Integrated Motivational Interviewing and Cognitive Behavioral Therapy (ICBT) for Adults With Substance Use and Co-Occurring Mental Disorders: A Practitioners' Guide

2022

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AUTHORS

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As the principal developers of this guide, we chose deliberately to write this for practitioners. This guide is written in plain English and practical, which continues to make it unique. In developing the original manuscript, we sought to make it portable across settings. We came to later know that not only are these clinical interventions transportable within settings, but the interventions are also transportable across most diagnoses. We looked at the work of Bruce Chorpita et al. (Chorpita, Daleiden, & Weisz, 2005), who published an article stating that across the majority of evidence-based practices, a common set of strategies and interventions exists for addressing substance use disorder, depression, and anxiety. Portability not only became a value that informed our thought, it is more recently reflected in contemporary scholarship regarding process-based CBT that is trans-diagnostic (Hayes & Hoffman, 2018).

INTRODUCTION

To Students and Fellow Practitioners:

The treatment approach for substance use and mental disorders described in this guide follows a clinical method that draws on innovations and essential elements influenced by screening, brief intervention, and referral to treatment (SBIRT) models; motivational interviewing (MI); motivational enhancement therapy (MET); mindfulness; values-based clinical practices; functional analysis; and cognitive behavioral therapy (CBT). Since the original guide was completed in 2013, we have continuously updated content as (1) our understanding has changed, informed by emerging science and experience; (2) we identified conspicuous gaps in what we have written; or (3) we recognized that previous content is now better informed by newer advances in behavior therapies. We also use gender-neutral language, where appropriate. New to this 2022 edition of *ICBT* is an important discussion for "Enhancing Cultural Relevance in Clinical Practice," thoughtful and practical guidance for clinicians working with diverse patient populations, and revisions to clinical Sessions 8, 10, 11 and 12.

Key references include:

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

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

Hayes, S. C., & Hofmann, S. G. (Eds.). (2018). *Process-based CBT: The science and core clinical competencies of cognitive behavioral therapy.* New Harbinger Publications, Inc.

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

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

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

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

The following features help make this guide practical for use:

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

The guide is organized into three main sections. This first section provides a review of MI, MET, CBT, the personal reflective summary as a treatment tool, and some of the newest thinking on the processes of therapy. The second section describes 16 clinical sessions. Some sessions focus on engagement, building motivation, clarifying treatment priorities for the patient, and developing a patient-clinician agreement. Other sessions address skills training, effective and healthy replacement activities, building personal awareness and mindfulness, developing specific skills to manage cravings and urges to use substances, and managing distressing thoughts and emotions. Two sessions cover known beneficial strategies equally useful with all treatment approaches: (1) use of medications in support of treatment and recovery, and (2) engagement with self-help. The format of each session in this guide facilitates delivery of sessions according to a common framework, while at the same time tailoring delivery of selected sessions to a patient's individual needs.

The third section of the guide provides a discussion of techniques and tools that support adoption and sustained implementation of interventions with a focus on enhancing fidelity. The techniques include a discussion of proven strategies for enhancing clinical supervision to increase competency in essential clinical skills. The tools will help clinicians learn and understand delivery of each session, facilitate specific session feedback, and reduce paperwork burdens. Session handouts and forms, other supporting materials, and references appear at the end of the guide.

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

SECTION 1. AN OVERVIEW OF PROVEN TOOLS AND TECHNIQUES FOR MI/MET & CBT TREATMENT

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

MOTIVATIONAL INTERVIEWING AND MOTIVATIONAL ENHANCEMENT THERAPY

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

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

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

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

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

Figure 1. The Three Types of Helping Interactions

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

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

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

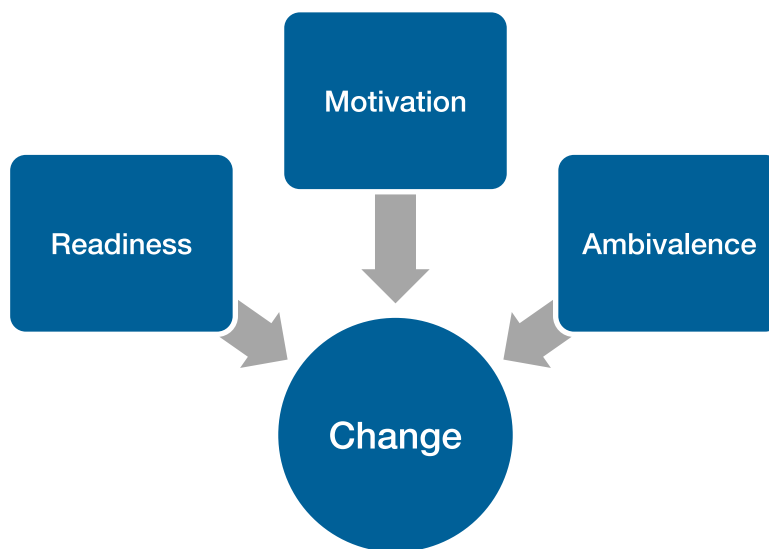
MOTIVATIONAL INTERVIEWING AND THE PROCESS OF CHANGE

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

applying for a job, increase alcohol use during a divorce, and decrease alcohol use after leaving college or military service.

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

Figure 2. The Elements of Change



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

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

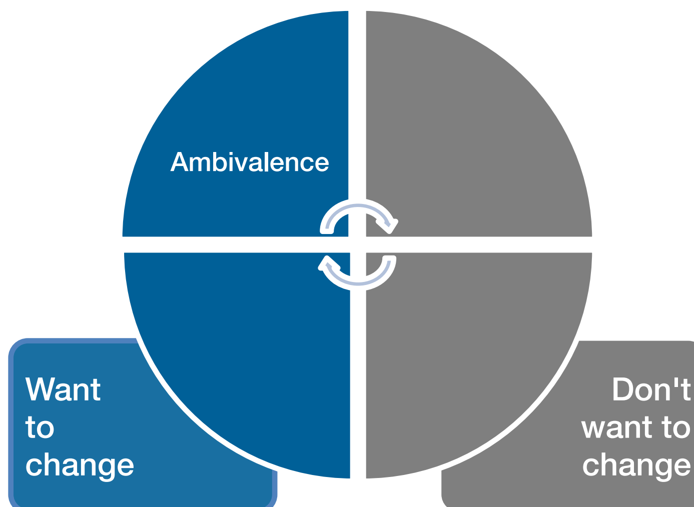
Characterizing a patient as resistant, unmotivated, lazy, manipulative, or difficult often becomes a self-fulfilling prophecy leading to more self-defeating attitudes, such as fear of failure, reluctance to being dependent on others, or a hypersensitivity to feeling controlled by someone else. The MI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

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

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

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

Figure 3. How a Patient Might Experience Ambivalence Toward Change



MI is based on the idea that people generally are not unmotivated but rather have multiple motivations that compete against one another. This is where people get stuck. Individuals might know they should make a change or that things could be better, but they also are attached to something that holds them back, such as drugs, friends, a relationship, convenience, familiarity, or security. Ambivalence is a normal

component of psychological problems, although the specifics are unique to each person and sometimes each situation. Ambivalence protects the side that does not want to change.

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

THE TWO PHASES OF MOTIVATIONAL INTERVIEWING

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

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

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

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

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

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

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

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

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

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

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

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

Motivational Interviewing Strategies

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

- **O**pen-ended questions
- **A**ffirmations
- **R**eflections
- **S**ummaries

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

Examples of open-ended questions

Where did you grow up?

Tell me a bit about your work.

What brings you here today?

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

Examples of affirmations

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

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

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

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

Example of simple reflection

Patient: *I didn't want to come in.*

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

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

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

Examples of complex reflection

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

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

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

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

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

Example of a summary

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

Giving Advice

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

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

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

Example of giving advice

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

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

In simple terms, cognitive dissonance is an uncomfortable feeling caused by contradictory ideas such as when beliefs and values contradict one's behavior. People are motivated to reduce the dissonance by changing attitudes, beliefs, and behaviors or justifying or rationalizing attitudes, beliefs, and behaviors. When encountering discord and/or expressions of "sustain talk," it is important to avoid arguments with the individual. Do not push back as this puts the individual in the position of defending the opposite side. The old term "rolling with resistance" implied that to help elicit change, the clinician would go with the direction of the conversation rather than confronting, preaching, or trying to control the conversation. The use of reflections, particularly complex reflections, is one way a clinician can help reduce sustain talk. It is also helpful to remind the patient (and for the clinician to remind themself) about autonomy and to let the patient know that change is ultimately their choice.

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

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

Recognizing Change Talk Versus Sustain Talk

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

Examples of change talk and sustain talk

Sustain talk: *"Marijuana has never affected me."*

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

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

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

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

Change Talk Discussion

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

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

Commitment Talk

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

Examples of change talk and commitment talk

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

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

Bridging Screening and Assessment to Treatment: The Personalized Reflective Discussion

The MI and MET approach to building intake collaborations from the "get go" all use assessment results to generate a specific type of reflective discussion aimed at gently increasing the following: a) awareness for areas of strength & risks, b) readiness and the desire to change c) the reasons and most needed targets of change and d) plans to work together to develop the most helpful path toward wellness. Although individuals may be aware that they are using a particular substance or depressed (or both), they may not realize they are at significant risk for negative health and other consequences. Or, they may not realize they are using at a rate, or in amounts, that are a health risk and much higher than the majority of the population. Simply hearing information reflected back—summarized to include the pros and cons/risks they themselves have shared—can be a powerful motivator.

The Personal Reflective Summary

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

- Alcohol and/or substances used by the patient
- Perceived benefits of use
- Levels of use, such as frequency and quantity
- Problems associated with using alcohol or other substances (e.g., physical/emotional health, relationships, work, role functioning)

- Current and past abuse or dependence symptoms
- Reasons to quit or to make a change
- Current motivational level regarding substance use and change
- Feelings of confidence or efficacy in being able to accomplish desired changes
- Other co-occurring concerns

The example in the list above (Sampl & Kadden, 2001) represents themes for substance use but you can imagine the same types of themes for mental health concerns helping to develop a collaborative understanding, themes for the goals of treatment and the most appropriate session skills to deliver. Assessment reflective discussion themes for mental health symptoms can include: age of onset, severity, past history of the MH symptoms, life stressors or periods of symptom relief & periods of worsening symptoms, helpful/nonhelpful medications taken, current and past social supports & commitment to engage in care.

This MI/MET sessions make use of the "personal reflective summary" (PRS) as an enhancement of previous reflective summary approaches, which focus on motivation only. The following describes the PRS process:

- As part of the intake process and after the assessment meeting with the patient; the clinician should be aware of the following:
- A working hypothesis on focus of treatment and that those services can be provided in this setting

  The focus of treatment can include the primary areas of concern and examine the domains listed above including severity which includes history, benefits of use, problems caused by use, reasons for considering change, and current motivation to change
- Client readiness (reasons for change)
- Client Priorities for Treatment
- Use of medications (if any), medication adherence
- Resources for social support
- Additional life domains such as passions or strengths including hobbies or interests, spirituality, and employment

The clinician delivers session one with the goal is to better understand the person's life, to build a working collaboration in order to the client on their path toward wellness. The session helps build a bridge from the intake assessment to the ICBT sessions through further helping to clarify client priorities and better understanding the internal and external context for patient issues. Details are described in Sessions 1 and 2.

As the next step in this approach, the clinician with use MI/MET reflective discussions and by applying functional analysis strategies will help identify and plan treatment sessions (Carroll, 1998; Leahy, 1996; Longabaugh, Zweben, LoCastro, & Miller, 2005; Agostinelli, Brown, & Miller, 1995; Davis, Baer, Saxon, & Kivlahan, 2003; Juarez, Walters, Daugherty, & Radi, 2006). This strategy help identify treatment priorities and help the patient to commit to engaging in specific treatment sessions that target those needs. The details of this process are further described in Session 2.

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

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

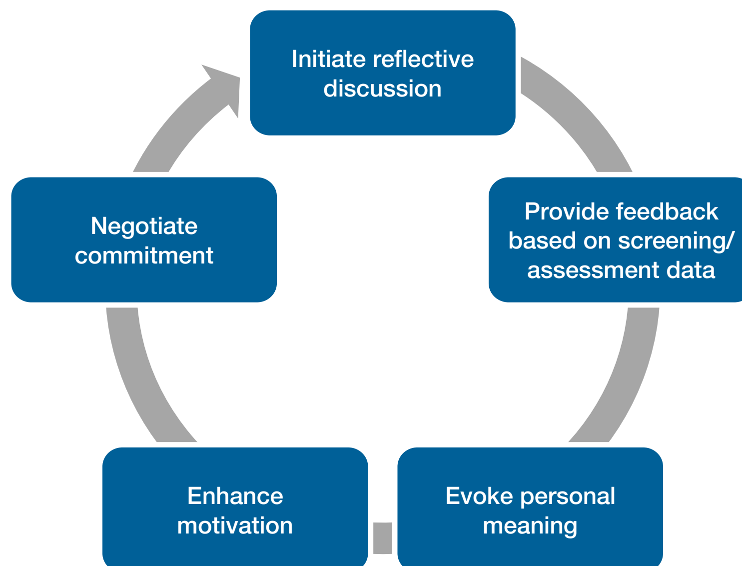
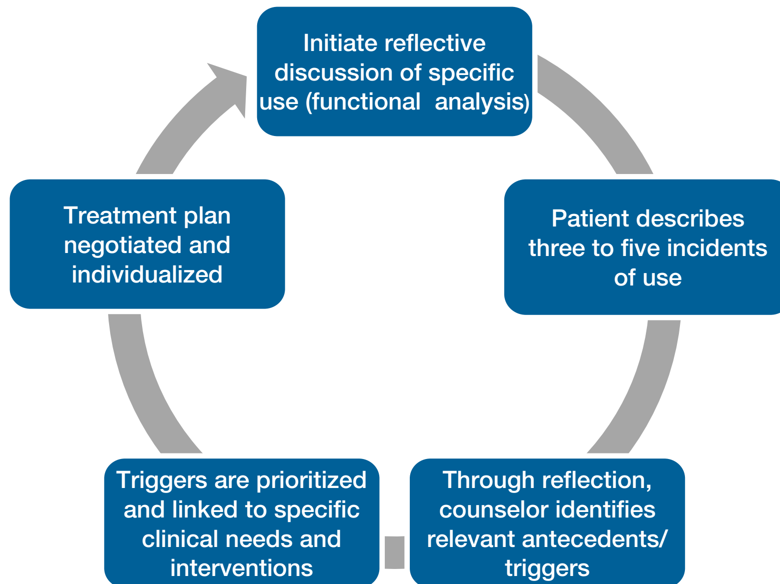


Figure 5. Phase 2, Using Functional Analysis to Identify Treatment Priorities and Individualize Treatment



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

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

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

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

handout concerning behavioral changes. The clinician-assisted change takes place through the agreed-upon brief treatment sessions.

COGNITIVE BEHAVIORAL THERAPY

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

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

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

Skills deficits are significant factors to be addressed as these challenges often lead to or perpetuate use of alcohol and drugs as a maladaptive coping strategy. To the extent the individual does not develop more

healthy coping skills, the risk for recurrence remains high if the deficits are not addressed. Similarly, certain kinds of skills deficits are associated with anxiety and depression (addressed in ICBT sessions). Managing these affective states is important in recovery and to the overall well-being of the patient.

Within this treatment guide, sessions are organized into three broad and interrelated categories—intrapersonal skills training, interpersonal skills training, and recovery support. These categories are based on the most common factors supporting recovery: situational awareness, managing uncomfortable feeling states, assertiveness, healthy committed relationships, replacement activities, guilt-free intimacy, and engagement with a spiritual community/connection to something greater than the self. Skills training also addresses causes of relapse, such as interpersonal and intrapersonal challenges resulting in negative emotional states that lead to continued substance use, relapse, and other associated problems (Marlatt, 1996).

Why Focus on Skills?

Motivation Leads to Skills Development

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

What Is a Skills-Building Approach?

The treatment skills-building approach is founded on the CBT social learning model, which focuses on learning interpersonal and self-management skills (CSAT, 1999). The emphasis is skill building rather than a deficit-oriented approach. Negative coping behaviors or thought patterns (e.g., substance abuse or depression) is considered a learned behavior that developed in response to external (e.g., environmental, relational) and internal (e.g., beliefs, feelings, thoughts, neurobiology) conditions. The skills-building treatment model suggests the habitual negative responses such as addictive behavior has become a favored strategy because of its repeated associations with predictable outcomes. For example, someone cuts themselves, or avoids others or uses substances when sad, angry, lonely, or upset; and feels less bad when cutting, using or alone; and associates the coping strategy with feeling better (at least in the short term). Over time, these immediately relieving strategies are selected more and more often as the quickest and immediate way to escape negative feelings or thoughts.

Coping with depression, anxiety, and trauma as well as improving other MH symptoms (co-occurring or not) also can be positively helped through a skills-building approach.

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

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

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

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

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

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

Intrapersonal Skills Training

Intrapersonal skills training begins with building personal awareness (mindfulness); identifying and managing thoughts and urges to use substances; managing powerful emotions such as fear or anger; and

addressing negative and self-defeating thoughts such as those associated with low self-esteem, low sense of self-efficacy, catastrophic expectations, and feelings of helplessness and hopelessness. On the positive and strengths-based side of treatment, skills training helps patients learn how to become calmer, problem solve situations, internally assess thoughts and feelings, and successfully manage and navigate what can be powerful and uncomfortable emotional states. Other skills that have proven useful and effective include relaxation training, skills for positive use of unstructured time, mastering healthy physical and mental activities, decision making, and planning for the unexpected.

Interpersonal Skills

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

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

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

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

Enhancing Social Support

Adequate social support is fundamental for most people. When individuals have struggled with depression, trauma, social anxiety and/or been involved in substance use, they can perceive their social networks as threats to continued safety & sobriety. Nurturing a vibrant social support system helps manage stress and reduce isolation and loneliness.

TREATING CO-OCCURRING DISORDERS

Behavioral health clinicians provide ideal capacity for the identification, treatment, and referral of patients with mental health and substance use conditions. Large-scale, population-based

epidemiological surveys have shown that people with a mental illness are more likely to have a substance use disorder, and the more incapacitating disorders have a higher incidence of substance use problems. Lifetime prevalence rates of 25–30 percent of patients with depression or anxiety have co-occurring substance use disorders (Miller & Carroll, 2006). Persons with primary substance use disorders have similarly high incidents of co-occurring mental disorders (37 percent of alcohol-abusing/dependent adults and 53 percent of drug-abusing/dependent adults (Regier et al., 1990). The incidence rates of PTSD in our health care systems have increased in part because of the number of male and female veterans returning home after serving in recent wars. Prevalence varies by a population's traumatic exposure but is estimated to be 12 to 14 percent among troops returning from Afghanistan and Iraq and 7 percent of all patients in routine primary care. All clinicians in behavioral healthcare need to maintain a high sensitivity for trauma, traumatic stress, symptoms of depression or anxiety or other signs of psychological distress, alcohol or substance abuse, or excessive health care utilization (Lecrubier, 2004).

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

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

Table 1 below illustrates the functionality of the model addressing mental health, substance use and/or co-occurring disorders.

Table 1. Clinical Interventions Addressing Substance Use and Mental Disorders

Treatment Sessions	Substance Use	Depression and Anxiety	Traumatic Stress
Session 1 Eliciting the Life Movie	✓	✓	✓
Session 2 The Change Plan (Use of Functional Analysis in Care Planning)	✓	✓	✓
Session 3 Learning Assertiveness	✓	✓	✓
Session 4 Supporting Recovery Through Enhanced Social Supports	✓	✓	✓
Session 5 Supporting Recovery Through Healthy Replacement Activities	✓	✓	✓
Session 6 Problem Solving	✓	✓	✓
Session 7 Handling Urges, Cravings, and Discomforts	✓	✓	✓
Session 8 Making Important Life Decisions	✓	✓	✓
Session 9 Enhancing Self-Awareness	✓	✓	✓
Session 10 Mindfulness, Meditation, and Stepping Back	✓	✓	✓
Session 11 Working With Thoughts	✓	✓	✓
Session 12 Working With Emotions	✓	✓	✓
Session 13 The Next Chapter: Wellness Planning, Writing the Story	✓	✓	✓
Session 14 Use of Medication in Support of Treatment and Recovery	✓	✓	✓
Session 15 Engagement With Self-Help	✓	✓	
Session 16 MET/CBT Approach for Traumatic Stress and Substance Use	✓	✓	✓

RECOVERY SUPPORTS

While many recognized recovery support services have emerged over the past 20 years—driven substantially by an appreciation of recovery-oriented systems of care principles—this guide addresses only two widely used recovery supports: the use of medications and self-help. The reason for this choice is there is firm evidence supporting the benefits of medications as a method of recovery support (Kelly & Yeterian, 2011), and not all recovery support services are available and accessible in all communities. However, nearly every community in the United States and elsewhere is home to 12-step, self-help meetings.

Session 14 addresses decision making related to the use of medications in the treatment of substance use and other disorders. Session 15 includes information about Alcoholics Anonymous and Narcotics Anonymous. The placement of these sessions after the skills training sessions is not intended to reflect when and how a clinician would use this information. The handouts and discussion tips may be used to inform patients about these essential recovery tools during any phase of treatment. In fact, depending on patient needs, it could be beneficial to introduce both addiction medication and self-help strategies early in ICT treatment.

PATIENT ACTIVATION WITHIN THE CONTEXT OF ICBT

This model offers clinicians a structured and systematic approach to support the transfer of learning and patient empowerment. This is done through enhancing the patient's motivation to engage in the therapy process and working to maintain a high level of engagement with in- and **out-of-session therapeutic activities**. The goal of patient activation in ICBT is to systematically support and guide the patient to increase purposeful action such that the patient experiences opportunities to manage and solve life problems with newly acquired skills and to increase self-efficacy in their ability to do so. While meaningful work can be done during the session, patients learn to become more effective in their lives by applying what is learned to real-life situations. Patient activation focuses on supporting the patient to plan and take action outside the clinical session to address problematic thoughts, feelings, and behaviors that inhibit purposeful action and self-efficacy, replacing them with healthy internal and external coping skills. Evidence shows that the more actively engaged the patient is in doing planned and purposeful actions outside the clinical encounter, the greater the likelihood of their long-term success in recovery.

ON SPIRITUALITY

Spirituality is referenced within this guide and is more commonly referenced today in clinical literature than in the past (Acceptance and Commitment Therapy: The process and practice of mindful change, SC Hayes, KD Strosahl, KG Wilson, Guilford Press (2012); Miller, G. (2003), Incorporating spirituality in counseling and psychotherapy: Theory and technique, John Wiley & Sons Inc.). We think it is important to define what we mean by the term, and to place spirituality and its relationship to the treatment of substance use and other disorders within a theoretical change framework.

We conceptualize spirituality **not as an attribute that human beings possess, but rather as activities we do.** Spirituality emerges from our actions, which are informed by self-knowledge and activated skills. From our perspective, spirituality is an action verb, not a noun or adjective. To paraphrase Erich Fromm "We are what we do" (Fromm, E. (1989). The art of loving. New York: Perennial Library). The following, therefore, is our working definition for spirituality: Spirituality is mindful awareness of, and participation in, the process of choosing based on our core values. Spirituality is taking actions (risks) based on our values, being fully present in this moment, relating intentionally to others, and recognizing we are all works in progress.

To Unpack These Interconnected Parts:

Mindful awareness happens as we quiet our busy mind's inner chatter and our mind's reactivity to the ongoing barrage of stimuli from outside and inside. Mindful awareness creates the space where we can participate as an observer of our thoughts, feelings, and behaviors. When we are aware of our thoughts, feelings, and behaviors rather than attached to them, we interpret circumstances around us more objectively, we expand and broaden our perspective, and we make conscious decisions about how to respond to those circumstances.

Cultivating mindful awareness can generate a sensation where the boundaries between ourselves and others and even the world around us can become indistinguishable. This sense can be experienced as experiencing a connection greater than ourselves, some find this in religion, others gazing at an infinite night sky, beholding vast and majestic mountains, feeling the rhythm of ocean waves, or becoming enchanted with art or music. These moments fill us with wonder and awe; they can foster a sense of connection and belonging. Those moments remind and affirm us of our connectedness to all things. This connectedness helps us understand our place, better equips us to embrace the uncertainty of life, and develops the resilience to lean in and learn from suffering rather than allowing it to victimize us.

Being present in the moment describes that we are aware and intentional of what is happening at this very moment. You are not distracted by our inner chatter about the past or worries about the future. In the present moment, you are not distracted by what has already happened or what is yet to come. Rather, you are aware of yourself. You are aware of your physical body. You may notice your heartbeat or the way you are breathing. You may be aware of your body temperature or whether you are hungry or thirsty. You notice the ways your body is communicating with you. You notice what you may be thinking and feeling. You are more aware of your surroundings, such as the sights, sounds, and smells. Being in the present moment takes practice, just like any other skill we learn, but it is an important one to develop.

Taking actions based on our personal values means living and acting intentionally; it means making conscious choices guided by what we hold most important. **Values** are our True North, our guiding principles, that keep us headed in a direction that is who we are and seek to be. Values are distinct from goals. **Goals** are targets we want to achieve in a period of our life.

Some examples of values include being an active contributing community member, being a loving and compassionate friend and partner, supporting others through good times and pain, or being a good parent by helping my children to become strong, kind and confident. These are values in action, and they unfold over a lifetime.

Goals have distinct start and end points. For example, saving money for a child's college tuition or becoming journeyman electrician. These are life goals.

Relating intentionally to others is aligned with the Spirit of Motivational Interviewing. Intentionality brings presence and power to each relationship that is important to us. Whether they are work relationships, intimate partners, or personal friendships, what we value grows if we give attention to it. Intentionality helps us understand the purpose and importance of every relationship we have.

We freely acknowledge the concept of spirituality we've outlined here differs from some religious views of spirituality. This perspective of spirituality is an active and interactive lifelong practice, and it is one that is central to overall health and wellness and to behavioral health treatment and recovery. From a clinical and recovery perspective, if spirituality is an active process, if it is something that we do, then we can be supported, and offer others support, in "doing it more fully" as part of intervention. In this context it is helpful to think of our spirituality as actions made real by these four interconnected attributes of our humanness. When we embody this spirit, we understand that the energy of relating within the space between two individuals is far more affirming and potent than the end transaction of relationship itself. This is the mindful experience of wonder and awe that fosters healing, wholeness, and connection.

ENHANCING CULTURAL RELEVANCE IN CLINICAL PRACTICE

Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender.

—Mental Health: A Report of the Surgeon General (1999, p. vi)

What Is Culture?

Culture is the product of group values, beliefs, norms, practices, expectations, and experiences (Alegria et al., 2010; Cooke & Szumal, 1993; López & Guarnaccia, 2005). Culture is social, complex, and continually evolving (Alegria et al., 2010). Culture—*our own and our clients*—affects our health and work in substantive ways. It informs how we conceptualize or understand illness and wellness, problem severity, the treatment system, attitudes toward medication, and the decision to seek care. Its influence cannot be overstated.

Culture is frequently a synonym for diversity, referring to individual characteristics (e.g., race, ethnicity, gender identity, sexual orientation, religion, country of origin, ability) that are essential to include. Yet, it is important that our conceptualization of culture be more expansive. Culture can also refer to other identities people hold, such as their profession or membership in a social group (e.g., military culture, police culture, in recovery, first-time parent, caregiver). Hinting at the complexity of culture and how we interact with it, culture must also be

understood through an intersectional lens. It is important to recognize that every individual carries within themselves multiple identities, like a Venn diagram with overlapping layers (Alegria et al., 2010), and that different layers are activated depending on the social context (e.g., at home, at work, with friends from country of origin, with friends from school).

TASK: Consider the experience of Jackie, a Black female police officer. Jackie is of Haitian descent. She has two children. Six months ago, her 16-year-old shared that they identify as queer. In the past, Jackie was very active in her church, but she recently stopped attending. Overcoming her concerns, she has come in to talk to you about feeling depressed.

- **In what ways do you think culture is playing a role in her life?**

The Importance of Culturally Relevant Practice

An essential component of culturally relevant practice is an awareness of how historical events shape current cultural climate and embedded disparities. For example, the legacy of slavery, colonization, and white supremacist beliefs embedded within institutional policies and practices continue to impact the experiences of racial/ethnic minorities and marginalized individuals living in the United States today. Maintaining an awareness of this history and a curiosity and openness to understanding how it is affecting clients today is a cornerstone of culturally relevant clinical practice. Disparities in terms of access to quality behavioral health care treatment, lower service use rates, higher attrition rates, and poorer health outcomes—based on race, ethnicity, and other marginalized identities—are well documented (Alegria et al., 2008; Jimenez et al., 2013; Nakash & Saguy, 2015; U.S. Department of Health and Human Services, 2001).

The social determinants of health (SDOH) framework is useful to identify the ways this history affects your client and their community (Marmot & Wilkinson, 2005). Using a life-course approach, the SDOH framework recognizes the impact of where we are born, live, and age on our overall health and well-being. It considers the non-medical factors that influence our health, including economic stability, access to work, neighborhood safety and the built environment, social supports and community context, and access to education and health care services. These non-medical factors also influence culture and are worth exploring with your client when developing a culturally relevant treatment plan.

Betancourt (2003) defined cultural competency in health care as "the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery of care to meet patients' social, cultural and linguistic needs." Culturally competent practice has been shown to improve engagement and retention in treatment (Huey et al., 2014; Sue et al., 1992) and health outcomes and symptoms post-treatment (Gainsbury, 2017; Huey et al., 2014; Jani et al., 2009). The shifting demographics of the U.S. have played an important role in raising the importance of cultural competency and culturally relevant practice and will continue to do so. The U.S. Census Bureau has predicted that Black, Indigenous, and other people of color (BIPOC) will comprise half of the population by 2044 (Colby & Ortman, 2015, p. 1). As the U.S. becomes more and more diverse, it is vital for all practitioners to consider the role of culture and to develop culturally relevant treatment plans.

Strategies to Improve Cultural Relevance

Part of being a culturally responsive clinician is taking the time to do your homework. Find out what you can about your client's identity and culture, their history, and any major milestones or events. Understanding these can

be useful and inform your practice. However, clinicians should also be aware of what researchers refer to as *ecological inferences* and *ecological fallacies* (Freedman, 1999). An ecological inference is made when we infer information about an individual based on group- or population-level data (e.g., children like candy, so this child must like candy). An ecological fallacy happens when we believe that a relationship observed at the group level holds for individuals (e.g., we observe a relationship between smoking and heart disease and infer that because my client smokes, they must also suffer from heart disease) (Freedman, 1999). To be culturally responsive means that you do the general research about the population and possible relationships between things but are prepared to discover that none of that information applies to your client (i.e., seeing the tree, regardless of the surrounding forest).

A culturally responsive clinician takes the time to learn about the client or family members' culture, with the goal of developing a treatment plan that acts as both a mirror and a window. It should reflect the cultural nuances you have learned about the client. It should also be a window into greater understanding, allowing the client to give feedback on its cultural relevance to the clinician, encouraging a dynamic, interactive exchange between the clinician and client that deepens knowledge and enriches the experience for both.

Making the journey from your first session to a place where dynamic, interactive exchange can happen takes purposeful action and time. The following content will help you identify strategies to navigate how to (1) address culture and explore experiences of discrimination, (2) discuss differences in understanding of the problem, (3) explore cultural perceptions of cause, and (4) examine the role of cultural identity and coping with your client.

Addressing Culture and Exploring Experiences of Discrimination

Many clinicians worry about broaching the topic of culture with their clients, concerned that they will cause offense or say the wrong thing. The worst thing you can do is ignore it. Choosing to engage in that conversation, the two most important things for you to know are that (1) no one is expecting you to be an expert on all cultures or identities, and (2) this work begins with you.

Clients are hoping for a clinician that wants to understand them and their experiences. They are not expecting perfection; they are coming to you for help. In these vulnerable moments, they are looking for respect and for someone who will see their humanity and individuality. They want and need a clinician who is interested in learning about their values, beliefs, views, and perspectives on the issue that brought them in to see you and willing to invest the time in getting to know them. To achieve this, practice thoughtful curiosity, and demonstrate cultural humility by asking questions in a respectful and sincere way with intention and purpose. Use open-ended questions like: Can you tell me what happened that made you decide to come in today? What do you think is causing the problem? Why do you think this is happening now? What would "better" look like? Are there any cultural practices or beliefs about the problem that inform how you have chosen to navigate it so far? How can I be helpful?

However, asking good questions is not enough. Prior to working with any client, it is essential for you to reflect on the assumptions and biases that you bring to your work and on how they may influence your level of engagement with your client and your treatment planning decisions. When working with your client, if appropriate, name the elephant in the room: How are we different? How are we similar? Even if you share a common thread, do not assume a shared understanding or experience. When there are differences that you feel are salient to your understanding, acknowledge them in a way that is thoughtful and clear, especially for ascribed identities, like gender or race. For example: "As a [CLINICIAN IDENTITY], I can appreciate that our experiences might be really different. I want to understand your experiences, and what's important to you. When I

have misunderstood something, please correct me. In our work together, if I say something that feels off-key, I'm hoping that you will let me know, correcting my misunderstanding and giving me a chance to learn and improve. I hope that we can have that kind of relationship."

Always be prepared to challenge your assumptions about your client, their beliefs, what they will share, or how they will work with you. After the session, reflect on how well you did. How did bias or assumptions influence the direction of your conversation or of your treatment plan ideas? Discuss this with your supervisor and come up with a plan for addressing this in your next session.

As part of this inquiry process, it is also important to get a sense of the individual's previous experience(s) with the treatment system, either for themselves or a loved one. Was it a positive experience? If so, why? Was it challenging or upsetting? If so, why? While it may take time for them to share the details of a difficult experience in the moment, letting them know that you are aware that systems can sometimes feel unfair, unkind, overwhelming, or scary signals your interest in learning more and in being able to tolerate hearing a critique of the system of which you are part without getting defensive. In addition, it is vital that your treatment plan incorporate what you learned from your work together and that you revisit the fit of your treatment plan on an on-going basis as trust is built.

In your first meeting, be sure to explain your role and confidentiality and to ensure that their expectations in terms of what you can and cannot do are clear. At all times, reflect on your language and vocabulary. Are you using jargon or unnecessarily complicated terms that would be difficult for anyone in distress to understand and remember? Check in with your client; make sure they are understanding your recommendations and treatment plan.

Finally, remember that you have skills! Your clients are looking to you for assistance in a difficult moment. They are counting on you to bring your knowledge, skills, and expertise to the table.

Differences in Understanding or Defining a Problem

It is important to recognize that we all make sense of our experiences and the world around us based on our values and beliefs. Individuals, families, communities, and cultures have different understandings of mental health, mental health treatment, what constitutes a problem, and when a problem rises to a level of concern. Even if there is consensus about the problem, different interpretations or understandings of the cause of and potential solutions to the problem will likely exist. Our beliefs may lead us to different conclusions, with implications for the next steps.

Patients share their understanding of the problem with us, providing us their interpretation. We apply our knowledge, training, experience, and cultural filter to their interpretation, generating our own interpretation; converting their interpretation into the language of our profession to develop a treatment plan; and funneling our interpretation up through the treatment system, where others will add their own interpretation and understanding (Alegria et al., 2018). Having an awareness of the inherent bias and flaws of the interpretation process is important. While this is changing, in our profession in the U.S. today, care typically centers the experience of white, cisgender, heterosexual, able-bodied, non-neurodiverse, adult men with stable housing and employment through a Western medical model of care, making adjustments for everyone that falls outside those parameters as they interact with the treatment system. Recognizing how this starting point informs or skews our interpretations can help us course correct and provide the client with the necessary resources and options they will need to receive the quality care they require.

So far, we have focused on differences between the client and the clinician. However, it is also important to recognize within-group differences also exist. For example, every member of a family may have a different interpretation of the problem, its causes, and ideas about the best response. Let's say your client is feeling intense anxiety. When they shared this with their family members, they got a range of responses based on each individual's beliefs and understanding about the cause of the problem and an appropriate response. This would likely be confusing for your client. This could be an important and rich topic for discussion when developing your treatment plan.

- **Family member 1:** "Let's get a prescription and get this taken care of"
- **Family member 2:** "I need time to pray on this; I am not sure what to do."
- **Family member 3:** "Let's give therapy a try."
- **Family member 4:** "I don't see anything wrong here; everyone is entitled to have a bad day"

Cultural Perceptions of Cause

Definitions, understandings, and theories about the cause of a problem will vary. As noted above, family members may disagree. Providers are also apt to develop different theories, based on their approach to clinical practice; relationship with the client; circumstances that brought the individual in for treatment; and, of crucial importance, the questions they ask. The Clinical Formulation Interview (CFI) embedded within the DSM-5 was designed to assist providers in any setting by offering possible questions to ask and tips when asking them (American Psychiatric Association, 2013). As Table 2 illustrates, the CFI addresses the following areas and subareas.

Table 2. Domains and Sample Questions from the Cultural Formulation Interview

CFI Content Areas	Sub-Area and Sample Question
Cultural Definition of the Problem	People often describe their problems in their own way, which may be similar to or different from how doctors describe the problem. How would you describe the problem?
Cultural Perceptions of Cause, Context, and Support	**Causes:** • Why do you think this is happening to you? What do you think are the causes of [PROBLEM]? **Stressors and Supports:** • Are there any kinds of support that make your [PROBLEM] better, such as support from family, friends, or others? • Are there any kinds of stressors that make your [PROBLEM] worse? Role of Cultural Identity: • For you, what are the most important aspects of your background or identity?
Cultural Factors Affecting Self-Coping and Past Help-Seeking	**Self-Coping:** • Sometimes, people have various ways of dealing with problems, like [PROBLEM]. What have you done on your own to cope with [PROBLEM]? **Past Help-Seeking:** • Often, people look for help from many different sources, including different kinds of doctors, helpers, or healers. In the past, what kinds of treatment, help, advice, or healing have you sought for your [PROBLEM]?

CFI Content Areas	Sub-Area and Sample Question
	Barriers: • Has anything prevented you from getting the help you need?
Cultural Factors Affecting Current Help-Seeking	**Preferences:** • What kinds of help do you think would be most useful to you at this time for your [PROBLEM]? **Client-Patient Relationship:** *Sometimes doctors and patients misunderstand each other because they come from different backgrounds or have different expectations.* • Have you been concerned about this, and is there anything that we can do to provide you with the care you need?

Cultural Identity: Strength and Coping

Cultural identity often focuses on the aspects of interactions with the majority culture or systems of care that are challenging for the client to navigate. Valid worries and concerns about access to treatment and the quality of care for racial/ethnic minorities and other marginalized identities exist. We do not need to look far to find a news article about a racist incident or to feel the sting of inequity or discrimination in our own lives. However, these situations do not define any group. It would be incredibly misleading and a disservice to discuss culture only through a negative lens. For those that identify as a racial/ethnic minority or a member of a marginalized group, there is true beauty, strength, and pride in these identities, both at the individual and the community level. Great joy and a determination to thrive, despite the challenges, inhabit these spaces. Clinicians that take the time to ask about the strengths, benefits, and pride of a client's cultural identity and what it means to them are better able to access this precious resource when it is needed.

In conclusion, taking the time to explore and understand the ways that culture influences the client's experience in the world generally, and in the treatment system specifically, is of vital importance. Taking the time to acknowledge difference and to approach difference with thoughtful curiosity is essential to good practice. Reflecting on your own identity and on the biases and assumptions that you carry is a crucial first step. Be prepared to explore what some researchers have referred to as the cultural transference and countertransference that comes into play in your clinical work (Rosenfield, 2020).

It takes a great deal of courage to seek treatment. Racial/ethnic minority clients and those that hold a marginalized identity are looking for a clinician who has an awareness of how scary and intimidating it can be to engage with providers who are unknown to them and are part of systems that may be unfamiliar or where they have had negative experiences. In these moments, these clients want what all clients want. They want to know: (1) *Are you a person of goodwill?* Are you going to approach them from a place of thoughtful curiosity, without judgment? (2) *Are you skilled?* Are you prepared to apply your skills and knowledge to the problems that they are struggling with? They are counting on you to bring your expertise; seek support if you need help; and to communicate clearly with them, especially when there are moments of tension or confusion; and (3) *Will you respect my values?* Are you open to learning about their values and beliefs? Will you respect their values in the treatment planning process? If you can commit to these three things, you will have gone incredibly far in building trust and in creating an environment that promotes culturally relevant practice.

SECTION 2. CLINICIAN GUIDANCE FOR 16 SESSIONS OF INTEGRATED COGNITIVE BEHAVIORAL THERAPY

INTRODUCTION

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

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

Sessions 1–7 are viewed as core and should be completed by all patients. Session 1 addresses engagement and motivation for change. Session 2 initiates the process of functional analysis to help the patient build situational awareness of internal and interpersonal factors affecting substance use and is used to individualize treatment strategies. Sessions 3, 4, 5, 6 and 7 are universally beneficial and necessary skill-training sessions supporting substance abuse recovery as well as other concerns. The clinician and patient may decide to complete more sessions based on identified needs. While there is flexibility in the model, the clinician should not assume the patient has the sole responsibility for deciding the number of sessions. Rather, the clinician should guide the course and plan for treatment with considerable input from the patient. The clinician must balance patient motivation and needs with clinician judgment when deciding on a reasonable duration of treatment for each patient.

We recommend that Sessions 1 and 2 are completed first and in order. These two sessions provide you (and your patient) valuable insights for setting priorities and for individualizing care. However, beyond that, we encourage you to sequence sessions based upon your patient's need. For instance, early in treatment some patients might benefit from mindfulness training and from working with self-limiting thoughts.

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

- Review relevant sections of the manual before each session.
- Develop and practice a natural style of conveying the material; avoid reading text to the patient or appearing overly didactic, dogmatic, or as though presenting a lecture.

- Maintain a motivational style; use open-ended questions and reflections; and avoid a directive, resistance-building style.
- Always provide a rationale for what you are doing. In this context, a patient rationale is describing why this activity is important to the patient.
- Encourage involvement and participation by the patient.
- Allow time for role-plays and feedback.
- Build self-efficacy; help the patient identify and acknowledge skills already in use.
- Avoid overwhelming the patient; present only one or two new skills per session.
- Remember to take a few minutes to review the between-session exercises at the start of each session.
- Attend to shifts in the patient's motivation and readiness for change.
- Explain practice exercises carefully; probe for the patient's understanding.

LAW OF THIRDS

ICBT is a structured treatment grounded in the "law of thirds." Studies in psychotherapy have determined that most successful therapy sessions occur in three phases. This came to be known informally as the law of thirds (Carroll, 1996) or the 20/20/20 rule. The law of thirds describes the first third of the therapy session as engaging, building, or reestablishing rapport and reviewing progress since the last contact and between-session practice activities. The second third is the core of that session's activity and addresses a particular skill to be introduced and practiced during the session. The final third summarizes what took place during the session and the clinician and patient identify a real-life practice opportunity and make a mutual commitment to practice the new skill in the coming week outside of the session.

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

First Third	Second Third	Third Third
▸ Establish & strengthen rapport ▸ Review of progress ▸ Review of between-session challenge	▸ Provide rationale ▸ Teach session skill(s) ▸ Clinician-led demonstration/role-play ▸ Patient-led practice (assess skill transfer)	▸ Identify real-world application ▸ Negotiate and prepare between-session challenge ▸ Elicit commitment ▸ Summarize and conclude

THE FIRST THIRD

The key goal of the First Third of the session is to **connect** and **engage**. Therefore, using the MI spirit is especially useful within this part of the session. There are three key activities delivered in the First Third of the session.

1. **Establish & Strengthen Rapport.** The clinician works to develop or strengthen rapport by using the MI spirit (compassion, acceptance, autonomy, and evocation) and core MI skills (open-ended questions, affirmations, reflections, summaries) while engaging the patient in non-problem focused rapport building (i.e., exploring areas of their life not directly related to treatment).

2. **Review Progress.** This is the clinician's opportunity to identify and explore any changes in the patient's substance use, mental health, and related experiences since the previous session. The clinician asks the patient about what has gone well what has not gone so well, changes they've made since the last session, and any other element of the patient's experience that is related to their identified challenges and treatment goals. Using the MI core skills of open-ended questions, affirmations, reflections, and summaries allows the clinician to learn more about the patient's thoughts and feelings around what they think is going well or not so well, and why. In addition, progress review serves as a feedback loop for the clinician to learn how the treatment to date is or is not working and the reasons for the treatment response (or lack thereof). Some clinicians may find it beneficial to structure their review of progress using a tool that suggests key domains relevant to most patients to review an ongoing basis over the course of treatment. An optional ***Review of Progress*** handout is provided at the end of this chapter. The domains assessed include physical activity, sleep, diet, pleasurable activities, mastery activities, work/school, substance use, and mood states.

3. **Review Between-Session Challenge.** In addition to reviewing progress over the course of treatment, it is critical in the ICBT framework to directly review the progress of between-session challenges. Between-session challenges provide patients the opportunity to apply the awareness and skills they are learning in the sessions, so they gain more confidence and practice applying the skills on their own "in the real world." By reviewing the patient's application of newly learned skills, the clinician is able to reinforce the patient's efforts, explore how skill application worked or did not work, and support the patient in identifying how to best continue working toward that skill on an ongoing basis. Some patients will benefit from re-training of the skill to maximize its utility for them. It is imperative the clinician ensure the patient knows the importance of the between-session challenges and that they will be expected to report on the application of new skills in every session. When a between-session challenge has not been completed, the clinician explores with the patient the barriers that led to that outcome. Common barriers that may need to be addressed include lack of motivation or perceived relevance of the skill, uncertainty about how to apply a newly learned skill, and external challenges outside of the patient's control (e.g.,

sudden crisis situation that takes priority, medical illness, etc.). The clinician continues to use the core MI skills and other MI tools (e.g., decisional balance) to explore motivation around skills application. Revisiting the rationale for the skill and its relevance to the patient is a strategy that can increase their willingness and perceived importance of completing the between-session challenge. General troubleshooting can also be helpful to identifying solutions to other barriers. By focusing attention on the review of between-session challenges, the clinician reinforces the expectancy of patient skills practice outside of session. Where appropriate, the clinician can use a portion of the session to support the patient applying any missed between-session challenges in session. For example, if a patient previously committed to making an assertive request to a colleague, the patient and clinician could role play a similar scenario to provide the patient an opportunity to practice and explore the outcome of their use of assertive communication.

The Second Third

The key goal of the Second Third of the session is for the clinician to **transfer a new skill** to the patient. Thus, the Second Third represents the core of that session's activity, where teaching and skill building occur. There are four key activities that occur during the Second Third of the session.

1. **Provide Session Rationale.** ICBT sessions are designed to support the patient in learning and applying new coping skills. Just as patients may experience fluctuations in motivation for treatment, they may also feel ambivalent about or have misconceptions about a particular skill or set of skills. Thus, prior to delivering any intervention activity, the clinician should explain the rationale for using it to the patient. Delivering a **personalized** session rationale helps the patient understand the activity and the potential benefit for them, thereby facilitating their increased engagement in session and commitment to skill learning and application. The rationale is not just a review of the planned session activity but an individualized discussion of how and why the session activity is important for their own clinical progress and recovery; why is it relevant for them. A sample rationale is presented within each of the ICBT session chapters in this guide.

2. **Teach Session Skill(s).** To effectively teach coping skills, the clinician shares relevant information to enhance the patient's understanding of the skill and engages in a collaborative step-by-step application of the skill. The clinician does not simply talk "at" the patient, but rather engages them in discussion along the way, eliciting their baseline knowledge, resolving misconceptions, and addressing questions or concerns.

3. **Clinician-Led Demonstration/Role Play.** To reinforce the teaching of new skills, the clinician models skill application in session through demonstration. Clinician demonstration most commonly occurs through clinician coaching the patient through skill application (i.e., walking the patient through the application of the skill using the patient's experiences as content while going through the step-by-step teaching of the skill) and/or engaging in a role play scenario where the clinician acts out the skill.

4. **Patient-Led Practice.** Observing the patient deliver or apply a skill is essential to assessing whether skills transfer has occurred. Following clinician modeling of the skill, the patient practices skill implementation in session. Patient practice helps to build confidence in their use of the skill while allowing the clinician opportunity to reinforce skill application and provide feedback.

THE THIRD THIRD

The key goal of the Third Third of the session is for the patient to prepare for transferring the skills they are learning in the ICBT sessions into their everyday life. The clinician uses their core MI skills and strategies to help patients make a connection between what they have learned in session and their daily life. There are three key activities that occur during the Third Third of the session.

1. **Identify Real-World Application.** The clinician works with the patient to connect newly learned skills to meaningful opportunities in their life. Patient's will be more likely to practice and ultimately adopt skills if they perceive them to be relevant. The clinician helps the patient to identify real-life situations in which they can apply a coping skill.

2. **Negotiate and Prepare Between-Session Challenge.** The clinician elicits from the patient how and where in their life they can apply awareness raising and other coping skills they are learning in session in their daily life. The negotiation of a challenge is a patient-centered, collaborative process, not an assignment given from the clinician to the patient. The more active the patient is in thoughtfully identifying real-world opportunities for skill application, the more relevant its implementation will be, thereby increasing buy in and the likelihood of follow through. Between-session challenges need to be specific. That is, it should be clear to both patient and clinician what they will do, when they will do it, and how often it will be done. To prepare the patient for the between-session challenge, the clinician walks through the application of the newly learned skill and supports the patient for how they will think through, approach, or deliver the skill in the identified scenario. This form of mental rehearsal sets the patient up for greater success in completion the activity. Generally, it is recommended that patient's complete at least 2 practice applications of newly learned skills in order for them to derive the intended benefit from the skill.

3. **Elicit Commitment.** After the patient has identified an area for real-world skill application, the clinician elicits commitment for engaging in skills practice. As needed, commitment can be directly assessed using the MI ruler and other MI skills used to strengthen patient commitment. The clinician also supports the patient in establishing a plan for success by having them write down their plan and think through any strategies they will use to set themselves up for success and overcome possible obstacles.

4. **Summarize and Conclude.** The clinician presents a session summary of what has been covered during the session and elicits the patient's feedback. While summaries are intended to be brief

and follow the general timeline of the session, they serve the important function of reinforcing relevant themes, setting the stage for what comes next, and setting the stage for the patient to provide targeted feedback. The clinician directly asks the patient about how the session went for them, what was particularly helpful or less helpful, and other areas in which the patient would like to provide feedback.

Delivering clinical sessions consistent with the Law of Thirds requires some accommodation in approach for many clinicians. However, with practice, this soon becomes second nature.

REVIEW OF PROGRESS & BETWEEN-SESSION CHALLENGES

Directions: Use the table below to support weekly progress review in key domains relevant to the patient's substance use and overall well-being. This table can also be used to review the between-session challenges.

Domain	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Physical Activity							
Sleep							
Diet							
Pleasure/ Replacement Activities							
Mastery Activities							
Work/School							
Mood states							
Tobacco/Nicotine							
Alcohol							
Marijuana							
Other Drugs							
Between-Session Challenge							

CBT PROCESS SKILLS

Within the law of thirds structure are process skills (sometimes referred to as microskills). These process skills are new for some clinicians and build on the customary skills of clinical training. These skills are summarized here.

1. **Motivational Interviewing.** MI is the conversational platform for ICBT delivery.
2. **Providing a Rationale.** Providing a rationale **is not** a review of the session agenda. A rationale is a discussion with your patient describing why this session or activity is important for and in service of their recovery (e.g., ***Enhancing Social Supports:*** *For any challenge in life, it is helpful to have support, whether you have chronic health problems, or employment trouble or are going through a tough time. Figuring out whom you can trust and who can help you in different types of situations creates a sense of stability in life. That is what many people call their social connections, net, or network—it supports us through many life experiences).*
3. **Use of Handouts/Worksheets.** Handouts and worksheets are tools that bring focus to a particular issue, support reflection and increased self-awareness, help to facilitate understanding, and provide tips for action or guides for planning, etc. Completing handouts is not an end in and

of itself; they are tools that support clinical objectives. *Remember: Do not confuse the menu for the meal.*

4. **Significant Experiential Elements of CBT.** For the clinician, this can include teaching and demonstrating skills, conducting roleplays with patient teaching back, and coaching to support skills acquisition. To do these well, it is important that you understand the skill and skill delivery from both a patient and clinician perspective.

5. **Negotiating Between-Session Challenges.** Negotiating a between-session challenge supports the patient transferring what is learned in session to real-life practice. This is a core behavioral activation that empowers the patient. Following through on negotiated plans of any sort are good indicators of positive outcomes. This activation is what makes CBT more potent. Important to remember: It is your patient's plan and not yours, even if your patient commits to doing something in the coming week that is **"modest"** and actually does it. That's great news!

6. **Having What Can Be an Uncomfortable Conversation.** When your patient does not follow through with their commitment for the between-session challenge, it is necessary to discuss and explore what happened. If not, you are unintentionally sending a message that the activity isn't that important. Here are the key principles for having these conversations:

    - *Saying nothing does not serve your client.*
    - *Remember and communicate that these challenges are an essential step for someone to make changes.*
    - *Saying something lets your client know that you care, and the work is important. Explore what happened.*
    - ***Important to remember:** Persons who have substance use history, or who are depressed or anxious, may not have great memory; it is often useful to start there. For that person, you can work out memory strategies.*
    - *If they agreed challenge with you to people-please or placate, address that directly.*
    - *If the challenge that was agreed to was overly optimistic and beyond capacity, next time, set modest expectations.*

SESSION 1. THE LIFE MOVIE

INTRODUCTION & SESSION GOALS

This session focuses on building rapport and building motivation for change through the Eliciting the Life Movie conversation. Eliciting the Life Movie is an important part of ICBT. The Life Movie is a motivational interviewing, semi-structured discussion designed to explore the following domains of the patient's life in relation to their primary reasons for seeking treatment including history and severity, benefits of use, problems caused by use, reasons for considering change, and current motivation to change. The Life Movie is an opportunity to explore themes from the initial assessment in greater depth to increase the patient's insight, motivation, and readiness to enact changes.

Prior to the first session, the clinician uses the patient's assessment and screening information to further understand the patient's current substance use and other domains of their life. In reviewing the assessment information, the clinician begins to develop an understanding of the patient's substance use, how it has affected their life, and potential areas to explore to further build rapport and build motivation for change. Then, the clinician and patient discuss the core areas of the Life Movie during the initial treatment session as a way to begin the conversation about where the patient stands in relation to alcohol or other substance use and what they would like to accomplish. The clinician identifies the patient's overall risk level related to substance use to share with the patient during the first session.

See the Session 1 handouts at the end of the guide, which provide the necessary framework to facilitate and deliver competent Life Movie discussions. The handouts include Treatment Information sheet as well as a clinician's reference sheet to help guide the Life Movie discussion.

With the approach described here, the patient experiences a nonjudgmental conversation with a skilled health person providing support, empathy, and a desire to collaborate on a journey toward wellness. The patient develops an awareness of substance-related health risks and begins to question their readiness to address the risks now. The patient commits to following through on any number of "readiness" tasks prior to the next meeting.

Clinician Preparation

Session 1. The Life Movie

Materials	**Session Length** / **Delivery Method**
- Treatment Information Sheet - Eliciting the Life Movie: MI Conversation - Change Plan - Optional: Learning New Coping Strategies	**Session Length** 45–60 minutes **Delivery Method** MET-focused individual therapy

Strategies

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

Goals for This Session

- Build the alliance between the patient and clinician.
- Orient the patient to what might be expected in treatment sessions, the demands on time to attend, and the time needed for practice between sessions.
- Build on the data gathered during the assessment session by engaging the patient in the Life Movie conversation.
- Explore the domains of the Life Movie, eliciting the patient's core values and enhancing the patient's motivation for change by:
  - Discussing the patient's substance use and associations with problems in the Life Movie domains;
  - Facilitating the patient's candid reflection on the consequences of substance use;
  - Exploring the patient's attitudes about change, including ambivalent attitudes;
  - Eliciting, acknowledging, and reinforcing the patient's expressions of motivation to change; and
  - Affirming any patient expressions of readiness to develop a "change plan," and identify change strategies.
- Develop a between-session challenge focused on having the patient complete the Change Plan handout.

Session 1 Outline and Overview

First Third

1. Establish Rapport:
    - Welcome the patient.
    - Share the session agenda. Invite items from the patient.
    - Engage in non-problem focused rapport building, exploring areas of the patient's life not directly related to treatment.
2. Review of Progress:
    - Ask the patient for their feelings and thoughts about the assessment session.
    - Engage the patient in a brief review of their progress related to their substance use, mental health, and related experiences since the previous session.
        - Did the patient make an effort to stop? Cut down?
        - Did the patient experience any high-risk or tempting situations?
    - Reinforce expressions of motivation.
3. Using the Treatment Information Sheet, discuss treatment expectations.

Second Third

4. Provide a rationale for the Eliciting Life Movie discussion
    - Ask the patient if they understand the reasons why the activity will be helpful in their treatment.
5. Explore each domain of the life movie, conveying the MI spirit and using MI strategies. Elicit and reflect any problems related to substance use and any positive reasons for change including living by core values.
    - Reinforce confidence in efforts to reduce use and/or quit.
6. Summarize the Eliciting Life Movie discussion emphasizing "ambivalence" and readiness.
    - Elicit and reinforce the patient's readiness to change

Third Third

7. Negotiate Between-Session Challenge

    For the patient ready to make change—

    - Assist the patient in preparing for change.

- Ask and elicit a commitment from the patient to complete the "Change Plan" Before the next session.
- If appropriate, discuss and help the patient develop a specific reduction target, "sampling sobriety period," or a stop date (if the patient has not already stopped using).
- Review previous successful experiences at quitting to identify useful strategies.

If time and if appropriate, discuss the following:

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

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

For the patient not ready to change—

- Using the MI approach of looking forward, explore what might need to be happening for them to experience concern about their use or motivation to change
- Explore what they might be willing to examine now; what might be some initial goals for them
- Discuss the Learning New Coping Strategies (Session 1 handout)

8. Assign an appropriate between-session challenge—often it can be selecting something new from the "Learning New Coping Strategies" for them to try.
    - Discuss with the patient the rationale and need to adopt or continue doing substance-free pleasurable activities.
9. Summarize and conclude the session.

Session 1 Protocol with Scripts

Establish Rapport

The clinician welcomes the patient and provides an overview of the first session, in which the clinician further builds rapport and explores domains of the patient's life with the goal of exploring the potential relationship between these domains, the patient's personal goals, and their substance use. The clinician invites the patient to provide additional agenda items for the session.

As part of building rapport, the clinician should ask the patient about non-problem areas of the patient's life. For example, the clinician may offer:

> ***Clinician (C):*** *Thank you for coming in today. I realize that you are here to explore your goals around your substance use. Before we get to that though, I would love to learn a little more about you. What do you feel it might be important for me to know about you – for example, your interests or ways you spend your time?*

Review of Progress

Next, the clinician may ask the patient to express their thoughts regarding the assessment process and any major changes that have occurred since the assessment session. Possible responses from the patient might be—

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

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

> ***Clinician (C):*** *I know last time you were here, you completed our assessment. I'm wondering how things have been since then.*
>
> ***Shirley (S):*** *After answering all those questions about my using, I am more aware of it than ever! Nothing has changed yet, but I'm thinking about it. My husband has been very supportive.*
>
> ***C:*** *And his support means a lot to you.*
>
> ***S:*** *You bet! He's someone I can count on.*
>
> ***C:*** *That's good to hear. Let's be sure to talk about specific requests you might make of him for support in the future.*

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

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

C: *How are things?*

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

C: *That sounds like an uncomfortable situation for you.*

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

C: *How has this affected your using?*

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

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

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

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

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

Review of Treatment Information Handout

The clinician presents the patient with the Treatment Information Handout. The clinician and the patient review the handout together with the clinician inviting questions and/or input from the patient.

Introduce Eliciting Life Movie and Provide Rationale

The clinician shares the rationale for the Eliciting Life Movie by expressing a desire to learn more about the patient in addition to the assessment with the goal of being able to better collaborate together. The clinician also fosters patient collaboration by asking permission to engage in the activity.

Clinician (C): *I would really like to understand more about you, your everyday life and important aspects of your background including family, other relationships, your work and other passions. This better prepares us to collaborate in ways that make sense for you. How does this sound to you as a place for us to start our work together, so you feel understand you better and that are on the same page?*

Shirley (S): *Sure, but didn't I just answer all those questions in the assessment?*

C: *Yes, you did and those were very helpful. However, those assessment questions tell me when you started drinking and how often you drink and other information like that. That information is important as it helps me begin to get a picture of your substance use and other areas of your life. The discussion I want us to have today actually builds on that by exploring areas of your life we may not yet have asked about as well as by exploring connections between different areas of your life and your drinking. This conversation is different from the assessment because it helps me to better understand how you think and feel about your life and it also helps you to see how different parts of your life may be related to your drinking.*

> ***S:*** *OK. That makes sense. I just didn't want to feel like I was telling you everything all over again.*
>
> ***C:*** *I get that, and I don't want you to feel that way either. Can I ask you – if you do start to feel that way, can you please let me know? I don't think you will but just in case, it is really important that you feel you can give me that feedback.*

Engage in The Life Movie discussion

The clinician progresses through the Life Movie handout, covering all of the more relevant domains. The session activity should feel like a conversation that builds or seeks elaboration beyond the initial assessment results. The goals of the activity are not only to build rapport and collaboration, to acknowledge and reflect patient core values and to develop discrepancies between the patient's goals and values and their current behaviors around substance use in order to build motivation for change. The clinician should not feel they need to ask every question in the handout but rather, focus on areas that seem more relevant to the patient's life and circumstances and that build on what is known already from the assessment.

Within the Life Movie, as different domains are discussed, it is important for the clinician to help explore connections between those domains and the patient's substance use. For example, one area of the patient's substance use could include what the patient likes about using or how it is helpful in navigating one or more of the domains. The clinician listens reflectively to the patient's responses to questions in the Life Movie domains, inserting additional open-ended questions or reflections in an effort to help elucidate connections between the domain and the patient's substance use. The goal in making these connections is to acknowledge the importance of the perceived benefits and expressions of potential readiness for change. This is an opportunity to use MI techniques; for example, expressing empathy, identifying discrepancy, eliciting self-motivational statements, rolling with sustain talk/discord, and supporting self-efficacy.

The clinician may also affirm with the patient's active and thoughtful engagement in this process (rolling with resistance) – their willingness to explore these domains and their potential relationship to substance use. In keeping with the MI/MET approach, the clinician uses open-ended rather than closed-ended questions. For example, "Did you say you used in unsafe situations?" is a closed-ended question that invites a mere yes or no answer and possible disagreement with the PRS item. Saying instead, "Tell me about using in unsafe situations" invites elaboration and discussion.

Below is an example of what an exchange might look like within the family domain.

> ***Clinician (C):*** *I know you shared that you currently live with your husband and 2 daughters. I'd like to ask you a bit about your family growing up. What were things in your family like for you growing up?*

> ***Shirley (S):*** *They were ok I guess. My mom was a single parent. She worked pretty hard between her job and raising my brother and me. We saw my dad occasionally. I think we had a pretty good childhood.*
>
> ***C:*** *So your mom was there to provide for you and your brother and make sure you were cared for.*
>
> ***S:*** *She was. She really was. I don't think it was always easy but she clearly put us first. I just think it was hard because she worked full time and then, when she got home, she had us to take care. Plus, as a mom, I realized how much she may have felt she missed out on because she was working so much.*
>
> ***C:*** *Being a mom yourself has helped you gain perspective of what it was like for your mom raising you. How do you feel all of this has shaped your own views or beliefs about being a parent?*
>
> ***S:*** *I want to be the best parent I can be for my kids. I want to be able to have the energy to be there for them. I don't want to miss anything.*
>
> ***C:*** *Being there for your kids – really there – present for each day is a core value for you. You really want to be fully engaged with them.*
>
> ***S:*** *Yes, I do and I that is part of why I want to stop drinking. It makes me so tired at the end of the night. I just need a better way to handle stress and worry.*

At the end of the Life Movie, the clinician should summarize the key themes voiced by the patient. The summary should be focused on themes that reinforce and help build motivation and a commitment towards change. Ideally, within the summary, the clinician will be able to include the following:

- Problems caused by substance use
- Reasons for quitting
- Risk factors for relapse: The clinician points out possible risky situations the patient identified as risk factors for relapse. The clinician explains that risk factors are warning signs that require the patient's attention and indicate a susceptibility to problems associated with substance use.

After summarizing the Life Movie discussion for the patient, the clinician asks the patient for reactions and responds to them with empathy.

Summarize the Eliciting Life Movie Discussion

The clinician summarizes the highlights from the Life Movie:

> ***Clinician (C):*** *Let's review and summarize what we've talked about so far. How does that sound to you?*
>
> ***Shirley (S):*** *I'm ready!*
>
> ***C:*** *You stated your evening smoking and drinking are the only way you've found to really relax and reduce stress. But you also acknowledged that the amount of regular drinking*

and smoking has caused several problems including missing work, difficulty sleeping, and feeling bad about your use. Is there anything else you want to add?

S: *No; those are the main problems.*

C: *You mentioned one of the main reasons for quitting are because one of the things you value most is your relationship with your kids. You want to be a mom who is really present and engaged with her kids.*

S: *Being the best parent I can be is really important.*

C: *Being a good parent is important to you, and your using gets in the way. You get tired and feel like you just don't have the energy to be fully with them at night.*

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

C: *When you talk about being a parent and your kids, you get enthusiastic and you light up, but when you talk about your using, you get discouraged and seem a bit down.*

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

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

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

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

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

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

S: *I really am.*

Elicit and Reinforce the Patient's Readiness To Change

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

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

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

C: *Related to your using?*

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

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

P: *I think that's related to the lower energy. I don't finish my work at my job, and I'm not as creative. And, like we talked about, I am so tired at home that I don't feel I'm there for my kids in the way I want to be.*

C: *And you think that if you quit using, you will increase your productivity and most importantly, your energy at night, when you are with your family.*

P: *Yeah.*

C: *That's important to you. You'd like to regain your energy and time with your children as well as your creativity and productivity at work.*

P: *I really would like that.*

Negotiate Between-Session Challenge

Assist the Patient in Preparing for Change

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

Elicit from the patient a commitment to complete the Change Plan on their own as the between-session challenge. The Change Plan would be discussed at the beginning of the next session.

Clinician (C): *The "Life Movie" conversation is designed to help you think about what changes in your life you might be willing to make to achieve your goals and have a healthier life overall. For many, the Change Plan focuses on their substance use. That said, the Change Plan can apply to identifying any kind of change you want to make for your emotional and physical health. I would like to give you a Change Plan as your between-session challenge. It can be helpful for you to take time to think about these different aspects of making these changes – your specific goals, why they are important, and the specific steps you want to take to achieve them. If you are focusing on substance use, it can be helpful to think about times when you haven't used in the past or when you have cut down or quit. In general, it can also be helpful to think about other behaviors you have made changes and what helped you to make those changes. If you get stuck, do not worry. Just do the best that you can. If you feel comfortable, you could talk to a support person about any part of the Change Plan. The goal would be for you to think through each of the questions or prompts and write out your responses. I would ask you to bring*

the Change Plan to our next session. We will start our next session by checking in on what you came up with. How does that sound to you?

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

In addition to the Change Plan, another between-session challenge involves engaging in healthy coping strategies. The clinician summarizes the patient's readiness by briefly reviewing the main reasons for and against changing use. Then, regardless of the patient's stage of change, the clinician provides the rationale for adopting or continuing substance-free pleasurable activities and completing the challenge to utilize at least one of the coping strategies from the *Learning New Coping Strategies* worksheet.

Clinician (C): *Regardless of how ready you are to change your use, it is important for you to remain healthy and happy. One of the most proven approaches to feeling good is doing pleasurable activities. These pleasurable activities increase chemicals in the body that make us all feel good and can also help us remain calm through daily stressors like a decision to cut back or not use substances. We have a worksheet I can give you that defines some of the types of activities that can be beneficial. Before I do that though, what activities can you think of that you would enjoy doing and would help release stress?*

Mary (M): *I used to be in a walking group with my friends. I haven't gone in a long time but I really liked it when I kept up with it. I just find it's easier to smoke when I get home from work.*

C: *I get that, but if you continue to try other rewarding or pleasurable activities, they also become easier to do without the negative side effects and possible legal hassles. So, if it's ok with you, I'm going to ask you to commit to doing one or two pleasurable activities in the next week while not using. If its hard to think of ones you want to do on your own, you could pick from this worksheet (Learning New Coping Strategies handout) and commit to doing them while not using.*

M: *Ok.*

The clinician elicits a commitment from the patient that is specific in that it identifies which activities and when the patient is going to do them, including the day of the week and possibly the time of day. The more specific, the better.

Summarize and Conclude the Session

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

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

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

Specific Suggestions for Addressing Common High-Risk Situations
Tension Relief and Negative Emotions (e.g., depression, anxiety, nervousness, irritability). Develop relaxation techniques, exercises; write down your feelings or talk to a friend or clinician; do something enjoyable that requires little effort; figure out what you're feeling and whether you can do anything about it.
Anger, Frustration, and Interpersonal Conflict. Try to handle the situation directly rather than hiding your feelings; if appropriate, be assertive; get some release by squeezing a rubber ball, pounding a pillow, or doing some physical activity; write down your feelings or tell them to someone; take deep breaths.
Fatigue and Low Energy. Do muscle relaxations; take a brisk walk; do something enjoyable; eat properly and get enough sleep.
Insomnia. Don't fight being unable to sleep. Get up and do something constructive or relaxing. Read a book, watch television, or do muscle relaxations until you feel sleepy. Remember that no one dies from losing a night's sleep.
Timeout. Read, do a crossword puzzle, prepare a healthy snack, take up a hobby, knit or do other needlework (things you can carry with you for easy access).
Self-Image. Try a new image: get a new haircut or buy new clothes.
Social Pressure. Be aware when others are using. Remember your commitment not to use. Be assertive and request that people not offer you alcohol or substances. If appropriate, ask that they not use around you for a while. If necessary, be prepared to leave the situation, especially when you've recently quit.
Cravings and Urges. The only way to interrupt cravings is to break the chain of responding to them. That is, don't give in. Eventually they will decrease. Do something to distract yourself; use the techniques suggested; breathe deeply; call a friend; go for a walk; move around; time the urge. You'll find that it will disappear like a wave breaking.

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

ICBT Session 1. The Life Movie and Change Plan Handouts

Treatment Information Sheet

I just want to take a few minutes to discuss what you can expect from us and what we expect from you. Over the coming weeks we will be meeting together (individually or as part of a group) and developing goals that are important to you and that seem reasonable for you to achieve in this amount of time. You can set the pace of our work together and let me know if, at any point, I am moving too quickly or slowly. I have some ideas for how we can work together on the goals that you have identified already and hope to share these ideas and help you develop effective skills or build upon abilities you already have but may not recognize or be using to your best advantage. Following are some general guidelines:

1. **Regular meetings**. Its most helpful if we can meet on a regular basis, such as weekly. If you need to cancel or are running late, I would appreciate your letting me know with as much advance notice as possible.
2. **Commitment to treatment**. Change is difficult for everyone. I ask that you make every effort to participate fully in the treatment by coming to sessions, sharing your thoughts and feelings and frustrations, and staying the course, even if you feel at times our work is not helping as quickly as you would like.
3. **Therapy process**. I will do my best to help you feel comfortable, and my hope is that we can work as a collaborative team. Therapy can be uncomfortable at times because different thoughts and feelings may come up. This doesn't mean that treatment isn't working. However, if at any point you find yourself upset with something that has happened, or something I have said or done, I encourage you to bring this up and let me know so that we can continue with a positive connection.
4. **Substance use**. I ask that you refrain from using alcohol or substances on days or at times when we will be meeting together. I think our discussions together can be most productive and helpful to you if you are not under the influence of any substances.
5. **Structure of meetings and practice exercises**. We will meet together for about an hour each time. I will usually want to hear about how things have been going the previous week and anything you want to share about events in your life. Then we will spend some time on a particular topic area or skill that will be helpful to you in accomplishing your goals. I may ask you to do some writing or thinking about what we have discussed between sessions. It is up to you whether you do this and the goal is not to make you feel pressured or burdened. You will never be graded or judged on what you write. The purpose is to keep the material alive between the times we meet and encourage you to practice or apply some of the new ideas and skills in your real life, as opposed to merely discussing them. If I ask you to write or practice something that you are not comfortable with, please let me know so we can come up with an exercise that is more suitable to you.
6. **Questions** you may have regarding treatment, what is involved, my background and role.
7. **I look forward to working together with you.**

Eliciting the Life Movie: MI Conversation

Goal:

Using motivational interviewing strategies focusing primarily on open ended questions and reflections, the goal of this conversation is to get a deeper understanding of the person's life. Use open ended questions and complex and compassionate reflections to promote an initial understanding of the person's values, beliefs and priorities.

Provide rationale for the life movie:

"I would really like to understand more about you, your everyday life & important aspects of your background including family, other relationships, your work and other passions. This better prepares us to collaborate in ways that make sense for you"

Ask permission:

"How does this sound to you as a place for us to start our work together, so you feel I understand you better and that we are on the same page?"

General questions to start off with:

- "What was your last week like?"
- "What do you feel has gone well for you recently?"
- "What has been troubling for you?
- "Has there been anything you'd like to change?"

Areas of Life Movie Exploration:

- Family of origin

  Tell me about what it was like for you growing up in your family?
  What are the ways in which your family has influenced your alcohol or drug use?
  What are the ways you feel your early experiences with your family affect you now?
  What are some values you developed growing up that are important to you now?

- Today's significant others

  Tell me about the people in your life that you are closest to.
  What is your relationship with your spouse/partner/significant other like?
  How does your significant other feel about your alcohol and/or drug use?

- Work (or school)

  What do you love about your work/school?
  What are the ways work/school causes stress or challenges for you?
  How has your alcohol and/or drug use affected your work/school?
  Ideally, what would you like to be doing for your career?

- Health (physical and mental)
  How do you feel physically? Emotionally?
  What are the ways you try to take care of yourself?
  What are the challenges you are experiencing in your health?

- Life activities that bring personal satisfaction
  What do you enjoy doing? What brings you happiness or joy?
  What is it like for you when you can do these activities more often?
  What gets in the way of being able to pursue these activities regularly?

- Spirituality

  How would you describe your spirituality? By spirituality, we do not necessarily mean a religion but rather what helps ground you, what feeds your spirit and your soul. It could even be a belief or value system that grounds you and helps to give you a sense of purpose and direction in life.

  What are the ways in which spirituality has been helpful to you in your life?

The conversation does not need to be complicated. Be present and curious. We have offered some questions within each domain that can serve as a starting point. However, do not feel you have to ask these questions if there are others that feel more natural and relevant to your conversation. Use your MI skills to explore deeper into feelings, values and beliefs.

Clinicians note: Some of our patients have had very difficult histories and in these early sessions with you, your patient may be only so ready just so far in these disclosures. That is understood and normal. You can respectfully "flag" content for future explorations.

> ***Clinician (C):*** *From what you are saying, it sounds like there is a lot going on there. Perhaps at a future time we can revisit that.*

Note to Clinician: Remember, use deeper/compassionate reflections, affirmations & summaries to better understand patient values, beliefs, areas of internal conflict, drivers of use behavior, etc.

In your final summary, link the key themes, especially values, you hear from your patient to help develop discrepancy and build motivation for change. Though the Life Movie discussion both the patient and you gain a richer understanding of the person's life, some of the drivers for use and the impact that substance use has had. The life movie conversation can add depth and context to these areas that may not have been explored during the clinical intake.

A Change Plan - Optional

It is important to be thinking about the changes you would like to make in your life now. Regarding substance use, you may be ready to become abstinent or perhaps you want to decrease your use or even consider changing when or how you use. You likely are thinking about other changes in addition to substance use as well. The change plan should be expressed verbally at a minimum but can also be in writing. Ideally, making changes and sticking to commitments works best when you actually write out your goals. Responses to the following questions will create a simple but powerful plan for change.

Change Plan

Person's Name ____

1. The changes I want to make are— (specifics)

____

____

____

2. The most important reasons I want to make these changes are—

a. ____

b. ____

c. ____

3. The steps I plan to make in changing are—

a. ____

b. ____

c. ____

Learning New Coping Strategies (Handout)

Developing Alternatives…

You can do many things to stop using. Some may work better than others. Some help you resist the urge to use or avoid tempting situations or satisfy your needs in more constructive ways than using. Expect to try several new strategies and add any that may be helpful for you. Think about what worked when you gave up (e.g., drinking, smoking, using substances) before or when you made other changes in your life. Be kind to yourself as you begin this change process—you're doing something to take care of yourself, and you deserve all the comfort and self-acceptance you can get! Remind yourself that learning and changing inevitably mean giving up old ways and that, in time, you will feel more comfortable. Remember the changes your body and mind went through when you learned to drive, got to know a new person, started a new job, or learned a new skill. Chances are you felt awkward, uncomfortable, silly, dumb, nervous, frustrated, impatient, or anxious, in addition to hopeful, excited, and challenged. What helped you then? How long did it take you to feel relaxed? Did you learn all at once, or were improvement and progress gradual?

First Actions

Avoid or escape from situations that make you want to use; sometimes this is the easiest and most effective way to resist temptation, especially at the beginning.

Delay decisions to give in to urges; for example, you could make a decision to wait 15 minutes. Take several deep breaths. Focus on the fresh air entering your lungs, cleansing and nourishing your body. Let out tension with each exhalation.

Change your physical position. Stand up and stretch, walk around the room, or step outside.

Carry things to put in your mouth: toothpicks, gum, mints, plastic straws, low-calorie snacks.

Carry objects to fiddle with: a rubber ball to squeeze, a small puzzle, a pebble, worry beads.

Have a distracting activity available: a phone call, a crossword puzzle, magazine, book, a postcard to write.

New Activities

Exercise or take a brisk daily walk. Get your body used to moving; use stairs instead of elevators; park farther away from your destination; walk instead of drive.

Practice relaxation or meditation techniques regularly (we will have opportunity to learn and practice these techniques later in our work together).

Take up a hobby or pick up an old hobby you used to enjoy.

Drink less coffee; switch to decaf; drink herbal teas.

Engage in an enjoyable activity that is not related to work several times a week.

Change routines associated with using, at least temporarily; for example, don't turn on the TV when you get home from work; don't spend time with friends who smoke.

New Thoughts

Self-talk. Give yourself a pep talk; remind yourself of your reasons for quitting; remind yourself of the consequences of using; challenge any wavering in your commitment to quit.

Imagery and visualization. Visualize yourself as a nonsmoker, happy, healthy, and in control; imagine your lungs getting pink and healthy; or focus on negative imagery and imagine yourself with cancer, emphysema, unable to breathe, needing constant care. Visualize yourself in a jail made of alcohol or substances, symbolizing the way it controls your life.

Thought-stopping. Tell yourself loudly to STOP; get up and do something else.

Distraction. Focus on something different: the task at hand, a daydream, a fantasy, counting

Social Interactions and Environment

Remove paraphernalia (pipes, papers, bongs, ashtrays, matches, lighters, etc.) from your home and car.

Go to places where it's difficult to get high, such as a library, theater, swimming pool, sauna, steam bath, restaurant, and public gatherings (not rock concerts).

Spend time with friends who don't smoke. Enlist support from family and friends. Announce that you've quit; ask people not to offer you alcohol or other substances, to praise you for stopping, to provide emotional support, and not to smoke around you.

Learn to be appropriately assertive; learn to handle frustration or anger directly instead of by using.

Specific Suggestions for Some Common High-Risk Situations

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

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

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

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

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

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

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

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

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

This handout is optional and offered to patients ready to think about immediate ways of changing. This will be reviewed with patients during the next session.

SESSION 2: ENHANCING SITUATIONAL AWARENESS

INTRODUCTION & SESSION GOALS

This session focuses on further building rapport, building situational awareness, setting priorities based on what is important to you and defining the goals and activities of the upcoming therapeutic journey. The clinician continues to use motivational strategies to increase change talk and reduce sustain talk and introduces the process of functional analysis to help the patient build situational awareness of internal and interpersonal factors affecting substance use. Clinicians may refer to the eliciting change talk strategies presented in Section 1 and reinforce any successful efforts at initiating change.

As the clinician expresses genuine interest in the patient's well-being since the last meeting, the patient experiences how a therapeutic relationship can provide the necessary support and guidance to push past obstacles and begin to make steps toward change. Through use of and continued practice of the Substance Use Awareness record is a potent strategy and set of patient skills for bringing unconscious thoughts, feelings and belief into conscious awareness and enabling the patient to make conscious decisions about behavior change. This awareness raising process also better enables both patient and clinician to prioritize and individualize treatment sessions. As a result of this exploration, the patient can gain a deeper understanding of their substance use, including internal and situational factors associated with use. The patient can receive support, guidance, and assistance in creating a personalized plan for change.

This experience can result in a rich conversation that may span more than one session. Patients often experience strong affect as they explore. Frequently, the clinician instructs the patient to continue completing the Awareness Record handout as a between-session challenge over several weeks and possibly months.

Note to Clinician: The Awareness Record is a universal strategy throughout all CBT. It can as easily apply to anxiety, depression, or anger management.

Clinician Preparation

Session 2. Enhancing Situational Awareness	
Materials - Review of Progress - Learning New Coping Strategies and The Change Plan (see Session 1 handouts) - Blank copy of the Alcohol/Substance Use Awareness Record - Planning to Feel Good (optional)	**Total Time** 1 hour **Delivery Method** MET-focused individual therapy with case conference elements
Strategies - Follow OARS techniques: Open-Ended Questions, Affirmations, Reflections, and Summary. - Use EDARS: Express Empathy, Develop Discrepancy, Awareness of Ambivalence, Roll with Sustain Talk/Discord, and Support Self Efficacy. - Identify stage of change. - Discuss and offer feedback to help emphasize personal reasons for change. - Develop "real-life practice challenge" and generate commitment.	
Goals for This Session - If not completed in a previous session, review the patient's Change Plan. - Support the patient to enhance awareness around the internal and situational factors associated with their use, mood and other behaviors. - Explore how a supporter may help the patient achieve and maintain change.	

Session 2 Outline and Overview

First Third

1. Strengthen Rapport:
   - Welcome the patient, and if present, the support person.
   - Share the session agenda; invite items from the patient.
   - Engage in non-problem focused rapport building, exploring areas of the patient's life not directly related to treatment.
2. Review of Progress:
   - Engage the patient in a brief review of their progress related to their substance use, mental health, and related experiences since the previous session. Use the *Review of Progress* handout as a guide.
     - Did the patient make an effort to stop? Cut down?

- Did the patient experience any high-risk or tempting situations?
- If the patient engaged in substance use, explore their use event(s) using the *Alcohol/Substance Use Awareness Record* to assess internal and external triggers, cravings, and consequences.

3. Review of Between-Session Challenge:
   - Review any between-session challenges from the previous session.
     - Did the patient complete the Change Plan? If so, review the Change Plan as a Personalized Reflective Discussion.
     - Did the patient use any strategies from the *Learning New Coping Strategies* handout? Were the strategies successful?

Second Third

4. Provide Rationale:
   - Provide a personalized rationale for the session activity
   - Ask the patient if they understand the reasons why the activity or skill will help build recovery strength.
5. Teach Session Skill:
   - Share relevant information to help the patient understand the skill and provide them the step-by-step approach of how to implement the skill.
   - Describe the components of the Alcohol/Substance Use Awareness Record to the patient.
6. Clinician-Led Demonstration/Role-Play:
   - Demonstrate the skill by leading the patient in a role-play of the skill to model the way it is done. Be clear and ensure the patient understands the lesson.
     - Have the patient identify one incident of use or craving to use in recent history.
   - Walk the patient step-by-step through the Alcohol/Substance Use Awareness Record using the identified event. Use open ended questions, reflections, and summaries to gain a deeper understanding of the patient's experiences within each of the components on the awareness record. Respond to any questions the patient has regarding skill application.
7. Patient-Led Practice (Assess Skills Transfer)
   - Have the patient lead a role-play or engage in real-play of the skill. If role-playing, encourage the patient to use real-life examples.

- Have the patient walk through each component of the Alcohol/Substance Use Awareness Record, step-by-step and aloud, for two recent incidents of use or craving to use. Ideally, one of these incidents will reflect a situation in which the patient was triggered but did not use.
- Use open ended questions, reflections, and summaries as patient completes the activity to elicit a deeper understanding of the patient's experiences.

Third Third

8. Identify Real-World Application:
   - Help the patient to identify real-life situations in which they can apply the skill.
9. Negotiate and Prepare Between-Session Challenge:
   - Elicits from the patient how and where in their life they can apply awareness raising and other coping skills they learned in session in their daily life.
     - The patient is encouraged to continue practicing awareness raising by complete the *Alcohol/Substance Use Awareness Record*
   - Ensure that the challenge is specific and support the patient by rehearing their application of the new skill—What will they do? When will they do it? How often will it be done (i.e., at least two times)?

8. Elicit Commitment:
   - Elicit commitment for completion of the between-session challenge at least two times before the next session.
   - Use MI strategies as needed to strengthen commitment.
9. Summarize and Conclude:
   - Present a session summary of what has been covered during the session and elicit the patient's feedback.
     - What did the patient learn through the awareness raising activity?
     - Use the information generated in completing the Alcohol/Substance Use Awareness Record to discuss relevant skills and associated treatment sessions.
     - Explore supporter involvement.
   - Conclude the session.

Session 2 Protocol with Scripts

Strengthen Rapport

The clinician welcomes the patient and provides an overview of the second session, in which the clinician further develops and reinforces the patient's change process and helps the patient to enhance their awareness around substance use. The clinician invites the patient to provide additional agenda items for the session.

Review of Progress: Examining the Patient's Recent Experiences

The clinician uses the *Review of Progress* handout to support a brief review of the patient's progress in key domains since the last session, including substance use, mental health symptoms, and related wellness areas.

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

- Did the patient stop use since the previous session?
- Did the patient make an effort to stop?
- Was the patient confronted with any high-risk or tempting situations?
- What strategies did the patient use? Did the patient try any of the strategies in *Learning New Coping Strategies*? Were they successful?
- Were there any instances when the patient effectively handled a "hot" situation (i.e., very high risk)?

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

> ***Shirley (S):*** *Well, I've almost completely stopped using since our last session.*
>
> ***Clinician (C):*** *You seem very pleased with yourself! How did you do that?*
>
> ***S:*** *Right after the last session I kept thinking about how alcohol has kept me from doing the things I want to do. I really want to be a teacher, and I realized that as long as I kept drinking, I would always feel bad. So I went home and drank one last time, then poured out the remainder of my stash into the sink! During the last week I've wanted to drink several times, but I didn't.*
>
> ***C:*** *What did you do when you felt like drinking?*
>
> ***S:*** *Well, I talked to my husband. I read about that in the handout you gave me last week.*

Review of Between-Session Challenge: Assessing the Patient's Progress and Readiness to Proceed

The clinician asks the patient how they feel about the previous session and responds to concerns, addressing any comments or questions about the *Change Plan or Learning New Coping Strategies* activities. If the patient has completed the *Change Plan*, they are asked to read it and discuss the choices. The clinician reviews the Change Plan as a Personalized Reflective Discussion. Specifically, the clinician reaffirms the patient's written statements, provides feedback and discusses adjustments (e.g., is the patient setting unrealistically high standards that may set them up for failure? has the patient identified salient reasons for wanting to make changes in alcohol or other substance use?), evokes the personal meaning of the change plan elements to the patient, enhances motivation and resolves ambivalence about change, and reinforces the patient's commitment to their goals. The clinician photocopies the agreement as a record of the patient's goals.

The clinician must be vigilant about maintaining the patient's level of motivation for change and engagement in treatment. If the Change Plan was **not** completed, the clinician elicits the patient's reasons for not engaging in the change process at home to assess, for example, ambivalence, other obstacles, or both. Strong ambivalence may be manifested in nonverbal behavior (e.g., level of comfort, reluctance to establish treatment goals). If the reason appears to be ambivalence, the clinician uses MI strategies described in section 1, asking open-ended questions, reflecting, etc. Specific MI strategies depend on the nature of the sustain talk and the assessed stage of change (i.e., precontemplation or contemplation). If the patient still is uncertain or unaware of any need to change, the clinician can focus the discussion on reflections, normalizing uncertainty, reviewing health risks again, asking future-oriented questions, or imagining extreme questions (e.g., "What would it take or what would have to happen for you to want to make a change?").

If there is awareness of a need to change, the clinician can use the *Decisional Balance* form (Session 8 handout) and reemphasize the benefits and risks. This technique can help the patient develop further discrepancy and swing the balance toward change. If the lack of follow-through was the result of more simple obstacles such as being too busy or forgetting, the clinician can brainstorm solutions and have the patient choose and commit to the choice. (One method for problem solving—I-SOLVE—will be presented in Session 6.) Forgetfulness is a common challenge for persons in treatment. A strategy that can help a patient remember the between-session practice is to encourage use of a smartphone calendar, typing in the assigned challenge using the alarm function. Regardless of why the assigned challenge was not completed, the clinician should reinforce the need to complete the practice work to achieve goals.

Provide Rationale

The clinician shares the rationale for the awareness raising activity by describing how and why building personal awareness is essential in the change process. The clinician also personalizes the rationale by sharing how personal awareness skills will support the patient's own recovery process.

Clinician (C): *I want to explain how we think about substance use. When someone has used alcohol or other drugs over time, we think of it as a negative habit, similar to other habits like biting your nails or eating junk food. We try to help the person figure out what has been keeping the habit going. This way, if someone wants to stop the habit and knows what is keeping it going, they can use this information to help stop it. Does thinking of it as a habit make sense to you?*

Shirley (S): *Completely! It's like to just start pouring my first drink without even thinking about it the second I walk into the door after work.*

C: *Yes, and after a while of drinking in similar situations, just being in those situations can make that person feel like drinking. We call that a trigger. It could be anything about the situation like the time of day, whom you're with, or even something like a type of music. You have mentioned some things that sound like triggers for you. What do you think some of your triggers are?*

S: *Well definitely the time of day. In fact, I even start thinking about drinking as I'm pulling out of the school parking lot and heading home from the day. On the weekends, I drink a lot with my close group of friends. So just getting together in the evening to hang out is a pretty strong trigger for me.*

C: *For you, some of the external aspects of a situation are strong triggers. Another type of trigger can be how someone is feeling. Some people say that they feel more like using alcohol or other drugs when they are feeling badly—like feeling bored, nervous, or angry. They say that using is a way of trying to cope with the bad feelings. Some people especially feel like using alcohol or other drugs when they are happy or excited. Does this part of it—someone using to affect how they feel—make sense to you?*

S: *You know, I think that my desire to drink after work is probably in large part due to having such stressful work days. There is very little down time in my job.*

C: *Stress is a very common trigger. I wonder whether you sometimes find yourself having certain thoughts or ideas about your use as these can also lead to urges to use. These might be thoughts like, 'My friends will think I'm boring if I don't drink,' or 'I deserve this after the day I've had'.*

S: *I often feel like my thoughts are my own worst enemy, and I really do believe that I deserve some type of reward for all the hard work of the day."*

C: *Based on all the triggers you just identified; this shows how substance use doesn't just suddenly happen. Usually there are things going on around a person or in the way someone is thinking or feeling that affect whether or not they make a choice to use. Knowing what affects your own use gives you more power to decide whether or not to use. And looking at both the pros and cons of what happens after you use also helps you understand why you use and helps you make decisions about what you want to do in the future.*

Figuring out the factors that lead to your own alcohol use, like the time of day, being around friends, work stress, and your town thoughts, gives you more power to decide what to do next, and to break the habit, if you want to. That's the main thing that we are trying to do in this treatment—to give you a lot of different ways to take back control instead of being under the control of the habit.

Teach Session Skill

Introduce the patient to the Alcohol/Substance Use Awareness Record. Provide them a blank copy and retain one for yourself. Describe the awareness record by walking the patient through each column in the awareness record and explaining each component in depth, checking in to assess the patient's understanding along the way.

The components of the Alcohol/Substance Use Awareness Record include:

- **Trigger.** Triggers here refer to external and situational characteristics that stimulate a craving for use and make it more likely that a patient will engage in substance use. Identifying external triggers involves pinpointing the many external stimuli that may be present in a given situation.
- **Thoughts, Feelings, and Beliefs.** These internal experiences often serve as triggers for use. The way people respond to external events are largely shaped by the thoughts people have about those events, the feelings that are generated, and the belief systems that are activated.
- **Intensity of Craving.** The experience of a craving of urge takes different forms for different people. It is helpful to understand patient's craving experience and the intensity of the craving. To capture the intensity of a craving, cravings are rated on an intensity scale from 0 (not at all intense) to 10 (extremely intense).
- **Behavior.** Behavior refers to the action(s) taken in response to urges and cravings which are triggered by external events and internal thoughts, feelings, and beliefs. Behavioral responses often serve to decrease or lessen the intensity of the craving and can range from healthy and helpful behaviors to unhealthy and less helpful behaviors.
- **Positive Results.** Whether a person's behavior results in use or not use, there are potentially both positive and negative outcomes. Here we explore the good things that came out of the behavioral choice.
- **Negative Results.** In addition to exploring positive outcomes, we explore the not as good things that resulted from the behavior response.

Clinician-Led Demonstration/Role Play

The clinician demonstrates the awareness raising activity by walking the patient through a detailed exploration of one incident of use or craving to use in recent history. The patient identifies the situation and the clinician uses core MI skills (open-ended questions, reflection, and summaries) to gain a deeper understanding of the patient's experiences. It is important to probe enough within each component of the awareness record to gain a comprehensive, thorough understanding of the incident. The clinician will most often need to ask multiple follow-up questions within each element to dive deeper into the details of the patient's experience. The clinician checks in with the patient as to their experience in completing the awareness raising activity and addresses any questions regarding how to complete the activity.

Patient-Led Practice (Assess Skills Transfer)

The patient then takes the lead at walking the clinician through each component of the awareness record for up to two recent incidents in which the patient did use and was triggered but did not use. The purpose for focusing on an event in which the patient did not use is to bring understanding to the factors that led to the choice to not use in a given situation. During the patient's application of the awareness raising activity, the clinician affirms the patient's skill application and offers follow-up questions to encourage the patient to explore the incident more thoroughly.

Identify Real-World Application

The clinician helps the patient to think through opportunities for how they might continue strengthening their awareness around substance use through additional awareness raising practice throughout the week. These might be situations in which the patient might benefit from "slowing down" their automatic behavioral response to use when having cravings. Relatedly, the patient may consider using the awareness raising activity before a potentially triggering event to prepare for how they may experience the trigger and plan for health choices. The patient may also consider reflecting back on incidents in which they did use to bring clarity to the multiple factors that led to their behavioral response and the outcomes of that response.

Negotiate and Prepare Between-Session Challenge

The exploration of real-world skill application is a natural transition into negotiation of a between-session challenge. The clinician encourages the patient to continue reviewing the materials handed out at this session and last week's session. The clinician asks the patient where, when, and how they can apply awareness raising in their daily life, working to generate a specific plan for continued practice of the awareness record and completing one of the newly developed specific steps in the Change Plan. If the patient is uncertain which one to choose, discuss options and indicate that one good initial choice would be the step the patient is most ready to complete. For any identified between-session challenges, the clinician works with the patient to ensure that they know what they will do, when they will do it, and how often it will be done, mentally rehearing its application in their daily life. Most patients benefit from writing down this plan somewhere accessible to them, to also serve as an ongoing reminder.

Elicit Commitment

The clinician explores the patient's commitment for completing the between-session challenge and uses MI strategies as needed to assess and strengthen commitment. The clinician also asks the patient to think through any potential obstacles to their skills practice and works with them to identify solutions and activate resources as needed to support their skill application.

Summarize and Conclude the Session

The clinician reviews the session, asks the patient for feedback, responds empathically to their comments, and troubleshoots any difficulties. Specifically, the clinician will want to explore the patient's response and perceived utility of learning the awareness raising activity. Through completing the

Alcohol/Substance Use Awareness Record with several different incidents, the clinician begins to identify substance use patterns and common challenges the patient experiences that increase their likelihood of using. The clinician engages the patient in their identification of use patterns and associated areas of difficulty (e.g., boredom, not asserting oneself, lack of coping skills to manage strong emotions).

With this information, the clinician and patient should also discuss the likely scenarios for future treatment sessions. At this point, the clinician reminds the patient they will be meeting for 4–10 more sessions (in most cases) and that they have some flexibility as to what they can do for those meetings. The clinician should suggest the kinds of skill topics they might cover based on what they've learned about the patient's use experiences thus far, and seek input from the patient about how to spend the remaining sessions. Explain that the sessions focused on skills are meant to provide the patient with new tools for being able to make the important changes they have begun. See the sample language.

> ***Clinician:*** *I appreciate being able to get to know you over these few weeks and admire your courage in undertaking the important goals you have started to work on regarding your use of cocaine. We will be meeting for 6 to 10 more weeks, and what I'd like to do is help you learn some new skills that are meant to help you with keeping your resolve. One of these sessions focuses on learning a skill called mindfulness, which can be very helpful for people trying to make a change the way you are. I also want to help you with the problem you described where you said it's sometimes difficult to say no when your friends offer you cocaine or invite you to a party. There are some other tools I want to share with you that I think will be useful. How do these ideas sound to you? Any questions so far?*

ICBT Session 2. Enhancing Situational Awareness Handouts

Review of Progress & Between-Session Challenges

Directions: Use the table below to support weekly progress review in key domains relevant to the patient's substance use and overall well-being. This table can also be used to review the between-session challenges.

Domain	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Physical Activity							
Sleep							
Diet							
Pleasure/Replacement Activities							
Mastery Activities							
Work/School							
Mood states							
Tobacco/Nicotine							
Alcohol							
Marijuana							
Other Drugs							
Between-Session Challenge							

Alcohol/Substance Use Awareness Record

As a way to increase awareness about your patterns of use, use this form to identify the kinds of situations, thoughts, feelings, and consequences that are associated with your alcohol/substance use.

Clinician Note: *The awareness record can be applied all manner of concerns such as mood, anxiety, anger etc.*

Describe Incident:

Trigger	Thoughts. Feelings and Beliefs	Intensity of Craving	Behavior	Positive Results	Negative Results
(What sets me up to be more likely to use alcohol or drugs?)	(What was I thinking? What was I feeling? What did I tell myself?)	Low–high, 1–10	(What did I do then?)	(What good things happened?)	(What bad things happened?)

Date and Time:______________________________

Alcohol/Substance Use Awareness Record Example

As a way to increase awareness about your patterns of use, use this form to identify the kinds of situations, thoughts, feelings, and consequences that are associated with your alcohol/substance use. Below is an example of how the form might be used.

Describe Incident: Spent evening with my friend smoking weed and drinking beer.

Trigger	Thoughts. Feelings and Beliefs	Intensity of Craving	Behavior	Positive Results	Negative Results
(What sets me up to be more likely to use alcohol or drugs?)	(What was I thinking? What was I feeling? What did I tell myself?)	Low–high, 1–10	(What did I do then?)	(What good things happened?)	(What bad things happened?)
Friend called and invited me to get high with him. Nothing else to do.	"I want to reward myself." "I'm bored." "Felt good about going 15 days without using, so felt OK about getting high today."		Went out with friend and used.	Had fun. Felt good to get high, having gone 15 days without.	Broke the 15-day abstinence (although wasn't too worried about this). Didn't get as much done. Didn't feel as healthy.

Planning To Feel Good (Optional)

I am doing this right now.	I used to do this and I want to try again.	I have never done this and I want to try.

SESSION 3. LEARNING ASSERTIVENESS

Introduction & Session Goals

During session 3, the clinician first provides a rationale by explaining the critical need for effective communication in general to get needs met and more specifically in trying to change substance using behaviors. The clinician then discusses the different communication styles illustrating effective and less effective communication. Through a series of engaging interactive discussions & role plays the clinician helps the patient identify their own style of communication and the communication style of family and friends. The clinician then assists the patient with practicing ways to be assertive in a variety of everyday situations and in challenging situations they are facing while moving toward recovery. The clinician helps the client realize the difference between their expression of a definite more assertive "no" and one where the client feels less definite and uncertain. The patient learns about effective and ineffective communication and develops increased awareness of their own communication and those of their social network. Patients become familiar with expressing their needs assertively in a variety of real-life situations and practices in and out of sessions. Patients commit to practicing assertiveness and assertive refusal in the upcoming weeks.

Clinician Preparation

Session 3. Learning Assertiveness	
Materials - Review of Progress and Between-Session Challenges - Alcohol/Substance Use Awareness Record (see session 2 handout) - Learning New Coping Strategies (see session 1 handout) - Communication Styles handout - Between-Session Challenge: Assertiveness	**Session Length** 1 hour **Delivery Method** CBT-focused individual or group therapy
Strategies - Follow OARS techniques: Open-Ended Questions, Affirmations, Reflections, and Summary. - Use EDARS: Express Empathy, Develop Discrepancy, Assist in Awareness of Ambivalence, Roll With Sustain Talk/Discord, and Support Self-Efficacy. - Identify stage of change. - Demonstrate skill, role-play, and give feedback. - Review handouts to help transfer knowledge and skills. - Develop “real-life practice challenge” and generate commitment.	
Goals for This Session - Enhance the patient’s understanding of different styles of communication. - Explain the four different communication styles: 1. Passive	

Session 3. Learning Assertiveness

2. Passive-Aggressive
3. Aggressive
4. Assertive

- Role-play relevant scenarios and different communication styles.
- Identify a current situation or relationship that can benefit from the patient's communicating in a more assertive way and practice using this technique.

Session 3 Outline and Overview

First Third

1. Strengthen Rapport:
   - Welcome the patient, and if present, the support person.
   - Share the session agenda; invite items from the patient.
   - Engage in non-problem focused rapport building, exploring areas of the patient's life not directly related to treatment.
2. Review of Progress:
   - Engage the patient in a brief review of their progress related to their substance use, mental health, and related experiences since the previous session. Use the *Review of Progress* handout as a guide.
     - Did the patient make an effort to stop? Cut down?
     - Did the patient experience any high-risk or tempting situations?
     - If the patient engaged in substance use, explore their use event(s) using the *Alcohol/Substance Use Awareness Record* handout form session 2 to assess internal and external triggers, cravings, and consequences.
3. Review of Between-Session Challenge:
   - Review any between-session challenges from the previous session.
     - Did the patient complete the Situational Awareness Record? If so, review the Record: triggers, beliefs, cravings, behavior, pros and cons.
     - Discuss the different situations recorded and see if patterns emerge to the reactions - note any signs of particular internal or external triggers that can be addressed through better communication to self or others.

- Did the patient use any strategies from the session one *Learning New Coping Strategies* handout? Were the strategies successful?

Second Third

4. Provide Rationale:
   - Provide a rationale for assertive communication in general and assertive refusal skill.
   - Ask the patient if they understand the reasons why the activity or skill will help build recovery strength.
5. Teach Session Skill:
   - Share relevant information to help the patient understand the skill and provide them the step-by-step approach of how to implement the skill.
   - Engage and elicit patient communication styles:
     - Offer to reveal the patient's communication style. For example, offer the patient a food you know they dislike or even despise or ask them to lend you $20. The objective is to make a request that you know the patient can refuse or say "no" to without internal conflict or guilt.
     - Discuss how the patient expressed their refusal.
   - Define aggressive, passive, passive-aggressive, and assertive communication.
   - Discuss benefits of assertiveness:
     - Increases likelihood person will achieve goal or objective
     - Increases chance the person will feel more satisfied with a situation
6. Clinician-Led Demonstration/Role-Play:
   - Model different styles of communication.
   - Identify scenarios exemplifying these styles.
   - Develop role-play exercise of relevance for patient.
   - Practice assertiveness in the context of role-play. Identify obstacles and barriers.
7. Practice and assess skills transfer (patient led).

Third Third

8. Identify Real-World Application:
   - Help the patient to identify real-life situations in which they can apply the skill

9. Negotiate and Prepare Between-Session Challenge: Review the patient's communication style and the skill of assertiveness.
    - Hand out *Between-Session Challenge: Assertiveness.* Ask the patient to commit to a weekly between-session real challenge using assertive communication in several upcoming situations.
    - Discuss the real-life "assertive" situation details: when, with whom, where.
    - If time allows, practice the between-session challenge to help client prepare.
10. Elicit Commitment.
11. Summarize and conclude the session.

Session 3 Protocol with Scripts

Strengthen Rapport

The clinician welcomes the patient and provides an overview of the third session, where the clinician further strengthens recovery skills through understanding and learning most effective types of communication. The clinician invites the patient to provide additional agenda items for the session.

Review of Progress: Examining the Patient's Recent Experiences

Review the current status regarding alcohol or substance use and the goals of change or abstinence. The clinician uses the *Review of Progress* handout to support a brief review of the patient's progress in key domains since the last session, including substance use, mental health symptoms, and related wellness areas.

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

- Did the patient stop use since the previous session?
- Did the patient make an effort to stop? If so, what was the result?
- Was the patient exposed to any high-risk or tempting situations? If so, how were they handled?
- What strategies did the patient use? Did the patient try any to see what triggers were most inviting to use and if so, did they try any of the strategies in the handout on *Learning New Coping Strategies*? Were they successful?
- Were there any instances when the patient effectively handled a "hot" situation (i.e., very high risk)? How were they handled?

Again, and throughout the model when the patient talks, the clinician's objective is to elicit information and to use that information to provide reflections, express empathy, identify discrepancies, elicit self-motivational statements, and roll with sustain talk/discord.

Review of Between-Session Challenge: Assessing the Patient's Progress and Readiness to Proceed

Inquire about any between-session practice challenge. Did the patient find recording situations in the awareness record helpful? If appropriate, praise the patient's efforts accomplishing the between-session challenge and maintaining changes or abstinence. If the patient did not complete the situational awareness record—ask them what happened—and why they did not complete the challenge. If they state they did not understand the challenge—it is fine to go ahead and do it with them but emphasize their taking the lead in the activity. Holding patients accountable in a clear manner but one that is not off putting is essential to potent CBT. Thus, the clinician again reaffirms that between-session challenges are an expectation of work in treatment and explains the reason for the between session again. Elicit a confirmation of patient if their understanding. Then have the patient do the challenge with you now to demonstrate the importance.

Provide Rationale. Introduce the current topic involving styles of communication.

> ***Clinician (C):*** *Have you ever been in a situation where you wanted to tell someone how you felt but couldn't for some reason? Can you explain to me what made it difficult? Did not saying anything help or hurt the situation or your feelings in general?*
>
> *What about a time when you felt really upset or angry but waited to tell the person so that when you finally spoke up you ended up saying a lot of negative things that you later regretted? Many of us can identify with both of these kinds of situations.*

Provide the Rationale

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

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

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

> ***C:*** *As one's use increases, there's a funneling effect or narrowing of your own thoughts and coping strategies. Your nonuse coping outlets like your circle of non-using friends gets smaller, while your circle of using friends gets bigger. This increases relapse risk.*
>
> *When was the last time you celebrated without using? When was the last time you handled a negative situation, feeling, or thought without using?*

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

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

Teach Session Skill

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

> ***C:*** *Tell me a food you dislike and would not eat.*

Pressure the patient to eat the disliked food and see how they respond. Use any strategy necessary to try to get the patient to accept it, such as saying, "I made it just for you" or "I made it a way that it tastes like candy." Discuss the patient's response and how clear they were about refusing the food.

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

Teach Communication Styles

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

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

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

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

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

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

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

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

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

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

Next, the clinician discusses the patient's understanding of the terms discussed and asks for examples that could be shared of each style. The examples could be situations the patient has experienced, heard

about, or imagined. The clinician also asks the patient to identify how they speak to themself (self-talk). For example: "Given that most of us are critical when we make mistakes, it is also important to realize the style of communication we use for self-talk and how practicing assertiveness with ourselves will likely lead to a better feeling inside and perhaps an increased desire to change."

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

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

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

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

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

- ***Determine the thought or fear.*** What am I afraid will happen? What's the worst that could happen?
- ***Assess the probabilities.*** How likely is the negative consequence?

- ***Evaluate the catastrophe.*** What would happen if the worst occurred? Would it really be so terrible?
- ***Identify the rules***. What assumptions and beliefs govern feelings?

Clinician-Led Demonstration/Role Play

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

Patient-Led Practice (Assess Skills Transfer)

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

Identify Real-World Application

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

Clinician (C):

"Today we covered a lot of information about your use, what sets you up to use, and communication skills that are helpful in working toward your recovery goals. You most frequently reported your triggers are likely to be [____] and that knowing these triggers ahead of time and avoiding certain places and people has helped increase successful experiences without use." (Summarize the types of triggers: the time of day, the situation, the feelings and thoughts—positive and/or negative). "But as you've stated, you can't avoid all people, places, or situations all the time, and trying to do is also stressful. As today's lesson has demonstrated, it's possible to practice assertive refusal skills that allow you to be clear on how to get your needs met, and to refuse in ways others will understand.

"For example: Today you practiced refusal skills in several situations with others and in self-talk to help you gain confidence in saying no and not feel guilty or confused during risky times or events in the upcoming weeks.

"I wonder if you can tell me how you would use the assertive refusal skills in the next weeks to help you meet your goals?"

Negotiate and Prepare Between-Session Challenge

Hand out the between-session challenge Assertiveness worksheet. Ask the patient to use assertive communication for self-talk and with others when confronted by a trigger to use (negative thought, feeling, celebration, or social pressure situation).

> ***Clinician (C):***
>
> *"During the next week, I would like you to practice using the Knowledge Is Power worksheet and your assertive refusal skills, similar to how we did today.*
>
> *"How does that sound to you?"*
>
> *If the patient says it will be hard, try to help remove any obstacles.*

Elicit Commitment

> ***Clinician (C):***
>
> *If the patient agrees, say, "I am asking you to commit to filling out the sheet and using your refusal skills in two situations between sessions." Elicit: "Please identify a specific day, time, and place when you will complete the worksheet. Is there anything I can do to help you complete the real-life practice at the times you committed to?"*
>
> *Provide a brief summary of the next session topic and how the lessons will help the patient strengthen recovery. The clinician might say: "In our next session together, we will focus on [___], working with your thoughts and learning a method to change them to enhance how you feel and what you do."*

Summarize and Conclude the Session

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

ICBT Session 3. Learning Assertiveness Handouts

Review of Progress & Between-Session Challenges

Directions: Use the table below to support weekly progress review in key domains relevant to the patient's substance use and overall well-being. This table can also be used to review the between-session challenges.

Domain	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Physical Activity							
Sleep							
Diet							
Pleasure/Replacement Activities							
Mastery Activities							
Work/School							
Mood states							
Tobacco/Nicotine							
Alcohol							
Marijuana							
Other Drugs							
Between-Session Challenge							

Communication Styles

Passive-Aggressive	Aggressive
With passive-aggressive communication or behavior, someone may appear to agree or go along with a plan of action but engage in other behavior that conveys their true feelings. Passive-aggressive communication can be difficult to identify because often people are not aware they are doing it. **Example:** A woman asks her husband to attend a family gathering. He is not enthusiastic about family events and has somewhat conflicted relationships with some of his wife's family members. He would prefer to stay home and watch a tennis match on television. Instead of telling his wife his feelings, he agrees to go to the family party and arranges to meet her there after he completes some errands. He ends up being "held up" with some of his chores and arrives at the party 2 hours late. This would be considered "passive-aggressive" because on the surface he seemed willing to go along with his wife's wishes, but by arriving late he conveyed indirectly his preference to be elsewhere.	When someone behaves or communicates in an aggressive manner, they tend to ignore the rights or feelings of another person. They prioritize their own experience and needs over and above others involved. They may communicate through loud tones, yelling, threatening, and/or intimidating. They may be insensitive to how their message is coming across to others. They also may not be willing to hear how someone else feels or what they want in a particular situation. **Example:** A group of friends goes out to dinner and begins talking about their children. One member of the group comments and gives unsolicited advice to the parents about all the mistakes they are making and how their behavior is damaging their children.
Passive	**Assertive Communication**
This style occurs when someone feels unable to or fearful of expressing themselves or their feelings directly. They tend to acquiesce, or go along with, what the other person wants. They may not feel entitled to their opinions, or believe the other person will not listen or care. **Example:** Someone is asked to attend an event for work that is really inconvenient, but rather than asking to be excused or reschedule the person agrees immediately. With this form of communication an individual does not express their needs and wants in a clear way.	With assertive communication, a person expresses their thoughts, feelings, or needs directly and clearly, but is respectful and sensitive to the rights and feelings of others. They do not yell or intimidate, but they also do not sugarcoat their message to the point of meaninglessness. ***Benefits of being assertive—*** • Most effective way to let others know what is going on or what effect their behavior has • Resolve uncomfortable feelings that otherwise build up • Can lead to feeling more in control of life • Increases the chances that goals will be met • Makes people feel better about their role in the situation

Between-Session Challenge: Assertiveness

Assertiveness

Remember the following points in practicing assertiveness—

- Take a moment to think before you speak.
- Be specific and direct in what you say.
- Pay attention to your body language (use direct eye contact; face the person you are addressing).
- Be willing to compromise.
- Restate your assertion if you feel that you are not being heard.

Practice Exercise

The following exercises will help you become aware of your style of handling various social situations. The four common response styles are **passive, aggressive, passive–aggressive, and assertive**.

Pick **two** different social situations. Write brief descriptions of them and of your responses to them. Then decide which of the four common response styles best describes each response.

Situation 1 (describe)—

____

____

Your response—

____

Circle response style: ***passive*** ***aggressive*** ***passive–aggressive*** ***assertive***

If your response was not assertive, think of an assertive response and write it down here:

____

____

Situation 2 (describe)—

____

____

Your response—

____

Circle response style: ***passive*** ***aggressive*** ***passive–aggressive*** ***assertive***

If your response was not assertive, think of an assertive response and write it down here:

____

____

Source: Monti, Abrams, Kadden, & Cooney, 1989.

SESSION 4. ENHANCED SOCIAL SUPPORTS

INTRODUCTION & SESSION GOALS

Effective therapy starts with building rapport and trust and enhancing the therapeutic alliance developed in earlier sessions. The therapeutic alliance is essential to honest appraisal and recall of situations, triggers, and consequences of use. A main goal of all ICBT skill sessions is activating the patient in and out of treatment; so sessions are not just discussions; but a chance to introduce and practice skills, where the client takes the lead.

In Sessions 4 and 5, the clinician and patient address two essential areas of recovery: a) social supports and b) healthy replacement activities. Both of these aspects of the patient's life are a necessity to finding a life worth living without using substances. The clinician teaches the patient about the quality and scope of their social network (using the social atom diagram). Session 4 includes skills introduced in Session 3. Clinicians discuss and ask the patient how they might use their assertive communication skills from the previous session to engage social supports in a clear fashion that helps to build connections. The patient will have an opportunity to better understand and resolve reluctance in reaching out for support. The patient will identify those who could be there are allies and develop and activate a plan for building a more vibrant network of support.

A main goal for this first part of the session is not only discussing social supports but actually role playing the social interaction and eliciting a commitment to asking for support from an identified person. finding alternative rewards and pleasures in life.

Note to Clinicians: Yes, there are some individuals who recover from a use disorder without social support. However, research demonstrates that social support is strongly associated with recovery (Atkins & Hawdon, 2007; Humphreys et al., 2011). In fact, social support is understood as so crucial that most evidence-based treatment maintains a significant focus on social support (Miller, Forchimes & Zweben, 2011).

In the Session 5, healthy replacement activities, the clinician provides insights into the rationales that underlie most substance use/drinking habits; which are often maintained because they increase feelings of pleasure and/or they take away pain. Such experiences result from chemical changes in the brain after drinking or using drugs. One of the primary neurochemicals involved is dopamine. Dopamine and other reward sensation chemicals such as serotonin can also be produced by activities that are healthy and pleasurable. These are called replacement activities.

One of the best ways to increase dopamine is through physically new and challenging activities that require making effort and practicing skills. In Session 5, the patient brainstorms both activities that give immediate pleasure (effortless) and those that require mastery (effortful) experiences and commits to engaging in both types in the next weeks.

Clinician Preparation

Session 4. Supporting Recovery Through Enhanced Social Supports	
Materials - Review of Progress - Social Atom Diagram Handout - Social Support - Between-Session Challenge: Plan for Seeking Support Handout	**Total Time** 1 hour **Delivery Method** CBT-focused individual or group therapy
Strategies - OARS (Open-Ended questions, Affirmations, Reflections, Summary) - EDARS (Express Empathy, Develop Discrepancy, Awareness of Ambivalence, Roll with Sustain Talk/Discord, Support Self Efficacy); identify stage of change - Demonstrate skill, role-play & give feedback - Handouts utilized to focus the session helping to transfer knowledge and skill - Develop "real-life practice challenge" and generate commitment	
Goals for Session 4 - Enhance the patient's understanding of their social network as it pertains to connections that strengthen recovery - Discuss, elicit and role-play how a helpful supportive relationship in the patient's life can become aware of their role as a recovery support. - Identify a current situation or relationship that could benefit from the patient's communicating in a more assertive way; about needing help and also offering help.	

Session 4 Outline and Overview for Enhancing Social Support

First Third

1. Strengthen Rapport:

    Welcome patient and build rapport:

    - Share the session agenda; invite items from the patient
    - Engage in non-problem focused rapport building, exploring areas of the patient's life not directly related to treatment
    - Use this as an opportunity to continue to explore patient's passions, interests, social connection and strengths.

2. Review of Progress:

    - Engage the patient in a brief review of their progress related to their substance use, mental health, and related experiences since the previous session. Use the *Review of Progress* handout as a guide.

        - Where is the patient in their readiness to fully commit to abstinence?
        - Did the patient make an effort to stop? Cut down?
        - Did the patient experience any high-risk or tempting situations?
        - If the patient engaged in substance use, explore their use event(s) using the *Alcohol/Substance Use Awareness Record* to assess internal and external triggers, cravings, and consequences.

3. Review of Between-Session Challenge:

    - Did patient make an effort to stop? Cut down? Maintain abstinence?
    - Did the patient experience any high-risk or tempting situations?
    - Did the patient use the communication assertiveness strategies from the previous sessions?
    - Were the strategies successful?
    - Did the patient complete the between-session challenge? How did it go?
    - If the patient did not complete the between-session challenge, explore what got in the way, practice it if time allows and potentially problem solve in anticipation of this week's challenge.

Second Third

4. Provide Rationale:

    - Explain the rationale for building the patient's social support networks (see *Social Support* handout and Social Atom handout).
    - Use the Social Atom to get a quick snapshot who are the persons in your patient's life today.
    - Ask the patient about the qualities of people that the patient has and would like to have in their social network. Elicit types of support the patient is currently receiving or has received in the past: Who provided it? What did it look like? In what ways was it helpful? Unhelpful? What type of support does the patient feel is needed most? Why?

5. Discuss the different types of social support:

- Continue reviewing the different types of support from the *Social Sup*port handout.
- Elicit examples from the patient for each type.
- Ask the patient to consider supports not used in the past but which they might be willing to consider. Reference Social Atom handout.

6. Develop a plan for enhancing social support:
    - Continue reviewing the different types of support from the *Social Support* handout.
    - Elicit examples from the patient for each type.
    - Ask the patient to consider supports they have not used in the past but might be willing to consider.
    - Have patient activate seeking support in session (if possible). Examples could be sending a text message, email of making a phone call -n session.

Third Third

7. Identify Real-World Application
    - Have the patient complete the *Plan for Seeking Support* handout.
8. Review tips on how to ask for support and address potential obstacles:
    - Continue reviewing the tips on how to ask for support from the *Social Support* handout (hint: draw from the assertiveness guidelines from previous session).
    - Discuss any potential barriers to getting the support identified in the patient's plans and engage the patient in group problem solving.
9. Negotiate between-session challenge & elicit commitment:
    - Elicit commitment from patient to seek out one support identified in the plan during the next week.
    - Have patient define specifically when they will seek out the support and how.

Session 4 Protocol with Scripts

Strengthen Rapport

The clinician welcomes the patient and provides an overview of the fourth session, where the clinician further strengthens recovery capitol through understanding and learning about the patient's relationships including the quality, the depth and type. The clinician and patient also explore the patient's healthy action based coping strategies. Both mastery and immediate pleasure replacement activities are discussed and activated. The clinician invites the patient to provide additional agenda items for the session.

Review of Progress: Examining the Patient's Recent Experiences

Review the current status regarding alcohol or substance use and the goals of change or abstinence. The clinician uses the *Review of Progress* handout to support a brief review of the patient's progress in key domains since the last session, including substance use, mental health symptoms, and related wellness areas.

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

- Did the patient stop use since the previous session?
- Did the patient make an effort to stop?
- Was the patient confronted with any high-risk or tempting situations?
- What strategies did the patient use? Did the patient try any to see what triggers were most inviting to use and if so, did they try any of the communication strategies from the last session or any other coping strategies? Were they successful?
- Were there any instances when the patient effectively handled a "hot" situation (i.e., very high risk)?

Again, and throughout the model when the patient talks, the clinician's objective is to elicit information and to use that information to provide reflections, express empathy, identify discrepancies, elicit self-motivational statements, and roll with sustain talk/discord.

Review of Between-Session Challenge: Assessing the Patient's Progress and Readiness to Proceed

Inquire about any between-session practice challenge. Did the patient find being assertive with themself or others helpful? If appropriate, praise the patient's efforts accomplishing the between-session challenge and maintaining changes or abstinence. If the patient did not complete the challenge - ask them what happened—and why they did not complete the challenge. Holding patients accountable in a clear manner but one that is not off putting is essential to potent CBT. Again, remind the patient that the between-session challenges are an expectation of work in treatment and explain the reason for the between-session challenge again and then have the patient do the challenge with you now to demonstrate the importance.

Provide a Rationale

Introduce the concept of enhanced social supports and how vital that is to creating a stimulating and fulfilling lifestyle. Share with the patient that often when reducing substance use, there is a sense of absence or loss as old habits, people and places may create risks for continued use. Social support is a very powerful and beneficial force in the recovery process and in living well. The benefits of social support are many:

- a sense of belongingness and inclusion,
- a sense of safety and security,
- reduced stress, decreased isolation and loneliness,
- an enhanced sense of meaning and purpose,
- hope and optimism about the future,
- the opportunity to escape the narrow world of substance use
- social support can counteract shame, isolation and secrecy

> ***Clinician:*** *Most of our patients talk about the importance of examining and rebuilding social supports. Let's face it. We are social creatures and social connection is part of our well-being.*
>
> ***Patient:*** *That's true, but a lot of my friends and family drink or do drugs. So what do I do?*
>
> ***Clinician:*** *An excellent question! So let us start with getting a better picture of who actually is in your world and can they be an ally for your making changes. Let us first use the social atom tool to understand who all in in your world today.*

***Clinician* and *Patient* complete the social atom together.**

> ***Clinician:*** *So, when you think about social support that would work for you, what do you want in that relationship.*
>
> ***Patient:*** *I want someone who will respect my privacy, someone who I can hangout with, someone who doesn't judge me if I use and someone who want to give me grief if I don't want to use.*
>
> ***Clinician:*** *This is good. You are clear about what's important for you in a person who could be a support. Let's take a look again at the social atom and see who might have those characteristics you value.*
>
> *Clinician and Patient review the social atom together and identify one or more persons who could be social supports.*
>
> ***Clinician:*** *Can you imagine for a minute that I am this person. How would you reach out to that person and what would you say?*
>
> *Clinician and Patient role play the conversation. The clinician may first model the behavior and next the patient demonstrates the behavior. The clinician may need to use MI skills to process uncomfortable feelings of the patient connected to help seeking.*
>
> ***Clinician:*** *Is there something you might do right now in session that gets this started?*

Patient-Led Practice (Assess Skills Transfer)

> ***Patient:*** *Patient: I'd feel too weird calling in the middle of the day, but I could send a text message about catching up tonight or over the weekend. And then when we talk, I can say what's going on and ask.*
>
> *Clinician has Patient send text message (Activation in session).*

Clinician and *Patient* complete the Plan for Seeking Social support and discuss any potential challenges to the plan.

Identify Real-World Application

Clinician and *Patient* negotiate between-session practice.

Elicit commitment from patient to seek out one support identified in the plan during the next week.

Negotiate and Prepare Between-Session Challenge

Have patient define specifically when they will seek out the support and how.

Note to Clinician: Mastery and immediate pleasure activities can be the focus of the seeking support from relationships in the social network. Again, since a main goal of the social support session to activate supportive relationships, this can be accomplished by directly seeking support to do a mastery activity together—and then the patient's challenge commitment integrates parts of this and the next the session.

ICBT Session 4. Enhanced Social Supports Handouts

Review of Progress & Between-Session Challenges

Directions: Use the table below to support weekly progress review in key domains relevant to the patient's substance use and overall well-being. This table can also be used to review the between-session challenges.

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Tobacco/Nicotine							
Alcohol							
Marijuana							
Other Drugs							
Between-Session Challenge							

Social Support

Why is social support important?

We all need support at different times in our lives. Having people in our lives to support us can help us reach our goals and deal successfully with any challenges that come our way. When trying to quit alcohol and/or drug use, you may experience the following:

- Continuing to interact with family and friends that use alcohol or drugs
- Missing out on social interactions that involve alcohol or drug use
- Feeling anxious about socializing without alcohol or drug use
- Facing a diminished social network of people who do not engage in alcohol or drug use

Having a network of people who understand and support your efforts to change can be extremely helpful.

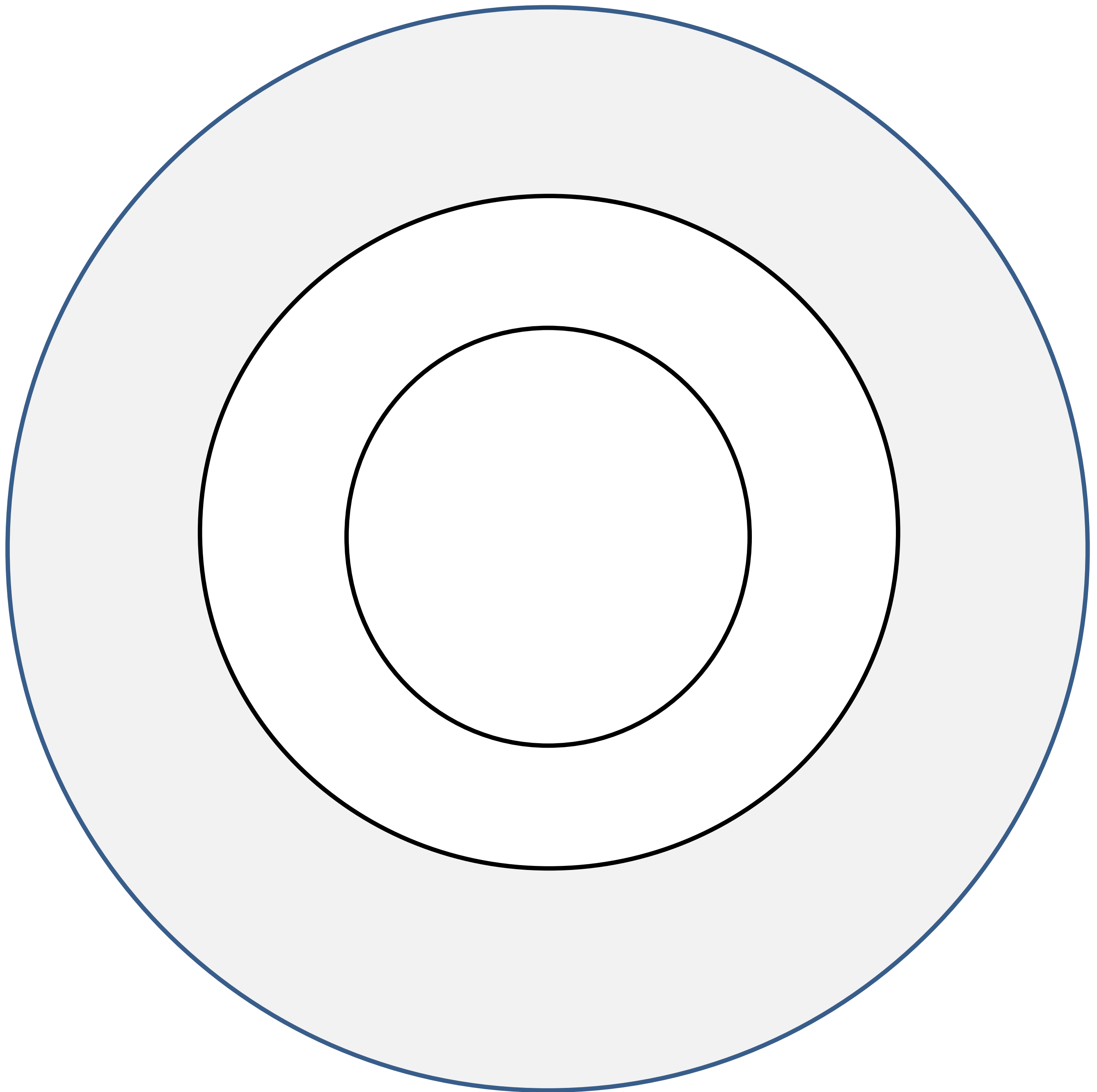
What types of support is out there?

- Self-help groups
- Professional help
- Spiritual or religious affiliations
- Personal relationships
- Coworkers
- Community service agencies

How to ask for support

- Be specific about what type of support you need
- Show appreciation for the person's support if it was helpful
- Give feedback to the person if they are giving support that was not helpful
- Find a way to support the other person

My Social Atom



Instructions: The social atom is a direct way to better understand your social world. In the center include yourself and those closest to you. In the next ring include associates and others with whom you have somewhat regular contact. In the third ring include those with whom you have occasional contact. Outside the circles include those with whom you have lost contact.

Plan for Seeking Support

Support	How this support will help	Plan for getting this support
Support	**How this support will help**	**Plan for getting this support**
Support	**How this support will help**	**Plan for getting this support**

SESSION 5. HEALTHY REPLACEMENT ACTIVITIES

INTRODUCTION & SESSION 5 GOAL

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

HEALTHY REPLACEMENT ACTIVITIES RATIONALE

Participating in healthy replacement activities is vital to creating an enjoyable and fulfilling lifestyle. Often when reducing substance use, patients feel a sense of absence, boredom or loss owing to the physiological and psychological effects of no longer using, or using less. Some of the best ways to increase feeling good is through physically new and challenging activities that require making effort and practicing skills. In this session, we will brainstorm activities that give immediate pleasure and those that require mastery experiences and to make commitment to engaging in both types in the next weeks.

CLINICIAN PREPARATION

Session 5. Supporting Recovery Through Healthy Replacement Activities	
Materials - Engaging in Replacement Activities (handout) - Increasing Pleasant Activities (handout)	**Total Time** 45–60 minutes **Delivery Method** Skill-focused individual or group therapy
Strategies - OARS (Open-Ended Questions, Affirmations, Reflections, Summary), support self-efficacy, identify stage of change - MI Eliciting Change Talk (Looking Back, Looking Forward, Pros and Cons, Decisional Balance Use) - Brainstorm - Develop “real-life practice challenge” (prescription for fun) - Follow CBT skills session reminders	

Session 5 Outline and Overview for Enhancing Healthy Replacement Activities

Note: If the session on replacement activities is done on its own and not coupled with the social supports, deliver all elements in a CBT session including the first third of the session: Engage & Build Rapport, Review Progress and Review Between-Session Challenge. Below we assume the social support and replacement activities are being delivered in one session; so, some of the full CBT elements are truncated but the goal of patient activation for the skills involved is met.

Second Third

- Rationale: Introduce increasing pleasant activities:
  - Explain the rationale that often people use alcohol and/or other drugs because of the pleasure they get from the experience or because they alleviate boredom.
  - Over time, it can be hard to have fun or enjoy oneself without using.
  - Related to this is the idea that drugs operate on specific reward centers in the brain.
  - Those reward centers are also affected by other, exciting, nonsubstance-related activities such as running or playing basketball.
  - Discuss the two different types of activities including the differences between mastery and pleasure and why having mastery activities is important.
  - Finding sober activities that are rewarding, challenging, and stimulating can help increase long-term abstinence.
- Explore the patient's interests and passions regarding sober activities:
  - Have the patient complete the top part of the Increasing Pleasant Activities handout by placing a 'P' next to activities they select which are pleasurable and an 'M' next to activities they select which incorporate a sense of mastery
  - Brainstorm additional activities if needed.

Third Third

- Identify real-world application
- Elicit commitment from the patient to engage in one activity two times between sessions:
  - Patient completes bottom portion of Increasing Pleasant Activities handout.
  - Explore with the patient what could get in the way or pose a barrier to engaging in the chosen activities.
  - Problem-solve to resolve any challenges to completing the task.

SESSION 5 PROTOCOL WITH SCRIPTS

Provide Rationale

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

Clinician: *Most of our patients tell us loud and clear that their substance use produced a sense of immediate pleasure and/or reward both biologically and psychologically—feelings that they depend on to get through the daily boredom or stress of life.*

Patient: *That's right! Using helps me spice up life when I need to, and at other times it chills me out so I don't feel so anxious.*

Clinician: *So it does different things for you and, either way, it is mind altering and you have come to rely on that experience. To replace the sense of loss as you reduce your use, most people find they need activities that include two important aspects of their life: pleasure and mastery. Pleasure activities bring us the immediate rewards that we all need to feel good; for example, watching a movie, reading a book, listening to music, and eating a nice meal. Mastery activities, because of the challenge they present, remain novel over time, lead to a long-term sense of accomplishment, and ultimately can produce feelings of passion for life (similar to passions for substance use). Mastery activities are challenging and demand creativity and effort in either or both the use of physical and mental skill.*

Patient: *That makes sense because we'd even get bored of using the same thing in the same amount every day. Besides, I always switch it up and smoke weed sometimes and drink booze on other days, or do both. It helps to give me different kinds of experiences.*

Clinician Led Brainstorm to Identify Real-World Application

Clinician: *Given the need for both pleasure and mastery activities, what can you do every day or week to engage in one type or the other so you feel passion in your life? Let's take a minute to brainstorm some possibilities, check off some listed ones, and discuss the choices in this handout on replacement activities.*

Offer the client the handout called Increasing Pleasant Activities Handout.

Clinician: *The handout lists a combination of Mastery activities (Ms) and Immediate Pleasures (Ps)- you'll notice some could be both dependent on how you commit to doing them.*

Patient: *How many of each should I choose?*

Clinician: *It is best to try to choose 3 to 5 of the different activity types that way you will have options should one or a few not work out.*

Patient: *Ok I'll do the immediate ones and some are not listed - drinking tea, listening to music, calling a friend and taking a brief walk outside all let me calm down and feel ok.*

Clinician: *Awesome list of pleasurable activities. What about the MASTERY (Ms) effort activities that you find rewarding, enjoyable and stimulating?*

(If needed prompt the patient with examples: playing a musical instrument, writing, singing, and playing a sport (golf, walking, distance running, skiing, etc.).

> ***Patient:*** *There are many I used do a lot - dance, cook and play the guitar. Dancing seems the most fun for next week as it lifts my mood and I don't need to do it alone all the time.*

Negotiate and Prepare Between-Session Commitment

Once the patient has listed three or more choices for each type of activity on the sheet, the clinician elicits a commitment for the upcoming week.

> ***Clinician:*** *Now on the Engaging Replacement Activities Handout, please write the choice in the appropriate space provided. Remember, all lifelong and stimulating habits take time to generate feelings of comfort. Even activities we think will be simple or enjoyable at first can become tedious or off-putting owing to the effort needed to begin and learn the basic skills (i.e., "the devil is in the details"). Mastery activities can take more initial effort to pursue, but once you acquire some success, the activities can become habit and enjoyable.*
>
> ***Patient:*** *That makes sense and I remember when I first started dancing it was actually embarrassing and I never thought I would get good at it. But, I realized I could do it over time and it got more fun as I could make the dance go with the music better and be in sync with my partner.*

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

Elicit Commitment

> ***Clinician:*** *The handout titled engaging in replacement activities is what you'll use to now write down your identified Ms and IPs and commit to one for next week.*
>
> *Take a couple of minutes to write down your ideas and then we can go over it together and determine when, where and with whom you will do your Mastery. It is harder to predict when you will do your immediate pleasure because you may have a craving at anytime during the week but still it is good for you to commit to using the IPs when you are triggered.*
>
> ***Patient:*** *Great I now have a few ways of coping with triggers and cravings - and I think since I committed to dance I will ask Bob - my main support person in my social network to join me in dancing.*

Summarize and Conclude Session

The clinician makes sure that the challenges are clear for both parts of the session if it is done combined and the client has specified how they will use the skill, where, when and with whom.

If the session skills on social supports and replacement activities are done in two sessions the sessions end with the challenge for the recovery skill discussed.

ICBT Session 5. Healthy Replacement Activities Handouts

Review of Progress & Between-Session Challenges

Directions: Use the table below to support weekly progress review in key domains relevant to the patient's substance use and overall well-being. This table can also be used to review the between-session challenges.

Domain	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Physical Activity							
Sleep							
Diet							
Pleasure/Replacement Activities							
Mastery Activities							
Work/School							
Mood states							
Tobacco/Nicotine							
Alcohol							
Marijuana							
Other Drugs							
Between-Session Challenge							

Increasing Pleasant Activities

Following is a list of both effortful Mastery and effortless immediate pleasure activities that people find pleasurable. Please check those that seem appealing to you, either because you know you like them, or you imagine you would like them if you tried. *Please put an M = Mastery or a P = immediate pleasure on any item checked*. Also check any items that you're not sure about but might be willing to consider if you had some support or encouragement to try it out. There are no grades on this exercise. Check as many as you wish. If there are things that are not listed that you want to include, please add them. Thanks.

- ☐ Reading a book
- ☐ Going to the movies
- ☐ Going out to a meal
- ☐ Exercising
- ☐ Listening to music
- ☐ Writing or journaling
- ☐ Dancing
- ☐ Singing
- ☐ Computer/Internet
- ☐ Photography
- ☐ Drawing
- ☐ Writing/calling friend
- ☐ Making jewelry
- ☐ Baking/cooking
- ☐ Shopping
- ☐ Painting
- ☐ Swimming
- ☐ Boating
- ☐ Ice skating
- ☐ Knitting/crocheting
- ☐ Taking a bath
- ☐ Gardening/lawn
- ☐ Fixing things
- ☐ Refinishing furniture
- ☐ Going to live theater
- ☐ Library
- ☐ Visiting park, garden
- ☐ Skydiving
- ☐ Running
- ☐ Organizing
- ☐ Party/social event
- ☐ Hiking
- ☐ Fishing
- ☐ Skiing
- ☐ Playing competitive sports
- ☐ Yard Sales
- ☐ Spending time with friends/family

Other activities:

____

Commitment:

I will do the following activity, ____

________number of times in the next week. I will do the activity on ____________________

(list specific dates) at ______________________________(list specific times).

Engaging in Replacement Activities

Why?

When we reduce immediate pleasure/reward, it is important to replace it.

Both immediate PLEASURE type activities and more skill-based MASTERY activities are needed.

They produce the same brain chemicals.

They tap into life passions and keep us feeling better.

What types of immediate pleasure activities do you like to do?

____

____

____

Which are you willing to commit to doing this week?

____

What types of skill-based MASTERY activities would you like to do?

____

____

____

Which are you willing to commit to doing this week?

____

____

____

SESSION 6. PROBLEM SOLVING

Introduction & Session Goals

Session 6 reviews the types of experiences and problems that cause stress for the patient and offers an easy-to-remember and effective method for how to choose the best possible solutions to most types of problems. The clinician explains that most relapses may be attributed to either interpersonal (the self in relation to others) or intrapersonal (within the self) stress, which often leads to unpleasant feelings such as anger, fear, shame, sadness, or guilt. The clinician explains that people successful at handling problems realize they cannot avoid all problems, but they can learn strategies to overcome them. They can develop ways of coping more skillfully and efficiently with predictable stresses that arise in the course of daily life and the larger, more life-altering and disruptive types of stressful events.

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

Clinician Preparation

<table>
<tr><th colspan="2">Session 6. Problem Solving</th></tr>
<tr><td>Materials
Review of Progress
Problem-solving (I-SOLVE) handout for between-session challenge
Large paper, poster board, or dry-erase board to diagram problem-solving steps</td><td>Total Time
1 hour

Delivery Method
Skill-focused individual or group therapy</td></tr>
<tr><td colspan="2">Strategies
Follow OARS techniques: Open-Ended Questions, Affirmations, Reflections, and Summary
Support self-efficacy
Demonstrate skill, role-play including transfer of skill – having patient go through an example on their own with you present
Follow CBT skills sessions</td></tr>
</table>

Session 6. Problem Solving

Goals for This Session

- Introduce a strategy for solving problems.
- Apply the problem-solving approach to alcohol or other substance use and related problems.
- Prepare for termination of treatment if applicable.

SESSION 6 OUTLINE AND OVERVIEW

First Third

1. Strengthen Rapport:
   - Welcome the patient, and if present, the support person.
   - Share the session agenda; invite items from the patient.
   - Engage in non-problem focused rapport building, exploring areas of the patient's life not directly related to treatment.
2. Review of Progress:
   - Engage the patient in a brief review of their progress related to their substance use, mental health, and related experiences since the previous session. Use the *Review of Progress* handout as a guide.
     - How is the patient doing with changing their substance use? What is going well? What are they struggling with?
     - If the patient engaged in substance use, explore their use event(s) using the *Alcohol/Substance Use Awareness Record* to assess internal and external triggers, cravings, and consequences.
3. Review of Between-Session Challenge:
   - Review any between-session challenges from the previous session.
   - Did the patient engage in pleasant activities? How did it go? If not, what got in the way?
   - Did the patient seek support? Explore their experience of doing so.

Second Third

4. Provide Rationale:
   - Discuss the importance of recognizing problems as opportunities to learn

- Explain the rationale that everyone has problems (the rich, the famous, the not-so-famous), and provide relevant examples.
- Provide the rationale that we often cannot control much of what happens in life, so we say problems are not the problem; rather, how we react to problems is important. Problems can be seen as opportunities rather than roadblocks.
- For patients, problem situations result in alcohol or substance use when people feel they have no effective coping responses to handle them or their range of abilities is narrow or constricted. However, these same situations can be managed by practicing effective problem-solving skills, so the choices diminish the negative consequences of the situations and even sometimes create opportunities.

5. Teach Session Skill:
    - Provide examples of problem-solving practice and how it is effective:
    - Explain how firemen practice setting fires to be prepared for the real fire, similar to other emergency workers who develop response routines so the incidents do not become overwhelming when they occur. This is similar to learning to do CPR or the Heimlich maneuver, gaining needed skills to respond to problem situations.

    Brainstorm problems and describe problem-solving skills:

    - Recognize the problem.
    - Identify or elaborate on the problem.
    - Consider various approaches.
    - Select the most promising approach.
    - Evaluate effectiveness.

6. Clinician-Led Demonstration/Role-Play:
    - Practice problem solving skills by identifying a problem and applying the problem-solving steps to solving the identified problem.
    - Once it is clear the patient understands the problem-solving process, collaborate with them to identify another problem they can try to solve. When the problem is identified, ask them to go through the problem-solving steps, out loud, so that they demonstrate to you, the clinician, that they can utilizes these steps on their own.
    - Role-play solutions to one of the problems and evaluate effectiveness.

7. Patient-Led Practice (Assess Skills Transfer)
    - Have the patient engage in a real-play of the skill.
    - Have the patient identify another problem and engage in the problem-solving steps, the I-SOLVE model, on their own.
    - Be there for questions or if the patient feels stuck. Ideally, the patient is able to move through the steps to identify solutions to the problem on their own and you are there to play a more supportive, affirming role.

Third Third

8. Identify Real-World Application:
    - Help the patient to identify a real-life problem in which they can apply the skill.
9. Negotiate and Prepare Between-Session Challenge:
    - Elicit from the patient when and where in their life they can use the problem-solving steps to address the identified problem.
    - Ensure that the challenge is specific and support the patient by rehearsing their application of the new skill—What will they do? When will they do it?
    - Encourage the patient to continue using the Alcohol/Substance Use Awareness Record when they are triggered to use, to continue engaging in pleasant activities, and to continue to build support.
10. Elicit Commitment:
    - Elicit commitment for completion of the between-session challenge for the identified problem before the next session.
    - Use MI strategies as needed to strengthen commitment.
11. Summarize and Conclude:
    - Present a session summary of what has been covered during the session and elicit the patient's feedback.
        - What did the patient learn through the problem-solving activity?
    - Conclude the session.

Session 6 Protocol with Scripts

Strengthen Rapport

The clinician welcomes the patient and provides an overview of the fifth session, in which the clinician further supports the patient to build coping skills by normalizing the experience of facing problems and enhancing their ability to resolve problems independently using a step-by-step system that has been shown to be helpful to others. The clinician invites the patient to provide additional agenda items for the session.

Review of Progress: Examining the Patient's Recent Experiences

The clinician uses the *Review of Progress* handout to support a brief review of the patient's progress in key domains since the last session, including substance use, mental health symptoms, and related wellness areas.

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

- How are their efforts to quit or cut down going?
- Was the patient confronted with any high-risk or tempting situations?
- What strategies did the patient use? Did the patient try any of the strategies in *Learning New Coping Strategies*? Were they successful?
- Were there any instances when the patient effectively handled a "hot" situation (i.e., very high risk)?

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

Review of Between-Session Challenge: Assessing the Patient's Progress and Readiness to Proceed

The clinician asks the patient how they feel about the previous session and responds to concerns, addressing any comments or questions about the patient's experience of seeking support and engaging in pleasant, healthy activities.

What type of support did they seek and from who? How did it go when they asked? Were they able to get the support they needed? What was it like for them to ask and then to receive support?

Note to Clinician: If the patient expresses discomfort or even guilt at asking for support, it is important for the clinician to explore with them their experience of providing support to others in the past. How did they feel when they were asked to offer their help? Often, the patients will indicate that they had a positive experience in being able to support someone else. The clinician reflects this back to the patient and asks if they people whom they ask for support from might feel the same way.

Provide Rationale

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

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

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

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

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

Teach Session Skill

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

I-SOLVE

I – **I**dentify the problem.

S – **S**tate the problem.

O – Consider **o**ptions.

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

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

E – **E**valuate effectiveness.

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

> *Okay, so we are going to go through the steps of problem solving using a tool called I-SOLVE. I will describe each and give an example. Please ask questions or make any comments as we go along, okay?*
>
> *The first step is to identify the problem. What clues indicate there may be a problem? You may get clues from your body (e.g., indigestion, craving), your thoughts and feelings (e.g., feelings of anxiety, depression, loneliness, fear), your behavior (e.g., have you been able to keep up with plans and commitments you make to others or yourself?), the way you respond to others (e.g., feeling irritable, impatient, having less interest in things, feeling withdrawn from people who might be supportive of you), and the way others respond to you (e.g., they appear to avoid you, seem frustrated or critical of you).*
>
> *The second step is to state or elaborate the problem. What is the problem? Having recognized that something is wrong, you identify the problem by gathering as much information as you can. Break the problem down into smaller parts; you may find it easier to manage several parts than to confront the entire problem all at once. State the problem beginning with an "I" statement. For example, if you must complete a large project at work, it can be helpful to break it up into smaller, more manageable parts and perhaps consult with colleagues on aspects that are particularly challenging for you. "I have a project due at work and will need someone with advanced computer skills to help me finish it on time."*
>
> *The third step is to consider options in addressing the problem. Develop several solutions; the first one that comes to mind may not be the best. Use the following methods to find a good solution:*
>
> *Brainstorm. Generate ideas without judging or stopping to evaluate how good or bad they are. Write down all the ideas that come to mind, even ones that seem unrealistic. Later*

> *you will review and make decisions about which you will actually try out. More is better. Don't evaluate these ideas at this stage.*
>
> *Consider strategies that require action or behavior change on your part (e.g., changing your routines related to social activity) and also strategies that involve your changing how you think about a situation. For example, when the problem involves negative emotional reactions to uncontrollable events, change how you view this situation and your role in it (cognitive coping). Some problems require both behavioral and cognitive coping.*
>
> *Once you have generated a list of ideas for coping with the problem, the fourth step is to look at the long and short term, including positive and negative consequences of choosing those options. Consider the resources you'll need for each solution. Here it is helpful to list the options and then write either +, –, or 0 = neutral next to each choice, depending on your thoughts about the outcome.*
>
> *The fifth step is to vote for the most promising approach. Rank the possibilities by their consequences and desirability. The solution with the most positive and fewest negative consequences is the one to try first.*
>
> *Finally, the sixth step is to evaluate effectiveness. How did it work out? Evaluate the strengths and weaknesses of your plan. What difficulties did you encounter? Are you obtaining the expected results? Can you do something to make the approach more effective? Use the same clues as before (e.g., from your body, thoughts, feelings, other people) to decide whether your solution is effective. If you give the plan a fair chance and it doesn't solve the problem, move to your second choice and follow the same procedure.*

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

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

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

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

Clinician-Led Demonstration/Role Play

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

Clinician (C): *Your upcoming 4th of July picnic will put you in a difficult situation because you'll be around old friends and family members with whom you used to get high. What is the problem as you see it?*

Steve (S): *Well, I have really enjoyed these parties in the past, even though they tend to be a blur because I've been so stoned. But it will be difficult to be there and not smoke with people. They will be offering me stuff for hours and I'm worried I'll just get worn down. Then I'll be mad at myself for not sticking to my guns.*

C: *You anticipate it being difficult to stick to your plans when you are around people you have used with in the past.*

S: *Yeah, I also don't want to let them down. I know that sounds kind of weird.*

C: *It doesn't sound weird at all. It also sounds like there's a tension between staying focused on your goals and plans and worrying about disappointing people you care about by not being "part of" things as usual.*

S: *Yes, I guess that's just how I feel.*

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

S: *Okay.*

C: *Great.*

The patient now uses the I-SOLVE model in the session to state the problem in a brief "I" statement, generate options, examine long-term and short-term consequences, vote, and then commit to trying the option chosen and evaluating the results of that choice.

Patient-Led Practice (Assess Skills Transfer)

The patient then takes the lead at walking the clinician through each component of the I-SOLVE model for a second problem the patient identifies. The purpose for focusing on a second problem in which the patient uses the I-SOLVE model is to allow the patient to demonstrate their ability using the model more autonomously, unless the patient specifically asks for help. During the patient's application of the I-SOLVE model, the clinician affirms the patient's skill application and offers follow-up questions to encourage the patient to explore the incident more thoroughly.

Identify Real-World Application

The clinician asks the patient to commit to applying the I-SOLVE model to another problem before the next session. They commit to check in next session on the outcome of the solutions identified and applied.

Negotiate and Prepare Between-Session Challenge

The exploration of real-world skill application is a natural transition into negotiation of a between-session challenge. The clinician encourages the patient to continue reviewing the materials handed out at this session and previous sessions including the Alcohol/Substance Use Awareness Record, Assertive Communication, Increasing Pleasant Activities, and asking or support. The clinician asks the patient where and when the patient can commit to working through the I-SOLVE model for a problem in their life. For any identified between-session challenges, the clinician works with the patient to ensure that they know what they will do, when they will do it, and how often it will be done, mentally rehearing its application in their daily life. Most patients benefit from writing down this plan somewhere accessible to them, to also serve as an ongoing reminder.

Elicit Commitment

The clinician explores the patient's commitment for completing the between-session challenge and uses MI strategies, as needed, to assess and strengthen commitment. The clinician also asks the patient to think through any potential obstacles to their skills practice and works with them to identify solutions and to activate resources, as needed, to support their skill application.

Summarize and Conclude the Session

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

ICBT Session 6. Problem Solving Handouts

Review of Progress & Between-Session Challenges

Directions: Use the table below to support weekly progress review in key domains relevant to the patient's substance use and overall well-being. This table can also be used to review the between-session challenges.

Domain	Sun	Mon	Tues	Wed	Thur	Fri	Sat
Physical Activity							
Sleep							
Diet							
Pleasure/Replacement Activities							
Mastery Activities							
Work/School							
Mood states							
Tobacco/Nicotine							
Alcohol							
Marijuana							
Other Drugs							
Between-Session Challenge							

Problem Solving

Here is a brief list of the steps in the problem-solving process:

I = Identify. Is there a problem? Recognize that a problem exists. We get clues from our bodies, our thoughts and feelings, our behaviors, our responses to other people, and the ways that other people respond to us.

S = State. What is the problem? Identify the problem. Describe the problem as accurately as you can using an "I" statement where the outcome is in your control. Break it into manageable parts.

O = Options. What can I do? Consider various approaches to solving the problem. Brainstorm to think of as many solutions as you can. Consider acting to change the situation; consider changing the way you think about the situation.

L = Look. What will happen if ...? Select the most promising approach. Consider all the positive and negative aspects of each approach.

V = Vote. Select the one most likely to solve the problem.

E = Evaluate. How did it work? Assess the effectiveness of the selected approach. After you have given the approach a fair trial, determine whether it worked. If it did not, consider what you can do to improve the plan, or give it up and try one of the other approaches.

Practice Exercise

Select a problem that does not have an obvious solution. Describe it accurately. Brainstorm a list of possible solutions. Evaluate the possibilities, and number them in order of your preference.

Identify the problem:

____

____

____

List brainstorming solutions:

____

____

____

Examine the (+, -, 0) long-term and short-term results.
Select the achievable option that has the most benefits.
Commit to using.
Evaluate outcome.

Source: Kadden, Litt, & Cooney, 1994.

SESSION 7. HANDLING URGES, CRAVINGS, AND DISCOMFORT (URGE SURFING)

INTRODUCTION & SESSION GOALS

Session 7 focuses on helping the patient gain an overall understanding of urges, cravings, and triggers. After normalizing the occurrence of automatic thoughts or urges, the clinician helps the patient identify how and when they experience urges or automatic thoughts. The clinician and patient collaborate on developing a menu of coping or response strategies that are relevant to the patient's experiences and environment. The session concludes with the clinician encouraging the patient to track their urges and coping and response strategies during the week. The clinician suggests reviewing them with the patient at the next session.

The patient will leave the session with—

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

CLINICIAN PREPARATION

<table>
<tr><th colspan="2">Session 7. Handling Urges, Cravings, and Discomfort (Urge Surfing)</th></tr>
<tr><td>Materials
- Review of Progress
- Coping with Cravings and Urges handout
- Urge Surfing handout
- Daily Record of Urges To Use handout</td><td>Total Time
1 hour

Delivery Method
CBT-focused individual therapy</td></tr>
<tr><td colspan="2">Strategies
- OARS (Open-Ended Questions, Affirmations, Reflections, Summary)
- Support self-efficacy
- Demonstrate skill, role-play including transfer of skill – having patient go through an example on their own with you present
- Discuss value of journaling/logging the patient's urges
- Follow CBT skills sessions</td></tr>
<tr><td colspan="2">Goals for This Session
- Enhance the patient's understanding about cravings and urges for alcohol or another drug.
- Identify specific triggers or cues for cravings (see Carroll, 1998).
- Review and practice specific skills for addressing cravings.
- Examine the patient's high-risk situations, triggers, and coping strategies.</td></tr>
</table>

Session 7 Outline and Overview

First Third

1. Strengthen Rapport:
    - Welcome the patient.
    - Share the session agenda; invite items from the patient.
    - Engage in non-problem focused rapport building, exploring areas of the patient's life not directly related to treatment.
2. Review of Progress:
    - Engage the patient in a brief review of their progress related to their substance use, mental health, and related experiences since the previous session. Use the *Review of Progress* handout as a guide.
        - How is the patient doing with changing their substance use? What is going well? What are they struggling with?
        - If the patient engaged in substance use, explore their use event(s) using the *Alcohol/Substance Use Awareness Record* to assess internal and external triggers, cravings, and consequences.
3. Review of Between-Session Challenge:
    - Review any between-session challenges from the previous session.
        - Did the patient use the I-SOLVE problem-solving approach? How did it go? If not, what got in the way?

Second Third

4. Provide Rationale:
    - Elicit from the patient their experiences with cravings and current coping methods.
    - Provide reasons for focusing on cravings, including basic information about the nature of cravings:
        - Cravings and urges are a part of the repeated use of any substance. Understanding urges and developing skills to address them is essential to recovery.
        - Cravings may feel very uncomfortable but are a common experience.
        - Cravings are experienced most often early in abstinence but can occur weeks, months, and even years later.
        - It is important to recognize urges and develop realistic strategies to manage them than can be practiced almost anywhere, and anytime.

5. Teach Session Skill:
    - Provide a framework for understanding urges or cravings. Provide the patient with a copy of the *Coping with Cravings and Discomfort* handout.
        - Urges/cravings are a subset of the universal experience of longing or desire.
        - The role of urges or cravings in substance use.
    - Discuss the patient's experience with and recognition of an urge.
    - Identify the patient's cues or triggers for cravings. Give the patient examples of common cues:
        - Exposure to alcohol, substances, or paraphernalia
        - Seeing other people using substances
        - Contact with people, places, times of day, or situations associated with using
        - Particular emotions and physical feelings
        - Distinguish external or environmental triggers from internal states.
    - Discuss strategies for coping with triggers.
        - Avoidance
        - Escape
        - Distraction
        - Embrace
6. Clinician-Led Demonstration/Role-Play:
    - Practice one of the Embrace strategies (Urge Surfing) for coping with triggers by walking the patient through a brief demonstration of how to implement the Urge Surfing strategy.
        - Focus on *how* the strategy is implemented (the steps involved)
        - Focus on the *experience* of the activity by walking through each step while sharing out loud your experiences, as if you were engaging in the strategy in that moment.
    - Once it is clear the patient understands the Urge Surfing technique, have them demonstrate the skill.
7. Patient-Led Practice (Assess Skills Transfer)
    - Have the patient identify a recent urge or craving. With that experience in mind, the patient is encouraged to practice Urge Surfing using a similar talk aloud method. The

clinician may need to support the patient by reading the instructions and prompts to them.

Third Third

8. Identify Real-World Application:
    - Help the patient to identify real-life situations in which they can apply the skill.
    - Work with the patient to make a list of cravings triggers and a cravings plan for responding to those triggers.
9. Negotiate and Prepare Between-Session Challenge:
    - Elicit from the patient how and where in their life they can apply Urge Surfing and other strategies they learned for coping with cravings.
        - Introduce and encourage the patient to use the *Daily Record of Urges To Use* handout to track their urge experiences throughout the week.
    - Ensure that the challenge is specific and support the patient by rehearing their application of the new skill—What will they do? When will they do it? How often will it be done (i.e., at least two times)?
10. Elicit Commitment:
    - Elicit commitment for completion of the between-session challenge at least two times before the next session.
    - Use MI strategies as needed to strengthen commitment.
11. Summarize and Conclude:
    - Present a session summary of what has been covered during the session and elicit the patient's feedback.
        - What did the patient learn through Urge Surfing activity and broader discussion of strategies for coping with urges and cravings?
    - Conclude the session.

Session 7 Protocol with Scripts

Strengthening Rapport

The clinician welcomes the patient and provides an overview of the seventh session, in which the clinician supports the patient in developing awareness around their experiences with urges and cravings and learning strategies for coping with these experiences. The clinician invites the patient to provide additional agenda items for the session.

Review of Progress: Examining the Patient's Recent Experiences

The clinician uses the *Review of Progress* handout to support a brief review of the patient's progress in key domains since the last session, including substance use, mental health symptoms, and related wellness areas.

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

- How are their efforts to quit or cut down going?
- Was the patient confronted with any high-risk or tempting situations?
- What strategies did the patient use? Were they successful?
- Were there any instances when the patient effectively handled a "hot" situation (i.e., very high risk)?

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

> If the patient engaged in substance use, explore their use event(s) using the *Alcohol/Substance Use Awareness Record* to assess internal and external triggers, cravings, and consequences.

Review of Between-Session Challenge

The clinician asks the patient how they feel about the previous session and responds to concerns, addressing any comments or questions about the patient's experience with implementing the I-SOLVE problem-solving model. The clinician elicits how the patient's implementation of the I-SOLVE technique went for them, exploring what went well and what went less well. If the patient did not complete the activity, the clinician engages the patient in a discussion about the barriers that got in the way and how they might respond to similar barriers in the future.

Provide Rationale

The clinician asks about the patient's experiences with cravings and current coping methods. See the sample discussion provided.

> *Many people report they have strong urges to drink or get high when they first stop using. In the beginning the urges can feel overwhelming and hard to manage.*

> *Is this something you've experienced when you've tried to stop using?*

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

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

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

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

Specify the rationale.

> *Cravings and/or urges are a part of the repeated use of any substance. Understanding*
>
> *your urges and developing skills to address them is essential to recovery. One thing we know about cravings is that everyone experiences them differently, and in the recovery process, how one person experiences them will change over time.*

> *The good news is that urges are like stray cats: If you don't feed them, they eventually go somewhere else. There are a number of strategies that can be used to manage urges. These fall into a few categories – escape, distraction, avoidance and embracing. Learning to use one or all of these strategies will help you to diminish the craving/urge.*
>
> *What I'd like us to focus on today is how we can work together to support you in recognizing urges and developing realistic strategies to recognize your triggers, reduce your exposure to them, and cope with urges.*

Teach Session Skill

Provide a Framework for Understanding Urges or Cravings and Their Role in Substance Use

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

Discuss the Patient's Experience with and Recognition of an Urge

The clinician shares a general overview of how cravings or urges are often experienced, then elicits from the patient their unique experiences.

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

> *die down, like a wave. Urges become less frequent and less intense as you learn more methods for coping with them.*

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

Some examples appear below:

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

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

> ***Clinician:*** *We've spent some time talking about your general experiences with urges. Before we move on to talking about coping with urges, I'd like to get a better sense of how you know when you're having an urge. Some urges may be very easy to recognize, but others are less obvious. I'm wondering how you know when you're having an urge.*
>
> *What is the first thing you notice when you are having an urge? How do you know that an urge is coming on?*
>
> *What is the most obvious sign that you are craving alcohol?*
>
> *If somebody were with you when you were experiencing an urge, would they notice anything?*

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

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

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

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

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

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

Identify Cues or Triggers for Cravings

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

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

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

The clinician should follow this brief explanation and presentation of examples by asking the patient about their triggers for urges. Once again, it is important for the clinician to begin by asking, in an open-ended format, about the patient's understanding of triggers. Triggers can be recorded on the *Coping with Cravings and Discomfort* handout as the patient identifies them. The *New Roads* worksheet

referred to in Session 9 may provide valuable information about triggers that can be used to supplement this discussion. If information about various types of triggers is not elicited, the clinician may follow with more directive questioning and discuss some of the common triggers listed below.

> ***Clinician:*** *It's important to learn how to recognize triggers so you can reduce your exposure to them. Common triggers include—*
>
> - *Exposure to alcohol, substances, or paraphernalia*
> - *Seeing other people using substances*
> - *Contact with people, places, times of day, and situations associated with using (such as people you used with, parties, bars, weekends)*
> - *Particular emotions (such as frustration, fatigue, feeling stressed), even positive emotions (elation, excitement, feelings of accomplishment)*
> - *Physical feelings (feeling sick, shaky, tense)*
>
> *Some triggers are more difficult to recognize. Self-monitoring can help begin to identify them. The easiest way to cope with cravings and urges is to minimize their likelihood of occurring. You can reduce your exposure to triggers by getting rid of alcohol or substances in your home, not going to parties or bars, and limiting contact with friends who use.*

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

External situations

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

Internal states

- Unpleasant emotions (e.g., frustration, depression, anger, feeling "stressed out")
- Pleasant emotions (e.g., elation, excitement)
- Physical feelings (e.g., sick, shaky, tense, in pain)

- Thoughts about drinking or drug use (e.g., "I'll feel better if I get high")
- Beliefs or ideas such as, "I will always be an addict"

Discuss Strategies for Coping with Triggers

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

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

The clinician teaches the client four key approaches for managing urges: avoidance, escape, distraction, and embrace.

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

Examples of avoidance strategies include—

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

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

The clinician should recommend that the patient consider the following when making their plan for escape:

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

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

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

- Talk it through with someone who is supportive and nonjudgmental. Talking can provide you with support when you need it and can help you to get through the urge without using again. Remember the "larger picture," including why you are trying to make this important change. It is important to talk with someone who won't judge or criticize you for having these feelings or urges but will give you permission to express yourself.
- Meditation or mindfulness activities can help you stay present with your experience without the need to act or react; they can also increase awareness generally.
- Wait it out; urges are only temporary.
- Take protection when faced with a high-risk situation.
- Use a reminder card.
- Urge surfing. Delay the decision to use. Most urges to use can be likened to ocean waves—they build to a peak and then dissipate. For many patients, if they choose to wait 15 minutes, the wave will pass. Try imagining you're a surfer riding the wave of craving until it subsides or use another image that works for you.
- Use imagery. If you feel you are about to be overwhelmed by urges to use, imagine scenes that portray those urges as storms that end with calmness, mountains that can be climbed, or waves that can be ridden. Everyone can find an image to maintain control until the urge peaks and then dissipates.

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

Additional cognitive, or thinking strategies, can also be helpful in managing urges or cravings.

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

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

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

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

    - **What is the evidence?** What is the evidence that if I don't drink in the next 10 minutes, I'll die? Has anyone ever died from not drinking? What's the evidence that people recovering from an alcohol problem don't have the feelings I'm having? What is the evidence that I'll *never improve?*

    - ***What's so awful about that?*** What's so awful about feeling bad? Of course I can survive it. Who said that abstinence would be easy? What's so terrible about experiencing an urge? I can get through it. I've gotten through other difficult feelings and experiences and can live to tell about them. These urges are not like being hungry or thirsty; they're more like a craving for a particular food or an urge to talk to a particular person—they'll pass.

    - **I'm a human being and have a right to make mistakes**. Maybe I worry about not getting everything done that I hope to, or not being as patient as I should be. What's so bad about that? We all make mistakes, and in a situation that's complicated, there may not be

> a clear "right" or "perfect" way to handle things. Some of these strategies will be necessary or helpful only initially to distract yourself from persistent urges; in the long run, you'll have an easier time if you replace the thoughts with other activities. After a while, abstinence will feel more natural. The urges will diminish in intensity and will come less often. You will also know how to cope with them.

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

> ***Clinician (C):*** *You identified one of your strongest triggers as seeing other people smoking, especially family members. Let's try to pinpoint exactly what's going on.*
>
> ***Shirley (S):*** *I feel that if I don't smoke with some family members, they might think I'm above them. They already make fun of me, calling me the college girl, and I want to fit in.*
>
> ***C:*** *You're sensitive to your family members and concerned they'll think you're trying to be better than they are by not smoking. What is the evidence this will happen?*
>
> ***S:*** *Well, I guess it's more a fear than a fact. I really do love them and know they love me. But I don't know how they would respond.*
>
> ***C:*** *What thoughts have you had about telling them?*
>
> ***S:*** *I almost told my uncle the other day when he lit up. But then I ended up smoking, and I just couldn't.*
>
> ***C:*** *You realize that once you get high, it's difficult to make changes.*
>
> ***S:*** *I've been thinking that I need to tell them when there's no chance that we would be smoking. But I dread it!*
>
> ***C:*** *What are some other ways you might let them know?*

Clinician-Led Demonstration/Role-Play

The clinician gives the patient the *Urge Surfing* handout and orients them to the activity by summarizing the rationale) Much of this will have already been discussed in the session. The clinician then walks the patient through a brief demonstration of how to implement the Urge Surfing strategy. This is done by describing each step in the activity and modeling how the technique is applied. A useful strategy when modeling this technique is to share out loud your experiences, step by step, as if you were engaging in the strategy in that moment.

Patient-Led Practice (Assess Skills Transfer)

To prepare the patient to practice Urge Surging, ask them to identify a recent situation in which they felt a strong craving or urge to use. Ask the patient to describe the trigger(s) and their experience of the craving/urge with enough detail to stimulate some degree of craving in that moment. Then, the clinician supports the patient in practicing Urge Surfing. The clinician walks the patient through the activity, step by step, reading the instructions and prompts aloud and checking in with the patient as needed

throughout the activity. When the practice is complete, the clinician affirms the patient's skill application and offers follow-up questions to encourage the patient to explore their physical, emotional, and cognitive experiences throughout the Urge Surfing activity.

Identify Real-World Application

The clinician helps the patient to think through opportunities for how they might continue strengthening their skills in managing cravings and urges. These might be upcoming situations in which the patient anticipates encountering a craving trigger. Ideally, the patient would initiate practice of new skills for managing cravings when they are experiencing mild-to-moderate intensity cravings. This intensity level is heightened enough to provide the patient with an opportunity to practice skill application outside of a high-risk situation. As the patient's skills strengthen, they will become more adept at using these coping strategies and more prepared for managing high-intensity cravings. At the same time, the clinician also supports the patient in planning response strategies for high-intensity cravings or urges by identifying a combination of strategies that can be deployed if needed.

The clinician introduces the following exercises to support the patient in identifying potentially triggering situations and a plan for responding to those triggers. Using the Coping with Cravings and Discomfort handout, the clinician asks the patient to generate a list of any additional triggers they encounter in daily life. The patient is then asked to circle any triggers they can more easily avoid or reduce their exposure to, such as having alcohol or substances in the home. The clinician then supports the patient in generating a craving plan. The clinician asks the patient to select two or three of the general coping strategies discussed and think through how they will put them into practice when experiencing an urge. For example, if the patient seemed to gravitate toward distracting activities, ask them to identify which specific activities would be most helpful? Encourage the patient to consider: Which strategies are available? Which take preparation? If one does not work, what will they try next?
Negotiate and Prepare Between-Session Challenge

The exploration of real-world skill application is a natural transition into negotiation of a between-session challenge. The clinician encourages the patient to continue reviewing the materials handed out at this session and previous sessions. The clinician asks the patient where and when the patient can commit to using avoidance, escape, distraction, and embrace coping skills to manage urges and cravings. The patient is encouraged to continue practice of Urge Surfing along with other strategies as relevant to their identified triggers and craving plan.

For any identified between-session challenges, the clinician works with the patient to ensure that they know what they will do, when they will do it, and how often it will be done, mentally rehearing its application in their daily life. Most patients benefit from writing down this plan somewhere accessible to them, to also serve as an ongoing reminder. For this session, the clinician also introduces and encourages the patient to use the *Daily Record of Urges to Use* handout to track their urge experiences and coping responses throughout the week.

Elicit Commitment

The clinician explores the patient's commitment for completing the between-session challenge (at least two times) and uses MI strategies as needed to assess and strengthen commitment. The clinician also asks the patient to think through any potential obstacles to their skills practice and works with them to identify solutions and activate resources as needed to support their skill application.

Summarize and Conclude the Session

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

ICBT Session 7. Handling Urges, Cravings, and Discomfort Handouts

Coping with Cravings and Discomfort

About Urges and Cravings

- Urges are common in the recovery process. Do not regard them as signs of failure. Instead, use your urges to help you understand what triggers your cravings.
- Urges are like ocean waves. They get stronger only to a point; then they start to subside.
- You win every time you defeat an urge to use. Urges get stronger the next time if you give in and "feed" them. However, if you don't feed it, an urge eventually will weaken and die.

My Craving Triggers:

Make a list of craving triggers. Circle the triggers you can more easily avoid or reduce your exposure to, such as removing alcohol or substances in your home.

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.
11.	12.
13.	14.

My Craving Plan:

Select two or three of the general strategies discussed and plan how to put them into practice if you experience an urge.

I will use these strategies if I experience an urge.

1. ____

2. ____

3. ____

4. ____

5. ____

Between-Session Challenge

For the next week, make a daily record of urges to use alcohol or substances, the intensity of those urges, and the coping behaviors you used.

Fill out the *Daily Record of Urges to Use* handout:

- Date
- Situation: Include anything about the situation and your thoughts or feelings that seemed to trigger the urge to use.
- Intensity of cravings: Rate your craving; **1 = none at all, 100 = worst ever**.
- Coping behaviors used: Note how you attempted to cope with the urge to use alcohol or substances. If it helps, note the effectiveness of your coping technique.

Daily Record of Urges to Use

Date	Situation (Include Thoughts and Feelings)	Intensity of Cravings (1–100)*	Coping Behaviors Used

*Intensity of cravings scale: 1 = none at all, 100 = worst ever

Urge Surfing

Many people try to cope with their urges by gritting their teeth and toughing it out. Some urges, especially when you first return to your old using environment, are too strong to ignore. When this happens, it can be useful to stay with your urge to use until it passes. This technique is called urge surfing.

Urges are like ocean waves. They are small when they start, grow in size, and then break up and dissipate. You can imagine yourself as a surfer who will ride the wave, staying on top of it until it crests, breaks, and turns into less powerful, foamy surf. The basis of urge surfing is similar to that of many martial arts. In judo, one overpowers an opponent by first going with the force of the attack. By joining with the opponent's force, one can take control of it and redirect it to one's advantage. This type of technique of gaining control by first going with the opponent allows one to take control while expending a minimum of energy. Urge surfing is similar. You can join with an urge (rather than meet it with a strong opposing force) as a way of taking control of your urge to use. After you have read and become familiar with the instructions for urge surfing, you may find this a useful technique when you have a strong urge to use.

Urge surfing has three basic steps:

1. Take an inventory of how you experience the craving. Do this by sitting in a comfortable chair with your feet flat on the floor and your hands in a comfortable position. Take a few deep breaths and focus inward. Allow your attention to wander through your body. Notice where in your body you experience the craving and what the sensations are like. Notice each area where you experience the urge and tell yourself what you are experiencing. For example, "Let me see—my craving is in my mouth and nose and in my stomach."
2. Focus on one area where you are experiencing the urge. Notice the exact sensations in that area. For example, do you feel hot, cold, tingly, or numb? Are your muscles tense or relaxed? How large an area is involved? Notice the sensations and describe them to yourself. Notice the changes that occur in the sensation. "Well, my mouth feels dry and parched. There is tension in my lips and tongue. I keep swallowing. As I exhale, I can imagine the smell and taste of [____]."
3. Refocus on each part of your body that experiences the craving. Don't try to escape from or avoid the experience of craving. Accept its presence. Pay attention to and describe to yourself the changes that occur in the sensations. Notice how the urge comes and goes.

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

SESSION 8. MAKING IMPORTANT LIFE DECISIONS

INTRODUCTION

There are many paths to recovery, and the path your client may take may differ from what science may suggest. The right path for your client is what works for that person.

So many people experiencing substance use, depression, or other life challenges live their lives by habit and circumstances. They often hope things will get better when circumstances change, not fully recognizing that we bring who we are wherever we go. And waiting for things to get better is often to consign ourselves to be the observer and not the architects of our own lives. Often this waiting for things to get better takes us away from what is most important to us: our values and beliefs of the person we want to be and the life we want to live.

One of the things we have learned from persons in long-term recovery is they strive to live and act each day grounded in their chosen values and acting with intention. This is the spiritual core often spoken of in the fellowships.

Our purpose in this session is to support our clients to become aware of and to own those values and to make decisions for living and acting in accord with that which they hold most important.

So, what do we mean by values? "Values are freely chosen ways that we understand our place in the world. They are patterns of behavior that evolve over time based on our actions and the satisfaction we feel doing those things for their own sake. Acting in accord with our chosen values is intrinsically rewarding (SC Hayes, et al 2011).

Session 8 expands on previous motivational activities and is applicable to anyone making an important life choice. We can normalize ambivalence and the **real, normal angst** that is healthy in making a change that is in line with that which is most important in the life your patient wants to live. Yes, change is not without risk and so is staying the same. We support our patients to identify and embrace areas where decisions need to be made. In your previous work in Sessions 1, The Life Movie, and Session 2, the Awareness Record (functional analysis), the clinician and patient have a growing awareness of those values and in what way your patient is living and acting. The first part of this session is a reflective discussion where you, the clinician, clarify and bring to light (again) your person's chosen values and determine is your patient acting in alignment with or disconnected from those values. This conversation about disconnection from valued living can be uncomfortable. (e.g., I feel like such a failure that I have not been here for my kids the way they need me). We facilitate agreement in those life areas where your patient seeks to make change.

When your patient is ready, you can provide them with a consistent decision-making method designed to provide clarity while increasing readiness and action. Handouts for this session include a values clarifying tool, readiness rulers, and the decisional balance. The primary discussion strategies include

scaling (using readiness rulers), double-sided reflections, pros and cons of change (using a decisional balance sheet), looking ahead, looking back, clarification of values using compassionate reflections, and imagining extremes.

A supportive other person may be invited to join Session 8 to provide additional statements about the benefits of making a decision to stop using (or another important prosocial change) and if necessary, an accurate recollection of "negative events associated with continued use." It is important for the clinician to monitor and prevent this from becoming a negative or overwhelming experience for the patient (e.g., the supporter is angry or frustrated with the patient over past use and threatens dire consequences).

Session 8 focuses on the following:

- Identifying key decisions that need to be made
- Explore and clarify core values that could inform decision
- Decisional balance to tip the scales in favor of change
- Readiness rulers
- Affirming the patient's ability to take action on a decision
- Use of double-sided reflection to showcase where your patient is and where they want to be
- Affirm that change can feel uncomfortable and so is staying the same.

The Patient's Experience

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

Clinician Preparation

Session 8. Making Important Life Decisions	
Materials - Values Clarifying Tool - Readiness Rulers (Pre and Post) - Decision-Making Guide	**Session Length** 45–60 minutes **Delivery Method** MET-focused individual therapy
Strategies - OARS (Open-Ended Questions, Affirmations, Reflections, Summary) - EDARS (Express Empathy, Develop Discrepancy, Awareness of Ambivalence, Roll with Sustain Talk/Discord, Support Self-Efficacy); identify stage of change	

Session 8. Making Important Life Decisions

- MI Eliciting Change Talk, Current Motivation (Readiness Ruler), Elaboration, Looking Back, Looking Forward, Pros and Cons (Decisional Balance), Imagining Extremes,
- Develop “real-life practice challenge” (sampling sobriety)

Goals for This Session

- Further explore the patient’s attitudes and values.
- Elicit ambivalence and increase verbalized discrepancies in favor of change.
- Use MI to strengthen change talk strategies and tools to enable visual record of the patient’s values and goals.
- Provide patient with clear set of strategies for making important life decisions.
- Elicit commitment from patient to take one action step to reinforce decision made during session.

Session 8 Outline and Overview

1. Engagement and assessment of the patient’s readiness to proceed
    - Welcome the patient and continue to build rapport; address any obstacles to the therapeutic alliance.
    - Share the session agenda.
    - Ask whether any changes have occurred since the last meeting.
    - Discuss the decision to continue use, the benefits, and any consequences.
    - Review the between-session challenge(s).
    - Review the daily check-in and supporter plan completion.
2. Motivational strategy involving readiness for change?
    - Introduce important life decision of concern for patient (e.g., being the person that I want to be; achieving abstinence from substances; being a good father, mother, or parent; leaving or remaining in uniformed service; marriage or divorce; disclosure of sensitive information to an important other. Explore through compassionate reflections patient core values
    - Introduce the readiness ruler.
    - Elicit the patient’s readiness score.
    - Use double-sided reflection to bring into the conversation where your patient is and where they want to be. Reflect on alignment or disconnect with values.

- Discuss real and potential future for patient without change and with change.

Note to Clinician: When exploring with patients where there is a values disconnect, this is often accompanied by strong effect of shame and guilt.

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

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

9. Conclude the session.

Session 8 Protocol

Strengthening Rapport

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

> ***Clinician (C):*** *Thanks for sharing the highlights of your week with me. You paint the picture of how busy you are at work and how much you need to find quick, easy ways to relax when you get home.*
>
> ***Michael (M):*** *That's right. My time feels so limited and my energy is pretty low by the time I get home, and I just look forward to a couple of cold beers and a few hits off my pipe. Then I can settle into being with my wife and family for dinner, or whatever else is on the schedule.*
>
> ***C:*** *You've identified an efficient and nice way of taking care of yourself to ease the transition from work to home life.*
>
> ***M:*** *Right, and so when my doctor asked me to see you, I was a bit annoyed and wondered why, in the scope of all the possible problems, she figured I needed to address this first. Anyway, I'm still not convinced I need to change, even though the assessment and our first discussions make it clear that my regular and long-term use of alcohol and weed, combined with my lack of exercise, is contributing to my risks for heart trouble.*
>
> ***C:*** *That makes sense because your habit of relaxing works well, and why bother changing if there is no immediately obvious sign of damage to your health but rather a risk in the future.*
>
> ***M:*** *You said that perfectly. There's just not enough reason for me to change right now.*

Engagement and assessment of the patient's readiness to proceed

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

> ***C:*** *All right, you sound pretty definite about your position here. And it can be helpful to actually state a number on where you stand now with regard to changing your use, a*

> *baseline marker (similar to a cholesterol test), so if for any reason you decide to make changes, we can see where you started. Here is a ruler and I'd like you to score where you believe you stand right now.*
>
> ***M:*** *That's easy. I'm like 10 percent on this. I know there are a few important health reasons to do something, but like I said, it's just not enough now.*

The clinician takes out the Decision-Making Guide and readiness ruler sheet and introduces the idea of learning a decision-making process. The clinician could say something like:

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

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

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

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

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

> ***C:*** *What will it be like in a few years if you continue using and go back to your doctor for a cardiac wellness visit? What's the worst news you can imagine getting?*
>
> ***M:*** *I never really like to think about that. Like I said, I just live day to day and that kind of thought is above my pay grade, but since you're asking…. I guess I could find out my cholesterol is too high and be told to take Lipitor or some pill like that. My doc might also tell me that he strongly recommends I quit substances to avoid some kind of stroke or heart attack or something. (My relative had a heart attack at 54. That was really scary)*
>
> ***C:*** *The risks get worse until you are forced to take medication and live with the chances of a serious heart condition.*
>
> ***M:*** *Yeah, but we all take risks every day. This is one my doc, my family, and now you care to talk about.*

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

Review and Conclude

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

ICBT Session 8. Making Important Life Decisions Handouts

Clinician's Quick Reference to Session 8

1. Welcome the patient and continue to build rapport.
    - Check in on past week
    - Follow up on between-session challenge
2. Share the session agenda and rationale.
    - Discuss the decision of concern, the benefits, and any consequences.
    - Review the between-session challenge(s).
    - Review the daily check-in and supporter plan completion.
3. Introduce motivational strategy involving readiness for change.
    - Reintroduce the readiness ruler.
    - Elicit the patient's readiness score regarding specific concern.
    - Seek elaboration and outcomes.
    - Discuss the history of patient's life prior to use or in relationship to current concern.
    - Discuss real and potential future for patient without change and with change.
4. Introduce and teach decision-making steps:
    - Discuss concept of decision-making, normalizing ambivalence as part of the process.
    - Provide a rationale for focusing on decision making.
    - Introduce idea that certain steps can make the decision-making process less overwhelming and potentially clearer.
    - Introduce how clarity of personal values helps guide decision making
    - Emphasize that while these steps can be used for any decision, today's session focus will be on the decision whether to continue to use.
    - Give patient Decision-Making Guide and review steps 1 through 5.
5. Complete steps 1 through 3 of the Decision-Making Guide for decision regarding use.
    - Elicit from patient what the decision topic is and from which options the patient can choose.
    - Using Decision-Making Guide, explore pros and cons of each choice, including how the choice relates to patient's short- and long-term goals and what feelings each decision evokes.
    - Review relevant history of patient's life.

- Discuss real and potential future for patient without change and with change.
- Elicit the patient's top three statements in each category; end with the benefits of changing.

6. Using the readiness ruler in the Decision-Making Guide, ask the patient to reassess their readiness.
   - Summarize the change talk discussions, emphasizing any change in readiness: Illustrate any increased readiness or continued ambivalence.
   - Have patient complete step 5 of the Decision-Making Guide.
   - If appropriate, assign a between-session challenge and elicit a specific commitment to complete the challenge:
   - If appropriate, discuss and help patient develop a specific plan such as: reduction target, "sampling sobriety period," or stop date (if the patient has not already stopped using).
   - If the patient is not ready to make changes but is willing to engage in continued exploration: If change is substance specific, suggest committing to accurately monitoring use to identify any possibility of change or reduction.
   - If the patient has made decision, affirm the patient's efforts to date and end in a positive fashion. It may be useful to ask the patient to think it over, talk about it with a significant other, and then call with a final decision in a day or two.
7. Conclude the session.

MI Skills and Strategies

Motivational Interviewing (MI) Spirit

- **I**nterviewing
- **C**ollaboration
- **G**uiding

MI Principles

- Express empathy
- Develop discrepancy
- Roll with resistance
- Support self-efficacy

Fundamental Skills

- Open-ended questions
- Affirmations
- Reflections
- Summarizations

Change Talk

- Desire to change
- Ability
- Reason
- Need
- Commitment

Eliciting Change Talk

- Importance/confidence ruler
- Querying extremes
- Looking back; looking forward
- Evocative questions
- Decisional balance
- Goals/values exploration
- Elaboration

Responding to Change Talk

- **R**eflection
- **E**laboration questions
- **S**ummary
- **A**ffirmation

Elicit-**P**rovide-**E**licit

Menu **o**f **O**ptions

Dealing With Resistance

- Simple reflections
- Amplified reflections
- Double-sided reflections and shifting focus
- Agreement with a twist
- Coming alongside
- Reframing
- Emphasizing personal control
- Disclosing feelings

Traps

- Premature focus
- Labeling
- Question/answer
- Confrontation/denial
- Expert
- Blaming

Readiness-To-Change Ruler

The Readiness-To-Change Ruler is used to assess a person's willingness or readiness to change, determine where they are on the continuum between "not prepared to change" and "already changing," and promote identification and discussion of perceived barriers to change. The ruler represents a continuum from "not prepared to change" on the left to "already changing" on the right.

The Readiness-To-Change Ruler may be used as a quick assessment of a person's present motivational state relative to changing a specific behavior and serve as the basis for motivation-based interventions to elicit behavior change. Readiness to change should be assessed regarding a specific activity, such as reducing use of alcohol, since persons may differ in their stages of readiness to change for different behaviors.

Administration

1. Indicate the specific behavior to be assessed on the Readiness-To-Change Ruler form. Ask the person to mark on a linear scale from 0 to 10 their current position in the change process. A 0 on the left side of the scale indicates "not prepared for change," and a 10 on the right side of the scale indicates "already changing."
2. Question the person about why they did not place the mark further to the left, which elicits motivational statements.
3. Question the person about why they did not place the mark further to the right, which elicits perceived barriers.
4. Ask the person for suggestions about ways to overcome identified barriers and actions that might be taken.

Interview Questions

"Could we talk for a few minutes about your interest in making a change?"

"On a scale from 1 to 10, with 1 being not ready at all and 10 being completely ready, how ready are you to make any changes in your alcohol use?"

"You marked (or said) [____]. That's great. That means you are [____] percent ready to make change."

"Why did you choose that number and not a lower one such as a 1 or a 2? Sounds like you have some important reasons for change."

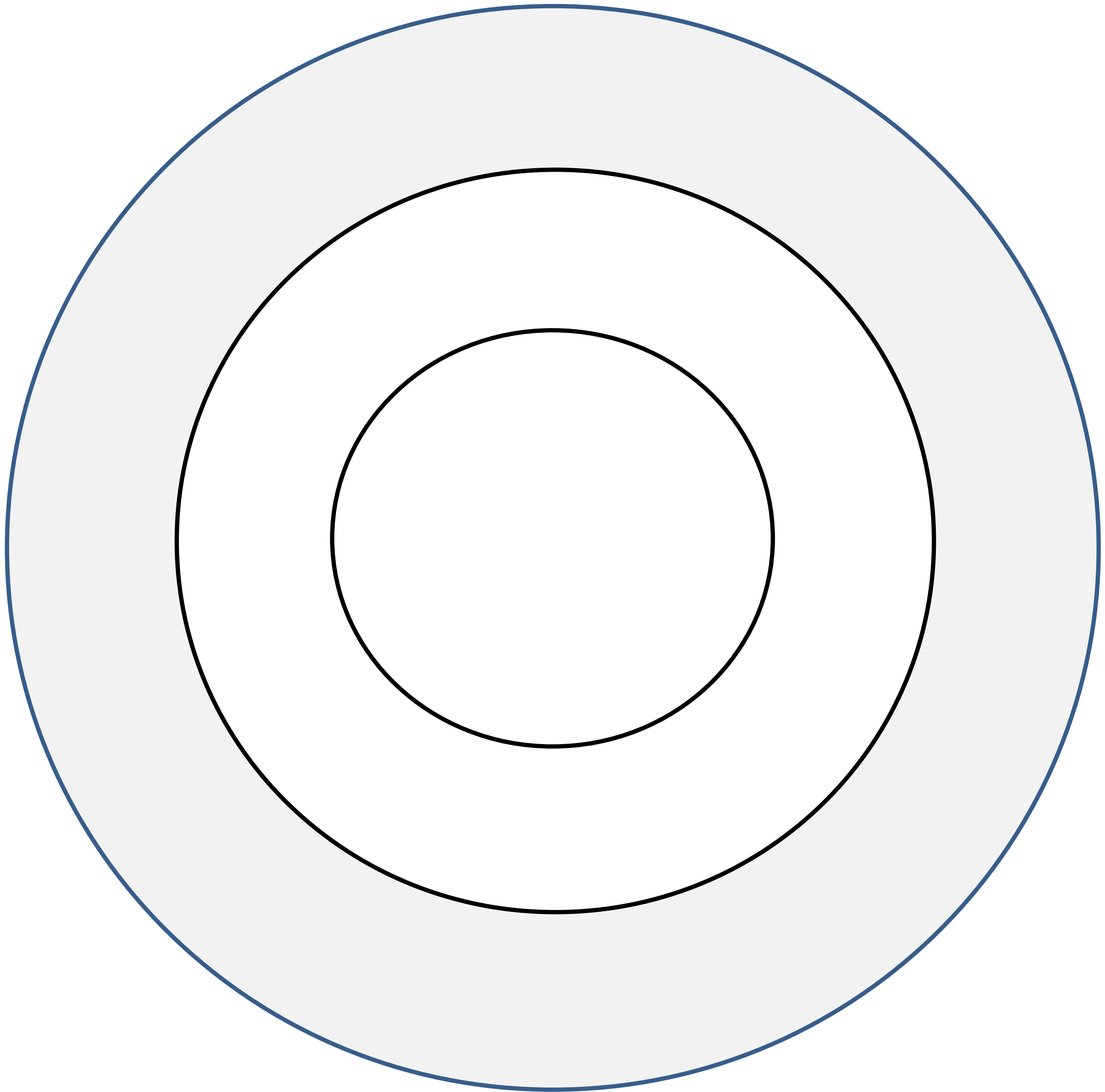
Values Exploration

In this simple exercise have your patient place the "My Values" sheet in front and take a minute to review the list of values. Have your patient without major deliberation write five or six values that they hold most important **today** in the center. Note today is important. In successive rings add five more and five more. Reflect and explore with your patient on each of the values at the center. Ask - Why are these of greatest importance? How aligned with these are you today? Where might you choose to make a change and why? This exploration will better prepare your patient and you for decision making and action planning.

A list of Values:

- Acceptance
- Achievement
- Adventure
- Helping Others
- Attentiveness
- Balance
- Beauty
- Caring
- Charity
- Courage
- Connection (Connecting w/others)
- Competence
- Creativity
- Curiosity
- Determination
- Discipline
- Friendliness
- Friendship Fun
- Generosity
- Grace
- Gratitude
- Honesty
- Hopefulness
- Humility
- Humor
- Independence
- Integrity
- Introspection
- Joy
- Justice
- Kindness
- Knowledge
- Leadership
- Learning and Growth
- Love
- Loyalty
- Nature (Appreciation of)
- Open-Mindedness
- Openness with others
- Optimism/being positive
- Peace
- Philanthropy
- Play/ Playfulness
- Reason/Logic
- Reliability
- Respect
- Responsibility – Keeping promises
- Self-control
- Spirituality/Faith
- Stability/Security Support
- Teamwork
- Thoughtfulness
- Trustworthiness
- Wisdom
- Wonder
- Work
- Others

My Values



Instructions: This is a direct way to better understand your values. In the center include five or six values **most** important to you today. Your true north. In the next ring include values that are important. In the third ring include those that have some importance in life.

It's important to remember that values can and will shift in priority over time

Decision-Making Guide

Why create this decision-making guide?

This will help you think about the choices you are being presented with so you can calmly and logically identify and consider the ***Good Things*** and the ***Not-so-Good Things*** about each choice. While you are being asked to complete this sheet around your choice as to whether to continue using or abstain, it can be a helpful strategy when making other important life decisions. Weighing the ***Good Things*** and the ***Not-so-Good Things*** helps people make decisions. For example, while drinking may sometimes help people relax, it could also cause problems with family or work. Ask yourself, "What are the good things and the not-so-good things about my current use?" "What are the good things and the not-so-good things about changing my use?"

STEP 1: Define what decision you have to make, including options.	Decision Topic:
STEP 2: Brainstorm the good and not-so-good things about **continuing** the behavior. Reflect on core values.	Option 1 (continuing behavior):
STEP 3: Brainstorm the good and not-so-good things about **changing** the behavior. Reflect on values.	Option 2 (changing behavior):

Continuing Behavior	
Cost	Benefits
1.	1.
2.	2.
3.	3.
4.	4.

Changing Behavior	
Cost	Benefits
1.	1.
2.	2.
3.	3.
4.	4.

Decision-Making Guide (continued)

Consider….

How will continuing the behavior help me act in accord with my values and reach my goals?	How will changing the behavior help me help me act in accord with my values and reach my goals?

STEP 4: Assess how ready you are to make a change in your behavior using the readiness ruler below.

STEP 5: Write down your decision below, including how you are going to act on your decision and when you want to look back and consider how well it is working

I intend to:

I will do this by:

I will evaluate my decision and how it is working in *(time frame)*:

Decision-Making Guide Example

Why create this decision-making guide?

This will help you think about the choices you are being presented with so you can calmly and logically identify and consider the ***Good Things*** and the ***Not-so-Good Things*** about each choice. While you are being asked to complete this sheet around your choice as to whether to continue using or abstain, it can be a helpful strategy when making other important life decisions. Weighing the ***Good Things*** and the ***Not-so-Good Things*** helps people make decisions. For example, while drinking may sometimes help people relax, it could also cause problems with family or work. Ask yourself, "What are the good things and the not-so-good things about my current use?" "What are the good things and the not-so-good things about changing my use?"

Here's an example from another individual. Remember, every person has different reasons for wanting to change use.

STEP 1: Define what decision you have to make, including options.	Decision Topic: My alcohol use
STEP 2: Brainstorm the good and not-so-good things about **continuing** the behavior.	Option 1 (continuing behavior): Keep drinking the way I have been—5 days a week, three to four 4 drinks per day.
STEP 3: Brainstorm the good and not-so-good things about **changing** the behavior.	Option 2 (changing behavior): Stop drinking alcohol altogether.

Good things about my use	Good things about changing my use
More relaxed Will not have to think about my problems for a while More comfortable with drinking friends	More control over my life Support from family and friends Less legal trouble Better health
Not-so-good things about my use	**Not-so-good things about changing my use**
Disapproval from family and friends Can't get as much work done Costs too much money I'm late for class I argue with my roommate	More stress or anxiety Feel more depressed Feel inhibited with people I don't know Harder to socialize at parties

Decision-Making Guide Example (continued)

Consider....

How will continuing the behavior help me reach my goals?	How will changing the behavior help me reach my goals?
Helps me handle my problems in the moment so I can keep going and get through the day.	Maybe my problems will get better, so I won't feel so stressed out and down all the time. I will have more money and do better at work and school, which will help me to stay independent.

STEP 4: Assess how ready you are to make a change in your behavior using the readiness ruler below.

STEP 5: Write down your decision below, including how you are going to act on your decision and when you want to look back and consider how well it is working

I intend to:

I intend to stop drinking entirely.

I will do this by:

I will do this by not going to the bar, asking my friends and family for support, coming to treatment, and reminding myself why I am doing this.

I will evaluate my decision and how it is working in *(time frame)*:

I will evaluate my decision and how it is working in 1 week.

Thinking About My Use Option 3

Use this page to complete your own thinking exercise about alcohol/drug use. Remember, everyone is different, and your exercise will be uniquely yours.

Good things about my use	Good things about changing my use
Not-so-good things about my use	**Not-so-good things about changing my use**

SESSION 9. ENHANCING SELF-AWARENESS

INTRODUCTION

Session 9 focuses on helping the patient to build self-awareness. Patients often view themselves and their behavior as somewhat of a mystery. They may feel puzzled and confused about what they do and why they do it. By helping a patient take greater notice of how things are happening in life, with specific focus on alcohol and substances or mood, the clinician provides a powerful tool and builds the important capacities for reflection and self-awareness.

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

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

THE PATIENT'S EXPERIENCE

In Session 9, the patient is able to explore patterns of use in a nonjudgmental atmosphere. They are encouraged to share many aspects of experience with alcohol or other substances, such as when, where, and under what circumstances use is likely. The patient is also supported in discussing the positive and negative impacts of use to develop better self-knowledge and a fuller picture for the clinician. The patient may begin to identify potentially useful coping strategies to reach goals in relation to substance use.

Clinician Preparation

Session 9. Enhancing Self-Awareness

Materials

- Substance Use Awareness Record
- Personal Awareness Form
- Learning New Coping Strategies/Menu of Options
- Future Self Letter
- Relaxation Training

Total Time
1 hour

Delivery Method
CBT-focused individual or group therapy

Strategies

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

Goals for This Session

- Begin to learn and practice skills that enhance self-awareness.
- Introduce the patient to the rationale for coping skills training.
- Examine the patient's high-risk situations, triggers, and coping strategies.

Session 9 Outline and Overview

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

- Elicit examples of feelings, beliefs, or automatic thoughts people may have about substances; use examples provided by the patient and ask the patient for more examples.
- Suggest that the patient start the process of change by understanding their behavior; ask, "Does this make sense to you?"

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

Session 9 Protocol

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

Building Rapport and Review

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

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

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

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

Continue by asking the patient how they have been doing over the past week regarding alcohol and/or drug use.

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

Guidelines

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

Explore the Development of Addictive Patterns

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

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

> *without it," "I can't take the way I feel when I've tried to quit," "I need to change, but it's not worth the effort." What other beliefs do you have about you and [____]?*
>
> *Substances can change the way a person feels, acts, and thinks. To help you avoid or cope with the situations in which you smoke and to help you find things you can do instead of using, let's start by working on understanding your behavior. Does this make sense to you?*

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

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

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

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

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

Guidelines

Knowing what affects someone's own use gives more personal awareness (power) to decide whether to use or not use. Looking at the pros and cons of what happens after use also increases understanding and helps the individual make the decision about use in the future.

Hence, the name of the worksheet for understanding more about triggers is *Knowledge Is Power*.

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

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

Ask the patient to read the columns in the *Knowledge Is Power* handout and follow up with a series of questions to help generate statements for each required column. Get the patient to verbalize responses to each section of the handout before writing it down. This enables offering feedback/suggestions before anything is put on paper. The patient is less likely to feel criticized this way.

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

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

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

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

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

Clinician (C): *In what situations do you find yourself using?*

Doug (D): *When things get hectic at home. Between my wife and my son, it seems as if everyone is out to get me. When I smoke, I can cope with them.*

C: *Using helps you cope with stress at home. Are there other situations when you smoke?*

D: *Not right now. When I go home, I should be able to relax, but with all the nagging, I end up using to escape.*

C: *You want your home to be peaceful, but conflicts over your using push you to smoke.*

> ***D:*** *Yeah; sounds crazy, doesn't it?*
>
> ***C:*** *Your situation is difficult. Things you identify that lead you to smoke are called triggers. You've said that conflicts at home trigger you to smoke. What are your thoughts and feelings during times of conflict at your house, right before you light up?*
>
> ***D:*** *I'm thinking that if everyone would get off my back, I might be able to quit using. But they don't, and it's the only way I know how to relax.*
>
> ***C:*** *You find yourself in a bind. Let's use the Knowledge Is Power document [presents it] to list the things we're talking about. You said using [____] helps you relax. What else does it do for you?*
>
> ***D:*** *It helps me sleep. When I don't get high, it's hard getting to sleep. I used to enjoy the high a lot more than I do now. I keep using, but I don't even get that high anymore.*
>
> ***C:*** *Sounds as if you're listing the negative parts of using. Are there others?*

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

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

Identify Positive Effects

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

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

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

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

Directive questions can also be used as needed:

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

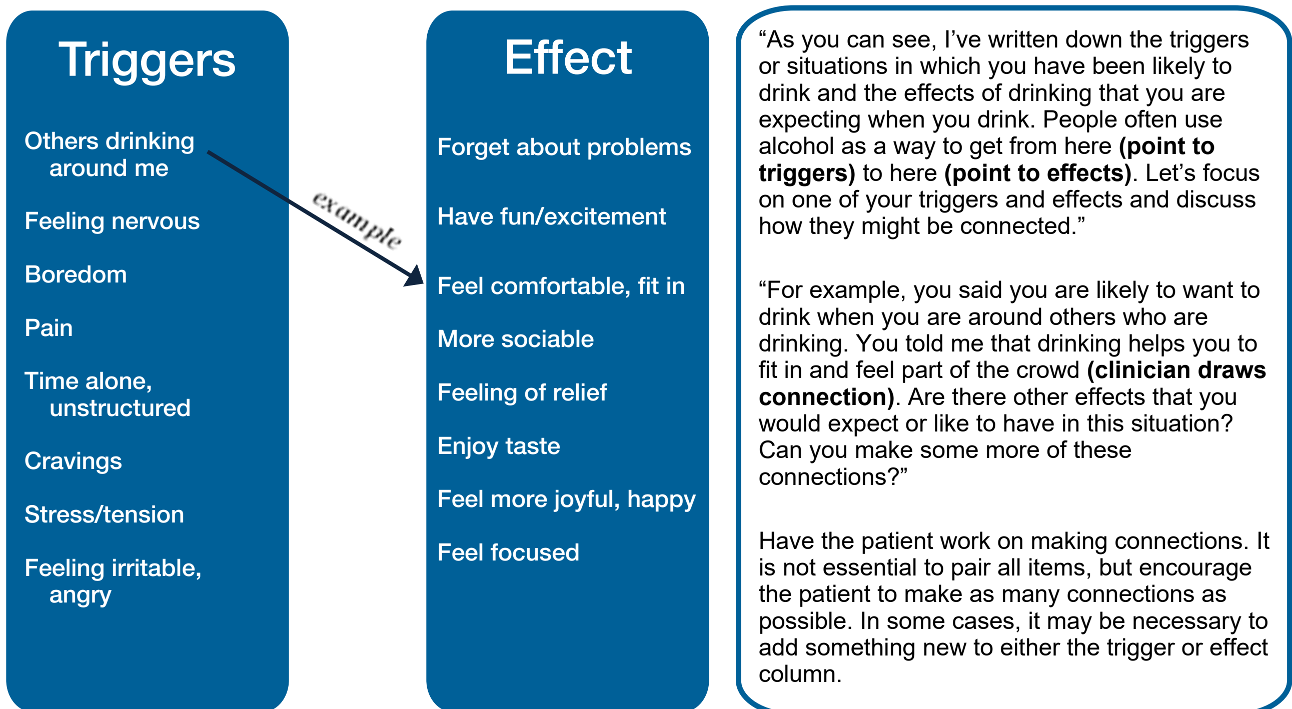
Summarize Effects

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

Draw Connections

The clinician should help the patient make a connection between the triggers and the effects on the *New Roads* Worksheet (see figure 7).

Figure 7. New Roads Worksheet



Discuss Psychological Dependence

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

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

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

Consider New Roads

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

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

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

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

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

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

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

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

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

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

Assign a Between-Session Challenge

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

- Write a future self letter
- Practice relaxation training

Review and Conclude

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

ICBT Session 9. Enhancing Self-Awareness Handouts

Clinician's Quick Reference to Session 9

1. Building Rapport and Review
    - Welcome the patient; check in about the week in general.
    - Review the patient's cravings, recent use experiences, and successes.
    - Review the between-session challenge.
2. Explore the Development of Addictive Patterns
    - Provide rationale, such as the learned or associative nature of addiction (pairing with alterations in thinking and feeling).
    - Using the patient's own experiences, illustrate how using alcohol or other substances can change one's feelings; if the patient has not stated any examples, provide examples that are appropriate to their situation.
    - From the patient's stated use situations, identify examples of environmental triggers for use; ask the patient for other triggers they have experienced.
    - Elicit examples of feelings, beliefs, or automatic thoughts people may have about substances; use examples provided by the patient, and ask the patient for more examples.
    - Suggest that the patient start the process of change by understanding their behavior; ask, "Does this make sense to you?"
3. Empowerment Though Self-Knowledge: Understanding High-Risk Situations and Triggers
    - Explore with the patient—
        - Typical use situations (places, people, activities, time, days)
        - Triggers for use
        - A recent use situation
        - Thoughts and feelings at use times (tense, bored, stressed, etc.)
        - Complete *Knowledge Is Power* and summarize the list
4. Putting the Pieces Together: Draw Connections, Consider New Roads, and Build Coping Strategies
    - Emphasize the importance of coping strategies.
    - Reintroduce Learning New Coping Strategies.
    - Introduce a drawing connection exercise and identify new pathways toward desired outcomes.
    - Ask patient to identify strategies they have tried and those that might work best.
5. Develop or Elicit a Specific Between-Session Challenge That Incorporates Material From the Session

Alcohol/Substance Use Awareness Record

As a way to increase awareness about your patterns of use, we'll use this form to identify the kinds of situations, thoughts, feelings, and consequences that are associated with your alcohol/substance use. It may be difficult initially, but once you get accustomed to paying more attention, you will become skilled at discovering the ways in which you typically use alcohol/substances.

Trigger (What types of events tend to make you want to use? For example, an argument, disappointment, loss, or frustration; spending time with friends who use; having alcohol/substances easily available to you; recalling positive memories of past use.)

1. ____
2. ____

Thoughts, Feelings, and Beliefs (What were you thinking or how were you feeling in relation to the triggers you have identified? For example, thinking you were incompetent or stupid or that you could never achieve a particular goal; feeling angry, sad, frightened, or glad.)

1. ____
2. ____

Behavior (What did you actually do when you were thinking and feeling in these ways? For example, used [____], went out to dinner, isolated yourself from people.)

1. ____
2. ____

Positive Consequences (What good came out of your response to the situation? For example, I felt much better for a short period.)

1. ____
2. ____

Negative Consequences (What negative things happened as a result of your response? For example, I felt bad about myself for using; I couldn't complete the work I needed to finish.)

1. ____
2. ____

Alcohol/Substance Use Awareness Record

As a way to increase awareness about your patterns of use, use this form to identify the kinds of situations, thoughts, feelings, and consequences that are associated with your alcohol/substance use.

Describe Incident:

Trigger	Thoughts. Feelings and Beliefs	Intensity of Craving	Behavior	Positive Results	Negative Results
(What sets me up to be more likely to use alcohol or drugs?)	(What was I thinking? What was I feeling? What did I tell myself?)	Low–high, 1–10	(What did I do then?)	(What good things happened?)	(What bad things happened?)

Date and Time:________________________________

Alcohol/Substance Use Awareness Record Example

As a way to increase awareness about your patterns of use, use this form to identify the kinds of situations, thoughts, feelings, and consequences that are associated with your alcohol/substance use. Below is an example of how the form might be used.

Describe Incident: Spent evening with my friend smoking weed and drinking beer.

Trigger	Thoughts. Feelings and Beliefs	Intensity of Craving	Behavior	Positive Results	Negative Results
(What sets me up to be more likely to use alcohol or drugs?)	(What was I thinking? What was I feeling? What did I tell myself?)	Low–high, 1–10	(What did I do then?)	(What good things happened?)	(What bad things happened?)
Friend called and invited me to get high with him. Nothing else to do.	"I want to reward myself." "I'm bored." "Felt good about going 15 days without using, so felt OK about getting high today."		Went out with friend and used.	Had fun. Felt good to get high, having gone 15 days without.	Broke the 15-day abstinence (although wasn't too worried about this). Didn't get as much done. Didn't feel as healthy.

Future Self Letter

Sometime during the next week, imagine that a year has passed and that you haven't used alcohol/substances for a year. Making believe that it's next year, write a letter to yourself (the old you). Write about your life as it has become. Include the reasons why you stopped a year earlier, what your lifestyle is like in the new year, and the benefits you enjoy from not using. Mention in your letter any problems you faced during the past year in giving up alcohol/substance use. Describe yourself without alcohol/substances as clearly as you can. As you visualize yourself in the future without alcohol/substances, it may help to think about friendships, self-esteem, health, employment, recreational activities, and general lifestyle satisfaction. If you prefer, draw, sketch, or paint a picture of this image of yourself in the future, rather than depicting it in writing. Choose a medium that will allow you to see another possibility for yourself.

This exercise is extremely useful. It helps you visualize your journey and your goal. Having a clear picture of where you're going, why, and how you're going to get there will be useful in the months ahead. At our next session, we'll talk about the future you foresee for yourself.

Relaxation Practice Exercise

Arrange to spend some quiet time in a room where you will not be interrupted. Try to practice this relaxation technique at least three times during the next week. Proceed through the eight groups of muscles in the list below, first tensing each for 5 seconds and then relaxing each for 15 to 20 seconds. Settle back as comfortably as you can, take a deep breath, and exhale very slowly. You may feel most comfortable if you close your eyes. Notice the sensations in your body; you will soon be able to control those sensations. Begin by focusing your attention on your hands and forearms.

- Squeeze both hands into fists, with arms straight. Then relax hands.
- Flex both arms at the elbows. Then relax arms.
- Shrug shoulders toward head. Tilt chin toward chest. Then relax shoulders and neck.
- Clench jaw, gritting your teeth together. Then relax jaw.
- Close your eyes tightly. Then relax eyes.
- Wrinkle up your forehead and brow. Then relax these muscles.
- Harden your stomach muscles, as if expecting someone to punch you there (continue to breathe slowly as you tense your stomach). Then relax stomach.
- Stretch out both legs, point your toes toward your head, and press your legs together. Then relax legs.

Self-Rating Task

Each day that you engage in this exercise, rate your relaxation level before and after, using the following guide: ***0 = highly tense; 100 = fully relaxed***.

Day	Time	Before	After

SESSION 10. MINDFULNESS, MEDITATION, AND STEPPING BACK

INTRODUCTION

Session 10 introduces the patient to the practice of mindfulness, which has been found effective in the treatment of substance abuse, depression, anxiety, and other health and psychological difficulties (Witkiewitz, Marlatt, & Walker, 2005) and has existed within the wisdom traditions for thousands of years.

MEDITATION

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

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

MINDFULNESS

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

There are numerous ways to increase mindfulness or the ability to stay in the present moment, and it is easy to recognize how often one becomes "non-mindful." Meditation is one method, which can involve

sitting (or lying down) and focusing on a single point of concentration (e.g., the breath, a mantra, a word or phrase, a nonword). There are other ways, such as engaging in daily activities like washing dishes or driving to work, but with extra attention on staying present, self-aware, and connected to the here and now.

Why might increasing mindfulness be helpful for change?

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

When conducting the session on enhancing self-awareness during session 9, the clinician may have learned about high-risk situations for the patient, such as feeling a certain way (e.g., powerless, discouraged). The information from the functional analysis can be helpful in teaching the patient about mindfulness and meditation. The clinician might remind the patient about certain high-risk or trigger emotions and suggest how mindfulness could help handle the feelings differently. For example, when meditating for any length of time, one becomes acutely aware of the transient nature of internal states. And yet, most people are likely to feel "attached" to these states. We feel as though our thoughts and feelings are ours that they belong to us. If one can approach a particularly disturbing thought and note, "Oh, it's just a thought," this can change the way one feels and reacts.

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

The Patient's Experience

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

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

Clinician Preparation

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

Session 10 Outline and Overview

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

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

Session 10 Protocol

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

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

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

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

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

Provide Overview of Session and Description of Mindfulness

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

Well, I am pleased to talk to you today about an important concept called "mindfulness." Have you ever heard this term before? Mindfulness is simply trying to stay focused on the present moment, what's happening with you right now. You know how everyone is so busy in this world, between our computers, cell phones, televisions, rushing here to there. Well, often people don't even have time to enjoy a simple meal. Or they are so distracted by all the things they have to get done that they don't even know how they feel or what they might like to do if they had a free moment. Does this sound familiar to you?

Some people think that using alcohol or substances is a way for them to just slow down, relax, or feel better in the face of all the stress they have. Is that how you tend to think about your substance use? But there are other ways to do this that don't have the harmful consequences that substances can. I want to teach you about mindfulness and some specific ways to increase this ability, which we all have.

Mindfulness can be increased in a variety of ways but the overall purpose is to help you to become more "present"—that is, more aware of your experience of the present moment. It is a way to help you feel less distracted and pulled in many directions. It is a way to help you perhaps feel more grounded, focused, calm. Increasing mindfulness has been found effective for people struggling with mood, anxiety, and substance use problems. I think this could be very helpful to you as you try to make these important changes in your use of [____]. For example, you told me during our first meeting that you have a hard time "shutting off your brain" and that [substance] seems to help you do this. Developing skills related to mindfulness may help you manage when you are feeling uncomfortable without using any substances. Are you willing to give it a try? Great!

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

The Raisin Exercise

Give the patient (or each group member) one raisin, piece of chocolate, or other small item of food. (Ask beforehand if there are any foods that might be problematic.) Have the patient put the food item

in the mouth, and ask them not to chew or swallow it right away. Then ask the individual to focus on various aspects, such as the taste, texture, feeling in the mouth. Ask to notice more complex experiences (e.g., the chocolate seems at first sweet, but then slightly salty), and ask about thoughts and feelings experienced while eating this small morsel. Eventually, the person may finish eating. Then inquire about any interesting observations (e.g., many people are astounded to realize how one small raisin can be quite satisfying when one is fully present in the moment to experience and enjoy it).

Okay, here is our first exercise in mindfulness. This may seem a little silly, but just bear with me. I want you to take this raisin. Now, first look at it and notice what you see. Okay, now you can place it in your mouth, but don't eat it right away. I just want you to see what happens when you stay present to eating this one, small raisin, rather than doing the automatic thing we all do of swallowing food and not even paying attention to the experience of eating. So put it in your mouth and just let it sit on your tongue….what do you notice? (You don't have to answer out loud. I'm just going to toss out questions for you to think about if you can.)

What sensations are there? What is the flavor? How does it feel to just sit there and not chew it right away? What happens when you think about where this raisin came from and how it got to this place so you could eat it? What is the actual texture? Does it change? How about the flavor? What do you notice about yourself as you are eating this raisin in this much slower way? Is it frustrating? Enjoyable? How does it compare to how you usually eat? Okay, now you can start to chew and swallow the raisin. Pay close attention to this as well. Notice each moment and how you feel as you eat the raisin. Are you feeling more or less hungry after this exercise? More or less satisfied? Anything else you noticed?!

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

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

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

Clinician Discusses Meditation

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

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

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

Meditation Involving the Breath

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

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

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

Review and Conclude

Thank the patient for being open to hearing about these concepts and for trying the exercises, especially if there was some disinclination initially. Provide the session handouts on meditation, mindfulness, and

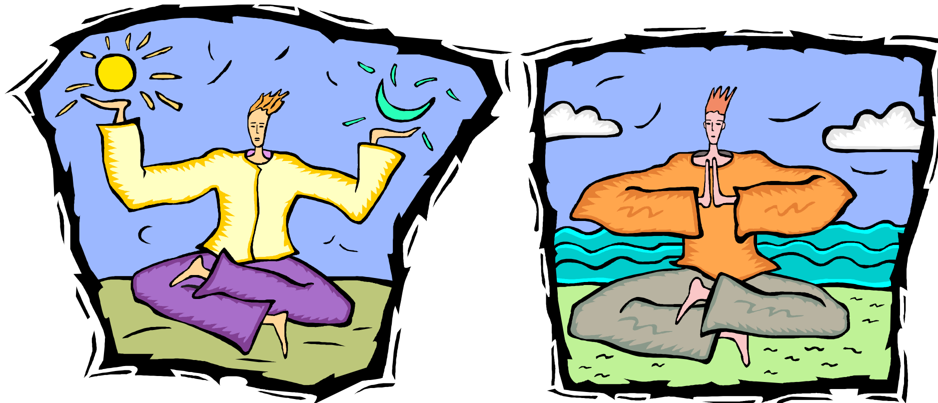
instructions for practice. Ask the patient to try the skills over the next week each day at a convenient time and to record the experience in a journal (e.g., day, length of sitting, overall experience). Discuss the next session planned for the patient and how the topic chosen, and skills learned will be valuable on the path toward wellness.

ICBT Session 10. Mindfulness, Meditation, and Stepping Back Handouts

Clinician's Quick Reference to Session 10

1. Build rapport and review
    - Check in on past week
    - Follow up on between-session challenges
2. Clinician introduces mindfulness and provides rationale
    - Awareness and acceptance of present moment
    - Connection to alcohol/substance use
    - Role of mindfulness in regulating internal states
3. Clinician conducts experiential exercises demonstrating mindfulness
    - Mindfulness exercise (e.g., eating raisin)
    - Process patient's experience and reaction
4. Clinician discusses meditation
    - Can be part of religious practice, but also incorporated into nonreligious health practices
    - Strategy for increasing mindfulness
    - Strategy for managing difficult emotions and thoughts
    - Approach for coping with alcohol/substance use
5. Clinician conducts experiential meditation exercise
    - Breathing meditation
    - Clinician processes patient's experience
6. Clinician provides the following to the patient
    - Provides meditation instructions
    - Provides alternate meditation exercise (*On the Riverbank*)
    - Encourages daily practice
7. Clinician closes session

Mindfulness Meditation Instructions



1. Find a quiet, comfortable location, with few distractions.
2. Choose a time of day that increases the chance you will be able to sit quietly with few distractions.
3. Sit on a cushion (cross-legged if not difficult) or chair. Try to keep back straight, but do not hold tension there to do this (i.e., do not try too hard).
4. Maintain a soft gaze.
5. Have a timer and signal for starting and stopping.
6. Choose a single point of focus (e.g., the breath, a word or phrase, a nonmeaningful word, an image or picture).
7. Sit quietly for 10 minutes and maintain focus.
8. Observe distracting sounds, thoughts, and feelings with mild disinterest and attempt to return to focus. This may happen many times during one sitting. Try not to be discouraged but, rather, recognize this is how our minds are.
9. Try to practice this daily, and journal or record in a log.

Source: Steinberg Gallucci, Damon, & McRee, 2012

Meditation Exercise: On the Riverbank

For this variation on a standard meditation, find a quiet place with few distractions. Begin by focusing on your breathing and trying to slow it down to increase a sense of peace and relaxation. Count slowly with each inhalation and exhalation, increasing from 1 to 10 so your breathing rate slows considerably. Imagine yourself sitting on a riverbank on a beautiful, sunny day, watching the water flow by. You may notice fish, stream currents; a small boat may sail by from time to time. Imagine that as you sit at the bank, observing what is happening, these objects passing by are your thoughts, feelings, and sensations that arise in the course of your meditation. Consider that with each object, each representing an experience of yours, you may choose how to relate to it.

For example, you can get into a boat of "worry" and ride downstream for a while. Or you can decide to let that boat pass you by. Perhaps you see a school of fish representing your thoughts that you will never be able to accomplish this or that. Do you decide to swim with those fish, or sit back and take notice saying, "Ah… doubt?"

For each thought, feeling, or interpretation that threatens to derail or take you off track, recognize you have the capacity to swim, sail, or sit back and watch it come and go. They are "just thoughts" or "just feelings." They are not necessarily true, good, or bad. They just are. Perhaps they do not even belong to you but are merely finding a host, temporarily, to attach to. You can become attached to them and their "stories," own them, hide from them, and live in fear of them. Or you can simply take notice as you might a sailboat passing by on a summer's day, but not go for a ride. And simply wait for the next interesting entity to pass your way. Keep your focus…

Source: Steinberg Gallucci, Damon, & McRee, 2012

SESSION 11. WORKING WITH THOUGHTS (COGNITIVE DEFUSION)

INTRODUCTION

Session 11 provides context for helping the patient understand and be prepared for the kind of thoughts that are likely to arise while trying to quit using substances or while making other important changes. It is normal to be troubled by thoughts related to one's ability to be successful in achieving and maintaining abstinence or any other goal. We help the patient recognize the brain as a "word-generating machine" and that these words are thoughts. To the extent that patients buy in to these thoughts, the thoughts control behavior and emotion. This can happen in a couple of ways. Either the patient believes the thoughts and they color their view of the world, like a lens through which the patient sees their experience, or the patient can go to war with the thought, trying to change it. This is a sort of Chinese Finger Trap Toy where the more the patient fights the thought, the more it persists. In both of these instances your patient is fused to the thought. Once this understanding is established, we will teach and give the patient a chance to try out new strategies to address the thoughts (so that they are neither buying into them nor fighting with them, (defusion) and make way for the patient to choose their actions based on what they value, as opposed to a thought to which they may be fused.

THE PATIENT'S EXPERIENCE

In this session, the patient is encouraged to recognize when they are fused to their thinking. Fusion refers to confusing thinking with actual experience. The clinician provides examples of when fusion can be helpful, and when it is not, and teaches the patient different strategies to defuse from thoughts. The interventions the clinician employs are largely experiential and used to help the patient recognize thoughts as internal, verbal dialogue; when the patient is fused to the thoughts, they can steer patients away from the value-driven life they are seeking. The patient may have some "aha" moments as they view thinking in this different way. They will also leave the session with additional skills to overcome the effects of fusion in their lives. As with other sessions, the patient experiences the clinician as nonjudgmental. There may be a sense of lightness and humor when examining certain thoughts that are clearly irrational or not in the patient's best interests, given what they are trying to achieve in treatment.

CLINICIAN PREPARATION

CBT Session 11. Working With Thoughts	
Materials - Cognitive Fusion and How to Defuse - Meditation Exercise, Watching Thought Clouds	**Total Time** 1 hour **Delivery Method** CBT-focused individual or group therapy

CBT Session 11. Working With Thoughts

Strategies

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

Goals for This Session

- Identify and learn to accept automatic thoughts without becoming fused to the thoughts.

Session 11 Outline and Overview

1. Maintain rapport and review.
2. Normalize fusion as helpful in some circumstances and express the importance of choosing to defuse from thinking when it is not.
3. Identify situations in which fusion to thinking can lead to drug use.
4. Discuss thought fusion and strategies to defuse:
    - Describe situations likely to trigger automatic thoughts.
    - Explore how fusion to these thoughts leads to lapse or relapse.
    - Provide in-session examples of fusion and defusion.
5. Explore conceptual difficulties:
    - Review material, and probe for the patient's understanding of basic concepts.
    - Use language that reflects thinking as separate from the thinker; provide metaphorical examples to further clarify fusion/defusion.
    - Walk patient through a using episode to understand how fusion contributed to use and how defusion can be employed.
6. Develop skills for coping with automatic thoughts:
    - Explain general principles of defusing from using thoughts.
    - Describe specific strategies for defusing from using thoughts; review *Managing Thoughts About Alcohol or Substances* form.
7. Practice skills for defusion from using thoughts:
    - Demonstrate the thoughts-as-passengers metaphor.

- Help patient experience Mind Watching and Naming the Brain
- Demonstrate Challenging Reason Giving

8. Assign between-session exercises.
9. Review and conclude session.

Session 11 Protocol

The clinician welcomes the patient and inquires about thoughts and feelings since the last session, use of information covered in earlier meetings, and engagement in practice efforts. They provide an overview of the session that will help identify times when the patient is fused with using thoughts. The clinician will teach one or more defusion exercises and encourage the patient to try the exercises on some of their own thoughts, both in session and between now and the next session.

Clinician Normalizes Fusion With Using Thoughts

The clinician discusses thought fusion using language deliberately to separate thinking from the thinker.

> ***Clinician (C):*** *The brains of people that have used substances for a long time often generate lots of thoughts about using. When you come into contact with situations where you previously used, the brain will generate thoughts about using. Sometimes it may not even be clear what happened that caused these thoughts to arise. This is normal; almost anyone who stops using has thoughts about starting up again pop up. The using thought is not a problem to be solved; it is a passing, internal experience that we can chose to buy or not. This skill topic will help you learn new ways to interact with those thoughts before you slip back into using behavior.*

Identify Fusion With Thoughts Associated With Use

The clinician explains how thought fusion relates to alcohol or other substance use, using the "Having, holding, and buying a thought" exercise:

> ***Clinician (C):*** *As any person goes through a normal day, their brain generates hundreds, if not thousands, of thoughts. Most of these pass right on through our awareness, and we do not dwell on them. This is just "having a thought." However, when we develop behavioral habits, like using drugs, particular thoughts catch our attention. For example, we may have the thought that "I am not going to have fun unless I get high," or "I cannot relax unless I get high." Oftentimes, we buy thoughts like this because this is the pattern we have developed in our behavior, and the thought seems like reality. This is what we call "buying a thought." When we do, we often follow it with behavior (e.g., in this case, using drugs). What we want to talk about today is how to hold a thought. In this case, we aren't trying to fight it, make it go away, or challenge it. Instead, we want to recognize it as a thought… not a reality, not an inevitability, just a string of words that our brain generated that we get to choose to buy or not.*

Discuss Fusion With Using—Thoughts by Using the Passengers on a Bus Metaphor

The clinician describes the Passengers on a Bus metaphor.

> So, I want you to imagine yourself as a bus driver. You have a route you have to drive, and you are doing that. You make a stop and pick up a rough-looking rider; he is kind of scary, has a knife on his belt, an angry look, and scowls at you when you get him on the bus. You keep driving, and as you are about to make a turn to follow your route, the mean-looking passenger yells, "Don't you dare turn here, or I will make you sorry!" Imagine you pick up three or four more passengers, all of them angry, a little scary, telling you what to do, and threatening you. Eventually you just do what they say. Then you realize you know what they are going to say, and you do it without even being asked to avoid the conflict.
>
> Imagine that your life is this bus, and the route is how you want to live your life based on what is valuable to you. For example, you may see being a parent as very valuable, and you want to live your life in ways that make you a better one. The angry passengers are thoughts your brain produces, using thoughts, and eventually these thoughts drive your decisions instead of your values. What is a thought that you have had in the past that you bought, and it led to using? What is another one? How about one more?
>
> So, what do you do? You could turn around and tell the passenger to sit down. If they don't sit down, you could stop the bus and go back there and try to make them stop or kick them off the bus. When you do that, you are no longer driving your bus or leading your life the way you want. Instead, you are caught up with your mind and still not leading the value-driven life you want. You have already tried obeying the passengers; that may even help you have a little peace, but it still keeps you from the life you want. Fighting the thoughts and giving in to the thoughts are both examples of being fused to thoughts, and both stand in the way of living the life you want to live.
>
> You need another option, and that is to hold your thoughts. Holding your thoughts is when you recognize them for what they are: a string of words that have been generated by your brain. They are not reality, they are not inevitable to happening, they are just words. When you use drugs for a long period of time, your brain may generate a lot of these thoughts. Some examples that people share oftentimes include some of the ones on this handout.

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

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

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

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

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

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

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

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

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

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

Explore Conceptual Difficulties

Some patients may have difficulty understanding this concept. If a concept is not understood, the benefits of defusion are compromised. This may be particularly true for patients with some cognitive limitations who are overly concrete in their thinking. With these persons, more behaviorally focused

skills training tends to yield better outcomes. A key concept to defusion is recognizing that thoughts are only language, sentences that the brain produces that we then accept as reality. One way to express this concept in more concrete terms is through the exercise below involving imagining water.

> ***Clinician:*** *Imagine for a second a glass of water. Can you see it in your mind? What does it look like?*
>
> ***Patient:*** *Well, it's cold, it's clear.*
>
> ***Clinician:*** *OK, cold, clear. Are there little beads of water outside the glass? Is there ice in it? Can you kind of remember what a cold glass of water feels like in your mouth? Can you remember the taste?*
>
> ***Patient:*** *Yeah, like when you are really thirsty, and you take a drink, and you can feel it run all the way down to your stomach almost. Or when you drink it too fast, and you get that headache.*
>
> ***Clinician:*** *Right! I know that feeling, super refreshing. Ok, so now take a drink.*
>
> ***Patient:*** *I don’t know what you mean; there is no water?*
>
> ***Clinician:*** *Exactly! Your brain is super powerful. It can almost reproduce the feeling of taking a drink; it can create a picture in your mind of the glass of water, but no matter how much your brain generates these images, it never really can make water. So, replace water with that using thought you mentioned that your brain likes to put out there for you, that “I won’t have any fun unless I get high.” It’s the same; it seems true when your brain spits that out, right? But it is no different than the water your brain was just imagining. Try to think of your brain as a word generator. Some of those words can be helpful, some may not be, but all of them are just words. What we want to do here is help you develop the ability to choose what things your brain puts out that you want to buy in to or fuse with.*

Being overwhelmed by thoughts and buying them as reality is what leads to taking actions on those thoughts. To help the patient gain an understanding of thinking as an ongoing action that over which they have little control, we want to use language deliberately to separate the patient from the thoughts the brain generates. Understanding thinking in this way gives the patient room to decide what thoughts they want to buy based on what they want from their lives.

When the patient is clear on what thought fusion and defusion are, then we can go into teaching skills to defuse. A few examples of exercises that can help with this are described below. It is very important to continue to be consistent in how you describe thoughts as you teach the defusion skills. For example, as opposed to saying things like “your thoughts,” replace with “thoughts that pop up,” “thoughts you are having,” or “thoughts your brain put out.” This will further drive home the concepts addressed above.

Develop Skills for Thought Defusion

The clinician helps the patient identify automatic thoughts and reviews some of the techniques used in previous sessions. Then they teach up to three of the skills described below to defuse from their thoughts.

Mind Watching

If you have used drugs or alcohol for a while and decide to quit, it is likely that your brain will produce some thoughts about using. As we discussed, the thought is not the problem; it's what we do with it. If you learn to slow down and recognize these thoughts, you can give yourself the option to hold or buy those thoughts.

One way to hold a thought is by "mind watching." You can work through a mind watching exercise with the client to impart the skill. There are several examples that can be tailored to fit your client; these include the Leaves on a Stream exercise or Watching Clouds. Dialogue with a client regarding these exercises is described below.

Clinician: *I want to do a simple exercise with you. It requires closing your eyes and just watching your mind for a bit. Would that be OK?*

Patient: *Sure*

Clinician: *Great. The purpose is to help you recognize when you are fused with your thoughts. Imagine that you are lying in some comfortable grass looking up at the sky, and you are just watching. Now imagine each cloud has a little sign on it, and what is written on the sign is the thought your brain is having at that moment. You may see some of these thoughts as pictures. That is fine; just see that little picture printed on the cloud. So go ahead and close your eyes. Your task is just to watch the clouds pass; let them float on by. At some points, you will notice that the clouds are gone, and you have been captured by a thought. When that happens, I want you to back up a bit and try to identify what thought you bought that took you out of mind watching.*

At this point, the clinician helps the patient center and observes the exercise. Try not to talk much. Offer encouragement like "Just watch the clouds float by, and notice when they stop." If you notice any changes in the client's face or body posture, note it to yourself, and let it trigger a gentle reminder to the patient to "just watch the clouds."

Clinician: *OK, let the last couple of clouds go by, and then come back to this room. OK, what did you notice?*

Patient: *Well, at one point, the clouds stopped, and when I looked back, I realized that I was stressing about going to this work party where I know people will be drinking.*

Clinician: *Oh, so what was the last thought you noticed before the clouds stopped? Did it start out being printed on the card?*

Patient: *Yeah, the cloud said, "You know you can't drink Friday!" Then 10 or 15 seconds went by, and I realized the clouds were gone.*

Clinician: *So that little moment was when you bought the thought! You were no longer watching your brain generate thoughts; you were in your thoughts. Remember how we said thoughts can be like a lens when we are fused with them? When this happens, we stop recognizing thoughts as just words our brains spit out and start experiencing the thought as something real that you have to do something about. The beauty of this*

exercise is you can do it any time and recognize that when the clouds stop, put the thought back on a cloud, and just watch more of them go by. This is what we mean by holding a thought.

Naming the Brain

When the patient understands that the brain is a constant word generator and not a reflection of who they are, we can then separate the person from the brain and even pit their interests against one another. One way to do this is through the Naming the Brain exercise. Some patients may want to give the brain human names; others may be uncomfortable with this and are more inclined to name a particular mode of thinking after the effect (e.g., "the judging mind" or "the using brain"). This name can then be used in dialogue with the patient and as a means for the patient not to buy in to thoughts on their own. To reinforce this, the clinician may say things like "It sounds like your using brain was having a field day with this."

Challenging Reason Giving

Reasons are explanations for behavior (e.g., "I got high because I was so upset with my husband"). People give reasons for behavior all the time, and these reasons are often connected to some understanding they have about themselves. Giving a reason for behavior is connected to particular behaviors, but this does not mean one caused the other. This is the heart of this exercise: not to challenge the actual thought but to challenge the whole idea of giving reasons for behaviors. An example dialogue of challenging reason giving is provided below. Like the other exercise examples provided above, we are not going to challenge the form of the thought but rather how the thought works in the patient's life.

Clinician: *You said you wound up drinking last Wednesday. Can we talk about that a bit?*

Patient: *Sure*

Clinician: *Why did you drink last Wednesday?*

Patient: *I don't know. I guess I drank because I just don't feel like my life is improving.*

Clinician: *So you drank because your life isn't improving?*

Patient: *Yeah*

Clinician: *Is that the first time you ever felt like your life is not improving?*

Patient: *No, I feel like that all the time!*

Clinician: *Well, isn't it interesting that you feel like this all the time, but you only drank on Wednesday? I mean, if feeling this lack of progress causes drinking, I would think you would be drinking every day.*

Patient: *Yeah, but I also have reasons not to drink. I mean, I want my relationship with my wife and kid to get back on track.*

> ***Clinician:*** *Right, so there are reasons not to drink, too. Those reasons were also there when you drank Wednesday. I bet if you thought about it, you could come up with more reasons not to drink, and you could probably come up with more reasons to drink as well. It sounds like there is an unending amount of reasons to drink or not drink we could come up with, but, in the end, we chose a behavior or don't, and the reasons are still there.*
>
> ***Patient:*** *So are you saying reasons don't matter?*
>
> ***Clinician:*** *I am saying that there are plenty of reasons to drink or not drink, but that none of those reasons cause drinking. You already uncovered that you avoid drinking even when the reason you provided is there. In fact, you didn't drink for 6 of 7 days last week, and you noticed you had that thought about not improving the whole time. So maybe the reasons your using brain produces do not cause the drinking.*

Assign Between-Session Exercises

Problems and Values

At the end of the session, the clinician explains the between-session exercise on *Problems and Values*. They should ask the patient to recap what they learned about defusion and address any misunderstanding. The clinician should then note that the patient has some ways to hold thoughts, and this week, we want the patient to identify times when their brain generates using thoughts. When that happens, use the worksheet below to identify problem thoughts and feelings.

- Column 1: Identify the thoughts and feelings they have that they get caught up with.
- Column 2: Identify actions they have taken that make their life worse in the long run.
- Column 3: Identify the values that they have for themselves.
- Column 4: Identify goals and actions that are aligned with the values they want to develop.

The patient uses this information to identify courses of action that are consistent with what is valuable to them, while holding the thoughts and feelings that could lead back to using.

Review and Conclude

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

ICBT Session 11. Working With Thoughts Handouts (Cognitive Defusion)

Clinician's Quick Reference to Session 11

1. Maintain rapport and review.
2. Normalize fusion as helpful in some circumstances, and express the importance of choosing to defuse from thinking when it is not.
3. Identify situations in which fusion to thinking can lead to drug use.
4. Discuss thought fusion and strategies to defuse:
    - Describe situations likely to trigger automatic thoughts.
    - Explore how fusion to these thoughts leads to lapse or relapse.
    - Provide in-session examples of fusion and defusion.
5. Explore conceptual difficulties:
    - Review material, and probe for the patient's understanding of basic concepts.
    - Use language that reflects thinking as separate from the thinker; provide metaphorical examples to further clarify fusion/defusion.
    - Walk patient through a using episode to understand how fusion contributed to use and how defusion can be employed.
6. Develop skills for coping with automatic thoughts:
    - Explain general principles of defusing from using thoughts.
    - Describe specific strategies for defusing from using thoughts; review *Managing Thoughts About Alcohol or Substances* form.
7. Practice skills for coping with automatic thoughts:
    - Demonstrate the thoughts-as-passengers metaphor.
    - Help patient experience Mind Watching, and Naming the Brain
    - Demonstrate Challenging Reason Giving
8. Assign between-session exercises.
9. Review and conclude session.

Managing Thoughts About Substance Use

When trying to stop using alcohol or other substances, it is common for your brain to generate lots of using thoughts and for these thoughts to act as triggers for potential lapses. There are a variety of approaches which may be helpful to you as you are faced with these thoughts.

1. Recognize that thoughts are just words generated by your brain.
    a. Having a thought does not mean you have to "buy it;" you can simply recognize you are having a thought without acting on it.
    b. One thought does not have to take on more significance or have more salience than any other thought; that is, one need not become "fused" to a particular thought or story.
2. Use mindfulness or meditation practice to work with challenging thoughts.
    a. See the thought as "separate" from you; step back from it.
    b. Name the type of thinking you are challenged by, for example, "using mind."
    c. Observe thoughts as they pass through your mind; recognize when you get caught up or fused with a thought.
    d. Imagine the thought is just passing through, as if stopping temporarily at a hotel, and is not "owned" by you.
3. Use creative visualization or imagery to work with challenging thoughts.
    a. Imagine you are lying in a comfortable place watching clouds pass, and each of the thoughts you have are printed on a cloud. Let the clouds pass.
    b. If/when you notice the clouds stop, notice the thought that you stopped on, and go back to letting the thoughts pass.
4. Remind yourself what is valuable to you, and ask if the thoughts your brain is producing are getting you closer to or further away from those values.
    a. Make a list of what is truly valuable to you. The list should include the qualities you want in yourself, your relationships, your work, etc.
    b. When the using mind starts producing thoughts, ask yourself if the thoughts are in line with living the life you want to live.
    c. Ask yourself what action(s) would be consistent with your values.

Problems and Values

Struggling, Suffering, and Fusion		Value-Driven Life	
Problematic Thoughts and Feelings: What thoughts and memories do you get "fused" to? What emotions, cravings, and feelings do you struggle with?	**Problem Actions:** What are you doing that makes your life worse in the long term, wastes your time and money, or negatively affects your relationships or goals?	**Values:** What really matters to you? What characteristics do you want to have in yourself? What qualities do you want in your relationships? How about in your work life?	**Goals and Actions:** What are you doing that makes your life better in the long term? What would you like to do more of? What life-enhancing actions do you want to take?

Source: Russ Harris 2009, www.actmadesimple.com

Gaining Distance and Perspective on Troubling Thoughts

This is a relatively simple and useful experiential intervention that enables your patient to step back from difficult or troubling thoughts and to view them in a broader and more compassionate context.

1. Take a few minutes for deep breathing relaxation.
2. Ask your patient to explore and identify self-limiting thoughts with you that interfere with their progress and well-being.
3. Summarize using compassionate and nonjudgmental reflections.
4. Ask your patient to summarize those thoughts, each in just a few words (three or less), such as "I'm a loser."
5. Using 3x5 cards or small, separate pieces of paper, have your patient write down those thoughts.
6. Once complete, have your patient place those cards on their lap or on the table in front of them.
7. Process that these thoughts are just words.
8. Explore how it feels having these words at a distance. Use compassionate, nonjudgmental reflections to model self-compassion for the patient.
9. Summarize that these thoughts never entirely go away, but their power and influence can be diminished, and with time, we gain a new perspective on those thoughts and our actions.

SESSION 12. WORKING WITH EMOTIONS: FOSTERING SOME, DISSOLVING OTHERS

INTRODUCTION

In Session 12, the clinician provides the patient with information about the evolutionary role of different types of emotions and the relationships among thoughts, emotions, and alcohol and other substance use. This information, along with discussion about the patient's unique experiences and handling of various emotional states, provides a rationale for trying to cultivate certain emotions while reducing the impact of others. The clinician may find it beneficial to cover this material in more than one session, depending on its relevance for the patient.

THE PERSPECTIVE ON EMOTION IN COGNITIVE BEHAVIORAL THERAPY

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

THE IMPORTANCE OF POSITIVE EMOTIONS

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

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

In contrast, negative emotions, which can be referred to as "withdrawal emotions" (e.g., fear, sadness, anger), tend to be narrowing or constricting because they reduce our "momentary thought-action" repertoire. This makes sense from an evolutionary standpoint because when we are faced with life-

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

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

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

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

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

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

The Patient's Experience

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

Clinician Preparation

Session 12. Working With Emotions: Fostering Some, Dissolving Others

Materials

- Focus on Emotion: Roles and Positive and Negative Emotions
- Focus on Emotion: Pleasant Activities
- Cognitive Distortions That Dampen One's Mood
- Managing Negative Moods and Depression
- Patient Health Questionnaire-9 (PHQ-9)
- Generalized Anxiety Disorder 7 – Item Scale (GAD-7)

Total Time
1 hour

Delivery Method
CBT-focused individual or group therapy

Strategies

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

Goals for This Session

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

Session 12 Outline and Overview

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

SESSION 12 PROTOCOL

Maintain rapport and review

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

Introduce session topic of working with emotions

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

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

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

"For example, it's important for us to feel sad when we have some kind of loss or disappointment. Or to feel scared when there is a threat to our safety. And even to feel angry when we have been treated unfairly. Those negative emotions are important because they help us to figure out what we need to be safe, or to take care of ourselves. However, those feelings can also make us feel kind of disconnected from people, withdrawn, and as though there aren't a lot of things we can do to feel better. For example, you seem to have come to believe that when you are feeling sad, drinking is the only thing you can do to feel better. There are actually many things you can do that have the potential for lifting your mood. And the really interesting thing is that when you start doing things that make you feel more positively (e.g., joyful, engaged, hopeful), you won't be feeling as negatively because it's difficult to feel both good and bad at the same time.

It's not that we should never have negative feelings, but we might want to step back and see whether we can have some greater control, or role, in the way we feel. If we can put effort into doing things that are likely to make us feel more positively, this will help us in other ways too. When we are feeling positively, we are more likely to be creative and able to work toward goals we have. We can think of different solutions to a difficult problem, rather than feeling as though there is only one way. Does that fit with your experience? Do you notice that when you are in a good mood, you feel more capable of handling challenges? Or your problems don't seem as big and unmanageable? Whereas when you are feeling down or negative, everything seems so hard and like too much work? And no one can really seem to understand or help you?"

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

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

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

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

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

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

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

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

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

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

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

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

Some examples of linking negative moods and substance use

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

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

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

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

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

S: *Yeah.*

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

Approaches to Reducing Negative and Constricting Emotions

The clinician focuses on negative moods through problem solving and increasing pleasant activities (may use handout from Session 4). If during the course of this session, the clinician suspects the patient can benefit from additional counseling or psychotropic medications, the clinician should explore these possibilities with the patient, particularly with a patient who is significantly depressed, has an anxiety disorder, or has a personal or family history of mental disorders such as major depression, suicidality, or aggression. Preview Session 14 on the use of medication to support treatment and recovery. The clinician may wish to complete a specific depression or anxiety screen such as the Patient Health Questionnaire-9 (PHQ-9) or the Generalized Anxiety Disorder 7-Item Scale (GAD-7), copies of which are in the handout section. Clinicians should be aware that the PHQ-9 includes a recommended intervention algorithm based upon the screening score. The clinician discusses the following strategies to help a patient with mild to moderate levels of depression identify negative feelings:

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

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

Reintroducing the Concept of Cognitive Fusion

Cognitive fusion (previously described) is described here as a thought process that involves rigidly attaching a thought and interpretation to an experience. Share with the patient this theory suggesting our feelings and thoughts are often closely linked. The clinician reviews the handout *Cognitive Fusion That Dampen One's Mood*. Either have the patient read it first or review it together with one of you reading aloud. After each item, inquire whether the patient relates to it, and if it is something they typically do. Explain how these automatic thought processes or distortions likely contribute to feeling negatively. The clinician explains that a connection exists among how people think, feel, and behave and that the patient can experience fewer negative moods if they think in realistic, balanced ways rather than in overly negative, self-defeating ways.

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

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

The clinician helps the patient address fused thoughts and feelings through a process of challenging these assumptions and their premises. The clinician might ask questions such as—

- What is the evidence?
- Are you certain about this?
- Are there other possible explanations/interpretations?
- So, what if that were true?

- How would your life be different if it was not true?
- What's the worst part about that?
- What is the likelihood this (fear of something terrible happening) will actually take place?

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

Review and Conclude

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

ICBT Session 12. Working With Emotions Fostering Some, Dissolving Others Handouts

Clinician's Quick Reference to Session 12

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

Focus on Emotion: Roles of Positive and Negative Emotions

All emotions have some role or function, and an evolutionary value.

Negative or "withdrawal" emotions tend to narrow our thinking and constrict our ability when approaching new situations and challenges. Examples include fear, grief, and anger. These emotions can be helpful when we are facing an acute threat and need to act quickly.

Positive or "approach" emotions tend to help us feel more capable, creative, optimistic, and connected with others. Examples include joy, contentment, curiosity, empathy, and enthusiasm. Positive emotions may be healing, have positive effects on our immune system, and counteract the effects of stress. Engaging in activities which promote positive feelings and experience can have both immediate and far-reaching benefits through building internal resources. Increasing positive emotions may have the benefit of undermining or diminishing negative emotions.

Emotion and Substance Use

Many people who use alcohol or other substances experience negative emotions both as triggers for, and consequences of, excessive use. Substances become a way of "regulating" emotional states. Increasing positive emotions through activities and experiences that enhance well-being may remove emotional triggers for substance use.

Describe a recent situation where you felt negatively, discouraged, angry, fearful, or sad. How did you cope with the situation and/or the feelings you had? In retrospect, could you have handled things differently? How might you rewrite or replay events if you could?

____

____

____

Describe a time when you felt really positively, content, or hopeful. What happened or what were you doing? What contributed to your positive feelings or outlook? Could you recreate this experience through your thoughts or actions?

____

____

____

What types of experiences are likely to result in positive emotions for you?

___

___

___

Can any of these experiences serve as replacements for alcohol or substance use?

___

___

___

Focus on Emotion: Pleasant Activities

Following is a list of activities that people find pleasurable to engage in. Please check those that seem appealing to you, either because you know you like them or you imagine you would like them if you tried. Also, check any items you are not sure about but might be willing to consider if you had some support or encouragement to try them out. There are no grades for this exercise. Check as many as you wish. If there are things not listed that you want to include, please add them.

- ☐ Reading a book
- ☐ Going to the movies
- ☐ Going out to a meal
- ☐ Exercising
- ☐ Listening to music
- ☐ Writing or journaling
- ☐ Dancing
- ☐ Singing
- ☐ Computer/Internet
- ☐ Photography
- ☐ Drawing
- ☐ Writing/Calling friend
- ☐ Making jewelry
- ☐ Baking/Cooking
- ☐ Shopping
- ☐ Painting
- ☐ Swimming
- ☐ Boating
- ☐ Ice Skating
- ☐ Knitting/Crocheting
- ☐ Taking a bath
- ☐ Gardening/Lawn
- ☐ Fixing things
- ☐ Refinishing furniture
- ☐ Going to live theater
- ☐ Library
- ☐ Visiting park, garden
- ☐ Skydiving
- ☐ Running
- ☐ Organizing
- ☐ Party/social event
- ☐ Hiking
- ☐ Fishing
- ☐ Skiing
- ☐ Antiquing
- ☐ Playing competitive sports
- ☐ Spending time with friends/family

Other activities

____

Cognitive Fusion That Dampen One's Mood and Restricts Behavior

Type of Distortions	Example
Personalizing	Thinking all situations and events revolve around you "Everyone was looking at me."
Magnifying	Blowing negative events out of proportion "This is the worst thing that could happen to me."
Minimizing	Downplaying the positives "I got the job, but probably no one else applied."
Either/or thinking	Not taking into account the full continuum "I'm either a loser or a winner."
Taking events out of context	After a successful experience, focusing on one or two rough points "I may have gotten the job, but I blew that one question in the interview."
Jumping to conclusion	Making a premature conclusion without enough data "I have a swollen gland. It must be cancer."
Overgeneralizing	Making a sweeping judgment based on one event "I failed this time; I fail at everything I ever try."
Self-blame	Blaming oneself rather than specific behaviors that can be changed "I'm no good."
Mindreading	Believing you know what everyone else is thinking "Everyone there thought I was fat and ugly."
Comparing	Comparing yourself unfavorably with someone else "That supermodel has a better figure than I do."
Catastrophizing	Focusing on the worst possible outcome or explanation. "He didn't call, and I know something terrible has happened to him."

Managing Negative Moods and Depression

Use the **three "A"s** to overcome negative feelings:

1. Be **aware** of signs of depression and negative states.
    a. Reflect on your moods and situations that influence them.
    b. Notice automatic negative thoughts that increase negative emotions.
    c. Observe experiences and situations that narrow or constrict your overall outlook.
2. **Answer** or respond to the automatic thoughts OR observe them with mild disinterest.
    a. Challenge the assumptions of the thoughts.
    b. Transform negative thoughts and feelings into constructive/healing emotions.
3. **Act** differently.
    a. Increase activities that promote positive emotions.
    b. Engage in pleasant activities.
    c. Reduce involvement with unpleasant and unnecessary activities and with people who have a negative effect on your outlook.
    d. Reward yourself for positive steps along the way and the process of change.

In the space below, take notes for each of the three areas above as they relate to your own struggles with negative moods.

____

____

____

____

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____

Patient Health Questionnaire–9 (PHQ-9)

Nine-Symptom Checklist

Patient Name ______________________________ **Date** ______________

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

   a. Little interest or pleasure in doing things

   b. Feeling down, depressed, or hopeless

   c. Trouble falling/staying asleep, sleeping too much

   d. Feeling tired or having little energy

   e. Poor appetite or overeating

   f. Feeling bad about yourself, or that you are a failure or have let yourself or your family down

   g. Trouble concentrating on things, such as reading the newspaper or watching television

   h. Moving or speaking so slowly that other people have noticed, or the opposite—being so fidgety or restless that you have been moving around a lot more than usual

   i. Thoughts that you would be better off dead or of hurting yourself in some way

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Total Score Depression Severity

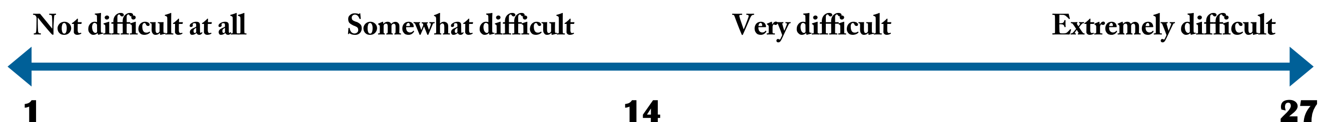
1–4 Minimal depression

5–9 Mild depression

10–14 Moderate depression

15–19 Moderately severe depression

20–27 Severe depression



Generalized Anxiety Disorder 7-Item Scale (GAD-7)

Patient Name ______________________________ **Date** ______________

Choose the one description for each item that best describes how many days you have been bothered by the following over the past 2 weeks:

	None	Several	Seven or more	Nearly every day
Feeling nervous, anxious, or on edge				
Unable to stop worrying				
Worrying too much about different things				
Problems relaxing				
Feeling restless or unable to sit still				
Feeling irritable or easily annoyed				
Being afraid something awful might happen				

Scoring

Sum scores from each question:

None = 0
Several = 1
Seven or more = 2
Nearly every day = 3

Total score: ___________

A total score of 5–9 suggests mild anxiety.

A total score of ≥ 10 suggests moderate to severe anxiety.

PDF available at http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. Archives of Internal Medicine. 2006;166:1092-1097.

SESSION 13. THE NEXT CHAPTER: WELLNESS PLANNING, WRITING THE STORY

INTRODUCTION

In session 13, which may be the final session with the patient, the clinician conducts a review, integration, and planning for the future. The clinician works with the patient to identify potential obstacles along the path ahead and strategies for handling these roadblocks. Obstacles might include upcoming high-risk situations the patient will confront or a lapse with using. It is important to highlight the nonlinear nature of recovery and to focus on the metaphor of "path" or "journey," which can include "under construction" signs, setbacks, speed limits, and detours. These obstacles can be seen as part of the trip and not an indication of failure. This session may be used to develop a project involving creative expression or writing to summarize, highlight, or celebrate the important work the patient has undertaken.

THE PATIENT'S EXPERIENCE

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

CLINICIAN PREPARATION

<table>
<tr><th colspan="2">Session 13. The Next Chapter: Wellness Planning, Writing the Story</th></tr>
<tr><td>Materials
Personal Care Plan: High-Risk Safety Plan
Personal Care Plan: Coping with a Relapse or Slip
My Story</td><td>Total Time
1 hour

Delivery Method
CBT-focused individual or group therapy</td></tr>
<tr><td colspan="2">Strategies
Open-Ended Questions, Affirmations, Reflections, Summary
Supporting Self-Efficacy
Closure with an open door</td></tr>
<tr><td colspan="2">Goals for This Session
Review the course of treatment and evaluate learning.
Identify next steps for the patient along the journey of healing.</td></tr>
</table>

Session 13. The Next Chapter: Wellness Planning, Writing the Story

- Increase preparedness for unexpected triggers and situations likely to promote relapse.
- Learn techniques to manage the aftermath of a lapse or relapse of alcohol or substance use.
- Encourage the patient to write their story in some form.

Session 13 Outline and Overview

1. Review treatment:
    - Elicit the patient's experience of engaging in the treatment process.
    - Review areas of progress and strength and continued challenges.
2. Explain the effects of major life changes:
    - Identify life changes the patient has or will experience.
3. Present a personal care plan: high-risk situation.
4. Present a personal care plan: lapse.
5. Review previous skill topics:
    - Review strategies from previous skill topics the patient found helpful.
6. Encourage the patient to write or record their story:
    1. Highlight the courage and effort the patient demonstrated.
    2. Encourage the patient to develop a creative project.
    3. Identify a format the patient might enjoy (e.g., writing narrative, journal, expressive art, collage, dream box).
7. Close the session.

Session 13 Protocol

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

Maintain Rapport and Review Progress

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

Slips, Lapses, and Relapse

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

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

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

If the patient has no past attempts at reducing use, ask what they have noticed during this attempt. The clinician explains to the patient that stories like theirs demonstrate that making any change in behavior is a process, as is a lapse or relapse. When the appropriate strategies are not used, or there is a family disagreement, increased use might result. Some important principles to convey follow:

- Patients may think that after one slip back to old use patterns (or even a fuller relapse), the whole wellness/reduction plan is ruined, and they might as well give up. Let them know this does not have to be the case.
- Patients may learn something from a slip/relapse. Tell them that by looking at the circumstances of the relapse, they may learn situations to avoid, or changes to make in their coping skills.
- Patients can choose to resume their efforts to live without substances after a lapse or full-blown relapse.

- The take-home message is this: Recovery strength is based on consistent management of "wellbriety," a lifestyle that incorporates refusal skills, sober social supports, replacement activities, and problem-solving skills.

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

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

Present a Personal Care Plan: High-Risk Safety Planning

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

Present Personal Care Plan: Lapse

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

Review Previous Skill Topics

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

Encourage the Patient to Write or Record Their Story

- Highlight the courage and effort the patient demonstrated.
- Encourage development of a creative project celebrating the patient's efforts and accomplishments.

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

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

Terminate Treatment

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

ICBT Session 13. The Next Chapter Wellness Planning, Writing the Story Handouts

Clinician's Quick Reference to Session 13

1. Rapport Building
   - Check in on past week
   - Follow up on between-session challenges
   - Elicit the patient's experience of engaging in the treatment process.
   - Review areas of progress and strength and continued challenges.
2. Explain the effects of major life changes
   - Identify life changes the patient has or will experience.
3. Present a personal care plan: high-risk situation
4. Present a personal care plan: lapse
5. Review previous skill topics
   - Review strategies from previous skill topics the patient found helpful.
6. Encourage the patient to write or record their story
   - Highlight the courage and effort the patient demonstrated.
   - Encourage the patient to develop a creative project.
   - Identify a format the patient might enjoy (e.g., writing narrative, journal, expressive art, collage, dream box).

Personal Care Plan: High-Risk Safety Planning

If I encounter a high-risk situation—

- I will leave or change the situation or environment.
- I will put off the decision to use for 15 minutes. I will remember that most cravings are time limited and that I can wait it out and not use.
- I will challenge my thoughts about using. *Do I really need to use _____?* I will remind myself that my only true needs are for air, water, food, shelter, and connections with others.
- I will think of something unrelated to using.
- I will remind myself of my successes to this point.
- I will call people on my list of emergency numbers:

	Names	Phone Numbers
1.		
2.		
3.		
4.		
5.		
6.		

Remember—Riding out this crisis will strengthen my program.

Source: Monti, Abrams, Kadden, & Cooney, 1989.

Personal Care Plan: Coping With a Lapse or Slip

A lapse can represent a crisis in recovery. Returning to abstinence requires an all-out effort. Here are some things you can do.

If I do experience a lapse—

- I will get rid of alcohol or substances and get away from the setting where I lapsed.
- I will realize that a little substance use or even 1 day of use does not have to result in a full-blown relapse. I will not give in to feelings of guilt or blame myself because I know these feelings will pass in time.
- I will call someone for help.

Remember—This lapse is only a temporary detour on the road to abstinence.

Write a detailed emergency plan for coping with high-risk lapse situations.

1. ______________________________

____

2. ______________________________

____

3. ______________________________

____

4. ______________________________

____

5. ______________________________

____

6. ______________________________

____

My Story

When one has undertaken a process of personal growth or change, it can be very helpful to capture this in some way, through writing, creative expression, or some other means as a way of further integrating what has been learned and accomplished. It can also just be an enjoyable way of highlighting the important work that has taken place. The following are some ideas to consider as you continue to progress along your journey of healing and self-discovery.

1. Write a story, journal/diary, or poem, or find existing poetry or inspirational literature and make it your own somehow (e.g., print on a small card or form that you laminate and carry easily).

2. Create a picture in some form, such as a drawing, painting (abstract is great—it only needs to be meaningful to you!), or collage.

3. Create an object, such as a dream box, containing "fortunes" that describe your most important wishes for the future.

4. Find music that expresses important feelings or values to you and create a "healing CD."

SESSION 14. USE OF MEDICATION IN SUPPORT OF TREATMENT AND RECOVERY

INTRODUCTION

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

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

GOALS FOR THIS SESSION

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

THE PATIENT'S EXPERIENCE

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

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

Clinician Preparation

Session 14. Use of Medication in Support of Treatment and Recovery	
Materials - Copy of the PHQ-9 (See Session 12 Handouts) - Copy of GAD – 7 (See Session 12 Handouts) - Medications to Treat Opioid Dependence	**Total Time** 1 hour **Delivery Method** MET-focused individual therapy with psychoeducation and care planning

Strategies

- OARS (Open-Ended Questions, Affirmations, Reflections, Summary)
- Use of decisional balance
- Information dissemination
- Support decision making and planning
- Care coordination in support of medication evaluation

Goals for This Session

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

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

If these medication discussions are being prompted because of concerns for a co-occurring mental disorder, the clinician may choose to use a valid screening tool to gather relevant information. The most common co-occurring disorders addressed in brief treatment are those of depression and anxiety. The

clinician may choose to use validated screening tools such as the PHQ-9 to screen for depression or the GAD-7 screen mentioned in Session 12. These are public domain tools readily available and easy to use (copies appear in the handout section for this session). Screening tools do not diagnose, but they help to better identify associated symptoms and inform clinical conversations.

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

Session 14 Outline and Overview

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

Session Protocol

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

Setting the Agenda

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

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

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

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

Asking Permission

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

Getting Started

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

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

Addressing Negative Perceptions

There are many common reasons patients may be reluctant to take medications, including side effects, cost, the inconvenience of taking pills each day, denial about the condition experienced, a sense of shame or stigma about taking psychiatric medications, and the negative influence of others. Among all medical conditions, there seems to be the greatest reluctance to take medications for addiction problems because of the negative perception of addiction medication.

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

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

A patient may say: *I'm afraid medication is going to harm my liver or some other part of my body if I don't give my body a rest.*

Response: *Some medications may adversely impact the health of the liver or other parts the body, but these medications would not be routinely prescribed to patients with significant impairment in liver or other bodily functions. The potential harm that is caused by medications is usually much less than the harm caused by the uncontrolled drinking or use of other drugs. When patients show impaired liver function from medication, dose reduction or discontinuation is usually effective in reducing any of these problems.*

The patient may say: *Medication is a crutch; I need to be completely drug-free to be truly in recovery.*

Response: *Abstinence from drugs of abuse certainly is important. And being 100 percent drug-free is an appealing goal for most people who have suffered through the disease of chemical dependence or other chronic diseases. Many people would choose to recover from the disease without the aid of medicine, if there was a clear chance of success. However, our role here is to provide you with the best information we can to support of your treatment and recovery. Often people who are active in the 12-step fellowships have strong beliefs about the use of medications. I would encourage you to read the documents prepared by Alcoholics Anonymous regarding the appropriate use of medication in support of treatment and recovery. Their approach is not anti medication; rather it is the use of medication appropriately prescribed.*

The patient may say: *Some of these medications are addictive. Taking this medication is just trading one addiction for another.*

Response: *None of the medications approved for alcohol dependence is physically addictive.*

Agonist and Partial Agonist Medications

For patients concerned about the dependency potential of medications, careful wording is recommended for those considering replacement therapies such as methadone or buprenorphine. While these

medications produce physical dependency, the harm associated with unsuccessful treatment outcomes far exceeds the harm of taking the medication. Replacement therapies have a proven track record of reducing harmful consequences of opioid-dependence health problems, overdose, HIV infection, crime, and family and social problems. Replacement therapies are also associated with an increased overall quality of life with an increased chance of achieving ultimate complete abstinence at some point in the future.

Conclusion

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

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

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

Summarizing the Session

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

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

ICBT Session 14. Use of Medication in Support of Treatment and Recovery Handouts

Clinician's Quick Reference to Session 14

1. Enhance rapport, review the week in general (pros and cons) and progress toward recovery goals, review the weekly challenge.
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Medications To Treat Opioid Dependence

The most common medications used in the treatment of opioid addiction are methadone and buprenorphine. Sometimes another medication, called naltrexone, is used. Cost varies for the different medications. This may need to be taken into account when considering treatment options.

Methadone and buprenorphine bind with the brain opioid (Mu) receptor sites. The person taking the medication feels normal, not high, and withdrawal does not occur. Methadone and buprenorphine also reduce cravings.

Naltrexone helps overcome addiction in a different way. It blocks the effect of opioid drugs. This takes away the feeling of getting high if the problem drug is used again. This feature makes naltrexone a good choice to prevent relapse (falling back into problem drug use).

These three medications have the same positive effect—they reduce problem addiction behavior. All three medications come in pill form. Methadone also comes as a liquid and a wafer. Methadone is taken daily. The other two medications are taken daily at first. After time, buprenorphine is taken daily or every other day, and doses of naltrexone are taken up to 3 days apart.

Methadone to treat addiction is dispensed only at specially licensed treatment centers. Buprenorphine and naltrexone are dispensed at treatment centers or prescribed by doctors. A doctor must have special approval to prescribe buprenorphine. Some people go to the treatment center or doctor's office every time they need to take their medication. People who are stable in recovery may be prescribed a supply of medication to take at home.

***Sources*:** Excerpted from Center for Substance Abuse Treatment. (2011). *Medication-assisted treatment for opioid addiction*. HHS Publication No. (SMA) 09-4443. Prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by the Knowledge Application Program, a joint venture of the CDM Group, Inc., and JBS International, Inc., under contract number 270-04-7049 with SAMHSA, U.S. Department of Health and Human Services.

Medications To Treat Alcohol Dependence

Currently, there are four medications approved by the FDA to treat alcohol dependence:

- Acamprosate
- Oral naltrexone
- Injectable naltrexone
- Disulfiram

Research has demonstrated that including approved medications for the treatment of alcohol dependence, in conjunction with treatment, improves treatment outcomes. These medications have been found to—

- Reduce persisting symptoms of withdrawal that can prompt relapse (acamprosate)
- Help minimize alcohol cravings
- Help to avoid relapse
- Prolong intervals between slips or relapses

- Increase the benefits of counseling or other alcohol treatments

Acamprosate (Campral)

Acamprosate helps restore brain function damaged by alcoholism.

Alcohol causes intense but relatively brief withdrawal symptoms, and much longer lasting but milder symptoms of withdrawal. Although milder, these enduring withdrawal symptoms (such as difficulty sleeping, irritability, and anxiety) can lead to alcohol relapse.

Acamprosate helps motivated patients maintain abstinence by reducing the severity of these longer lasting withdrawal symptoms. Acamprosate is thought to reduce glutamate activity, but its exact means of action remains poorly understood.

Advantages of Acamprosate—

- Acamprosate is not metabolized in the liver, and so can be used by patients with liver damage or cirrhosis.
- It can be used by patients taking methadone or Suboxone, and by those requiring opiates for pain control (unlike naltrexone).
- It causes no withdrawal symptoms and can be stopped suddenly, if needed. It can also be taken safely with benzodiazepines.
- It cannot be abused and it is not dangerous, even at overdose quantities.
- Side effects are generally minimal, and those that occur are well tolerated.

Acamprosate becomes fully effective between 5 and 8 days after treatment initiation.

Oral Naltrexone (ReVia)

Patients taking oral naltrexone experience reduced cravings for alcohol, and while taking the medication, drinking alcohol will not produce as much pleasure. Since drinking does not make people on naltrexone feel as good, people who slip while taking the medication tend to drink lesser amounts.

Oral naltrexone is effective at helping people maintain abstinence or drink less. Studies of oral naltrexone have shown that, compared to people taking a placebo, people taking the medication—

- Have lower rates of relapse
- If they do drink, drink less often and drink less in a sitting

Advantages of oral naltrexone—

- It works well, particularly for people who experience heavy alcohol cravings and who are motivated to maintain abstinence.
- It is well tolerated, causing few side effects (the most common side effect is nausea).
- It has no abuse potential and causes no withdrawal symptoms.

Disadvantages of oral naltrexone—

- It cannot be used by some people with liver problems.
- It cannot be used by anyone using methadone, Suboxone, or requiring opiate pain medications.
- It may increase a person's vulnerability to opiate overdose by decreasing opiate tolerance.

Injectable Naltrexone (Vivitrol)

Injectable naltrexone works in the same way as oral naltrexone to reduce alcohol cravings and decrease the pleasures of alcohol consumption. While oral naltrexone needs to be taken daily, intramuscularly injected naltrexone works for a continuous month. With a monthly injectable dose, everyday compliance is not an issue.

Studies that have examined the efficacy of naltrexone as a treatment for alcoholism have consistently encountered patient noncompliance as a barrier to successful treatment.

The advantages and disadvantages of injectable naltrexone treatment closely mimic those of oral naltrexone treatment. The main benefit of injectable naltrexone is increased patient compliance. Some points of concern include—

- There is a possibility of an injection site reaction.
- The duration of effectiveness means that any adverse reactions experienced will be experienced for 30 days.

Disulfiram (Antabuse)

Patients talking disulfiram cannot consume alcohol without becoming ill. Patients taking this medication know this and so avoid drinking alcohol while taking the medication. Normally, alcohol is metabolized by the body into acetaldehyde and then into acetic acid. Disulfiram disrupts the final stage of this process (the metabolization of acetaldehyde into acetic acid), causing a much higher level of acetaldehyde in the body after any alcohol consumption.

High levels of acetaldehyde in the bloodstream lead to very uncomfortable reactions, such as the following:

- Hyperventilation
- Thirst
- Nausea and vomiting
- Chest pains
- Dizziness
- Confusion
- Muscle weakness

At higher doses, the combination of disulfiram and alcohol can lead to serious reactions that can include symptoms such as the following:

- Seizures
- Heart failure

- Respiratory depression
- Death

Does Disulfiram Work?

Studies have shown that disulfiram helps to reduce drinking days among those actively drinking but does not seem to work better than placebo in supporting abstinence. Patients who are supervised while taking their medication (to ensure compliance) seem to do better than those who are left unsupervised.

Disulfiram is not an appropriate medication for people with any of the following—

- Mental illness
- Poor impulse control
- Cognitive impairments

Medications To Treat Anxiety Disorders

Antidepressants, antianxiety medications, and beta-blockers are the most common medications used for anxiety disorders.

Anxiety disorders include—

- Obsessive-compulsive disorder (OCD)
- Posttraumatic stress disorder (PTSD)
- Generalized anxiety disorder (GAD)
- Panic disorder
- Social phobia

Antidepressants

Antidepressants were developed to treat depression, but they also help people with anxiety disorders. Selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine (Prozac), sertraline (Zoloft), escitalopram (Lexapro), paroxetine (Paxil), and citalopram (Celexa) are commonly prescribed for panic disorder, OCD, PTSD, and social phobia. The serotonin-norepinephrine reuptake inhibitor (SNRI) venlafaxine (Effexor) is commonly used to treat GAD. The antidepressant bupropion (Wellbutrin) is also sometimes used. When treating anxiety disorders, antidepressants generally are started at low doses and increased over time.

Some tricyclic antidepressants work well for anxiety. For example, imipramine (Tofranil) is prescribed for panic disorder and GAD. Clomipramine (Anafranil) is used to treat OCD. Tricyclics are also started at low doses and increased over time.

Monoamine oxidase inhibitors (MAOIs) are also used for anxiety disorders. Doctors sometimes prescribe phenelzine (Nardil), tranylcypromine (Parnate), and isocarboxazid (Marplan). People who take MAOIs must avoid certain foods and medicines that can interact with their MAOI and cause dangerous increases in blood pressure. For more information, see the section on medications used to treat depression.

Benzodiazepines (antianxiety medications)

The antianxiety medications called benzodiazepines can start working more quickly than antidepressants. The ones used to treat anxiety disorders include—

- Clonazepam (Klonopin) is used for social phobia and GAD.
- Lorazepam (Ativan) is used for panic disorder.
- Alprazolam (Xanax) is used for panic disorder and GAD.
- Buspirone (Buspar) is an antianxiety medication used to treat GAD. Unlike benzodiazepines, however, it takes at least 2 weeks for buspirone to begin working.
- Clonazepam, listed above, is an anticonvulsant medication.

Beta-Blockers

Beta-blockers control some of the physical symptoms of anxiety, such as trembling and sweating. Propranolol (Inderal) is a beta-blocker usually used to treat heart conditions and high blood pressure. The medicine also helps people who have physical problems related to anxiety. For example, when a person with social phobia must face a stressful situation, such as giving a speech or attending an important meeting, a doctor may prescribe a beta-blocker. Taking the medicine for a short period of time can help the person keep physical symptoms under control.

What are the side effects?

See the section on antidepressants for a discussion on side effects. The most common side effects for benzodiazepines are drowsiness and dizziness. Other possible side effects include—

- Upset stomach
- Blurred vision
- Headache
- Confusion
- Grogginess
- Nightmares

Possible side effects from buspirone (BuSpar) include—

- Dizziness
- Headaches
- Nausea
- Nervousness
- Lightheadedness
- Excitement
- Trouble sleeping

Common side effects from beta-blockers include—

- Fatigue
- Cold hands
- Dizziness
- Weakness

In addition, beta-blockers generally are not recommended for people with asthma or diabetes because they may worsen symptoms.

Medications to Treat Depression

Depression is commonly treated with antidepressant medications. Antidepressants work to balance some of the natural chemicals in our brains. These chemicals are called neurotransmitters, and they affect our mood and emotional responses. Antidepressants work on neurotransmitters such as serotonin, norepinephrine, and dopamine.

The most popular types of antidepressants are SSRIs. These include—

- Fluoxetine (Prozac)
- Citalopram (Celexa)
- Sertraline (Zoloft)
- Paroxetine (Paxil)
- Escitalopram (Lexapro)

Other types of antidepressants are SNRIs. SNRIs are similar to SSRIs and include venlafaxine (Effexor) and duloxetine (Cymbalta). Another antidepressant that is commonly used is bupropion (Wellbutrin). Bupropion, which works on the neurotransmitter dopamine, is unique in that it does not fit into any specific drug type.

SSRIs and SNRIs are popular because they do not cause as many side effects as older classes of antidepressants. Older antidepressant medications include tricyclics, tetracyclics, and MAOIs. For some people, tricyclics, tetracyclics, or MAOIs may be the best medications.

What are the side effects?

Antidepressants may cause mild side effects that usually do not last long. ***Any unusual reactions or side effects should be reported to a doctor immediately***.

The most common side effects associated with SSRIs and SNRIs include—

- Headache, which usually goes away within a few days
- Nausea (feeling sick to your stomach), which usually goes away within a few days
- Sleeplessness or drowsiness, which may happen during the first few weeks but then goes away—Sometimes the medication dose needs to be reduced, or the time of day it is taken needs to be adjusted to help lessen these side effects.

- Agitation (feeling jittery)
- Sexual problems, which can affect both men and women and may include reduced sex drive and problems having and enjoying sex

Tricyclic antidepressants can cause side effects, including—

- Dry mouth
- Constipation
- Bladder problems—It may be hard to empty the bladder, or the urine stream may not be as strong as usual. Older men with enlarged prostate conditions may be more affected.
- Sexual problems, which can affect both men and women and may include reduced sex drive and problems having and enjoying sex
- Blurred vision, which usually goes away quickly
- Drowsiness—Usually, antidepressants that make you drowsy are taken at bedtime.

People taking MAOIs need to be careful about the foods they eat and the medicines they take. Foods and medicines that contain high levels of a chemical called tyramine are dangerous for people taking MAOIs. Tyramine is found in some cheeses, wines, and pickles. The chemical is also in some medications, including decongestants and over-the-counter cold medicine.

Mixing MAOIs and tyramine can cause a sharp increase in blood pressure, which can lead to stroke. People taking MAOIs should ask their doctors for a complete list of foods, medicines, and other substances to avoid. An MAOI skin patch has recently been developed and may help reduce some of these risks. A doctor can help a person figure out if a patch or a pill will work for them.

Source: National Institute of Mental Health. (2012). *Mental health medications*. NIH Publication No. 12–3929. Bethesda, MD: National Institutes of Health, Department of Health and Human Services.

SESSION 15. ENGAGEMENT WITH SELF-HELP

INTRODUCTION

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

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

THE PATIENT'S EXPERIENCE

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

CLINICIAN PREPARATION

Session 15. Engagement With Self-Help	
Materials ▸ What Happens in an Alcoholics Anonymous (or Narcotics Anonymous) Meeting? ▸ Up to date rosters of community self-help meetings (Trainee Provided)	**Total Time** 1 hour **Delivery Method** MET-focused individual therapy with psychoeducation
Strategies ▸ OARS (Open-Ended Questions, Affirmations, Reflections, Summary) ▸ EDARS (Express Empathy, Develop Discrepancy, Awareness of Ambivalence, Roll With Sustain Talk/Discord, Support Self-Efficacy); identify stage of change ▸ Link self-help involvement with increased social support for recovery ▸ Support patient decision making and plan to attend self-help ▸ Develop "real-life practice challenge" and generate commitment	

Session 15. Engagement With Self-Help

Goals for This Session

- Clarify patients thought and feelings about self-help involvement
- Increase patient understanding of the role of self-help in recovery
- Build patient motivation and Commitment to attend or at least sample self-help meetings
- Develop commitment and plan for self-help attendance

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

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

Session 15 Outline and Overview

- Ask permission to discuss this topic.
- Link attendance in self-help meetings with enhancing patient need for improved social supports.
- Discuss the patient's previous experience, knowledge, and beliefs regarding AA and NA.
- Using MI skills, process patient ambivalence regarding participation in self-help.
- Negotiate an agreement to attend a certain number of meetings to learn more.
- Agree upon a concrete plan of activity in the coming week regarding patient attendance.
- Close the session.

Session 15 Protocol

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

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

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

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

ICBT Session 15. Engagement With Self-Help Handouts

Clinician's Quick Reference to Session 15

1. Rapport building
    - Check in on past week.
    - Follow up on between-session challenge.
    - Assess progress.
2. Orient patient to session agenda.
3. Link attendance in self-help meetings with enhancing patient need for improved social supports.
4. Discuss the patient's previous experience, knowledge, and beliefs regarding AA and NA.
5. Using MI skills, process patient ambivalence regarding participation in self-help.
6. Negotiate an agreement to attend a certain number of meetings to learn more.
7. Agree upon a concrete plan of activity in the coming week regarding patient attendance.
8. Close the session.

What Happens in an Alcoholics Anonymous Meeting?

Most meetings take place in public buildings with defined dates and times. As a meeting begins, the chairperson usually asks if anyone is attending Alcoholics Anonymous (AA) for the first, second, or third time ever. The chair may then ask if there are any out-of-town visitors. The purpose is to welcome guests and newcomers. Individuals who are at their first AA meeting or have less than 30 days of sobriety may be welcomed with a hug and awarded a “keep coming back” coin or chip. The chair may talk for a few minutes and then call on meeting participants to talk or “share” and may request they limit their comments to 3 to 5 minutes and restrict their discussion to issues relating to alcoholism and recovery.

Sometime during the meeting, the chair may open the meeting to anyone who has not been called on who really needs to talk, frequently referred to as a “burning desire to share.” People who are called upon to speak usually do so by identifying themselves, for instance, “My name is Michael, and I am an alcoholic.” The group usually responds with “Hi, Michael,” and then the individual speaks for a few minutes. If a person is called upon and does not wish to talk, they have only to say, “I think I will just listen today,” or, “I’ll pass.” Another safety feature of the meetings is the absence of crosstalk or interruption. Unlike group therapy, AA members share their own experience, strength, and hope with each other, rather than telling one another what to do.

At some point, the meeting pauses for announcements and to collect funds for AA’s Seventh Tradition, which states that AA groups are self-supporting through their own contributions. Cash donations of a dollar or two are usual, although newcomers are not required to contribute until they understand what AA is about.

Most meetings last 1–1½ hours. At the end of the meeting, the group members stand, join hands, and recite the Lord’s Prayer or the Serenity Prayer, for those who care to join. With slight variations, this basic meeting format is the same throughout the world, varying only in language. An AA member can walk into a meeting anywhere and feel at home.

If you are interested in attending an AA meeting or any of the other 12-step programs, please call your local central service committee for information about a meeting near you.

At meetings, you may witness a lot of laughter and joking. People in AA are not a glum lot, and they insist on having a good time. The humor shows itself in an AA meeting, and newcomers are frequently surprised to hear members laughing about an incident that might seem grim or unfortunate. Usually, the laughter is based on identification with the speaker, as well as relief that sober people are no longer getting arrested, crashing automobiles, or engaging in unmanageable drunken behavior.

Some people who have never attended an AA meeting express unease with 12-step programs because of "all the talk about God." In AA, "God" is to be understood as "a higher power"—interpreted in any way that works for you. Therefore, a "Group of Drunks" (GOD) providing "Good, Orderly Direction" (GOD) can be the higher power for the alcoholic if they so decide. AA is a spiritual program, not a religious one, and takes no position on political issues or controversy.

The success enjoyed by AA has been so great that many other groups use the AA model for meetings and the 12-step format. There are Gamblers Anonymous (GA), Overeaters Anonymous (OA), Cocaine Anonymous (CA), Narcotics Anonymous (NA), Sex Addicts Anonymous (SAA), Co-Dependents Anonymous (CODA), and Adult Children of Alcoholics (ACOA), just to name a few. Of course, there is Al-Anon for the spouses, family members, and friends of alcoholics. For the purpose of simplicity, this article talks about AA, but the word cocaine, sex, emotions, gambling, and so on, can be substituted for the word "alcohol" in the 12 steps of Alcoholics Anonymous, and other 12-step programs follow similar formats.

Research also indicates that participation in 12-step programs increases an individual's chances for sustained recovery. A 1999 study at the University of California, Los Angeles, found that patients who completed treatment and participated in 12-step meetings had twice the abstinence rate compared to those who completed treatment and did not go to meetings. In a 1994 study of 65,000 patients who attended AA after treatment, those who attended AA weekly for 1 year had a 73 percent rate of staying sober. Of those who attended AA only occasionally, 53 percent stayed sober. In contrast, those who never went to 12-step meetings or stopped going had a 43 percent rate of sobriety.

The 12 Steps

1. Admitted that we were powerless over alcohol (and/or drugs) and that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Them.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Them to remove our shortcomings.
8. Made a list of all persons we had harmed and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory, and when we were wrong, promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Them, praying only for knowledge of Their will for us and the power to carry that out.
12. Having had a spiritual awakening as a result of the steps, tried to carry this message to alcoholics and practice these principles in all our affairs.

The 12 Traditions of Alcoholics Anonymous

1. Our common welfare should come first; personal recovery depends upon AA unity.
2. For our group purpose there is but one ultimate authority—a loving God as He may express Themself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.
5. Each group has but one primary purpose—to carry its message to the alcoholic who still suffers.
6. An AA group ought never endorse, finance, or lend the A.A. name to any related facility or outside enterprise, lest problems of money, property, and prestige divert us from our primary purpose.
7. Every AA group ought to be fully self-supporting, declining outside contributions.
8. AA should remain forever nonprofessional, but our service centers may employ special workers.
9. AA, as such, ought never be organized; but we may create service boards or committees directly responsible to those they serve.
10. AA has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

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SESSION 16. A MET/CBT APPROACH FOR TRAUMATIC STRESS AND SUBSTANCE USE

INTRODUCTION

Session 16 is a cluster of three staged sessions that address posttraumatic stress disorder (PTSD). The sessions may take place any time after ICBT Session 1 has been completed. This protocol is included here because patients screening positive for drug and alcohol use risk are at an elevated risk for having experienced trauma(s), "trauma-type" symptoms, and/or a full diagnosis of PTSD. It is essential for health care providers integrating behavioral and medical care to be ready to identify, intervene, and if necessary, refer patients they suspect might have a history of trauma or stress-related disorder. The clinician should conduct initial and secondary screenings for trauma using the Primary Care PTSD (PC-PTSD) screen and PTSD Checklist (PCL) (military and civilian versions are included in the handouts) as soon as the need is identified, and the patient agrees.

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

DIAGNOSIS AND SYMPTOMS

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

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

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

Prevalence and Types of Trauma

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

Combat Exposure

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

Treatment Integration: The Opportunity of SBIRT

The integration of behavioral and medical health presents an important opportunity to identify and intervene with patients not often motivated to seek treatment. Most individuals with either PTSD or substance use disorders (or both) do not seek treatment (Cottler, Compton, Mager, Spitznagel, & Janca, 1992; Grant et al., 2004). A study of soldiers returning from Iraq and Afghanistan found that only 38 to 45 percent of those who showed signs of a mental disorder demonstrated an interest in receiving treatment (McFall, Malte, Fontana, & Rosenheck, 2000). Even among those who do seek treatment,

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

Treatment Types and Efficacy

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

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

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

The Patient's Experience

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

Clinician Preparation

Session 16. A MET/CBT Approach for Traumatic Stress and Substance Use

Materials

- Copy of the GAD-7, PHQ-9 (See Session 12 Handouts)
- Copy of the PC-PTSD; PCL (civilian or military, depending on patient)
- Handouts: Sample Safety Plan, Psychoeducation
- Deep-Breathing Relaxation
- The Suicide Behaviors Questionnaire- Revised (SBQ-R) Overview
- SBQ- R
- Optional ICBT Sessions 9, 10, 12, 14

Session Length
60 minutes

Delivery Method
MET/CBT

Strategies

- Follow OARS: Open-Ended Questions, Affirmations, Reflections, Summary
- Psychoeducation: Trauma Information
- Situational Awareness Monitoring
- Cognitive Coping/Restructuring

Goals for This Session

- Welcome patient and continue to build rapport.
- Accurately screen patients for severity of trauma using the PCL-C for civilians and the PCL-M for military-based trauma to determine severity.
- Discuss in a personalized reflective discussion with patient the PCL results, and review results from AUDIT/DAST or similar substance use screens to determine the extent to which the patient's trauma symptoms influence the misuse of substances and vice versa.
- Increase the patient's knowledge of the biological, physiological, and psychological effects of trauma exposure.
- Provide nonjudgmental understanding when discussing the patient's current coping strategies (including the use of substances); normalize the fact that many trauma survivors struggle to find successful and healthy coping strategies.
- Provide hope and build positive expectations that effective treatment now exists; that by working together, it will be possible to treat and reduce both trauma symptoms and substance misuse.
- Reduce patient's "overreactions" based on past experiences that are not adaptive for coping appropriately with present-day situations.
- Reduce ambivalence to change and increase willingness to adopt new coping strategies: relaxation and cognitive coping/restructuring.
- Enhance patient coping skills specifically helpful in reducing both trauma and substance use disorder symptoms.

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

SESSIONS 16-1, 15-6, AND 16-3 OUTLINE AND OVERVIEW

Session 16-1: Personalized Reflective Discussion Addressing Trauma and Substance Use

1. Welcome the patient and build rapport.
   - Assess the patient's readiness to proceed
2. Introduce the topic
   - Share session model/approach: include the main activities of treatment Sessions 1–7

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

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

Session 16-2: Safety Planning, Deep Breathing Relaxation, and Psychoeducation

1. Welcome, build rapport, and review substance use and trauma symptoms and possible interactions. Review between-session challenge.

    - Introduce the topic.
    - Provide rationale.
    - Briefly educate the patient on the effects of trauma: the main symptoms, the best treatment and the negative long-term effects of using substances to reduce trauma symptoms (see handout on trauma psychoeducation).

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

    - Ask your patients what they know about the effects of trauma experiences in general, and how the trauma is affecting them (and others).
    - Since they are using substances, how do they believe the use of alcohol/drugs is affecting their feelings and behaviors?"
    - After eliciting a personal discussion, ask the patient to specifically describe the most disturbing symptoms or feelings and behaviors experienced recently.
    - Describe ICBT session activities that can address these feelings and behaviors.

2. Introduce and explain the need to create a safety plan (see handout on safety plan).

    - Safety plan rationale: *"Upsetting feelings may come up as you discuss daily feelings and stressors, or even consider talking about the past trauma experience. I am here to help with this and anything else that makes you feel unsafe while you are involved the ICBT program."*
    - Elicit (screen) for past suicidal history (e.g., thoughts, incidents) and indicate that you will need to know how the patient will alert you if they feel unsafe, threatened, or a risk of harming themself or others (see handout on Suicide Behaviors Questionnaire, Revised—SBQ-R).
    - Assess the past and current history of suicide and determine the appropriateness of ICBT as a helpful intervention. Determine if there is risk of suicide based on past or current ideations, or if intentions appear minimal.
    - As appropriate, determine if it is clinically appropriate to continue and to introduce the safety plan. If the risk is determined to be great based on past or current suicidal or homicidal ideations or intentions, seek the involvement of a medical/psychiatric/crisis team for evaluation (prior to the patient's leaving the health care facility if indicated).

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

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

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

Session 16-3: Enhancing Self-Awareness and Introducing Cognitive Restructuring

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

   Note: Session 16-3 builds off ICBT Session 9. Refer to Session 9 for detailed descriptions of enhancing self-awareness and discovering new roads. Whenever applicable, incorporate both trauma and substance use effects into the session's written protocol (use the Session 16 handout on trauma/substance use awareness record).

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

ICBT Sessions 11 and 12

1. Introduce and deliver ICBT Session 11 (Working With Thoughts) and Session 12 (Working With Emotions: Fostering Some and Dissolving Others). Sessions 11 and 12 focus on cognitive restructuring and coping strategies for reducing the effects of trauma.
2. For each session listed above (11 and 12), integrate trauma-based reactions and substance misuse into the session outline and discussions. The Session 16 handouts provide a good example of the types of specific trauma-related additions needed to focus the ICBT intervention on reducing both trauma symptoms and substance misuse.
3. A clearer collaborative understanding of how the patient's inner and outer world leads to continued distress is generated through the personalized reflective discussion and the review of situational analysis patterns for trauma-based reactions, substance misuse, triggers, thoughts, behaviors, and outcomes in Session 16.
4. Once these triggering patterns are revealed in Session 16-3, follow Sessions 11 and 12 steps and handouts to work on reducing cognitive distortion and automatic thinking associated with trauma-based reactions and substance misuse.
5. Assign a between-session challenge associated with the session materials delivered. Include the daily use of both the trauma/substance awareness record and deep-breathing relaxation between each session.

ICBT Session 16. An MET/CBT Approach for Traumatic Stress and Substance Use Handouts

Clinician's Quick Reference to Session 16-1

1. Rapport building
    - Check in on past week.
    - Follow up on between-session challenge.
    - Assess progress.
2. Orient the patient to the session agenda.
    - Personalized reflective discussion addressing trauma and substance use.
3. Describe model/approach for trauma sessions.
    - Personalized reflective discussion addressing trauma and substance use, safety planning
    - Learning a (stress-reducing) relaxation technique
    - Psychoeducation about trauma
    - Identifying, understanding, and monitoring for internal and external triggers
    - Developing skills for working with feelings/thoughts
4. Complete PTSD screening if indicated.
5. Review and summarize the results of the personalized reflective discussion (substance use) and PTSD screen as part of reflective discussion.
6. If indicated, seek further evaluation.
7. Summarize session and elicit between-session challenge.
8. Conclude session.

Clinician's Quick Reference to Session 16-2

1. Rapport building
    - Check in on past week.
    - Follow up on between-session challenge.
    - Assess progress.
2. Orient patient to session agenda.
    - Safety planning, deep breathing relaxation, and psychoeducation
    - Educate on effects of trauma
3. Educate patient on effects of trauma.
4. Elicit personal discussion with patient on trauma and substance use.
    - Ask patient what they know about the effects of trauma experiences in general, and how the trauma is affecting them (and others).
    - Ask how they believe the use of alcohol/drugs is affecting their feelings and behaviors.
    - Describe the ICBT session activities that can address those feelings and behaviors.
5. Introduce safety plan and rationale.
6. Screen for past suicidal history (SBQ-R handout).
7. Complete safety plan (handout).
8. Introduce, train, and practice deep-breathing relaxation.
9. Distribute PTSD information sheet.
10. Conclude session with between-session challenge.

Clinician's Quick Reference to Session 16-3

1. Rapport building
    - Check in on past week.
    - Follow up on between-session challenge.
    - Assess progress.
2. Orient patient to session agenda.
    - Enhancing self-awareness and introducing cognitive restructuring (skills training).
3. Introduce and ask patient to complete trauma/substance use awareness handout.
4. Discuss and elicit three to five situation that trigger trauma symptoms and/or substance use.
5. Discuss situations to gain full understanding using personalized reflective discussion.
6. Identify and prioritize skills and strategies to address trauma symptoms and associated ICBT sessions/activities.
7. Individualize plan by negotiating specific skills sessions and other indicated supports.
8. Summarize the session.
9. Assign a between-session challenge.
10. Conclude session.

PTSD Checklist, Civilian Version (PCL-C)

Patient's Name:___________________________________

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each item carefully, and put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut* off from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD. Behavioral Science Division

This is a Government document in the public domain

The PCL is a standardized self-report rating scale for PTSD composed of 17 items that correspond to the key symptoms of PTSD. Two versions of the PCL exist: (1) PCL-M is specific to PTSD caused by military experiences, and (2) PCL-C is applied generally to any traumatic event.

The PCL can be easily modified to fit specific time frames or events. For example, instead of asking about "the past month," questions may ask about "the past week" or be modified to focus on events specific to a deployment.

How is the PCL completed?

- The PCL is self-administered
- Respondents indicate how much they have been bothered by a symptom over the past month using a 5-point (1–5) scale, circling their responses. Responses range from **1** *Not at All to* **5** *Extremely*

How is the PCL Scored?

1. Add up all items for a total severity score

or

2. Treat response categories **3–5** (*Moderately* or above) as symptomatic and responses **1–2** (below *Moderately*) as nonsymptomatic, then use the following DSM criteria for a diagnosis:

    - Symptomatic response to at least 1 "B" item (Questions 1–5)
    - Symptomatic response to at least 3 "C" items (Questions 6–12)
    - Symptomatic response to at least 2 "D" items (Questions 13–17)

Are Results Valid and Reliable?

- Two studies of both Vietnam and Persian Gulf theater veterans show that the PCL is both valid and reliable (additional references are available from the DHCC)

What Additional Follow-Up Is Available?

- All military health system beneficiaries with health concerns they believe are deployment-related are encouraged to seek medical care
- Patients should be asked, **"Is your health concern today related to a deployment?"** during all primary care visits.
    - If the patient replies "**yes**," the provider should follow the Post-Deployment Health Clinical Practice Guideline (PDH-CPG) and supporting guidelines available through the DHCC and www.PDHealth.mil

DHCC Clinicians Helpline: 1 (866) 559-1627 DSN: 662-6563 www.PDHealth.mil

PDH-CPG Tool Kit Pocket Cards Version 1.0 December 2003

PTSD Checklist, Military Version (PCL-M)

Name: ______________________________

Unit: ______________________________

Best contact number and/or email:

____

Deployed location:

____

Instructions: Below is a list of problems and complaints that veterans sometimes have in response to a stressful military experience. Please read each one carefully, put an "X" in the box.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful military experience?					
2.	Repeated, disturbing *dreams* of a stressful military experience?					
3.	Suddenly *acting* or *feeling* as if a stressful military experience *were happening again* (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful military experience?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful military experience?					
6.	Avoid *thinking about* or *talking about* a stressful military experience or avoid *having feelings* related to it?					
7.	Avoid *activities* or *talking about* a stressful military experience or avoid *having feelings* related to it?					
8.	Trouble *remembering important parts* of a stressful military experience?					
9.	Loss of *interest* in things that you used to enjoy?					

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
10.	Feeling *distant* or *cut off* from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be cut *short?*					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

Has anyone indicated that you've changed since the stressful military experience? Yes ___ No____

Primary Care PTSD Screen (PC-PTSD)

Description

The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

Scale

Instructions

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that in the past month, you—

1. Have had nightmares about it or thought about it when you did not want to?

   Yes/No

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

   Yes/No

3. Were constantly on guard, watchful, or easily startled?

   Yes/No

4. Felt numb or detached from others, activities, or your surroundings?

   Yes/No

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any 3 items.

Prins, Ouimette, & Kimerling, 2003

Sample Safety Plan

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing

1. ______________________________
2. ______________________________
3. ______________________________

Step 2: Internal coping strategies: Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity)

1. ______________________________
2. ______________________________
3. ______________________________

Step 3: People and social settings that provide distraction

1. Name ______________________ Phone ______________
2. Name ______________________ Phone ______________
3. Place ______________________ Phone ______________

Step 4: People whom I can ask for help

1. Name ______________________ Phone ______________
2. Name ______________________ Phone ______________
3. Place ______________________ Phone ______________

Step 5: Professionals or agencies I can contact during a crisis

1. Clinician Name ______________________ Phone ______________

   Clinician Pager or Emergency Contact Number ______________________
2. Clinician Name ______________________ Phone ______________

   Clinician Pager or Emergency Contact Number ______________________
3. Local Urgent Care Services ______________________

   Urgent Care Services Address ______________________

   Urgent Care Services Phone ______________________
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe

1. ______________________________
2. ______________________________

The one thing that is most important to me and worth living for is:

____

____

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Deep-Breathing Relaxation

Deep-Breathing Relaxation	
Key Aspects	Deep-breathing relaxation is a well-known and widely used stress reduction technique. The essential elements include the following: a. Provide the rationale: relieves stress, can replace the need for substances, balances body chemistry, and helps calm and focus the mind. There are two parts: 1. Centering helps you reach a state of feeling present and stable. 2. The breathing technique helps you balance the breath for full inhalations and exhalations. b. After you have given rationale, demonstrate centering and deep-breathing, emphasizing the centering position and the enlarged abdomen, then chest expansion. c. Next, ask the patient to center themself. Have the patient get in a comfortable position with both feet on the ground and focus the mind on the core between the spine and belly button. d. Next, have the patient take a normal breath in through the nose and extend the exhalation out through the mouth. e. Coach the skill acquisition; repeat in through nose, longer out through mouth, 10–15 times. f. Talk with the patient about how it feels. g. Assign life work suggesting the patient practice twice a day so the relaxation technique becomes automatic when needed. In the following scene, the clinician delivers the relaxation technique and coaches the attempts by the patient to adopt and practice the skill.
Relaxation Discussion	
Clinician	*“You’ve told me you are most tempted to drink when there is a lot of stress, and alcohol almost immediately helps you stay calm.”*
Patient	*“Yes, but it has its down side. I do not get as much done so the pressures are actually worse.”*
Provider	*“Other students tell me that too. May I suggest another way of dealing with your stress that other people have found particularly helpful?”*
Patient	*“Like taking some Xanax? It makes me groggy. I just fall asleep and still get nothing done.”*
Clinician	*“Actually an even more effective way to relax is called deep-relaxation breathing. There are no negative side effects, and it can change and reduce your body’s cortisol levels. Cortisol is one of the main stress hormones. If you want, we could take a moment now for you to learn and practice the technique.”*
Patient	*“Sure, why not.”*
Clinician	*“Ok. First notice your breathing. Is it shallow? Is it quick?”*

Deep-Breathing Relaxation	
Patient	*"Both shallow and quick."*
Clinician	*"Watch as I demonstrate [puts hands on stomach]. I breathe deeply through the nose and into my stomach, which gets larger, then to release the air, I simply let it flow out from my mouth."* *"To begin, I need you to begin to focus your mind and sit in a relaxing, but well-supported position."*
Patient	*"Okay. I'll try."*
Clinician	*"Try to sit with both feet firmly on the ground. Then, begin to breathe normally, focusing your mind on your core—the place between the belly button and spine. Let all your other thoughts go, as you focus on your core.* *Now just inhale through your nose, and as you exhale, extend your breath out through your mouth."*
Patient	*"What should I think about?"*
Clinician	*"Just prior to breathing out, it helps to think of a calming word such as "relax" or picture yourself relaxing." scene – like the beach or woods.*
Patient	*"So, all I really need to do is just breathe air through my nose, into my stomach. It expands and then I release by slowly exhaling through my mouth. And do this 10–15 times."*
Clinician	*[Observing] "Yes, that's right."*
Patient	*"Okay, but it's weird to have you watch me breath."*
Clinician	*"Understandably, but I'll just get you started so you can do this on your own. Try to focus your mind on your core and relax. If you need to, place your hands on your stomach do so you can make sure it expands when you breathe in and contracts when you breathe out."* *"Many people express it is harder at first but always worth the effort."* *"It is best to practice twice a day for 10–15 breaths, so it becomes more automatic when you begin to feel stress or experience a lot of pressure.* *What do you say you try this for the next few months, and we revisit this the next time you come in?"*
Patient	*"This is bit stressful for me now, but I could see how it could help."*

The Suicide Behaviors Questionnaire-Revised (SBQ-R) Overview

The SBQ-R has four items, each tapping a different dimension of suicidality[1]

- Item 1 taps into lifetime ideation and/or suicide attempt.
- Item 2 assesses the frequency of suicidal ideation over the past 12.
- Item 3 assesses the threat of suicide attempt.
- Item 4 evaluates self-reported likelihood of suicidal behavior in the future.

Clinical Utility

Due to the wording of the four SBQ-R items, a broad range of information is obtained in a very brief administration. Reponses can be used to identify at-risk individual and specific risk behaviors.

Scoring

See scoring guideline on following page.

Psychometric Properties[1]	Cutoff score	Sensitivity	Specificity
Adult General Population	≥7	90%	95%
Adult Psychiatric Inpatients	≥8	80%	91%

SBQ-R Scoring

Item 1: Taps into lifetime suicide ideation and/or suicide attempts			
Selected response 1	Nonsuicidal subgroup	1 point	Total Points ______
Selected response 2	Suicide risk ideation subgroup	2 points	
Selected response 3a or 3b	Suicide plan subgroup	3 points	
Selected response 4a or 4b	Suicide attempt subgroup	4 points	

Item 2: Assesses the frequency of suicidal ideation over the past 12 months			
Selected Responses	Never	1 point	Total Points ______
	Rarely (1 time)	2 points	
	Sometimes (2 times)	3 points	
	Often (3–4 times)	4 points	
	Very Often (5 or more times)	5 points	

[1] Osman A., Bagge, C. L., Guitierrez, P. M., Kooper, B. A., & Barrios, F. X. (2001). The Suicidal Behaviors Questionnaire, Revised (SBQ-R): Validation with clinical and nonclinical samples. *Assessment, 5*, 443–454.

Item 3: Taps into the threat of suicide attempt		
Selected response 1	1 point	Total Points ______
Selected response 2a or 2b	2 points	
Selected response 3a or 3b	3 points	

Item 4: Evaluates self-reported likelihood of suicidal behavior in the future			
Selected Responses	Never	0 points	Total Points ______
	No chance at all	1 point	
	Rather unlikely	2 points	
	Likely	3 points	
	Unlikely	4 points	
	Rather unlikely	5 points	
	Very unlikely	6 points	
Sum all the scores circled/checked by the respondents. The total score should range from 3 to 18.			Total Points ______

AUC = Area Under the Receiver Operating Characteristics Curve; the area measures discrimination; that is, the ability of the test to correctly classify those with and without the risk (.90–1.0 = Excellent; .80–.90 = Good; .70–.80 = Fair, .60–.70 = Poor)

	Sensitivity	Specificity	PPV	AUC
Item 1: A cutoff score of ≥ 2				
Validation Reference: Adult Inpatient	0.80	0.97	0.95	0.92
Validation Reference: Undergraduate College	1.00	1.00	1.00	1.00
Total SBQ-R: A cutoff score of ≥ 7				
Validation Reference: Undergraduate College	0.93	0.95	0.70	0.96
Total SBQ-R: A cutoff score of ≥ 8				
Validation Reference: Adult Inpatient	.080	0.91	0.89	0.89

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SBQ-R: The Suicide Behaviors Questionnaire, Revised

Patient Name ______________________________ Date of Visit ______________________________

Instructions: Please check the number beside the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself? (check one only)

- ☐ 1. Never
- ☐ 2. It was just a brief passing thought
- ☐ 3a. I have had a plan at least once to kill myself but did not try to do it
- ☐ 3b. I have had a plan at least once to kill myself and really wanted to die
- ☐ 4a. I have attempted to kill myself but did not want to die
- ☐ 4b. I have attempted to kill myself and really hoped to die

2. Have you ever thought about or attempted to kill yourself? (check one only)

- ☐ 1. Never
- ☐ 2. Rarely (1 time)
- ☐ 3. Sometimes (2 times)
- ☐ 4. Often (3–4 times)
- ☐ 5. Very often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it? (Check one only)

- ☐ 1. No
- ☐ 2a. Yes, at one time but did not really want to die
- ☐ 2b. Yes, at one time and really wanted to die
- ☐ 4a. Yes, more than once but did not want to do it

- [ ] 4b. Yes, more than once and really wanted to do it

4. How likely is it that you will attempt suicide some day? (Check one only)

- [ ] 0. Never
- [ ] 1. No chance at all
- [ ] 2. Rather unlikely
- [ ] 3. Unlikely
- [ ] 4. Likely
- [ ] 5. Rather likely
- [ ] 6. Very likely

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SECTION 3. TECHNIQUES AND TOOLS SUPPORTING FIDELITY OF IMPLEMENTATION AND CLINICAL SUPERVISION

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

ADHERENCE TOOLS AND TECHNIQUES: CHECKLISTS

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

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

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

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

CLINICAL SUPERVISION TECHNIQUES TO IMPROVE ADHERENCE

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

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

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

The detailed supervision agenda below also integrates the use of new training technologies or short video clinical skills vignettes. There are many video resources available on the Web for illustrating MET and CBT clinical skills. This type of structured approach to clinical supervision clearly highlights the

focus on learning, practicing and monitoring competency in essential clinical strategies to improve outcomes.

STRUCTURED SUPERVISION MODEL

Step	
1 Step One	1. Build rapport; find out how things are going 2. Check in on patients, general 3. Is there a case they want to talk about owing to concerns? 4. Needs feedback for improvement?
2 Step Two	1. Assess patient and staff readiness By reviewing the clinician and adherence/competence checklists— 2. Talk about specifics of the clinical session work 3. What strategies have been delivered by staff? 4. What strategies will now be helpful to the patients?
3 Step Three	Choose from the list of strategies below. **Motivational Interviewing and Motivational Enhancement Therapy** ▸ Building rapport ▸ Collaboration ▸ Increasing change talk ▸ Working with resistance/unwillingness ▸ Providing feedback (severity, problems, reasons for quitting, motivation) ▸ Goal setting ▸ Generating commitment **Cognitive Behavioral Treatment Skills Development** ▸ Monitoring urges/cravings ▸ Awareness training ▸ Replacement activities ▸ Mindfulness ▸ Assertiveness ▸ Emotions

	- Managing thoughts - Social support - Problem solving - Medication - Self-help
4 Step Four	1. State, "Let's watch a video that applies to that patient needs" 2. Watch clinical skills video vignette (one or two) 3. Discuss the strategy or strategies and answer any questions 4. Role-play clinical skills 5. Discuss how staff will deliver the skills for the patient next week 6. State, "Let's discuss how to use this skill in the next week with this patient"
5 Step Five	1. Elicit a commitment to practice and deliver using clinical skills in next week 2. Staff commits to a specific date, time, and patient session

Continuing Structured Supervision

- Review the practice of skills in upcoming supervision
- Repeat steps one through five
- Try another video and skill

To summarize, while more studies are needed across all populations and types of disorders, it is evident that factors affecting implementation and dissemination in delivering ICBT and any evidence-based practice require attention from providers and supervisors. All developers of evidence-based practices fear the pressures of "real-world" demands, including workforce factors (education, attitude, experience, turnover) and organizational factors (increasing caseloads, billing mandates, record keeping), and the like will override the importance of fidelity.

The word "drift" is used to describe the difference between the intended delivery of techniques and tools in a guide or manual and the actual delivery. The ICBT tools and techniques offered in this section, along with the technical assistance available (Web-based and onsite training), should provide sufficient user-friendly resources to thwart drift and facilitate implementation and dissemination. As with any guide or manual, the feedback from clinicians and others using ICBT will be critical to ICBT's ultimate success in helping brief treatment become a routine practice to enhance the quality of patient care.

BRIEF TREATMENT CLINICIAN CHECKLIST PROTOCOL

Brief treatment clinicians are encouraged to complete a brief checklist following each ICBT session. This checklist inquires about aspects of the session from the clinician's perspective and can be used to self-monitor the quality of delivery of ICBT and as a tool in supervision.

HOW TO COMPLETE THE CLINICIAN CHECKLIST

1. **Patient identification (ID)**: This ID consists of the initials for your site and a number corresponding to the patient referred to you. Assign the number based on which patient you are working with. Please keep track of this number/ID in your records by keeping a sheet that lists the name of the patient and this ID.
2. **Clinician ID**: Insert first initial and last name (e.g., GWASHINGTON).
3. **Date of session**: Use the following format for recording the date: MM/DD/YYYY.
4. **Approximate length of session**: Record the number of minutes you met with the patient.
5. **Session conducted**: Please check **(✓)** the session that was conducted with the patient. If you planned to conduct a particular session (e.g., session 1) but needed to respond to an urgent situation or crisis, indicate this by checking the "other" space and then describe.
6. **Please indicate which elements were used in your session:** Check **(✓)** the strategies or elements that were used during the session with the patient.
7. **Please indicate your experience during the session with patient:** Circle the number that corresponds closest to your experience.
8. For these items, use the Likert scale (from 1 to 5) to describe your experience with the patient during the session. Each item asks about an aspect clinicians are often able to describe regarding a session with a patient. We are interested in (1) how engaged you felt with the patient during the session, (2) how well you felt you and the patient were working together, (3) how smoothly you felt the session went, (4) your subjective sense about whether the patient benefited from the work during the session, and (5) your sense of ease with incorporating the BT material with this patient during this session.
9. Finally, if you have any other comments to add about the session, please describe in the space provided.

ICBT Clinician Checklist

(based on today's session)

1. Patient ID: ________________________________ **2. Clinician ID**: ________________

3. Date of Session: ________________________ **4. Approximate Length** _______ Minutes

5. Please check ("√") which session you conducted today:

- ☐ MET1, Life Movie
- ☐ MET2, Awareness Record
- ☐ MET3, Social Support
- ☐ CBT, Awareness
- ☐ CBT, Just Thoughts
- ☐ CBT Problem-Solving
- ☐ CBT, Urges/Cravings
- ☐ CBT, Assertiveness
- ☐ CBT, Emotions
- ☐ CBT, Mindfulness
- ☐ CBT, Wellness Planning
- ☐ CBT, Replacement Activities
- ☐ Self-help
- ☐ Medication
- ☐ Other, describe:____

6. Please check ("√") any of the following that were elements of your session with this patient:

- ☐ Life Movie
- ☐ Awareness Record
- ☐ Supporter/ Family member
- ☐ Emotions
- ☐ Mindfulness or meditation
- ☐ Reviewed information on cravings/coping
- ☐ Thoughts/ cognitive distortions
- ☐ Problem solving
- ☐ Assertiveness
- ☐ Plan for handling a high-risk situation
- ☐ Plan for coping with a lapse or slip
- ☐ Gave between-session challenge
- ☐ Discussed termination issues
- ☐ Provided referral information
- ☐ Addressed a crisis with patient
- ☐ Thoughts about alcohol/substance use

7. Indicate your experience of the session with the patient (circle number that best fits):

I felt engaged in session with patient — I felt somewhat removed

1 2 3 4 5

Patient and I seemed to be working well — Patient and I had difficulty connecting

1 2 3 4 5

The session went smoothly				The session felt fragmented
1	2	3	4	5

Patient seemed to benefit from session				I'm not sure whether patient benefited
1	2	3	4	5

It was relatively easy to incorporate ICBT material				Was difficult to incorporate ICBT material
1	2	3	4	5

8. Comments

ADHERENCE/COMPETENCE CHECKLIST PROTOCOL

This checklist provides a succinct method for evaluating the extent to which the essential elements of each session are delivered. Both clinical supervisors and clinicians will find it a useful tool in helping to provide specific direction for how the session should be delivered to avoid drift. Many clinicians print these checklists prior to delivering the session and use them as agendas to check as they go through each activity. Clinical supervisors are advised to complete the *Adherence/Competence* checklist following review of any session recorded. As the supervision agenda above illustrates, the tool can also be used for ongoing supervision/training in both individual and group formats. The following recommendations may help supervisors discuss and review competency:

1. Focus first on the clinician's strengths in delivering the session.
2. Discuss the therapeutic alliance and patient factors, such as engagement, readiness, and motivation.
3. Next, describe the overall quality in delivering the basic structure of the session including the 20/20/20 rule, providing rationales, teaching/transferring main skill, skill demonstration and practice, eliciting commitment to practice between sessions, etc.
4. Use the competency ratings for each specific element (checklist row) to provide feedback on how to further refine the technique.
5. Teach through written examples, video examples, and role-plays.
6. Elicit a commitment to incorporate feedback in upcoming sessions.

Adherence and Competence Checklists

ICBT Session 1: Eliciting the Life Movie Adherence and Competence Checklist

Client ID ______________________ Date ____________

To what extent did you demonstrate the following:	Extensively	Sufficiently	Missed Opportunity
1. Building rapport between clinician and patient	☐	☐	☐
2. Review Treatment Information sheet and discuss expectations	☐	☐	☐
3. Orient patient to session agenda and rationale for session activity	☐	☐	☐
4. Facilitate the “Life Movie” discussion, exploring multiple domains of the patient’s life	☐	☐	☐
5. Explore the patient attitudes about change, including ambivalent attitudes	☐	☐	☐
6. Affirming readiness for change and change strategies	☐	☐	☐
7. Summarize the “Life Movie” discussion, emphasizing change talk and patient values that support change	☐	☐	☐
8. Negotiate between-session challenge focused on having patient complete the “Change Plan” handout and/or commit to using or engaging 1-2 coping strategies	☐	☐	☐
9. Summarize motivation, review, and conclude session	☐	☐	☐

MI Skills and Strategies Practiced

To what extent did you demonstrate the following:	Extensively	Sufficiently	Missed Opportunity
1. MI Spirit (evocation, collaboration, compassion, autonomy)	☐	☐	☐
2. OARS (including complex reflections)	☐	☐	☐
3. Change talk strategies (used 1 or more of pros & cons, readiness rulers, looking forward/backward, going to extremes)	☐	☐	☐
4. Ratio of clinician-to-patient talk	70/30	50/50	30/70

Comments ______________________________

Name ______________________________

Reviewer ______________________ Date ____________

ICBT Session 2—16
Fidelity Monitoring Form

Client ID ______________________________ Date ______________

To what extent did you demonstrate the following:	Extensively	Sufficiently	Missed Opportunity
1. Strengthen Rapport	☐	☐	☐
2. Review of Progress	☐	☐	☐
3. Review of Between-Session Challenge	☐	☐	☐
4. Provide Rationale	☐	☐	☐
5. Teach Session Skill	☐	☐	☐
6. Clinician-Led Demonstration/Role Play	☐	☐	☐
7. Patient-Led Practice (Assess Skills Transfer)	☐	☐	☐
8. Identify Real-World Application	☐	☐	☐
9. Negotiate and Prepare Between-Session Challenge	☐	☐	☐
10. Elicit Commitment	☐	☐	☐
11. Summarize and Conclude the Session	☐	☐	☐

MI Skills and Strategies Practiced

As a reminder, consider to what degree you demonstrated the following:

- MI Spirit (evocation, collaboration, compassion, autonomy)
- OARS (including complex reflections)
- Change talk strategies (used 1 or more of pros & cons, readiness rulers, looking forward/backward, going to extremes)
- Ratio of clinician-to-patient talk: Goal 70/30

Comments ______________________________

Name ______________________________

Reviewer ______________________________ Date ______________

REFERENCES

Agostinelli, G., Brown, J. M., & Miller, W. R. (1995). Effects of normative feedback on consumption among heavy drinking college students. *Journal of Drug Education, 25*(1), 31–40.

Alegria, M., Atkins, M., Farmer, E., Slaton, E., & Stelk, W. (2010). One size does not fit all: taking diversity, culture and context seriously. *Administration and Policy in Mental Health and Mental Health Services Research, 37*(1), 48–60. https://doi.org/10.1007/s10488-010-0283-2

Alegria, M., Chatterji, P., Wells, K., Cao, Z., Chen, C. N., Takeuchi, D., Jackson, J., & Meng, X. L. (2008). Disparity in depression treatment among racial and ethnic minority populations in the United States. *Psychiatric Services, 59*(11), 1264–1272. https://doi.org/10.1176/ps.2008.59.11.1264

Alegria, M., Nakash, O., Johnson, K., Ault-Brutus, A., Carson, N., Fillbrunn, M., Wang, Y., Cheng, A., Harris, T., & Polo, A. (2018). Effectiveness of the decide interventions on shared decision making and perceived quality of care in behavioral health with multicultural patients: A randomized clinical trial. *JAMA Psychiatry, 75*(4), 325–335. doi:10.1001/jamapsychiatry.2017.4585

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed., Vol. 21). https://www.psychiatry.org/psychiatrists/practice/dsm

Anonymous. (2001). *Alcoholics Anonymous: The story of how many thousands of men and women have recovered from alcoholism* (4th ed.). New York, NY: Alcoholics Anonymous World Services.

Arkowitz, H., Westra, H. A., Miller, W. R., & Rollnick, S. (2008). *Motivational interviewing in the treatment of psychological problems*. New York, NY: Guilford Press.

Azrin, N. H., Sisson, R. W., Meyers, R., & Godley, M. D. (1982). Alcoholism treatment by disulfiram and community reinforcement therapy. *Journal of Behavior Therapy and Experimental Psychiatry, 13*, 105–112.

Baker, A. L., Thornton, L. K., Hiles, S., Hides, L., & Lubman, D. I. (2012). Psychological interventions for alcohol misuse among people with co-occurring depression or anxiety disorders: A systematic review. *Journal of Affective Disorders 139*(3), 217–229.

Barlow, D., (2008). *Clinical handbook of psychological disorders: A step-by-step treatment manual* (4th ed.). New York, NY: Guilford Press.

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

Betancourt, J. R. (2003). Cross-cultural medical education: Conceptual approaches and frameworks for evaluation. *Academic Medicine, 78*(6), 560–569. https://psycnet.apa.org/doi/10.1097/00001888-200306000-00004

Bowers, T. G., & Al-Redha, M. R. (1990). A comparison of outcome with group/marital and standard/individual therapies with alcoholics. *Journal of Studies on Alcohol, 51,* 301–309.

Buber, M. (1971). *I and thou.* (W. Kaufman, Trans.). New York, NY: Scribner's.

Buckner, J. D., D. R., Heimberg, R. G., & Schmidt, N. B. (2008). Treating comorbid social anxiety and alcohol use disorders: Combining motivation enhancement therapy with cognitive-behavioral therapy. *Clinical Case Studies* 7(3), 208–223.

Carroll, C., Patterson, M., Wood, S., Booth, A., Rick, J., & Balain, S. (2007). A conceptual framework for implementation fidelity**.** *Implementation Science, 2*, 40.

Carroll, K. M. (1996). Relapse prevention as a psychosocial treatment: A review of controlled clinical trials. *Experimental and Clinical Psychopharmacology, 4*(1), 46–54.

Carroll, K. M. (1998). *A cognitive-behavioral approach: Treating cocaine addiction.* Manual 1: Therapy Manuals for Drug Addiction Series. NIH Publication No. 94–4308. Rockville, MD: National Institute on Drug Abuse. Retrieved from http://www.drugabuse.gov/txmanuals/cbt/CBT1.html

Chorpita, B. F., Daleiden, E., & Weisz, J. R. (2005). Identifying and selecting the common elements of evidence-based interventions: A distillation and matching model. *Mental Health Services Research, 7*, 5–20.

Chorpita, B. F., & Regan, J. (2009). Dissemination of effective mental health treatment procedures: Maximizing the return on a significant investment. *Behaviour Research and Therapy, 47,* 990–993.

Colby, S. L., & Ortman, J. M. (2015). Projections of the size and composition of the U.S. population: 2014 to 2060. Population estimates and projections. *Current Population Reports*. P25-1143. U.S. Census Bureau. https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf

Cooke, R. A., & Szumal, J. L. (1993). Measuring normative beliefs and shared behavioral expectations in organizations: The reliability and validity of the Organizational Culture Inventory. *Psychological Reports, 72*(3_suppl), 1299–1330. https://doi.org/10.2466%2Fpr0.1993.72.3c.1299

Cornelius, J. R., Douaihy, A., Bukstein, O. G., Daley, D. C., Wood, D. S., Kelly, T. M., & Salloum, I. M. (2011). Evaluation of cognitive behavioral therapy/motivational enhancement therapy (CBT/MET) in a treatment trial of comorbid MDD/AUD adolescents. *Addictive Behaviors 36*(8), 843–848.

Cottler, L. B., Compton, W. M., Mager, D., Spitznagel, E. L., & Janca, A. (1992). Posttraumatic stress disorder among substance users from the general population. *American Journal of Psychiatry*, 149(5), 664–670.

CSAT (Center for Substance Abuse Treatment). (1999). *Brief interventions and brief therapies for substance abuse*. Treatment Improvement Protocol (TIP) Series 34. HHS Publication No. (SMA) 99-3353. Rockville, MD: Substance Abuse and Mental Health Services Administration.

CSAT (Center for Substance Abuse Treatment). (2011). *Medication-assisted treatment for opioid addiction*. HHS Publication No. (SMA) 09-4443. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Davis, T. M., Baer, J. S., Saxon, A. J., & Kivlahan, D. R. (2003). Brief motivational feedback improves post-incarceration treatment contact among veterans with substance use disorders. *Drug and Alcohol Dependence, 69,* 197–203.

Dennis, M. L., & Scott, C. K. Managing addiction as a chronic condition. (2007). *Addiction Science and Clinical Practice, 4*(1), 45–55.

Diagnostic and Statistical Manual of Mental Disorders. (2013). 5th Ed. American Psychiatric Publishing.

DiClemente, C. C. (2006). Natural change and the troublesome use of substances: A life-course perspective. In W. R. Miller & K. Carroll (Eds.). *Rethinking substance abuse: What the science shows, and what we should do about it.* New York, NY: Guilford Press.

Drake, R. E., & Wallach, M. A. (2008). Conceptual models of treatment for co-occurring substance use. *Mental Health and Substance Use: Dual Diagnosis 1*(3), 189–193.

D'Zurilla, T. J., & Goldfried, M. R. (1971). Problem solving and behavior modification. *Journal of Abnormal Psychology, 78*(1), 107–26.

Emery, G. (1981). Cognitive therapy with the elderly. In G. Emery, S. D. Hollon, & R. C. Bedrosian (Eds.). *New directions in cognitive therapy* (pp. 84–98). New York, NY: Guilford Press.

Frederickson, B. (2000). Cultivating positive emotions for optimizing health and well-being. *Prevention and Treatment, 3*.

Freedman, D. A. (1999). Ecological inference and the ecological fallacy. *International Encyclopedia of the Social & Behavioral Sciences, 6*(4027-4030), 1–7. https://www.stat.berkeley.edu/users/census/549.pdf

Gainsbury, S. M. (2017). Cultural competence in the treatment of addictions: Theory, practice and evidence. *Clinical Psychology & Psychotherapy, 24*(4), 987–1001. https://doi.org/10.1002/cpp.2062

Glasner-Edwards, S., Tate, S. R., McQuaid, J. R., Cummins, K., Granholm, E., & Brown, S. A. (2007). Mechanisms of action in integrated cognitive-behavioral treatment versus twelve-step facilitation for substance-dependent adults with comorbid major depression. *Journal of Studies on Alcohol & Drugs* 68(5), 633–672.

Goleman, D. (Ed.). (2003). *Healing emotions: Conversations with the Dalai Lama on mindfulness, emotions, and health.* Boston and London: Shambala Publishing.

Granholm, E., Tate, S. R., Link, P. C., Lydecker, K. P., Cummins, K. M., McQuaid, J., … Brown, S. A. (2011). Neuropsychological functioning and outcomes of treatment for co-occurring depression and substance use disorders. *American Journal of Drug and Alcohol Abuse 37*(4), 240–249.

Grant, B. F., Dawson, D. A., Stinson, F. S., Chou, S. P., Dufour, M. C., & Pickering, R. P. (2004). The 12-month prevalence and trends in DSM-IV alcohol abuse and dependence: United States, 1991–1992 and 2001–2002. *Drug and Alcohol Dependence*, 74(3), 223–234.

Hamblen, J. L., Schnurr, P. P., Rosenberg, A., & Eftekhari, A. (2010). *Enhancing PTSD treatment and delivery*. National Center for PTSD, U.S. Department of Veterans Affairs. Retrieved from http://www.ptsd.va.gov/professional/pages/enhancing-ptsd-treatment.asp)

Hepner, K. A., Hunter, S. B., Paddock, S. M., Zhou, A., & Watkins, K. E. (2011). Training addiction counselors to implement CBT for depression. *Administration & Policy in Mental Health & Mental Health Services Research 38*(4), 313–323.

Hien, D. A., Wells, E. A., Jiang, H., Suarez-Morales, L., Campbell, A. N. Cohen, L. R, … Nunes, E. V. (2009). Multisite randomized trial of behavioral interventions for women with co-occurring PTSD and substance use disorders. *Journal of Consulting and Clinical Psychology 77*(4), 607–619.

Hobbs, J. D. J., Kushner, M. G., Lee, S., Reardon, S. M., & Maurer, E. (2011). Meta-analysis of supplemental treatment for depressive and anxiety disorders in patients being treated for alcohol dependence. *American Journal on Addictions 20*(4), 319–329.

Hoge, C. W., Auchterlonie, J. L., & Milliken, C. S. (2006). Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *Journal of the American Medical Association, 295*, 1023–1032.

Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine, 351*, 13–22.

Hoppes, K. (2006). The application of mindfulness-based cognitive interventions in the treatment of co-occurring addictive and mood disorders. *CNS Spectrums 11*(11), 829–851.

Huey Jr., S. J., Tilley, J. L., Jones, E. O., & Smith, C. A. (2014). The contribution of cultural competence to evidence-based care for ethnically diverse populations. *Annual Review of Clinical Psychology, 10*, 305–338. https://doi.org/10.1146/annurev-clinpsy-032813-153729

Hunter, S. B., Watkins, K. E., Hepner, K. A., Paddock, S. M., Ewing, B. A., Osilla, K. C., & Perry, S. (2012). Treating depression and substance use: a randomized controlled trial. *Journal of Substance Abuse Treatment 43*(2): 137–151.

Jacobsen, L. K., Southwick, S. M., & Kosten, T. R. (2001). Substance use disorders in patients with posttraumatic stress disorder: A review of the literature. *American Journal of Psychiatry, 158*, 1184–1190.

Jani, J. S., Ortiz, L., & Aranda, M. P. (2009). Latino outcome studies in social work: A review of the literature. *Research on Social Work Practice, 19*(2), 179–194. https://doi.org/10.1177%2F1049731508315974

Jankowski, K. (2013). *PTSD and physical health*. National Center for PTSD, U.S. Department of Veterans Affairs. Retrieved from www.ptsd.va.gov/professional/pages/ptsd-physical-health.asp

Jimenez, D. E., Cook, B., Bartels, S. J., & Alegría, M. (2013). Disparities in mental health service use of racial and ethnic minority elderly adults. *Journal of the American Geriatrics Society, 61*(1), 18–25. https://doi.org/10.1111/jgs.12063

Juarez, P., Walters, S. T., Daugherty, M., & Radi, C. (2006). A randomized trial of motivational interviewing and feedback with heavy drinking college students. *Journal of Drug Education, 36*(3), 233–246.

Kadden, R. M., Litt, M. D., & Cooney, N. L. (1994). Matching alcoholics to coping skills or interactional therapies: Role of intervening variables. *Annals of the New York Academy of Sciences, 708,* 218–29.

Kelly, J. F., & Yeterian, J. D. (2011). The role of mutual-help groups in extending the framework of treatment. *Alcohol Research and Health, 33*(4), 350–5.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 592–602.

Kessler, R. C., Chiu, W. T., Demler, O., Merikangas, K. R., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62,* 617–627.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52*, 1048–1060.

Kushner, M. G., Donahue, C., Sletten, S., Thuras, P., Abrams, K., Peterson, J., & Frye, B. (2006). Cognitive behavioral treatment of comorbid anxiety disorder in alcoholism treatment patients: Presentation of a prototype program and future directions. *Journal of Mental Health, 15*(6), 697–707.

Kushner, M. G., Maurer, E. W., Thuras, P., Donahue, C., Frye, B., Menary, K. R., … Van Demark, J. (2013). Hybrid cognitive behavioral therapy versus relaxation training for co-occurring anxiety and alcohol disorder: A randomized clinical trial. *Journal of Consulting and Clinical Psychology 81*(3), 429–442.

Kushner, M. G., Sletten, S., Donahue, C., Thuras, P., Maurer, E., Schneider, A., … Van Demark, J. (2009). Cognitive-behavioral therapy for panic disorder in patients being treated for alcohol dependence: Moderating effects of alcohol outcome expectancies. *Addictive Behaviors 34*(6–7), 554–560.

Leahy, R. (1996). *Cognitive therapy: Basic principles and applications*. New York: Jason Aronson.

Leake, G. J., & King, A. S. (1977). Effect of counselor expectations on alcoholic recovery. *Alcohol*

Lecrubier, Y. (2004). Posttraumatic stress disorder in primary care: A hidden diagnosis. *Journal of Clinical Psychiatry, 65*(Suppl1), 49–54. *Health and Research World, 11*, 16–22.

Longabaugh, R., Zweben, A., LoCastro, J. S., & Miller, W. (2005). Origins, issues and options in the development of the combined behavioral intervention. *Journal of Studies on Alcohol (Suppl. 15)*, 179–187.

López, S. R., & Guarnaccia, P. J. (2005). Cultural dimensions of psychopathology: The social world's impact on mental illness. In J. E. Maddux & B. A. Winstead (Eds.), *Psychopathology: Foundations for a contemporary understanding* (pp. 19–37). Lawrence Erlbaum Associates Publishers.

Magill, M., & Ray, L. A. (2009). Cognitive-behavioral treatment with adult alcohol and illicit drug users: A meta-analysis of randomized controlled trials. *Journal of Studies on Alcohol and Drugs, 70*(4), 516–527.

Marcus, D. A. (2009). *Chronic pain: A primary care guide to practical management* (2nd ed.). Totowa, NJ: Humana Press.

Marlatt, G. A., & Gordon, J. R. (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors*. New York, NY: Guilford Press.

Marlatt, G. A. (1996). Taxonomy of high-risk situations for alcohol relapse: Evolution and development of a cognitive-behavioral model. *Addiction, 91*(Suppl.), 37–49.

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

Marmot, M., & Wilkinson, R. (2005). *Social determinants of health*. Oup Oxford.

Martino, S. (2010). Strategies for training counselors in evidence-based treatments. *Addiction Science and Clinical Practice, 5*(2), 30–39.

McCrady, B. S., Noel, N. E., Stout, R. L., Abrams, D. B., & Nelson, H. F. (1991). Effectiveness of three types of spouse-involved behavioral alcoholism treatment: Outcome 18 months after treatment. *British Journal of Addictions, 86*, 1415–1424.

McFall, M., Malte, C., Fontana, A., & Rosenheck, R. A. (2000). Effects of an outreach intervention on use of mental health services by veterans with posttraumatic stress disorder. *Psychiatric Services, 51,* 369–374.

McGovern, M. P., Lambert-Harris, C., Acquilano, S., Haiyi, X., Alterman, A., & Weiss, R. D. (2009). A cognitive behavioral therapy for co-occurring substance use and posttraumatic stress disorders. *Addictive Behaviors 34*(10), 892–897.

McGovern, M. P., Lambert-Harris, C., Alterman, A. I., Haiyi, X., & Meier, A. (2011). A randomized controlled trial comparing integrated cognitive behavioral therapy versus individual addiction counseling for co-occurring substance use and posttraumatic stress disorders. *Journal of Dual Diagnosis 7*(4), 207–227.

McGovern, M. P., & Stecker, T. (2011). Co-occurring substance use and posttraumatic stress disorders: reasons for hope. *Journal of Dual Diagnosis, 7(4)*, 187–193.

Meichenbaum, D. (2007). Stress inoculation training: A preventative and treatment approach. In P. Leher, R. Woolfork, & W. Sime (Eds.). *Principles and practices of stress management* (3rd ed.). New York, NY: Guilford Press.

Miller, W. R., Benefield, R. G., & Tonigan, J. S. (1993). Enhancing motivation for change in problem drinking: A controlled comparison of two therapist styles. *Journal of Consulting and Clinical Psychology, 61*(3), 455–61.

Miller, W. R., & Carroll, K. M. (Eds.) (2006). *Rethinking substance abuse: What the science shows, and what we should do about it.* NY: Guilford Press.

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

Miller, W. R., Yahne, C., Moyers, T., Martinez, J., & Pirritano, M. (2004). A randomized trial of methods to help clinicians learn motivational interviewing. *Journal of Consulting and Clinical Psychology, 72*(6), 1050–1062.

Monti, P. M., Abrams, D. B., Kadden, R. M., & Cooney, N. L. (1989). *Treating alcohol dependence*: *A coping skills training guide*. New York, NY: Guilford Press.

Monti, P. M., Kaden, R., Rohsenow, D. J., Cooney, N., & Abrams, D. (2002). *Treating alcohol dependence*: A *coping skills training guide* (2nd ed.). New York, NY: Guilford Press.

Moyers, T. B., & Huck, J. (2011). Combining motivational interviewing with cognitive-behavioral treatments for substance abuse: Lessons from the COMBINE Research Project. *Cognitive and Behavioral Practice, 18*(1), 38–45.

Muck, R., & Dennis, M. (2011). Toward effective quality assurance in evidence-based practice: Links between expert consultation, clinician fidelity, and child outcomes. *Journal of Child and Adolescent Psychology, 33*(1), 393–407.

Mueser, K. T., Jankowski, M. K., Rosenberg, H. J., Rosenberg, S. D., & Hamblen, J. L. (2004). *Cognitive-behavior therapy for PTSD in adolescents*. Provider manual. Lebanon, NH: Medical School and New Hampshire-Dartmouth Psychiatric Research Center.

Murphy, R. T., Thompson, K. E., Rainey, Q., & Murray, M. (2004). *Early results from an ongoing randomized trial of the PTSD ME Group*. Poster presented at the annual meeting of the International Society for Traumatic Stress Studies, New Orleans, LA.

Nakash, O., & Saguy, T. (2015). Social identities of clients and therapists during the mental health intake predict diagnostic accuracy. *Social Psychological and Personality Science, 6*(6), 710–717. https://doi.org/10.1177%2F1948550615576003

National Institute of Mental Health. (2012). *Mental health medications*. NIH Publication No. 12–3929. Bethesda, MD: National Institutes of Health, U.S. Department of Health and Human Services.

O'Farrell, T. J., Cutter, H. S. G., Choquette, K. A., Floyd, F. J., & Bayog, R. D. (1992). Behavioral marital therapy for male alcoholics: Marital and drinking adjustment during the two years after treatment. *Behavior Therapy*, 23, 529–549.

O'Farrell, T. J., & Fals-Stewart, W. (2006). *Behavioral couples therapy for alcoholism and drug abuse.* New York, NY: Guilford Press.

Prochaska, J., & DiClemente, C. (1998). Toward a comprehensive, transtheoretical model of change. In W. Miller & N. Heather (Eds.). *Treating addictive behaviours*. New York, NY: Plenum Press.

Regier, D. A., Farmer, M. E., Rae, D. S., Locke, B. Z., Keith, S. J., Judd, L. L., & Goodwin, F. K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse: Results from the Epidemiologic Catchment Area (ECA) Study. *JAMA 264*(19), 2511–2518.

Rosenfield, L. (2020). Unraveling cultural countertransference: The experience of Caucasian therapists working with Asian-American adults. *Psychoanalytic Social Work, 27*(1), 61–82. https://doi.org/10.1080/15228878.2020.1712660

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

Schillinger, D. (2010). *An introduction to effectiveness, dissemination, and implementation research*. P. Fleisher & E. Goldstein (Eds.). Clinical Translational Science Institute, Community Engagement Program. San Francisco: University of California San Francisco.

Schoenwald, S. K., Chapman, J. E., Sheidow, A. J., & Carter, R. E. (2009). Long-term youth criminal outcomes in MST transport: The impact of therapist adherence and organizational climate and structure. *Journal of Clinical Child Adolescent Psychology, 38*(1), 91–105.

Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine, 166*(10), 1092–1097.

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

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*(4), 477–486. https://doi.org/10.1002/j.1556-6676.1992.tb01642.x

U.S. Department of Health and Human Services (HHS), National Institute of Mental Health (NIMH). (1999). *Mental health: A report of the Surgeon General.* https://profiles.nlm.nih.gov/spotlight/nn/catalog/nlm:nlmuid-101584932X120-doc

U.S. HHSs, NIMH. (2001). *Mental health: Culture, race and ethnicity. A supplement to mental health: A report of the Surgeon General*. https://pubmed.ncbi.nlm.nih.gov/20669516/

Webb, C., DeRubeis, R., & Barber, J. (2010). Clinician adherence/competence and treatment outcome: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 78*, 200–211.

Wilson, S. J., & Lipsey, M. W. (2005). The effectiveness of school-based violence prevention programs for reducing disruptive and aggressive behavior. Washington, DC: U.S. Department of Justice. Unpublished report. Available at https://www.ncjrs.gov/pdffiles1/nij/grants/211376.pdf

Witkiewitz, K., Marlatt, G. A., & Walker, D. (2005). Mindfulness-based relapse prevention for alcohol and substance use disorders. *Journal of Cognitive Psychotherapy, 19*(3), 211–228.