you'd like is to go to this honoring celebration, not drink, and have a good time. Even though you've been able to have fun without drinking in the past, now it's like a new idea for you all over again. What ideas do you have about how you might be able to have a good time and not drink?

Jim: I don't really have any ideas.

Therapist: Will there be anyone else at the event that is not drinking?

Jim: One of the guys used to be in "the program" and I believe he drinks juice and club soda. Not someone I consider a good friend though.

Therapist: I wonder how it would feel to talk to him during the event if you were feeling tempted to drink, maybe even ask him for some advice about how he does it.

Jim: I suppose it's possible. He has asked me to go to meetings with him, although I've never taken him up on it. At least he would understand what it's like not to be able to drink when everyone else is living it up.

Therapist: So, that's one possibility. Talk to this particular guy – find out how he chooses not to drink. I'm going to write this down as something that might be helpful to you to get through the event without drinking. Are you planning to bring anyone with you?

Jim: No. Should I?

Therapist: Sometimes people find it helpful to bring along a supportive friend so they have someone to talk to if they're having a difficult time.

Jim: I hadn't thought about it, but I could bring someone. I don't know who would want to go to something like this, though.

Therapist: Sometimes people have friends who don't drink, who are willing to offer some support. Or it's possible you might want to ask your wife since she has said she doesn't want you drinking. It does mean asking somebody for help, though.

Jim: I guess I could think about that.

Therapist: You're not too sure about this, but let's write that down as another possible coping response for this situation. Anything else you could do in this situation that would help with the temptation to drink?

Jim: I need to make sure I always have a soda so someone doesn't shove something alcoholic in my hand.

Therapist: That sounds like a really good idea. I'll write that down too. And I wonder what you think about this some people are more comfortable if they have something in their hand that looks like an alcohol beverage – maybe ginger ale – while other people choose to make it clear that they are not drinking alcohol. What do you think?

Jim: I don't see where it would be of any benefit to pretend to drink when I'm not. I think I'd just have a soda.

Therapist: Sounds good. Now, what about an escape plan? How would you go about leaving the event if the temptation gets to be too much? Will you have your own car?

Jim: Yeah. I guess I can stay as long as I can handle it and then if I need to I'll leave. I guess that's all I can do.

Therapist: So you have several good ideas here. You might take someone with you for support. You could talk to the Veteran who is in the program about what's happening. You would keep a soda in your hand. And you would leave the event if you felt like it was getting to be too much for you rather than taking the chance of drinking. What about the possibility that someone at this event might offer you a drink?

Jim: Sure. Most everyone there will be drinking. I'm sure someone will ask me if I want a drink.

Therapist: How could you turn down the offer and feel okay about it?

Jim: I don't know. It's been so long it feels like I never have.

Therapist: This is really seems new for you. Okay, we'll come back to that situation a bit later. Are there any other situations that you think you might be in that include drinking?

Jim: There's the Wednesday afternoon post-golf gathering. I play once a week with some guys and when we finish 18 we head to the club house.

Therapist: And there's a lot of drinking there.

Veteran: You could say that.

Therapist: Anyone stay sober after the game?

Jim: No. I would have to say that no one goes home without a few beers on board.

Therapist: I wonder what it would feel like for you to go without then drinking.

Jim: I always tend to play without drinking but afterwards I think it would be really difficult. I've never gone to the clubhouse and not had at least a couple of beers.

Therapist: What do you think it would be like for you to go without having those beers?

Jim: It is hard to say. I think I would feel out of sorts. Maybe if I ordered a beer and just held onto it.

Therapist: You believe you would feel uncomfortable without a something in your hand. How do you think your friends would react if you ordered a non-alcohol beverage?

Jim: I have no idea. It might make them uncomfortable.

Therapist: This is so new that you just don't know what would happen. It might be interesting to see. Do you think they would try to get you to drink if you said you weren't drinking?

Jim: I think they would have a hard time believing I didn't want to drink. They might think it was a practical joke or something.

Therapist: And if they did feel uncomfortable, it would be harder for you to keep from drinking. You don't want them to feel uncomfortable.

Jim: Probably. I'd say that is a fairly accurate statement.

Therapist: So what do you think is the best approach for you to take for now, in order to refrain from drinking? What do you think?

Jim: I thought about going for the game and then bugging out early and skipping the clubhouse but that is really a major part of the day. It would be really hard to do that.

Therapist: Is this a situation that you think you might want to avoid for now or do you think that you want to try facing it without drinking.

Jim: I think the upcoming card game I am hosting is enough challenge. I'll probably avoid the golfing for a few weeks at least.

Therapist: Is that a problem for you in any way?

Jim It's one activity I really do enjoy. My weekly outing with the guys. It really stinks.

Therapist: Being out with the guys is fun for you. Is there anything other than playing golf that you guys do together?

Jim: We used to go catch the local ball games or different sporting events.

Therapist: Was there a lot of drinking involved in that?

Jim: Well, there was some. I have to say though it is different than drinking at the clubhouse. When we would go to a game the drinking would be variable. Sometimes one of us would either really make it a light drinking day or not drink at all. Whoever that would be would be the driver.

Therapist: So, avoiding golf seems like a good idea right now, but maybe you could suggest to your friends that you'd like to go take in a ball game instead and you could be the designated driver. Ok, I'll write that down.

For each of the risk situations on the worksheet, particularly for those likely to occur in the near future, develop at least one coping strategy and preferably more. Distinguish situations that the Veterans choose to avoid from those for which they need active coping strategies. This sets the stage for the next step.

Engage in Role Plays/Behavioral Rehearsal

The following section illustrates this important component through the scenario of refusing an offered drink. Introduce the idea of having an escalating sequence of responses for handling a social situation. For some situations, a single simple refusal will suffice. For others, it may be necessary to have a more assertive reply if the person persists, as shown below:

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

Engage the Veteran in coming up with escalating refusals when a person persists. The goal is to find a refusal that is clear and firm, yet respectful. Below is a list of points to use when coaching an assertive, effective refusal response:

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

One type of strategy to rehearse with the client is called the "broken record" technique. This technique can be a useful strategy for making a refusal when the person making the offer is persistent in the face of resistance. When a person is trying hard to persuade they may not really even hear the refusal. Using the broken record technique, the Veteran would simply repeat the same clear, single message in response to each pressuring statement. The Veteran can also acknowledge some part of the other person's statement and then go back to the simple broken-record assertion.

One type of strategy to rehearse with the client is called "the broken record" technique.

"Hey, come on out back, we're going to smoke a joint."
"No, I'm not smoking."
"Come on, just a few hits."
"No, I'm not smoking."
"Come on man, we have good stuff. We'll be right back."
"That's good, but no. I'm not smoking."
"Look man, what are you afraid of? You won't get caught."
"I'm not afraid, but no. I am not smoking."

Introduce behavior rehearsal by emphasizing the importance of being prepared and *practicing "refusal" ahead of time* to enhance skills and confidence. Present the idea of participating in a practice situation in

session where each takes on a role. Clients often find "practice" a more comfortable concept than "role-play." If the Veteran already has reasonably good social skills, the Veteran can begin in the refusal role while the therapist takes on trying to persuade use. If the Veteran is not confident with assertiveness skills, start with reversed roles in which the Veteran pressures the therapist to use while the therapist models good assertive refusal.

To construct a role-play situation, ask the Veteran to provide details about the person(s) who might make the offer, where the offer might occur, who else might be in the situation, and anything else that might influence using at the time the offer is made. Let the Veteran know that this type of specific information helps to construct a more realistic role-play so that practice can be most helpful.

Then try it out. When the Veteran is in the assertive refusal role, start off easy and build up to more difficult scenarios. Following each practice, review with the Veteran whether the role-play triggered urges to use, how refusing the offer felt, and thoughts about the refusal strengths or weaknesses. Provide feedback about the Veteran's responses. Look for specific things that the Veteran did *well*, and point them out. Let the Veteran know what was skillful about his or her response and also how they might improve the response. Coach gently. Use affirmations. Practice the same situation several times, as needed, to improve confidence and performance.

If the Veteran feels particularly stressed when refusing an offer, even though they are able to do it skillfully, then it may be appropriate to ask the Veteran to practice seeking support after refusing an offer. Who would the Veteran call, and what might be said to this person to obtain support?

In the example below, the therapist and Veteran discuss direct social pressure and rehearse refusal techniques.

Therapist: You've said that you also have had some difficulty avoiding the temptation to smoke pot when you are in situations where other people are pressuring you to use. Let's talk about some of those situations and see if we can come up with a plan to help you avoid using. Okay?
Matt: Sure.
Therapist: You mentioned earlier that you believe that when you show up for work Monday your coworker will ask you to go for a break and smoke. Is that right?
Matt: Yeah – the guys all smoke. It breaks up the day. It is sure to happen.
Therapist: Who do you think might be the one to offer you pot?
Matt: Could be any one of the guys. It might be any one of them. As I mentioned, they all smoke.
Therapist: Let's pick one of your coworkers who might be likely to ask you to smoke pot with him. Which one would it be?
Matt: I'd say Joe, he tends to start early.
Therapist: Okay, tell me a little bit about Joe. What is he like when he's asking you if you want to smoke pot?
Matt: Well, he's always headed around the back to take a few hits off a joint. He'll probably be high when I get there. He might walk over and say, "Hey guy! The weather is great. The coast is clear, how about stepping around to my "outdoor" office?"
Therapist: So he would take it for granted that you would want to smoke pot.
Matt: Yes. Without a doubt.
Therapist: How hard would he push you? How loud would his voice be when he asked you?

Matt: He's kind of a big guy and he talks pretty loud, but in this case he is not likely to be very loud, just persuasive.

Therapist: So he would be sort of quiet but forceful in asking you if you'd like to smoke pot with him?

Matt: Yes, I guess you could say that.

Therapist: Can you show me again what his making an offer might be like? Give me his voice.

Matt: "Hey! How's it going? Come on around back?"

Therapist: Okay, I have an idea what that would look like. Now, what might you say to him to avoid going out back to smoke pot?

Matt: I guess I could say, "Not right now, I just got here."

Therapist: How do you think he would take that?

Matt: He might be insulted, like I was blowing him off and maybe even being rude. After all he was offering to share his pot with me.

Therapist: So he doesn't know you've stopped using?

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

Therapist: I see. Well, it sounds like you are not exactly sure how but your plan is to refuse the offer to smoke, so I'm going to write down this situation and put "refusal" as the coping response under this situation. Does that seem right?

Matt: Yeah.

Therapist: Let's talk a little bit more about how to refuse that offer in a way that you'll feel comfortable with and also will give Joe a clear message. I am wondering if you might feel comfortable that he would leave you alone if you said "Not right now, I just got here."

Matt: I don't know. I've never said that before. It seems okay, might work.

Therapist: I like the directness of it. You're saying no clearly. There is one concern I have about the way you said it, though. I'd like to share it with you.

Matt: Sure.

Therapist: I wonder if it leaves the door open to the possibility that you might want to go out and smoke with him later. You say, "I just got here," which kind of implies that you'll be interested later.

Matt: I see what you mean.

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

Matt: How about, "I'm not smoking pot anymore."

Therapist: I think that is good. It is simple and clear. Now let's try this situation again. This time I'll be Joe and you be yourself. Respond as you would if your co-worker were asking you to smoke a joint with him. Let's say we're at work. You just arrived and are headed in. You see Joe headed toward you and you know he's going to ask you to step around back with him. You can tell he's high and is feeling pretty good. He says, "Hey, what's happening, guy?"

Matt: Not much.

Therapist: It is a beautiful morning, coast is clear, come on and step this way to my "office"!

Matt: Not a bad morning at all, I am just going to go on inside.

Therapist: Hey what's this, don't want to hang with me for a few, huh? I was just about to step around back and smoke a joint. Join me.

Matt: No that's not it. I appreciate the offer, but you know – I'm not smoking pot anymore.

Therapist: What do you mean? On a morning like this, what's wrong with just a puff or maybe two?
Matt: I'm not smoking pot anymore. That's it.
Therapist: Man, you always do this at the worst times. What's with you? You know you're not going to stick with this.
Matt: What's with me is that I decided not to smoke. I'm not smoking pot anymore. I'd really appreciate it if you'd respect my decision on this and it would be great if you could support me. I've decided to stop smoking pot and let's leave it at that. Now I'm going to go in and get set up. I'll talk to you later.
Therapist: Whatever.
Therapist: *(out of role)* So, how did that feel to you?
Matt: I felt kind of tense, but actually I think it went pretty well. I felt like I really got my point across and didn't hang around too long to get into an argument.
Therapist: I agree. I felt like you were clear with Joe without being defensive. Sounds like you might need to talk to him at a later time if he continues to bug you. What do you think?
Matt: Probably, he would.
Therapist: What do you think you might say?
Matt: Same thing. I've decided to stop smoking pot and I don't want you to keep asking me about it. If you don't back off I'm not talking to you anymore.
Therapist: Sounds pretty clear. You know, I liked even better what you said before – asking him to respect your decision. But you're right – you might have to set a hard line if he doesn't support you.
Matt: I just hope I can say that when the time comes.
Therapist: Why don't we practice it one more time?

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

Therapist: Is there another situation in which someone might offer you a drink?
Jim: Well, usually Friday nights early in the evening. A group of us, we are all Veterans, we go out on Fridays to one of the local service organizations- a few have pretty good fish dinners and mostly it's the same group of us guys that get together and go. They have cheap pitchers of beer on Fridays and that is what we order. We work it so each one of us catches a pitcher for the table.
Therapist: Tell me a little bit more about what happens after you sit down at the table.
Jim: Well, the bartenders know us pretty well. When we walk in they usually start pouring a pitcher right away and call out a hello. Something like, "Hey, how are you – The usual for you men tonight?"
Therapist: And that means pitchers of beer?
Jim: Right. Two usually gets us started.
Therapist: Who usually does the ordering when the bartender asks you this?
Jim: Any one of us. It doesn't really matter. The answer is always, "Yes" and the pitcher is typically nearly full within a short time after we arrive.
Therapist: Does anyone ever order anything else?
Jim: Once in a while one of the guys who still works and doesn't usually come with us will order a mixed drink or someone's spouse will come along and order something else. One guy who was dealing with some kind of medical issue came and he ended up ordering a club soda.
Therapist: So it's possible. How do people react when someone orders something different?

Jim: Well, as far as I can recall, no one said anything about it. I think it was probably seen as understandable.

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

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

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

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

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

Jim: I'd be seen as a real wimp that couldn't hold my liquor. They might think I was sick. I don't know.

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

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

Therapist: So, you're feeling like it would be pretty awkward for you to order something without alcohol in this situation. Remember, one option you always have is to avoid the situation altogether, at least for a while. Have you thought about whether you want to continue going on Friday nights given the way you feel?

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

Therapist: How important is it?

Jim: It's very important. I want to do it.

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

Jim: Sure.

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

Jim: Cindy.

Therapist: Okay. Here we go *(stands up)*. "Hi guys! Happy Friday to you. What'll it be? The usual? Okay, I'll be right back with those pitchers *(turns to walk away)*.

Jim: Hey, Cindy, could I have a club soda with lemon please?

Therapist: Sure – no problem. Feeling a little under the weather?

Jim: No, I'm fine. I'd just like a club soda thanks.

Therapist: Okay. *(Breaks role)*. How did that feel?

Jim: Not bad. I think that would be okay. It's what the guys say to me next that I worry about.

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

Jim: Thanks.

Therapist: So Cindy just left the table.

At the end of each session, summarize the situations the Veteran feels are risky for resuming substance use as a result of social pressure. Also, review the kinds of coping strategies the Veteran has chosen to rely on to make changes in substance use. Emphasize the different possibilities for coping with social pressure, including avoidance, escape, using social support, and refusal. Discuss with the Veteran where additional practice is needed to increase confidence in refusal skills before moving on, or how ready the client is

to move on to another topic. Continue to record risk situations and coping strategies on the worksheet throughout the session(s). Use as many worksheets as needed. Provide the Veteran with a copy at the end of the session.

Identifying Situations that Call for Assertive Communication

The first step in teaching clients to become more assertive is to help them identify situations that call for assertive behavior. Do this by asking the Veteran to identify times or experiences that typically elicit strong emotional states such as anger, resentment, embarrassment or frustration. Frequently, clients are adept at naming particular situations that produce strong emotions, but it helps sometimes to have a list of such situations available. A few examples are shown in the ***Examples of Situations Where Assertive Communication Is Needed*** handout. A copy of the handout is provided at the end of this section and in the Appendix.

Another important step in teaching assertiveness involves a discussion about basic beliefs. Explain that for people to be effective, assertive communicators there are two general beliefs they should hold or at least agree with (listed below). Be sure to ask Veterans what they think about the information that is presented.

1. I have a right to express my feelings, make requests for a change in behavior that affects me, and agree or disagree with what other people say.
2. All other people have a right to express their feelings to me, make requests for a change in my behavior that affects them, and agree or disagree with what I say.

It can be useful to discuss these basic beliefs with clients, and ask whether they agree with each of them. In the process, some basic assumptions may be uncovered that need to be addressed for the Veteran to accept assertive communication.

In the following example, the therapist introduces this topic and uses the ***Examples of Situations Where Assertive Communication Is Needed*** handout to explore situations in which the client needs greater skill in assertive communication.

Therapist: So as we discussed last time, today we're going to work on assertive communication skills. Okay?

Matt: Yeah, I guess so. I'm not really sure what you mean.

Therapist: Well, that's a great place to start. Most people can benefit from some practice in assertiveness. What that means is skill for good communication, expressing your feelings, or getting your point across in a way that is respectful of both yourself and the other person. I plan to explain this in more detail to you today, and I hope we can also spend some time practicing. How does that sound?

Matt: Sounds all right to me.

Therapist: Good – well the first thing we need to do is to make a list of some situations where more assertive communication might be helpful to you. One good indicator of this is situations in which you feel emotional red flags around other people – negative emotions, like when you feel nervous, or resentful, or irritated by someone, or when you feel put down. Those are good times to have some assertive communication skills handy.

Matt: Yeah – I can see that.

Therapist: Here's a list, for example, that shows a few situations where people might need good communication skills. Do any of these sound like situations that you encounter sometimes?

Matt: Well, sure – just before I came into treatment, I got a traffic ticket and had to deal with a cop. And recently I've been really irritated with a couple of my co-workers. They say some things about me that really make me mad.

Therapist: Great – now that first example would fall under this category – of dealing with an authority figure, so I'll circle that one. What other real situations might be coming up where it could be helpful for you to have good assertive communication skills?

Matt: I'm due to go to court in a couple of weeks.

Therapist: All right – that's a good example. I'm going to write that down here on these extra lines. What else occurs to you?

Matt: I have to ask my dad for some money to cover me for a few days. I hate asking him for anything and I hate for him to know that I don't always make enough to take care of my bills. It makes me nervous and mad at the same time.

Therapist: These are great examples. What else?

Matt: That's about it, I guess.

Therapist: Okay. We may think of some more later, but that's a great start. Now that we've got these situations identified, I'd like to explain a little more about how assertive communication works, and then we'll have some time to try some practice with these skills. With these situations, we can use examples that will be really meaningful to you.

After the worksheet is completed, move on to describe assertive communication and how it differs from passive and aggressive styles. Ask clients to share what they already know about assertive communication. It may be necessary to explain the differences among passive, aggressive, and assertive communication. This will be dependent on the Veteran's level of knowledge about these communication styles. When information is being provided to the Veteran, use the EPE format. Throughout this process, engage the client actively in the discussion. Avoid any long spans of time talking while the Veteran is just listening passively. Ask for and encourage feedback, examples, questions, disagreement, concerns, and so on.

In the example below, the therapist defines these communication styles:

Therapist: So, now that I've explained the basics, I want to be sure that you're clear on the differences between these three styles of communication: passive, aggressive, and assertive.

Matt: Okay – let's see. I know that if I shout at someone, or tell them off, that's aggressive.

Therapist: Very true; that is indeed aggressive communication. Aggressive communication occurs whenever someone acts on their own thoughts or feelings while running directly over the listener's rights. Yelling, name calling, shouting someone down – those are all types of aggressive communication. Why do you think people sometimes use aggressive communication?

Matt: Well – it usually makes you feel better. At least when you really say it like it is, you get some of the steam out.

Therapist: At least in the short term, you feel as though you are accomplishing something, getting it out.

Matt: Right. It works. It gets through. Just a few weeks back I told one of my co-workers to get off my case, or I would lose it. He stayed away from me the whole rest of the day.

Therapist: And is he still leaving you alone?

Matt: Not really. He is in charge of the schedule and I'm pretty sure he purposefully signed me up for weekend shifts when he knows I don't want them. He hasn't been talking to me anymore though.

Therapist: Sounds like you got what you wanted in the short run, but it cost you something in the long term.

Matt: I hadn't really thought of it that way. I just haven't been enjoying my job much and I'm just not in a great mood when I'm there.

Therapist: Let's step back from this example for a minute. You've told me some of the reasons why people use an aggressive style sometimes. What do you see as some of the less good things about an aggressive style?

Matt: Well, I guess it doesn't last. I mean, you get an immediate jump, but then you're right back where you started or worse.

Therapist: In what ways?

Matt: Even if you win, then the person has it in for you and you have to watch out all the more.

Therapist: It's more like a competitive game than a relationship.

Matt: Well – yeah. Me against them.

Therapist: I think you're really getting the idea here. In talking about your communication, you correctly labeled telling your co-worker off as an example of aggressive communication. You also recognize that it felt good in the moment, and even got you what you wanted in the short run, but that in the long run his scheduling looks pretty discouraging. You also described very well the opposite extreme of communication – the one that your co-worker uses.

Matt: I don't get what you mean.

Therapist: Your co-worker communicated with you after you told him off – by not communicating. He used a passive communication style. Instead of talking with you he assigned you a schedule you don't want and never said anything about why he was doing it.

Matt: I knew what he was doing, though.

Therapist: Well, that's the point. He was communicating with you, but not very clearly. He may have been angry, or you may have scared him, or maybe he just had to schedule someone to work weekends. The problem with passive communication is that it is so open to interpretation, that you have no way of knowing if your interpretation is correct, unless another type of communication is used. He wasn't communicating with you in a very direct or helpful way.

Matt: That's for sure.

Therapist: Any more than you're likely to get a better co-worker by communicating with him in an aggressive way.

Matt: Okay, okay! I understand aggressive, and I see what you mean about passive. So what's this other way of talking?

Therapist: Good question! Let's use this same example. Either you or your co-worker could have communicated assertively, and it might have helped the situation go better. Instead of basically threatening him, you could have expressed your feeling of frustration and asked if he would be willing to treat you in a little different way. He could have asked you not to raise your voice when asking for a change, and told you directly that he didn't like it rather than just scheduling you to work on weekends. If both of you had communicated assertively, it would have gone even better, but you can make a real difference just by how you communicate yourself.

Matt: Easier said than done.

Therapist: You're right – it's not easy at first. Like anything else, it takes time to get the hang of it, but in the long run it's worth it. But it sounds like you get the basic idea now.

Matt: I think so. Usually, the most effective way is to be direct, but not in a way that sets the other person back.

Therapist: Exactly. Now that you have the "why," the next step is to get some basic "how to." There are a few simple rules you can remember, that are really helpful. And then we'll still have some time to start some practice today, and I'll give you some things to try this week before we get together again.

Practice Assertive Communication

Assertive communication involves skills that take practice. Engaging the Veteran in role-plays during the session is essential.

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Begin by giving the Veteran a copy of the ***Basic Tips for Assertive Communication*** sheet. This sheet is available at the end of this section and in the Appendix. Then proceed with role-play practice of assertive communication skills.

Practice "I" Statements. A fundamental skill to teach here, which is applicable across many forms of assertive communication, is the "I" message (Gordon, 1970). The basic idea is that when expressing a feeling or opinion, the sentence should begin with "I" rather than "You." This makes it clear that the person is expressing a personal feeling or opinion, and is less likely to elicit defensiveness from the listener.

There are various levels of complexity to "I" messages. The most basic is "I feel . . . ." Even here, people mix up feelings with opinions. The expression "I feel that . . . . ." is not a feeling, but an opinion. If the word "that" can be logically inserted, what the person is expressing is not a feeling. In a true feeling statement the word "that" doesn't fit, as shown in the two examples below:

I feel that this conversation is going nowhere. (not a feeling)

I feel frustrated. (feeling)

Another component of a clear "I" message can tie it to a particular situation or action of the other person. "I feel _____ when you _____" is more clear, less likely to be perceived as blame, than a "You" message. Examples of both types of sentences are below:

You never talk to me! ("you" message)

I feel lonely when you keep quiet like this and don't talk to me. ("I" message)

Again, this is likely to be only an idea, quickly lost, unless the Veteran can apply and practice it in personally meaningful contexts. Ask about recent situations when the Veteran had a strong feeling, and things didn't turn out as well as the Veteran would have liked. Explore how (if) the Veteran expressed his or her own feelings, opinions, or preferences in this situation. Practice different ways in which the Veteran might have communicated assertively. Consider how others might have responded differently.

Practice Asking for a Change. Rehearse with clients how to ask someone for a change in their behavior. Assertive people decide what they want, plan an appropriate way to involve other people, and then act on this plan. Explain to the Veteran that the most effective plan usually is to clearly state one's own feelings or opinions in a respectful way, and directly request the change that one would like from others. Assertive people do this without using threats, demands, blaming, or negative statements directed at others. When communicating assertively, people are more likely to say what they mean, and less likely to get sidetracked on other issues. As a result, the person is more likely to have their needs met.

Share with the Veteran the three parts of assertive change messages (Husztı, 1997) described below:

1. Describe the behavior.	Describe (but don't criticize) what the other person is doing. Be sure you are describing behaviors and not calling the other person names or making accusations.
2. Describe your feeling or reactions.	This is a brief description of how you feel about the behavior or how it affects you.
3. Describe what you want to see happen.	This is what you would like the other person to do differently.

Engage Veterans in role-plays that are relevant and meaningful to their lives. Ask the Veteran to use "I" messages to request a change. Practice including the three parts of assertive change messages described above.

Closing the Session/Planning the Home Assignment

As always, at the end of session, conduct a final summary or, alternatively, have the client summarize the most important lessons gleaned from the session. In addition to summarizing content, consider including an affirmation of the Veteran's efforts or strengths. Also ask about how the Veteran felt about the session, especially if a particularly upsetting or sensitive topic was discussed. When relevant and time-permitting, begin home assignments in session so that clients have a model when they attempt to complete it on their own. See the section titled General Structure (pages 10-11) for additional guidance on closing a session and planning a home assignment.

Below are several home assignment options. Remember to collaboratively choose home assignments with the Veteran.

1. Self-monitor urges and cravings using the ***Urge Monitoring*** cards.
2. Complete the ***Three-Column Thought*** Record.
3. Complete the ***Five-Column Thought Record-Urges.***
4. Continue to *practice refusal skills with a supportive significant other.* Specify the types of situations and the number of times to practice.
5. Complete the ***Identifying Social Pressure Situations and Coping Responses*** worksheet.
6. Return to the ***Identifying Situations That Call for Assertive Communication*** handout and identify situations for which the Veteran will practice assertiveness skills in between session.
7. With the Veteran, decide on a specified number of times to practice assertive communication between sessions. It may be helpful for the Veteran to review the ***Basic Tips for Assertive Communication*** prior to each time practicing the skill.

Checklist of Social Pressure Situations

To what extent do you expect that these situations could pose a problem for you in achieving your treatment goals?

	No Problem	Some Problem	Big Problem
1. I am around other people who are drinking and/or using other drugs.			
2. Someone who is important to me is still drinking and/or using other drugs.			
3. Family members disapprove of my not drinking and/or using other drugs.			
4. Friends disapprove of my not drinking and/or using other drugs.			
5. Other people feel uncomfortable because I am not drinking and/or using other drugs.			
6. People offer me a drink and/or other drug.			
7. I am embarrassed to tell other people that I am not drinking and/or using other drugs.			
8. Someone I live with is a drinker and/or uses other drugs.			
9. Most of my close friends drink and/or use other drugs.			
10. I go to parties and celebrations where there is drinking and/or other drug use.			
11. I try to help someone who drinks and/or uses other drugs too much.			
12. Someone I love drinks and/or uses other drugs too much.			

Identifying Social Pressure Situations and Coping Responses

Situation	Coping Response

Examples of Situations Where Assertive Communication Is Needed

1. When dealing with people in authority (as in asking for a raise, talking to a police officer about a ticket, discussing treatment with your doctor).
2. When expressing anger or criticism, especially to people who are important to you.
3. When receiving criticism from someone, especially from people who are important to you (as in explaining yourself, taking responsibility for your actions, apologizing to someone, or making amends).
4. When expressing positive feelings or complimenting someone.
5. When accepting a compliment or receiving positive feedback from someone.
6. When refusing a direct request from someone.
7. When making a request or asking for help, a favor, or support from someone.
8. When expressing an opinion.
9. When…

10. When…

11. When…

Basic Tips for Assertive Communication

Use an "I" Message	When you are expressing yourself (your thoughts, feelings, opinions, requests) begin with the word “I” rather than “You.” By starting with “I” you take responsibility for what you say. Statements that start with “You” tend to come out as more aggressive, blaming, threatening, and so on.
Be Specific	Address a specific behavior or situation and not general “personality” traits or “character.” A specific request, for example, is more likely to result in a change, whereas general criticism is unlikely to get your needs met.
Be Clear	Say what you mean. Don’t expect the other person to read your mind, to just “know” what you want or mean. When you make a request, make it clear and specific. When you respond to a request, be direct and definite. “No, I don’t want to do that,” is clearer than, “Well, maybe . . . I don’t know.” Your facial expression and body language should support your message. Speak loudly enough to be easily heard and use a firm (but not threatening) tone. Look the person in the eye (not at the floor). Don’t leave long silences.
Be Respectful	Don’t seek to intimidate, win, or control the other person. Speak to the person at least as respectfully as you would like to be spoken to. If you have something negative or critical to say, balance it with a positive statement before and after. Recognize that people have different needs and hear in different ways. In conflict situations, take partial responsibility for what has happened and is happening.

Elective Components

This manual contains five different elective categories of cognitive behavioral strategies that are often useful in treatment (e.g., Problem Solving). Again, the case conceptualization will guide therapist and client in making decisions about which strategies will be most useful and how many sessions will be spent on a particular category of strategies. The elective cognitive behavioral strategies build on many of the basic core strategies covered in these initial sessions. For instance, the section on coping with cravings and urges introduces the Veteran to cognitive restructuring while the elective component on mood management builds on the cognitive restructuring skills developed in these initial core sessions.

Mood Management

Mood Management: Therapist Information Sheet

Recommended session content

Below are some suggested guidelines for covering the content.

Session 1: Reviewing the Relationship Among Situations, Thoughts, and Feelings, and Identifying Patterns in Unrealistic Thinking

Session 2: Cognitive Restructuring, and Addressing Behavior

Background

Some people report using substances in an attempt to cope with negative moods. The strategies covered in this topic provide an alternative, adaptive way to cope with negative moods. The perspective a person takes on events that occur influence their mood. Examples of different moods are happy, sad, angry, and anxious. Moods are transitory and temporary. Negative mood states can compromise the efforts people make to stop or reduce their use of substances.

The purpose of this section is to provide Veterans with further instruction in the use of cognitive behavioral techniques. Clients will build on the skill of cognitive restructuring that was introduced in the section on cravings and urges. Instead of applying cognitive restructuring to urges and cravings to use, Veterans will learn to challenge and replace unhelpful, inaccurate thoughts that contribute to negative moods.

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

As a general rule, people do not expect things to change when they attribute a situation to a stable cause but do expect change when they attribute a situation to an unstable cause. People usually have a somewhat optimistic attitude, attributing successes to internal and/or stable causes but failures to external and/or unstable causes. Though a bit self-deluding, this normal attributional style is one that encourages a positive outlook and continued personal effort.

Negative mood and depression are associated with a rather different attributional pattern. When people are in the midst of depression, they tend to attribute negative outcomes to stable, generally negative characteristics of themselves.

Once a person begins to experience a negative mood, how they respond to that feeling can make a big difference. Be alert for two generally maladaptive response patterns, avoidance and aggression, that often follow from negative mood.

Avoidance

A common and often unhealthy response is avoidance, or withdrawal. The reaction may seem quite understandable, even natural. When a person is feeling down or experiencing low self-esteem, they feel like poor company. They may not feel up to usual social contacts or may not want others to see them in this dejected state. Feelings of fatigue may contribute to the tendency to avoid and withdraw. Yet avoidance tends to strengthen negative emotions. If a person, once thrown from a horse, continues to avoid horses, they will become even more afraid of them. Depressed individuals who withdraw from their social support network are cutting themselves off from important sources of feedback and reinforcement, which in turn amplifies the depression. The general remedy here is to do the opposite of the seemingly natural tendency to withdraw. For the depressed person, it is important to continue seeing friends and engaging in previously pleasurable activities, even though it requires an effort and may not immediately feel pleasant. The same applies to feeling down and suffering from low moods.

Aggression

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

Mood Management: Implementing the Session(s)

Overall Goal

Assist Veterans in learning how to restructure automatic thoughts and challenge maladaptive behaviors so that they have greater control over the frequency and intensity of negative moods.

Cognitive Behavioral Strategies

- Reviewing the Relationship Among Situations, Thoughts, and Feelings
- Identifying Patterns in Unrealistic Thinking
- Cognitive Restructuring
- Addressing Behavior

Materials

- BAM or BAM-C (consult Figure 3)
- Other assessment measures (consult Figure 3)
- Breathalyzer and urine drug screen (consult Figure 3 and as clinically indicated)
- Exploring Triggers handout (for the functional analysis)

Structure of Session(s)

✓	Bridge from previous session
✓	Functional analysis (as indicated)
✓	Agenda setting
✓	Discussion of agenda items/Cognitive behavioral strategies: Mood Management
✓	Closing the session/Planning the home assignment

Beginning the Sessions

As with each session, begin with a bridge from the previous session, followed by a functional analysis, and set the agenda. Detailed instructions for each of these tasks are provided on pages 11-13 in the section titled "General Session Structure." If the Veteran is also receiving pharmacotherapy, this is a good time to check in about how that is going and whether or not the Veteran is using medications as prescribed.

Discussion of Agenda Items/Cognitive Behavioral Strategies

Provide a Rationale

Always preface the discussion and practice of cognitive behavioral strategies by providing a rationale. Read the information provided in the Therapist Information Sheet and substitute words that provide a rationale in a way that the Veteran will understand. Check in with the Veteran to determine if the rationale is understood.

Explain that negative moods (e.g., anxiety, irritability, depression) are common among people making changes in substance use. Consider saying something similar to the following:

Therapist: Moods may relate to the effects of stopping alcohol and/or other drugs, or the losses (e.g., family, job, finances) that resulted from using substances. Difficulties with negative moods (e.g., depression) may have started before substance use and may serve as a trigger for continued use. Often times, mood improves for individuals who stop using substances altogether, but some individuals experience depression or other negative moods even after being abstinent for several weeks. Because negative moods often pose a risk for returning to use or increasing use, we want to address them directly during treatment. What are your thoughts on that?

Reviewing the Relationship Among Situations, Thoughts, and Feelings

It is helpful to review the ***Situations, Thoughts, and Feelings*** handout that was used in the section on cravings and urges. Explain that the model is also useful both in understanding negative moods and in finding ways to change them. Use the material to tailor an explanation appropriate to the Veteran's cognitive style and level of conceptual understanding.

Start this section with a discussion of how certain types of thoughts lead to negative emotions. Emphasize that emotions are transient, tending to come and go. For an emotion such as anger to persist, it has to be fueled by thoughts. Going over and over certain thoughts is like putting logs in the fireplace. If no one feeds the fire it eventually goes out. Ask clients for examples to determine the extent to which they grasp the concept.

In the exchange below, the therapist uses reflections and questions to identify the situation, thoughts and feelings surrounding a recent event in the client's life.

Matt: I'm typically fine. That is until I'm not.
Therapist: Okay, that's a start. What kinds of situations might contribute to you becoming "not fine"?
Matt: People don't know how to drive. Yesterday someone was following way too close to me, and then passed me, got in front of me, and slowed down.
Therapist: Okay. So the way the person was driving was one thing. What else was going on that might have influenced your mood?
Matt: The air conditioner in the car was broken and it was really hot.
Therapist: Good. What else?
Matt: Well, I got off work late and I was running behind.

Therapist: The way the person was driving, the temperature in the car, and being late. You've given me some really good examples of aspects of a situation that contributed to a negative mood for you. Now let's talk some about the thoughts and feelings that are present in that situation. You are stuck behind this person and you were feeling a strong mood. What name would you give that mood?

Matt: I didn't feel anything in particular. I just thought about what jerks people are, and how I wished I was anywhere but there. I kind of wanted to get high.

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

Matt: I guess you could call it irritated.

Therapist: You felt irritated, possibly even angry. What thoughts, specifically, were you having?

Matt: I was angry. And I was thinking that I'd be able to deal better with that other driver if I was high. I'm glad I didn't get high.

Therapist: So even though you had the thought about getting high, you made a decision not to use. What other thoughts were you having?

Matt: I remember wondering why this guy wanted to get me all worked up. I think he was trying to start something with me.

Therapist: So the thought you had about the situation was that the other driver was intentionally trying to start something. And that thought probably contributed to you feeling angry.

Identifying Patterns of Unrealistic Thinking

Veterans will be familiar with evaluating automatic thoughts because of prior work with cognitive restructuring in the context of urges and cravings. As a review, it is good to remind the client that the thought-changing process is a two-step process. First, the Veteran needs to recognize the automatic thoughts, to catch them as they go by. Second, the Veteran needs to learn to replace them with more balanced and realistic thoughts. In order to extend what the Veteran already knows about cognitive restructuring, this section will focus on how to identify patterns in unrealistic thoughts.

As Veterans begin to identify their unhelpful thoughts, they may begin to notice specific patterns in the types of thoughts. Veterans may even begin to notice that they have a particular style of interpreting events and situations. These styles are referred to as types of *cognitive distortions*.

As Veterans begin to identify their unhelpful thoughts, they may begin to notice specific patterns in the types of thoughts.

In some cases it may be helpful to introduce Veterans to a list of cognitive distortions (similar to the one on the following page). However, for most clients it will likely be enough to share a limited amount of information about relevant cognitive distortions. For some, it is useful to see that they are prone to making a small subset of the cognitive distortions. Once clients recognize specific cognitive distortions, they may begin to conceive of ways to correct certain cognitive patterns rather than having to address numerous negative automatic thoughts. It is best to become familiar with the different types of these cognitive distortions. It is important to have a good understanding of cognitive distortions in order to form relevant questions for the Veteran.

Below are some common cognitive distortions: [11]

All-or-nothing thinking	Viewing a situation in only two categories instead of on a continuum.
Catastrophizing	Predicting the future negatively without considering other, more likely outcomes.
Disqualifying the positive	Unreasonably telling yourself that positive experiences, deeds, or qualities do not count.
Emotional Reasoning	Thinking something must be true because you "feel" it so strongly, ignoring evidence to the contrary.
Labeling	Putting a fixed, global label on yourself or others without considering that the evidence does not support such an extreme negative conclusion.
Magnification/ Minimalization	When you evaluate yourself, another person, or a situation, you unreasonably magnify the negative and/or minimize the positive.
Mental Filter	Paying a lot of attention to one negative detail instead of seeing the whole picture.
Mind Reading	Believing you know what others are thinking.
Over-generalization	Making a sweeping negative conclusion that goes far beyond the current situation.
Personalization	Believing others are behaving negatively because of you and not considering other possible explanations.
"Should" and "Must" Statements	Having a fixed idea of how you or others should behave and overestimating how bad it is that these expectations are not met.
Tunnel Vision	Only seeing the negative aspects of a situation.

[11] © J. Beck, 2011. Adapted from *Cognitive Therapy: Basics and Beyond, Second Edition* and used with permission.

Cognitive Restructuring

Begin by having the Veteran identify a recent situation in which a negative mood was experienced. Have the Veteran record the situation, along with any associated thoughts and feelings in the ***Five-Column Thought Record-Mood***. This is very similar to the thought record the Veteran used earlier in treatment except (a) the situation being identified is a situation that triggered a negative mood rather than a situation that triggered an urge or craving, and (b) the Veteran is asked to rate the intensity of the initial feeling and re-rate that intensity again after developing an alternative, more realistic thought.

Once thoughts and thought patterns that lead to negative emotions have been identified, work together to find ways to challenge and replace those thoughts. Again, emphasize that this perspective is a matter of choice. Rather, the Veterans can choose how to think about situations, and thus have some choice about how to feel and act as well. It is not the therapist's job to prescribe for clients the "correct" or "rational" thoughts that they ought to have. It's fine to suggest different possible interpretations if they get stuck, but always first invite clients to suggest different ways of looking at situations and feelings.

It is inconsistent with this treatment's overall style to argue with Veterans about whether or not their thoughts and beliefs are correct. Instead, invite the Veteran to consider how else it would be possible to view or interpret the same situation. Perhaps say something similar to, "This is an opportunity to evaluate your own thinking. Not necessarily how I think you should think." Explain that no matter what the situation is, they always have the freedom to choose how to think about and understand the situation. This perspective, in turn, provides a Veteran the freedom to choose how to feel about life as well.

It is inconsistent with this treatment's overall style to argue with Veterans about whether or not their thoughts and beliefs are correct.

Below is an example of the therapist and Veteran using the ***Five-Column Thought Record-Mood***. Following the dialogue is a sample ***Five-Column Thought Record-Mood*** that has been filled out based on the Veteran's report.

Therapist: What we're going to focus on today is how your thoughts affect your moods and what you can do about that. Sound okay?
Laura: Sure.
Therapist: Let's look at a recent time when you experienced a negative mood.
Laura: Yeah – Friday night was particularly bad. I was really down.
Therapist: Well – close your eyes for a minute, and imagine it's Friday night again. You're sitting in the chair at home alone, channel surfing. What are you saying to yourself?
Laura: Here I am on a Friday night, watching television by myself.
Therapist: Any thoughts going through your head at that time? Negative ones?
Laura: Well... What a loser I am!
Therapist: A loser – and that kind of says, "It's just how I am. It will never get better." Does that sound right?
Laura: Uh huh.
Therapist: So how are you feeling? Can you feel it now?
Laura: Lonely. Down . . . discouraged.
Therapist: How intense is the feeling, one a scale of 0 to 100?
Laura: I'd say 85. It was bad.

Therapist: It makes sense that it was intense. The way you're describing your thoughts, the problem is *who you are* – if this is something hopeless that can never change, then of course you feel that way. It follows. That's the kind of thought that can very much impact mood.

Laura: I can see that.

Therapist: Are you willing to try to pick some weeds here, clean out the garden a little? And by that I mean work on challenging some of those thoughts.

Laura: Sure.

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

Laura: Not really – but I do think that there's a good chance things won't improve. At least I think that some of the time.

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

Laura: No, I'd say there's a 25% chance that things will improve.

Therapist: The doctor only gives you a 25% chance of having a life. Are you going to take the doctor's word for it?

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

Therapist: Yes! A second opinion. That's good!

Laura: Yeah – I don't know about this.

Therapist: You're not too sure you can do this – maybe a 25% chance?

Laura: *(Smiles)*.

Therapist: I agree. It's not easy. Here – let's take a look at that thought about things never getting any better. I'm going to use this sheet here. (Takes out ***Five-Column Thought Record-Mood***.)

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

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

Laura: Okay, I guess. Yeah – I had some stuff to do, and I hadn't drank anything Friday night, so I was feeling a little better.

Therapist: Your mood was improved the next day.

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

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

Laura: It would have been much worse. I probably would have ended up crying myself to sleep. Okay – I see where you're headed with this. I have some choice about what happens.

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

Laura: Right.

Therapist: Now, just use your imagination. *What else* could you have said to yourself, sitting there at the television, besides, "I'm a loser, and I'm always going to be a loser."

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

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

Laura: A little more peaceful, maybe. Less discouraged.

Therapist: Peaceful. Okay. I'll put that in here. How would you re-rate feeling discouraged?
Laura: Less. Maybe a 50.
Therapist: Okay, great. I think you've got this. How about we take another example and you walk me through it this time.

Situation Describe the people, place, or thing that led to the negative mood.	**Thought** Write down any automatic thoughts (or self-talk) you had about using.	**Feeling** What feeling(s) did you experience? (Rate on a 0-100 scale)	**Alternative, Realistic Thought** Use the questions to come up with a more balanced, realistic thought.	**Outcome** Re-rate the intensity of the feeling listed in Column 3 or list a new feeling you are experiencing.
Home alone Friday night watching TV	I'm a real loser. It's never going to change. I'm always going to be this way.	Lonely, down, discouraged (85)	I'm feeling lonely right now, but I'll probably feel better in the morning. What else could I be doing besides sitting here watching TV?	Less discouraged (50) Felt a little more peaceful (40)

Addressing Behavior

In the same way thoughts have been examined, it is also important to examine what the Veteran *does* in specific situations and how behavior may contribute to negative mood. Also, explore what else the Veteran *could have done* instead. As with thought substitution, the idea is to emphasize choice. Common examples of behaviors that may serve to reinforce negative moods are: withdrawing, arguing, sulking, drinking, getting high, driving aggressively, smoking, overeating, criticizing, or blaming.

In the same way thoughts have been examined, it is also important to examine what the Veteran does in specific situations and how behavior may contribute to negative mood.

As before, it is not the therapist's job to confront, criticize, or correct the client's behavior. Instead, invite Veterans to consider, as a mental exercise or experiment, what else they could have done, and what different consequences might have followed as a result.

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

Therapist: Now a piece we haven't talked about yet is how what you do can also influence how you think and feel. Looking back at your Friday night, you say you were watching TV alone. And doing

that, you felt lonely, discouraged, down. Now what are some other possibilities? What else could you have done when you were feeling that way?

Laura: I could have had a few drinks.

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

Laura: Like I said, I would have felt a lot worse on Saturday. I would probably have stayed home on Saturday all day, instead of going out and getting some exercise.

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

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

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

Laura: I don't know – when I'm in that mood it's best just to be alone.

Therapist: I hear some mood magnifying thoughts right there!

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

Therapist: AA is a great idea. You can meet people at meetings. You can also meet them at other places too. The Thursday night newspaper every week has pages of things that are happening in the community. And going out and doing something around other people is just one set of possibilities. What else could you do?

Laura: You mean like call somebody on the phone?

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

Closing the Session/Planning the Home Assignment

As always, at the end of session, conduct a final summary or, alternatively, have the Veteran summarize the most important lessons gleaned from the session. In addition to summarizing content, consider including an affirmation of the client's efforts or strengths. Also ask about how the Veteran felt about the session, especially if a particularly upsetting or sensitive topic was discussed. When relevant and time-permitting, begin home assignments in session so that Veterans have a model when they attempt to complete it on their own. See the section titled General Structure (pages 10-11) for additional guidance on closing a session and planning a home assignment.

Below are several home assignments options. Remember to collaboratively choose home assignments.

1. Self-monitor urges and cravings using the ***Urge Monitoring*** cards**.**
2. Complete the ***Three-Column Thought*** record**.**
3. Complete the ***Five-Column Thought Record-Urges.***
4. Complete a specific number of ***Five-Column Thought Record-Mood*** worksheets.
5. Search for patterns, or cognitive distortions, in the automatic thoughts identified in the thought record.
6. Engage in a specified number of positive or meaningful activities. Work together to identify potential activities during the session.
7. List behaviors that might have a positive influence on thoughts and feelings. Try a specified number of the behaviors and evaluate whether it made a difference.

Five-Column Thought Record-Mood

Situation Describe the people, place, or thing that led to the negative mood.	**Thought** Write down any automatic thoughts (or self-talk) you had about using.	**Feeling** What feeling(s) did you experience? (Rate on a 0-100 scale)	**Alternative, Realistic Thought** Use the questions to come up with a more balanced, realistic thought	**Outcome** Re-rate the intensity of the feeling listed in Column 3 or list a new feeling you are experiencing.

Social and Recreational Counseling

Social and Recreational Counseling: Therapist Information Sheet

Recommended Session Content

Below are some suggested guidelines for covering the content.

Session 1: Assess Sources of Reinforcement
Session 2: Review Reinforcer Sampling Process

Background

Often when people seek treatment for substance use disorders, they have few outside interests and activities. As substance use disorders develop, drinking and/or using other drugs occupies more and more time, and drinking/using companions displace prior associates. Conversely, an important part of the Veteran's process of recovery is rebuilding a life without alcohol or other drugs. This rebuilding may include the Veteran finding a non-using peer group, sampling and pursuing positive social-recreational activities that do not involve drinking or using other drugs, and establishing or re-establishing stable employment.

Sometimes it has been so long since clients have had a sober lifestyle (if they ever did as an adult) that they cannot list enjoyable substance-free activities, people, or places. Here it can be helpful to have a menu of options. Ideally, the menu should be tailored for the specific area, but the ***Menu of Possibly Pleasurable Activities*** worksheet provides a generic head start. Local newspapers carry weekly lists of clubs, free activities, support groups, volunteer opportunities, and/or entertainment options.

Another purpose here is for Veterans to create and maintain friendships with those who will support them in their sobriety. If possible, start with an activity that involves someone who is already supportive of the Veteran's substance use goals. It is useful for Veterans to discuss with friends and family how they might be helpful in supporting them.

Be familiar enough with activities to make informed recommendations that will not end in a bad experience for the Veteran.

Reinforcer sampling is the process by which Veterans try out or experiment with new social activities. The idea here is that by trying a variety of new activities, particularly activities that bring Veterans into contact with people outside of using contexts, they will find at least one that is rewarding.

Reinforcer sampling is the process by which Veterans try out or experiment with new social activities.

It's a common problem: many clients have good intentions of sampling a new activity, yet do not follow through, perhaps because they don't have the skills, are embarrassed, or are not well prepared to begin something new.

Social and Recreational Counseling: Implementing the Session(s)

Overall Goal

Assist the Veteran to connect with reliable sources of positive reinforcement that do not involve or depend on using alcohol and/or other drugs.

Cognitive Behavioral Strategies

- Assess Sources of Reinforcement
- Review Reinforcer Sampling Process

Materials

- BAM or BAM-C (consult Figure 3)
- Other assessment measures (consult Figure 3)
- Breathalyzer and urine drug screen (consult Figure 3 & as clinically indicated)
- Exploring Triggers handout (for the functional analysis)
- Menu of Possibly Pleasurable Activities handout

Structure of Session(s)

✓	Bridge from previous session
✓	Functional analysis (as indicated)
✓	Agenda setting
✓	Discussion of agenda items/Cognitive behavioral strategies: Social and Recreational Counseling
✓	Closing the session / Planning the home assignment

Beginning the Session(s)

As with each session, begin with a bridge from the previous session, followed by a functional analysis, and set the agenda. Detailed instructions for each of these tasks are provided on pages 11-13 in the section titled "General Session Structure." If the Veteran is also receiving pharmacotherapy, this is a good time to check in about how that is going and whether or not the Veteran is using medications as prescribed.

Discussion of Agenda Items/Cognitive Behavioral Strategies

Provide a Rationale

Always preface the discussion and practice of cognitive behavioral strategies by providing a rationale. Read the information provided in the Therapist Information Sheet and substitute words that provide a rationale in a way that the Veteran will understand. Check in with the patient to see if they understand the rationale.

Start by discussing with the Veteran the importance of healthy, supportive relationships and rewarding recreational activities. As much as possible, encourage the Veteran to offer reasons why it is important to have rewarding activities and companions not associated with using alcohol or other drugs. Avoid lecturing on matters that it is likely the Veteran already knows. Consider saying something similar to the following:

Therapist: Using _____ has occupied a lot of your time and energy in the past, and it sounds like many of your regular contacts were people you used with. One of the important challenges is to develop new interests, friends, and rewarding ways to spend your time that don't involve alcohol or other drugs. What do you think might be the advantages of having fun, finding some new interests, or being with friendly people without using?

Use questions that elicit change talk and reinforce the language with reflection.

Below is a list of points that often arise in discussions of this kind. If the Veteran does not come up with advantages, mention these points and ask which of them seem like the best reasons for finding friends who do not use and activities that do not involve alcohol or other drugs. Rephrase them as necessary.

- Using friends, even if they don't pressure you, can be powerful triggers for using, especially early in sobriety.
- Empty time (including time spent in relatively mindless activities) is not rewarding, tends to promote low moods, and does not support self-esteem.
- If you're sober but not enjoying it, you're not likely to stay that way.
- Getting positive reinforcement is like taking vitamins. It helps to be sure you have some every day.

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

Assess Sources of Reinforcement

Have Veterans describe people, places and activities that they often associated with substance use. Similarly, ask them to describe recreational events, people, and places that they enjoyed in the past that are not associated with alcohol or other drug use. Compare the two lists, discussing how they are different, to clarify patterns that support both using and sobriety.

Sometimes it has been so long since clients had a sober lifestyle that they cannot list enjoyable substance-free activities, people, or places. Here it can be helpful to have a menu of options. The ***Menu of Possibly Pleasurable Activities*** worksheet provides a generic menu of options.

Ask the Veteran to review the worksheet and to think of activities, hobbies, and interests of friends or acquaintances who do not use substances. Also ask the Veteran to identify activities, pleasurable or not, that do not involve substance use.

If possible, move smoothly from discussing enjoyable substance-free activities to making either a specific plan for increasing ones the Veteran currently takes part in or for trying a few new ones. This is easier when the Veteran already knows of activities, people, and places that are fun and don't involve or emphasize alcohol or other drugs.

In the example below, the therapist and Veteran discuss ways to find substance-free activities:

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

Jim: I can see how that might help. I never use around my daughter or grandkids. I want my daughter to know that she can trust me around the kids. She still thinks I'm going to get drunk and start driving the kids around town. Just so you know, I never did that with the grandkids. She's just a worrier.

Therapist: That is exactly what I'm talking about. Your daughter wants to see you succeed in treatment and you've told me that she's helped by inviting you to some of your grandchildren's school activities. What other fun activities, places or friends can you think of that aren't associated with using? How does your daughter spend her time? Or your wife?

Jim: Both my daughter and my wife are really interested in gardening. I used to help them out by building raised beds and bringing truckloads of mulch. I did enjoy being outside and I didn't drink because I was with them. Drinking around the family has never really appealed to me.

Therapist: Good! What else?

Jim: I have some friends I used to ride motorcycles with. We never drank when we were riding. I didn't want to drink when I was on my bike.

Therapist: So that's something you enjoy and you don't miss drinking when you're doing it. What else?

Jim: I've got a couple of older neighbors that I used to go help out and visit with. One woman lost her husband several years ago and I like to go over there and help her around the house. And I like to stay and visit with her and I've never gone over there after drinking. I want to be respectful. I knew her husband for many years before he passed. I've been feeling bad about not getting over there more often.

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

Jim: My buddy Ted and I always drink together. He just shows up at my door with a bottle of bourbon. I've also got a group of friends I go hunting with a few times a year. We stay in a cabin and in the evenings everyone is drinking. I mean really drinking. Same thing when we go fishing. Everyone sits around drinking all day.

Therapist: Okay. It sounds like hunting and fishing may be smart things to stay away from for now. Also, you mentioned that you tend to drink with Ted. On the other hand, you have a lot of activities that you enjoy when you're not using. Working in the garden, riding your motorcycle, helping out the neighbors, and being with your family are all positive activities that provide support for not using.

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

Therapist: I wonder if there are people you could go hunting with that don't drink afterward? That may be a good way for you to continue doing something you enjoy without the alcohol.

Jim: I know some people that just go hunting for the day. I could try going with them and then come home at night. I could give one of them a call this week.

Therapist: Perfect! I'm writing down that you're going to look at hunting with some different people. Is that okay with you? You really have the hang of this!

Ask the Veteran to pick five to 10 activities that sound the most enjoyable or exciting.

Review Reinforcer Sampling Process

Begin a discussion with the Veteran about trying substance-free activities. Below is a list of ways to interest the Veteran in trying substance-free activities.

- Explain to the Veteran that trying an activity once does not mean a lifetime commitment to it. The purpose is to sample activities to find one or more that is enjoyable and can support them in staying sober.
- Find a suitable analogy, such as tasting different kinds of ice cream.
- Take some time to discuss any apprehension or fears about trying something new.
- Problem-solve factors that might interfere with the Veteran trying or enjoying a designated activity. This may mean reviewing communication skills for interacting with strangers, asking a friend who does not use to go along, or generating a plan for transportation.
- Assign between-session tasks that involve sampling at least one new activity. The more specific the plan, the more likely the Veteran is to carry it out. The Veteran stating, "I'll go ask my neighbor if she needs help Saturday afternoon" is better than "I'll look for something fun to do."

Once Veterans agree on an activity, do not assume they will make the first contact. Instead, have the Veteran practice contacting the organization by phone. Role-play the phone interaction and if possible, ask the Veteran to make the phone call during the session. This will allow for immediate encouragement and affirmation of the Veteran for something he or she is doing well while gaining valuable behavioral information about how to interact with others.

Review with Veterans the reinforcement value of the activity. Was the activity something they enjoyed and would like to do again? Problem-solve any barriers to engaging in the activity again such as transportation to the activity or childcare. If the Veteran did not attend, problem-solve to create a plan that will assist him or her in attending the following week.

In the example below, the therapist discusses with the Veteran how to get involved in an activity:

Therapist: You talked last time about finding some different people to go hunting with. You mentioned that you know some people that just go for the day and that there's no alcohol involved. That sounds like a good idea to me too. What would you say to calling one of them now to see what you can find out?
Jim: I don't have any of their numbers with me.
Therapist: I've got a phone book here or we could look them up on the internet.
Jim: The name is John Smith.
Therapist: Here's the number. Ready to call?
Jim: From the office? I wouldn't know what to say.
Therapist: Well, how about starting by asking if he's going hunting anytime soon?
Jim: Okay. I think I can do that.
Therapist: All right then, how about if we practice it once before making the actual call. I'll start you out. Hi, this is Jim. Hunting season is around the corner and...
Jim: I was wondering if you have any plans to get out into the woods.
Therapist: Great!! Sounds like you're ready!

Closing the Session/Planning the Home Assignment

As always, at the end of session, conduct a final summary or, alternatively, have the Veteran summarize the most important lessons gleaned from the session. In addition to summarizing content, consider including an affirmation of the Veteran's efforts or strengths. Also ask about how the patient felt about the session, especially if a particularly upsetting or sensitive topic was discussed. When relevant and time-permitting, begin home assignments in session so that Veterans have a model when they attempt to complete it on their own. See the section titled General Structure (pages 10-11) for additional guidance on closing a session and planning a home assignment.

Home assignments for this session focus on the Veteran sampling new substance-free activities. Collaboratively, identify a new activity for the client to engage in prior to the next session. For those who struggle in this area, it is suggested that this activity become an ongoing home assignment. The goal is to continue to sample until finding several that the Veteran enjoys and is likely to stick with. Continue to assign the sampling of a new activity each week while focusing on other cognitive behavioral intervention strategies during sessions.

Additional options for home assignments include:

1. Self-monitor urges and cravings using the ***Urge Monitoring*** cards.
2. Complete the ***Three-Column Thought*** record.
3. Complete the ***Five-Column Thought*** record.

Menu of Possibly Pleasurable Activities

- Take a drive to see something new.
- Relax and read the newspaper.
- Help your child with homework.
- Plant something to watch it grow.
- Go for a walk.
- Take a nap.
- Build something from wood.
- Feed the birds or ducks.
- Hang a hummingbird feeder.
- Enjoy a special dessert.
- Go for a run.
- Get up early to watch the sunrise.
- Walk a dog.
- Play frisbee.
- Sew something.
- Play golf or miniature golf.
- Read poetry.
- Start a memory box.
- Call a friend who makes you laugh.
- Enjoy the quiet of an early morning.
- Have lunch with a friend.
- Grow (or shave off) a beard or mustache.
- Have a relaxed breakfast.
- Compliment someone.
- Send a care package to a student.
- Call someone special in your family.
- Write to an old friend.
- Enter a contest.
- Volunteer to be a coach.
- Paint a room.
- Search your family history.
- Lie under a tree and watch the sky.
- Go camping.
- Ride a motorcycle.
- Hum or sing.
- Add an item to your collection.
- Make some food for a friend.
- Play tennis.
- Watch a funny movie.
- Read a book you've heard about.
- Listen to your favorite music.
- Go to a movie, perhaps with a child.
- Go out for a special meal.
- Lie on the grass.
- Cook a favorite meal.
- Visit an old friend.
- Pray.
- Visit a shopping mall.
- Go to a yard sale or garage sale.
- Have your own yard sale.
- Go skateboarding or rollerblading.
- Have coffee with a friend.
- Visit a museum.
- Walk along the water.
- Visit someone who is homebound.
- Spend an hour in a favorite store.
- Walk or ride a bicycle path.
- Buy a small gift for a friend or child.
- Find a place for a moment of solitude.
- Visit the library.
- Play a card or board game.
- Wash and wax your car.
- Take a class.
- Play a musical instrument (or learn to).
- Look at maps for places to visit.
- Meditate.

Support for Sobriety

Recommended session content

Below are some suggested guidelines for covering the content.

Session 1: Assess Sources of Social Support/Rehearse How to Ask for Support
Session 2: Mutual-Support Group Facilitation

Background

Veterans are surrounded by people who can influence their recovery for better or worse. Those people may be family members, friends, counselors, and self-help group members. Below is a list of things Veterans may say about such people:

- My cousin keeps offering me marijuana and won't stop.
- My AA sponsor told me that I shouldn't be on any psychiatric medications, that those are just as bad as drugs like heroin or cocaine.
- I get into abusive fighting with my parents. Before I know it, I'm yelling.

This section has two primary components. The first section focuses on helping Veterans assess whether people in their lives are supportive of the changes they are making in their use of alcohol and/or other drugs. Veterans are encouraged to educate others about how to be most helpful during the difficult process of change. Second, information on facilitating mutual-support group participation is addressed. There is strong evidence that participation in these groups can provide support that results in improved treatment outcomes, particularly for individuals with low social support or a support system that encourages continued use (Project MATCH Research Group, 1998).

Some Veterans have a social network that promotes substance use. These Veterans may have using peers and/or perhaps a spouse or partner who also uses. These key people who are using can pose an active threat to the commitment Veterans have made during or after treatment. Addressing this set of problems will require tact, skill and patience, in that these Veterans are likely to experience the greatest loss on a personal and social level when they stop using. Encourage Veterans to sample mutual-support groups (even within a single program like Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)), looking for a good fit, because involvement in such groups is particularly helpful to people with high network support for using. The Veteran can accomplish this by attending one group several times or several groups one time. Discuss these experiences during therapy sessions.

If Veterans have only people who support continued drinking and/or other drug use, or are totally isolated with no family or friends, focus them on seeking more help from other sources. It is an important goal to help the client start new relationships with healthier people, but this can take a while. Look for more immediate sources of support from mutual-support groups, professionals, agencies, churches, or other supportive communities (see also the "Social and Recreational Counseling").

All Veterans in this treatment are encouraged to at least sample mutual-support groups.

All Veterans in this treatment are encouraged to at least sample mutual-support groups. Mutual- support groups can augment the social network, providing drug-free friends, and an orientation toward long-term recovery. This is likely to increase the resiliency

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

The information on mutual-support group facilitation included in this manual is adapted from the *Combined Behavioral Intervention: Therapist Manual* (Miller, 2004) which was adapted from *Twelve-Step Facilitation Therapy Manual* (Nowinski, Baker & Carroll, 1995). Focus on mutual-support group facilitation will be particularly important for Veterans with inadequate social support for the changes they are making or have made in their use of substances.

People with problems in their lives seek many routes to alleviate their distress. One common response is to seek the help of others with similar problems. It is helpful to already be familiar with mutual-support options available in the Veteran's area as well as online. To be useful to the Veteran, knowledge about the various options is essential.

Some of these groups use language such as "alcoholic" or "addict" when describing their members. If that is the case, that language has been preserved in the descriptions below:

12-Step Support Groups. AA is the earliest of the contemporary mutual-support groups. AA is a fellowship of men and women who help one another stay sober by living without alcohol through following the 12 steps of recovery. The core beliefs reflected in the 12 steps include the "powerlessness" of the alcoholics to control their drinking and the existence of a "higher power" (i.e., "God as we understand him") who can restore a life (paraphrased from steps 1, 2, and 3). Several other groups based on AA's steps and traditions have developed to help individuals addicted to other psychoactive substances such as narcotics through the aforementioned NA, and cocaine via Cocaine Anonymous (CA). AA groups are peer led, and the organization of AA is non-professional, relying on its volunteer members to chair meetings, coordinate activities, and represent the interests of its members at the state and national levels.

Other groups exist that either complement AA or provide an alternative. Overcomers Outreach (OO) is a program for evangelical Christians that applies biblical teachings to the 12 steps. OO emphasizes abstinence and the disease concept, and is open to persons with any kind of addiction. The Calix Society, a program for Catholics who are recovering from alcoholism, was founded in 1947 and is present at least in the United States, Canada, Scotland and England. Both of these programs focus on spirituality and religious study in the context of recovery from alcoholism through AA.

Several other mutual-support groups have developed based on a different view of substance use disorders, emphasizing rationality and personal responsibility rather than spirituality. These are intended to be alternatives to AA and other more spiritual or faith-based recovery programs.

Women for Sobriety (WFS) is a mutual-support program designed specifically to meet the needs of women in recovery. The program is based on the belief that many of the underlying principles of AA such as powerlessness and surrender are counter therapeutic to the needs of women. WFS believes that many woman develop drinking problems as a way of coping with negative emotional states. Although emphasizing abstinence as a necessary goal, WFS emphasizes personal control and a positive self-identity as the appropriate mechanisms of recovery. The assertion is that once a woman can cope without drinking, she is no longer in need of support services. WFS meetings are led by a moderator (often a mental health professional and/or a former WFS member), and in that regard are not strictly mutual-support groups.

Secular Organizations for Sobriety — Save Our Selves (SOS) began in 1985 as a self-help program promoting a scientific (as opposed to a spiritual or religious) method of achieving sobriety. SOS emphasizes the importance of supporting others in achieving and maintaining sobriety and promotes abstinence as the only rational approach to living. SOS meetings are peer-led and are structured around a set of suggested guidelines for sobriety.

SMART Recovery (Self-Management and Recovery Training) is designed to help people recover from a variety of addictive behaviors. SMART has both in person and online meetings. It is a four-point program that focuses on building and maintaining motivation, coping with urges, managing thoughts, feelings and behaviors, and living a balanced life.

Moderation Management (MM) is designed for people who are "problem drinkers" rather than chronically dependent on alcohol and MM specifically departs from a disease model of alcoholism. Meetings are peer-led by volunteers. Specific guidelines and limits are prescribed, drawn from research on behavioral self-control training.

Other groups that fit the general definition of a mutual-support group may exist in certain communities. Many urban churches have special outreach ministries established to help in recovery from substance use disorders. These are generally peer-led, often by a church member who is in recovery. In addition, communities with large ethnic populations often establish organizations to promote cultural identification and affiliation within the community. These organizations may sponsor groups organized to offer positive role models and social or recreational outlets for constituents. These natural support systems represent indigenous resources that can be used to support Veterans who are in need of enhanced social resources and supports.

Online Resources are another option. Links are provided below. This list of resources, along with resources for clinicians, is also contained in Appendix B.

- National Institute on Alcohol Abuse and Alcoholism (NIAAA): http://www.niaaa.nih.gov
- National Institute on Drug Abuse (NIDA): http://www.nida.nih.gov or http://www.drugabuse.gov
- Substance Abuse and Mental Health Services Administration (SAMHSA): http://www.samsha.gov
- U.S. Department of Agriculture (USDA): http://www.health.gov
- U.S. Department of Health and Human Services (USDHHS): http://www.hhs.gov
- The Drinkers Check-Up: http://www.drinkerscheckup.com
- Rethinking Drinking: http://www.RethinkingDrinking.niaaa.nih.gov
- SMART Recovery: http://www.smartrecovery.org and http://www.overcomingaddictions.net
- Women for Sobriety: http://www.womenforsobriety.org
- Alcoholics Anonymous: http://www.aa.org
- Narcotics Anonymous: http://www.na.org
- Al-Anon/Alateen: http://www.al-anon.alateen.org

Matching Considerations in Mutual-Support Referrals

Below is a list of possible considerations in matching Veterans with optimal mutual-support programs.

- *Availability.* One obvious limitation is the range of mutual-support programs available in the community. AA is the most likely to be accessible. In some areas it will be the only mutual-support resource. A broader range of alternatives is often available in more populous areas.
- *Program Philosophy.* There are substantial differences in the philosophy, structure, orientation and leadership of the various mutual-support groups. If the leanings of both the Veteran and the available programs and groups are known, it may help in providing guidance in the selection of initial meetings to try.
- *Spirituality.* A major distinction between 12-step and the more secular organizations (e.g., SOS, WFS) is the emphasis placed on spirituality – a central and consistent component of 12-step. It is not necessary for Veterans to be "religious" to be comfortable in or respond to AA or NA. Nevertheless, some Veterans may be offended by the God language. Open prayer and spiritual steps of meetings may be alien to them.
- *Similarity*. An important determinant of social affiliation is perceived similarity. Consider who the Veteran is likely to encounter at various programs and groups in terms of gender, age, or ethnicity.

Support for Sobriety: Implementing the Session(s)

Overall Goal

Assist the Veteran in increasing sources of social support and facilitate participation in mutual-support groups.

Cognitive Behavioral Strategies

- Assess Sources of Social Support
- Rehearse How to Ask for Support
- Mutual-Support Group Facilitation

Materials

- BAM or BAM-C (consult Figure 3)
- Other assessment measures (consult Figure 3)
- Breathalyzer and urine drug screen (consult Figure 3 & as clinically indicated)
- Exploring Triggers handout (for the functional analysis)
- List of mutual-support groups

Structure of Session(s)

✓	Bridge from previous session
✓	Functional analysis (as indicated)
✓	Agenda setting
✓	Discussion of agenda items/Cognitive behavioral strategies: Support for Sobriety
✓	Closing the session / Planning the home assignment

Beginning the Session(s)

As with each session, begin with a bridge from the previous session, followed by a functional analysis, and set the agenda. Detailed instructions for each of these tasks are provided on pages 11-13 in the section titled "General Session Structure." If the Veteran is also receiving pharmacotherapy, this is a good time to check in about how that is going and whether or not the Veteran is using medications as prescribed.

Discussion of Agenda Items/Cognitive Behavioral Strategies

Provide a Rationale

Always preface the discussion and practice of cognitive behavioral strategies by providing a rationale. Read the information provided in the Therapist Information Sheet and substitute words that provide a rationale in a way that the Veteran will understand. Check in with the Veteran to determine if the rationale is understood. The use of a motivational interviewing style continues to be important and will be particularly important for any Veterans who feel that they have been forced to attend mutual-support groups in the past.

Assess Sources of Social Support

A good place to start is by asking the Veteran to list characteristics of supportive and non-supportive people. Record this information on a whiteboard or piece of paper so that the information can be looked at together. Identify and discuss supportive and non-supportive individuals that the Veteran interacts with.

Rehearse How to Ask for Support

A principal goal here is to help Veterans articulate what they need from others in the way of social support for sobriety. Some may wish to have a conversation with a friend or family member about ways they can be supportive. For others, it may be more important to them to write down what they would like the person to know. Help clients think through what they would like to say. This is a good opportunity for a role-play in session.

A principal goal here is to help Veterans articulate what they need from others in the way of social support for sobriety.

Some questions the Veterans may want to think through during this process follow:

- Who would you like to ask for support?
- What do you most want people in your life to understand about your recovery?
- What help can people in your life give to you? Can you ask for this help?

Work with the Veteran to identify people who would be good candidates to reach out to.

Encourage Veterans to rehearse aloud what support they would want from others. This is an excellent opportunity for role-plays. This can be useful even if in real life there are reasons they cannot express it (e.g., the Veteran is too afraid to say it).

Mutual-Support Group Facilitation

When having this discussion with the Veteran, it is helpful to have a written list of available options.

As is the case throughout this manual, explicitly acknowledge the Veteran's autonomy and state that the decision about whether or not to participate in mutual-support groups is completely up to the Veteran. Encourage participation and provide information on why participation is beneficial, but ultimately the decision is the Veteran's.

… Explicitly acknowledge the Veteran's autonomy and state that the decision about whether or not to participate in mutual-support groups is completely up to the Veteran.

Below is an example of Jim's therapist initiating a conversation about the possibility of beginning to engage in mutual-support groups:

Therapist: When we discussed your goals for treatment, one of the things you said you would like to do is increase your support system. You said that a lot of your friends drink and that, other than your wife and daughter, you're not sure who in your life will be supportive of your decision to stop drinking. Would it be OK with you if we spent some time talking about mutual-support groups as a possibility?

Jim: What do you mean by mutual-support groups?

Here, Jim has invited the therapist to provide more information. The therapist then has the option to provide an overview and a written list of mutual-support resources that are available.

Therapist: Mutual-support groups include a variety of different types of groups designed to help people reach and maintain their goals. Different groups have different ideas about what goals should be, how to reach them, and why. I have a list of the different groups available in this area [provides Veteran with list] and I would like to talk with you some more about them and see what thoughts and questions you have about them.

Jim: [accepts the list of different groups] That would be alright. I tell you though, I've been to some awful AA meetings in my time. Sometimes I would go in feeling OK and come out wanting to head to the liquor store.

Therapist: So you have some experience with AA already, even if you didn't always find it helpful. Tell me a little more about your experience with AA.

Jim: It wasn't all bad. I went for quite a while, maybe a year, after I went through treatment last time. There are just some people who like to hear themselves talk and they tell stories about their drinking days. That part wasn't helpful to me. Other parts of it were helpful though. I didn't use during the time I was going and I met some people who seemed to really want to help me out. There was a guy who would pick me up and take me to meetings, and I know I exchanged phone numbers with several people and actually made some calls when I was struggling.

Therapist: While there were some things about it you didn't really like, you were able to take what you found helpful and get something out of that. And whether you decide to go back to AA, or try another type of group, or not go at all, is up to you. I can't make that decision for you. I am interested to hear how you think some additional support might be helpful to you.

Below is a list of steps for involving the Veteran in mutual-support groups.

1. *Provide a rationale.* Begin by providing a clear rationale for mutual-support group involvement that is both factual and congruent with the Veteran's beliefs or circumstances. Elicit from the Veteran what the potential benefits of participation in different types of groups would be (invoke self-motivational statements). It may be useful to provide information from research about mutual-support group participation, emphasizing its value in maintaining long-term, stable changes in substance use.

Therapist: I can tell you that there's quite a bit of research that shows attending these types of meetings helps people maintain the progress they've made. I'm interested to hear your thoughts about trying out some meetings again. It could be AA, or you might find it helpful to check out some of these other ones and see if they're a good fit. Based on what I know about you so far, I'd like to share some information with you about a couple of them that I think you might find particularly helpful.

2. *Explore attitudes about mutual-support groups.* Some Veterans may say they are not interested in sampling mutual-support groups because they have had negative experiences with them in the past, dislike the spiritual component, or disagree with labels used in some of the groups such as "alcoholic" or "addict". Explore any such negative experiences to see how they may be impacting the Veteran's current decision. Also explore any past positive experiences the Veteran has had with mutual-support groups. What did Veterans like or appreciate about the groups they attended? For Veterans with no prior mutual-support experience, ask what they could imagine would be

helpful about participating in such groups. Consistent with the MI style, be careful not to get into a disagreement with the Veteran in which you argue for mutual-support participation and the Veteran argues against it.

3. *Give information about available groups.* Answer any questions the Veteran has about the different types of groups and what might be expected (procedurally) from them. Be sure to use language that the Veteran will appreciate. It will be helpful to have "approved" literature on the different mutual-support programs to provide to the Veteran as appropriate. Ask permission to provide information on a variety of different groups and assist Veterans in selecting one that is acceptable to them.

Besides general information, also give practical information about exactly what a Veteran is likely to experience in attending a meeting. One way to know these specifics is to personally sample meetings. Most programs allow people not in recovery to attend; AA has specific "open" meetings. Give a fair and accurate description of the various groups available in the area. In addition, many VA facilities offer AA groups on campus which may be a convenient way to experience a group.

4. *Encourage sampling.* Particularly if Veterans are new to mutual-support groups, encourage them to "try it out" or "shop around" without making an initial commitment. Emphasize that groups vary widely and they should find the group(s) most comfortable and appropriate for their own situation. A specific endorsement may be provided, as in the example below:

Therapist: I would really like you to give serious thought to trying out AA or another kind of group, in addition to the work we are doing together here. Treatment and mutual-support together seem to lead to the best outcomes. Which of these groups that I've described do you think might be the best place for you to start - the one you might check out first?

5. *Provide referral information.* Give the Veteran contact information, such as local or toll-free numbers, introductory literature, and a list of local meeting times and places. Use officially approved literature when referring Veterans to 12-step meetings.

6. *Make a specific plan.* For many people, it is not enough just to give the information. Consider specific steps to help your client get to meetings. Which mutual-support group is the Veteran interested in visiting? When and where? How will the Veteran get there? Troubleshoot any obstacles to attendance that may be encountered. For example, contact a group member in advance and arrange to call that person during the session, with the Veteran's permission; give the phone to the Veteran so that the member can offer to meet the Veteran at the group, perhaps provide transportation, and so on.

✓	Provide a rationale
✓	Explore attitudes about mutual-support groups
✓	Give information about available groups
✓	Encourage sampling
✓	Provide referral information
✓	Make a specific plan

Addressing Negativity about Mutual-Support Group Attendance

Veterans may express directly (e.g., by complaints) or indirectly (e.g., by not attending) their dissatisfaction with or disinterest in mutual-support groups. Explore the roots of negativity in a supportive, nonjudgmental manner. Value the Veteran's own perceptions and experiences, offering accurate reflection. If clients are not ready to consider going now, put the topic on hold and come back to it later in treatment when they may be more receptive.

Closing the Session/Planning the Home Assignment

As always, at the end of the session, conduct a final summary or, alternatively, have the Veteran summarize the most important lessons gleaned from the session. In addition to summarizing content, consider including an affirmation of the client's efforts or strengths. Also ask about how the Veteran felt about the session, especially if a particularly upsetting or sensitive topic was discussed.

When relevant and time-permitting, begin home assignments in session so that Veterans have a model when they attempt to complete it on their own. See the section titled General Structure (pages 10-11) for additional guidance on closing a session and planning a home assignment.

Home assignments focusing on increasing sources of social support and sampling mutual-support groups may include:

1. Asking the Veteran to write one page answering the following questions:
   Who would you like to ask for support?
   What do you most want people in your life to understand about your recovery?
   What help can people in your life give to you? Can you ask for this help?
2. Asking the Veteran to practice asking for support. With this assignment discuss with the Veteran who to practice this with to increase the chance that a supportive person is chosen.
3. Asking the Veteran to sample a specific number of mutual-support groups.

As with many of the other home assignment in this manual, this activity may become an ongoing assignment. Consider encouraging mutual-support group attendance while focusing on other cognitive

behavioral intervention strategies during sessions. The goal is for Veterans to continue to discover a support system that works for them.

Other options for home assignments include:

1. Self-monitor urges and cravings using the ***Urge Monitoring*** cards.
2. Complete the ***Three-Column Thought*** record.
3. Complete the ***Five-Column Thought*** record.

Listening Skills

Listening Skills: Therapist Information Sheet

Recommended session content

Below are some suggested guidelines for covering the content.

Session 1: Discuss the Process of Interpersonal Communication
Session 2: Increasing Positive Interactions (applicable to individuals who have a primary relationship)

Background

Listening skills are covered in this section. Select manageable, relevant sections of new information to cover, and spend a substantial amount of time practicing within sessions. Before ending a session, double-check and review the Veteran's understanding of what was covered. Provide handouts as appropriate.

Listening skills are likely to be useful for Veterans who would benefit from learning more effective social communication skills. It may be particularly useful for Veterans who have a supportive significant other who is also attending sessions. This section will also focus on intentional planning of positive reinforcement in relationships.

Listening skills are likely to be useful for Veterans who would benefit from learning more effective social communication skills.

For those who struggle with problematic substance use, lack of good communication skills can hinder progress in a number of ways. Some Veterans may have never developed good communication skills, while others' skills may have diminished as a result of isolation related to their substance use. Veterans' communication skills may also have become distorted as their social interactions have become increasingly defensive and argumentative as a result of their using. Important relationships are often damaged or lost in relation to problematic substance use. Learning to listen and communicate well can often help people take steps to rebuild important relationships or establish new ones. Effective communication skills can enhance Veterans' ability to cope with high-risk situations and can strengthen the social support network that is important to the maintenance of successful change in substance use.

The overall aims of this section are to help the Veteran:

- become more aware of the *process* of interpersonal communication.
- understand that effective interpersonal communication depends on skills that can be acquired.
- learn how to understand more clearly what other people mean when they speak.
- avoid misunderstandings and build stronger relationships.

As throughout the rest of this treatment manual, maintain a client-centered, empathic style. Through this motivational interviewing style the therapist is already modeling good non-verbal communication and reflective listening as well as a number of other important communication strategies. Good modeling in itself is a powerful way to teach effective communication.

Discuss the process of interpersonal communication. As a beginning, point out that interpersonal communication takes place every time people interact (and indeed is happening at this very moment). People talk, listen, observe and react to each other, exchanging all kinds of information, in many different ways. While communicating effectively can be one of the most satisfying and interesting of human activities, it can also be hard work to do it well. Good communication doesn't come naturally to most people. The good news is that good communication involves skills that can be learned and improved.

Listening Skills: Implementing the Session(s)

Overall Goal

Improve listening skills through practice.

Cognitive Behavioral Strategies

- Discuss the Process of Interpersonal Communication
- Increasing Positive Interactions

Materials

- BAM or BAM-C (consult Figure 3)
- Other assessment measures (consult Figure 3)
- Breathalyzer and urine drug screen (consult Figure 3 & as clinically indicated)
- Exploring Triggers handout (for the functional analysis)
- How Communication Happens
- Reflection sheet

Structure of Session(s)

✓	Bridge from previous session
✓	Functional analysis (as indicated)
✓	Agenda setting
✓	Discussion of agenda items/Cognitive behavioral strategies: Listening Skills
✓	Closing the session/Planning the home assignment

Beginning the Session(s)

As with each session, begin with a bridge from the previous session, followed by a functional analysis, and set the agenda. Detailed instructions for each of these tasks are provided on pages 11-13 in the section titled "General Session Structure." If the Veteran is also receiving pharmacotherapy, this is a good time to check in about how that is going and whether or not the Veteran is using medications as prescribed.

Discussion of Agenda Items/Cognitive Behavioral Strategies

Provide a Rationale

Always preface the discussion and practice of cognitive behavioral strategies by providing a rationale. Read the information provided in the Therapist Information Sheet and substitute words that provide a rationale in a way that the Veteran will understand. Check in with the Veteran to determine if the rationale is understood.

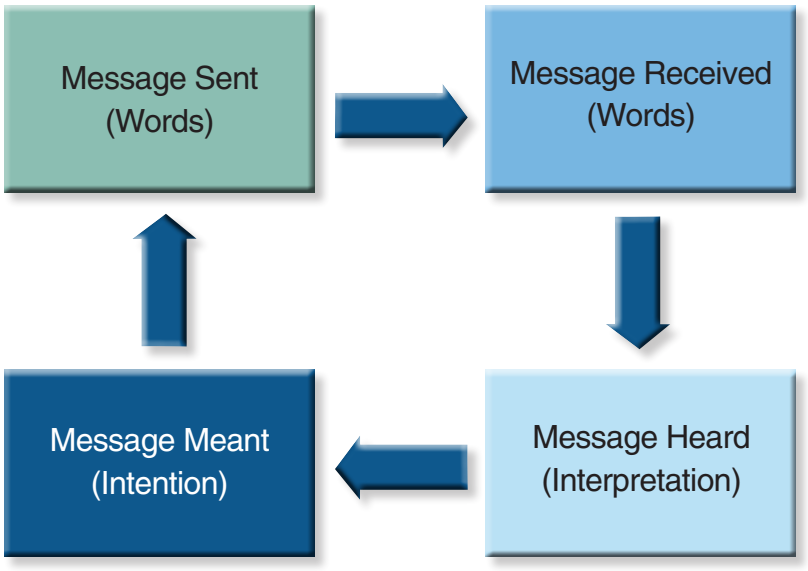
This section focuses on listening skills. Review of the material in advance will enable a discussion with the Veteran on which skills from this section, if any, would be useful to focus on in treatment.

Discuss the Process of Interpersonal Communication

Start by asking the Veteran to recall some communication situations. Use the following sample questions to guide the process.

- Think of someone you know who you think is really a good listener-someone who makes you feel good, feel understood when you talk. What does that person do to be a good listener? What sort of body language does the person use?
- Think of a recent situation in which you had something important to say to someone and that person really put some effort into understanding your point of view. How did you feel after that? (Most likely the Veteran left the situation feeling good.)
- Recall a different situation when you tried to say something important to someone, but it didn't go well and you left the situation feeling frustrated or discouraged. Why did that communication not go as well?

Everyone likes to be understood. Much of our communication is aimed at getting others to see the world as we see it. But for each person who is understood, there needs to be someone who understands. See the depiction that follows on how communication happens.



Give the Veteran a copy of the ***How Communication Happens*** handout and discuss in detail what is actually happening when two people are trying to communicate. Clients generally find this diagram interesting and helpful in understanding how communication problems can develop. Below is an example of a therapist explaining the concept of communication using this handout.

Therapist: One useful way to think about interpersonal communication is as a series of messages – information that goes back and forth between people. You send a message, you receive a message. Now, when you, the sender, want to let someone know something, you start out with an intention, your own private thought - which is what you MEAN to communicate. This is the "Message Meant (Intention)" box on the form [point out the correct box]. To get across what you mean, however, you have to put it into words. You know that people don't always say exactly what they mean, right? As you put your meaning into words, there are a lot of things that

influence the words you choose: your previous experiences in life, with that person, with this particular topic, any feelings you might be having, and your expectations of how the other person might react. It's like what you mean to say passes through a kind of filter. This means that the message you send in words [point out box "Message Sent (Words)"] doesn't always match what you meant to communicate. Does that make sense so far? This "message sent" includes not only your words but your tone of voice, body language, and facial expression. After the words are spoken and the message is sent, the receiver or listener gets involved. First of all, listeners have to hear the words, and it's possible that they don't even receive the words accurately. Why might it be that the listener doesn't get your words right?

Note that the therapist discusses factors like attention, culture, accent, distance, expectations, hearing problems, and so on.

Therapist: Once the words you send are received, then the message is interpreted by the listener, much the same way it was filtered by you before you sent it. What the listener hears might be influenced by culture, past experiences, expectations, feelings, and many other things. By the time the listener interprets your message, it may look quite different from the one you were intending to send.

Ask clients whether this makes sense, and if it reminds them of any experiences like this. Discuss the steps along the way in an example: the message that was intended, the words that were said, the words that were received, and the message that was heard. If Veterans cannot provide an example from their experience, offer an example that is appropriate to their situation. The overall point here is to motivate the Veteran to learn effective communication skills. Given that there are so many ways that communication can go wrong, it is really important to learn how to send and receive messages accurately. Communication can go very wrong in just one round, unless someone does something to keep it straight.

Discussing the process of communication leads naturally to discussing the skills necessary for clear communication. Do the following practice exercises in session and then have Veterans work on them as home assignments to provide practice in their own environments.

Attending. Draw on the earlier discussion of what a good listener does to discuss the nonverbal aspects of listening. Good listening, first of all, involves some silence. It is necessary to give the person time to talk without interruption. In the example below, the therapist explains the importance of being a good listener.

Therapist: A good way to illustrate this is to try something that is kind of hard. I'll do it first, and you can tell me how I did. My job is to be a good listener – to let you know that I am hearing and understanding what you are saying – without saying a word. I will allow myself some little noises like "hmm" and "mm hmm," but I'll try to say no words at all, yet have you know that I'm listening and caring about what you are saying.

Now, to do that, you need something you can talk about for a while without much help from me, because you are going to do all of the talking for a few minutes while I just listen. Here's one that most people can talk about for a while: what it was like in my home when I was growing up. That lets you choose what to talk about - where you grew up, what your parents were like, what your home looked like, other family members, school, whatever. So if you will talk about that for a while, I'll do my best to let you know without words that I'm listening. Okay?

As the Veteran talks for a few minutes, illustrate some nonverbal aspects of listening, such as the ones described below.

- Devote your whole attention to what the other person is saying. Don't do anything else (look at your watch, look around, read, and etc.). Even if you "can do two things at once," don't.
- Keep your body and head turned towards the other person.
- Maintain good eye contact. A speaker naturally looks at you and then looks away. A good listener keeps fairly constant eye contact without giving the speaker the feeling of being stared at. Don't let your gaze wander about as though you are thinking about other things or looking for someone more interesting.
- Use nods and facial expression appropriately to reflect feeling and understanding.
- Use some non-word sounds that encourage the person to keep talking (e.g., hmm, ah, mm-hmm).

Assure the Veteran that often this sort of listening is as valuable as discussing a problem. In fact, often what people want from us is not problem-solving, but just to listen and understand. Good listeners show that they are interested, that the speaker is not boring to them, and that we are putting the speaker's needs first. Just being listened-to can encourage people to communicate what is on their minds and can sometimes help them to sort out problems for themselves. For Veterans who need to establish new relationships, point out that good listening is one of the most effective conversational skills and it helps to build friendly relationships quickly.

Next, as appropriate, ask the Veteran to be the listener, using the same skills illustrated. Choose an appropriate topic to talk about for a few minutes while the Veteran listens. If a SSO has accompanied the Veteran, ask the SSO to be the speaker and the Veteran the listener. Then debrief first by asking what it was like to be the listener – what the Veteran was experiencing. (For example, many people say that they thought of all the things they *would* have said ordinarily.) Be sure to comment positively on what the Veteran did well to communicate listening and understanding. If there is something specific that the Veteran could still do to be a better listener, comment on it, but be sure to begin and end with positive reinforcement. If an SSO is present, reverse roles and ask the Veteran to be the speaker and the SSO the listener.

Avoiding Roadblocks. Share information about avoiding roadblocks with the Veteran and then practice engaging in a conversation without roadblocks. It may be useful to model this way of communicating first and then ask the Veteran to practice.

Review with the Veteran that in a good conversation the listener talks as well as listens — this is give and take. But there are many things that people do, often with the best of intentions, which are not part of good listening and are in fact impediments to conversation. Most of these have to do with listener's putting in their own "stuff" — advice, opinions, suggestions, and so forth. Sometimes this is okay, but such insertions tend to put up roadblocks to speakers' natural flow of thought that they must detour around (Gordon, 1970). Most often the conversation goes off in a different direction, and never gets back to the speaker's original path.

Below is a list of common roadblocks listeners may erect.

- Giving advice, making suggestions, or telling the speaker what to do.
- Agreeing or disagreeing with what the speaker says.
- Criticizing, blaming, or shaming.
- Interpreting, analyzing, or being logical.
- Reassuring or sympathizing.
- Asking questions.
- Ignoring, withdrawing, or humoring.

Again, it's okay to do these things at times. Asking questions, for example, gives people information that is of interest to them. But in good listening, people let the other person talk. In that way, good listening is a sacrifice. People give up their own "stuff" for a while and give their whole attention to listening.

While practicing communicating without roadblocks, also make mental notes about what the Veteran is doing well so that you can affirm those skills after (or if appropriate, during) practice.

Guessing About Meaning. The third part of this section helps the client learn what to say to be a good listener.

Go back to the ***How Communication Happens*** worksheet and point out that when communication is going well, the "Message Heard (Interpretation)" box-what the listener thinks the speaker means-closely matches the "Message Meant (Intention)" box-what the speaker really means. Most people react to their *interpretation* as if it were what the speaker really meant. Good listeners check out whether what they think the speaker means ("Message Heard (Interpretation)" box) is what the speaker really means ("Message Meant (Intention)" box).

One way for listeners to do this is to tell speakers what they thought they were saying and ask the speakers if that is what they meant. Though this does work, it tends to get in the way of a smooth conversation. Nevertheless, it's worth demonstrating. Again, the therapist is the listener first while the Veteran is the speaker, then reverse roles. The roles are described below.

Speaker: One thing that I like about myself is that I _____.
Listener: Ask a series of questions about what the speaker might mean. Always use the form, "Do you mean that you _____?"
Rule: The speaker may answer only "Yes" or "No" and say nothing more.

The exercise makes it obvious that the listener is "guessing" what a speaker means; often the guess is incorrect. It also becomes clear that a speaker often means more than one thing - there are levels of meaning.

After going through this exercise with the client as the listener, find out what she was feeling and experiencing in that role. People in the listener role often feel frustrated because they wanted to hear more than yes or no. Similarly, people in the speaker role usually feel frustrated because they wanted to say more than yes or no. This exercise illustrates that good listening naturally keeps a conversation going, making the speaker eager to say more and the listener eager to hear more.

If the Veteran brought an SSO to the session, ask the Veteran to practice this with the SSO as a speaker. Their roles may then be reversed for a third round of practice. It can be good practice for both people who are not the speaker to generate "Do you mean" questions.

Understanding Statements. Asking questions is not the best way to listen. Teach the Veteran to form understanding statements: to say as a statement what the Veteran believes the speaker means. It's a short step from the "Do you mean..." exercise. All the listener has to do is drop off the words, "Do you mean that" and inflect the sentence down (for a statement) rather than up (for a question) at the end. Examples of such statements are below:

Example 1:

Speaker: I feel really low on energy this week.
Question: Do you mean that you're feeling pretty tired?
Understanding statement: You're feeling pretty tired.

Example 2:

Speaker: I don't like the way you handled that.
Question: Are you saying that how I handled it didn't seem fair to you?
Understanding statement: How I handled it didn't seem fair to you.

Discuss how the speaker might feel and respond to each of these. In general, questions pull subtly for more defensiveness, argument, and negative response. A simple statement just tends to keep the conversation going, and it doesn't really matter if the guess was right or wrong. Either way people provide more about what they meant.

To consolidate this next step, ask the Veteran to practice making understanding statements. As before, go first to show how it's done, then reverse roles with the Veteran. The roles are explained below.

Speaker: Complete this sentence: One thing about myself that I would like to change is that I _____.
Listener: Make an understanding statement (not a question).
Rule: Speakers should then respond with "Yes" or "No" *and also say some more* about what they mean. In response to this, the listener makes another understanding statement, taking in the new information.

Note that some speaker statements don't go anywhere. "One thing about myself I'd like to change is my hair color." Or, "One thing about myself that I'd like to change is that I smoke." Even these sometimes lead in surprising directions, but in general the speaker should offer something that has some feeling, importance, and ambiguity attached to it. Below is an example of a conversation with understanding statements that help keep it going.

Speaker: One thing about myself that I'd like to change is that I'm scatter-brained.
Listener: You have a hard time concentrating on one thing at a time.
Speaker: No, it's not really that. But I'm losing things all the time, even in my small apartment.
Listener: And that doesn't seem normal to you.

Speaker: Yeah, well I guess everybody loses things, but I just feel like I can't keep track of anything — where my life is going, what day it is, birthdays, anything.
Listener: It's like you're out of touch with what's going on around you.
Speaker: Yes, and even with what's going on inside me.
Listener: And that's pretty upsetting. You feel a little out of control.
Speaker: I feel *a lot* out of control...

If an SSO is present, start as the speaker and ask both the Veteran and SSO to be listeners. Coach them along the way in forming understanding statements, with lots of positive reinforcement. Then have one of them become the speaker, and coach the other on making understanding statements. Be careful not to usurp the listener role.

Don't try to cover this whole skill area in one session. Cover an appropriate amount of material, and then craft a home assignment to allow the Veteran some practice in his or her own social environment. Listening skills can be tried out with a partner who knows that it's practice or with someone unaware that the Veteran is practicing new skills.

Increasing Positive Interactions

This section pertains particularly to Veterans who have a primary relationship, whether or not the Veteran's significant other is participating in treatment. Decreasing negative communications and replacing them with more positive patterns of communication is only one piece of the puzzle. Cognitive behavioral relationship therapy also typically includes increasing the level of shared positive activities — another way of making deposits in the relationship piggy bank.

Begin this section by explaining that good relationships are fostered by people having fun together. During dating and courtship, most of the time that people spend together is focused on pleasant activities: sharing meals, dancing, physical intimacy, and so on. Over the course of a relationship, it is possible that the couple could start to spend less time in pleasant activities and more time in routine or even aversive activities. Sharing positive experiences strengthens a relationship (including friendships) and deepens positive feelings for each other. Make sure that this rationale makes sense to the Veteran (and SSO) before proceeding.

The key here is to find fun, pleasant, positive activities that can be shared and that do not involve substance use. For Veterans involved in a long-term relationship, ask how it began-what attracted them to their partner, what enjoyable things they did together early on in the relationship, and so on. When both partners are present, keep this discussion free of implicit criticism ("Well, back then he was fun to be with."). Use reflective listening to emphasize positive aspects that are offered (a relationship-building form of change talk). Brainstorm things that the Veteran and SSO could do together, focusing on experiences that would be pleasant for both of them.

The key here is to find fun, pleasant, positive activities that can be shared and that do not involve substance use.

Closing the Session/Planning the Home Assignment

As always, at the end of session, conduct a final summary or, alternatively, have the Veteran summarize the most important lessons gleaned from the session. In addition to summarizing content, consider including an affirmation of the client's efforts or strengths. Also ask about how the Veteran felt about the session, especially if a particularly upsetting or sensitive topic was discussed.

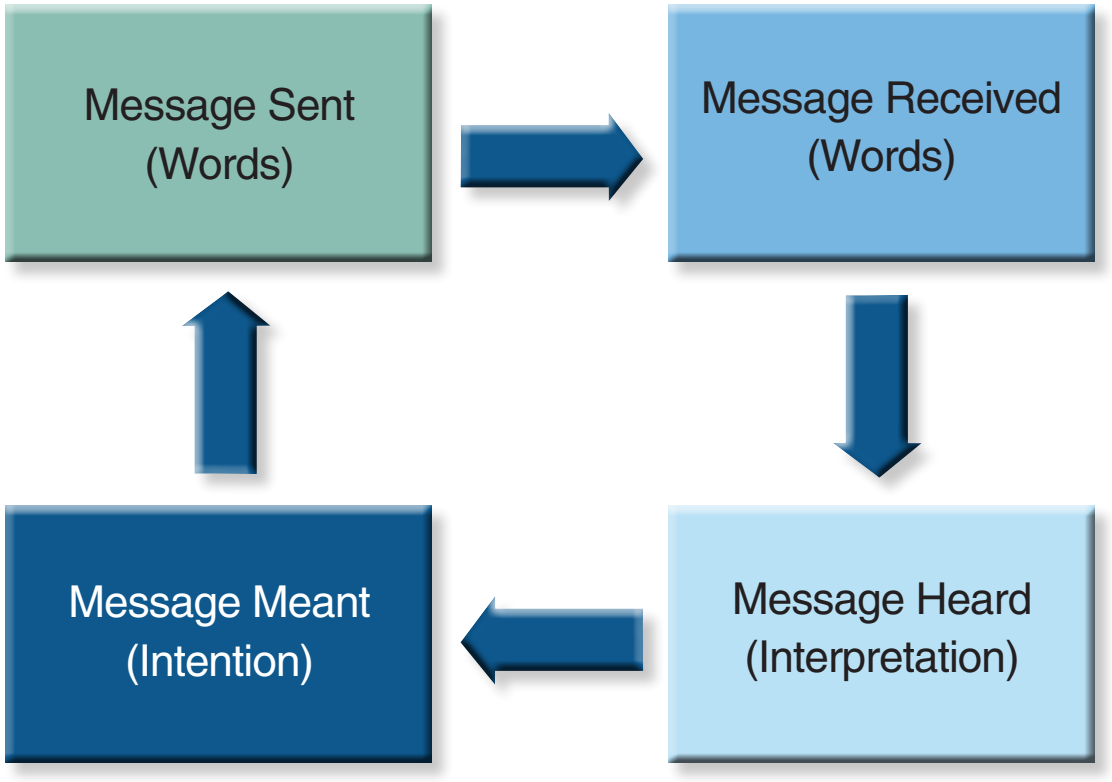
When relevant and time-permitting, begin home assignments in session so that Veterans have a model when they attempt to complete it on their own. See the section titled General Structure (pages 10-11) for additional guidance on closing a session and planning a home assignment.

1. Ask the Veteran to practice one of the following skills a specified number of times: (a) Attending, (b) Avoiding Roadblocks, (c) Guessing About Meaning, or (d) Understanding Statements. It is most useful to ask the Veteran to practice a skill that was previously practiced during the therapy session. After one or two practices, the Veteran can fill out the ***Reflection Sheet*** which will be a helpful aid for discussing their progress at the next session.
2. For Veterans who have a primary relationship, collaboratively identify specific shared positive activities as assignments between sessions. Be careful not to make too big a jump at first. If it has been a long time since they shared fun activities, start small and simple. The goal is just to have a good time together without substances. Integrate positive communication practice into these assignments. For example, assign a "sofa session" in which the partners take turns talking about their day, feelings, hopes, and so on. Try 5-minutes each at first, while the listener gives full attention to the speaker without erecting roadblocks. If both partners are participating in treatment, it is wise to try this in the office first to make sure that the needed skills are in place or can be coached. Assignments of having fun can continue while other skills become the main focus of sessions.

Other options for home assignments include:

1. Self-monitor urges and cravings using the ***Urge Monitoring*** cards**.**
2. Complete the ***Three-Column Thought*** record**.**
3. Complete the ***Five-Column Thought*** record**.**

How Communication Happens



Reflection Sheet

I practiced listening with (person): _____

On (date and time): _____

The other person knew that I was practicing my listening skills: ☐ Yes ☐ No

Here's how I think I did as a listener:

	NOT WELL		OK		REALLY WELL
Paying complete attention and letting the person see that I was listening.	1	2	3	4	5
Keeping my own "stuff" out of it (advise, opinion, interpreting, etc.).	1	2	3	4	5
Keeping good eye contact.	1	2	3	4	5
Making understanding statements.	1	2	3	4	5

Notes: (What we talked about, how I felt, what happened afterward, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Problem Solving

Recommended session content

Below are some suggested guidelines for covering the content.

Session 1-2: The Problem Solving Process

Collaboratively cover the information in this section and, importantly, ensure the Veteran has adequate time in session and between sessions to practice and incorporate problem solving into their daily lives.

Background

Skillful problem solving can help Veterans to cope with a wide array of life issues and demands.

Very little explanation is likely needed for how a section devoted to problem solving fits within cognitive behavioral therapy for substance use disorders. Consistent with social learning theory, the use of substances often becomes the primary, yet maladaptive, means of coping with life problems (Marlatt, 1996; Bandura, 1969). People encounter problems of varying intensity regularly and problem solving skills can help to keep those problems from becoming too overwhelming. Skillful problem solving can help Veterans to cope with a wide array of life issues and demands. In fact, problem solving skills training has been included in treatments across a variety of populations and in a variety of settings. Whether a person is trying to reduce or stop substance use, manage serious mental illness, adjust to new life situations, or simply trying to improve and maximize their effectiveness, the cognitive skills for problem solving can serve as an invaluable roadmap or "paradigm for survival" (Mahoney, 1974).

A problem can be defined as a situation that requires an effective response but for which no such response is immediately apparent to the individual (Dobson, 2010; D'Zurilla & Goldfried 1971; Mahoney, 1974). In such situations, the individual perceives a discrepancy between "what is" (i.e., the current conditions) and "what should be" (i.e., the desired conditions) but the means for reducing this discrepancy are not apparent or available to the person. Demands of the situation can come from the environment (e.g., task demands, expectations of others) or can originate within the person (e.g., a personal goal, need or commitment). Problem solving has been defined as "the self-directed cognitive behavioral process by which one attempts to find effective solutions for specific problems encountered in daily living" (Dobson, 2010). Those with substance use disorders may turn to use of substances as a means for managing or avoiding the immediate problem. The acquisition of problem solving skills can help people find alternative ways to cope with perceived demands by providing a means (or roadmap) for determining what they want to do when a problem situation arises. Developing these problem-solving skills also leads to higher self-efficacy which supports change processes.

The aim for this section is to guide Veterans in the development of a skill set that can improve their ability to evaluate problems logically and then consistently use the skill to resolve problems. This topic may be particularly useful for Veterans who have impulsive cognitive styles or are unaccustomed to thinking through alternative behaviors and consequences. It is also useful for people who may be unaware of problems when they arise, or perhaps ignore problems until they become crises, or people who may believe they have the skills but when confronted with problems tend to act impulsively. Practicing the

skills in session is important for these reasons. Having a strategy for dealing with problems can make solving the issues that arise much easier. A point to keep in mind is that some Veterans use substances specifically to try to avoid or ignore problems. Once they cease using substances, the underlying problems may be impossible to continue to ignore and may seem more present. One Veteran, for example, started to experience a flooding of intrusive recollections and images after stopping alcohol. As always it is important to continue to regularly check in with Veterans to see how they are managing.

The aim for this section is to guide Veterans in the development of a skill set that can improve their ability to evaluate problems logically and then consistently use the skill to resolve problems.

Online Resource

In addition to learning and practicing problem solving skills in and between sessions, sharing information about http:\\StartMovingForward.org is encouraged. This is a free, on-line resource that teaches problem solving skills. It is designed to be particularly helpful to Veterans, Military Service Members, and their families.

Problem Solving: Implementing the Session(s)

Overall Goal

Learn and practice a skill set aimed at improving the ability to evaluate and resolve problems in a logical and consistent manner.

Cognitive Behavioral Strategies

- Provide a Rationale
- Explain the Problem Solving Process

Materials

- BAM or BAM-C (consult Figure 3)
- Other assessment measures (consult Figure 3)
- Breathalyzer and urine drug screen (consult Figure 3 & as clinically indicated)
- Exploring Triggers handout (for the functional analysis)
- Problem Solving Steps worksheet

Structure of Session(s)

✓	Bridge from previous session
✓	Functional analysis (as indicated)
✓	Agenda setting
✓	Discussion of agenda items/Cognitive behavioral strategies: Problem Solving
✓	Closing the session/Planning the home assignment

Beginning the Session(s)

As with each session, begin with a bridge from the previous session, followed by a functional analysis, and set the agenda. Detailed instructions for each of these tasks are provided on pages 11-13 in the section titled "General Session Structure." If the Veteran is also receiving pharmacotherapy, this is a good time to check in about how that is going and whether or not the Veteran is using medications as prescribed.

Discussion of Agenda Items/Cognitive Behavioral Strategies

Provide a Rationale

Always preface the discussion and practice of cognitive behavioral strategies by providing a rationale. Read the information provided in the Therapist Information Sheet and substitute words that provide a rationale in a way that the Veteran will understand. Check in with the Veteran to determine if the rationale is understood.

Explain the Problem Solving Process

First, convey that everyone has problems. A problem can be rather benign such as figuring what time to get out of bed in the morning to more serious and stressful demands involving an array of life issues (e.g., illness, relationship strain, lost keys when in a hurry, etc.). Most of the problems encountered can be effectively handled. Effective problem solving takes time and concentration and may cause some Veterans to feel anxious. However, the time spent on problem solving often pays off while the impulsive first solution that comes to mind is frequently not the best solution.

Next, review the basic steps in problem solving summarized below (adapted from D'Zurilla & Goldfried, 1971; Monti et al., 1989).

Problem Solving Process

1. Problem Recognition

Is there a problem? Recognition of problems can come from different clues. We get clues from our bodies, thoughts, feelings, behaviors, reactions to others, and ways others react to us. Those clues include anger, depression, having problems pointed out by others, being preoccupied, or always feeling like you're in crisis.

2. Problem Identification

What is the problem? Describe the problem as accurately as you can. Break it down into manageable parts. It is easier to solve problems that are concrete and well-defined than those that are global or vague.

3. Considering Various Approaches

What can I do? Brainstorm to think of as many solutions as you can. Consider acting to change the situation and/or changing the way you think about the situation.

4. Selecting the Most Promising Approach

What will happen if...? Consider all the positive and negative aspects of each possible approach and select the one likely to solve the problem.

5. Assess the Effectiveness

How did it work? After you have given the approach a fair trial, does it seem to be working out? If not, consider what you can do to improve the plan or give it up and try one of the other possible approaches. It may be necessary to repeat steps one through five several times before a complex problem is solved.

Ask Veterans to focus on a couple of recent problems, one that is closely related to substance use and one that is less so. Work with them through the problem solving steps for both. Some clients will have difficulty recognizing current problems. Others may lack practice with brainstorming and considering alternatives and will quickly select a solution. In such cases, use the EPE format to assist the Veteran in identifying problems to focus on.

For those who struggle with impulsivity, it can be particularly important to write down the problem and the selected approach so that the steps are not forgotten when it is time to implement them.

Following are two examples of a therapist and client working through a problem in session. The therapist works collaboratively with the Veteran and fills out the ***Problem Solving Steps*** worksheet (available at the end of this section and in the Appendix). The worksheet is provided to the Veteran at the end of the session.

Example 1

Matt has been isolating more, feeling discouraged, and having the following automatic thoughts:

- "I don't fit in anywhere."
- "I mess up everything."
- "I cannot manage without taking something to take the edge off."
- "I don't get along with people without alcohol or pot."

Step 1: Recognizing the Problem

Matt: I've just been having a hard time. It seems like everything is messed up. I've let everything get out of hand.

Therapist: Things have been overwhelming recently.

Matt: Yes. I just don't feel right. I'm always angry.

Therapist: Something is bothering you quite a bit.

Step 2: Identifying the Problem

Therapist: Matt, I'm curious what you think is going on? What the problem might be? What's your best guess?

Matt: My wife doesn't get what's going on with me. She thinks she does. I've never talked to her about some of the things that bother me. She says I use my anxiety disorder as an excuse. I get so angry when she says that. I get angry and it happens so fast I can't stop myself. She thinks I should be able to just let things go like I did before the deployments. It's like I just don't measure up anymore. A couple of beers is the only thing that calms me down.

Therapist: So if we had to write it in one sentence what would we write?

Matt: I guess it would come down to having a problem really talking to each other.

Therapist: The two of you are having trouble communicating about certain issues. Let's try to break this down into some smaller, manageable pieces. One issue you mentioned is that your wife doesn't really understand the impact anxiety is having on you. A second issue is that you feel pressure to handle things the way you did before the deployments. Third, your anger gets to the point where

you feel that only a drink will give you relief. Is that the gist of what you were saying? What am I leaving out?

Matt: That's it.

Therapist: So which of these issues would you like to work on first?

Matt: I would say that if my wife could understand my diagnosis better and not keep coming at me with "it's an excuse," it would be helpful.

Step 3: Considering Various Approaches

Therapist: Okay, so the next thing is to figure out how to help her better understand you and the effect that the statements about using your anxiety diagnosis as an excuse have on you. Let's brainstorm and try to come up with as many solutions as possible. For now, just try to come up with options without making judgments as to which are good or bad options.

Matt: Well, at times I could put my hand through the wall but that would only make things worse. Maybe she could come into to a session with me and hear what the doctor says. If she could hear it from the doctor maybe she wouldn't be so critical.

Therapist: How else might she learn about what anxiety is like for you?

Matt: I heard there is a four session group for spouses to learn more about the symptoms of anxiety and the types of issues we go through. Maybe I could talk to her about going to that.

Therapist: Okay, what about something that you yourself could do to improve your situation? It is hard to change other people's behavior including your wife's behavior. You are here because you are motivated to make some changes. So, let's focus on what you can do to positively impact the situation. What can you think of?

Matt: I can take a time-out when I feel myself getting angry. Go outside or something.

Therapist: Great, what else?

Step 4: Selecting the Most Promising Approach

Therapist: Well, let's take a look at this list of possible solutions you've generated. Is there one on the list that you would be willing to try out before the next session?

Matt: Let's go with the first one. She could come to an appointment to learn more about the anxiety from the doctor.

Therapist: Do you have an appointment before our next session?

Matt: I do.

Therapist: Okay, so asking her to accompany you to a doctor's appointment — how would you go about doing that?

Matt: I could explain to her that the doctor had said to bring her along to a session and that it could help her better understand why I get the way I do at times. I can let her know that she can ask any questions she wants to.

From there the therapist will help the Veteran identify pros and cons of each strategy that was identified during the brainstorming process.

Step 5: Assessing the Effectiveness

In this step, the therapist will review with the Veteran which strategy was implemented and what the outcome was.

Example 2

Jim has been more anxious lately and having the following automatic thoughts:

- "I cannot manage another situation without a little something to take the edge off. I don't do well with people without alcohol."
- "I am no fun without a couple on board."
- "I am socially inept. I have nothing to say."

Step 1: Recognizing the Problem

Jim: I'm really not looking forward to this wedding. I find I have no tolerance for people anymore. I am just not much of a talker if I haven't been drinking. I'm no fun at all. What do I have to say that will be of any interest? I feel like people are going to see through me and see that I am not the brightest bulb on the block.

Therapist: This wedding will put you in a tough situation because you'll be around a lot of people who will want to talk to you and you'll also be around a lot of people who are drinking.

Step 2: Identifying the Problem

Therapist: What is the problem as you see it? If you were going to summarize the problem in one sentence what would it be?

Jim: I guess it would come down to feeling not real secure without some alcohol.

Therapist: Let's try to simplify this or break it down into smaller, more manageable pieces. You mentioned several different things related to anxiety. One is that you're having some anxiety about not having much to say when you haven't been drinking. Two is that you are concerned people won't find you to be interesting or fun. Three is that you're worried that you will be perceived as not very bright. What am I missing?

Jim: That seems to sum it up.

Therapist: So which of these issues would you like to work on first?

Jim: I would say that if I could calm down some without having to drink that would be a big help. Then perhaps, I could think of something to say.

Step 3: Considering Various Approaches

Therapist: Okay so the next thing is to figure out how you could manage the upset or your anxiety without drinking. Let's brainstorm and try to come up with as many solutions as possible.

Jim: I could call the whole thing off. Or, maybe I could go to the gym that day and work out so hard that I exhaust myself.

Therapist: Okay. How else might you manage the anxiety without drinking?

Jim: Hmmm. I guess I could face it and "ride out" urges to drink if they come like you showed me. If the urges get too strong I could leave early.

Therapist: Great. What else?

Jim: I could be ready to order a club soda with lime. I guess you're thinking I should try to use some relaxation techniques to stay calm.

Step 4: Selecting the Most Promising Approach

Therapist: Okay. Let's take a look at the list you've generated. We have quite a few possible solutions. Is there one on the list that you would be willing to try out before the next session?
Jim: Let's go with riding out the urge.
Therapist: Do you have any social situations coming up before our next session?
Jim: I do.
Therapist: Okay, so would you be willing to practice — how would you go about doing that?
Jim: I still keep the sheet for riding the urges on my fridge. I could practice that and use some of the self-talk we did before — maybe keep a copy in my wallet when I am going to be around people.
Therapist: Sounds like a plan. What thoughts or feelings do you have about putting this plan into action?

Step 5: Assessing the Effectiveness

This should include an evaluation of the results of the chosen solution. The important take away message for Veterans is that they can apply a logical and stepwise process for meeting the demands of daily life. The five-step sequence in this section can help them with ultimately choosing what direction to take when faced with the vast array of life's problems.

Closing the Session/Planning the Home Assignment

As always, at the end of session, conduct a final summary or, alternatively, have the Veteran summarize the most important lessons gleaned from the session. In addition to summarizing content, consider including an affirmation of the client's efforts or strengths. Also ask about how the Veteran felt about the session, especially if a particularly upsetting or sensitive topic was discussed.

When relevant and time-permitting, begin home assignments in session so that Veterans have a model when they attempt to complete it on their own. See the section titled General Structure (pages 10-11) for additional guidance on closing a session and planning a home assignment.

1. Ask the Veteran to complete a ***Problem Solving Steps*** worksheet**.**
2. Ask the Veteran to identify a problem and practice brainstorming as many potential solutions as possible.
3. Ask the Veteran to implement the most promising approach that was selected during the therapy session and then write a paragraph assessing the effectiveness of that strategy.

Other options for home assignments include:

1. Self-monitoring urges and cravings using the ***Urge Monitoring*** cards**.**
2. Completing the ***Three-Column Thought*** record**.**
3. Completing the ***Five-Column Thought*** record**.**

Problem Solving Steps Worksheet

1. Is there a problem?

2. What is the problem?

3. What can I do?

4. What is the Most Promising Approach?

5. How did it work?

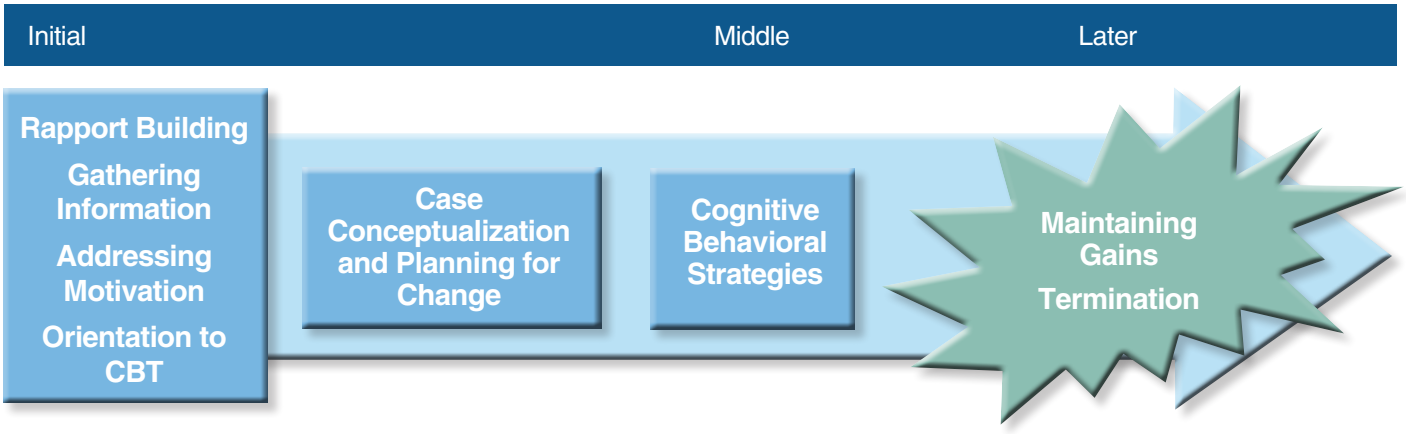
Later Phase of Treatment: Maintaining Change and Termination

Later Phase of Treatment: Maintaining Change and Termination (pages 172-176) Minimum of One Session	
Maintaining Treatment Gains	Termination

Maintaining Change

This section of the manual focuses on the maintenance phase of treatment and on termination.

Figure 10. Timeline for CBT SUD: Maintaining Gains and Termination



Possible Reasons for Ending the Middle Phase of Treatment

1. The Veteran and the therapist reach a mutual agreement that regular treatment sessions will end (normal termination). This could occur for any of a variety of reasons including (a) the therapist and Veteran agree that the goals of treatment have been achieved; (b) there are no further cognitive behavioral strategies to cover that address the Veteran's needs; or (c) the therapist and the Veteran agree for other practical reasons to stop having regular treatment sessions.
2. The Veteran unilaterally decides to terminate treatment. This could occur in any of several ways including (a) announcing that they are terminating; (b) refusing to schedule another session; or (c) stopping attending sessions, missing three or more sessions in a row, without formally announcing that they are terminating. In this case, follow national and local procedures for no-shows. Be sure to contact the Veteran by telephone and/or letter, suggest less frequent sessions, and schedule the next session (termination session) at the earliest agreeable date. When Veterans have missed three consecutive sessions and have not responded to attempts to reach them, the treatment episode is over. Document all attempts to reach and engage the Veteran.

3. If sessions focusing on cognitive behavioral strategies have extended into the 14th week of treatment, transition to focusing on termination (see section on termination on page 174) in the remaining weeks.

Presenting the Rationale for Check-Up Sessions

Maintenance sessions, or check-up sessions, consist of periodic sessions that may take place until the 16 week treatment period ends.

Once there is agreement that relevant cognitive behavioral strategies have been adequately addressed in treatment, explain that the normal procedure now is to meet every few weeks for a check-up, until the 16th week. Even for people who are doing very well, it can be useful to check in periodically through the first 16 weeks. Ask whether the Veteran is willing to come back periodically for the next ___ weeks (until the 16th week), and schedule the first check-up session. If the Veteran declines at this point, explain that it will be possible to see them for further sessions up until the 16th week, after which this particular treatment comes to an end. Invite the Veteran to call back if it seems that a session might be useful.

Remember not to use "relapse" language. The rationale for this final phase of treatment is not to "keep from relapsing." Rather present these sessions as an option that can be useful in maintaining health, like routine health check-ups with a doctor
or dentist.

The Basic Structure of Check-up Sessions

Think of this final phase of treatment as "booster" sessions to reinforce the motivational processes and cognitive behavioral skills developed earlier in treatment. As before, the significant other should be involved in these sessions.

Think of this final phase of treatment as "booster" sessions to reinforce the motivational processes and cognitive behavioral skills developed earlier in treatment.

Review Progress. Begin each session with a discussion of what has transpired since the last visit, and a reflection on what the Veteran has accomplished thus far. Emphasize the positive; reinforce all forms of progress. If substance use has occurred, review what happened in a nonjudgmental way, with a goal of gaining an accurate understanding.

Renew Motivation. The primary therapeutic style in this final phase of treatment, as throughout, should be consistent with a motivational interviewing style. Be careful not to assume that ambivalence has been resolved, and that commitment to the maintenance of goals is now solid. It is safer to assume that the Veteran is still at least somewhat ambivalent, and to continue using the motivational approach. Elicit change talk. What are the Veteran's goals now? Why are these goals important? What aspects of "how it was" does the Veteran particularly want to avoid?

Complete each check-up session with a summary reflection of where the Veteran is at present, eliciting the Veteran's perceptions of what steps should be taken next. The prior plan for change can be reviewed, revised, and (if appropriate) rewritten.

It can be helpful during these final sessions to discuss specific situations that have occurred since the last session. Two kinds of situations can be explored: Situations in which the Veteran used a substance (or increased use), and situations in which the Veteran did not use a substance.

Using Situations. If the Veteran used substances since the last session, discuss how it occurred. Remember to remain empathic, avoiding any judgmental tone or stance. Renew motivation, eliciting from the Veteran further change talk by asking for the Veteran's thoughts, feelings, reactions, and realizations. It may be appropriate to use motivational enhancement strategies or to review cognitive behavioral strategies. Remember that motivational problems can be a lack of *confidence* as well as a lack of perceived *importance.*

Non-using Situations. Veterans may also find it helpful and rewarding to review situations in which they might have consumed alcohol or other drugs previously, or in which they were tempted to use, but did not do so. Reinforce self-efficacy by asking for clarification of what the Veteran did to cope successfully in these situations. Encourage the Veteran for all small steps, little successes, even minor progress.

Returning to Cognitive Behavioral Strategies. As indicated above, it is permissible to resume sessions focused on cognitive behavioral strategies through regular (weekly) sessions if both agree that it could be useful. Avoid communicating to the Veteran, of course, that *"you won't make it without my additional help."* Rather, offer additional sessions and discuss whether the Veteran might find these helpful.

Termination

The last session(s) should be a formal termination session. In most cases, termination will be the primary focus of this session, although it is acceptable to combine this with finishing up or reviewing a prior cognitive behavioral strategy.

Preparing the Veteran

Never surprise the Veteran with, *"This is our last session."* From the beginning it should be clear that treatment ends within the 16 weeks and it is wise to remind Veterans from time to time of the approximate ending date. Three sessions before the last (termination) session, let the Veteran know that, *"We have three more sessions together after this one, so I want to be sure we have time to talk about anything we may have missed along the way."* Renew this reminder at the next-to-last session, that *"Next time will be our last session together."*

Therapist Preparation for Termination

Discussing the termination process with a consultant or supervisor when there are still at least three sessions left is encouraged. It is helpful to review all progress notes, paying particular attention to positive change and progress that the Veteran has made during this time. Consider also whether the Veteran may need to seek additional treatment or services.

Timing

Normally the termination session will occur within the last two weeks of the 16 week treatment period. If meeting less frequently (e.g., only for check-up sessions), be sure to schedule in advance the termination session for the appropriate time period.

If sessions focused on cognitive behavioral strategies continue and no check-up sessions are initiated, schedule the termination session for the appropriate week and let the Veteran know that it will be the last session together.

In some cases, a Veteran will insist on terminating treatment earlier, and will be unwilling or unable to return for a final session at the end of the 16 weeks. In this case, seek to persuade the Veteran to return for one more wrap-up session at a scheduled time before the end of the 16 weeks, "just to review together what we have done, and what you want to do after we've finished."

In rare cases where a Veteran refuses to return even for one more session, complete the termination session procedures (below) during the current (and last) session.

Essential Elements of the Termination Session

- Express your appreciation for the Veteran and the work you have done together.
- Ask the Veteran what important changes he has made during treatment.
- Review the positive changes and progress that the Veteran has made.
- Attribute positive change to the Veteran.
- Explore termination feelings.
- Ask what's next.
- Support self-efficacy.
- Consider additional treatment.

1. *Express your appreciation for the Veteran and the work you have done together.* This should not be "canned," but genuine, and individualized to this Veteran.
2. *Ask what important changes the Veteran has made during treatment.* Start by eliciting the Veteran's own perceptions of positive changes. Use reflective listening to reinforce positive elements of what the Veteran offers. Emphasize personal choice and autonomy.
3. *Review the positive changes and progress that the Veteran has made.* Provide a perspective on changes the Veteran has made. As appropriate, remind the Veteran of where he or she started prior to treatment, and comment positively on steps taken toward change. Keep this positive and relatively free of qualifiers (such as, "Even though you..." or "except for... "). This is generally accomplished by a final recapitulation of the Veteran's situation and progress through the sessions. Be careful to acknowledge success without suggesting that the Veteran was in a terrible place to begin with – this implicit comparison can be shaming.
4. *Attribute positive change to the Veteran.* Explicitly give the Veteran credit for positive changes that have been made. For example, *"I'm glad if I have been helpful, but really it is you who have done the work and made the changes. I certainly didn't do it. Nobody else could do it for you. I appreciate how much you've accomplished in this relatively short time."*

5. *Explore termination feelings.* Ask an open question such as, "How are you feeling now that treatment is coming to an end?" Reflect what the Veteran offers. If negative feelings emerge, normalize them ("That's pretty common.") and express understanding. If the Veteran is terminating early, leave the door open to come back within the 16 week window *("Sometimes after a while people have second thoughts, or think it might be useful to check in. If that happens, it would be okay to call during the next weeks.").*
6. *Ask what's next.* Ask the Veteran to reflect on what is likely to happen in the months ahead. Are there additional changes that the Veteran would like to make? What new goals does the Veteran want to pursue? Elicit change talk for the maintenance of changes that have occurred, and for any additional changes the Veteran would like to make.
7. *Support self-efficacy.* Emphasize the Veteran's ability to choose and change. Express hope and optimism for the future, based on knowledge of the Veteran.
8. *Consider additional treatment*. If appropriate, discuss whether additional treatment (e.g., aftercare, continuing care) might be helpful. If there is a specific concern, describe it and encourage the Veteran to consider seeking further treatment. Provide specific referral information as appropriate.

Pull-Out Procedures

Pull-out procedures are provided in this section of the manual. Pull-out procedures offer guidance on the management of specific issues that may arise during the course of treatment. They are procedures that are designed to be used as needed. It is strongly recommended to become familiar with the content of these procedures in the event they are needed.

The three pull-out procedures are:

1. Addressing Resumed/Increased Use
2. Assessing Safety and Safety Planning
3. Management of Acute Intoxication

Addressing Resumed/Increased Use

At the first session following resumed use after at least one full week of abstinence, or if there is increased use, directly discuss the conditions that surrounded initiation of use or increase in use.

This is also a good time to revisit the issue of medication and make a referral for medication, if appropriate. If the Veteran is already prescribed medication to help achieve substance use related goals it is important to check in about whether the medication is being taken as prescribed. The Veteran should also be encouraged to discuss any increased use, or a return to use, with their prescribing provider.

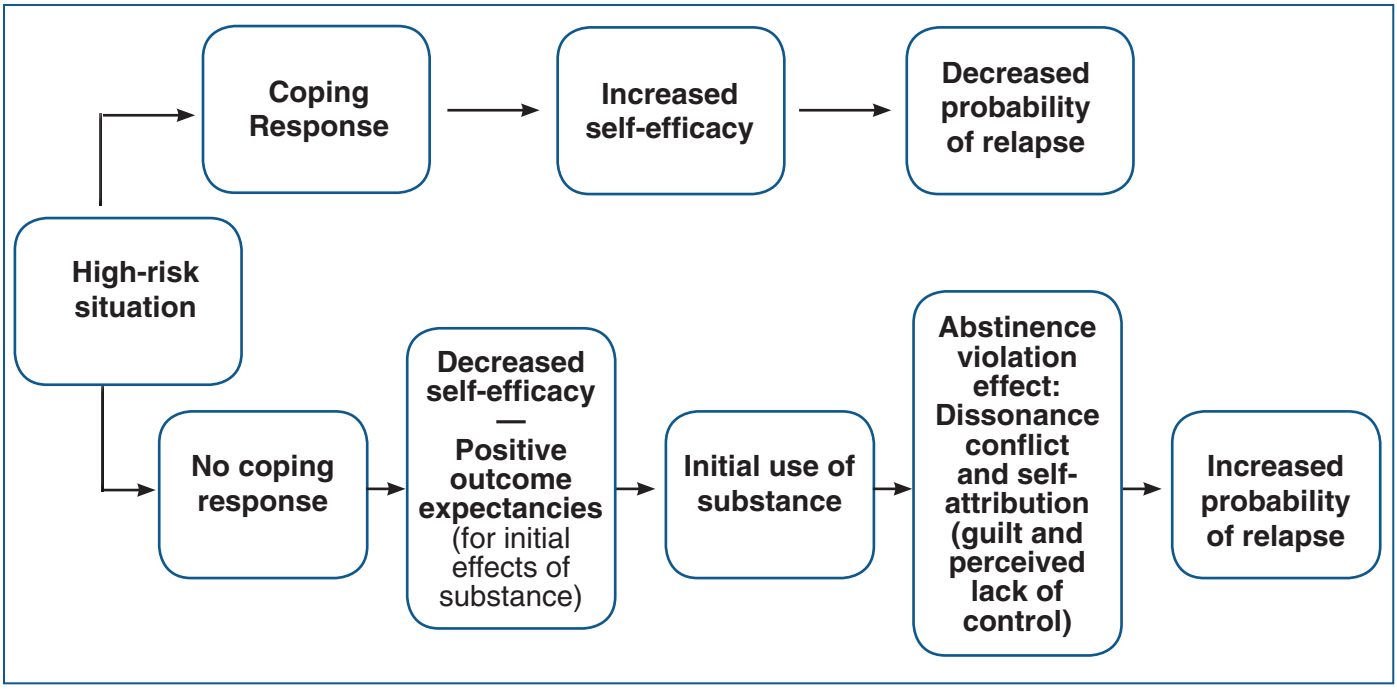
The *VA/DoD Clinical Practice Guideline for Management of Substance Use Disorders* (2009) is an excellent resource for information on addressing returns to use or episodes of increased use.

Background on the Cognitive-Behavioral Model of the Relapse Process

Marlatt and Gordon (1985) described what they referred to as "The Relapse Process." It is a cognitive behavioral model that provides a useful way to conceptualize substance use, increased substance use, and resumed use after a period of abstinence. The process includes (a) immediate determinants and reactions, and (b) covert antecedents.

The immediate determinants and reactions are depicted in Figure 11 on the following page. When an individual is exposed to a high-risk situation, two different paths are possible. Frequently, high-risk situations involve negative emotional states, social pressure, and/or interpersonal conflict (Cummings, Gordon, & Marlatt, 1980).

Figure 11. Cognitive-Behavioral Model of the Relapse Process[12]



Path 1: If individuals have a wide variety of healthy coping skills, they may choose to use these skills as a response to the high-risk situation. If the individual uses a healthy coping response, this will result in increased self-efficacy for responding to the high-risk situation in the future. Increased self-efficacy for managing high-risk situations leads to a decreased probability of relapse.

Path 2: Alternatively, an individual who is exposed to a high-risk situation may not have the coping skills necessary to respond in an effective, healthy way. Or, an individual may have the coping skills but not put them to use. It is possible that the person does not believe in their ability to abstain from substance use when facing a particular high-risk situation. It is also possible that the individual has positive outcome expectancies for substance use. That is, the person believes that the outcome of using will be something positive. "Taking a hit will calm me down right away," or, "I could handle this situation after a couple of drinks," are examples of positive outcome expectancies. Low self-efficacy and/or positive outcome expectancies contribute to the use of the substance. In this model, use of the substance can trigger what Marlatt and Gordon termed the abstinence violation effect (AVE) or the rule violation effect (RVE) when applied more broadly to goals of reduced use. The AVE may occur when, after a period of abstinence, a person resumes use. If a person is committed to abstinence from substances and views substance use from an all-or-none perspective, any amount of substance use may trigger AVE. Similarly, if someone has a goal of reduced use, maintains reduced use for a period of time, and then increases use again, it is possible the RVE may be triggered. The person experiences guilt over the behavior and perceived lack of control and, in turn, continues to use substances.

[12] Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors, G. Alan Martlatt & Judith R. Gordon. 1985. Copyright Guilford Press. Reprinted with permission of The Guilford Press.

The goals of this procedure are to help the Veteran:

1. Explore competing motivations to continue using (or continue using with a higher frequency and/or quantity) and to resume abstinence (or decrease use again).
2. Identify specific triggers for using and determine whether abstinence/reduced use can be aided by learning new coping skills.
3. Explore the Veteran's cognitive affective reactions to resumed (or increased) using.
4. Develop a plan (as appropriate) to resume abstinence (or the previous lower level of use).

There are many reasons that an individual might increase use or return to use following a period of abstinence. Some of the possibilities include: (a) the Veteran has experienced a change in motivation, (b) the Veteran is having difficulties coping with specific triggers, and/or (c) the Veteran has been unable to recover from the impact of using (or using more than intended) remember the abstinence or rule violation effect described earlier (Marlatt & Gordon, 1985).

A first step in managing resumed or increased use is to determine whether it resulted from (or has resulted in) a shift in the Veteran's motivation for change. How does the Veteran understand what happened? How does the change in use fit in with the client's short-term and long-term goals? Here are a few examples of ways to talk with the Veteran about resumed use.

- Elicit from the Veteran the advantages of resumed abstinence (or decreased use) and the risks/costs involved in continued using (or continued use at the increased level). Avoid the situation of arguing for change, while the Veteran argues against it.
- Review the Veteran's originally stated reasons for making a commitment to change, and for initially making those changes. Ask whether any of these reasons have changed, and whether using has for some reason become more important. While abstaining (or using less), did the Veteran "miss" certain aspects of using?
- If reluctance or defensiveness are met while exploring resumed/increased use, use the style and procedures outlined in the section on managing sustain talk and discord.
- Encourage the Veteran to anticipate actual or possible adverse effects of resumed/increased use. What problems have occurred in the past as a result of resumed/increased use? Has the Veteran had any problems yet as a result of resuming/increasing use this time (medical, emotional, financial, legal, social, relationship, etc.)? What possible negative consequences could occur with continued use? Remember to use open questions and reflective listening so that it is the Veteran who voices adverse effects.
- Ask the Veteran to review possible short-term and long-term benefits of reducing use or resuming abstinence (e.g., improved health, relationships, emotions, school or job performance). If the Veteran was abstinent for a period of time before resuming use, did he or she experience any positive change or benefit? Were there immediate benefits that the Veteran had hoped for, but did not occur?
- Reassess the Veteran's goal with regard to using, emphasizing autonomy and responsibility for making this choice.
- Use or reuse one or more of the motivational enhancement strategies described in this manual.

Here is a possible scenario in exploring motivational issues related to resumption of substance use.

Jim: Well, I did it again. The alcohol got the best of me and I think part of me liked it.
Therapist: You drank since I last saw you.
Jim: I really did enjoy it. I think I missed drinking more than I thought I did. I'm wondering if it would be OK to drink from time to time.
Therapist: You've got a decision to make. In the past you've told me that you really want to stop altogether for health and family reasons. You had said that you didn't think cutting down was an option for you. Now you're not so sure. Would it be OK for us to talk through some of the reasons you decided you wanted to make changes to begin with?
Jim: I can tell you what the reasons were. I wanted my wife to stop nagging me, my daughter to let me see my grandchildren, and my liver to work. I still want all of those things. What I really want is to have all those things and be able to drink occasionally.
Therapist: So you're feeling two ways about the situation. Your reasons for wanting to stop drinking haven't changed and at the same time you find yourself wanting to drink.
Jim: Yes. I'm an adult. If I want to have a beer I should be able to have a beer.
Therapist: You don't want people to tell you that you can't drink. You want people to know that the choice to drink or not drink is yours.
Jim: You've got it.
Therapist: Okay. So you drank and you said that "part of you" liked it. Does that mean that a part of you didn't like it? I'm curious about that.
Jim: Sure. I did feel disappointed in myself. Also my wife has been giving me the silent treatment since I drank. We had been doing a lot better.
Therapist: So part of you felt bad about drinking and your wife isn't too happy about it. How much does this concern you?
Jim: A lot really. I don't want her to leave me. She had been talking about leaving before I came into treatment. Since I stopped drinking we've been getting along really well. Until this week that is — when I drank.
Therapist: So even though you enjoyed drinking, the price you're paying for it is pretty high.
Jim: Yes. Very high. I hope my wife doesn't tell my daughter. I don't need another person on my case about it.
Therapist: The negative consequences might be even worse if your daughter finds out.
Jim: Listening to myself talk, I don't know what my problem is.
Therapist: You're questioning whether drinking was worth it after all.

This use of a motivational interviewing style would continue, leading to a summary, key question, and new process of setting goals and renewing commitment. The summary might sound like this:

Therapist: Jim, I want to let you know that I'm glad you decided to come in today and I appreciate that it is not easy to talk about these things. I also appreciate your honesty about using alcohol during the past week. You could have just cancelled the appointment and kept on drinking, but instead you came in and you were willing to talk some of this through. To summarize, you started drinking again this past week and part of you really enjoyed it. You've felt like people are telling you that you can't drink and that has really been bothering you. By drinking, you're letting people know that they can't tell you what to do. At the same time, after you drank you felt disappointed in yourself and this was because you have a lot of reasons for wanting not to drink. And those

reasons are your reasons, not someone else's. Your wife, seeing your grandchildren, and your health are reasons that you came up with when you made the decision to stop drinking. Those reasons are still there and are still important to you. What am I leaving out?

Jim: That's it.

Therapist: So where do you want to go from here?

Situational Risks and Coping Issues

A client may resume/increase use not because motivation has changed, but because the client has had difficulty coping with specific high-risk situations or with an ongoing high-risk lifestyle. In this case, the Veteran may express a *desire* to remain abstinent but difficulty in doing so. To determine whether resumed drinking has such a *functional* importance, perhaps the simplest approach is to conduct a functional analysis and inquire carefully about the antecedents and consequences of resumed drinking. If specific circumstances do not seem to explain the resumption of use, also explore more global lifestyle issues that may make it difficult to remain abstinent. Remember that factors which contributed to the resumption of use may differ from those that were uncovered in previous functional analyses and also that use is often maintained by different contingencies than those which prompted initial use. For example, Veterans may *continue* to use after an initial episode in response to: (a) anticipated or unanticipated reinforcement that followed initial use; (b) the belief that once one uses, control is impossible; or (c) a feeling of guilt or shame about using, or a sense of having "blown it" in the initial episode.

In sum, there are within the category of risk and coping issues, at least three general kinds of factors to consider, which may be operating to trigger or maintain resumed/increased use:

1. The Veteran is having difficulty coping with a specific kind of situation.
2. The Veteran is having difficulty in managing more global lifestyle issues, and this makes using more attractive.
3. The Veteran is continuing to use in response to beliefs or feelings resulting from the initial episode of resumed use.

If the problem appears not to be primarily motivational, but rather related to situational or coping factors, complete a functional analysis. According to Marlatt and Gordon (1985), covert antecedents frequently contribute to increased or resumed use. Covert antecedents are not in the person's awareness and can be thoughts, emotions, or behaviors that contribute to resumed or increased substance use. A careful functional analysis aids the therapist and Veteran in identifying these components. Marlatt and Gordon (1985) provided an example of a person who found himself gambling following a period of 6 months not engaging in the behavior. At first, the client explains to the therapist that he does not know what happened-that he just found himself gambling. The therapist has the client walk through all of the events leading up to the gambling. Through this process, the client and the therapist identify several choice points where the client made a decision that brought him a step closer to resuming gambling.

If the problem appears not to be primarily motivational, but rather related to situational or coping factors, complete a functional analysis.

Therapists implementing this treatment are already familiar with how to conduct a functional analysis. Below are some additional example questions for the therapist to consider incorporating into the process.

1. *What were the antecedents?* Help the Veteran understand which elements of a specific situation might have triggered use. *Where* was the Veteran? *What* happened in the situation? *Who* was the Veteran with at the time? What *feelings* was the Veteran having at the time? What *thoughts* was the Veteran having at the time? What occurred in the situation that triggered the urge or decision to use?
2. *What kinds of expectations did the Veteran have about using in that situation?* Often Veterans return to using in a situation where they have positive expectations about the outcome of using. For example, did the Veteran expect alcohol or other drugs to decrease social tension, improve a celebration, or make conflict more tolerable? If this is the case, then it may be important to work with the Veteran to determine if there is an alternative route to obtaining these benefits, other than by using.
3. *What (if anything) did the Veteran actually enjoy about using in the situation?* If nothing, exploring this discrepancy may encourage the Veteran to consider other alternatives for dealing with the situation.
4. *Did the Veteran have coping strategies available to handle the situation differently?* If so, did the Veteran attempt any coping strategies to avoid using in the situation? A good predictor of whether using recurs in any situation is whether the Veteran has coping strategies to handle that situation without using. Does the Veteran feel able to cope with the situation without using? Has the Veteran had success coping with this type of situation in the past without using? Would it be useful to learn new coping strategies?
5. *What was happening in the Veteran's life at the time using (or an increase in use) occurred that made using look attractive or increased the risk?* People often think about using (or using more) and start taking risks with sobriety before using actually occurs. Sometimes using represents a response to more global lifestyle issues or problems that a person has difficulty managing without using. Were there accumulating problems that the Veteran felt ill-prepared to deal with? Was the Veteran placing him or herself in risky situations in which using was more likely to occur, without consciously acknowledging an intention to use? If the Veteran chose to initiate using as a way of dealing with an ongoing stressor this information would lend itself to a focus on coping strategies. A focus on coping would be most appropriate if the Veteran appears to lack coping skills (rather than already having the requisite skills but not using them for motivational reasons).
6. *How did the Veteran react to the initial episode of using (or increased use)?* Once a Veteran has an initial episode of using there is still a choice about how long the using will continue. Veterans who resume alcohol and/or other drug use may experience a strong reaction to using if they had made a public commitment to abstinence. Emotional reactions that may fuel continued using include guilt, frustration, shame, disappointment, and anxiety. Discouraging thoughts can also fuel continued using (e.g., "I can't change. I can't cope.") Instead of thinking, "I just didn't handle the situation well — next time I'll stay away from those friends"), people may make reattributions of their commitment to making changes in their substance use ("I guess I don't really want to change or I wouldn't be using."), identity as a sober person ("I guess I'll always be a drunk"), or ability to change substance use ("What's the point of trying to stay sober — once again it's clear that I have no control over my using and never will"). In this way, what starts out as a single episode of substance use can lead to sustained using.

Recovering from an Episode of Using/Increased Use

If the problem seems to be a secondary cognitive emotional reaction to abstinence/rule violation, help the Veteran reframe what happened. There are several messages that may be helpful for a person to hear in order to decrease the negative impact of an episode of using, including:

1. Achieving substance use related goals is a process during which "mistakes" can occur.
2. If using (or increased use) occurs, it can be used as an opportunity for learning, rather than a reason to be discouraged or to beat up on yourself. Think through what happened, and figure out how to avoid such situations and/or be better prepared for them.
3. Even if using (or increased use) occurs, it is not a reason to continue. Each day is a new day.

Assessing Safety and Safety Planning[13]

Although a detailed description of specific strategies for conducting a comprehensive suicide risk assessment is beyond the scope of this manual, additional information can be found in the VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide (2013). The guideline may be accessed at: http://www.healthquality.va.gov/srb/.

Veterans who are seeking mental health treatment, including CBT, in the community or in a VA health care facility may be at risk for suicide, and it is typically recommended that a *suicide risk assessment* be conducted during the initial assessment. There may be other reasons for conducting a suicide risk assessment, such as the Veteran's report of suicide intent or plan, a recent suicide attempt, new or increased severity or frequency of suicide ideation, threat or other behavior indicating imminent risk, an abrupt positive or negative change in clinical presentation, lack of improvement or worsening despite treatment, significant loss, or other negative life event. Thus, although it is recommended that the risk assessment be completed during the assessment, it may be completed during any phase of treatment as indicated by warning signs or other risk factors as reported by the Veteran, as indicated by the medical record, or as indicated by direct observation of the Veteran's behavior.

All Veterans should be provided with the number for the Suicide Prevention Lifeline: 1-800-273-TALK (8255)

Other resources include *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (Center for Substance Abuse Treatment, 2009) and in *Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors* (American Psychiatric Association, 2003).

The following page contains a list of risk and protective factors for suicidal behavior that are often considered in the context of a suicide risk assessment. Assess for these risk factors by the Veteran's verbal self-report as well as by other sources, such as the medical record, other therapists, or family members. Note whether each risk factor is present or absent.

[13] Adapted from Wenzel, A., Brown, G. K., & Karlin, B. E. (2011). Cognitive Behavioral Therapy for Depression in Veterans and Military Servicemembers: Therapist Manual. Washington, DC: U.S. Department of Veterans Affairs.

Potential Risk Factors

- History of single or multiple suicide attempts (lifetime and especially in the past 30 days)
- History of non-suicidal self-injury behavior
- History of aggressive or violent behavior toward others
- Preparations to kill self (purchased a gun, wrote a suicide note)
- Current wish to die, or wish to die outweighs wish to live
- Current suicide ideation with intent to kill oneself
- Current specific plan to kill oneself, lethal method currently or easily available
- Reluctant to reveal suicide ideation
- Regrets surviving a previous attempt
- Any recent stressful life event such as a job loss, break-up of a relationship, interpersonal conflict
- Any abrupt negative or positive change in clinical presentation
- Current severe hopelessness
- Current major depressive disorder
- Current psychosis (especially command hallucinations to kill oneself)
- Traumatic images
- Current mania or other highly impulsive behavior
- Resumed substance use or current substance abuse (illicit drugs, alcohol, and/or medication)
- Exacerbation of physical pain or other serious medical problem (e.g., Chronic Obstructive Pulmonary Disease)
- Current agitation or acute anxiety
- Current perceived burden to the family
- Current homicidal or aggressive ideation
- A problematic treatment history, including hopelessness, indifference, or dissatisfaction about current treatment, history of treatment noncompliance, current unstable or poor provider relationship, or other problem interfering with treatment

Potential Protective Factors

- Current hopefulness
- Current reasons for living
- Current wish to live outweighs wish to die
- Current perceived self-efficacy in the problem area
- Current responsibility to children, family, others, or pets
- Current living situation with dependents
- Current engagement in treatment and/or emotionally connected to the provider
- Current supportive social network
- Current fear of death, dying, or suicide
- Current belief that suicide is immoral
- Current lethal method of suicide unavailable
- Current participation in religious or spiritual activities

After the risk and protective factors have been assessed, determine whether or not the Veteran is imminently or highly dangerous to him or herself. The reasons for this determination should be noted in the medical record.

Next, choose an appropriate *action plan* given the Veteran's level of suicide risk. Although this is not intended as an exhaustive list of possibilities, one or more of the following action plans may be implemented:

1. If the Veteran is determined to be at high risk for suicide, the Suicide Prevention Coordinator is consulted.
2. The Veteran should receive an enhanced level of care. This may include the development of a safety plan, more frequent visits, and/or hospitalization and treatment plan modifications.
3. Veterans may be hospitalized if the therapist or another clinician determines that they are at a high or an imminent risk for homicide or suicide or are otherwise a danger to themselves and cannot be safely treated on an outpatient basis.

A safety plan may be completed with the Veteran for any level of risk. A safety plan is a prioritized written list of coping strategies and sources of support that Veterans can use during or preceding suicidal crises. The intent of safety planning is to provide a pre-determined list of potential coping strategies as well as a list of individuals or agencies that Veterans can contact in order to help them lower their imminent risk of suicidal behavior. It is a therapeutic technique that provides Veterans with something more than just a referral at the completion of suicide risk assessment. By following a pre-determined set of coping strategies, social support activities, and help-seeking behaviors, Veterans can determine and employ those strategies that are most effective in managing acute distress. It is strongly recommended to consult the following VA manual, *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version* (Stanley & Brown, 2008) for a full description of the safety plan protocol.

Consider referring the Veteran to another provider or agency, or assisting with the coordination of care, including referral to a VA clinic or agency, to a physician for a medication evaluation, to a Suicide Prevention Coordinator, or to an emergency department or urgent care service. The Veteran's agreement to go for additional consultation should be noted, and the method of transporting the Veteran to this evaluation should also be disclosed. Regardless of the referral options provided, be familiar with and follow specific guidelines established at local facilities.

Finally, identify *follow-up procedures*. These may include ensuring continuation of care in the days or weeks following the suicidal crisis or plans for conducting a follow-up risk assessment (interview time and date are noted), examining the medical record (especially from any recent hospital admissions), contacting a provider or agency also responsible for the Veterans care, or contacting family members or other responsible individuals (especially to alert them of increased suicide risk).

Management of Acute Intoxication

Before beginning treatment, make clear to the Veteran that there is an expectation that the he will refrain from using alcohol or other drugs prior to arriving for treatment sessions. This should be explained in a non-punitive, non-confrontational way. Make clear that the primary reason for this expectation is so that the Veteran will be able to experience maximum benefit from treatment sessions.

When evaluating a Veteran that is intoxicated, care must be used to establish and promote a clinical relationship of trust and compassion that may provide an opportunity to engage the Veteran in further clinical assessment and appropriate follow-up with clinical services.

Resources

Local facilities may have procedures in place for managing acute intoxication. Be familiar with any such policies. In addition, the following documents contain guidance relevant to the management of acute intoxication:

1. VA/DoD Clinical Practice Guideline for Management of Substance Use Disorders (2009) available at: http://www.healthquality.va.gov/Substance_Use_Disorder_SUD.asp
2. Under Secretary for Health's Information Letter: Procedures for Assessing Suspected Alcohol Intoxication and Behavior Risk Including Use of Breathalyzers (January 2, 2008) This document is relevant only for clinicians working within VA. Note this is not active policy.
3. Memorandum from the Deputy Under Secretary for Health for Operations and Management: Management of Substance Use Disorders (November 23, 2007) This document is relevant only for clinicians working within VA. Note this is not active policy.

Important Considerations for Clinicians Working Within VA

- The Veteran must provide informed consent for the use of breathalyzers or blood alcohol tests except in the case of a medical emergency.
- The resources above provide specific guidance on what a clinician is required to do in the event that a Veteran is intoxicated, or appears intoxicated, and it is suspected that the he intends to operate a motor vehicle.
- The resources above also provide guidance on disclosing patient information to entities outside of VA (e.g., law enforcement).

When to Reschedule a Session

The VA/DoD Clinical Practice Guideline for Management of Substance Use Disorders (2009) provides useful information on signs and symptoms of acute intoxication and withdrawal for a variety of substances.

If a Veteran presents for treatment who appears to be under the influence of alcohol or other drugs, self-reports that they are under the influence, or has a positive BAC, *and* there is concern about the client's ability to benefit from a session then reschedule the session.

In place of the planned session, a truncated session should take place that focuses on any immediate safety concerns and problem solving surrounding any barriers that could potentially interfere with the Veteran returning to the next session sober. When a therapy session is rescheduled due to acute intoxication, it should be rescheduled as soon as possible. Encourage the Veteran to return to the next session and continue with treatment.

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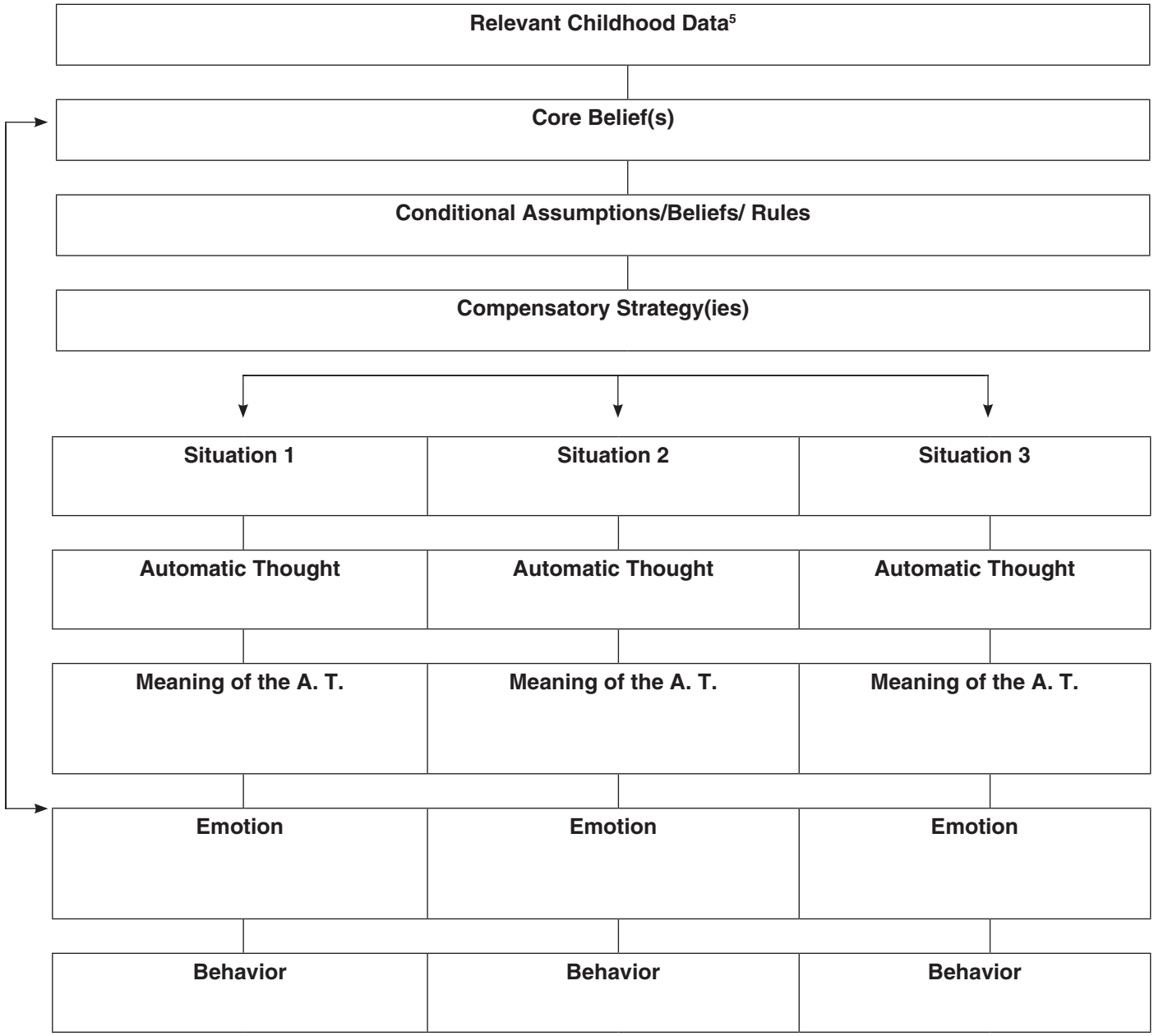
Appendix A

Session Handouts

Exploring Triggers				
Triggers What sets me up to use?	**Thoughts and Feelings** What was I thinking? What was I feeling?	**Behavior** What did I do then?	**Positive Consequences** What positive things happened?	**Negative Consequences** What negative things happened?

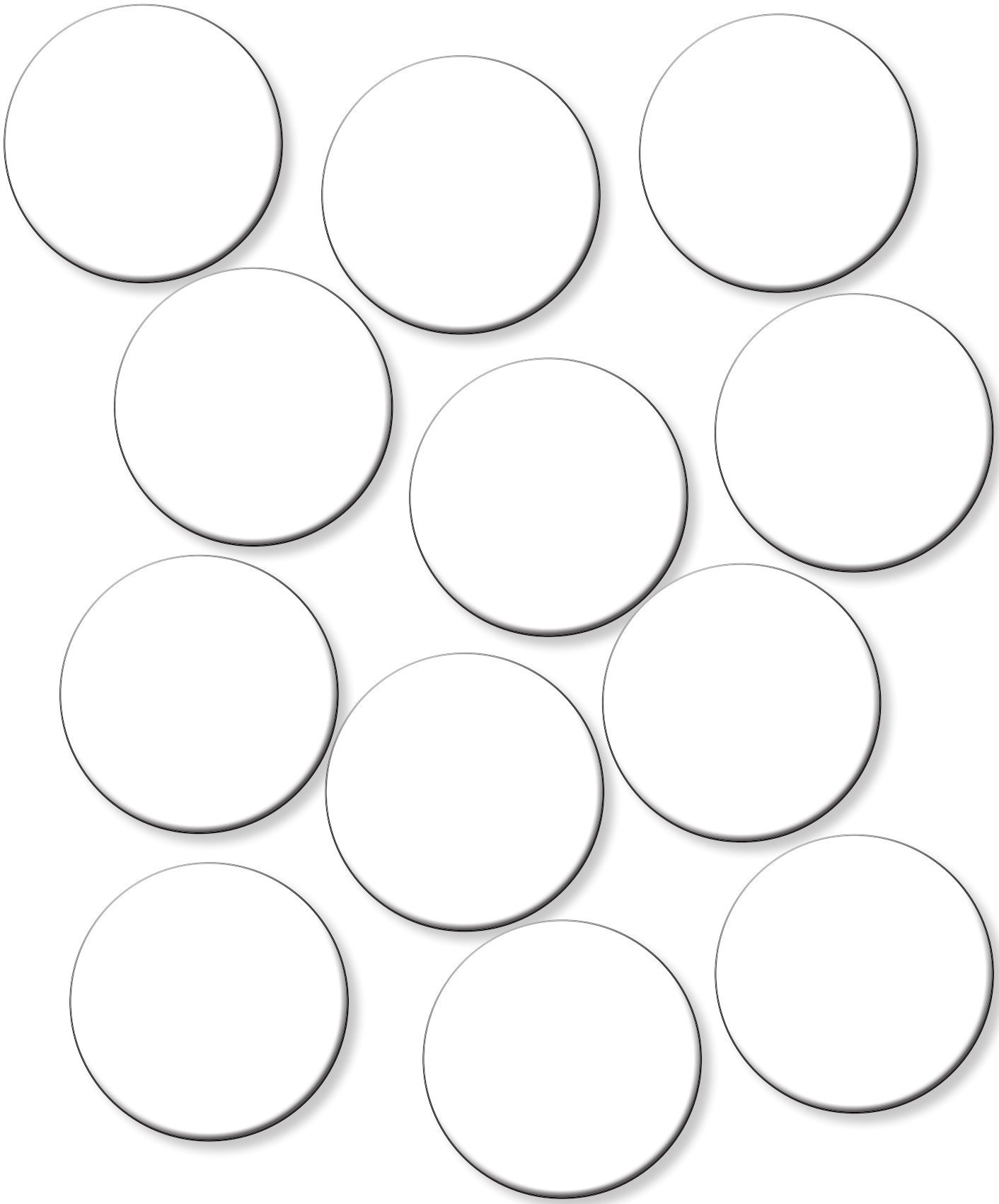
Cognitive Conceptualization Diagram[4]



[4] © J. Beck, 1996. Reprinted from *Cognitive Therapy Worksheet Packet* and used with permission.

[5] For the purpose of this manual, formative experiences in adulthood that impact the Veteran's present-day cognitive, emotional, and/or behavioral functioning are also included.

Options



Change Plan

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

Facts about Cravings

Cravings are a common occurrence when stopping or reducing alcohol and/or drug use. Understanding cravings helps people to overcome them, so here are some simple facts.

1. Cravings are the result of long-term alcohol and/or other drug use and can continue for some time after the use has stopped. People with a history of heavier use might experience stronger or more frequent urges. These are *common*.

2. Cravings can be triggered by people, places, things, feelings, situations, or anything associated with past use. Cravings are *predictable*.

3. A craving is just like a wave at the beach. Every wave in a set starts off small, builds up to its highest point, and then breaks and flows away to shore. Each individual wave never lasts more than a few minutes. A craving is just the same. It starts off small and then builds up. But it peaks, just like a wave, and will eventually break and disappear. This whole process usually doesn't last more than minutes. Cravings are *time-limited***.**

4. Cravings will lose their power if force is not given to them by using or drinking in response. Even if use occurs only once in a while, it will still keep those cravings alive. Cravings are like a stray animal – keep feeding them and they will keep coming back. So in a very real sense these cravings are *controllable*.

5. Cravings tend to be stronger earlier on, then weaken, and eventually fade over time.

6. Each time a person does something other than drink and/or use others drugs, the craving loses power.

7. Stopping alcohol and other drug use completely is the quickest way to get rid of the cravings.

8. There are medications that help people manage cravings for alcohol and some other drugs.

Urge Monitoring

Instructions

1. Keep a couple of cards of forms and a pen or pencil with you all the time. (Discuss how the Veteran can do this - where to carry the cards, etc. Elicit the Veteran's own ideas.)
2. Whenever you feel an urge to drink or use, write it down as soon as possible. Records are much less accurate and useful if they are made later. Do not, for example, wait until the end of the day and then try to reconstruct your day. Still - better late than never, though.
3. Write down the following four things with each entry:
   - The date and time of day.
   - The situation: Where you were, whom you were with, what you were doing or thinking.
   - Rate how strong the urge was, from 0 (no urge at all) to 100 (strongest you've ever felt).
   - What you did – how you responded to the urge. If you do use, write that down. If you don't, write down what you did instead.

Urge Monitoring Card Sample

Date/Time	Situation	Rating (0-100%)	How I responded
Sept 12 2:10	Talking about what it was like using with friends. Started to feel a little antsy.	40%	Practiced riding out the urge and using the surfing instructions. Did not use.

Urge Monitoring Card

Date/Time	Situation	Rating (0-100%)	How I responded

Urge Monitoring Card

Date/Time	Situation	Rating (0-100%)	How I responded

Urge Surfing

Many people try to cope with their urges by gritting their teeth and toughing it out. Some urges may be too strong to ignore. When this happens, it can be useful to stay with your urge to use until it passes. This technique is called *urge surfing*.

Urges are like ocean waves. They start out small, grow to a peak then break and fade off. You can imagine yourself riding the wave, staying on top of it until it crests, breaks, and turns into less powerful, foamy surf. The basis of urge surfing is similar to that of many martial arts. In judo, it is possible to overpower an opponent by first *going with* the force of the attack. By joining with the opponent's force, control is taken and redirected to obtain the advantage. To practice this type of technique, of gaining control by first going with the opponent, take the following steps:

1. Take inventory of your craving experience. Sit in a comfortable chair with your feet flat on the floor and your hands in a comfortable position. Take a few deep breaths and focus inward. Allow your attention to wander through your body. Notice where in your body you experience the craving and what the sensations are like. Notice each area where you experience the urge and tell yourself what you are experiencing. For example, "Let me see. My craving is in my mouth and nose and in my stomach."

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

3. Refocus on each part of your body that experiences the craving. Pay attention to and describe to yourself the changes that occur in the sensations. Notice how the urge comes and goes.

Many people notice that after a few minutes of urge surfing the craving vanishes. The purpose of this exercise, however, is not to make the craving go away but to experience the craving in a new way. If you practice urge surfing, you will become familiar with your cravings and learn how to ride them out until they easily go away.

Situations, Thoughts, and Feelings

Situations

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

Thoughts

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

Feelings

Your Feelings: Feelings may include being happy, excited, agitated, angry, upset, afraid, and so on.

Feelings from A to Z

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

Three-Column Thought Record

Situation Describe the people, place, or thing that triggered the urge/craving.	**Thought** Write down any automatic thoughts (or self-talk) you had about using.	**Feeling** What feeling(s) did you experience?

Five-Column Thought Record-Urges

Situation Describe the people, place, or thing that triggered the urge/craving.	**Thought** Write down any automatic thoughts (or self-talk) you had about using.	**Feeling** What feeling(s) did you experience?	**Alternative, Realistic Thought** Use the questions to come up with a more balanced, realistic thought.	**Outcome** What feeling or behavior might result from the alternative, realistic thought?

Coping Plan

It is not always possible to avoid triggers. Be prepared with some different coping strategies when you are confronted with an urge.

If I run into a trigger situation:

1. **I will escape/leave or change the situation.**

   Safe place I can go: _____

2. **I will delay/put off the decision to use or drink for 15 minutes. I'll remember that my craving usually goes away in ___ minutes and I have dealt with cravings successfully in the past.**

3. **I'll distract myself with something to do.**

   Good distracters: _____

4. **I'll call my list of emergency numbers.**

   Name: _____

   Name: _____

   Name: _____

5. **I'll remind myself of my success to this point.**

6. **I'll think of the positives of not using and/or the negative consequences of using.**

7. **I will reward myself for taking positive actions based on the warning signs by (list rewards below):**

_____

_____

_____

_____

_____

_____

Checklist of Social Pressure Situations

To what extent do you expect that these situations could pose a problem for you in achieving your treatment goals?

	No Problem	Some Problem	Big Problem
1. I am around other people who are drinking and/or using other drugs.			
2. Someone who is important to me is still drinking and/or using other drugs.			
3. Family members disapprove of my not drinking and/or using other drugs.			
4. Friends disapprove of my not drinking and/or using other drugs.			
5. Other people feel uncomfortable because I am not drinking and/or using other drugs.			
6. People offer me a drink and/or other drug.			
7. I am embarrassed to tell other people that I am not drinking and/or using other drugs.			
8. Someone I live with is a drinker and/or uses other drugs.			
9. Most of my close friends drink and/or use other drugs.			
10. I go to parties and celebrations where there is drinking and/or other drug use.			
11. I try to help someone who drinks and/or uses other drugs too much.			
12. Someone I love drinks and/or uses other drugs too much.			

Identifying Social Pressure Situations and Coping Responses

Situation	Coping Response

Examples of Situations Where Assertive Communication Is Needed

1. When dealing with people in authority (as in asking for a raise, talking to a police officer about a ticket, discussing treatment with your doctor).
2. When expressing anger or criticism, especially to people who are important to you.
3. When receiving criticism from someone, especially from people who are important to you (as in explaining yourself, taking responsibility for your actions, apologizing to someone, or making amends).
4. When expressing positive feelings or complimenting someone.
5. When accepting a compliment or receiving positive feedback from someone.
6. When refusing a direct request from someone.
7. When making a request or asking for help, a favor, or support from someone.
8. When expressing an opinion.
9. When…

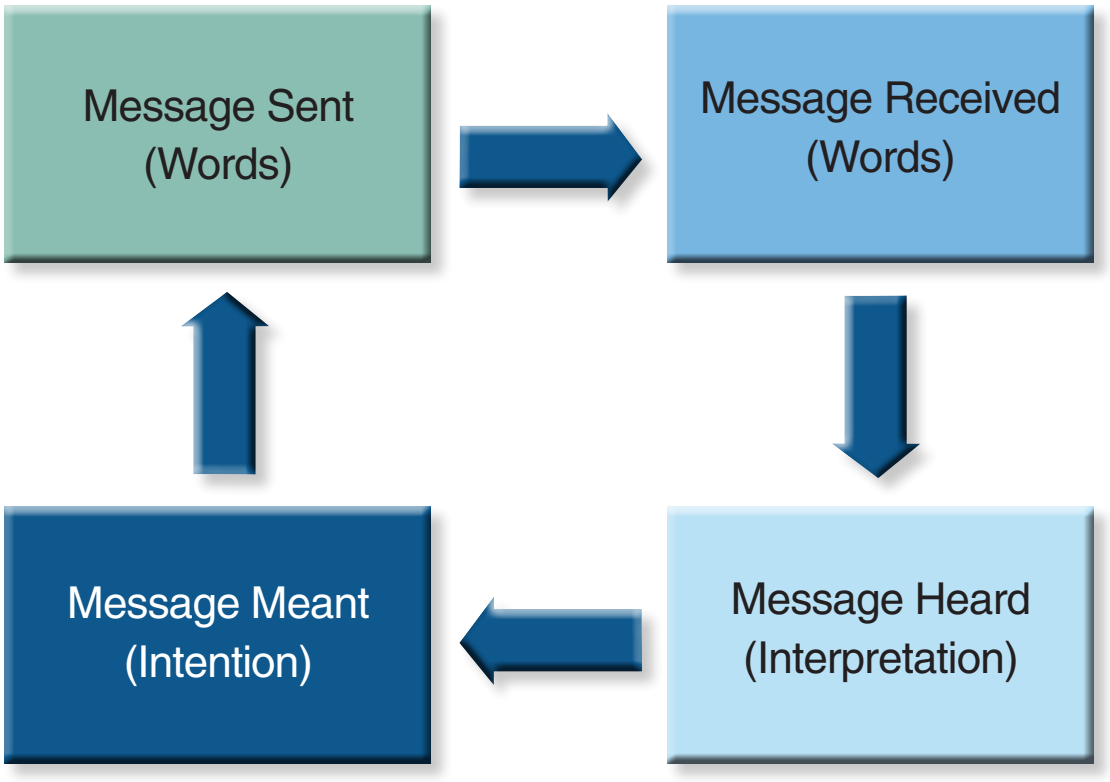
10. When…

11. When…

Basic Tips for Assertive Communication

Use an "I" Message	When you are expressing yourself (your thoughts, feelings, opinions, requests) begin with the word “I” rather than “You.” By starting with “I” you take responsibility for what you say. Statements that start with “You” tend to come out as more aggressive, blaming, threatening, and so on.
Be Specific	Address a specific behavior or situation and not general “personality” traits or “character.” A specific request, for example, is more likely to result in a change, whereas general criticism is unlikely to get your needs met.
Be Clear	Say what you mean. Don’t expect the other person to read your mind, to just “know” what you want or mean. When you make a request, make it clear and specific. When you respond to a request, be direct and definite. “No, I don’t want to do that,” is clearer than, “Well, maybe . . . I don’t know.” Your facial expression and body language should support your message. Speak loudly enough to be easily heard and use a firm (but not threatening) tone. Look the person in the eye (not at the floor). Don’t leave long silences.
Be Respectful	Don’t seek to intimidate, win, or control the other person. Speak to the person at least as respectfully as you would like to be spoken to. If you have something negative or critical to say, balance it with a positive statement before and after. Recognize that people have different needs and hear in different ways. In conflict situations, take partial responsibility for what has happened and is happening.

How Communication Happens



Five-Column Thought Record-Mood

Situation Describe the people, place, or thing that led to the negative mood.	**Thought** Write down any automatic thoughts (or self-talk) you had about using.	**Feeling** What feeling(s) did you experience? (Rate on a 0-100 scale)	**Alternative, Realistic Thought** Use the questions to come up with a more balanced, realistic thought	**Outcome** Re-rate the intensity of the feeling listed in Column 3 or list a new feeling you are experiencing.

Menu of Possibly Pleasurable Activities

- Take a drive to see something new.
- Relax and read the newspaper.
- Help your child with homework.
- Plant something to watch it grow.
- Go for a walk.
- Take a nap.
- Build something from wood.
- Feed the birds or ducks.
- Hang a hummingbird feeder.
- Enjoy a special dessert.
- Go for a run.
- Get up early to watch the sunrise.
- Walk a dog.
- Play frisbee.
- Sew something.
- Play golf or miniature golf.
- Read poetry.
- Start a memory box.
- Call a friend who makes you laugh.
- Enjoy the quiet of an early morning.
- Have lunch with a friend.
- Grow (or shave off) a beard or mustache.
- Have a relaxed breakfast.
- Compliment someone.
- Send a care package to a student.
- Call someone special in your family.
- Write to an old friend.
- Enter a contest.
- Volunteer to be a coach.
- Paint a room.
- Search your family history.
- Lie under a tree and watch the sky.
- Go camping.
- Ride a motorcycle.
- Hum or sing.
- Add an item to your collection.
- Make some food for a friend.
- Play tennis.
- Watch a funny movie.
- Read a book you've heard about.
- Listen to your favorite music.
- Go to a movie, perhaps with a child.
- Go out for a special meal.
- Lie on the grass.
- Cook a favorite meal.
- Visit an old friend.
- Pray.
- Visit a shopping mall.
- Go to a yard sale or garage sale.
- Have your own yard sale.
- Go skateboarding or rollerblading.
- Have coffee with a friend.
- Visit a museum.
- Walk along the water.
- Visit someone who is homebound.
- Spend an hour in a favorite store.
- Walk or ride a bicycle path.
- Buy a small gift for a friend or child.
- Find a place for a moment of solitude.
- Visit the library.
- Play a card or board game.
- Wash and wax your car.
- Take a class.
- Play a musical instrument (or learn to).
- Look at maps for places to visit.
- Meditate.

Reflection Sheet

I practiced listening with (person):_____

On (date and time): _____

The other person knew that I was practicing my listening skills: ☐ Yes ☐ No

Here's how I think I did as a listener:

	NOT WELL		OK		REALLY WELL
Paying complete attention and letting the person see that I was listening.	1	2	3	4	5
Keeping my own "stuff" out of it (advise, opinion, interpreting, etc.).	1	2	3	4	5
Keeping good eye contact.	1	2	3	4	5
Making understanding statements.	1	2	3	4	5

Notes: (What we talked about, how I felt, what happened afterward, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Problem Solving Steps Worksheet

1. Is there a problem?

2. What is the problem?

3. What can I do?

4. What is the Most Promising Approach?

5. How did it work?

Appendix B

Additional Resources

For Veterans and Therapists:

- National Institute on Alcohol Abuse and Alcoholism (NIAAA): http://www.niaaa.nih.gov
- National Institute on Drug Abuse (NIDA): www.nida.nih.gov or http://www.drugabuse.gov
- Substance Abuse and Mental Health Services Administration (SAMHSA): http://www.samsha.gov
- U.S. Department of Agriculture (USDA): www.health.gov
- U.S. Department of Health and Human Services (USDHHS): http://www.hhs.gov
- The Drinkers Check-Up: http://www.drinkerscheckup.com
- Rethinking Drinking: http://www.RethinkingDrinking.niaaa.nih.gov
- SMART Recovery: http://www.smartrecovery.org & http://www.overcomingaddictions.net
- Women for Sobriety: http://www.womenforsobriety.org
- Alcoholics Anonymous http://www.aa.org
- Narcotics Anonymous: http://www.na.org
- Al-Anon/Alateen: http://www.al-anon.alateen.org
- Moving Forward: http://www.StartMovingForward.org

For Therapists:

- VA/DoD Clinical Practice Guideline for Management of Substance Use Disorders (2009): http://www.healthquality.va.gov/Substance_Use_Disorder_SUD.asp
- VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide (2013): http://www.healthquality.va.gov/srb/
- NIDA Clinical Toolbox: http://www.nidatoolbox.org/
- Brief Motivational Interviewing Basics (available in the Talent Management System (TMS))
- Brief Motivational Interviewing for Veterans (available in the TMS)
- Pharmacotherapy: http://www.dpt.samhsa.gov/medications/medsindex.aspx

The “BRIGHT intervention” is designed specifically for delivery by Addiction Therapists/Chemical Dependency Counselors. The courses are intended for counselors who would like to provide treatment for depression within treatment programs for substance use disorders.

- CBT Basics: https://www.tms.va.gov/va_content/2012_05_25_0656_CBTBasics_v4/default.htm
- BRIGHT INTRO: https://www.tms.va.gov/va_content/TMS_IntroToBright_v3/lesson00/00_001.htm
- BRIGHT Essentials: https://www.tms.va.gov/va_content/TMS_CBTSessionEssentials_v4/lesson00/00_001.htm