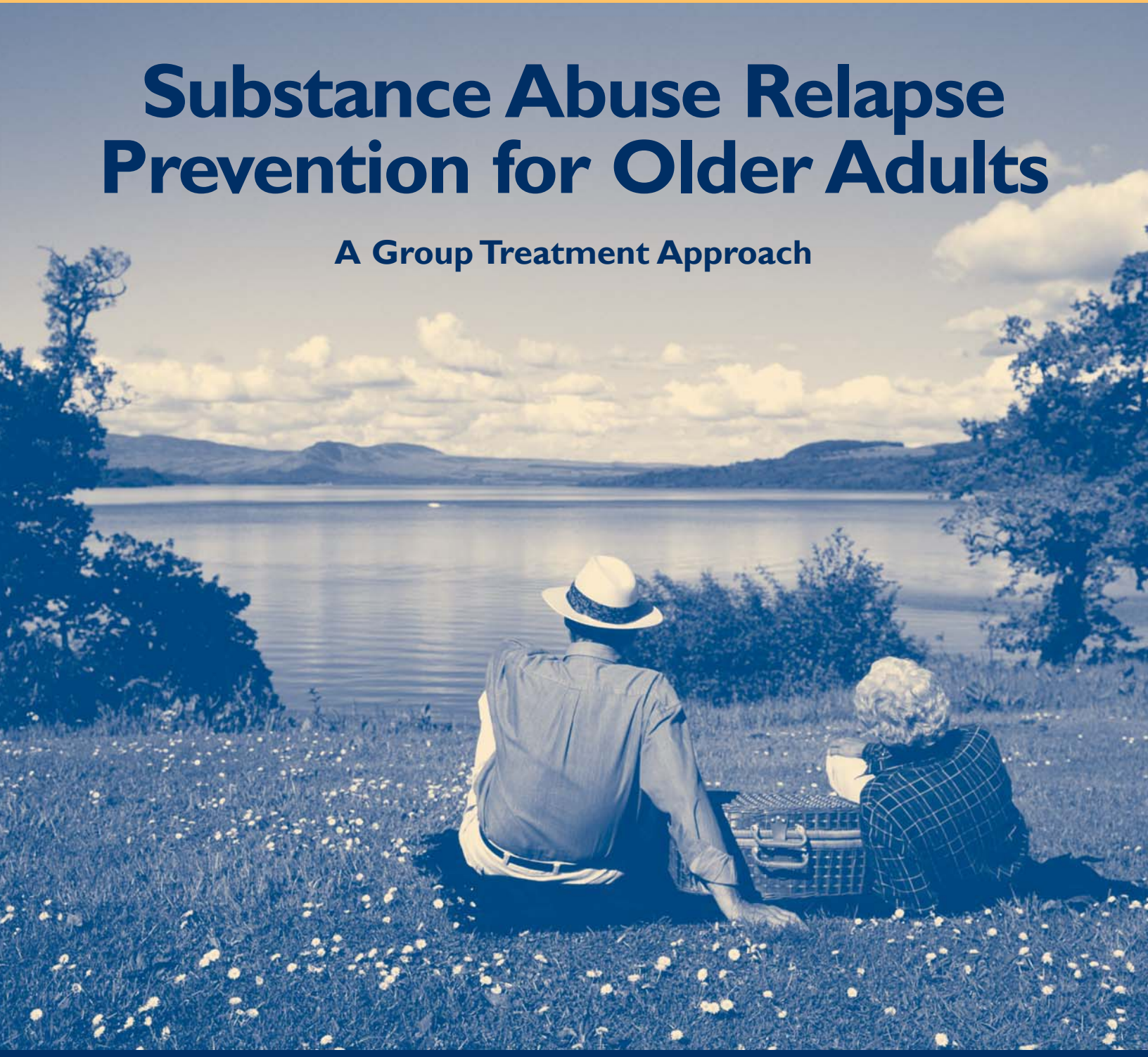
Substance Abuse Relapse Prevention for Older Adults

A Group Treatment Approach



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
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Acknowledgments

The document was written by Larry W. Dupree, Ph.D., and Lawrence Schonfeld, Ph.D., Department of Aging and Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa. It was prepared for publication for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Johnson, Bassin & Shaw, Inc. (JBS), under Knowledge Application Program (KAP) contract number 270-04-7049 with SAMHSA's Center for Substance Abuse Treatment (CSAT), U.S. Department of Health and Human Services (DHHS). Christina Currier served as the CSAT Government Project Officer. Lynne McArthur, M.A., A.M.L.S., served as the JBS KAP Executive Project Co-Director, and Barbara Fink, R.N., M.P.H., served as the JBS KAP Managing Project Co-Director. Other JBS KAP personnel included Dennis Burke, M.S., M.A., Deputy Director for Product Development; Debra Schiebel, M.S., Senior Writer; Wendy Caron, Editorial Quality Assurance Manager; Frances Nebesky, M.A., Quality Control Editor; Leah Bogdan, Junior Editor; Pamela Frazier, Document Production Specialist; and Andrew Bailey, Graphic Artist. The manual was field reviewed by substance abuse counselors and treatment providers. A list of reviewers is in appendix C.

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Recommended Citation

Center for Substance Abuse Treatment. *Substance Abuse Relapse Prevention for Older Adults: A Group Treatment Approach*. DHHS Publication No. (SMA) 05-4053. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

Originating Office

Practice Improvement Branch, Division of Services Improvement, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 1 Choke Cherry Road, Rockville, MD 20857.

DHHS Publication No. (SMA) 05-4053
Printed 2005

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I. Introduction and Overview

Introduction

This manual presents a relapse-prevention approach that uses the cognitive–behavioral and self-management intervention (CB/SM) in a counselor-led group treatment setting to help older adults overcome substance use disorders. It is for counselors and other treatment providers working with older adults who have substance use disorders. (For simplicity, "counselor" refers to any staff member who uses the manual for its intended purpose, and "CB/SM" refers to the specific forms and combination of cognitive–behavioral and self-management treatment approaches described in this manual for use with older adult clients.)

CB/SM has been used by counselors from a range of backgrounds and professional disciplines, including social workers, peer counselors, addiction counselors, nurses, and psychologists. Although the primary intended audience for this manual is counselors in substance abuse treatment programs, others such as primary care clinicians, social workers, and senior center staff who have regular contact with older adults may find the manual useful. Minimal requirements for counselors using CB/SM are provided in Section III.

Although CB/SM was designed for use in outpatient group treatment settings, it can be adapted for use in other types of treatment for older adults, including individual counseling sessions, and in a variety of settings, such as inpatient, outpatient, or intensive outpatient treatment settings. CB/SM is flexible enough to be used regardless of an older adult's level of substance use or particular antecedents to use. However, as discussed under Scope of This Manual and CB/SM (below), CB/SM should be used within a comprehensive care program that includes appropriate assessment, determination of level-of-care needs, comprehensive treatment planning, and treatment of co-occurring physical and mental disorders along with substance use disorders.

Before a client begins CB/SM group sessions, he or she completes a structured interview called the Substance Abuse Profile for the Elderly (SAPE) (appendix A). The results of SAPE are used to identify the client's unique relapse antecedents. Later, the counselor tailors the CB/SM group sessions to address each group member's needs identified by SAPE. The group sessions are tailored to recall factors about each participant's substance use disorder that affect his or her risk of relapse. CB/SM is used as a tool to facilitate individual recovery from substance use disorders in a group setting.

Scope of This Manual and CB/SM

This manual is not a comprehensive substance abuse treatment guide. Instead, it provides background and how-to directions for introducing relapse-prevention techniques to older clients. Another publication from the Substance Abuse and Mental Health Services Administration (SAMHSA), Treatment Improvement Protocol (TIP) 26, *Substance Abuse*

Among Older Adults (Center for Substance Abuse Treatment 1998), presents comprehensive evidence-based information about treating older adults with substance use disorders. The section Additional Resources (below) provides a list of other SAMHSA resources with information on this treatment population.

The treatment approach and main goals of CB/SM are clear:

- To engage and support clients as they receive skills training, using CB/SM
- To analyze, understand, and control the day-to-day factors that have led clients to abuse substances

Clients in CB/SM are not terminated from treatment if they have a slip; instead, recommendations to discharge clients from CB/SM usually are based on clients' successful acquisition and use of the skills taught. Clients demonstrate mastery of these skills by

- Being able to diagram, understand, and prevent or interrupt their individual substance use behavior chains
- Using the appropriate skills learned in treatment sessions to manage high-risk situations in real life

Typically, as clients learn to manage the antecedents (i.e., situations, thoughts, feelings, cues, urges) that trigger their substance abuse, they can maintain their abstinence.

Each client needs a comprehensive care program to support or reinforce the work of the CB/SM sessions. Counselors need to follow their facility's intake and admission procedures for each client and perform a comprehensive admission assessment, determine the appropriate level of care, and arrange appropriate referrals if necessary. Clients should be assessed for polydrug use, severe medical or mental conditions, and severe withdrawal symptoms that may necessitate medical detoxification. (More information on detoxification is available in the forthcoming TIP *Detoxification and Substance Abuse Treatment* [Center for Substance Abuse Treatment in development].) Although CB/SM sessions address use of alcohol and illicit drugs and misuse of medications, these sessions are not designed as stand-alone treatment for older clients with severe addictions to these substances, those with social anxiety disorders severe enough to prevent participation in group sessions, or individuals with acute psychological or cognitive disorders that prevent full treatment comprehension and group participation.

During CB/SM, the counselor and clinical supervisor monitor each client's progress. If a client's substance abuse continues or escalates or if his or her quality of life deteriorates, he or she may require transfer to a more intensive level of care.

History of CB/SM

In the 1970s, behavioral and cognitive–behavioral interventions for persons with substance use disorders were developed at Patton State Hospital in California (Sobell and Sobell 1976), the University of Mississippi Medical Center in Jackson (P.M. Miller 1976), the Seattle Veterans Administration (VA) Alcoholic Treatment Program (Chaney et al. 1978), and the University of Oregon (W.M. Miller 1978). In the last program, treatment consisted of cognitive–behavioral skills training, instruction, and roleplaying in alcohol refusal skills and techniques for effectively coping with emotional states such as depression, anxiety, or anger. When feasible, skills training was individualized to address each person's high-risk situations for alcohol abuse.

From 1979 to 1981, the Gerontology Alcohol Project (GAP), an early version of the approach described in this manual, operated at the Florida Mental Health Institute (now part of the University of South Florida). GAP, which was funded by the National Institute on Alcohol Abuse and Alcoholism, was a day treatment program for people ages 55 and older with late-onset alcohol use disorders. Similar to CB/SM, this relapse-prevention model combined behavioral assessment with cognitive–behavioral and self-management approaches to teach clients how to recognize and cope with high-risk substance abuse situations.

Over a 2-year period, GAP received 153 client referrals that met program criteria. Of those, 48 entered treatment, and 24 completed treatment and entered the followup phase. Results of followup assessments showed that 75 percent of those who completed the program maintained their abstinence, improved their independent living skills, and increased their social support networks over the 1-year followup. In addition, reports from family members or significant others indicated notable decreases in clients' drinking behavior. GAP demonstrated that late-onset alcohol abuse was a difficult problem to identify but that it could be treated successfully (Dupree et al. 1984).

From 1987 to 1994, the GAP model was used at the Florida Mental Health Institute in its Substance Abuse Program for the Elderly. This program admitted clients ages 55 and older with alcohol use or medication misuse problems, regardless of their age when the problems began (Schonfeld 1992; Schonfeld and Dupree 1991). Both early- and late-onset clients tended to abuse substances in response to depression, boredom, and loneliness (Schonfeld and Dupree 1991). Another program that has used components of the GAP model is the Hillsborough County Jail Substance Abuse Program in Tampa, Florida (Peters and Schonfeld 1993). The GAP treatment approach also was used in an outpatient program for older military veterans called the Geriatric Evaluation Team: Substance Misuse/Abuse Recognition and Treatment (GET SMART) at the VA Greater Los Angeles Healthcare System—West Los Angeles Healthcare Center (Schonfeld et al. 2000).

The GAP model currently is being used in a large-scale pilot program for older adults in the Florida Brief Intervention and Treatment for Elders (BRITE) Project (Schonfeld and Lawton-Barry 2004; Schonfeld 2005). The BRITE Project, funded by the Florida State

Department of Children and Families, provides screening, brief intervention, and short-term treatment for older adults with substance use disorders in three Florida counties. Clients also are screened for depression and suicide risk. Providers are trained to work with older adults.

This treatment model has been used with both older men and older women. Almost half the clients treated in GAP and the Substance Abuse Program for the Elderly at the Florida Mental Health Institute have been older women. The BRITE Project also serves a substantial number of women.

Advantages of CB/SM

For many older adults, CB/SM offers a more attractive and positive intervention than more traditional approaches. In CB/SM, the counselor neither reinforces nor punishes relapse but instead enhances clients' efforts to manage behavior that can lead to relapse. The goal is to help clients develop effective coping skills for the antecedents that can trigger their relapse.

CB/SM differs from many other treatment approaches that focus on abstinence without offering individualized methods to accomplish it. CB/SM is tailored to each client's antecedents to substance abuse. Provided that a client has adequate cognitive functioning to recall recent antecedents or high-risk situations and to learn new, adaptive behaviors, the skills learned and practiced in group sessions can be applied to situations beyond the treatment setting. The treatment plan also can be evaluated and modified as needed, based on the data collected with the SAPE individual assessment tool.

Through discussion or negotiation with the group counselor, each client sets individual goals by which success can be judged. For clients with alcohol or illicit drug use problems, a typical goal is abstinence, whereas for clients who misuse medications, the goal is likely to be safe use of over-the-counter medications or use of prescription medications as directed by a physician. Success in the program is equated with reaching such a goal, mastery of the relapse-prevention skills taught by counselors, and the absence of relapses during and after discharge from treatment. Other goals indicating successful participation in treatment include improvements in a client's emotional state, rebuilding support networks, and mastery of skills necessary for long-term prevention of relapse. TIP 26 (Center for Substance Abuse Treatment 1998) provides additional information on the need for flexibility in setting goals for older adult clients.

Phases of CB/SM

CB/SM has four phases:

- Analysis of previous substance use behavior (SAPE interview)
- Identification of each client's high-risk situations for substance abuse, referred to as the ABCs (antecedents, behaviors, and consequences) of substance use (Module 1)

- Skills training to cope with high-risk situations and prevent relapse (Modules 2–9)
- Continuing care and followup

All four phases can be accomplished in either group or individual treatment.

Analyzing Previous Substance Use Behavior

CB/SM relapse prevention begins with SAPE, which is analyzed to create each client's substance use behavior chain (see Figure III-1, page 23). The counselor uses SAPE to identify what typically triggers or precedes a client's substance abuse (the antecedents) and what follows substance abuse (the consequences). Based on a client's responses to SAPE, the counselor performs a functional analysis of that individual's problem behaviors.

The substance use behavior chain represents the sequence beginning with common antecedents to substance abuse, followed by a client's initial alcohol or drug use on a typical day, and ending with the consequences or events that follow substance abuse.

Identifying the ABCs of Substance Use

A central tenet of CB/SM is that clients begin to understand their alcohol or drug abuse when they can identify and diagram its components and their sequence (the behavior chain). Learning to recognize the ABCs of substance abuse refers to identifying the antecedents (A), behaviors (B), and consequences (C) defining each client's substance use behavior chain. Analysis and understanding of the substance use behavior chain are important elements in resolving problem behaviors of any kind and important steps in learning how to interrupt substance abuse. In CB/SM, the ABC identification is necessary to select appropriate interventions to break the chain.

In this phase (Module 1 in this manual [see Section IV]), the counselor, using the information from SAPE, helps clients identify, understand, and respond to their high-risk substance abuse antecedents, which helps them break their substance abuse behavior chain. In a sense, CB/SM is a form of self-intervention that helps clients regain independence and reduce the likelihood of relapse. Clients also learn that substance abuse behavior is reinforced by relatively immediate and seemingly positive consequences, such as feeling better or having a sense of coping better with high-risk situations, although the long-term consequences always are negative.

Skills Training for Coping With High-Risk Situations for Substance Abuse

The third phase of CB/SM (Modules 2 through 9) helps clients take responsibility for their behavior by learning and practicing skills to cope with the types of high-risk antecedents that have triggered slips or relapses in the past. Self-management techniques require clients to become active participants in their treatment process. How these

self-management skills are taught may vary with the number and types of problems identified, the content of the broad treatment program, and the pace or speed at which individual clients and the treatment group can function. The cognitive–behavioral skills help clients cope with problems such as anger and frustration, depression and grief, tension and anxiety, and lack of social support.

Continuing Care and Followup

The goals of continuing care and followup, the fourth and final phase of CB/SM, are to provide clients with the additional support they may need to maintain their abstinence from substances or to maintain proper use of medications and to cope with slips if they threaten or occur. Clients' motivation to use CB/SM skills after finishing the treatment program is likely to be influenced by

- The degree to which training focused on changing each client's antecedents to substance abuse (versus generalized factors)
- The degree of clarity each client attained about his or her substance abuse triggers
- Each client's perception of his or her growth in self-control as a result of this training

During continuing care and followup, contact is maintained with a client for at least 12 months after discharge. These contacts are important for long-term success for many older adults, especially after they have established a level of trust with a counselor. Continuing care in CB/SM provides informal support, nonconfrontational methods for handling a slip or relapse, and encouragement to maintain the gains made during and after treatment. Followup may be minimal contact with clients for clinical or program evaluation purposes. Older adults, in particular, seem to respond well to a simple telephone call to inquire about their general health and well-being and to let them know that someone cares. Section III provides additional information about continuing care and followup.

Organization of the Manual

Section II of this manual provides an overview of the target population for CB/SM—older adults who have substance use disorders. It gives counselors a sound knowledge base about the older adult treatment population. The section includes a brief review of current and projected substance use prevalence data for this group and a discussion of factors found to affect both substance abuse and its treatment in older adults. Challenging aspects of assessing and diagnosing substance abuse and related disorders in older adults are examined, including treatment barriers and needs and issues likely to affect older women.

Section III describes how to implement CB/SM, using the information in this manual. It covers staffing recommendations and roles, general planning for treatment sessions, how to administer SAPE to a client before the sessions begin, how to develop each client's

substance use behavior chain from SAPE results, and how to conduct group sessions. Information on continuing care and followup also is given.

Section IV comprises the nine group session modules, which are organized and written to be as accessible and useful as possible for counselors. The modules are identified by their main topic and are covered in 16 group sessions, with most sessions intended to last approximately 75 minutes each. Each module begins with a brief overview of the topic, followed by an outline and a written presentation for the counselor of each session in the module.

Additional Resources

SAMHSA has developed other information resources that address substance abuse treatment for older adults. These treatment resources include the following:

- TIP 26, *Substance Abuse Among Older Adults.* Presents treatment providers and other healthcare professionals with practical advice for identifying, screening, assessing, and treating alcohol and prescription drug abuse among those ages 60 and older. DHHS Publication No. (SMA) 01-3496, 1998, reprinted 2001.

- *KAP Keys for Clinicians* (Based on TIP 26). Contains several instruments and clinical tools, including a list of clinical characteristics of early- and late-onset problem drinkers, a chart detailing the effects of aging on responses to certain drugs, and the Michigan Alcoholism Screening Test—Geriatric Version. DHHS Publication No. (SMA) 01-3586, 2001.

- *Quick Guide for Clinicians* (Based on TIP 26). Clearly and concisely presents the primary information contained in TIP 26 in a pocket-sized booklet. DHHS Publication No. (SMA) 01-3585, 2001.

- *Substance Abuse Among Older Adults: Physicians Guide* (Based on TIP 26). Provides a concise desk reference guide for primary care physicians, treatment providers, social services providers, and administrators of treatment programs to best-practice guidelines for treating substance abuse in older adults. DHHS Publication No. (SMA) 00-3394, 2000.

- *Alcohol Use Among Older Adults Pocket Screening Instruments for Health Care and Social Service Providers.* Provides health service professionals working with older adults with facts about alcohol abuse by older adults and screening instruments, including the Short Michigan Alcoholism Screening Test—Geriatric Version. DHHS Publication No. (SMA) 02-3621, 2001.

- *Aging, Medicines and Alcohol.* Contains information for older adults on signs of medicine and alcohol misuse and provides steps for avoiding problems resulting from mixing medications and alcohol. DHHS Publication No. (SMA) 02-3619, 2001.

- ***El Envejecimiento, los Medicamentos y el Alcohol.*** Contains the Spanish-language version of *Aging, Medicines and Alcohol*. DHHS Publication No. (SMA) 04-3898, 2004.

- ***Get Connected! Toolkit (Linking Older Adults With Medication, Alcohol, and Mental Health Resources).*** Provides health and social service providers in the aging services field with health promotion and health education activities to prevent substance abuse and mental health problems in older adults. DHHS Publication No. (SMA) 03-3824, 2003.

- ***Good Mental Health is Ageless.*** Provides older adults with reasons for maintaining good mental health, typical signs of emotional problems, and resources to call for help when feeling unusually sad or depressed. DHHS Publication No. (SMA) 02-3618, 2001.

- ***La Buena Salud Mental No Tiene Edad.*** Contains the Spanish-language version of *Good Mental Health is Ageless*. DHHS Publication No. (SMA) 04-3897, 2004.

- ***Point-of-Purchase Display for Consumer Brochures.*** Contains a cardboard display for the *Good Mental Health is Ageless* and *Aging, Medicines and Alcohol* brochures. DHHS Publication No. (SMA) 02-3620, 2001.

- ***Older Adults and Substance Use Disorders: A Guide to Recovery from Misuse, Dependency and Addiction Problems.*** Provides older adults and their loved ones with information about why older adults develop substance use disorders, how to recognize when an older adult has a substance use disorder, and where to go for help. DHHS Publication No. (SMA) 04-3942, 2004.

- ***Substance Use by Older Adults: Estimates of Future Impact on the Treatment System.*** Examines available data on substance use by older adults and reviews the issues regarding substance abuse treatment needs and the projected demand for substance abuse treatment services for older Americans over the next 20 to 30 years. DHHS Publication No. (SMA) 03-3763, Analytic Series A-21, 2002.

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Who Are "Older Adults?"

While recognizing the arbitrary aspects of the term "older adults," the originators of the cognitive–behavioral and self-management intervention (CB/SM) described in this manual considered the population of Americans older than age 55 with substance use disorders as their target population. Clearly, effective treatment solutions for clients must be geared to their individual circumstances, not arbitrary guidelines; each client is an individual who may manifest the physical, mental, affective, or attitudinal characteristics associated with older age either earlier or later than chronological age might indicate.

The Older Adult Treatment Population

CB/SM is appropriate for older adults with substance use problems ranging from occasional risky behavior to heavy substance abuse and signs of dependence. Programs using CB/SM typically have admitted older adults who meet the criteria for substance use disorders given in the *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition (DSM-IV) (American Psychiatric Association 1994). They also have admitted clients who do not meet DSM-IV criteria but have a history of risky substance use behaviors, such as misuse of prescription medications and inappropriate use of alcohol, alone or in combination with drugs.

Prevalence of Substance Use Disorders in Older Adults

According to the 2003 National Household Survey on Drug Use and Health, extrapolating from its survey participants' responses, approximately 15.5 percent and 4.2 percent of adults ages 55–59, 11.9 percent and 2.5 percent of adults ages 60–64, and 7.2 percent and 1.8 percent of adults ages 65 and older reported binge alcohol use (drinking five or more drinks on the same occasion) and heavy alcohol use (binge use on at least five occasions in the past month), respectively, in the month preceding the survey (Office of Applied Studies 2004*b*).

In 2003, 4.4 percent of adults ages 55–59, 2.9 percent of adults ages 60–64, and 0.7 percent of adults ages 65 and older used illicit drugs (including nonmedical use of prescription psychotherapeutic drugs) during the year preceding the survey (Office of Applied Studies 2004*b*).

In 2001, 58,000 of the 1.7 million people admitted to publicly funded substance abuse treatment programs were ages 55 and older. Although this total has increased over the years, the proportion of older adult admissions to all admissions has remained about 3 percent (Office of Applied Studies 2004*a*). About 3.7 percent of survey respondents ages 55–59, 1.2 percent of respondents ages 60–64, and 1.6 percent of respondents ages 65 and older reported that they were dependent on or abused illicit drugs or alcohol during the past year (Office of Applied Studies 2004*a*).

Projected Treatment Needs

The Substance Abuse and Mental Health Services Administration has identified the abuse of alcohol, prescription drugs, and illicit drugs as a "hidden epidemic" in the expanding older adult population. It is estimated that as many as 17 percent of adults older than age 60 are affected by alcohol abuse and prescription drug misuse (Substance Abuse and Mental Health Services Administration 2002).

Given the often-hidden nature of substance abuse and dependence and the isolation common to older adults, the full extent of substance use disorders in this population is unknown. However, it is anticipated that the number of older adults who abuse substances will increase. Estimates suggest that the number of people ages 50 and older in need of substance abuse treatment will increase—from 1.7 million in 2001 to 4.9 million in 2020 (Gfroerer et al. 2003). Even if rates of substance abuse stay the same, the growth of the older adult population will increase the number of people needing help.

Population Diversity Among Older Adults With Substance Use Disorders

Although this manual discusses some common themes related to older adults with substance use disorders, it is important for counselors to appreciate the diversity of this population in America. Older Americans in treatment programs vary widely in cultural background, educational level, economic situation, health status, and chronological age. They bring many views, attitudes, experiences, and expectations to treatment. The average counselor will see both healthy, active, independent older clients and those who are weak and frail. CB/SM methods encourage counselors to work with older adults as individuals with a wide range of needs and perspectives.

CB/SM has been implemented effectively in older adult groups with mixed demographic characteristics such as race, socioeconomic group, gender, and geographic origin. The counselor needs to be culturally aware of and sensitive to group members, provide relevant examples, and use language understood by all clients. The counselor needs some knowledge of clients' belief systems to communicate effectively with them and interpret their responses.

Factors Affecting Substance Abuse by Older Adults

Sense of Loss

The transition from middle age to older adulthood brings significant changes to many areas of living, but whether these changes are viewed positively or negatively depends on the individual. Many older adults are coping with loss. As individuals age, they may lose their spouses, other family members, and friends to death and separation. Retirement may mean a reduction or loss of income, disappearance of job-related social support systems, and loss of the structure and professional identity that work provides. Difficulty using public

transportation, walking, or driving may lead to reduced mobility. Chronic illnesses may accelerate other changes, including impaired sensory capabilities (i.e., hearing and sight), which may contribute to isolation, and declining physical health. Adjusting to these changes often is difficult and stressful.

Compounding Effects of Lifelong Substance Abuse

For some older adults, substance abuse has been a way to cope with problems for much of their lives. Those who began abusing substances early in life may have substance-related illnesses that are compounded by aging. Lifelong substance abuse may have alienated some individuals from family and friends or depleted their financial resources. For many older adults, feelings of depression, loneliness, boredom, and helplessness may trigger substance abuse.

Increased Use of Medications

Misuse of prescription and over-the-counter medications can lead to serious medical concerns for older adults. This type of substance use disorder occurs partly because older adults take more prescription medications and because aging often changes drug metabolism (Center for Substance Abuse Treatment 1998). Older adults who experience dizziness or start acting "senile" may be taking too much medication or having a drug reaction. These situations may go unnoticed, even by physicians (Center for Substance Abuse Treatment 1998).

Older adults' problems with dependence-inducing prescription drugs often are unintentional. Unintentional misuse may progress to deliberate misuse if an older adult continues to use a prescribed medication nonmedically for the unintended effects it provides (e.g., using pain pills to sleep, relax, or elevate a low mood).

Among the most common prescription drugs that lead to addiction in older adults are the benzodiazepines, a group of minor tranquilizers including diazepam and its chemical cousins. These drugs often are prescribed after a traumatic event, such as loss of a spouse. Although they may help older adults sleep better and feel calmer, they are habit forming. Benzodiazepines should be used only for short periods, yet the Public Citizen's Health Research Group in Washington, D.C., estimates that 1.5 million Americans use benzodiazepines daily for more than a year (Fackelmann 2001). The Hanley Center (formerly the Hanley/Hazelden Center), a treatment center for older adults in West Palm Beach, Florida, reports seeing seniors who have taken these drugs for 20 to 25 years (Addiction Treatment Forum 2004).

Substance Abuse Treatment for Older Adults

Challenges in Assessment and Diagnosis

The number and interrelationship of physical and mental disorders in some older adults can complicate diagnosis and treatment of their substance use disorders. Substance abuse often goes undetected among adults ages 60 and older (Center for Substance Abuse Treatment 1998). As a group, older adults are more likely to hide their substance abuse and less likely to seek professional help. Family members also may be ashamed of or embarrassed by the problem and uncertain about what to do. Healthcare providers may overlook substance abuse among older adults or confuse it with age-related changes, such as dementia and depression. Older adults sometimes lack the social indicators commonly associated with substance use disorders, such as arrests for driving under the influence or employment problems, and their substance-related problems may be identified only when they are hospitalized for physical illnesses. Because older adult substance use disorders often remain unidentified, thousands who need treatment may not receive it.

Treatment Barriers for Older Adults

Barriers to appropriate treatment for older adults may include the following:

- **Ageism.** "Ageism" is society's tendency to dismiss older adults' problems as a function of aging rather than to investigate possible medical, social, or psychological causes. Ageist beliefs may suggest that older adults are unmotivated or uninterested in treatment, cannot change addictive behaviors, and derive few, if any, benefits from substance abuse treatment (Oslin et al. 2002).

  Some researchers have concluded that substance abuse in older adults does not inspire the same urgency for care as it does in younger adults. Furthermore, they have found that American society supports the unspoken but widespread assumption that treating older adults for substance use disorders is not worthwhile and is a waste of healthcare resources (Center for Substance Abuse Treatment 1998).

- **Lack of awareness or denial.** Older adults, similar to many others with addictions, and their loved ones may not recognize or may deny signs of a substance use disorder.

- **Multiple disorders.** Medical conditions, cognitive impairment, mental disorders, sensory deficits, and lack of mobility in older adults can complicate diagnosis of a substance use disorder. Symptoms such as fatigue, irritability, insomnia, chronic pain, or impotence may be caused or affected by substance abuse, common medical and mental disorders, or a combination of these conditions. Co-occurring medical and mental disorders may influence treatment choices and priorities and affect treatment outcomes.

- **Transportation problems.** Some older adults, particularly in rural and poor urban communities, cannot transport themselves and lack access to public transportation. Some may not know how to drive.

- **Limited family and social support.** Some older adults have no family members or friends living nearby to support them, participate in their treatment, or take them to group sessions.

- **Time demands.** Although some people assume that older adults have unlimited free time, frequently they are 24-hour caregivers for a spouse, relative, friend, or grandchild.

- **Insufficient insurance coverage.** Medicare coverage for substance abuse treatment programs has been limited. Most private insurance plans do not cover substance abuse treatment, or they cover it at far lower rates than services for other medical conditions.

Unique Treatment Needs of Older Adults

Many treatment models and approaches for substance abuse do not account for age-related physiological, cognitive, and social changes and may not translate well to older adults. In addition, older adults who abuse substances may be more likely to have undiagnosed psychiatric and medical conditions than older adults who do not abuse substances, complicating their treatment even more (Center for Substance Abuse Treatment 2000).

The consensus panel for Treatment Improvement Protocol (TIP) 26 (Center for Substance Abuse Treatment 1998) identified several characteristics of treatment that contribute to positive outcomes for older adults with substance use disorders:

- Emphasis on age-specific rather than mixed-age treatment

- Use of supportive, nonconfrontational approaches that build self-esteem

- Focus on cognitive–behavioral approaches to address negative emotional states such as depression, loneliness, and feelings of loss

- Development of skills for improving social support

- Recruitment of counselors trained and motivated to work with older adults

- Capacity to provide referrals to medical, mental health, and aging services

- Appropriate pace and content for older adults

The TIP 26 consensus panel also recommended that treatment programs be respectful of older clients; use a holistic approach that considers common psychological, social, and medical problems of older adults; and respond to gender differences (Center for Substance Abuse Treatment 1998).

Self-Esteem Needs

Some older adults who enter treatment are depleted physically, socially, and emotionally and may be convinced that their situation is hopeless. In the past, they may have sought help, only to have experiences that were impersonal, dehumanizing, or humiliating. Throughout treatment, counselors should nurture clients' self-esteem and validate their sense of themselves as valuable, competent human beings. To increase clients' self-esteem, counselors frequently should express confidence in their clients' ability to participate, persevere, and succeed in treatment in a way that is positive, but not patronizing. Counselors should acknowledge that a client needs help with a substance use problem, without implying that he or she is impaired or helpless.

By beginning with an individual assessment such as the Substance Abuse Profile for the Elderly (SAPE) (appendix A), CB/SM eliminates the tendency to generalize about older adults and their reasons for substance abuse. SAPE lays the foundation for an individualized approach by identifying individual differences in reasons for and responses to substance abuse.

Counselors are encouraged to create a supportive atmosphere, remembering that older adults may be anxious about and resistant to learning new behaviors. Although a client may recognize an effective solution, he or she may be hesitant to try it.

Counselors need to avoid patronizing behavior, demonstrate respect, be patient and courteous, and refrain from profanity. They should ask clients how they want to be addressed and introduced to the group. Impersonal forms of address such as "dear" or "hon" may seem condescending to clients and should be avoided. Surnames and formal terms of address convey deference and should be used until a client gives permission to be more familiar, especially when counselors are younger than clients. Counselors also should respect and make provisions for a client's privacy, personal space, and the security of his or her possessions in group settings.

At the beginning of the group process, counselors should introduce themselves and make the environment welcoming. They should demonstrate that they accept clients and want to hear their concerns. Counselors might mention looking forward to working together and invite clients to ask questions as they arise. Counselors should explain their role and their expectations of clients.

Perceptual Needs

The group approach may pose difficulties for some older adults, who may have grown up in an age when group therapy and mutual-help meetings were less common and talking about feelings was less acceptable. Having little or no "talk therapy" exposure can hamper clients' ability to benefit from group sessions. Some clients may have trouble switching their attention from one group member to the next during open group discussions. Some may prefer to raise their hands to request to speak rather than engage in free discourse. The gesture of raising hands may aid some group members in switching their attention and moderating the pace of the discussion. When counselors change the subject, they should alert clients, for example, by pausing briefly, speaking more loudly, gesturing toward visual aids, or asking questions.

Remembering that perceptual acuity and speed may diminish with age, the counselor needs to adjust the pace of sessions and complexity of information to suit each group, after determining the clients' abilities. The 75-minute session time is approximate and can be adjusted to accommodate the learning rate of a group. It is particularly important that the counselor engage clients in discussions and relate the presented material as much as possible to issues and problems relevant to group members as individuals, keeping in mind that the degree to which many clients remember material is related to how meaningful it is to them.

Counselors should use terminology that is likely to be understood by older adult clients and is unlikely to evoke negative reactions that could detract from treatment outcomes. For example, although the term "substance abuse" is used commonly among substance abuse treatment professionals in reference to unhealthy preoccupation with using addictive substances, some clients may not understand or associate their behavior with the term "substance," and they may have a defensive or negative reaction to the term "abuse." "Substance use"—and more specifically alcohol use, drug use, sedative use, cocaine use, and so forth—is more likely to be understood and less likely to evoke a negative reaction.

Cognitive Needs

Some clients have cognitive impairments that make it difficult for them to keep up with the group. Counselors can help these clients as follows:

- **Keep explanations simple.** Rephrase and repeat difficult or complicated ideas in more simplified terms.

- **Create a safe environment** for asking questions. Encourage clients to ask about any concepts or words they do not understand, and then provide simple answers.

- **Prevent ridicule** when a client makes a comment that shows a lack of understanding. The counselor may try to find something accurate or relevant in what the client has said, comment on that to the group, and then correct the inaccuracy.

- **Consider referring the client** for evaluation and possible treatment. A client's cognitive difficulty may be caused by a mental or learning disorder that requires further assessment and treatment by a trained professional.

Older adults in treatment groups receive, process, and recall information better if they receive a clear statement of the goal and purpose of the session and an outline of the content to be covered (outlines for all sessions are included in the modules in Section IV). The counselor can post an outline and refer to it throughout the session. The outline also can be prepared as a handout and given to clients to include in their notebooks (provided by the facility) for personal note-taking and as a review-and-recall aid. Clients should be encouraged to take notes, and counselors should be ready to supply pens or pencils.

Counselors should avoid overloading clients with too much information. Many clients need multiple opportunities to absorb and act on new information. Spaced repetition is an important technique for communicating with some older adults. In spaced repetition, the counselor introduces a unit of information and then exposes clients to it several more times. To provide adequate exposure, information may be presented in a group session and then reinforced in individual sessions. To help group members retain the content of discussions, counselors can paraphrase and clarify clients' comments or ask clients to repeat key points.

Literacy and Language Needs

Group members may vary widely in educational levels. Some older adults are adept at hiding a lack of literacy skills; they need to be helped in a way that maintains their self-respect. Counselors should choose vocabulary in accordance with clients' communication skills. If a client has trouble reading, the counselor may ask the client whether a friend or relative can read written material to the client. If so, the counselor can send copies of the material to that person.

Language barriers can exist, even if a client's first language is English. In addition to being unfamiliar with clinical terms, some older adults may not be acquainted with recently coined words or expressions or new uses of old words. For example, an older client may not know what it means to contact a support group or helpline or to network with others. Older clients also may use expressions unfamiliar to younger counselors. When presenting information, counselors should use simple, everyday language; avoid clinical jargon; use analogies or examples; and provide clarification when needed.

Sensory Needs

Counselors should consider the sensory decline of some older adults and maximize the use of as many senses as possible. For example, they should deliver audible presentations backed by visual aids and use amplification devices and chalkboards or newsprint pads. The session room should have adequate lighting without glare. Any handwritten instructions

should be large and clear. When printed materials are used to reinforce concepts, the typeface should be large and clear. Some older clients cannot bring objects into focus at close range and may pull away to see more clearly.

Interruptions and background noise should be minimized. Counselors should speak clearly and face the group so that clients can lipread or pick up visual cues and counselors can determine whether they are being understood. Counselors should avoid shouting, which distorts language sounds, may be uncomfortable to the listener, and may suggest anger. Oral presentations should be reinforced through gestures, simple diagrams, and written materials.

Treatment Issues for Older Women

Although research in the substance abuse treatment field often has focused on male subjects, more women than men are in the aging population, and the ratio in favor of women increases steadily with age. Despite the greater number of older women, older men appear more likely to have substance use disorders. However, because more older women live alone, their substance use is more difficult to measure (Moore et al. 1989). Older women tend to hide their substance use because they attach greater stigma to it than men do (Center for Substance Abuse Treatment 1998). With the aging of the baby boomers, this attitude among older women could change.

Although no definite risk factors have been identified for substance abuse among older women, research suggests that increased free time and decreasing role responsibilities may be contributing factors (Wilsnack and Wilsnack 1995). In addition, women may be more vulnerable than men to social pressure, so they may be more affected by moving into a retirement community where substance abuse is common (Center for Substance Abuse Treatment 1998).

Several treatment challenges pertaining particularly to older women have been identified:

- **Economic support.** Compared with older men, older women tend to have less insurance coverage and supplemental income. Older women are less likely to have worked, more likely to lose insurance coverage with the death of a spouse, and more likely to lack financial resources.

- **Visibility.** Older women are less likely to drink in public than older men, so they are less likely to drive while intoxicated or engage in other behaviors that might reveal a substance use disorder.

- **Isolation.** Older women are more likely than older men to live at home alone. Although older women tend to be healthier and more independent overall than older men, many also are more isolated. Therefore, they are more likely to drink alone.

- **Medications.** Older women are more likely than older men to take psychoactive prescription drugs. Among older women, the use of these drugs correlates with higher rates of middle- and late-life divorce, widowhood, stress, and mental disorders and lower educational attainment, income levels, and health status (Substance Abuse and Mental Health Services Administration 2000).

The Modular Structure

The structure of the cognitive–behavioral and self-management intervention (CB/SM) comprises nine modules covered in 16 group sessions. These modules are presented in detail in Section IV of this manual. During the sessions in the first module, clients learn about the substance use behavior chain, which consists of the antecedents (triggers) to, behaviors during, and consequences of substance abuse. Subsequent modules provide behavioral interventions to teach clients the skills to recognize and interrupt their substance use behavior chain. Sessions in the modules have defined objectives, ready-to-use teaching techniques and handouts, and ways to evaluate clients' skills mastery. Counselors leading group sessions are provided with a standard list of ground rules to review with clients at the start of each session (see Figure III-6 , page 29). The pace and content of the sessions are geared to older adults.

The nine module topics are summarized in Figure IV-1 in Section IV (page 33). Much of the content and many of the specific examples used in the group sessions are based on the information gathered from the Substance Abuse Profile for the Elderly (SAPE) (appendix A) further discussed under Starting Treatment below.

Staffing Recommendations and Roles

Counselor Requirements

To prevent inappropriate applications of behavioral approaches to treatment, counselors need to understand cognitive–behavioral theory and be sensitive to cultural and other types of differences among older adult clients that may affect their responses to treatment. Treatment Improvement Protocol (TIP) 34, *Brief Interventions and Brief Therapies for Substance Abuse* (Center for Substance Abuse Treatment 1999), provides an explanation of cognitive–behavioral therapy and compares it with other brief interventions for substance abuse. Counselors need good interpersonal skills and familiarity with the CB/SM treatment materials to deliver skills training successfully and to serve as credible role models. Counselors also should be willing to play an active role during the group sessions.

Counseling Approach

A counselor is encouraged to use an understanding and supportive approach to earn the trust of the client. The counselor's role in CB/SM is a blend of supportive listener and knowledgeable consultant. The counselor listens respectfully and accepts a client's perspective on his or her situation as a starting point, helps the client identify the consequences of substance abuse, empowers the client to identify alternative solutions for substance abuse, expresses belief in and support for the client's capacity to change, and places the responsibility for change on the client. This respectful and supportive approach reduces real or imagined ageism and other stigmas.

A nonconfrontational approach facilitates open discussion between counselors and clients and puts clients more at ease to report their slips or relapses. CB/SM differs from approaches that encourage clients to view slips as failures, which makes them reluctant to admit to slips or relapses. Counselors using CB/SM encourage clients to view a slip as an opportunity to determine which prevention skills they did not use and identify what they can do in future high-risk situations. Counselors review the circumstances with a client, in either individual or group treatment sessions, using cognitive–behavioral analysis to diagram the components of the slip on the substance use behavior chain. When done in group sessions, this review also benefits other clients who can learn how to avoid or manage their own high-risk situations.

The counselor demonstrates a nonjudgmental attitude and discourages labels and accusations, stating clearly that confrontations among group members or between the counselor and group members are not permitted. This is an important point because some clients may have participated in other treatment programs where confrontations were tolerated or even encouraged. However, a nonconfrontational, supportive style of group interaction has proved effective among older adults in substance abuse treatment (Colleran and Jay 2002). Instances requiring a counselor to be frank or question the truthfulness of a client's statement are handled in a one-on-one session between the counselor and client.

Counselors encourage clients to be honest and open when reporting events, behaviors, slips, and relapses. Counselors avoid giving the impression that they are trying to convince clients of the error of their ways. Although clients may shy away from being open and honest at first, eventually they are likely to open up and be forthright when they realize they are not penalized for honesty. Statements by other group members in response to the client's self-disclosure are permitted only if instructive and supportive. Criticism needs to be constructive, rather than negative and unhelpful. Group members are urged to coach, learn from, and support one another.

Session Supervision and Monitoring

Session monitoring by senior clinical staff is important to maintain treatment quality and continuity. Frequent, intermittent monitoring is standard and enables counselors to become accustomed to being observed during sessions. The content and procedures in this manual provide the standard for evaluating the performance of counselors leading CB/SM groups. Therefore, except as indicated below, counselors should not individualize or greatly alter module content, processes, or evaluation steps without approval from their clinical supervisor.

General Session Planning

Session Format

CB/SM group sessions are for a classroom-style format, with clients sitting in a semicircle facing the counselor. The ideal size for a group is 8 to 12 clients. When group size is limited, everyone can participate, practice new behaviors, and provide comments in a reasonable time. Each session is intended to last about 75 minutes.

Module Order

The modules do not have to be presented in the same order as in this manual. If a counselor decides to rearrange the module order, he or she should be careful to change the instructions for homework assignments and followup activities so that these components reflect the new order. It is mandatory for each client to complete Part II of SAPE and attend the first two group sessions covering the analysis of substance use behavior (Module 1) before proceeding with subsequent modules. However, the remaining treatment modules can be rearranged based on the counselor's judgment of group needs.

Schedule Adjustments

If clients occasionally miss group sessions for good reasons, perhaps because of illness, conflicting medical appointments, or transportation problems, counselors need to help them get caught up with the rest of the group. Makeup sessions can be scheduled before or after regular group sessions. If two or more clients need to make up the same session, they can be seen together. Makeup sessions can be abbreviated and focus on reviewing the main points missed. Additional sessions can be scheduled to help clients who are having difficulty in mastering parts of the treatment.

A client may remain in treatment longer than originally planned if program staff recommends retention. If a client agrees to continue, one option for the counselor is to meet individually with the client to tutor him or her in the skills needing remediation. Another option is to have the client attend selected modules again as they occur, with new members.

Each group should remain together as a cohort throughout the program for best results. However, when a new client is admitted to a CB/SM program but there are not enough new admissions to create a new group, staff may work with the new client to teach the ABC sessions, and then the client can join a group in progress. All clients should be required to complete Module 1 before entering any other modules, and they should begin each module at Session 1, regardless of module order.

Determining Family Involvement

Depending on a client's situation, a counselor may want to involve family members in treatment planning and offsite monitoring, although family members do not participate in or monitor group sessions. Family involvement can lead to more comprehensive assessment, further reinforcement of treatment strategies, and improvements in treatment outcomes. Family members can provide the counselor with additional information about a client, including an understanding of specific family issues and problems that relate to the client's substance abuse pattern. Before a counselor attempts to gather information from or enlist the help of family members, he or she should ask the client's permission to do so and carefully follow the established client confidentiality procedures of the treatment program.

The types of family members who are appropriate to involve in treatment planning and offsite monitoring vary from client to client. For married clients, it may be beneficial to involve spouses. For older adults who are widowed or divorced, engaging adult children may be important. However, some older clients may be out of touch with family members or live far from relatives. The person closest to a client may be a golfing partner, housemate, healthcare provider, trustee of the person's estate, or social worker. Such nontraditional family members may be considered "family" for purposes of treatment. There also may be cultural reasons to involve or not to involve certain family members.

Mutual-Help and Peer-Support Groups

Information on local Alcoholics Anonymous (AA) and mutual-help groups is provided in Module 3. Counselors should warn clients that such groups might seem confrontational and alienating. If possible, counselors should tell clients exactly what to expect. For example, in a mixed-age group, discussions may include profanity and some members' accounts of their behavior may be disturbing. To orient clients to these groups, counselors can invite representatives from local groups to address the CB/SM group. Counselors also can help clients develop their own mutual-help groups or facilitate the development of an AA or other group specifically for older adults in the area. Especially in metropolitan areas, many different kinds of group meetings may be available. Clients may need to try several different meetings before they find one they are comfortable attending.

Starting Treatment

Administering SAPE

The counselor administers SAPE to clients individually when they enter the treatment program. Results guide the counselor in shaping group session content, designing relapse-prevention interventions tailored to the specific needs of clients, and later determining client readiness to leave treatment. This assessment is based on the premise that antecedents to substance abuse, if not addressed in treatment, will continue to lead to slips and relapses after treatment.

SAPE has two parts. Part I covers the client's history of substance use. It includes questions related to family substance use history, age of onset of the substance use disorder, history of treatment and attendance at mutual-help or 12-Step meetings, and circumstances surrounding previous relapses. This part of SAPE is optional when time is limited. However, these answers are helpful in planning individual and group sessions.

Part II of SAPE focuses on recent substance abuse behavior (i.e., during the 30 days before the last use of alcohol or drugs). It includes questions about the types of substances used, those that caused the most problems, the frequency and pattern of abuse, and reasons for abuse. It also includes questions about antecedents to and consequences of substance abuse and the reasons for seeking treatment at the time. Administering Part II of SAPE is

mandatory because the information gathered is used to plan CB/SM, enabling counselors to identify the components of a "typical" behavior chain for each individual in the group.

Completion of both parts of SAPE usually takes 2 hours, 1 hour for each part. Depending on the severity of a client's substance use disorder and his or her ability to understand and respond to questions about recent substance abuse, completion time may take longer. When administering SAPE, counselors should read each question as written. Clients may need to clarify some of their answers. For example, if a client indicates that feeling lonely and depressed was the primary reason for substance abuse, the counselor might probe for more information (e.g., by asking, What were you depressed about? or Please explain what you mean by depressed.).

Some SAPE questions require respondents to select from a series of options. These options are provided in large type in SAPE as Lists A through G (appendix A) so that counselors can reproduce them for clients.

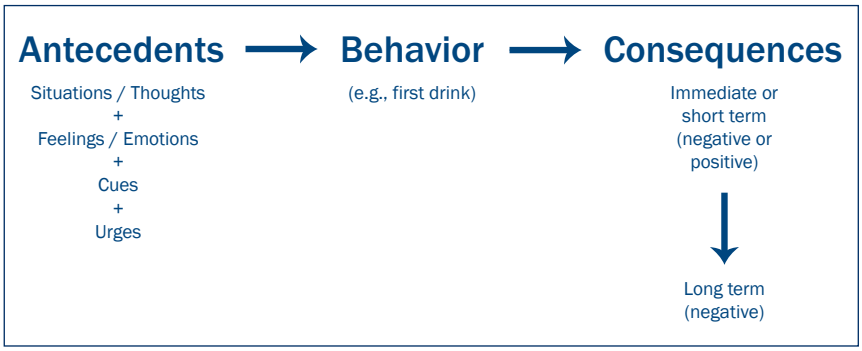
After the client has completed the SAPE interview and left the room, the counselor should take 10 to 15 minutes to transcribe the information gathered into a formatted table like that provided at the end of appendix A. Once completed, this table provides the basis for the client's substance use behavior chain and the foundation for the treatment approach used in the group sessions. The counselor gives each client a copy of his or her completed table at the first group session. Clients are encouraged to keep their tables in the notebooks they bring to all group sessions.

Developing the Substance Use Behavior Chain

Antecedents to Substance Use

Antecedents to substance use may include situations or locations where substance use occurs, typical activities during substance use, people involved in substance use, and thoughts, feelings, or emotions before substance use. As Figure III-1 illustrates, antecedents involve a progression, beginning with what a person is doing (i.e., situations) and thinking about on a typical day of substance abuse, followed by the feelings or emotions that person then experiences. As antecedents continue to progress toward substance use behavior, the person experiences cues or reminders that one method of coping has been substance abuse. Cues are stimuli, possibly including the appearance or

Figure III-1. Substance Use Behavior Chain



smell of a substance itself, certain places (e.g., bars, lounges, restaurants, TV room), or conversations about substance use. In addition, any activity in which a client engages (e.g., watching television, sitting in a particular chair, reading, gambling) may become a cue for substance abuse. Certain times of day and special events or holidays may be cues.

The last type of antecedent before substance use behavior (e.g., the first drink) is an urge. CB/SM defines an urge as a strong desire for alcohol or drugs, followed by self-talk in which a person gives himself or herself permission to use a substance. An urge is linked to individual expectations about what will follow substance use, generally based on personal experience. Clients learn that those who expect positive immediate or short-term consequences from substance abuse (e.g., feeling more relaxed) are more likely to have substance use problems and be at risk for relapse. They also learn that an urge not acted on eventually goes away.

The first goal of the SAPE analysis is to identify an individual's pretreatment antecedents to substance abuse. The counselor inserts a client's answers from SAPE into appropriate categories such as those listed in Figure III-2, which identifies each category of antecedents. Some answers may require rephrasing to fit the categories. For example, if a client reports feeling relaxed after substance use, the urge category might read, "I'll just have one to relax!" Open-ended responses should be summarized.

Figure III-2. Antecedents Categories

Categories	Situations/Thoughts	Feelings	Cues	Urges
Responses	Being at home alone Thinking about deceased husband	Lonely Sad and depressed	A bottle of wine in the cabinet	If I have a drink, maybe I'll feel better
	Having marital problems Thinking about how wife picks on him	Angry Helpless and resentful	Fight with wife	She hates it when I drink; I'll get even with her

An urge may be the most difficult type of antecedent to identify, particularly as self-talk. If immediate, seemingly positive consequences of substance abuse reinforce the abuse, it is likely that the condition opposite these positive consequences is the urge. For example, if a client reports feeling relaxed after drinking, then tension might be the urge. When written as self-talk, this antecedent might be stated as "A drink would help me feel less tense." If a client feels less anxious in certain social situations after taking a tranquilizer, the urge might be stated as "If I take another pill, I'll feel more comfortable being with others." A widow or widower with little to look forward to may feel bored, lonely, and depressed. The self-talk he or she uses might be, "A good, cold beer would help me forget my problems."

Figure III-3 provides guidance on where to insert a client's answers to selected questions from SAPE to develop the antecedents component of the client's substance use behavior chain (see appendix A for the questions in this component).

Figure III-3. Using SAPE Responses To Identify Client Antecedents*

Categories	Situations/Thoughts	Feelings	Cues	Urges
Questions	#17: Locations where alcohol/drug use typically took place #18: Activities preceding use #19: People with whom substances were used (See also #12: People who gave client alcohol or drugs)	#20: Feelings immediately *before* using alcohol or drugs	#10: Where substances were bought #13: Where substances were kept at home #14: Time of day/week when client would start using alcohol or drugs	#21: Using the responses under feelings immediately *after* substance use, determine the opposite of that reported feeling #23: What client liked about using the problem substance (use the opposite condition as the urge) #26: Main reason for use (use the opposite condition as the urge)

*Numbers correspond to questions in Part II of SAPE.

Substance Use Behavior

The behavior component of the substance use behavior chain refers to a client's initial use of a substance on a typical day during the 30-day period before the last substance use, before SAPE was administered and the client entered treatment. For older adults who use alcohol, the behavior is the first sip of a drink on a typical day of drinking. For a person who uses marijuana, it is the first puff of a marijuana cigarette. For those who misuse prescription medications, it might be the first nonmedical use of a prescription tablet on that day. Behavior based on the initial use provides a frame of reference for identifying typical antecedents to that use.

Consequences of Substance Abuse

The last part of the substance use behavior chain is the consequences. Consequences refer to emotional effects, physical symptoms, and related effects in other areas of life that result from substance abuse. Immediate or short-term consequences happen right after the first drink or use of a drug and are perceived as either negative or positive. Negative consequences might include feeling guilty about using substances or fear that someone observed the use. However, immediate seemingly positive consequences reinforce a person's substance abuse and encourage repeated abuse.

Although some argue that results such as socializing with other people who abuse substances (e.g., getting together with drinking buddies) can be considered positive consequences, CB/SM principles hold that all long-term consequences ultimately are negative. They may include falling, forgetting things, getting into arguments, and even

getting arrested. For older adults, chronic substance abuse may have a substantial effect on physical health. However, negative consequences such as liver or neurological damage, hypertension, or diabetes often are too far removed in a client's mind from the initial substance use and perceived immediate positive consequences to deter future abuse.

The consequences section of SAPE identifies the immediate or short-term results of substance abuse that clients might regard as positive. Client anticipation of these consequences leads to substance abuse, and the actual experience of them reinforces continued substance abuse. It is necessary to identify negative short- and long-term consequences that have deterred substance abuse in the past and that may serve as useful reminders when clients encounter high-risk situations.

Figure III-4 (see opposite page) provides examples of possible consequences in the substance use behavior chain. It is designed to guide counselors in identifying different types of consequences.

Figure III-5 (see opposite page) provides guidance on where to insert a client's answers to selected questions from SAPE to develop the consequences component of the client's substance use behavior chain.

Conducting Group Sessions

Although each counselor adds his or her personal touch to group sessions, some general guidelines for leading sessions should be followed:

- Maintain a consistent delivery approach
- Set ground rules
- Review the substance use behavior chain at the beginning of each session
- Ensure that clients create and update their notebooks
- Moderate group discussions
- Conduct behavior rehearsals
- Teach problemsolving skills
- Administer exercises, quizzes, and ratings

Figure III-4. Examples of Substance Abuse Consequences

	Positive Consequences	Negative Consequences
Immediate Short-Term Consequences of Initial Abuse	Feel less lonely Feel more relaxed Feel less afraid	Feel guilty about sneaking a drink Worried that children might see alcohol/drug use Forget things more often Have an irritated stomach Lose balance or fall more often
Long-Term Consequences of Continued Abuse	NONE	Show signs of deteriorating health Experience marital problems Experience legal problems (e.g., for driving under the influence of alcohol or drugs)

Figure III-5. Using SAPE Responses To Identify Client's Consequences*

	Positive Consequences	Negative Consequences
Short-Term Consequences of First Use on a Typical Day	#20: Anticipated short-term positive consequences may be inferred from the negative feelings experienced immediately *before* substance use; for example, if a client reports feeling tense, then relaxation can be inferred as the desired short-term consequence #21: Positive feelings anticipated immediately *after* substance use #23: What client liked about using the problem substance #26: Main reason for use	#21: Negative feelings immediately *after* substance use #24: What client disliked about using the problem substance
Long-Term Consequences of Continued Abuse	NONE	#7: Reasons for not using #24: What client disliked about using the problem substance #25: Experiences with withdrawal, delirium tremens (DTs), hallucinations, shakes #27: List of problems #28: Motivation or main reasons for seeking treatment

*Numbers correspond to questions in Part II of SAPE.

Maintain a Consistent Delivery Approach

The modules are designed so that all counselors, regardless of level of experience or training, can deliver nearly the same content, exercises, and general examples to groups. Adherence to the outlined step-by-step approach has several advantages:

- Counselors with a range of treatment experience who work in various disciplines can use the manual effectively to lead group sessions.
- Counselor turnover does not necessarily affect the consistency of program content and methodology.
- Senior clinical staff members can monitor and supervise multiple, concurrent treatment sessions.
- Counselors can review the treatment manual before group sessions to increase their familiarity with the goals, content, and process for each session.

Therefore, counselors are encouraged to follow the content and wording of the treatment modules as closely as possible, except in situations requiring adaptation for particular groups and needs, for example, to accommodate cultural factors affecting group and individual responses.

Each module provides an overview, an outline that includes a materials list, and a presentation script. Instructions to counselors are *italicized* in the session descriptions. The presentation portion of each session should be delivered essentially as written. Counselors also are urged to review and practice delivering the sessions to avoid sounding stiff or artificial. The more familiar they are with the content, the easier it is to involve participants. Counselors should be familiar with each client's behavior chain and high-risk situations, based on SAPE. This information is used to prompt or ask clients about their antecedents to and consequences of substance abuse.

As counselors become more familiar with the content, they may begin to paraphrase the scripted dialog. However, they should avoid adding unrelated content or content that may interfere with the basic treatment approach, without first consulting their clinical supervisor. Following the treatment manual in this way ensures that every counselor delivers similar basic content, exercises, and examples—in the same format.

Set Ground Rules

Figure III-6 (opposite page) provides a list of ground rules. To encourage compliance, counselors should clearly state these rules at the first group session, post them, and review them at each subsequent session.

Figure III-6. Ground Rules for Group Members

- All group members will be courteous and listen to one another without interrupting.
- Group members will show respect for others' opinions and support one another.
- Attacking another member or using labels that seem insulting is not permitted.
- All group members will be honest and serious when offering feedback to others.
- What others say will be received as sincere and with merit.
- Counselors are here to help you, not scold you, look down on you, or label you.
- Anything said by anyone in this group will be kept confidential by group members.

Review the Substance Use Behavior Chain

Counselors begin each session with a review of the substance use behavior chain. The chain can be drawn on a large poster or newsprint and placed prominently in the room as a visual aid.

Ensure That Clients Create and Update Their Notebooks

Each client is provided with a three-ring, loose-leaf binder. The first item to be inserted is the table prepared for each client, based on his or her responses to Part II of SAPE, so that clients have the components of their substance use behavior chain at their fingertips. As clients gain understanding of the behavior chain components listed in their SAPE tables, they will add more information about these components to their notebooks. Client notebooks also hold handouts from group sessions, as well as blank pages for notes. Each client is responsible for his or her notebook and should be reminded to bring it to group sessions.

A handout always appears at the end of the module session in which it is presented. Instead of page numbers, handouts are identified by their module and session numbers and the order in which they occur in the session presentation. For example, Module 2 Handout 1-2 is the second handout located after the Module 2 Session 1 presentation. Handouts are designed to be removed from the manual binder for ease of copying and then returned to their original place.

Moderate Group Discussions

The counselor encourages group discussion or participation in the sessions where indicated and keeps discussions on track. He or she needs to balance the time and consideration each group member receives to ensure that all clients receive sufficient attention. If some clients monopolize group time and attention, other clients may lack adequate opportunity to voice issues of concern or get the counseling attention they need, and they may lose interest in the sessions. Counselors tactfully should ask clients who monopolize discussions to speak less, without embarrassing or alienating these clients. Clients should be discouraged from telling "war stories" that seem to glorify substance abuse. When this

occurs, counselors should point out what is happening and redirect the discussion. This effort may require both firmness and a touch of humor. Permitted testimonials may describe strategies to cope with a high-risk situation and avoid substance abuse.

Conduct Behavior Rehearsals

The success of CB/SM training is determined largely by the extent to which clients practice and apply the new skills. Throughout the CB/SM process, counselors are encouraged to use a technique similar to roleplaying called behavior rehearsal. In behavior rehearsal, the counselor models the appropriate behavior and then asks a client to rehearse what was modeled. Behavior rehearsals during group sessions give clients a chance to test unfamiliar coping skills in a safe environment and get feedback from other group members. Rehearsing new skills in group sessions increases the likelihood that clients will try these new skills outside treatment. The 15 recommended steps to conducting a behavior rehearsal are

1. Read the situation aloud.
2. Help group members state the situation with a positive, how-to statement.
3. Discuss appropriate responses; brainstorm with the group.
4. Choose an appropriate response with which the group is comfortable, and explain the choice.
5. Model the effective overt behavior demonstrating the selected response.
6. Get feedback from the group on the response.
7. Ask each client, in turn, to choose a response and give a reason for his or her choice.
8. Discuss the effectiveness of each choice, and modify it as necessary.
9. Read the situation a second time, and ask a client to imagine it happening right now and to imagine a successful response.
10. Choose a client to rehearse the overt behavior.
11. Ask the group to provide feedback to the client.
12. Coach the client, if necessary.
13. Rehearse again, if necessary.
14. Ask for group feedback again.

15. Move to the next client. Start over with the same situation from step 10 on this list or introduce a new situation (i.e., by starting over from step 1), whichever is appropriate.

Some behavior rehearsals require client interaction with other group members (e.g., to rehearse situations involving social pressure). Others require a client to rehearse an "internal monolog." In the latter, the client says aloud the directions he or she would give himself or herself and the plan of action he or she would take.

The treatment modules in Section IV present a standard format for counselors to help clients rehearse both covert and overt behaviors. During rehearsals of covert behaviors, clients practice self-talk to demonstrate what they would say or think to themselves during a high-risk situation. During rehearsals of overt behavior, dialogs with the counselor are used to simulate real situations.

Some clients may feel uncomfortable at first about rehearsing behaviors. Counselors should acknowledge that such feelings are normal when trying a new interpersonal activity like behavior rehearsals. Counselors are encouraged to praise client volunteers who go first. If counselors establish a safe environment, clients are more likely to participate in behavior rehearsals.

Teach Problemsolving Skills

Figure III-7 provides the five basic steps in problemsolving. These steps can be used as part of each treatment module.

Figure III-7. Problemsolving Skills

1. Recognize that a problem exists. Examine physical signs, thoughts and feelings, behavior, reactions to other people, and others' reactions for clues.
2. State the problem as a positive goal, beginning with a how-to statement, and break it down into manageable parts.
3. Brainstorm to generate various solutions to the problem.
4. Consider the positive and negative aspects of each solution, and rank the solutions from best to worst.
5. Implement solutions, beginning with the most promising, until the problem is solved.

Stating the problem with a how-to statement gives it a positive focus. For example, if a client's problem involves being at home alone, the goal could be learning how to make new friends. If a client is bored, the goal could be learning how to participate in new leisure activities. The key is to identify a goal that implies positive action rather than focus on what must be prevented or stopped. With help from the counselor and group members, clients learn to brainstorm possible solutions before deciding which ones to try.

Administer Exercises, Quizzes, and Ratings

Each treatment module contains handouts, such as group exercises, quizzes, or rating sheets for behavior rehearsals. An exercise helps clients practice skills in a nonconfrontational, supportive group environment. A quiz or rating sheet is used to assess

how well clients learn and apply the skills taught in group sessions. Comparing pretests and posttests for a client and requiring that a minimum criterion be met ensure that the client's demonstrated mastery of the material is the determinant for when to progress to the next module or to receive individual tutoring. The handouts are located immediately following the session in which they are first used; several handouts are used in more than one session.

Maintaining Client Information

When a counselor makes or maintains copies of documents related to a client's treatment activities and progress in CB/SM, the counselor must do so in accordance with the treatment program's standard policies and procedures for the creation, maintenance, and protection of confidential client information.

Continuing Care and Followup

Previous experience (Dupree et al. 1984) suggests that clients who successfully complete the program can enhance their success by participating in a followup and continuing care program in which scheduled visits and telephone appointments decrease in frequency over time. After discharge from the skills training phase of treatment, clients return to the program (transportation assistance is provided if necessary) for followup sessions after 2 weeks and after 1, 3, 6, and 12 months. Clients who cannot return are interviewed by telephone. During return visits, clients have one-on-one sessions with a counselor to report on progress, discuss problems and solutions, and review their substance use self-monitor logs. With the client's permission, family members and significant others may be contacted for additional insight that is incorporated into these individual sessions. Counselors obtain information from family members and others through either telephone interviews or short assessment forms sent by mail, with questions addressing the client's substance use, emotional and social well-being, and physical health.

Any slip during the 12-month followup period is used as a teaching experience to prevent a recurrence of substance abuse. A client who experiences a slip during the followup period is encouraged to come in immediately for an individual session with a counselor to review the substance use behavior chain, identify reasons for the slip, and talk about how to avoid slips in the future. The client also may be encouraged to return to the program.

Figure IV-1. Module Topics and Content

Module	Number of Sessions	Topic	Content
1	2	Analysis of Substance Use Behavior	Clients learn how to analyze their behavior by breaking down their individual substance use behavior chains into antecedents, behaviors, and consequences.
2	2	How To Manage Social Pressure	Clients learn the refusal skills they need when social pressure creates high-risk situations for substance abuse relapse. The objective is to teach clients how to control their behaviors and still be able to socialize.
3	½ or 1*	How To Manage Situations at Home and Alone	Clients learn how to cope with feelings of boredom and loneliness and manage leisure time.
4	1½ or 2*	How To Manage Negative Thoughts and Emotions Associated With Substance Abuse	Clients learn how to recognize negative self-talk and repetitive thoughts, interrupt these negative patterns, and find ways other than substance abuse to cope with changes in mood.
5	3	How To Manage Anxiety and Tension	Clients learn how to manage feelings of anxiety, ways to avoid situations that produce these feelings, and skills to reduce these feelings.
6	3	How To Manage Anger and Frustration	Clients learn ways to handle feelings of anger and frustration by using assertive behavior.
7	1	How To Control Substance Abuse Cues	Clients learn how to recognize their personal substance abuse cues, and they practice skills to control these cues.
8	2	How To Cope With Urges	Clients learn that urges last for various periods; have a beginning and an end, even during abstinence; can be waited out; become weaker and end sooner each time they are resisted; and become easier to resist each time they are managed successfully.
9	1	Preventing a Slip From Becoming a Relapse	Clients learn more techniques to help them resist substances. They are taught that one slip does not have to lead to relapse, negative self-talk can be replaced with positive self-talk, and self-management skills and requests for help can be used to avoid a relapse.

*The counselor may decide whether to make the Module 3 and 4 sessions longer. If these sessions are increased from ½ to 1 and 1½ to 2, respectively, then the total number of CB/SM sessions will be 17, not 16.

Overview

The cognitive–behavioral and self-management intervention (CB/SM) for relapse-prevention treatment begins with identifying the components of the client's substance use behavior chain, including the antecedents to and the consequences of substance use. Before group sessions begin, each client's substance abuse is analyzed individually, using the Substance Abuse Profile for the Elderly (SAPE). Appendix A presents SAPE. Section III provides a complete discussion of how to administer SAPE, analyze the responses, and develop each client's substance use behavior chain.

After administering SAPE and constructing the client's substance use behavior chain, the counselor gives the client lists of his or her antecedents and consequences for review and use during the first two group sessions. During Module 1 the client, with the counselor's help, has an opportunity to modify his or her antecedents and consequences lists. These lists are used several times throughout the course of CB/SM. A diagram of each client's personal substance use behavior chain provides the client with insight into what is prompting substance abuse, what sustains it, and what cognitive and behavioral skills are needed to increase self-control and personal success.

Session 1 of this module introduces group participants to the fundamental components of a behavior chain and then defines substance abuse in terms of these components. It focuses particularly on the antecedents to substance abuse and immediately begins to teach participants how to relate these concepts to their own substance abuse.

Session 2 of this module further develops clients' understanding of the key concepts introduced in Session 1 and focuses on the consequences of substance abuse. This session introduces the substance use self-monitor log as a tool that clients use to understand and control their substance use behavior chain, including both their antecedents and their consequences.

Session 1 Outline

Objectives

1. To help clients understand key concepts of CB/SM, including the
    - ABCs of behavior
    - Substance use behavior chain
    - Antecedents to substance use

2. To teach clients how to relate these concepts to their own behavior and help them better understand why they use substances

Procedures

1. Distribute notebooks
2. Present and review the ABC behavior chain
3. Analyze simple and advanced behavior situations
4. Introduce the substance use behavior chain
5. Explain how to break the substance use behavior chain
6. Practice identifying high-risk situations for substance use behavior
7. Provide personal antecedents lists to clients
8. Assign homework to reinforce concepts

Materials

1. Three-ring notebook for each client
2. Newsprint with simple ABC behavior chain (Figure IV-2)
3. Copies of Module 1 Handout 1-1: ABC Examples Exercise
4. Newsprint with the three simple and three advanced situations (Module 1 Handout 1-1)
5. Copies of Module 1 Handout 1-2: Substance Use Behavior Chain
6. Newsprint with substance use behavior chain (Figure IV-3)
7. Copies of Module 1 Handout 1-3: Sample Situations—Identify Substance Use Antecedents Exercise
8. Clients' personal antecedents lists (developed from SAPE)

Session 1 Presentation

1. Distribute Notebooks

These notebooks are to be used for your personal note-taking and as a review-and-recall aid. You are encouraged to take notes during the sessions and to keep copies of all the handouts and other materials in order in your notebooks. In upcoming sessions, we will review information distributed in earlier sessions. Please take care of your notebooks, keep them up to date, and bring them to all sessions.

2. Present and Review the ABC Behavior Chain

A central principle of this treatment program is that you begin to understand and gain self-control of substance use when you can identify and diagram your own antecedents to and consequences of substance use behavior. In this first session, we will talk about how you can analyze your behavior. Behavior occurs as part of a connected chain of events called a behavior chain. This is a simple behavior chain: Antecedents ➜ Behavior ➜ Consequences (ABC). *(Display Figure IV-2 on newsprint.)* Every behavior (B) we perform has antecedents (A) and consequences (C).

Figure IV-2. Simple ABC Behavior Chain

Antecedent means coming before. We are interested in finding out what comes before a certain behavior. The antecedents that come before a behavior influence whether the behavior happens. If we are to understand a behavior, we need to know its antecedents—the factors that can lead to the behavior.

The consequences of a behavior come after a behavior and determine whether the behavior will happen again.

Positive consequences support or reinforce a behavior, and negative consequences discourage a behavior. For example, if, while you are driving, a stranger waves to thank you for letting her merge into your lane of traffic, you are more likely to do it again—that would be a positive consequence. However, if the stranger ignores you, you are less likely to do it again.

Many behaviors have both negative and positive consequences. If a behavior has even a slight positive consequence, often we keep repeating the behavior despite any negative consequences. For example, taking a drink may help you unwind and relax, although you also may feel pangs of guilt. However, it is usually the positive consequence—feeling more relaxed—that sticks out in your mind, so you repeat the behavior.

The more immediate a consequence, the more power and control or behavioral influence it has. A consequence that is both positive and immediate has a powerful influence in making a behavior recur.

3. Analyze Simple and Advanced Behavior Situations

(Distribute Module 1 Handout 1-1.) We'll spend a few moments using the ABC behavior chain to analyze different behaviors. Let's review the examples in this handout. These situations are unrelated to substance use. We will use them merely to demonstrate that behaviors in any situation can be analyzed in terms of their behavior chain.

In advance, display the newsprint that lists the simple and advanced situations on the handout. Display simple situation 1 from Module 1 Handout 1-1 on newsprint, and point to the antecedent (A), behavior (B), and consequence (C) while reading the example aloud. Ask the group to discuss the consequence and to rate with a plus or minus sign or both on their handouts whether the consequence is negative, positive, or both. Display the next situation on the newsprint, and encourage clients to label each part of the behavior chain on their handouts and to discuss and rate the consequence. The correct answers are on the ABC Examples Scoring Sheet on page 43. When all clients appear to understand, proceed to the third situation. Call on clients to assess whether they understand the analysis. If there is a controversy about whether the behavior is an appropriate response to the antecedent, acknowledge that alternative behaviors might have been used.

These three examples are simple situations. We will now analyze the three advanced situations on Handout 1-1.

Follow the same procedures that were used for analyzing the three simple situations. For scoring, see the ABC Examples Scoring Sheet on page 44.

4. Introduce the Substance Use Behavior Chain

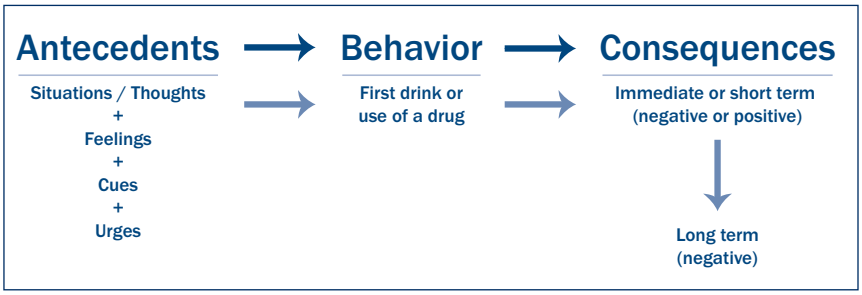
Using the same method, we will analyze substance use behavior.

Substances mean anything you drink, swallow, smoke, inhale, or inject that may cause you to become intoxicated, be under the influence, or experience a change in certain feelings or emotions. Substance use can refer to drinking alcoholic beverages, using illegal drugs, or misusing prescription drugs. Substance use is a behavior that has antecedents and consequences just like any other behavior. We already have talked about one behavior chain, the simple ABC chain. Now we will look at a longer version of that chain, the substance use behavior chain. *(Distribute Module 1 Handout 1-2, and display Figure IV-3 on newsprint.)*

This chart is similar to the ABC chart. We have antecedents, a behavior (alcohol or drug use), and consequences. In most situations leading to substance use, there are several antecedents. With problem substance use, these antecedents often occur in regular chains

or sequences of their own, starting with situations or thoughts and progressing through feelings, cues, and urges. These are the four antecedent categories.

Figure IV-3. Substance Use Behavior Chain



Situations or Thoughts

The first antecedent in the substance use behavior chain often is a situation—where you are, whom you are with, and what you are doing. You do not have to be in the actual situation to set off a reaction in the substance use behavior chain. You may be thinking about a situation. Personal situations and thoughts are antecedent conditions that can lead to substance use.

What are some situations or thoughts that lead you to substance use? *(Encourage discussion. List each response on newsprint headed "Situations/Thoughts.")*

Feelings

A situation, or the thought of it, can set off feelings. For example, you are home alone and begin to feel down. You receive some bad news and become tense and worried; or a friend asks you to have a drink, and you feel like being friendly and sociable. Feelings are important factors in substance use. We need to understand how situations or thoughts trigger unwanted feelings that we may try to self-medicate by substance use or how they trigger the desire for other immediate positive consequences. What are some of the feelings you have before you use a substance? *(Encourage discussion. List each response on newsprint headed "Feelings.")*

Cues

Cues to substance use are part of your environment. A cue is a specific sight, sound, or smell that triggers self-talk—words you think or say to yourself—such as "Have a drink" or "Take a pill." A cue seems like an invitation to use a substance. It may be a beer in your refrigerator or an ad on TV. Sometimes you see, hear, or smell something that triggers the urge to use a substance. That "something" is a cue. Sometimes the cue appears when you are already struggling with an urge *(defined below)* and is just enough to make a substance irresistible. What are some of your cues for substance use? *(Encourage discussion. List each response on newsprint headed "Cues.")*

Urges (Self-Talk)

The urge to use can be triggered by a cue. With substance use, an urge does not refer to a physical craving. An urge to use is almost always something you say silently to yourself,

rather than aloud, that gives you permission or a reason to use a substance. Yet, it is directed at you and by you. The self-talk may be "One won't hurt" or "Things can't get any worse; I might as well have a drink." What do you say silently to yourself that urges you to use? *(Encourage discussion. List each response on newsprint headed "Urges.")*

5. Explain How To Break the Substance Use Behavior Chain

An important goal of this treatment program is to break or interrupt your substance use behavior chain. This chain can be broken or interrupted in several ways.

Changing the Antecedents

First, you can try to change the antecedents to substance use by avoiding the situations/thoughts, feelings, cues, and urges that might have led you to use substances in the past. However, you cannot always change the antecedents that lead to substance use. Often you need to learn to substitute another behavior—one that leads to more positive consequences than does substance use. For example, we all feel down or depressed sometimes. This emotion is natural. When this happens, you can learn to substitute another behavior for substance use, such as calling a friend or taking a walk.

Changing the Consequences

Second, you can learn to change how you think about the consequences you might have looked forward to with substance use. For most people, the immediate consequences of normal substance use seem positive. One alcoholic drink seems to perk up your spirits. The prescribed dose of pain pills or tranquilizers relieves your pain or anxiety. You also can learn to be aware of and to remind yourself of the negative long-term consequences of your substance use behavior. What is most important is that you can remind yourself of the positive consequences of not using alcohol or illegal drugs or not misusing addictive prescription drugs and the positive consequences of finding a substitute for these types of substance use.

Breaking the Chain

Now let's go back to the antecedents of the behavior chain. Remember that they are the situations/thoughts, feelings, cues, and urges that may trigger substance use. One or more of these antecedents may lead to substance use. Sometimes you can identify all the antecedents when you have an urge to use. At other times, you may be able to pinpoint only one. It is important to learn to (1) identify your antecedents to substance use, (2) manage the situations/thoughts, feelings, cues, and urges that have led to your use, and (3) handle situations when the urge to use occurs again.

6. Practice Identifying High-Risk Situations for Substance Use Behavior

The substance use behavior chain shows a typical sequence of events for people who use alcohol or drugs, but you can learn to break the chain and regain control over your life. Let's look at some sample situations that might lead to substance use and practice identifying and labeling the antecedent categories. *(Distribute Module 1 Handout 1-3. Read each situation aloud, and ask the group to read along. With input from group members, identify and label the substance use antecedent categories. The correct answers are on the Sample Situations—Identify Substance Use Antecedents Scoring Sheet on page 47.)*

7. Provide Personal Antecedents Lists to Clients

Situations/thoughts, feelings, cues, and urges are transcribed from answers to questions 17 through 20 in Part II of SAPE, Antecedents to Substance Use, to create each client's antecedents list. State that changes and additions can be made to this list over time as more information is gathered. Keep a copy of each client's antecedents list in case he or she forgets to bring it to a session.

In the coming weeks, we are going to look carefully at your substance use behavior chain and identify ways to break it to help you regain control of substance use situations. To do this, you first have to look carefully at the antecedents to your substance use. I have made a list for each of you of the antecedents that seem to be particularly important to your substance use. *(Hand each client his or her personal antecedents list.)* Each person's list is different. The antecedents in this list are based on the questionnaire you completed in the assessment session. Some questions were about the people, places, and feelings that were antecedents to your substance use.

It is critical that your antecedents seem accurate to you. Therefore, please take a few moments now to review the list. Place an X next to any antecedent you feel is not correct, and add any antecedent you feel is missing. You may decide not to make any changes now. Keep in mind that it is not unusual for clients to change their antecedents in future sessions as they become more aware of their reasons for substance use.

Please place your antecedents list in your notebook, and review it at home.

8. Assign Homework To Reinforce Concepts

As a homework assignment, I'd like you to review and memorize the antecedent categories of the substance use behavior chain. Remember, these categories are situations/thoughts, feelings, cues, and urges. I'd also like you to review the personal antecedents list I gave you today and modify it if necessary. In the next session, we will continue developing the substance use behavior chain with particular emphasis on your antecedents and consequences.

ABC Examples Exercise

Simple Situations

1. Manuel sees his friend sitting on the porch. He walks across the street, sits down, and begins to talk to his friend. In a few minutes, Manuel and his friend are laughing.

2. Rosa feels sad about getting a parking ticket. She tells herself, “I’ll have to read the parking signs more carefully. Tomorrow is another day.” Rosa smiles and goes outdoors to drive to her friend’s house.

3. Bob’s wife comes home from work, walks into the kitchen, and cheerfully says, “Hello!” Bob, who is in a bad mood, snaps at her. She turns and quickly leaves the room.

Advanced Situations

1. Now that she is retired, Eva has been thinking about taking classes at the local community college. She calls the registrar’s office to request a catalog. When the catalog arrives in the mail, Eva finds two classes that interest her. She is excited about the prospect of learning something new as she begins her retirement.

2. Around the Thanksgiving holiday, Carmen’s thoughts turn to Christmas. The day after Thanksgiving, she sees the pre-Christmas sale ads in the morning newspaper. Carmen takes her checkbook and goes shopping. That evening she feels pleased that her shopping is done and that she found so many bargains. However, she worries that she spent too much money.

3. Antonio feels sad that his only son rarely comes to visit. He thinks about the long talks they used to have and misses the times when his son would ask for his advice. Antonio phones his daughter and begins to complain about his son. He tells his daughter what a thoughtless, uncaring person he thinks his son is. Antonio’s daughter sticks up for her brother. She tells her father that he’s a miserable old bore and it’s little wonder that no one wants to visit him.

For Counselor's Use Only

ABC Examples Scoring Sheet

The **A**, **B**, or **C** in the left column identifies the antecedent, behavior, or consequence in each situation. Plus or minus signs after the **C**s indicate whether the consequence is positive or negative.

Simple Situations

1.	
A	Manuel sees his friend sitting on the porch.
B	He walks across the street, sits down, and begins to talk to his friend.
C+	In a few minutes, Manuel and his friend are laughing.

2.	
A	Rosa feels sad about getting a parking ticket.
B	She tells herself, "I'll have to read the parking signs more carefully. Tomorrow is another day."
C+	Rosa smiles and goes outdoors to drive to her friend's house.

3.	For Bob
A	Bob's wife comes home from work, walks into the kitchen, and cheerfully says, "Hello!"
B	Bob, who is in a bad mood, snaps at her.
C–	She turns and quickly leaves the room.

4.	For Bob's wife
A	Bob's wife comes home from work, walks into the kitchen,
B	and cheerfully says, "Hello!"
C–	Bob snaps at her.

scoring sheet continues on the next page...

Advanced Situations

1.	
A	Now that she is retired, Eva has been thinking about taking classes at the local community college.
B	She calls the registrar's office to request a catalog.
C+	When the catalog arrives in the mail, Eva finds two classes that interest her.
C+	She is excited about the prospect of learning something new as she begins her retirement.

2.	
A	Around the Thanksgiving holiday, Carmen's thoughts turn to Christmas.
A	The day after Thanksgiving, she sees the pre-Christmas sale ads in the morning newspaper.
B	Carmen takes her checkbook and goes shopping.
C+	That evening she feels pleased that her shopping is done and that she found so many bargains.
C-	However, she worries that she spent too much money.

3.	
A	Antonio feels sad that his only son rarely comes to visit.
A	He thinks about the long talks they used to have and misses the times when his son would ask for his advice.
B	Antonio phones his daughter and begins to complain about his son. He tells his daughter what a thoughtless, uncaring person he thinks his son is.
C-	Antonio's daughter sticks up for her brother. She tells her father that he's a miserable old bore and it's little wonder that no one wants to visit him.

Substance Use Behavior Chain

Sample Situations—Identify Substance Use Antecedents Exercise

1. You go to a party with a friend. Your friend seems to ignore you during the course of the evening. You are on your way home and feeling hurt because of her behavior. As you approach the liquor store, you say to yourself, “I need a drink. That would help!”

2. You and your spouse have not been getting along well lately. Your spouse has accused you of not doing your share of the housekeeping. You feel that your spouse is taking advantage of you by spending too much money. You have avoided discussing the problem, but your anger is building. You pass the refrigerator and get the urge to have a beer. You say to yourself, “I could use a drink.”

3. A close friend constantly tries to borrow money from you but never pays you back. She leaves several phone messages asking you for a substantial loan. You feel nervous and tense and don’t know what to do. Then you remember the bottle of tranquilizers in your medicine cabinet. You say to yourself, “I’m so nervous. I’ll take two of these pills.”

For Counselor's Use Only

Sample Situations—Identify Substance Use Antecedents Scoring Sheet

Key:

Situation
Feeling
Cue
Urge (Self-Talk)

1. You go to a party with a friend. Your friend seems to ignore you during the course of the evening. You are on your way home and feeling hurt because of her behavior. As you approach the liquor store, you say to yourself, "I need a drink. That would help!"

2. You and your spouse have not been getting along well lately. Your spouse has accused you of not doing your share of the housekeeping. You feel that your spouse is taking advantage of you by spending too much money. You have avoided discussing the problem, but your anger is building. You pass the refrigerator and get the urge to have a beer. You say to yourself, "I could use a drink."

3. A close friend constantly tries to borrow money from you but never pays you back. She leaves several phone messages asking you for a substantial loan. You feel nervous and tense and don't know what to do. Then you remember the bottle of tranquilizers in your medicine cabinet. You say to yourself, "I'm so nervous. I'll take two of these pills."

Session 2 Outline

Objectives

1. To improve client understanding of the substance use behavior chain and antecedents to substance use
2. To help clients understand the consequences of substance use
3. To give clients a tool to monitor their substance use

Procedures

1. Review the substance use behavior chain and antecedent categories
2. Modify client antecedents lists
3. Complete substance use antecedents recall quiz
4. Present consequences of substance use
5. Identify categories of consequences
6. Introduce client consequences lists
7. Complete substance use consequences recall quiz
8. Introduce and practice using the substance use self-monitor log
9. Assign homework to reinforce concepts

Materials

1. Newsprint with substance use behavior chain (Figure IV-3) without the antecedent categories
2. Clients' antecedents lists (developed from SAPE)
3. Copies of Module 1 Handout 2-1: Substance Use Antecedents Recall Quiz
4. Newsprint with categories of substance use consequences (Figure IV-4)
5. Copies of Module 1 Handout 2-2: Sample Situations—Identify Substance Use Consequences Exercise
6. Clients' consequences lists (developed from SAPE)
7. Copies of Module 1 Handout 2-3: Substance Use Consequences Recall Quiz
8. Copies of Module 1 Handout 2-4: Substance Use Self-Monitor Log
9. Copies of Module 1 Handout 2-5: Substance Use Log Examples

Session 2 Presentation

1. Review the Substance Use Behavior Chain and Antecedent Categories

Display the substance use behavior chain on newsprint, but do not include the categories of antecedents in the chain.

At the end of the last session, I asked everyone to memorize the categories of antecedents on the substance use behavior chain. Let's see whether you can recall them. *(Call on members, and write correct responses on the newsprint.)* Now let's put the antecedents in the order in which they typically occur. *(Make sure the responses are in the following order on the newsprint: situations/thoughts, feelings, cues, and urges.)*

If you had trouble recalling the antecedents in the substance use behavior chain, take a sheet of paper from your binder and write them down using arrows to link each antecedent category.

2. Modify Client Antecedents Lists

In the last session, I also asked you to review your personal antecedents list for accuracy and to put an X next to any antecedent you thought should be changed. I also asked you to add any antecedent you felt was missing. Let's look at those lists. *(Keep copies of client lists handy in case anyone forgets to bring his or hers.)*

Who feels comfortable discussing his or her list with the group? *(If no one volunteers, ask one of the more outspoken clients in the group to talk about his or her list. After discussing that client's antecedents list, call on another group member. Continue going around the room until everyone has an opportunity to comment on his or her personal antecedents to substance use. Spend time with each client rewording any antecedents he or she feels should be changed. If a client disagrees with what seems to be a relevant antecedent, suggest that he or she discuss it with the counselor outside the group. At the end of the group session, collect the modified antecedent lists for rewriting and redistribution at the next group session. Modify the antecedents lists between sessions. Give clients their corrected lists for their notebooks at the beginning of the next session.)*

3. Complete Substance Use Antecedents Recall Quiz

We now will focus on how your personal substance use behavior chain reflects each type of antecedent. *(Distribute Module 1 Handout 2-1.)* This handout lists the four different categories of antecedents. Take a few moments and try to recall at least five personal examples for each category of antecedent. Write them down. I will collect the forms in 10 minutes and give them back to you at the next session.

Give members 10 minutes to complete the form. Collect the forms, and review them before the next session. Give clients feedback at the next group session. Occasionally, individual sessions are required for clients who need extra help. Clients who have trouble listing their antecedents

under the correct categories should be tutored before continuing in the group sessions so they can be brought up to speed. Tutoring can be done just before or after a regular group session. Repetition typically helps older clients acquire a sufficient level of knowledge to benefit from the treatment program and regulate their own substance use. Clients with limited literacy and language skills may need extra assistance from counselors. Such assistance should be provided in a respectful and nonpatronizing manner. Additional staff may be needed during some group sessions to assist counselors with these clients.

4. Present Consequences of Substance Use

Some consequences of alcohol and illegal drug use or misuse of addictive prescription drugs are immediate. Some consequences are short term, and others are long term. When I presented the simple ABC behavior chain, I said that, if a behavior is followed by a positive consequence, that behavior tends to be repeated.

Ordinarily, immediate consequences have more influence over whether a behavior is repeated than do long-term consequences. According to cognitive–behavioral theory, people learn to use and continue using substances because of the immediate, perceived positive consequences. For example, you may enjoy the taste of a drink. Initially, a drink seems to make you feel better (more social, calmer, relaxed, less worried, or less depressed), or you think it is helping you avoid a problem. One client reported that, when she drank, family members rallied around her immediately because they were worried. She was lonely but did not know how to tell her family members that she wanted to see them. Because her family gave her immediate attention when she drank, and she never had to ask for attention, she experienced two positive consequences: the attention and not having to ask for it. Similarly, the relief you feel from taking more painkillers or tranquilizers than prescribed may lead you to repeat the behavior as a way to cope with future problems, rather than to take your medication as directed by your doctor. Over the long term, however, your body develops a tolerance for these medications, and greater doses are needed to achieve the same short-term results. Long-term use of these medications also can lead to physical dependence and withdrawal if use is reduced or stopped.

Often there also are immediate negative consequences of substance use. For example, you may get angry with yourself for using alcohol or drugs as a way to escape. You may feel guilty. You may experience a hangover, forget what you did, or fall and injure yourself. The short-term consequences of using alcohol or drugs are usually a combination of negative and positive consequences. However, the immediate positive consequences of substance use increase the chances that substance use will continue until you find other ways of getting similar positive consequences.

5. Identify Categories of Consequences

The long-term consequences of substance use are all negative. Can you think of some examples? *(Ask clients to provide personal examples, and list them on the newsprint.)* These

examples can be grouped into several categories. *(Display the newsprint listing the categories and consequences in Figure IV-4 and briefly discuss.)*

Figure IV-4. Categories of Substance Use Consequences

Categories	Consequences
Mental Health Problems	Can increase the risk of both depression and anxiety. Also may cause you to be suspicious of others' motives.
Family/Marriage/Social Problems	Can cause problems in your relationships with family members, your spouse, or your friends who do not use substances, or may lead to the threat of eviction from your home.
Medical/Health Problems	Can affect your health negatively, including your mental clarity. Many of these effects can be serious and life threatening.
Legal Problems	Can lead to problems with the law, such as arrests for driving under the influence.
Employment/Financial Problems	Can impair job performance, leading to problems with employers and even termination of employment. Also can drain finances.

These negative long-term consequences rapidly can decrease the quality of your life.

We now will practice identifying substance use consequences. We also will determine whether they are short or long term and whether they are positive, negative, or mixed. Let's review the sample situations on Module 1 Handout 2-2.

Distribute Module 1 Handout 2-2, and read situation 1 aloud as clients follow along. After reading the situation, ask clients to circle the consequences, indicate whether they are short or long term, and show with a plus or minus sign or both whether they are positive, negative, or mixed. Review and discuss with clients. The correct answers are on the Sample Situations—Identify Substance Use Consequences Scoring Sheet on page 57. Repeat this process for situations 2 and 3.

6. Introduce Client Consequences Lists

I now will give each of you your personal consequences list. Just like your antecedents list, this list is based on your responses to questions on SAPE. *(Hand each client his or her personal consequences list. This list is constructed from the client's answers to questions 21 through 27 in Part II of SAPE. Keep a copy of each client's consequences list in case he or she forgets to bring it to a session.)*

Please take a few moments now to review your consequences list, and decide whether the negative and positive consequences on your list are correct for you. Place an X next to any consequences that are inaccurate, and add any consequences you feel are missing. When you are satisfied that the list is accurate, hand it in. I will give you a revised consequences list at the next session to carry with you. That will allow you to review the list often, especially when you get an urge to use alcohol or drugs. Your list of consequences must seem real and important to you if it is to be helpful.

Give clients time to review and revise their consequences list. Be sure clients have marked an X next to consequences that do not seem accurate to them. Clients often state that a consequence on the list no longer applies because their situation has changed. In most cases, these consequences should be kept on the list. Explain to the client that, although circumstances are different now, they could arise again in the future. If a client disagrees with what seems to be an obvious consequence for that person, suggest that he or she discuss it with the counselor outside the group. Collect the modified consequences lists from clients. A corrected, abbreviated version of the consequences list should be returned to each client at the next session. Lengthy statements about consequences should be abbreviated. Examples of how to abbreviate consequences are "My health will be impaired" or "I'll have less money for expenses." The counselor also should keep a copy of each client's corrected list.

7. Complete Substance Use Consequences Recall Quiz

We now will look at your personal consequences for substance use. *(Distribute Module 1 Handout 2-3.)* This handout is similar to the one you filled out earlier on antecedents. It asks for five negative and five positive consequences of your substance use and for five positive consequences of not using a substance. Take a few moments to try to remember at least five of each type of consequence. I will give you about 10 minutes to list your consequences. Then I will collect them. You will get them back at the next session.

Give clients 10 minutes to complete the form. Collect the forms, and review them before the next session. Give clients feedback at the next group session. Before clients can continue in the CB/SM program, they must be able to identify their behavior consequences. This may require tutoring some clients in individual sessions.

8. Introduce and Practice Using the Substance Use Self-Monitor Log

Now you are going to learn another way to recognize the antecedents and consequences of your substance use. You also will learn about behaviors and activities you can substitute for alcohol or illicit drug use or misuse of prescription medications whenever you have an urge to use these substances.

It is essential to become aware of the situations/thoughts, feelings, and cues that lead to your urges for substance use. One tool for this is the self-monitor log. Your substance use

self-monitor log will be very helpful in transferring what you learn here to everyday situations outside this treatment program. I strongly encourage you to keep this log on a daily basis.

You can understand your substance use behavior only if you are aware of the antecedents that prompt you to use substances. Keeping a substance use log will help you track your substance use behavior. The more you understand your behavior, the more you will be empowered to cope with your urges for substance use. On days that you have urges to use a substance, I would like you to record carefully the following *(Write the four points on newsprint.):*

- Date, time, place, people you are with, events preceding the urge, and your feelings
- Whether you used a substance, what kind of substance you used, and how much you used
- If you used a substance, how you felt after you used and what happened after you used
- If you didn't use, what you did instead

When you have an urge to use a substance and you do not give in, your substance use log will help you identify the behaviors you substituted for substance use. It is necessary for you to be honest when keeping this log. On occasions when you give in to an urge, admit it. We're not here to look down on you or to judge you. However, for the program to work, I need to know when and how much you are using, under what circumstances, and with what consequences.

At the beginning of each session, I will collect your individual self-monitor logs and give you new ones. Your substance use self-monitor logs also will be reviewed in an individual session. If you are not controlling your substance use behavior, this will be discussed with you individually. Our discussion during group sessions will not be punitive. Instead, we will use this time to explore the behaviors you must learn to gain control over individual factors that can lead to substance use. You are encouraged to learn from one another and to contribute to one another's success. Confrontation of any type is not permitted. Giving in to substance use is not desired. When that happens, however, we will focus on new behaviors that need to be learned or available behaviors that are not being used and why, so your occurrences of substance use become less frequent and you can maintain abstinence.

Let's take a look at a sample substance use log. *(Distribute Module 1 Handout 2-4, and draw a sample log on newsprint. Go through the log format step-by-step, and tell clients what they should record after each heading. Emphasize the importance of completing the log. Encourage client participation, questions, and discussion and give each client an opportunity to contribute. Module 1 Handout 2-5 provides practice examples if clients are having trouble understanding how to fill in the log. If practice is required, distribute Module 1 Handout 2-5 with a practice log form, and ask clients to fill in the practice form. Review clients' practice logs, and correct any errors. Repeat the practice exercises if necessary. Clients should strive for 100-percent accuracy with their log data. Initially, counselors should review client logs carefully, and clients should be told when they are making errors. Clients are required to write in their logs every day, regardless of whether they use a substance.)*

9. Assign Homework To Reinforce Concepts

I'd like you to keep a self-monitor log between now and the next group session. If you get an urge to use a substance, record the day, time, place, and other antecedents. If you do not engage in substance use at that time and substitute another behavior instead, put a checkmark in the "did not drink or use drugs" row, and write down what you did instead. Also place a checkmark next to those days on which you did not use a substance. If you used a substance, write down exactly what and how much you used and the consequences. I'm going to ask you to keep a log from now on.

Clients sometimes have strong feelings about carrying around a substance use log. This issue should be addressed at this point.

Keep your log with you, and fill it out when you have an urge to use a substance. It may be a nuisance to carry a substance use log with you, but I strongly urge you to do it. The act of recording your urge to use substances and its antecedents can be a valuable tool in breaking the substance use chain. Keeping a daily log will give you insight into your "real world" behavior, and it can be a source of reinforcement on days that you successfully handle urges. You also will be able to chart your progress over time.

By recording and interrupting your urge for substance use, you can see that the urge ends, even when you do not give in to it. If you can substitute another activity or behavior for substance use, you will prove to yourself that you can resist your urge. Every time you say no, you weaken the link between your urge and substance use, making it less likely that the urge will be as strong or last as long when it happens again.

If you get to the end of the day without having an urge to use alcohol or illicit drugs or misuse addictive prescription medications, write "no urge" in the appropriate space under that day. On the "no urge" days, try to figure out what may have occurred that was different from the days on which you had strong urges, and record a few notes about the situation in the blank space under the appropriate columns. Write something in your log every day. At the moment you have an urge, immediately record what preceded it in your log. If you use alcohol or drugs, write down exactly what you used and how much. You can overcome your problem with substance use only if you learn how to analyze your behavior, and your substance use log can help you do that.

Print each client's name and date on the blank logs before handing them out at each group session. Collect completed logs from clients at the beginning of each session, and distribute blank copies of the log. Review completed logs carefully each week for accuracy and the types of information provided. After reviewing each log, make a photocopy of it and place the copy in the client's treatment chart. Return the original to the client and ask him or her to place it in his or her notebook. Counselor attention to client logs is a critical factor in motivating clients to keep a log.

Substance Use Antecedents Recall Quiz

CLIENT'S NAME_____ **DATE** _____

Situations/Thoughts:	List situations or thoughts that affect your substance use.

1. _____
2. _____
3. _____
4. _____
5. _____

Feelings:	List feelings that affect your substance use.

1. _____
2. _____
3. _____
4. _____
5. _____

Cues:	List cues that affect your substance use.

1. _____
2. _____
3. _____
4. _____
5. _____

Urges:	List urges/self-talk that affect your substance use.

1. _____
2. _____
3. _____
4. _____
5. _____

Sample Situations—Identify Substance Use Consequences Exercise

1. You feel let down by a friend, and you are puzzled and hurt by her behavior. You decide that a drink would help, so you go to the store and buy a bottle of liquor. After your first drink, your spirits lift a little, and, even though you feel guilty about it, you decide to have another. In a few hours, you drink a third of the bottle. Now the depressive effects of alcohol set in, and, instead of feeling uplifted, you feel more sad and lonely. The day is almost over, and the plans you had are no longer possible. When your niece arrives at 5 p.m. to take you out to dinner, you are in no condition to go. She says she is sorry, but she really can't make plans to go out with you anymore.

2. You and your spouse have been arguing about how to spend money. You are angry and tense over the difference of opinions, but you have avoided sitting down with him or her to come up with a solution. Instead, you decide to calm your nerves with a drink. After the first drink, you feel relaxed and much calmer, so you have a second. After four drinks, you fall asleep. You have forgotten to take your blood pressure medication. The next day at your doctor's appointment, your doctor tells you he is concerned about your blood pressure and about the chronic stomach pains you have developed.

3. You just received upsetting news that a family member was rushed to the hospital. You decide to go there right away. You become very upset thinking about what might happen, and you take two tranquilizers (double the prescribed dose) to calm down. You soon feel calm, but you recognize that now you may have trouble driving. After about 30 minutes, you become groggy and fall asleep. You never make it to the hospital.

For Counselor's Use Only

Sample Situations—Identify Substance Use Consequences Scoring Sheet

Key:

Short-Term Positive

Short-Term Negative

Long-Term Negative

1. You feel let down by a friend, and you are puzzled and hurt by her behavior. You decide that a drink would help, so you go to the store and buy a bottle of liquor. After your first drink, your spirits lift a little and, even though you feel guilty about it, you decide to have another. In a few hours, you drink a third of the bottle. Now the depressive effects of alcohol have set in, and, instead of feeling uplifted, you feel more sad and lonely. The day is almost over, and the plans you had are no longer possible. When your niece arrives at 5 p.m. to take you out to dinner, you are in no condition to go. She says she is sorry, but she really can't make plans to go out with you anymore.

scoring sheet continues on the next page...

Key:

Short-Term Positive

Short-Term Negative

Long-Term Negative

2. You and your spouse have been arguing about how to spend money. You are angry and tense over the difference of opinions, but you have avoided sitting down with him or her to come up with a solution. Instead, you decide to calm your nerves with a drink. After the first drink, you feel relaxed and much calmer, so you have a second. After four drinks, you fall asleep. You have forgotten to take your blood pressure medication. The next day at your doctor's appointment, your doctor tells you he is concerned about your blood pressure and about the chronic stomach pains you have developed.

3. You just received upsetting news that a family member was rushed to the hospital. You decide to go there right away. You become very upset thinking about what might happen, and you take two tranquilizers to calm down. You soon feel calm, but you recognize that now you may have trouble driving. After about 30 minutes, you become groggy and fall asleep. You never make it to the hospital.

Substance Use Consequences Recall Quiz

CLIENT'S NAME_____ **DATE** _____

Negative Consequences of Substance Use:	List as many as you can that are important to you.
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	

Positive Consequences of Substance Use:	List as many as you can that are important to you.
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	

Positive Consequences of Not Using a Substance:	List as many as you can that are important to you.
1. _____	
2. _____	
3. _____	
4. _____	
5. _____	

Substance Use Self-Monitor Log

WEEK _____ **CLIENT'S NAME** _____

General Instructions: Use this log to monitor your urges to use alcohol or drugs, what brings about those urges (antecedents), and what happens after you use a substance (consequences).

Antecedents (Situations/Thoughts, Feelings, Cues, Urges)	Day of the week							
	What time is it?							
	Where are you?							
	Whom are you with?							
	What has just happened?							
	How are you feeling?							
Behavior and Consequences	If you drank or used a substance... What and how much?							
	If you drank or used a substance... How do you feel?							
	If you drank or used a substance... What happened afterward?							
	If you did not drink or use drugs what are you doing instead?							

Place a ☑ next to days you did not drink or use drugs

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐

Substance Use Log Examples

1. You have not had a drink in 6 months. On Monday you go out to lunch with someone you recently met at a senior citizens' gathering. You don't know him very well, but you'd like to get to know him better. You start talking about politics, and you tell him what you think about the war on terrorism. To your surprise he says, "That's ridiculous. You don't know what you're talking about!" You feel angry and put down, but you're not sure how to handle your feelings. You order a martini to calm down. After you drink it, you feel relaxed. Then you decide that this man isn't worth your time, and you leave.

2. Your best friend's wife recently passed away. You've invited him to stay with you for a few months until he gets back on his feet emotionally. On Tuesday morning, you learn he has been going through your things, and your clothes are scattered all over the bedroom. You are furious, and you're not sure what to do about the situation. In your frustration, you feel like having a drink. Instead, you decide to consult a trusted friend and brainstorm some possible solutions.

3. It is Friday afternoon at 5 p.m. Your daughter and her husband are supposed to drop by to see you, but they are late. You are bored, lonely, and angry that they have not yet arrived. You feel like having a drink, but you know they don't like it when you drink. You finally say, "The heck with it! It serves them right!" After you've had three beers, they arrive, and they are angry. You are angry, too. You yell at them for being late and blame your drinking on them.

Overview

Once clients understand and can identify the components of their substance use behavior chains, they are ready for the next modules, which teach them skills for preventing relapse. In Module 2, clients learn how to use cognitive–behavioral and self-management skills to cope with one type of common antecedent to substance use and relapse—social pressure. Teaching individuals how to manage, preclude, or terminate antecedents to substance abuse, such as social pressure, gives them tools they can use immediately and helps them maintain self-control in the future.

Many people who abuse substances are influenced by social pressure, which can be a difficult antecedent to manage or eliminate. It creates high-risk situations because it incorporates fears of being disliked or losing a friend and because powerful cues, such as seeing or smelling a substance or being in a bar or restaurant, often contribute to the situation. Clients who abuse substances can learn the skills necessary to change their behavior and still keep their friends.

This module teaches self-management skills for use in social pressure situations. It teaches clients how to recognize and respond to social pressure situations that influence substance abuse. During the activities in this module, clients practice substance use refusal skills in sample situations involving social pressure. Clients begin to assume primary responsibility for their own behavior as they receive training in substance use refusal skills.

During this module, counselors also assess clients' abilities to refuse a substance in situations involving social pressure by asking questions such as

- Does the client actually say no?
- Does the client have good eye contact with the person exerting the social pressure, as the client says no?
- Does the client speak firmly and convincingly?
- Does the client try to change the subject or suggest an alternative to substance use?
- Does the client ask the person to stop pressuring him or her?

Session 1 Outline

Objectives

1. To improve and strengthen clients' substance use refusal skills
2. To teach clients new ways to handle social pressure

Procedures

1. Return clients' modified antecedents and consequences lists, and provide feedback on antecedents and consequences recall quizzes
2. Review the substance use behavior chain
3. Assess clients' substance use refusal skills
4. Explain the importance of changing substance use situations
5. Discuss social pressure as an antecedent to substance use
6. Introduce substance use refusal skills
7. Describe the five refusal steps
8. Rehearse refusal skills
9. Assign homework to reinforce concepts

Materials

1. Copies of Module 1 Handout 2-4: Substance Use Self-Monitor Log (Module 1 Session 2)
2. Clients' modified antecedents and consequences lists and copies of Module 1 Handout 2-1 and Module 1 Handout 2-3 completed by clients in Module 1 Session 2
3. Newsprint with substance use behavior chain (Figure IV-3)
4. Copies of Rating Form: Substance Use Refusal Behavior Rehearsal (page 72)
5. Copies of Module 2 Handout 1-1: Substance Use Refusal Bill of Rights
6. Newsprint with substance use refusal bill of rights (Module 2 Handout 1-1)
7. Copies of Module 2 Handout 1-2: Five Steps to Refusing a Substance
8. Newsprint with five steps to refusing a substance (Module 2 Handout 1-2)
9. 3- by 5-inch index cards with the scripts on pages 69 and 70

Session 1 Presentation

Collect substance use self-monitor logs from clients, and distribute blank copies of the log. Photocopy each completed log, and place a copy in the client's treatment chart before returning the original to the client.

1. Return Clients' Modified Antecedents and Consequences Lists, and Provide Feedback on Antecedents and Consequences Recall Quizzes

Distribute clients' modified antecedents and consequences list, and tell clients to review them briefly and place them in their notebooks.

Return Module 1 Handout 2-1: Substance Use Antecedents Recall Quiz and Module 1 Handout 2-3: Substance Use Consequences Recall Quiz (both were completed in Module 1 Session 2), and provide feedback as appropriate. Tell clients to place them in their notebooks.

2. Review the Substance Use Behavior Chain

As you already know, the events that happen before you use substances on a typical day are called antecedents. Usually situations or thoughts are the first antecedents you experience. Today we will focus on social pressure situations. *(Display newsprint chart that shows the substance use behavior chain [Figure IV-3].)*

3. Assess Clients' Substance Use Refusal Skills

To begin this session, we will practice some sample situations, and I will rate each of you on how well you cope with a situation. Then you will learn refusal skills, which you will use to improve how you cope with different situations.

Read one of the sample situations below to the group, and ask clients to imagine themselves in the situation. Rehearse the situation with each client in turn. The counselor plays the role of the "provoker," and the client is the "refuser." Give each client adequate time to react. Rate each client using the Rating Form: Substance Use Refusal Behavior Rehearsal on page 72. Do not give oral feedback to clients at this time. On each client's rating form, note which situation was used. In Session 2, clients will rehearse the same situation at the end of the session, and their performance will be scored. The two scores will be compared to determine whether the client has mastered the skill.

Situation 1. You are at a party, and you have been careful not to drink alcohol or use drugs. After an hour, an old friend you haven't seen in several years comes over to you with a drink, hands it to you, and says, "Come on, how about a drink for old times' sake?"

Situation 2. You are at your family reunion. You have been careful not to drink alcohol, but others are drinking and seem noticeably more relaxed and uninhibited, and you feel a little left out. A cousin turns to you and says, "Won't you have just one with the rest of us?"

Situation 3. You have been discharged from the hospital and need a place to stay for a few days until your housing is available. An old friend offers her couch, and you agree to stay at her place. You know that she takes a lot of tranquilizers and pain pills. She takes out some tranquilizers and says, "Here's a little welcoming gift. I bet you could use these now."

Situation 4. When you visit your friend at her apartment, she takes out a bottle of peppermint schnapps. You get a whiff of peppermint as she pours some into a glass. She tries to pass you the glass and says, "Here's to friendship."

4. Explain the Importance of Changing Substance Use Situations

What is a situation? For our purposes, a situation refers to where you are, what you are doing, and whom you are with just before using a substance. The situation is the earliest antecedent of the substance use behavior chain. *(Point to newsprint chart.)* If you can change something about the situation, you can break the chain at its earliest link. In other words, by recognizing a situation that poses a high risk for substance use, you can do something about it immediately before you move any closer to using a substance.

In some situations, other people may be around. In others, you may be alone. In this session and the next one, we will discuss situations in which other people are present. These situations involve social pressure to use alcohol or drugs.

5. Discuss Social Pressure as an Antecedent to Substance Use

When other people try to influence you to use substances, it's called social pressure. Has anyone ever pressured you into using alcohol, drugs, cigarettes, or any other substance you were trying to give up? How did you respond? *(Call on a few clients.)* Sometimes your friends may ask you to join them, and you may find refusing their offer difficult. Why? *(Encourage discussion. Write responses on newsprint.)*

Sometimes you may find it difficult to refuse an offer because you don't want to say no to a friend. For those of you who live alone or have lost your spouses, good friends may be hard to come by. You may have few friends to count on, so you fear losing or alienating them.

Sometimes, you may not even recognize social pressure. Imagine, for a moment, that you are at a restaurant, and the server asks you whether you would like a drink. You may experience pressure just from seeing other people around you who are drinking. How does seeing others using substances affect you? *(Encourage discussion.)*

Do you know why it is so difficult to say no to your friends? Take another look at the substance use behavior chain, and tell me what follows the situation and thoughts. As you can see, the situation—in this case social pressure—leads to feelings. If you say no to a friend who was trying to be kind by offering you alcohol or drugs, what feelings might you experience? *(Encourage discussion.)* Many of us might feel anxious or fearful. We're afraid that, if we refuse the substance, we are saying no to our friends, or we fear that our friends may think we are rejecting them.

What about when you see others, even strangers, using substances? How do you feel? *(Encourage discussion.)* If you refuse a substance, you might be worried that you'll be seen as different; you might be worried that others will make fun of you; or you might think that everyone but you is having a good time. Would these feelings make you uncomfortable? *(Encourage discussion.)*

Our goal is to break the substance use behavior chain at its earliest point by learning new coping skills for situations that create social pressure to use a substance. In some cases, you will have to remove yourself physically from the situation. You may choose to "take a vacation" from friends who use substances, develop new friendships, or find alternative places to go and activities to do.

6. Introduce Substance Use Refusal Skills

Every time you refuse an offer to use a substance in real situations, this refusal will be reinforced by the positive consequences of not using a substance. However, what happens when a good friend pressures you to join him or her? When this happens, you also need to be prepared with other things you can do or say to handle the situation.

Let's try an exercise. Imagine the following situation: You are in a restaurant with a couple of friends. One friend says, "It's Happy Hour. You can have two drinks for the price of one. I'm buying us all rounds of bourbon on the rocks. Let's celebrate our friendship!" How would you feel? *(Encourage discussion.)*

Sometimes it's easy to say, "No thank you," to a stranger, such as a server, because you know he or she will not think badly of you. However, you might find it more difficult to handle situations with your friends. Let's talk about how to refuse a drink and still keep a friend.

The first step in coping with high-risk situations for substance use is to think about the goals you want to accomplish. In this case, the goals would be to refuse the offer and to avoid offending the friend. Let's look at the substance use refusal bill of rights. *(Distribute Module 2 Handout 1-1, and display newsprint listing these rights. Read them aloud.)* What do you think of these rights? *(Encourage discussion.)*

7. Describe the Five Refusal Steps

The five basic steps in refusing a substance are listed on Module 2 Handout 1-2. *(Distribute handout, and display newsprint listing these rights. Read them aloud.)*

Refusing a substance should never be viewed as rejecting the person making the offer. However, if you wish to succeed at refusing, you must communicate convincingly. Sometimes it will be enough to say, "No, thank you." That works well for the server waiting for your drink order at a restaurant or with your understanding friends. When a person continues to insist, however, you must show that you are serious about your position. Say, "No, thank you," firmly and convincingly, and look at the person when you are speaking. Eye contact and a serious demeanor are key to getting the point across.

If the person who pressures you is a friend or someone you want to continue to see, suggest an alternative activity; for example, say, "I would enjoy having a soda or coffee with you," or change the subject by saying something like, "Hey, have you been exercising recently? You look as if you've lost weight."

What happens if that person continues to pressure you and won't take no for an answer? You might try asking that person to change his or her behavior by saying something like, "Please don't ask me again to have a drink."

8. Rehearse Refusal Skills

Let's practice these techniques in common social pressure situations. I'll read some situations. Then we'll talk about how to handle them. *(Read situation 5 aloud.)*

Situation 5. You are in a restaurant having dinner with two friends. The server has taken your friends' drink orders. She turns to you and says, "How about you? Will you have a drink before dinner?" Your friends chime in and say, "Of course Bob wants a drink. What will you have?"

Let's state the problem in a positive how-to statement. For example, we could state the problem as "how to say 'No, thank you,' to the server and get your friends to stop insisting." *(Take suggestions from the group. Once the problem has been stated, ask for the group's agreement.)* Does everyone agree?

Once the group agrees, or at least understands why this problem statement is appropriate, discuss various ways of responding, and write appropriate responses on newsprint.

The goal is to refuse clearly and firmly but in a pleasant manner. I am going to rehearse this situation with a volunteer from the group. The volunteer will be the server. We'll call the server the provoker, and I'll be the refuser. *(Hand the volunteer the following script on a 3- by 5-inch index card.)*

Script

Provoker:	Would you like a drink before dinner?
Refuser:	No, thank you. I'm fine.

I tried to refuse firmly and maintain good eye contact with the server. How did I do? *(Encourage feedback.)* I also could have said, "Yes, thank you. I'll have tomato juice." What else could I have said? What would you have said? *(Encourage responses, and ask each client what he or she would have said. Discuss each client's response, and involve group members in modifying responses.)*

Saying no to the server is an example of a simple situation. You do not have a relationship with the provoker, and there is little likelihood of a relationship. In this situation, we needed to act out only the first three steps of refusal: say no thank you, make eye contact, and speak firmly and convincingly.

Now we will talk about the last two steps to refusing a substance. When you have a relationship with the other person and you want to maintain it, as you do, for example, with the friends you are dining with, you can change the subject, suggest another activity, or both. What happens when you change the subject? It lets the person know you don't want to discuss it further. For example, you can say, "No, thank you. I don't drink. Tell me, how is your new job going?" That way the refuser doesn't have to continue discussing a topic that makes him or her uncomfortable.

What happens when you suggest another activity? It lets the person know that you are not rejecting him or her even though you are rejecting the alcohol or drugs. This approach is appropriate with a friend or with someone you would like to know better. You can say something like, "No, thanks; I don't drink anymore. How about joining me for a cup of coffee?"

When the person does not accept a simple no gracefully, you must ask him or her not to offer you a substance again. For most people, this is the hardest step in refusing a substance. It may be too intimidating for a refuser to say to a friend or potential friend, "John, I've quit drinking alcohol, so please don't ask me again" or "Mary, I don't use drugs, so please don't ask me again." If you are serious about refusing a substance, you have the right to tell the person that you will not be pressured into something you don't want now or in the future.

In a situation with someone you want to get to know better, you can use the first four steps to refusing a substance. If the person asks again, say, "No thank you," again firmly and convincingly, and then use step 5. In your own words, tell him or her not to ask again.

Let's practice another situation, but this time we will pay attention to all five steps to refusing a substance. *(Refer to the newsprint listing Module 2 Handout 1-2.)* Let's review the steps:

1. Say, "No thank you."
2. Make eye contact.
3. Speak firmly and convincingly.
4. Change the subject, or suggest an alternative activity.
5. Ask for a change in behavior.

Let's look at another situation. *(Read situation 6 aloud.)*

Situation 6. You've seen a woman several times in your apartment complex or neighborhood. You've exchanged hellos many times and chatted about the weather. You seem to get along well together. You see her at the mailbox one afternoon, and, after talking for half an hour, she asks whether you would like to come up to her apartment for a glass of wine. You don't want to drink or to offend her, but you want to continue the conversation.

Let's state the problem as a positive goal, beginning with how to. *(By this point, the group should understand why the how-to statement is important [i.e., it focuses on solutions rather than merely restates the problem].)* For example, we could state the problem as "How to say no thank you without putting the woman off and losing a potential friendship." Does everyone agree with this how-to statement? If not, what would you say in this situation to state a how-to solution to the problem?

Brainstorm other alternatives for the how-to statement, and write them on the newsprint. Discuss the pros and cons of each. Choose one, and explain why.

Now I am going to rehearse the situation with a volunteer from the group. *(Ask for a volunteer to play the role of provoker, and hand him or her the following script on a 3- by 5-inch index card.)*

Script

Provoker:	Why don't you come over to my place for a glass of wine?
Refuser:	No, thanks. I don't drink, but I'd be glad to come up for a cup of coffee or tea. *(Be sure to model eye contact and conviction.)*
Provoker:	I just bought a new bottle of wine I'd like you to try.
Refuser:	No, thanks. Please don't offer me a drink again because I've quit, but I'll be glad to come up for a cup of coffee or tea.

I am trying to resist this person's offer without rejecting her or putting her off. Did I succeed? *(Encourage feedback. Ask each client to state his or her preferred response and the reason. Briefly discuss the effectiveness of each client's choice, and suggest modifications, as necessary.)*

Now I am going to read the situation again. This time, I want you to lean back in your chairs, and close your eyes. Take a deep breath and relax. Relaxation will help you imagine the scene more clearly. Imagine yourself in the situation. Rehearse in your mind how you would refuse the drink offer but let the person know you would like to spend time with him or her. *(Allow several minutes for this exercise. Then ask each client, in turn, to rehearse this situation. Encourage group feedback. Coach the client, and ask him or her to rehearse again, if necessary.)*

Let's practice two more situations.

Situation 7. You are at a party getting acquainted with another guest. Your host asks what the two of you would like to drink. Your friend asks for a cocktail, and you ask for a soft drink. She turns to you and says, "What's the matter? Don't you drink?"

Situation 8. You are out with old friends. They want to stop at the local spot where you used to drink with them.

Let's first state the problem in a positive how-to statement: How to say no thank you without rejecting a person you like. *(Follow the same process you used to rehearse situations 5 and 6. Ensure that each client has an opportunity to rehearse a situation.)*

You should keep a couple of things in mind when encountering these situations. First, look at the problem in a positive how-to way. Second, have positive goals such as refusing substance use and getting acquainted with someone or maintaining a friendship without using alcohol or drugs.

9. Assign Homework To Reinforce Concepts

Your homework assignment is to think of a situation in which you felt social pressure to use a substance in the last 6 months or to think of a possible situation that could happen in the future. It must be one that you are willing to share with the group because we will rehearse these situations in our next session. Write down the situation. Be specific about the person and the place. Describe the problem, the goal, and your response. If you cannot think of an actual situation, make up one.

Also, remember to continue filling out your substance use self-monitor log.

For Counselor's Use Only

Rating Form: Substance Use Refusal Behavior Rehearsal

CLIENT'S NAME _____

RATER'S NAME _____

Problem Situation (State the situation in the box below.)	Rehearsal 1 Date: _____			Rehearsal 2 Date: _____		
	No Evidence of Desired Behavior	Some Evidence of Desired Behavior	Clearly Performed Desired Behavior	No Evidence of Desired Behavior	Some Evidence of Desired Behavior	Clearly Performed Desired Behavior
1. Did the client say no (e.g., use the words "No, thank you")?	1	2	3	1	2	3
2. Did the client look at the provoker (e.g., by either making direct eye contact or looking toward the person)?	1	2	3	1	2	3
3. Was the client firm and convincing when responding?	1	2	3	1	2	3
4. Did the client change the subject or suggest an alternative activity to substance use?	1	2	3	1	2	3
5. Did the client ask for a change of behavior in the future (e.g., use a phrase such as "in the future," "again," "next time")?	1	2	3	1	2	3

Scoring: To receive a passing score, the client must receive at least a 2 in each category.

A client who does not receive a passing score may need additional help in individual treatment sessions.

Substance Use Refusal Bill of Rights

1. You have the right to refuse a substance.
2. You have the right to refuse without feeling guilty.
3. You have the right to stand up for yourself.
4. You have the right to manage your own life.
5. You have the right to be the final judge of your own behavior, and you are responsible for your behavior.
6. You do not have the right to deprive others of their rights.

Five Steps to Refusing a Substance

1. Say, “No thank you.”
2. Make eye contact with the person offering the substance.
3. Speak firmly and convincingly.
4. Change the subject, or suggest an alternative activity.
5. Ask the person to change his or her behavior.

Session 2 Outline

Objective

1. To increase client comfort level in using substance use refusal skills through situation rehearsals

Procedures

1. Review substance use refusal steps
2. Rehearse personal situations
3. Reassess clients' substance use refusal skills
4. Assign homework to reinforce concepts

Materials

1. Copies of Module 1 Handout 2-4: Substance Use Self-Monitor Log (Module 1 Session 2)
2. Copies of Module 2 Handout 1-1: Substance Use Refusal Bill of Rights (Module 2 Session 1)
3. Copies of Rating Form: Substance Use Refusal Behavior Rehearsal (partially completed in Module 2 Session 1)

Session 2 Presentation

Collect substance use self-monitor logs from clients, and distribute new blank copies of the log. Photocopy each completed log, and place a copy in the client's treatment chart before returning the original to the client.

Before beginning the session, make sure everyone has done the homework assignment from the last session, which was to write down a personal social pressure situation. Ask clients who have not done the assignment to write down a situation before the session begins.

1. Review Substance Use Refusal Steps

In the last session, we discussed the five steps to refusing a substance. Do you remember them? *(List the five steps on the newsprint as clients name them.)*

When someone offers you a substance and pressures you to use it, you may find it difficult to say no. In these situations, you may feel social pressure. You may be afraid that you'll insult the person or be viewed as odd. If this describes the way you feel, think about the substance use refusal bill of rights. *(Ask clients to take Module 2 Handout 1-1 from their notebooks, and review it with them.)* If the person pressuring you is a true friend, he or she will respect your decision and attempt to understand your refusal of the substance without feeling hurt or judging you. If the person continues to pressure you, you must decide which is more important—your well-being or that person's opinion of you.

2. Rehearse Personal Situations

In our last session, we discussed theoretical situations for refusing a substance. All the situations involved social pressure. For your homework assignment, I asked you to write down a situation in which you experienced social pressure to use a substance in the last 6 months or a possible situation that could happen in the future. If you could not think of an actual situation, I asked you to make up one. We will use these situations to rehearse using the refusal steps.

If the person in the situation you have written about is someone you associate with often or might associate with in the future, use the first four steps to refusing a substance. If you are pressured further, use step 5. Now we are going to rehearse some of the situations you have faced or might face in the future.

Ask for a volunteer or select one of the more confident clients to describe his or her situation. With group input, formulate a correct how-to statement. Then ask the client what he or she would say or do in this situation. Ask the group for other suggestions. Write everyone's ideas on the newsprint.

From all of these suggestions, I am going to select this response: I would say or do _____. *(Choose one of the responses from the newsprint.)* Here's why. *(Explain why you chose the particular response. Model the steps to refusing a substance, and ask for feedback from the group. Ask each client, in turn, to take another look at the alternatives, choose the one that best suits him or her, and explain why.)*

(Ask permission to use _____'s [name of client] situation. Then continue with the group, using the following narrative.) Okay, now I would like you to sit back, close your eyes, relax, and try to imagine _____'s *(name of client)* situation. Imagine a successful response to this situation—a response that says no to the substance without rejecting the person.

Ask another client to read his or her situation. Rehearse the situation with the client using the steps to refusing a substance. Ask the rest of the group for feedback. Then move to the next client. Continue this process until all clients' situations have been rehearsed and discussed.

3. Reassess Clients' Substance Use Refusal Skills

We are going to rehearse again the first situation we rehearsed in the last group session. We'll compare your responses from that first rehearsal with this rehearsal. This time use all the refusal steps. I'll read the situation to you and ask you how you would say no to a substance in that situation. I would like you to begin thinking about how you would respond.

Retrieve the rating forms that were used in Session 1. Ensure that each client rehearses the same situation that he or she was rated on earlier. Rate the client on his or her second performance, and compare the two scores. Repeat this exercise with each client. To complete the exercise successfully, the client must score at least a 2 on each question. Clients who are unsuccessful should get additional coaching and be reassessed later. Clients who continue to score below a 2 for each question must repeat both sessions of Module 2 at a time to be determined by the counselor and the client.

Situation 1. You are at a party, and you have been careful not to drink alcohol. After an hour, an old friend you haven't seen in several years comes over to you with a drink, hands it to you, and says, "Come on, how about a drink for old times' sake?"

Situation 2. You are at your family reunion. You have been careful not to drink alcohol, but others are drinking and seem noticeably more relaxed and uninhibited, and you feel a little left out. A cousin turns to you and says, "Won't you have just one with the rest of us?"

Situation 3. You have been discharged from the hospital and need a place to stay for a few days until your housing is available. An old friend offers her couch, and you agree to stay at her place. You know that she takes a lot of tranquilizers and pain pills. She takes out some tranquilizers and says, "Here's a little welcoming gift. I bet you could use these now."

Situation 4. When you visit your friend at her apartment, she takes out a bottle of peppermint schnapps. You get a whiff of peppermint as she pours some into a glass. She tries to pass you the glass and says, “Here’s to friendship.”

4. Assign Homework To Reinforce Concepts

Your homework assignment is to continue practicing these substance use refusal skills. You also should continue to fill out your substance use self-monitor log.

Overview

Situations and thoughts are the earliest links in the substance use behavior chain and the point farthest from the first use of alcohol or drugs. This is the best time to intervene and break the chain.

Often, people with no plans or activities scheduled are at high risk for substance abuse. Many older adults abuse substances when they are at home and alone (Dupree et al. 1984; Schonfeld and Dupree 1991; Schonfeld et al. 2000). In Module 3, the group spends a short session talking about how being home and alone presents a high-risk situation for them personally. The purpose of this brief session is to make clients aware of these risks and to introduce coping skills to address them. This session also sets the stage for upcoming sessions that address feelings of depression, boredom, and loneliness.

Module 3 is scheduled to require approximately 35 minutes of the group session. The remaining 40 minutes may be used to cover the material in Module 4 Session 1. Alternatively, the counselor may wish to use the full 75 minutes for Module 3, for example, by adding a guest speaker.

Session 1 Outline

Objective

1. To teach clients new ways to handle being at home and alone

Procedures

1. Review substance use refusal skills
2. Discuss being at home and alone
3. Identify alternative activities and enjoyable events
4. Assign homework to reinforce concepts

Materials

1. Copies of Module 1 Handout 2-4: Substance Use Self-Monitor Log (Module 1 Session 2)
2. Newsprint with substance use behavior chain (Figure IV-3)
3. Newsprint with at home and alone antecedents (Figure IV-5)
4. Clients' modified antecedents lists
5. A list of phone numbers of senior organizations, such as the local area agency on aging, senior centers, and aging nutrition organizations, as well as Alcoholics Anonymous (AA) and other local mutual-help groups
6. A list of volunteer organizations appropriate for older adults

Session 1 Presentation

Collect substance use self-monitor logs from clients, and distribute blank copies of the log. Photocopy each completed log, and place a copy in the client's treatment chart before returning the original to the client.

1. Review Substance Use Refusal Skills

Spend a few minutes reviewing the substance use refusal skills presented in Module 2. Ask clients whether they used the five steps to refusing a substance and what the results were. If clients had difficulty with the steps, offer suggestions on ways to improve their ability to use these steps.

2. Discuss Being at Home and Alone

Some older adults commonly use alcohol or drugs when they are at home and alone. How many of you used alcohol or drugs when you were at home? Were you usually with someone or were you alone? *(Encourage discussion.)*

Let's take another look at the substance use behavior chain. *(Display the newsprint chart that shows the substance use behavior chain.)* You will recall we said that a situation—in this case, being at home and alone—is the earliest link in the chain, making this the best time to break the chain. If you can break the chain at this point, you are much less likely to use alcohol or drugs.

Imagine for a moment that you are sitting at home by yourself with no plans for the day. In this situation, what are you thinking? *(Encourage discussion.)*

Some of you may have been thinking about an event that has occurred. Others may have been thinking, "I have nothing to do today." How do you feel when you have nothing to do? *(Encourage discussion.)* Many people with no plans for the day feel bored. If you are sitting alone and reminiscing about the past, you may begin to feel sad, lonely, or depressed. Let's diagram those parts of the substance use behavior chain. *(Display the newsprint chart that shows antecedents for substance use when at home and alone. See Figure IV-5.)*

Figure IV-5. At Home and Alone Antecedents

Situations/Thoughts	Feelings	Cues	Urges
Sitting at home alone with no activities planned	Bored		
Thinking about a recent event	Depressed or lonely		

At this point, it's still early in the chain. However, if you continue to dwell on your negative feelings, you might remember that you have some liquor, drugs, or addictive prescription medications hidden away somewhere. Where might you stash them? *(Encourage discussion. Ask clients to review their antecedents lists if they cannot recall the items on their lists.)*

If you feel bored or lonely and remember you have a substance somewhere in your home, you are moving another step closer to the behavior we are trying to change, that is, taking a drink or using drugs. When you have felt bored, lonely, or depressed, what happened if you had a drink or used drugs? Let's take a closer look at this as we continue to diagram the chain. *(Record client responses in the "Cues" and "Urges" columns. See Figure IV-6 for an example.)*

Figure IV-6. At Home and Alone Antecedents (Examples)

Situations/Thoughts	Feelings	Cues	Urges
Sitting at home alone with no activities planned	Bored	Liquor in the kitchen cabinet	"I'll have something to do if I have a drink."
Thinking about a recent event	Depressed or lonely	Pain pills in the medicine cabinet	"I'll feel better if I take a pill."

3. Identify Alternative Activities and Enjoyable Events

When you are bored or lonely, you're more likely to use substances than when you are busy with people or activities you enjoy. What could you do to feel less bored or lonely? *(Write clients' responses on the newsprint.)*

One thing you can do is identify places where people who do not use substances spend time and have fun. Where can you go to be involved in activities with people who do not use alcohol or drugs? *(Write clients' responses on the newsprint.)* If you want to find activities among people with similar interests, you might check with your local agency on aging, senior centers, YMCA, YWCA, public gym, faith-based organizations, or aging nutrition organizations. I've put together a list of resources that have special activities for seniors. Think about which organizations might interest you.

This list also includes phone numbers for local Alcoholics Anonymous (AA) and other mutual-help groups. Attending these group meetings can be a good way to meet new people, develop a support network, and discover new opportunities for engaging in social situations not involving substance use. I strongly encourage you to go to a meeting and to do it sooner rather than later. It is a good idea to find a group in which you feel comfortable and then attend meetings regularly. That way you will have contacts to call when you don't know what to do or where to turn. These group meetings can be a valuable resource throughout the treatment and recovery process. *(Distribute the list of local resources that was prepared in advance. Use personal and professional contacts with local community organizations, notices in local community newspapers, recommendations from the faith community, and so on to prepare this list.)*

Consider trying things you always have wanted to do, such as an art, pottery, sewing, painting, or square-dancing class. Now is a good time to think about taking up a new hobby.

Have you thought about volunteer activities, especially if you are retired? You could volunteer at a local hospital, school, or library. Volunteering can be challenging and rewarding, and it is a good way to learn new activities and meet new people of all ages. I've compiled a list of organizations that are always looking for volunteers. Think about which organizations might interest you. *(Distribute the list of volunteer organizations that was prepared in advance. Use formal and informal contacts with community agencies and services; recommendations from the local AARP chapter; bulletin boards of local hospitals, schools, libraries, and places of worship; and so on to prepare this list.)*

If you often are bored and have no activities planned, you can make a list of people and activities you enjoy and make time for them regularly. The more you become involved and the more you associate with others who share your interests, the less likely you will be to experience boredom, loneliness, and depression. In our next session, we will talk about how to handle negative emotions or feelings.

4. Assign Homework To Reinforce Concepts

Your homework assignment for this part of the session is to call one of the volunteer organizations on the list I gave you. Find out what volunteer opportunities are available, and be prepared to report on what you learned at our next group meeting. Also, continue to fill out your substance use self-monitor log.

Module 4: How To Manage Negative Thoughts and Emotions Associated With Substance Abuse

Overview

Being at home and alone leads many older adults to dwell on the past. They may spend too much time thinking about people and things they have lost, including their spouses, marriages, careers, or social networks. Such thoughts can lead to negative emotions such as depression, loneliness, anxiety, or boredom.

This module may comprise either one approximately 40-minute session and one approximately 75-minute session or two 75-minute sessions, based on counselor judgment. If the counselor chooses the former, he or she should combine Session 1 with Module 3 Session 1. Together the two sessions in Module 4 assist clients in recognizing when negative emotions occur and what to do about them. Through behavior rehearsals and practice sessions, clients learn to use skills such as thought stopping and covert assertion. These sessions help clients understand how negative emotions play a part in their substance abuse and teach skills and methods for interrupting those emotions before they lead to substance abuse. Clients need to be screened for the presence of psychiatric disorders and referred for appropriate assessment and treatment. Clients with severe disorders, including some with dementia, may be better off being treated in a mental health or long-term care setting than in a substance abuse treatment program. Over the course of treatment, counselors should assess clients continually for potential suicide risk, deterioration in mental condition, or symptoms severe enough to warrant a referral to a mental health professional for assessment and treatment.

Session 1 Outline

Objectives

1. To teach clients how to recognize negative thoughts and emotions, such as depression and loneliness, as antecedents to substance use
2. To teach clients techniques for interrupting negative thoughts and emotions

Procedures

1. Introduce the concept of negative emotional states
2. Assess clients' ability to address negative thoughts and emotions
3. Discuss recognizing negative emotional states
4. Discuss recognizing self-talk
5. Introduce the concept of repetitive thoughts
6. Introduce the thought-stopping procedure
7. Practice exercises
8. Assign homework to reinforce concepts

Materials

1. Copies of Module 1 Handout 2-4: Substance Use Self-Monitor Log
2. Newsprint with substance use behavior chain (Figure IV-3)
3. Clients' modified antecedents and consequences lists
4. Copies of Rating Form: Negative Thoughts and Emotions Associated With Substance Use Behavior Rehearsal (page 94)
5. Copies of Module 4 Handout 1-1: Thought-Stopping Procedure

Session 1 Presentation

If this is a full 75-minute session, collect substance use self-monitor logs from clients, and distribute blank copies of the log. Photocopy each completed log, and place a copy in the client's treatment chart before returning the original to the client. Also briefly discuss clients' experiences with calling volunteer organizations.

If this session is combined with Module 3, continue to procedure 1 below.

1. Introduce the Concept of Negative Emotional States

Let's look again at the substance use behavior chain. *(Review the links of the chain displayed on the newsprint.)* The situation part of the chain refers to people you are with, places you go, activities you participate in, and thoughts you may have before your first substance use on a given day. Following situations, your feelings—particularly unpleasant ones—are a critical link in your substance use behavior chain.

As we discussed in Module 3, being at home and alone with no planned activities is a typical situation for substance use. Such situations are associated with thoughts. A thought is private or covert—only you can perceive it. Thoughts include memories. Another example of a thought is conversing with yourself without actually using your voice. The conversations we have with ourselves in our heads are called "self-talk." For example, you're at a party (place) and talking to another person (activity). If talking to that person brings back a memory of someone else, you might say to yourself, "This person reminds me of someone I used to work with." This is self-talk. It's the words you use to express to yourself your private thoughts. You do not say these words aloud.

At times, thoughts have little effect on your mood or emotional state. At other times, your thoughts can lead to unpleasant feelings. In this session, we will focus on those unpleasant feelings or moods because they are connected closely to substance use.

2. Assess Clients' Ability To Address Negative Thoughts and Emotions

I am going to read a sample situation and ask each of you to tell the group what you would do.

Read situation 1 or 2 aloud, and ask clients to imagine themselves in the situation. Call on each client, in turn, to provide a response. Rate each client using the Rating Form: Negative Thoughts and Emotions Associated With Substance Use Behavior Rehearsal on page 94. Do not give oral feedback at this time. On each client's rating form, note which situation was used. In Session 2, clients will rehearse the same situation at the end of the session, and the two scores will be compared to determine whether the client has mastered the skill.

Situation 1. You've moved to a new apartment. You realize that you have no plans for the day, no place to go, and no one to see. You think about your experiences in the past and say to yourself, "I'm no good. No one likes me." You continue to repeat these thoughts to yourself.

Situation 2. You've lived alone ever since your spouse died. One night, you lie awake thinking about how bad your health has become and how many doctor visits you've had in the past few months. You start feeling hopeless and say to yourself, "What did I do to deserve this? I give up!"

3. Discuss Recognizing Negative Emotional States

Everyone has negative thoughts sometime in life. Often when we are alone and start to think about or dwell on bad things that have happened, we begin to feel bad, and these negative thoughts take over. For some people, this way of thinking can lead to substance use.

Depression is not part of the normal aging process. However, feeling sad or depressed is a normal reaction to unpleasant events. But you can take steps to prevent these unpleasant feelings and to cope with unpleasant situations. The first step is to identify the thoughts that lead you to feel depressed or sad. The second step is to learn to manage those feelings in a different way than you did in the past. In this session and the next, you will learn coping skills to handle these feelings. You can break the substance use behavior chain early by learning to recognize and address unpleasant thoughts and feelings.

The presence of a mental disorder may complicate the treatment of substance abuse and addiction. Mental disorders influence treatment choices and priorities and affect treatment outcomes. When disorders such as clinical (major) depression are detected, immediately refer clients for appropriate assessment and treatment. Also, be alert to the possibility of current or evolving suicidal tendencies. Clients who exhibit warning signs of suicide require immediate intervention and often intensive, likely inpatient, care. In general, the terms "depression" and "depressed" used with clients in this and other cognitive–behavioral and self-management intervention sessions primarily refer to symptoms and behaviors associated with subclinical (subsyndromal) depressive states (not meeting Diagnostic and Statistical Manual for Mental Disorders *[DSM] [American Psychiatric Association 1994] criteria for major depression). However, "minor" (subclinical/subsyndromal) states often are associated with substance use and abuse by acting as triggers or antecedents to use.*

Look at your antecedents lists. You'll recall that these lists are based on the information you provided in your interview before we started our group sessions. You may have modified your list since that assessment session. Looking at the "feelings" category, raise your hand if you listed depressed, sad, bored, or lonely as an antecedent to use.

What makes you feel depressed, sad, bored, or lonely? *(Ask clients for specific situations, thoughts, or events that have led to such feelings. On the newsprint, write some of the clients' responses and their examples of what they might have said to themselves.)*

These examples show that what you think affects how you feel. Unpleasant feelings often are called negative emotions or negative emotional states. What causes people to think negatively about themselves? Albert Ellis, a well-known psychologist and therapist, identified a number of beliefs people have about themselves that lead to negative self-talk and emotional upset. There are two main beliefs:

1. "I must be loved and approved of by every significant person in my life" or "I should be able to make everyone happy." These are extremely high standards. If you hold these beliefs about yourself, you may tell people what you think they want to hear, deny or exaggerate the truth, or become overly sensitive to others' criticism. You worry constantly about whether others accept you.

2. "I should be able to do everything and do it perfectly, or I'm no good." If this is one of your beliefs, you're likely to be afraid of trying new things because you're afraid of failing. You'll find fault with everything you do and never will be satisfied with yourself.*

Both beliefs are unreasonable. They set you up for negative emotions such as depression or sadness. Examine the logic of your beliefs. Do you really have to be liked by everyone you meet? Must you do everything perfectly? I'm quite sure you don't expect perfection from other people you know. Let's face it; you won't like everyone you meet in life, and rarely will you find someone who always is correct or perfect. Do you have unreasonable beliefs about yourself? *(Encourage discussion.)*

4. Discuss Recognizing Self-Talk

To control negative feelings, you can learn to recognize when your self-talk becomes negative. Negative self-talk is any statement by you to yourself that would qualify as a criticism, a put-down, or even an insult if someone else said it to you. If you frequently make such negative statements to yourself and dwell on them in your mind, they may lead to depression, sadness, worry, and low self-esteem. To help you understand, let's imagine the following situation:

Situation 3. You've been living alone for a number of years. You have nothing planned for today. While sitting at the breakfast table, you think about your children who are grown and living elsewhere. You think to yourself, "They don't care about me anymore. I'm just an old man. I'm all washed up."

In this situation, did you recognize the negative self-talk? *(Encourage discussion.)*

*In 1955, Dr. Albert Ellis developed rational-emotive behavioral therapy (REBT), which is an action-oriented therapeutic approach that stimulates emotional growth by teaching people to replace their self-defeating thoughts, feelings, and actions with new and more effective ones. REBT is the foundation of all cognitive–behavioral approaches in use today. Dr. Ellis is the founder and president of the Albert Ellis Institute in New York City (www.rebt.org), an international center for research, training, and the clinical practice of REBT.

5. Introduce the Concept of Repetitive Thoughts

When negative self-talk runs through your mind and little can distract you, we say that you are having repetitive thoughts. When you repeat the same negative thought over and over, it is likely that you will experience unpleasant feelings or negative emotional states. For example, you say to yourself, "I'm no good. No one likes me, and I don't have any friends." Imagine saying that to yourself over and over again. How does it make you feel? Let's look at another example. What if you were to repeat to yourself, "Why can't I be successful? Everyone else is doing well. I'm just a failure!" How would that make you feel? *(Encourage discussion.)*

6. Introduce the Thought-Stopping Procedure

One technique you can use to address negative self-talk is called thought stopping. The five steps to thought stopping are listed on this handout. *(Distribute Module 4 Handout 1-1, and review the steps with the group.)*

These five steps may sound easy at first, but you will need to practice them. You may be thinking to yourself right now, "How can I stop a thought? Is making a positive statement about myself enough to change how I feel? If I could change how I feel with a positive statement, would I be in this program in the first place?" Together we will learn to recognize disturbing repetitive thoughts and the signs of unpleasant emotions they may cause, such as depression, anger, frustration, and tension, as well as how to stop these thoughts and emotions.

Unpleasant feelings often produce high-risk situations for substance use. Our goal is to find a way to stop them from leading you to use substances. The thought-stopping procedure is one method for changing what you think and feel.

Let's take another look at the steps to the thought-stopping procedure. Over the next few sessions, we will use this technique to interrupt disturbing thoughts and replace them with positive and accurate thoughts. The rest of this session will focus on steps 1 and 2.

Recognize Unpleasant Thoughts

The first step of this procedure is to recognize unpleasant thoughts and the feelings or emotions you associate with them. We've discussed negative self-talk and repetitive thoughts. Let's make a list of examples of statements you might say or think to yourself that are associated with negative emotions. *(Write a few examples on the newsprint.)*

1. Now that I am old, I have no control over my life.
2. Since I am retired, I am worthless.
3. My kids don't need me anymore.
4. Every one of my friends is now sick or gone.

Do these statements sound familiar? Which ones? Have such thoughts run through your mind? Can you provide other examples? *(Encourage discussion. Ask clients for self-talk examples, and write them on the newsprint.)*

Interrupt Repetitive Thoughts or Self-Talk

The second step of the thought-stopping procedure is to stop repetitive thoughts. As we said earlier, repetitive thought is the process of going over and over the same thoughts in your mind. This is never productive, and it interferes with problemsolving. If you are busy repeating the same negative thought, you are not giving yourself an opportunity to solve the problem or address the issue that brought about the negative thought. If you can't solve the problem, you will feel worse.

You may not repeat the exact statement to yourself, but if your self-talk always has a negative tone, you constantly are giving yourself negative messages, which can affect how you feel and behave. The thought-stopping technique can help you control repetitive thoughts, but it takes self-discipline and practice.

7. Practice Exercises

In general, older adults may be reluctant to participate actively in group sessions. Try to encourage client participation. The treatment sessions include some exercises in which each client is asked to share a response to ensure that everyone gets a chance to speak. Make sure that each client takes his or her turn and that the other group members pay attention while each person is speaking. Some inactive clients may be anxious, shy, or frightened. They may communicate these feeling through nervous movements, soft speech, and hesitant responses. Try to involve these clients directly in the discussion. For example, address them by name, and ask them an easy question that is unlikely to provoke stress.

Thought-Stopping Exercise

Let's practice the first two steps of the thought-stopping procedure. We'll do several exercises.

Select a few negative statements from the examples clients gave earlier in the discussion on recognizing unpleasant thoughts. Ask clients to close their eyes and listen as you repeat the words. Repeat the statement aloud several times. After about five repetitions, make a loud noise such as a loud clap, and simultaneously yell stop. Then ask clients to describe what they experienced. Their answers will probably be something like, "I couldn't remember the statement you were repeating."

What just happened? Were you able to keep thinking about the statement I was repeating? Did you notice that the loud noise made you stop thinking about anything else? This exercise demonstrates that you can interrupt a repetitive thought, even one that is unpleasant.

Let's try another exercise. This time I will give you a negative statement, and I want you to begin repeating it in your head. When you hear a loud clap, I want you to yell stop as loudly and quickly as you can. Now imagine yourself in a situation where you've just had an argument with your best friend. Repeat to yourself, "I'll get even with her. I hate her! I'll get even with her. I hate her! I'll get even with her. I hate her!" *(Clap hands loudly. Clients should yell stop. Ask clients to describe what they experienced.)*

Were you able to stop the thoughts again? Once more, this exercise shows that you can interrupt negative self-talk.

Let's practice one more time. I'll say the words aloud again while you listen. This time, however, when you hear a loud clap, do not say stop aloud. Instead, mouth or whisper the word stop with as much energy as you can. Let's try it. *(Repeat the phrase, "I'm too nervous to work right now. I can't do it. I'm too nervous to work right now. I can't do it." Clap hands. Watch to see whether clients mouth the word stop.)* How did that go? *(Ask clients to describe their experiences.)* Let's move on to the next exercise.

Counselor Interruption of Covert Thoughts Exercise

In this next exercise, I want you to focus on a negative thought. Close your eyes, and repeat several times, "No one likes me. I feel like a loser!" When I yell stop, stop the thought. If you were able to stop the thought, raise your hand. Okay, let's begin.

Wait about 5 seconds, then yell stop. Wait a few moments, and look for raised hands.

How did you do? *(Encourage discussion.)*

Client Interruption of Covert Thoughts Exercise

This time I want you to control the process. When I say begin, close your eyes, and repeat these words to yourself, "Now that I am older, I have no control over my life." Say them five times, and then yell stop aloud. Okay, please begin.

How did you do? Were you able to interrupt the negative thoughts? *(Encourage discussion.)*

Let's try the exercise a different way because it would be odd to yell stop in public. Instead of yelling out loud, I want you to say stop silently to yourself with as much energy as you can. Tighten your vocal cords, and move your tongue as if you were trying to say it aloud. *(Demonstrate.)*

When I say begin, close your eyes, and repeat to yourself, "I feel like a failure. I'm too old to change." After five repetitions, give yourself a silent command to stop. If the first stop doesn't work, try it again. Raise your hand when you have interrupted the thought successfully. Okay, close your eyes and begin. *(Wait silently and observe clients practicing the technique. Wait until all clients have raised their hands.)* How did you do? *(Encourage discussion.)*

8. Assign Homework To Reinforce Concepts

Your homework assignment is to practice recognizing negative thoughts and self-talk and interrupting them using the thought-stopping procedure. Make notes about where you were, what you were doing, and what you recall thinking about right before you recognized the negative thoughts and self-talk.

Also, continue to fill out your substance use self-monitor log.

For Counselor's Use Only

Rating Form: Negative Thoughts and Emotions Associated With Substance Use Behavior Rehearsal

CLIENT'S NAME _____

RATER'S NAME _____

Problem Situation (State the situation in the box below.)	Rehearsal 1 Date: _____			Rehearsal 2 Date: _____		
	No Evidence of Desired Behavior	Some Evidence of Desired Behavior	Clearly Performed Desired Behavior	No Evidence of Desired Behavior	Some Evidence of Desired Behavior	Clearly Performed Desired Behavior
1. Did the client recognize the negative self-talk?	1	2	3	1	2	3
2. Did the client say stop or something similar to disrupt the behavior?	1	2	3	1	2	3
3. Did the client make a positive statement?	1	2	3	1	2	3

Scoring: To receive a passing score, the client must score at least a 2 in each category.

A client who does not receive a passing score may need additional help in individual treatment sessions.

Thought-Stopping Procedure

1. Recognize unpleasant thoughts and negative self-talk.
2. Interrupt repetitive thoughts or self-talk.
3. Make a positive and accurate statement.
4. Relax.
5. Solve the problem or address the issue that brought about these unpleasant thoughts and negative self-talk.

Session 2 Outline

Objectives

1. To improve clients' thought-stopping skills
2. To teach clients other ways of overcoming negative self-talk

Procedures

1. Review the concepts of self-talk and repetitive thoughts
2. Introduce how to make a positive and accurate self-statement
3. Introduce negative self-talk categories
4. Explain how to overcome negative self-talk
5. Reassess clients' ability to address negative thoughts and emotions
6. Assign homework to reinforce concepts

Materials

1. Copies of Module 1 Handout 2-4: Substance Use Self-Monitor Log
2. Newsprint with examples of positive self-statements (Figure IV-7)
3. Newsprint with examples of negative self-talk (Figure IV-8)
4. Newsprint with examples of negative self-talk and positive/accurate self-statements (Figure IV-9)
5. Clients' modified antecedents and consequences lists
6. Copies of Module 4 Handout 2-1: Overgeneralization, Misinterpretation, and Catastrophizing
7. Copies of Module 4 Handout 1-1: Thought-Stopping Procedure (Module 4 Session 1)
8. Copies of Rating Form: Negative Thoughts and Emotions Associated With Substance Use Behavior Rehearsal (partially completed in Module 4 Session 1)

Session 2 Presentation

Collect substance use self-monitor logs from clients, and distribute blank copies of the log. Photocopy each completed log, and place a copy in the client's treatment chart before returning the original to the client. If not done in Module 4 Session 1, briefly discuss clients' experiences with calling volunteer organizations.

1. Review the Concepts of Self-Talk and Repetitive Thoughts

In the last session, we talked about the concepts of self-talk and repetitive thoughts. We said that self-talk involves recalling memories, remembering familiar events, and conversing with yourself without actually using your voice.

We also practiced the thought-stopping procedure. Do you recall the five steps of this technique? *(Write the steps on the newsprint as clients say them.)* Today we will continue discussing the thought-stopping procedure and how to use it to control negative self-talk. Remember, your goal is to learn to recognize negative self-talk and to do something about it before it leads to sadness, loneliness, or depression.

Your homework assignment was to practice recognizing negative self-talk and interrupting it using the thought-stopping procedure. Did anyone do this? *(Encourage discussion. Ask for volunteers to talk about their experiences with using the technique.)* Today we're going to talk about the third step of the thought-stopping procedure, which is to make a positive and accurate self-statement.

2. Introduce How To Make a Positive and Accurate Self-Statement

Once you recognize and interrupt the negative self-talk, the next step is to make a positive and accurate self-statement. Sometimes a person has trouble finding something positive to say about himself or herself.

Can you come up with a positive statement about yourself? Perhaps there is something you do extremely well. Let me give you some examples. As I write them on the newsprint, think about whether some of these statements describe you. *(Write the statements listed in Figure IV-7 on the newsprint.)*

Figure IV-7. Examples of Positive Self-Statements

- Now that I'm retired, I can relax and enjoy the fruits of my labor.
- I am a worthwhile person.
- I help others, and people appreciate that.
- I enjoy my relationships with my family members and friends.
- I am a creative, talented person.
- I have at least one close friend I can count on.
- I am well respected in the community.

I want you to think of one positive thing that you believe about yourself. We'll go around the room, and I'm going to ask each person to make a positive self-statement. *(Write each client's answer on the newsprint. Help clients expand on their statements as a way to emphasize the positive. For example, if a client talks about how many close friends he or she has, ask what other people like about him or her. Encourage bragging when possible.)*

3. Introduce Negative Self-Talk Categories

In our last session, we said that some self-talk can lead to negative emotions. The following are examples of such self-talk:

- No one likes me, and I don't have any friends.
- I don't do anything well anymore.
- My kids no longer ask for my advice.
- I guess I am destined to be lonely.

What thoughts pop into your mind when you're feeling sad? *(Write clients' responses on the newsprint.)* Have you noticed that this self-talk is almost always negative and inaccurate? Such statements rarely are based on truth or concrete evidence. We're going to talk about categories of negative self-talk. Although there are many other categories of negative self-talk, we will focus on three of the most common. They are listed on this handout. *(Distribute Module 4 Handout 2-1, and review it with clients.)*

Overgeneralization. When we overgeneralize, we draw a conclusion based on one small event. For example, if I fail in an attempt to ask someone out on a date, I might conclude that I am unattractive or that no one likes me.

Misinterpretation. Sometimes, we interpret someone's actions or words incorrectly and take a response personally. For example, if one of your co-workers seems to ignore you, you might say to yourself, "She really dislikes me!" and feel depressed about how she treats you. In reality, your co-worker may be having a bad day or may be preoccupied with work. If you take the time to observe how she interacts with other people or make the effort to ask whether you did something to offend her, you may find that you misinterpreted her behavior.

Catastrophizing. When you catastrophize, you turn a small mistake or a trivial problem into a big or important one. I'm sure you know what it means to "make a mountain out of a molehill." For example, imagine that you forgot to invite your best friend to a party. You may say to yourself, "He will never speak to me again." You've taken a mistake and turned it into a disaster in your mind.

4. Explain How To Overcome Negative Self-Talk

Let's take a look at a chart. *(Display Figure IV-8 on the newsprint.)* The column on the left is labeled "Examples of Negative Self-Statements," and the column on the right is labeled "Examples of Positive/Accurate Self-Statements." Can you think of other statements that are examples of overgeneralizations, misinterpretations, or catastrophizing to add to the list on the left? *(Add suggestions from clients to the chart.)*

Figure IV-8. Examples of Negative Self-Talk

Examples of Negative Self-Statements	Examples of Positive/Accurate Self-Statements
No one likes me.	
I don't do anything well anymore.	
I feel like a failure!	
My children moved away from me. My family doesn't care about me.	

Now, for each example in the left column, let's try to think of a positive and accurate statement to replace it. Do you have any ideas? *(Write clients' responses in the right column. If necessary, rephrase statements to make them both positive and accurate. Ask clients to jot down in their notebooks each statement that affects them personally. After this exercise, the chart should look something like Figure IV-9.)*

Figure IV-9. Examples of Negative Self-Talk and Positive/Accurate Self-Statements

Examples of Negative Self-Statements	Examples of Positive/Accurate Self-Statements
No one likes me.	I have some close friends who care about me. My friend Joe always helps me when I need a favor.
I don't do anything well anymore.	I still enjoy (building things, sewing, painting, cooking, etc.).
I feel like a failure!	I've raised a good family. I've had a good career and traveled to many places.
My children moved away from me. My family doesn't care about me.	The children moved away because of their jobs. They want me to visit them in their new homes.

Let's review the thought-stopping procedure once more. So far, we've discussed the first three steps of the technique. Let's practice them one more time. I want you to think about the phrase, "I feel like a failure." Repeat it to yourself. Then tell yourself to stop! Think about an accomplishment you are proud of or an example of a positive self-statement we used in this session that describes you. Now, close your eyes and follow the three steps. *(Allow*

several seconds for clients to close their eyes and practice the steps.) How did it go? Is it becoming easier to use this technique? *(Ask for feedback.)* We'll practice this some more during the next few sessions.

Right now I would like you to rehearse a sample situation. I'll read you a situation and ask each of you, in turn, to tell the group what you would do.

It's been a long time since you have seen your son. He called you yesterday and said he would pick you up for lunch today. Several hours have gone by, and he still hasn't arrived. You start to think to yourself, "He doesn't care for me anymore. No one cares about me."

Can you imagine yourself in this or a similar situation? What was the category of negative self-talk in this example? *(Encourage discussion. Help clients identify the overgeneralizations.)*

5. Reassess Clients' Ability To Address Negative Thoughts and Emotions

Now we will rehearse two sample situations we rehearsed in the last session.

Retrieve the rating forms that were used in Session 1. Ensure that each client rehearses the same situation that he or she was rated on. Rate the client on his or her second performance, and compare the two scores. Repeat this exercise with each client. Clients who are unsuccessful should get additional coaching and be reassessed later. Clients who continue to score below a 2 for each question must repeat both sessions of Module 4 at a time to be determined by the counselor and the client.

Situation 1. You've moved to a new apartment. You realize that you have no plans for the day, no place to go, and no one to see. You think about your experiences in the past and say to yourself, "I'm no good. No one likes me." You continue to repeat these thoughts to yourself.

Situation 2. You've lived alone ever since your spouse died. One night, you lie awake thinking about how bad your health has become and how many doctor visits you've had in the past few months. You start feeling hopeless and say to yourself, "What did I do to deserve this? I give up!"

6. Assign Homework To Reinforce Concepts

Your homework assignment is to continue to practice recognizing negative thoughts and self-talk and interrupting them using the thought-stopping procedure. In addition, when you have a negative thought, write down a corresponding positive self-statement similar to the examples we talked about today. We will discuss the concept of positive self-statements again at the beginning of the next session. Also, continue to fill out your substance use self-monitor log.

Overgeneralization, Misinterpretation, and Catastrophizng

1. **Overgeneralization.** You consider one small event to be representative of all events.
2. **Misinterpretation.** You jump to the wrong conclusion.
3. **Catastrophizing.** You turn one small mistake into a major problem.

Overview

Anxiety and tension are a normal part of everyone's life. How an individual manages the feelings and physical sensations that go along with anxiety and tension is key. Prolonged anxiety and tension can lead to unhealthy behaviors like substance use. Clients can break the substance use behavior chain by avoiding anxiety-producing situations (which is not always practical) or by learning and using anxiety- and tension-reducing skills. The anxiety and tension self-management sessions in this module emphasize how repetitive thoughts and self-talk promote unwanted feelings linked to substance use. In these sessions, clients prepare personal lists of anxiety-producing situations, which then are used to develop behavior rehearsals that will help them learn the following five steps to managing anxiety and tension:

1. Recognize the signs of anxiety in the body. (People experience anxiety in different ways.)
2. Stop repetitive thoughts by using the thought-stopping procedure.
3. Make a positive and appropriate self-statement, for example, "I can handle this."
4. Relax.
5. Solve the problem or address the situation that brought about the anxiety and tension.

Problemsolving skills are a critical part of relapse prevention, and the following problemsolving steps are used throughout this treatment approach:

- Recognize that a problem exists.
- State the problem as a positive goal, beginning with a how-to statement, and break it down into manageable parts.
- Brainstorm to generate various solutions to the problem.
- Consider the positive and negative aspects of each possible solution, and rank the order of the solutions from best to worst.
- Implement solutions, beginning with the most promising approach, until the problem is solved.

Clients receive feedback on their potential solutions from the group leader and group members until they are ready to try the solutions in natural settings.

Anxiety and agitation can be symptoms of a psychiatric disorder. In such instances, these sessions are not intended to be a treatment intervention for the underlying disorder. For clients with such disorders, treatment options must be evaluated on a case-by-case basis.

Session 1 Outline

Objectives

1. To improve and strengthen clients' skills for coping with anxiety and tension
2. To help clients understand how anxiety can be an antecedent to substance use and how learning to cope with stress can relieve symptoms of anxiety and tension
3. To teach clients the first step in managing anxiety and tension

Procedures

1. Review interrupting negative thoughts and self-talk with the thought-stopping procedure
2. Assess clients' ability to address anxiety and tension
3. Explain anxiety and tension and their place in the substance use behavior chain
4. Discuss stress, anxiety, and tension
5. Introduce steps for managing anxiety and tension
6. Discuss clients' skills for identifying signals for anxiety and tension
7. Assign homework to reinforce concepts

Materials

1. Copies of Module 1 Handout 2-4: Substance Use Self-Monitor Log
2. Copies of Rating Form: Anxiety and Tension Behavior Rehearsal (page 110)
3. Newsprint with substance use behavior chain (Figure IV-3)
4. Copies of Module 5 Handout 1-1: Steps for Managing Anxiety and Tension

Session 1 Presentation

Collect substance use self-monitor logs from clients, and distribute blank copies of the log. Photocopy each completed log, and place a copy in each client's treatment chart before returning the original to the client.

1. Review Interrupting Negative Thoughts and Self-Talk With the Thought-Stopping Procedure

Briefly review clients' experiences with recognizing negative self-statements, and ask clients to comment on their use of the thought-stopping procedure to control negative thoughts and emotions.

2. Assess Clients' Ability To Address Anxiety and Tension

Today we will focus on anxiety and tension. Anxiety and tension are a normal part of everyday life. Each of us experiences anxiety and tension to different degrees, and our individual reactions can vary widely. How we manage the feelings and physical sensations that go along with anxiety and tension is highly important to our health and well-being. When anxiety and tension make us feel that we are unable to control events in our lives, and these feelings are persistent and unrelenting, we may turn to unhealthful behaviors such as substance use. That's why it is important to find healthful ways to reduce anxiety and tension. We'll talk more about some of those ways today and in our next two sessions.

I'm going to read a situation that might cause you to feel anxious or tense.

Read situation 1 or 2, and ask clients to imagine themselves in the situation. Rate each client using the Rating Form: Anxiety and Tension Behavior Rehearsal on page 110. Do not give oral feedback at this time. On each client's rating form, note which situation was used. In Session 3, clients will rehearse the same situation at the end of the session, and the two scores will be compared to determine whether the client has mastered the skill.

Situation 1. You arrive home at the end of the day and in your mail is a letter from an acquaintance who lent you $1,000 last year when you needed money to pay some bills. He says he needs the money immediately, but you don't have it. Over the next few hours, you realize you are tense and worried, and you turn the words in the letter over and over in your mind. What do you do?

Situation 2. You have agreed to give a talk to a local group next week on a subject you know well. However, this is the first time you have spoken before an audience. As the day approaches, you grow increasingly tense and anxious. You have a lot of self-doubts, and you are preoccupied with thoughts that you might make a fool of yourself by not speaking well or not knowing the answers to audience questions. What do you do?

3. Explain Anxiety and Tension and Their Place in the Substance Use Behavior Chain

In earlier sessions, we discussed negative feelings (e.g., depression, sadness, grief) as antecedents to substance use. Now we'll talk about anxiety and tension as antecedents to substance use.

We use different words to describe the feelings and physical sensations that often accompany anxiety, such as worries, tension, or nervousness. If you look at the substance use behavior chain, you can see that anxiety or nervousness can happen quickly in certain situations. *(Display the newsprint chart with the substance use behavior chain.)* In fact, we can experience anxiety just by thinking about some situations.

How and what you think influence how you feel. A situation, or the thought of it, may lead to feelings of anxiety, nervousness, or tension, which in turn can lead to the urge to use a substance and self-talk such as "Have a drink. You'll feel better" or "I can't relax. Maybe I'll feel better if I take another tranquilizer."

If anxiety is a common antecedent to your substance use, your goal is to break the substance use behavior chain at the situation- or thought-to-feeling link and at the feeling-to-urge link. First, if you can anticipate the situations that cause anxiety and learn to cope with them ahead of time, you can minimize the amount of anxiety in these situations. Several techniques can help you do this, and we'll talk more about them later in the session. Second, if anxiety does increase, you can learn to reduce it.

Anxiety is a complicated concept because sometimes it is a good thing. Adaptive anxiety is a fear that makes sense because it helps us take good care of ourselves. For example, it makes sense to be anxious about driving 100 miles per hour on the highway. It makes sense to experience anxiety if you encounter a grizzly bear. It makes sense to be anxious if you suddenly remember you left your house with your teakettle on a burner that is set on high. Can you think of other examples of adaptive or helpful anxiety? *(Encourage discussion.)*

Anxiety is bad when it prevents us from doing things that could make our lives more productive and happier or when it causes us to avoid new experiences that could make life richer and more interesting. It is not good when it makes our muscles tense; gives us headaches, ulcers, or high blood pressure; or affects our health negatively. Anxiety is certainly not good when it leads to substance use.

What is the connection between substance use and anxiety and tension? Why do you suppose that so many people use substances when they are in situations or when they start thinking about situations that make them anxious or upset? *(Encourage discussion.)* When a person feels anxious, a number of things may happen shortly after he or she takes a drink. Alcohol makes some people feel calmer, more peaceful, and less uptight. What many people don't know is that, after these initial effects, alcohol actually produces more nervousness. Alcohol is a depressant, so after the initial effects wear off, you experience its increasingly depressive effects.

Substance use in response to anxiety or tension is common because the immediate consequence of the first use may be relaxation. Substance use as a means of reducing tension and anxiety therefore is reinforced.

4. Discuss Stress, Anxiety, and Tension

Now I want to talk briefly about stress, anxiety, and tension. In this treatment program, we use these terms in a variety of ways, so let's clarify their meanings.

Stress

Stress is the adjustment your body makes when faced with changes. These changes may come from outside (the environment) or from within (physical, mental, and emotional factors).

Stress is not necessarily harmful. In fact, without stress, you probably would not be stimulated to learn anything new or to look for new and creative solutions to problems. Some forms of physical stress, such as physical exercise, can relieve other more harmful stress caused by emotional strain. You cannot eliminate all stress in your lives, nor would you want to. However, you can learn ways to cope with bad stress or distress.

Stressor is the term we use to refer to the actual cause of stress. Any time you must adjust to something from your outside environment, the thing or event that requires your adjustment is a stressor. What are some common stressors? *(Encourage discussion.)*

It may surprise you to know that even happy events (e.g., winning the lottery, getting married) may result in some stress simply because these events require us to adjust our behavior. However, research suggests that the most common stressors causing bad stress for older adults are illness and the death of family members and friends. Retirement and changes in residence also are common stressors for older adults. Aging, physical illness, poor diet, loss of sleep, and the effects of drugs, alcohol, or medication all may be stressors.

A powerful stressor can be your own thoughts. The way you think about the changes and events within your bodies and from your environment can mean the difference between positive stress and distress. You can learn to cope with stressors and stress by changing your thoughts so that your self-talk produces neutral feelings and leads to problemsolving behavior.

Anxiety

Anxiety is a complex set of behaviors that involves a person's body chemistry, muscles, and thoughts. Anxiety is a negative stress signal. The capacity to experience anxiety is part of being human, and normal anxiety can be helpful when it signals you to take care of yourself. Anxiety is harmful when it leads to behavior that makes you physically ill or limits your ability to lead a satisfying and happy life.

Muscle Tension

Tension involves tightening your muscles. It is another stress signal. Obviously, some muscle tension is necessary and normal to perform daily activities. Excessive muscle tension, however, drains your energy and leads to pain and fatigue. It is a sign that you are not coping effectively with stress. Excessive muscle tension is only one symptom of too much bad stress. In a few minutes we will talk about some other important physical signs.

5. Introduce Steps for Managing Anxiety and Tension

Managing anxiety and tension is a learned skill. This handout lists the five steps to managing anxiety and tension. *(Distribute Module 5 Handout 1-1.)*

Let's look at step 1, which is to recognize the signs of anxiety and tension. Most people have not learned how to pay attention to what is going on inside their bodies. We find ourselves in situations, or we think about them, and automatically our muscles tense, our head begins to throb, or our blood pressure soars. We may reach for a substance without even recognizing the signs of anxiety and tension. The first step in taking control of stress before it gets out of hand is to learn to recognize your body's first signs.

How do you feel when you get anxious or tense? Some people are "muscle reactors"; they feel uptight, which means their muscles get tense. They may frown, get a stiff neck, or tense their jaw muscles. If you get tension headaches, grind your teeth, get backaches, or feel general fatigue, chances are you are a muscle reactor. Other people are "stomach reactors." They experience indigestion, heartburn, stomach pains, or nausea when they get anxious or tense. Some people are "heart reactors." When they get nervous or anxious, their blood pressure rises, their pulse rate increases, they have palpitations, they get flushed, or they breathe fast.

Some people behave differently with others when they are anxious or tense. They may dash around the house, snap at family members, or fly off the handle easily. Others are "silent worriers." They clam up because they are too busy thinking and worrying. They go over the same thoughts in their minds, sometimes for hours. They often have trouble falling asleep at night or wake up in the middle of the night because they are worrying. Unfortunately, night worrying rarely results in solutions to a problem. Going over and over the same negative thought doesn't solve a problem either, because repetitive thoughts are always unreasonable and irrational.

6. Discuss Clients' Skills for Identifying Signals for Anxiety and Tension

Now let's examine your signals for anxiety and tension. How do you know when you are anxious or tense? *(Encourage discussion. Help each client identify his or her internal signs of anxiety and excessive stress.)*

7. Assign Homework To Reinforce Concepts

Your homework assignment is to make a list of your personal signs of anxiety and stress. Also, continue to fill out your substance use self-monitor log.

For Counselor's Use Only

Rating Form: Anxiety and Tension Behavior Rehearsal

CLIENT'S NAME _____

RATER'S NAME _____

Problem Situation (State the situation in the box below.)	Rehearsal 1 Date: _____			Rehearsal 2 Date: _____		
	No Evidence of Desired Behavior	Some Evidence of Desired Behavior	Clearly Performed Desired Behavior	No Evidence of Desired Behavior	Some Evidence of Desired Behavior	Clearly Performed Desired Behavior
1. Did the client demonstrate the use of thought control or thought stopping?	1	2	3	1	2	3
2. Did the client make a positive self-statement?	1	2	3	1	2	3
3. Did the client use relaxation skills (e.g., take a deep breath and release it to relax tense muscles or tell himself or herself aloud to relax)?	1	2	3	1	2	3
4. Did the client pinpoint the problem behind the anxiety or tension (preferably by stating the problem in a how-to statement)?	1	2	3	1	2	3
5. Was the solution the client offered appropriate for the problem situation? Was the solution plan specific?	1	2	3	1	2	3

Scoring: To receive a passing score, the client must score at least a 2 in each category.

A client who does not receive a passing score may need additional help in individual treatment sessions.

Steps for Managing Anxiety and Tension

1. **RECOGNIZE** the **signs** of anxiety in your body.
2. **STOP** repetitive **thoughts** ("thought stopping").
3. Make a **POSITIVE SELF-STATEMENT**. A simple one is "I can handle this."
4. **RELAX**. Remember the relaxation skills you have learned.
5. **PROBLEMSOLVE**. Remember your problemsolving skills.*

USE YOUR SKILLS:

Problemsolving skills

Assertive skills

Leisure skills

Community network

Talking about the problem with someone

Relaxation skills

*Pinpoint and state the problem, and brainstorm solutions. When you are looking for solutions, don't forget your assertive skills, your community supports, and your leisure skills. We will be talking about some additional solutions specifically for certain kinds of anxiety.

Session 2 Outline

Objectives

1. To help clients understand how feelings and beliefs lead to negative self-talk
2. To improve clients' thought-stopping skills
3. To help clients understand the irrational or unreasonable beliefs that underlie negative self-talk
4. To teach clients how to replace negative self-talk with positive self-statements

Procedures

1. Review list of personal signs of anxiety and stress
2. Review the substance use behavior chain and the steps for managing anxiety and tension
3. Practice the thought-stopping procedure
4. Discuss how feelings and beliefs lead to negative self-talk
5. Discuss the effects of unreasonable beliefs
6. Discuss the effects of errors in thinking
7. Demonstrate how to think positively
8. Assign homework to reinforce concepts

Materials

1. Copies of Module 1 Handout 2-4: Substance Use Self-Monitor Log
2. Newsprint with substance use behavior chain (Figure IV-3)
3. Copies of Module 5 Handout 1-1: Steps for Managing Anxiety and Tension (Module 5 Session 1)
4. Copies of Module 5 Handout 2-1: Correcting Negative Self-Talk
5. Newsprint with correcting negative self-talk (Figure IV-10)
6. Copies of Module 5 Handout 2-2: Personal Anxiety-Producing Situations

Session 2 Presentation

Collect substance use self-monitor logs from clients, and distribute blank copies of the log. Photocopy each completed log, and place a copy in the client's treatment chart before returning the original to the client.

1. Review List of Personal Signs of Anxiety and Stress

Ask clients to discuss the signs of anxiety and stress that they listed in their homework assignments. List a few on the newsprint, and point out the similarities and differences on clients' lists.

2. Review the Substance Use Behavior Chain and the Steps for Managing Anxiety and Tension

In the last session, we talked about the first step in managing anxiety and tension, which is to recognize the signals your body gives you. I'd like you to take out the handout from the last session that shows the steps for managing anxiety and tension. *(Ask clients to remove Module 5 Handout 1-1 from their notebooks.)* We talked earlier about negative self-talk and repetitive thoughts. Why is stopping repetitive thoughts important in managing stress effectively? It is because repeating the same negative thought over and over not only signals anxiety and stress but also aggravates anxiety and stress. Your thinking affects the way you feel, and that can lead to substance use. *(Display newsprint with substance use behavior chain, and point to thoughts in the antecedents.)*

Let's do an exercise to demonstrate this. I'd like you to close your eyes and imagine yourself in the following situation:

Situation 1. You are on a bus. You begin thinking about the argument you had with your son (or daughter) last evening. You can picture the scenario in your mind's eye. You are sure that, by now, your son (or daughter) has decided to stop visiting you, and you'll never see your grandchildren again. How are you feeling? *(Discuss each client's internal signals of anxiety.)*

3. Practice the Thought-Stopping Procedure

The second step in managing anxiety and tension is to stop repetitive thoughts. Repeating the same negative thought over and over is unproductive and interferes with problemsolving. If you are busy repeating the same thought, you cannot focus your attention on solving a problem. As we discussed in an earlier session, thought stopping is a simple technique to control repetitive thoughts. You'll recall we practiced this technique earlier. Although it is simple to understand, it takes self-discipline and practice to master it. Therefore, I'd like you to practice it some more.

Thought-Stopping Exercise 1

Choose a negative, repetitive thought that was mentioned during this or a previous session, e.g., "I will not be able to do it."

Counselor interruption of overt thought. I want you to close your eyes and repeat this statement aloud. When I say stop, I want you to stop saying the statement. *(Allow about 5 seconds, and then say stop.)*

Counselor interruption of covert thought. Now, I want you to close your eyes and repeat the same statement silently to yourself. When I say stop, stop the thought. When you successfully have turned off the thought, raise your hand. *(Allow 5 seconds, and then say stop.)*

Client overt interruption of covert thought. Now I want you to control your own thinking. Once again repeat the statement silently to yourself, but this time I want *you* to say stop aloud to order yourself to stop. Now close your eyes and begin.

Client covert interruption of covert thought. Since it's not realistic to yell stop to yourself in public, I want you to repeat the statement silently to yourself and say stop silently to yourself. Do not say it aloud. Tighten your vocal chords, and move your tongue as if you were going to say the word aloud. When you successfully have turned off the thought, raise your hand. If you are unsuccessful at first, try it again. Now close your eyes and begin.

Thought-Stopping Exercise 2

For the next exercise, I'd like you to close your eyes and think of a situation that has been worrying you. Notice the thoughts that come into your mind. Some will be related to your problem, and some will not. When you begin to have a repetitive, unproductive thought, give yourself a silent command to stop. Tighten your vocal chords, and move your tongue as if you are going to say stop aloud. Be as emphatic as possible. When you have stopped the repetitive thought, raise your hand, and sit quietly with your eyes closed for a moment until everyone has finished the exercise.

When everyone is finished, discuss reactions, and practice one more time. Encourage clients to practice on their own.

Between now and our next session, I would like you to be more aware of any times when you repeat negative thoughts over and over. If you find yourself having these repetitive, unproductive thoughts, order yourself to stop.

4. Discuss How Feelings and Beliefs Lead to Negative Self-Talk

In most anxiety-producing situations, we make negative statements to ourselves. We may think "They won't like me," "I won't know what to talk about," "If I say something, it will

sound stupid," "I won't be able to do this," "I should do better," or "I cannot make a mistake." Most of us never say these words aloud. We may not even be aware we are thinking them, but they are a natural response to anxiety and tension.

Let's look at the effects of this negative self-talk. I want you to close your eyes and say to yourself, "I can't do it. I'll never make it." How does that make you feel? *(Encourage discussion.)*

5. Discuss the Effects of Unreasonable Beliefs

In the sessions on thoughts and negative emotions associated with substance use, we learned that people often have two main unreasonable beliefs about themselves that lead to negative self-talk and emotional upset.

The first is "I must be loved and approved of by every significant person in my life." An alternative version of "I must be loved" might be "I should be able to make everyone happy." People who believe this about themselves spend a lot of time worrying about whether they are accepted by those around them. The truth is that not everyone will like you and you cannot make everyone happy. Do you like everyone you meet? No, of course you don't. Do they fall apart because you don't like them? Not usually. Life would be wonderful if we liked everyone and everyone liked us, but that's unrealistic. When we insist on approval from others, it leads only to unwanted feelings and behaviors.

The second unreasonable belief that most people have is "I should be able to do everything and do it perfectly, or I'm no good." If you're not sure this belief applies to you, ask yourself the following questions:

- Am I afraid to try new things because I think I might not succeed?
- Do I criticize my own efforts because they are less than perfect?

If you answered yes to these questions, then you probably share this belief.

The truth is that no one does everything perfectly. We all do some things well, some things poorly, and most things adequately. At times, we will handle a situation well, but at other times, not so well.

We talked about catastrophizing in an earlier session. Do you tend to catastrophize—exaggerate your mistakes? People who tend to exaggerate are likely to view ordinary mistakes as catastrophes. These people believe they must be perfect; if they make a mistake, they are convinced that something awful will happen. The truth is that the world and the people in it usually don't judge us as harshly as we judge ourselves.

Are you a person who says, “I should,” “I should have,” “I should have done more,” or “I should have done better?” The problems with “shoulds” are that they create guilt and they do not solve the problem. Telling yourself what you should have done or not done does not bring you any closer to a solution.

When we know how to identify and challenge these unreasonable beliefs about ourselves, we can learn to stop the negative self-talk that upsets us and leads to behavior that interferes with a satisfying life.

6. Discuss the Effects of Errors in Thinking

Some behavior is adaptive, that is, it solves a problem in a way that creates a more satisfying life. Other behavior may be harmful or maladaptive. You cannot solve problems using maladaptive behavior. Maladaptive behavior limits satisfaction with life and can lead to ill health.

Negative self-talk based on unreasonable beliefs leads to maladaptive behavior in two ways. First, negative self-talk makes us feel more upset. Second, negative self-talk involves errors in thinking that interfere with problemsolving. Let’s talk about five common errors in thinking:

- Exaggerating. This is another word for catastrophic thinking. When you exaggerate, you look at and interpret events and situations in an extremely negative way and minimize the positive. Everyday difficulties are seen as disasters. For example, you let the battery run down on the car, and, before long, you tell yourself how stupid you are, that others don’t get into these situations, and that nothing can save a person as careless and stupid as you from repeated disasters. Of course, an error is rarely a disaster. When we make a mistake, we almost always find a positive side and change our behavior or our thinking so that we can fix the error and move on.

- Black-and-white thinking. This is also known as all-or-nothing thinking. People who think in black-and-white terms see only the two extreme sides of an issue. In their eyes, behavior is either good or bad or right or wrong. There is no in-between for these people. Black-and-white thinking is unrealistic. The truth is that the world is not black and white—it is somewhere in-between. We need to be able to see the gray areas to accept our imperfections and those of others.

- Overgeneralizing. We talked about this in an earlier session. People who overgeneralize make sweeping statements about themselves or others based on a single behavior or event. Phrases such as “I always” and “you never” are overgeneralizations. We usually use overgeneralizations to emphasize the negative. For example, a person living in your apartment building is unfriendly to you, and you overgeneralize by saying, “Nobody likes me.”

- **Ignoring the positive.** Many people have a tendency to focus on the negative. They don't pay attention to or don't remember positive events in their lives. Take the example of a woman who becomes tense before every social event. She is certain she will be unable to converse with others and will be ignored. She does not think about social gatherings where she is accepted and well liked. She chooses to ignore the positive.

- **Discounting positive reinforcement from others.** Some people refuse to accept compliments. You pay someone a genuine compliment about what he or she is wearing, for example, and he or she says, "Oh, this old thing." These people may automatically discount positive feedback because they have an unreasonable belief that they are inferior.

Negative self-talk has several characteristics that make it particularly harmful. First, it serves no useful purpose because it does not help solve problems; it just wastes time. Second, it is destructive because it increases anxiety, tension, and depression. Third, it becomes automatic. Much of the time we don't even realize we are engaged in negative thinking.

To stop thinking this way, you need to focus on the kinds of automatic negative thinking you do when you feel bad—when you begin to worry, feel uptight, or feel down in the dumps. Negative self-talk is tricky because, even though we might learn that it is based on unreasonable attitudes or beliefs, what we tell ourselves seems plausible. We become so accustomed to having these unreasonable thoughts about ourselves that we simply accept them as the truth.

To summarize, we know we have certain unreasonable beliefs about ourselves. In some situations, our unreasonable beliefs automatically lead to negative self-talk. Negative self-talk often is repetitive and causes or increases anxiety and tension. This high level of emotional upset and the poor quality of our thinking may lead us to look for ways to reduce the emotional upheaval. We may turn to ineffective and often destructive behavior, such as substance use, as a way to self-medicate unwanted feelings and thoughts.

The next time you are upset emotionally, try to pinpoint your negative self-talk and ask yourself, "What kind of unreasonable beliefs do I have about myself?" and "What negative statement am I making about myself?"

7. Demonstrate How To Think Positively

Now let's talk about how to think positively. This is the third step in managing anxiety and tension. I want you to close your eyes and say this simple statement to yourself: "I can handle this." Say it calmly and slowly. Repeat it several times to yourself. What are you feeling inside? *(Encourage discussion.)*

I am going to give each of you a handout to practice correcting negative self-talk. This brief exercise will help you identify your negative self-talk when you feel anxious and tense. *(Distribute copies of Module 5 Handout 2-1 and display Figure IV-10 on the newsprint.)*

Figure IV-10. Correcting Negative Self-Talk

What Negative Statements Are You Making to Yourself?	What Realistic Positive Statements Could You Substitute?

Try to remember something that makes you anxious and tense. How did you know you were anxious or tense? What were the signs? Try to pinpoint your negative self-talk, and write it in the left column. Then ask yourself, "What realistic positive statements could I make instead?" Write them in the right column.

Give clients a few minutes to do the exercise. Discuss the statements the clients write down. Collect their answers at the end of the discussion.

8. Assign Homework To Reinforce Concepts

I would like to give you two brief homework assignments to help you practice what we have learned today. First, here is a blank form just like the one we used today. *(Hand out copies of Module 5 Handout 2-1.)* Each night, write down in the left column on the form an example of your negative self-talk. On the right side of the form, write down a realistic, positive self-statement. The second, brief assignment is to think of an anxiety-producing situation you have experienced. *(Hand out copies of Module 5 Handout 2-2.)* On this form, write down situations that cause you to worry or become tense. Place a checkmark by any situation that might lead you to drink or use drugs. Include only those situations you are willing to share with the group; we will use these situations in rehearsals during the next session.

Once again, please continue to fill out your substance use self-monitor log.

Correcting Negative Self-Talk

CLIENT'S NAME_____ DATE _____

What Negative Statements Are You Making to Yourself?	What Realistic Positive Statements Could You Substitute?

Personal Anxiety-Producing Situations

CLIENT'S NAME_____ **DATE** _____

☐ 1. _____

_____

☐ 2. _____

_____

☐ 3. _____

_____

☐ 4. _____

_____

☐ 5. _____

_____

☐ 6. _____

_____

Place a checkmark ☑ by the situation that contributes most to your drinking or drug use.

Session 3 Outline

Objectives

1. To teach clients a quick relaxation technique
2. To teach clients alternative methods for relieving anxiety and tension
3. To improve and strengthen client skills in managing anxiety and tension

Procedures

1. Review correcting negative self-talk
2. Review the substance use behavior chain and the steps for managing anxiety and tension
3. Demonstrate and practice a quick relaxation technique
4. Discuss other methods for relieving anxiety and tension
5. Discuss the steps for managing anxiety and tension
6. Rehearse personal anxiety-producing situations
7. Reassess clients' ability to address anxiety and tension
8. Assign homework to reinforce concepts

Materials

1. Copies of Module 1 Handout 2-4: Substance Use Self-Monitor Log
2. Newsprint with substance use behavior chain (Figure IV-3)
3. Copies of Module 5 Handout 1-1: Steps for Managing Anxiety and Tension (Module 5 Session 1)
4. Copies of Module 5 Handout 3-1: Quick Relaxation Technique Instructions
5. Copies of Rating Form: Anxiety and Tension Behavior Rehearsal (partially completed in Module 5 Session 1)

Session 3 Presentation

Collect substance use self-monitor logs from clients, and distribute blank copies of the log. Photocopy each completed log, and place a copy in the client's treatment chart before returning the original to the client.

1. Review Correcting Negative Self-Talk

Ask clients to discuss the comments that they've included on Module 5 Handout 2-1. Write some of the most common statements on newsprint. Instruct clients to insert this form in their notebooks for future reference.

2. Review the Substance Use Behavior Chain and the Steps for Managing Anxiety and Tension

Today we will continue discussing how to manage anxiety and tension. First, let's review the substance use behavior chain and the steps for managing anxiety and tension. *(Review the chain on the newsprint chart and the steps on Module 5 Handout 1-1.)*

3. Demonstrate and Practice a Quick Relaxation Technique

When you feel increasing tension, one way to counteract it is by relaxing. Have you ever been worried and relaxed at the same time? It's difficult to be anxious and relaxed simultaneously. These two feelings are incompatible. You can't be anxious or uncomfortable when you are relaxed. Relaxation refers to both a mental and a physical state. When we focus on relaxing the muscles of the body, thoughts associated with relaxation begin to replace those associated with tension. When we relax, we can prevent or reduce the negative emotional state of anxiety.

I'm going to introduce a relaxation technique. This technique is not difficult to learn, and the more you practice, the better you'll become at it. In the steps to managing anxiety and tension, after you make a positive self-statement, the next step is to take a moment and relax. We call this technique QR, which stands for quick relaxation.

After you interrupt a negative thought by commanding yourself to stop, I want you to sit down (if you're not already sitting). Breathe in slowly, and exhale slowly. As you exhale, I want you to focus on relaxing the muscles in your legs, torso, shoulders, and neck. Let your arms go limp. I'll demonstrate for you. *(Demonstrate at least twice.)*

Another quick relaxation technique may be substituted for this one. However, this QR technique is easy to learn and use.

This handout describes another QR technique. *(Distribute Module 5 Handout 3-1, and read the steps aloud.)* This QR technique helps you relax immediately, and it takes only about 6 seconds from start to finish.

Observe me as I demonstrate the QR technique on this handout. Practice each step along with me. Ready? First, I'll sit down in a chair, and I'll make myself stop the self-talk. Then I'll say to myself, "I can handle this." (*Say this aloud using enthusiasm, hand gestures, and positive facial expressions.)* You don't need to say this aloud or use hand gestures as I did, but notice my energy and enthusiasm. We've already talked about the importance of thinking positively and how it contributes to your well-being. You'll notice that this QR technique begins with a positive self-statement.

Now I'll take one long, slow breath. I'll breathe from deep down inside, as though I am taking in air through imaginary holes in my feet. I'll expand my stomach with my breath as I inhale. I'll draw this breath up through the imaginary holes in my feet all the way to my shoulders. Notice how just thinking about this actually makes me slow down and breathe naturally. Try it. Breathe in slowly and deeply. Expand your stomach as you inhale. *(Wait for clients to take in a slow breath.)* Remember, we're trying to relax, starting with the feet and moving through the body all the way to the shoulders.

Once the breath reaches my shoulders, I drop my jaw and tongue to release the tension. *(Demonstrate the four steps: Stop the self-talk; say, "I can handle this"; take a deep breath; and drop the jaw and tongue.)* Finally, I relax my shoulders and exhale to let the air out. *(Exhale slowly and fully.)* As I exhale, I imagine a wave of pleasant heaviness and warmth moving down my body.

Let's practice this together. First, close your eyes and imagine yourself in a tense situation. You may be thinking about upcoming surgery or worrying about your health or your spouse's health. You may be thinking about an upcoming stressful event or problem. For example, you may be facing a judge in court, a job interview, or a confrontational friend or family member; or your spouse may need an operation. Can you think of a stressful situation that might happen to you? *(Look around the room for acknowledgment from clients.)* Think about this anxiety-producing situation for a few seconds with your eyes closed.

Now let's practice the QR technique. *(Look around the room to make sure everyone is ready.)* First, stop the self-talk. Then say to yourself, "I can handle this." Then breathe in slowly and deeply as if from your feet. Expand your stomach with your breath as you inhale. Let the breath rise through your body to your shoulders. As it reaches your shoulders, drop your jaw and tongue to release the tension and exhale. How did you do? Let's try it again. *(Do the QR technique three more times with the group.)*

Let's practice the QR technique again. This time we will use the personal anxiety-producing situations that you wrote down for your homework assignment on Module 5 Handout 2-2. *(Give participants time to look at their situations on the handout.)* While you are thinking about your anxiety-producing situation, I will say stop. Immediately, I want you to breathe in slowly and deeply as if from your feet, expand your stomach with your breath, drop your jaw and tongue when your breath reaches your shoulders, and relax your muscles as you exhale. Let's begin. *(Ask clients to close their eyes. Give them enough time to focus on their*

anxiety-producing situation. Say stop, and observe clients as they try to relax. Pay attention to how clients react to keeping their eyes closed in the beginning, and adjust the timing of the exercise accordingly. Some people get increasingly anxious the longer they are asked to keep their eyes closed among strangers. It is not imperative that their eyes be closed to learn the technique and become relaxed, but it helps block distractions. With practice, older adults can use the QR technique while sitting or standing, with or without their eyes closed. However, closing their eyes during initial QR training helps clients focus completely on what is being said, their feelings and thoughts, and the relaxation steps.)

If you find it difficult to relax at this point, don't worry. As you practice this more, you will get the hang of it.

Let me emphasize again that the QR technique requires you to come up with a positive self-statement, making this technique helpful once you've mastered it. It is important to practice QR. The more you practice, the better you'll become at relaxing your muscles quickly.

4. Discuss Other Methods for Relieving Anxiety and Tension

We have learned that muscle relaxation is one way to reduce tension. What are some other ways you have used to relax? *(Briefly discuss.)*

Other methods may include

- Exercising or walking to relieve mental stress
- Getting enough sleep and rest
- Balancing work and play (A change of pace can relieve stress.)
- Taking a hot bath
- Getting a massage
- Playing music
- Listening to relaxation tapes
- Doing something for someone else
- Being with people
- Going to an Alcoholics Anonymous or other mutual-help group meeting
- Above all, avoiding alcohol or drugs

5. Discuss the Steps for Managing Anxiety and Tension

The QR technique is step 4 in the five steps for managing anxiety and tension. By now, you should be familiar with the signs of anxiety and tension in yourself. You have learned that step 1 is to recognize your internal behavior (what goes on inside you) and external behavior (how you interact with others) when you are anxious or tense. Step 2 is to manage repetitive thoughts by using the thought-stopping procedure. You've learned the importance of positive self-statements about yourself, and step 3 is to identify at least one true, positive self-statement you can use to calm yourself when you become tense. Step 4 is to use relaxation techniques.

The techniques in the first four steps for managing anxiety and tension are aimed at reducing the amount of anxiety and tension quickly. Their purpose is to break the substance use behavior chain at the feelings point before anxiety gets out of hand. *(Indicate the feelings point on the newsprint chart that shows the substance use behavior chain.)*

Anxiety and tension often are generated by a situation or even just the thought of it. The situation may be happening in the present, it may be one you anticipate, or it may be one that happened in the past with consequences that continue to worry you. If we can break the chain at the situations or thoughts point before we reach the feelings point, that's even better than focusing on what happens after the feelings occur. *(Point to the substance use behavior chain newsprint chart as you explain this.)*

Step 5 to managing anxiety and tension is problemsolving. In step 5, you pinpoint the problem that is causing the anxiety and tension and brainstorm solutions. A problem may have more than one solution. *(Again, review the five steps to managing anxiety and tension, using Module 5 Handout 1-1, and conduct a brief behavior rehearsal on problemsolving.)*

6. Rehearse Personal Anxiety-Producing Situations

Now that we've discussed all the steps to managing anxiety and tension, we're going to rehearse them using your personal anxiety-producing situations that you listed for homework on Module 5 Handout 2-2.

Ask each client to read aloud to the group an anxiety- or tension-producing situation. Clarify the problem situation as necessary. Be sure the client uses steps 2 through 5 for managing anxiety and tension as he or she rehearses the situation. If the client is unable to identify an anxiety- or tension-producing situation, help identify one using the client's antecedents list or one of the samples from Examples of Anxiety-Producing Situations on page 128. A client who has serious problems with controlling anxiety may need additional help in individual treatment sessions.

7. Reassess Clients' Ability To Address Anxiety and Tension

We're going to rehearse again the situation we rehearsed in Session 1 of Module 5. We'll compare your responses from that first rehearsal with this rehearsal. This time we'll use the five steps for managing anxiety and tension. I'll read the situation to you. I would like you to begin thinking about how you would respond.

Retrieve the rating forms that were used in Session 1. Ensure that each client rehearses the same situation that he or she was rated on earlier. Rate the client on his or her second performance, and compare the two scores. Repeat this exercise with each client. To complete the exercise successfully, the client must score at least a 2 on each question. Clients who are unsuccessful should get additional coaching and be reassessed later. Clients who continue to score below a 2 for each question must repeat all three sessions of Module 5 at a time to be determined by the counselor and the client.

Situation 1. You arrive home at the end of the day and in your mail is a letter from an acquaintance who lent you $1,000 last year when you needed money to pay some bills. He says he needs the money immediately, but you don't have it. Over the next few hours, you realize you are tense and worried, and you turn the words in the letter over and over in your mind. What do you do?

Situation 2. You have agreed to give a talk to a local group next week on a subject you know well. However, this is the first time you have spoken before an audience. As the day approaches, you grow increasingly tense and anxious. You have a lot of self-doubts, and you are preoccupied with thoughts that you might make a fool of yourself by not speaking well or not knowing the answers to audience questions. What do you do?

8. Assign Homework To Reinforce Concepts

Your homework assignment is to continue filling out your substance use self-monitor log.

Quick Relaxation Technique Instructions

This technique takes 6 seconds from start to finish.

The moment you realize something is annoying you or making you tense

1. Command yourself to stop.

2. Think positive. Tell yourself, “I can handle this” or “I can stay calm.”

3. Breathe in slowly and deeply as though taking in air through imaginary holes in your feet. Draw this breath up through your body to your shoulders. Using your imagination will help you slow down and breathe naturally.

4. Once the breath reaches your shoulders, drop your jaw and tongue to release the tension.

5. Then relax your shoulders and exhale.

6. Imagine a wave of pleasant heaviness and warmth moving down through your body as you exhale.

FOR COUNSELOR'S USE ONLY

Examples of Anxiety-Producing Situations

1. I have an appointment, and I am stuck in traffic. It is getting late, and I am feeling tense. I begin to think about how angry the person I am going to meet will be.

   Goal. Control my tension and relax. Accept the situation because I cannot change it, and plan to leave earlier next time. Stop and telephone the person to say I will be late.

   Sample how-to statement. I will know how to control my tension and relax.

2. I just was introduced to a new person at a party when a long-time friend walks up. I know I should introduce my friend, but I already have forgotten the new person's name. I feel myself getting tense, and I think, "I can't remember her name." I am getting so anxious I cannot even concentrate on what my friend is saying.

   Goal. Take control of my anxiety and relax. Be honest about forgetting, ask for the person's name again, and introduce my friend.

   Sample how-to statement. I will know how to control my anxiety and make the introduction as gracefully as possible.

3. My friend invited me for lunch at an exclusive restaurant to celebrate a special occasion. I got involved in other activities and forgot. The next day, I suddenly remember our date. I feel terrible, and I am sure she will be angry and hurt. For the past hour, all I can think about is what a terrible thing I have done.

   Goal. Take control of your worry, and confront the situation. Call your friend, explain honestly, and apologize. Try to set up another date.

   Sample how-to statement. I will know how to handle the situation so that my friend and I both feel comfortable.

Overview

These sessions look at anger and frustration as determinants of relapse for people who abuse alcohol or drugs or misuse prescription medications. When anger and frustration are major determinants for relapse to substance abuse, they typically occur in an interactive situation. An appropriate assertive response can be a coping response other than substance abuse. An assertive response enables a person to cope effectively with the situation, decreases the probability of substance abuse, increases a person's sense of self-sufficiency, and enhances the person's perception of maintaining self-control.

Anger and frustration are emotional states that represent common high-risk situations for substance abuse. Counselors teach clients how to avoid substance abuse by giving clients another way of handling anger and frustration. For many older adults, anger and frustration can be controlled by learning more assertive behavior.

Clients are taught the components of assertive behavior with the help of a memory aid called DESC. Skills training and the rating of client behavior are based on four points:

- **D**escribing the objectionable behavior to the other person in nonjudgmental language and getting the other person's point of view if it has not been stated
- **E**xpressing to the other person how the objectionable behavior makes you feel (paying attention to tone of voice, posture, eye contact, and hand gestures)
- **S**pecifying the desired change in behavior, which includes saying no to unreasonable demands, negotiating or compromising, and persisting
- Indicating to the other person both the positive **C**onsequences of changing the behavior and the negative **C**onsequences of not changing the behavior

Anger and persistent irritability (without obvious cause) can be physical symptoms of a psychiatric disorder or side effects of certain prescribed sedatives and hypnotic medications. In such instances, these sessions are not intended to be a treatment intervention for the underlying disorder or problem. For clients with such disorders, treatment options must be evaluated on a case-by-case basis.

Anger Management for Substance Abuse and Mental Health Clients: A Cognitive Behavioral Therapy Manual (Reilly and Shopshire 2002) provides additional anger management techniques to be taught in a group setting. Developed by the Center for Substance Abuse Treatment, the manual describes the anger cycle, conflict resolution, assertiveness skills, and anger control plans. An accompanying workbook for participants, *Anger Management for Substance Abuse and Mental Health Clients: Participant Workbook* (Reilly et al. 2002), provides worksheets and homework assignments using the core concepts of the program and is used in conjunction with the therapy manual.

Session 1 Outline

Objectives

1. To help clients understand how anger and frustration relate to their own behavior
2. To teach clients ways to handle anger and frustration
3. To improve and strengthen clients' assertiveness skills
4. To help clients understand the differences among passive, aggressive, passive-aggressive, and assertive behaviors

Procedures

1. Review the substance use behavior chain
2. Assess clients' assertiveness skills
3. Discuss anger and frustration as antecedents to substance use and alternative assertive responses
4. Compare aggressive, passive, and passive-aggressive behaviors with assertive behavior
5. Rehearse passive, aggressive, passive-aggressive, and assertive responses
6. Discuss components of assertive behavior
7. Assign homework to reinforce concepts

Materials

1. Copies of Module 1 Handout 2-4: Substance Use Self-Monitor Log
2. Newsprint chart with substance use behavior chain (Figure IV-3)
3. Copies of Rating Form: Assertiveness Behavior Rehearsal (page 137)
4. Copies of Module 6 Handout 1-1: The DESC Model for Assertive Behavior

Session 1 Presentation

Collect substance use self-monitor logs from clients, and distribute blank copies of the log. Photocopy each completed log, and place a copy in each client's treatment chart before returning the original to the client.

1. Review the Substance Use Behavior Chain

Display the newsprint chart with the substance use behavior chain, and briefly review each element with clients.

2. Assess Clients' Assertiveness Skills

Today we will discuss how to manage anger and frustration. But before we do, we will rate your assertiveness skills. I will read aloud a situation and then rehearse the situation with each of you.

Read situation 1 or 2 to each client. Rate each client using the Rating Form: Assertiveness Behavior Rehearsal on page 137. Do not give oral feedback at this time. On each client's rating form, note which situation was used. In Session 3, each client will rehearse a personal situation, and the two scores will be compared to determine whether the client has mastered the skill.

Situation 1. Since you left the hospital, you have been living with your son. When you first went to stay with him, you were not allowed to drive so your son took your car keys and put them away. You had driven your own car for years. Your doctor has told you it is okay to drive again, and you feel ready to get around on your own now. Your son avoids discussing the issue. You feel frustrated and angry because you have been denied the freedom to drive.

Situation 2. You have been working on a home repair job for some time. It has been a difficult and frustrating task, but you've finally finished. A family member comes over, criticizes your work, and tells you what he or she would change. You think the criticism is unfair and the changes are unreasonable.

3. Discuss Anger and Frustration as Antecedents to Substance Use and Alternative Assertive Responses

Substance use often is a way of coping with situations that create anger or frustration or both. If you look at the substance use behavior chain, you will see that feelings, which include anger and frustration, follow immediately after situations or thoughts.

When a situation leads to anger or frustration or both, for many people who use substances the first response is "I'll have a drink" or "I'll take an extra (pain/tranquilizer/sleeping) pill." A situation can lead to feelings of anger and frustration, which can lead to the urge to use a

substance. Of course, if certain cues are present, such as a bottle of liquor on the counter, beer in the refrigerator, or a bar on the way home, you may be more likely to give in to the urge. One way to avoid using substances when you are angry or frustrated is to be prepared with another way of handling these situations.

We generally get angry or frustrated when we are unable to reach a goal. When we cannot get something we want or need, we feel frustrated. Often frustration leads to anger even if we don't express it. Using assertive behavior is one way to try to get what we want without driving others away or hurting ourselves. What does it mean to be assertive? *(Encourage discussion.)*

4. Compare Aggressive, Passive, and Passive-Aggressive Behaviors With Assertive Behavior

It sounds as though you have some understanding of what it means to be assertive. Some people may believe that being assertive is undesirable. If so, they probably are confusing assertiveness with aggressiveness, so let's talk first about aggressive behavior. People who are aggressive protect their rights but also violate the rights of others. They often get what they want by being hostile or threatening, and that drives others away. Sometimes people who behave aggressively feel guilty later. For people who use substances, aggression followed by guilt often leads to substance use.

Now let's talk about passive behavior. People who are passive do not protect their rights and do not protect the rights of others. They also do not get what they need. Often when people who are passive are unable to get what they need, they become angry, anxious, and frustrated and lose respect for themselves. Others also may lose respect for them, and passive people, like people who are aggressive, often drive others away. For people who use substances, anger, frustration, anxiety, and loss of self-respect often lead to substance use.

Another type of behavior is known as passive-aggressive. People who are passive-aggressive use an indirect approach. Often, they hint at what they want or disguise their true intentions. People who are passive-aggressive cause confusion and often spark resentment in others.

Assertive people protect their rights and do not violate the rights of others. They often succeed at getting what they want without being threatening or driving others away. To illustrate the differences between aggressive, passive, passive-aggressive, and assertive behaviors, let's take an example that is familiar to everyone. Imagine you buy something that is damaged. You take it back to the store, but the salesperson refuses to give you your money back. What can you do? Some people become aggressive. They get angry, explode, and insult the clerk. Aggressive people may get what they want, but they offend others and drive people away. They usually wind up feeling rejected, and sometimes they feel guilty.

What else can you do? You can be passive. Passive people may accept the salesperson's response that they cannot return the item and leave the store. How do you think passive

people end up feeling? They end up feeling angry and frustrated because they don't get what they want. In addition, passive people don't get much respect, and others constantly take advantage of them.

What else can you do? You can be passive-aggressive. Passive-aggressive people may respond indirectly, perhaps by turning to another customer and commenting that the store or the salesperson apparently does not value older adults as customers. How do you think passive-aggressive people end up feeling? They don't get what they want either, because they don't know how to ask for it. So they also end up feeling angry and frustrated.

What else can you do? You can learn to be assertive by asking for what you want firmly and convincingly. Becoming assertive is a lifetime project. As you begin to practice some basic assertiveness skills, you will develop confidence in yourself. Some situations are more difficult than others, so it may help to practice assertiveness skills first in uncomplicated situations. When you have mastered assertiveness skills, you will have one of the most effective tools for navigating the recovery process.

Assertiveness does not always work, but the odds are much better that you will get what you want if you know how to behave assertively. Also, being assertive often prevents people from exploding with anger or from bottling up their anger and frustration.

It can be difficult to understand the difference between aggressive and assertive behavior. Think of it this way. Aggressive people force others to meet their needs by using unpleasant means such as shouting, physical roughness, manipulation, or threats. In contrast, assertive people are able to express feelings, ask for what they want, or set limits without demanding results or intimidating people. To provide clarity, let's compare an aggressive response and an assertive response, using a real-life example. Imagine that you and a group of friends have come together on a Sunday afternoon to watch a football game. The friend who is hosting the party offers you a drink. An example of an aggressive response might be: "I'm not drinking, and I don't want anyone drinking around me. I'm pouring everyone's drinks down the drain."

An assertive response might be: "I've quit drinking, so please don't ask me to drink with you anymore. I still want to get together with you to do other things, like watch the game or play some poker, okay?"

5. Rehearse Passive, Aggressive, Passive-Aggressive, and Assertive Responses

Now let's rehearse a sample situation to demonstrate passive, aggressive, passive-aggressive, and assertive responses. *(Read situation 3, and demonstrate responses.)*

Situation 3. A friend borrowed a valuable book that was given to you by your grandmother. The friend promised to return the book in 1 week. The friend phones you and

during the course of the conversation mentions that she has lent the book to someone else.

Demonstrate a passive response.

Responder (Passive): Oh, uh, well, uh, I hope she likes it. Well, uh, maybe you could let me know when she's done.

(Ask clients the following questions.) Does this person get what she wants (the book back)? How does she feel after she hangs up the phone? Do you think her friend respects her? How likely is it that her friend will take advantage of her in the future?

Demonstrate an aggressive response.

Responder (Aggressive): You had no right to lend my book to her! If I don't get that book back within 1 hour, I'm going to call the police!

(Ask clients the following questions.) Does this person get what she wants? How does she feel after she hangs up the phone? Do you think she will have this friend for long? How likely is it that her friend will take advantage of her in the future?

Demonstrate a passive-aggressive response.

Responder (Passive-Aggressive): Well, please let me know when you get it back. (She hangs up the phone and then calls a mutual friend): You won't believe what _____ (their friend's name) did this time! She borrowed a very important book from me and then lent it to someone else without my permission. I don't think she cares about others' feelings.

(Ask clients the following questions.) Does this person get what she wants? How does she feel after she hangs up the phone? Do you think the friend who borrowed her book respects her? How likely is it that this friend will take advantage of her in the future?

Demonstrate an assertive response using DESC.

Responder (Assertive): I told you I needed my book back in 1 week, but you lent it to someone else. I'm frustrated that you did this. I really need that book back. It's very valuable to me, and I wish you hadn't lent it without first asking me. Please ask your friend to return the book to you right away. I would like it back by tomorrow afternoon. If I receive it by then, I will be able to lend you more of my books. *(The four components of the DESC model, which is introduced to the group below, are included in this example.)*

(Ask clients the following questions.) Does this person get what she wants? How does she feel after she hangs up the phone? Do you think her friend respects her? How likely is it that her friend will take advantage of her in the future?

As you can see, by being assertive you protect your rights and express your feelings clearly. Assertive behavior allows you to express both positive and negative feelings clearly and comfortably. In this session, we are going to concentrate on situations that arouse anger and frustration so that you can learn to manage your anger appropriately and to behave in ways that allow you to get what you want or need without turning others away unnecessarily.

Why do you suppose people who lack assertiveness often use substances after situations that make them feel angry and frustrated? *(Encourage discussion.)*

There are several reasons. Alcohol and drugs temporarily lower the anger level for many people. They reduce frustration. Some people report feeling calmer or more peaceful when they use a substance in situations like these. Alcohol and drugs also temporarily reduce the anxiety or guilt some people have when they get angry. For passive people who find it difficult to speak up, alcohol or drugs can reduce their frustration or give them false courage. However, assertive handling of situations that make you angry and frustrated gets you what you want without your using a substance and without your alienating others.

Assertive behavior is a learned skill. It is not automatic. In fact, being assertive is difficult for many people. Why do you think that's the case? *(Encourage discussion.)*

Many people are afraid that, if they use assertive behavior and persist in asking for what they want and need, they will be disliked or rejected by someone who is important to them. Some people even fear being attacked physically. In fact, just the opposite is likely to happen. Think about it. Do you like and respect passive people who never protect their rights? Do you like and respect aggressive people who explode in anger and threaten others to get what they want? As you practice assertive behavior, it may help to keep in mind that you are not directing your behavior at the person. You are using assertive behavior to handle a problem or correct a situation that is causing you anger or frustration.

6. Discuss Components of Assertive Behavior

Now I will present the DESC Model for Assertive Behavior. The letters D-E-S-C are a memory aid to help you remember the four steps of assertive behavior. Let's go through the steps together. *(Distribute Module 6 Handout 1-1.)*

First, describe (**D**) the behavior that is annoying you. Use nonjudgmental language. Don't call the other person names or put that person down. Stick to the point. Don't generalize (e.g., don't use words like "you always," "you never," or "you do this every time"), and don't dwell on the past (what happened last year or 10 years ago usually will not solve the

current problem). Listen to the other person's point of view if he or she hasn't presented it. You may hear something that calms your anger immediately.

Second, express (**E**) your feelings about the situation. Say something like, "I am amazed when . . ." or "I am worried that you . . . ." Your tone of voice should be firm and serious because if you are laughing, smiling, or soft-spoken while trying to be assertive, you may not be convincing. However, if you shake your fist, make threatening gestures, or yell, you will demonstrate that you have lost control of yourself. Be aware of your posture and hand gestures. Don't slump or turn away from the person. Don't clasp your hands or try to hide them. That gives the appearance of being passive. Look at the person you are addressing. If you look away, you may seem fearful or anxious, and you won't be convincing. It is your responsibility to communicate as clearly as you can with your gestures and words.

Third, specify (**S**) the change you want. Only you can tell the other person exactly what he or she can do to solve the current problem or avoid a similar problem in the future. Say no to unreasonable demands, but be ready to compromise if a compromise is justified. Be persistent. Don't give up easily if you believe you are right. One technique you can use to persist is called "broken record": If the other person tries to ignore your request, simply keep repeating it.

Fourth, describe the consequences (**C**). Tell the person the advantage for him or her and for you if you can agree on a specific change or can work out a compromise. You also may have to point out the negative consequences if he or she does not agree to a change or a compromise. However, be cautious about stating negative consequences. Never suggest a negative consequence unless you are willing to follow through on it.

7. Assign Homework To Reinforce Concepts

Continue to fill out your substance use self-monitor log.

For Counselor's Use Only

Rating Form: Assertiveness Behavior Rehearsal

CLIENT'S NAME _____

RATER'S NAME _____

Problem Situation (State the situation in the box below.)	Rehearsal 1 Date: _____				Rehearsal 2 Date: _____			
Rehearsal 1 / Rehearsal 2	Not Applicable	No Evidence of Desired Behavior	Some Evidence of Desired Behavior	Clearly Performed Desired Behavior	Not Applicable	No Evidence of Desired Behavior	Some Evidence of Desired Behavior	Clearly Performed Desired Behavior
DESCRIBE 1. Did the client describe the objectionable behavior of the other person in nonjudgmental language (e.g., did not attack, make "who did what to whom" statements, generalize to other situations, dwell on the past)?		1	2	3		1	2	3
2. If the other person did not give his or her point of view, did the client ask for it? (In some situations, this may not apply.)		1	2	3		1	2	3
EXPRESS 3. Did the client make eye contact (e.g., eyes toward other person, but not necessarily direct eye contact)?		1	2	3		1	2	3
4. Was the client's tone of voice firm, serious, and convincing?		1	2	3		1	2	3
5. Did the client's posture and hand gestures suggest firmness of purpose (e.g., client stood or sat erect; turned toward other person; did not slump in chair, turn away, clasp hands, or use threatening gestures)?		1	2	3		1	2	3
6. Did the client state his or her feelings about the objectionable behavior?		1	2	3		1	2	3

form continues on the next page...

	Rehearsal 1 Date: _____				Rehearsal 2 Date: _____			
	Not Applicable	No Evidence of Desired Behavior	Some Evidence of Desired Behavior	Clearly Performed Desired Behavior	Not Applicable	No Evidence of Desired Behavior	Some Evidence of Desired Behavior	Clearly Performed Desired Behavior
SPECIFY 7. Did the client request a change and specify the behavior necessary to solve the current problem or avoid a future problem?		1	2	3		1	2	3
8. Did the client use negotiation or compromise where appropriate? (In some situations, this may not apply.)		1	2	3		1	2	3
9. Did the client persist until he or she got a commitment to change or reached a compromise? (Or is it clear no change can be expected?)		1	2	3		1	2	3
10. Did the client say no to unreasonable demands?		1	2	3		1	2	3
CONSEQUENCES 11. Did the client state the positive consequences of changing the objectionable behavior or reaching a compromise?		1	2	3		1	2	3
12. Did the client state the negative consequences of not changing or not compromising? (If the other person cooperated early in the interchange this does not apply.)		1	2	3		1	2	3

Scoring: To receive a passing score, the client must score at least a 2 in each category.

A client who does not receive a passing score may need additional help in individual treatment sessions.

The DESC Model for Assertive Behavior

1. **D**escribe the objectionable behavior.
   - Use nonjudgmental language.
   - Get the other person's point of view.

2. **E**xpress your feelings.
   - Use a firm voice and stand or sit straight.
   - Make eye contact.

3. **S**pecify the change you want.
   - Say no to unreasonable demands.
   - Compromise if necessary.
   - Be persistent.

4. Describe the **C**onsequences.
   - Indicate the positive consequences of changing to the other person.
   - Suggest the negative consequences, if necessary, of not changing.

Remember

- You have the right to say no without feeling guilty.
- You have the right to stand up for yourself.
- You have the right to manage your own life.
- You do not have the right to deprive others of their rights.

Session 2 Outline

Objective

1. To increase clients' comfort level in responding effectively to situations that evoke anger and frustration

Procedures

1. Review the substance use behavior chain
2. Review the DESC Model for Assertive Behavior
3. Discuss how to recognize when assertive behavior is appropriate
4. Rehearse assertive responses
5. Rehearse sample situations with clients
6. Rehearse personal situations with clients
7. Assign homework to reinforce concepts

Materials

1. Copies of Module 1 Handout 2-4: Substance Use Self-Monitor Log
2. Newsprint with substance use behavior chain (Figure IV-3)
3. Copies of Module 6 Handout 1-1: The DESC Model for Assertive Behavior (Module 6 Session 1)
4. Newsprint with the DESC Model for Assertive Behavior

Session 2 Presentation

Collect substance use self-monitor logs from clients, and distribute blank copies of the log. Photocopy each completed log, and place a copy in each client's treatment chart before returning the original to the client.

1. Review the Substance Use Behavior Chain

Display the newsprint chart with the substance use behavior chain, and briefly review each element with clients.

2. Review the DESC Model for Assertive Behavior

Let's quickly review the DESC Model for Assertive Behavior that we learned in our last session.

Ask clients to refer to Module 6 Handout 1-1 in their notebooks, and review.

3. Discuss How To Recognize When Assertive Behavior Is Appropriate

At times you may be in situations that are irritating and frustrating, but it's just not worth using assertive behavior. When this happens, it is best to relax and let go of your irritation and frustration. Each person has limits to what he or she can tolerate. However, if you tend to get ruffled about nearly everything and everyone who gets in your way, you probably need to take a closer look at your behavior and consider giving in occasionally or just walking away from an irritating situation.

Many of us, however, have the opposite problem. We have trouble standing up for ourselves. Whenever you give in or walk away and you find that the situation continues to bother you, you have failed to assert yourself when you should have. In some situations, it is very difficult to figure out whether to stand up for yourself or to walk away.

4. Rehearse Assertive Responses

Let's practice using assertive behavior again. I'll read a situation to you, and then we'll brainstorm possible responses. Think of your DESC responses.

Display the DESC newsprint chart. Read situation 1 aloud.

Situation 1. You are in a crowded grocery store and in a hurry. You pick up one small item and get in the express line to pay for it. A woman with a shopping cart full of groceries cuts in line in front of you. She says, "You won't mind if I cut in here, will you?"

Goal. Explain that you and others are in line to check out quickly. Firmly state that you expect her to move to the appropriate line.

How-to statement. How to get the woman out of the line without starting a fight and without giving in.

Brainstorm possible responses with the group. Encourage all ideas. Choose one response, and explain why it would be effective. Rehearse the effective response with a client. Diagram it on the DESC newsprint chart. Incorporate all the steps of the DESC Model for Assertive Behavior. Encourage the group to discuss the rehearsed responses.

5. Rehearse Sample Situations With Clients

We will practice assertive behavior using other sample situations. Like the situation we just finished discussing, these situations do not involve someone close to you. You'll find that it almost always is easier to use assertive behavior in situations that involve strangers.

Read situation 2, 3, or 4, and rehearse assertive responses with each client.

Situation 2. You are in a drug store, and you pick up an item that costs 75 cents. You go to the cashier to pay for it and hand her a $5 bill. She rings up the sale and hands you 25 cents, which would be the correct change for a dollar, saying, "Here's your change, sir."

Goal. Get your correct change. Be persistent. If necessary, ask to see the supervisor or manager, and explain what happened.

How-to statement. How to get the correct change without fighting and without giving in.

Situation 3. You are in a restaurant with friends. You order a rare steak, and the waitress brings a steak to the table that is so well done it looks burned. She says, "I hope you enjoy your dinner, sir."

Goal. Ask the waitress to bring you the steak as you ordered it. Avoid letting social pressure prevent you from asking for what you want.

How-to statement. How to ask for another steak cooked correctly without feeling uncomfortable or making your friends uncomfortable.

Situation 4. A salesperson shows up at your door and asks for 15 minutes of your time. You can afford the time, but you don't want to buy anything. Besides, you dislike sales talk. The salesperson says, "Just give me 15 minutes to show you my products with no obligation. If you don't like them, you haven't lost anything."

Goal. Make yourself clear by saying no and closing the door.

How-to statement. How to let the salesperson know quickly that you are not interested without getting into an argument.

6. Rehearse Personal Situations With Clients

We just practiced using assertive behavior to handle situations with strangers. Now we will practice being assertive in situations that involve someone close to you. Managing anger or frustration is much more difficult with someone you know well, such as a friend or family member, because it involves considerable risk. What kinds of risks can you think of? *(Encourage discussion.)*

There are two types of risks. The first comes from outside you, that is, from another person who may get angry and reject you if you express your opinion or annoyance and ask for a change in behavior. Often we exaggerate this risk in our minds. Although the people you care about may not be happy when you express negative feelings about their behavior, they nearly always can cope with hearing what you have to say and rarely desert you for speaking your mind.

The second kind of risk comes from inside us. If you have trouble speaking up, you may notice that just thinking about telling someone you don't like his or her behavior creates anxiety and tension and increases frustration. If you assert yourself, you must accept the fact that you probably will have some anxiety about it. You have to learn to live with that anxiety as you address the objectionable behavior of people close to you. As you practice being assertive, you will find that your anxiety decreases. You also will find that the rewards of honest relationships make the risks worth taking.

Now let's rehearse some situations involving close relationships. If these situations seem familiar to you, I'd like you to share with the group how you might handle these situations in your lives. Remember the DESC model.

Select two situations for each client, and rehearse the situations.

Situation 5. You go to a party with a friend. Your friend seems to ignore you throughout the evening. You are on your way home and feeling hurt by her behavior.

Goal. Change the way you feel. Describe your view of the situation to your friend. Listen to her point of view. Express your feelings about the situation. Try to agree on the reasons for the situation and a remedy to prevent it from happening again. Point out the benefits of agreeing and maintaining the friendship. State the disadvantages of not reaching an agreement, if necessary, but be prepared to back up the consequences.

How-to statement. How to express your feelings of anger and hurt and prevent the situation from happening again without ruining the friendship.

Situation 6. You and your spouse have not been getting along well lately. Your spouse has accused you of not doing your share of housekeeping, and you feel that your spouse is taking advantage of you by spending too much money. You have avoided discussing the problem, but your anger is building.

Goal. Set aside some time to speak with your spouse about your feelings. Describe the conflict as you see it, and express your feelings of anger, but make it clear that you share the responsibility. Try to see your spouse's point of view. Point out the benefits of reaching a compromise. Compromise, but don't lose sight of your needs.

How-to statement. How to confront your spouse about the situation while preserving your relationship.

Situation 7. During the last few months, you have experienced stress as a result of life events and your drinking problem. You have not been taking care of your business and money affairs as you did in the past. You now are feeling physically and mentally stronger, but a family member is treating you as though you are incompetent. While discussing your business one day, your family member says, "I think you ought to let me take over your banking for you."

Goal. Let the family member know that you intend to keep control of your affairs, but try to ease his or her worries about you. Describe your past situation. Explain why your behavior will be different now. Express your anger at being put in a dependent position, but use restraint. Specify the change you want from the other person, and be persistent about your need to manage your affairs.

How-to statement. How to confront a family member with your feelings and make your intentions known without damaging your relationship.

Situation 8. During the last year, your drinking and health problems have prevented you from holding down a job. You are on a job interview, and the interviewer says, "It looks as though you haven't been able to stay with a job very long lately."

Goal. Handle the implied criticism calmly but directly. Explain your past record and why your behavior will be different now. You want something from the other person, and presumably you already have stated your reason for being there. There is no need to restate it at this point. Tell the interviewer the benefits of hiring you—what skills you have for the job and why he or she can expect you to perform well.

How-to statement. How to handle criticism without becoming angry and aggressive.

7. Assign Homework To Reinforce Concepts

Your homework assignment is to write down in your notebooks a personal situation in which you became frustrated or angry and did not respond assertively. It must be one that you are willing to share with the group because we will use the situation in our next session. Also, continue to fill out your substance use self-monitor log.

Session 3 Outline

Objective

1. To improve and strengthen client skills in responding assertively to situations that evoke anger and frustration

Procedures

1. Review assertive behavior
2. Reassess clients' assertiveness skills
3. Assign homework to reinforce concepts

Materials

1. Copies of Module 1 Handout 2-4: Substance Use Self-Monitor Log
2. Copies of Module 6 Handout 1-1: The DESC Model for Assertive Behavior (Module 6 Session 1)
3. Copies of Rating Form: Assertiveness Behavior Rehearsal (partially completed in Module 6 Session 1)

Session 3 Presentation

Collect substance use self-monitor logs from clients, and distribute blank copies of the log. Photocopy each completed log, and place a copy in each client's treatment chart before returning the original to the client.

1. Review Assertive Behavior

Let's spend a few minutes reviewing the DESC Model for Assertive Behavior. *(Ask clients to refer to Module 6 Handout 1-1 in their notebooks and review it.)*

2. Reassess Clients' Assertiveness Skills

At the end of our last session, I asked you to think of a personal situation in which you became frustrated or angry and did not respond assertively and to record it in your notebooks. In this session, we will practice assertive behavior using these personal situations.

We will spend the rest of the session rehearsing the situations from your homework assignment, and I will rate you on your responses.

Retrieve the rating forms that were used in Session 1. Ask the client to read or describe his or her situation. Then ask each client to practice assertive responses to his or her situation. Rate the client on his or her performance, and compare the two scores. Repeat this exercise with each client. To complete the exercise successfully, the client must score at least a 2 on each question. Clients who are unsuccessful should get additional coaching and be reassessed later. Clients who continue to score below a 2 for each question must repeat all three sessions of Module 6 at a time to be determined by the counselor and the client.

3. Assign Homework To Reinforce Concepts

Your homework assignment is to continue filling out your substance use self-monitor log.

Module 7: How To Control Substance Abuse Cues

Overview

As discussed in the Module 1 group sessions, cues are another link in the substance use behavior chain. A cue is an object, a time, an event, or a thing that stimulates a person to use alcohol or drugs. Obvious cues include remembering bottles of liquor or beer are hidden in the house or being present when other people are using substances. Such overt cues are difficult to cope with because of their proximity to the actual use of the substance. Although disposing of substances or staying away from people who use substances removes these cues, it is not easy for a person who abuses substances to do this.

Subtle cues include sitting in a special chair to drink while watching television, seeing a beer or wine list in a restaurant, passing a liquor store on the way home, or arriving home from work with nothing to do. Some older adults cite the beginning of each month as a major cue for substance abuse because this is when they receive their Social Security or pension checks. The Substance Abuse Profile for the Elderly assessment (appendix A) identified each client's personal cues for substance use, and this information should be used in tailoring the content of group sessions.

This module helps clients understand the role of cues in substance use. Clients learn to recognize and manage their personal cues for substance use. They become familiar with a new behavioral model for controlling cues to substance use, called the CARD Model.

Session 1 Outline

Objectives

1. To help clients understand the role of cues in substance use
2. To teach clients how to recognize and manage their personal cues for substance use
3. To teach clients how to avoid or eliminate cues in the environment

Procedures

1. Complete controlling substance use cues quiz
2. Review cues on the substance use behavior chain
3. Introduce the CARD Model
4. Practice controlling substance use cues
5. Identify cues in the clients' antecedents lists
6. Complete individual cues quiz
7. Discuss client cues and responses to them
8. Complete controlling substance use cues postquiz
9. Assign homework to reinforce concepts

Materials

1. Copies of Module 1 Handout 2-4: Substance Use Self-Monitor Log
2. Newsprint with substance use behavior chain (Figure IV-3)
3. Newsprint with the CARD Model for controlling cues (Figure IV-11)
4. Copies of Module 7 Handout 1-1: Controlling Substance Use Cues Quiz
5. Clients' original antecedent lists
6. Copies of Module 7 Handout 1-2: Individual Cues Quiz

Session 1 Presentation

Collect substance use self-monitor logs from clients, and distribute blank copies of the log. Photocopy each completed log, and place a copy in each client's treatment chart before returning the original to the client.

1. Complete Controlling Substance Use Cues Quiz

Before we begin our discussion of cues and what to do about them, I would like you to take a short quiz. The questions on this quiz will stimulate your thinking about cues and provide an indication of what you already know about this topic. *(Distribute Module 7 Handout 1-1, and give clients a few minutes to answer the questions. Collect the forms for scoring later in the session.)*

2. Review Cues on the Substance Use Behavior Chain

Let's take another look at the substance use behavior chain. *(Display newsprint chart.)* We are focusing on the antecedent called "cues." Generally, the word "cues" is used loosely. Cues can refer to anything that serves as a prompt or reminder. Today, we will use it to refer specifically to stimuli in a situation—things you can see, hear, smell, or touch—that are associated specifically with your substance use. Obvious cues include the substances themselves; places where alcohol is served, such as bars, restaurants, or homes of certain friends; people with whom you commonly use substances; or exposure to others' talk about substance use.

Cues that stimulate the urge for substance use are not always obvious. In most instances, cues develop into urges; therefore, learning to recognize the onset of these cues is important. What you do while using substances may become a cue. For example, if you watch TV, work in the kitchen, read, or sit in a particular chair, the sight of the TV, kitchen, book, or chair may stimulate thoughts about using substances. If you are accustomed to using alcohol or drugs at 4 p.m., having a cocktail before dinner, or having a drink first thing in the morning or before bedtime, these particular times may become strong cues for substance use.

Receiving exceptionally good news may be a cue for substance use. Similarly, certain holidays such as New Year's Eve may be cues for substance use. The presence of these cues can have a strong influence on your decision to use substances. Even if you are not using now, the presence of these cues in the future may lead to a strong urge for substance use.

3. Introduce the CARD Model

There are effective ways to control cues to substance use. Let's look at one way of controlling cues, using what we call the CARD Model. *(Display Figure IV-11 on newsprint.)*

Figure IV-11. The CARD Model for Controlling Cues

1. Competing responses
2. Avoiding
3. Rearranging your life
4. Disposing of substances

The letters C-A-R-D are a memory aid to help you learn and remember methods for controlling cues.

C stands for competing responses. This entails finding something to do that makes substance use difficult or impossible when you are in the presence of a cue you can't avoid. For example, if you use substances while watching TV, decide that you will not watch TV unless you have something to keep your hands busy, such as knitting or building models. If you commonly use substances at home and you get the urge to use, leave the house. Do something that makes substance use difficult such as going for a walk or visiting a neighbor.

A stands for avoiding. This is perhaps the most important method for controlling cues for substance use. Advance planning can help you avoid substance use cues. The sight and smell of alcohol and certain drugs are strong cues. Avoid all people who use substances until you feel confident that you have firm control over your behavior. Avoid going to bars, restaurants, and other places where alcohol is served. Establish friendships with people in groups and organizations that do not include alcohol or drugs as part of their social events. Spend more time with friends who do not use substances or who drink sensibly and infrequently or not at all. Avoid relationships with people who use illicit substances.

R stands for rearranging your life. Start with your obvious cues for using substances at home. Did you always sit in a particular chair? If so, move it or reupholster it. Did you use substances at a particular time? If so, rearrange your daily schedule. For example, if you are accustomed to using substances when you arrive home in the afternoon, schedule an activity during that time. One person took a walk every afternoon at 3:30. He would stop to talk or visit with a neighbor who didn't drink. He successfully scheduled an activity that conflicted with a time that was a strong cue for his substance use. Another person who used to unwind by smoking marijuana when she arrived home at 6 p.m. started going to a health club at 6 p.m. instead of going home. Another individual who used to start drinking between 4 and 5 p.m. when he arrived home because he was hungry, and dinner was not ready until 6 p.m., decided to ask his wife to serve dinner at 5 p.m.; he planned not to arrive home until 4:30 p.m., whenever possible, or to plan an activity he could do until dinner was ready. When a cue creates an urge for substance use, remind yourself of the consequences and just say no. If you can do that, great; but scheduling activities in place of substance use will make it easier.

You may have to rearrange your entire lifestyle. Although that may seem drastic, it may be necessary. If you have spent a lot of time with friends who used substances or who engaged in activities in which substance use was likely, you may have to stop seeing them. If you tended to use substances alone at home, you may have to spend more time with other people and work at overcoming your shyness about meeting others and feeling more comfortable in groups. If you have had problems following the instructions for your

prescribed medications, you might want to use a weekly pill organizer or ask a trusted family member to help you manage your medications. This will require a great deal of effort on your part, and it will not be easy. Keep in mind that you have the skills to make these changes.

D stands for disposing of substances. If you don't have substances, you can't use them. Don't keep alcohol and drugs at home, in the car, or at work. Get rid of them. Some people claim that they keep alcohol or drugs around to test themselves. This isn't smart when you are trying to overcome a substance use problem. Others keep alcohol at home because they say they're not tempted anymore or they offer it to guests. If your goal is to be abstinent and you have alcohol or drugs at home, you have not made a commitment. You are keeping it "just in case."

4. Practice Controlling Substance Use Cues

Now we will practice how to control substance use cues. *(Read situation 1 to clients. Demonstrate to the group how to handle the situation using the CARD Model, and then encourage discussion. When clients appear to understand the elements of the CARD Model, practice a situation with each client, and give feedback.)*

Situation 1. You're given a bottle of your favorite booze for a birthday present. Let's define the problem situation in a positive how-to statement—for example, how to eliminate the cue without insulting the person who gave it to you.

Goal. To get rid of the bottle as soon as possible by throwing or giving it away.

Situation 2. Your bus stop is in a neighborhood known for heavy drug trafficking and use. Let's define the problem situation in a positive how-to statement—for example, how to avoid this area or reduce the amount of time spent there.

Goal. To minimize temptation by limiting time spent at the bus stop in this area or by finding another bus stop.

Situation 3. You are at a party, and many people around you are drinking alcohol and using marijuana. The smell of marijuana is in the air. You feel like joining in. Define the problem in a positive how-to statement—for example, how to stay away from substances in a social situation where people are using.

Goal. To reduce temptation by leaving the party or by focusing on past negative consequences of using substances.

5. Identify Cues in the Clients' Antecedents Lists

I'd like you to take out your personal antecedents list, which identifies the cues you gave in earlier sessions. I want you to select one of your cues, and we'll rehearse a solution to that cue. *(Rehearse solutions to each client's cue.)*

6. Complete Individual Cues Quiz

The handout that I will distribute now is a brief quiz that asks you to identify your cues and your responses to them. *(Distribute Module 7 Handout 1-2.)* Take a few moments to complete it. Copy each cue from your antecedents list onto the form. Under each cue, write your response for controlling it. Add any cues you may think of that are not on your antecedents list. Place an X beside your most frequent or powerful cue to substance use. *(Collect the quiz at the end of the session. Use the information on the forms to update each client's antecedents list. Note how many times clients respond with a method from the CARD Model. Return the modified antecedents list and the quiz to clients at the next session.)*

7. Discuss Client Cues and Responses to Them

Now I want to give you an opportunity to talk about some of the situations you have faced or might face in the future. I'd like you to describe your most frequent or powerful substance use cues and your responses to them.

Ask for a volunteer or select one of the more confident clients to describe his or her cues. Make sure that the rest of the group members pay attention while a client is speaking, and encourage group feedback. If necessary, provide guidance to clients in following the CARD Model.

8. Complete Controlling Substance Use Cues Postquiz

At the beginning of this session, you'll recall that I asked you to take a short quiz to test your knowledge about cues for substance use. Now that we've talked about cues, I'm going to ask you to take the quiz again, and we will compare the results.

Distribute clean copies of Module 7 Handout 1-1, and allow time for clients to complete them. While clients complete the posttest, score the initial copies of Handout 1-1, which were administered at the beginning of the session. Use the Scoring Directions for the Controlling Substance Use Cues Quiz on page 156. Collect the second set of quizzes, and compare results with the initial quiz. Comment in general on any differences noted.

9. Assign Homework To Reinforce Concepts

Your homework assignment is to continue filling out your substance use self-monitor log.

Controlling Substance Use Cues Quiz

CLIENT'S NAME _____ **DATE** _____

RATER'S NAME _____ **PRETEST:** ☐ **POSTTEST:** ☐

1. What should you do with alcohol and drugs in your home?

_____

_____

2. What should you do if someone gives you your substance of choice for a present?

_____

_____

3. If you were likely to use a substance at a certain time of day (e.g., in the late afternoon) when you were using substances, what should you do?

_____

_____

4. If you frequently used a substance in a certain place or bought it at a certain location, what should you do?

_____

_____

5. If that location is beside your bus stop, favorite restaurant, or closest grocery store or on your way home from work, what should you do?

_____

_____

6. If you often use substances at home while sitting in a particular chair, what should you do?

_____

_____

For Counselor's Use Only

Scoring Directions for the Controlling Substance Use Cues Quiz

Examples of Acceptable Answers	Points
1. Get rid of them.	1
2. Thank the giver, but firmly state that you are abstinent. Allow the giver to take it back if he or she offers, or tell him or her you know someone who will appreciate it. Then get rid of it as soon as you can.	1
3. Plan an activity for the time that you are likely to use a substance. Go to an Alcoholics Anonymous or a mutual-help group meeting.	1
4. Avoid the location.	1
5. Go to another bus stop, restaurant, or grocery store or take another route home. If that bus stop or grocery store is your only choice, minimize your time there and focus your attention on something other than the place you used or bought substances.	1
6. Minimize the effect of the cue by moving the chair to another place in the room or to a different room. If possible, reupholster the chair.	1

Scoring: If the client's answer to each of the quiz questions captures the gist of the above examples, give him or her the allotted point for each answer.

Individual Cues Quiz

CLIENT'S NAME _____ **DATE** _____

Instructions: Open your notebooks to your personal antecedents list, and copy each cue from your antecedents list onto this form. Then using what you have learned about controlling cues, under each cue write all the ways you can think of for controlling it.

Cue #1:	_____

Your Response:

_____

_____

Cue #2:	_____

Your Response:

_____

_____

Cue #3:	_____

Your Response:

_____

_____

Cue #4:	_____

Your Response:

_____

_____

form continues on the next page...

Cue #5:	_____

Your Response:

_____

_____

Cue #6:	_____

Your Response:

_____

_____

Cue #7:	_____

Your Response:

_____

_____

Cue #8:	_____

Your Response:

_____

_____

Cue #9:	_____

Your Response:

_____

_____

form continues on the next page...

Cue #10:	_____

Your Response:

_____

_____

Cue #11:	_____

Your Response:

_____

_____

Cue #12:	_____

Your Response:

_____

_____

Cue #13:	_____

Your Response:

_____

_____

Cue #14:	_____

Your Response:

_____

_____

Overview

The urge to use a substance is the final antecedent in the substance use behavior chain. It should be explained as a strong desire for a substance that lasts for various lengths of time; has a beginning and an end, even when no substance is used; can be waited out successfully; becomes weaker and ends sooner each time it is resisted; and becomes easier to resist every time it is handled successfully. The cognitive–behavioral and self-management intervention (CB/SM) emphasizes that self-control is based on the knowledge that it is possible to wait out an urge successfully, given the time and ability to focus thoughts on something else and support from others. In CB/SM, an urge is not a physical craving but rather self-talk giving an individual permission or what seems like a good reason to use a substance. An urge also is linked to individual expectations about substance use, generally based on personal experiences or cultural expectations. CB/SM focuses on the cognitive components of thoughts, self-talk, and expectations. People are more likely to develop substance use disorders and to relapse if they do not master the necessary skills to cope with urges.

The self-talk "A few drinks will help me be more at ease at the boss's party" exemplifies an urge linked to a specific expectation about alcohol use. Another self-talk example of an urge linked to a specific expectation is "If one pain pill gets rid of these aches and pains, imagine how good I'll feel if I take two or three." Situations/thoughts, feelings, cues, urges, and real or expected short-term, positive consequences such as those indicated in the self-talk examples are the bases for substance abuse.

The CRASH Model explained in Session 1 of this module is used to teach clients how to cope with urges. Clients also should be taught how to use their personal consequences lists (discussed in Module 1 Session 2) to handle urges.

Clients are taught how to plan to cope with urges and practice implementing the plan in the group sessions rather than wait until an urge occurs before deciding what to do. Clients should be instructed to call a counselor they have been seeing, a support group sponsor or contact, an understanding friend who does not drink or abuse drugs, or a supportive family member for help if their urge for substance use persists.

Session 1 Outline

Objectives

1. To help clients understand how CB/SM defines urges
2. To teach clients new ways to handle urges

Procedures

1. Return clients' modified antecedents lists and quizzes completed during Module 7 Session 1
2. Assess clients' skills for handling urges
3. Review the substance use behavior chain
4. Discuss urges and how to handle them
5. Introduce the CRASH Model
6. Practice coping with urges using the CRASH Model
7. Assign homework to reinforce concepts

Materials

1. Copies of Module 1 Handout 2-4: Substance Use Self-Monitor Log
2. Copies of Module 7 Handout 1-1 and Module 7 Handout 1-2 completed by clients in Module 7 Session 1
3. Copies of clients' modified consequences and antecedents lists
4. Copies of Module 8 Handout 1-1: How To Handle an Urge
5. Newsprint for clients to draw the substance use behavior chain
6. Newsprint with the CRASH Model for coping with urges (Figure IV-12)
7. Copies of Module 8 Handout 1-2: The CRASH Model for Coping With Urges

Session 1 Presentation

Collect substance use self-monitor logs from clients, and distribute blank copies of the log. Photocopy each completed log, and place a copy in each client's treatment chart before returning the original to the client.

1. Return Clients' Modified Antecedents Lists and Quizzes Completed During Module 7 Session 1

Distribute clients' modified antecedents lists, and tell clients to review them briefly and then place them in their notebooks.

Return Module 7 Handout 1-1: Controlling Substance Use Cues Quiz and Module 7 Handout 1-2: Individual Cues Quiz (both were completed in Module 7 Session 1), and provide feedback as appropriate. Tell clients to place them in their notebooks.

2. Assess Clients' Skills for Handling Urges

Today we will talk about the final antecedent in the substance use behavior chain, the urge to use substances. First, however, we'll do an exercise. Take out the modified consequences lists. I'd like you to use this information to complete the exercise on this handout. The handout asks you to list the steps you would take to handle an urge.

Distribute Module 8 Handout 1-1. Give clients a few moments to complete the handout, and then collect it. After the session, rate clients' responses based on the CRASH Model you will teach in this session. Hold on to the rated handouts, and compare them with clients' responses to the handout that they will fill out at the end of Session 2 after they learn the CRASH Model.

3. Review the Substance Use Behavior Chain

Let's do another quick review of the substance use behavior chain. Would someone volunteer to draw the chain on the newsprint based on input from the rest of the group? *(Give clients a few minutes to construct the chain. After a client has drawn the chain on the newsprint, briefly review each link of the chain.)*

4. Discuss Urges and How To Handle Them

What is an urge? An urge is a strong desire for something. In this group, it refers to a strong desire to use alcohol or drugs. How many of you have experienced an urge to use alcohol or drugs and have not acted on it? How long did the urge last? *(Get input from each client during this discussion.)*

An urge has a beginning and an end. An urge can last for various lengths of time, but it will end even if you do not use a substance. You can wait out an urge successfully. Every time

you have an urge to use and you do not act on it, it will be a little easier to resist the next urge, which will be weaker or shorter. The more times you resist an urge, the easier it becomes.

Why do you think that happens? As we have said many times, any behavior that is followed immediately by positive consequences is likely to happen again. The immediate consequences of substance use almost always seem positive. When you follow every urge with substance use, you are building a habit. The strength of the habit depends on how many times you follow an urge with alcohol or drugs. If you want to break the habit, you must stop giving in to the urge. When you do that, you weaken the urge and your substance use habit. To handle an urge successfully, you need time to wait it out, something else to think about, and support from others.

5. Introduce the CRASH Model

Now I will present a way to handle an urge. It is called the CRASH Model. The letters C-R-A-S-H are a memory aid to help you remember the five steps for coping with an urge. Let's go through the steps together. *(Display newsprint of Figure IV-12.)*

C stands for consequences. The first step is to remember your consequences. Reflect on the long-term negative consequences of substance use and the positive consequences of not using substances. Refer to your consequences lists. You will take these lists with you when you leave the program. Look at them from time to time. Use them to remind yourself of what you have to lose by using a substance and what you have to gain by not using a substance.

Figure IV-12. The CRASH Model for Coping With Urges

If you have the urge to drink or use drugs
1. Remember your **C**onsequences.
2. **R**emove all substance use cues.
3. Find an incompatible **A**ctivity.
4. Use your coping **S**kills to manage negative thoughts and emotions.
5. If the urge persists, call for **H**elp.

R stands for remove. The second step of the CRASH Model is to remove all substance use cues. If you have alcohol around, pour it down the sink. If you are in a place where others are using alcohol or drugs, leave. In other words, remove the cue.

A stands for activity. The third step of the CRASH Model is to find something else to do that does not involve using substances—what we call an incompatible activity. Take a walk. Get busy with something that requires using your hands and demands your attention. Find a support group. Have a plan for what you will do if you have an urge to use alcohol or drugs. Planning ahead is the key. By the time you have an urge, it may be too late to start thinking about how to handle it.

S stands for skills. The fourth step of the CRASH Model is to use the coping skills you've learned in earlier sessions to manage negative thoughts and emotions.

H stands for help. The fifth and final step of the CRASH Model is to call for help if the urge persists. Call a counselor you have been seeing, a support group sponsor or contact, an understanding friend who doesn't drink or use drugs, or a supportive family member. I hope that, by now, you have found an Alcoholics Anonymous or other mutual-help group in which you feel comfortable and that you are attending meetings regularly. That way you already have contacts in place when an urge persists.

This handout will help you remember the five steps for coping with urges. *(Distribute Module 8 Handout 1-2.)*

6. Practice Coping With Urges Using the CRASH Model

Now we will practice using the CRASH Model. I will read you a sample situation, and I want you to imagine yourself in it and to think about how you would respond. I'd like each of you to tell the group what you would say to yourself in the situation and what you would do to handle the urge to use alcohol or drugs. Then I'd like other group members to provide feedback. As you provide feedback, keep in mind the following questions:

- Did the person repeat the consequences to himself or herself?
- Did he or she remove the substance use cues or remove himself or herself from the presence of cues?
- Did he or she find an incompatible activity?
- If applicable, did he or she use skills to cope with the situation, thoughts, or feeling that led to the urge?
- Did the person indicate specifically whom he or she would call for help, if necessary?

Write the questions on the newsprint. Read the situation aloud. After each client has a chance to speak, encourage comments from the group.

Sample situation. You are sitting at home alone one evening, and there is nothing on television that interests you. You are bored, and you think about the bottle you bought "just in case." The idea of getting out the bottle and having a drink is tempting.

7. Assign Homework To Reinforce Concepts

Your homework assignment is to continue filling out your substance use self-monitor log.

How To Handle an Urge

CLIENT'S NAME _____ **DATE** _____

RATER'S NAME _____ **PRETEST:** ☐ **POSTTEST:** ☐

If you get the urge to drink or use drugs, what should you do? List the steps you would take below.

1. _____

   _____

   _____

2. _____

   _____

   _____

3. _____

   _____

   _____

4. _____

   _____

   _____

5. _____

   _____

   _____

The CRASH Model for Coping With Urges

If you have the urge to drink or use drugs

1. Remember your **C**onsequences.
2. **R**emove all substance use cues.
3. Find an incompatible **A**ctivity.
4. Use your coping **S**kills to manage negative thoughts and emotions.
5. If the urge persists, call for **H**elp.

Session 2 Outline

Objectives

1. To help clients understand the cognitive components of urges
2. To teach clients new ways to handle urges
3. To improve and strengthen client skills for coping with urges

Procedures

1. Review the substance use behavior chain
2. Discuss urges and their cognitive components
3. Review steps to handling urges
4. Rehearse sample situations using the CRASH Model
5. Reassess clients' skills for handling urges
6. Assign homework to reinforce concepts

Materials

1. Copies of Module 1 Handout 2-4: Substance Use Self-Monitor Log
2. Newsprint with substance use behavior chain (Figure IV-3)
3. Copies of clients' modified consequences lists
4. Newsprint with the CRASH Model for coping with urges (Figure IV-12, Module 8 Session 1)
5. Copies of Module 8 Handout 1-1: How To Handle an Urge (Module 8 Session 1)
6. Copies of Module 8 Handout 1-2: Coping With Urges—The CRASH Model (Module 8 Session 1)

Session 2 Presentation

Collect substance use self-monitor logs from clients, and distribute blank copies of the log. Photocopy each completed log, and place a copy in each client's treatment chart before returning the original to the client.

1. Review the Substance Use Behavior Chain

Display the newsprint chart with the substance use behavior chain, and review the elements with clients.

2. Discuss Urges and Their Cognitive Components

Let's quickly review the definition of an urge. The urge to use is the final antecedent in the substance use behavior chain. It is a strong desire to consume alcohol or drugs that lasts for various lengths of time; has a beginning and an end, even when a person does not use a substance; can be waited out successfully; becomes weaker and ends sooner each time it is resisted; and becomes easier to resist every time it is handled successfully. To control an urge, you need time to wait it out, something else to think about, and support from others.

With substance use, an urge is not a physical craving but rather self-talk that gives you permission or what seems like a good reason to use a substance (e.g., "I've had a rough day. A drink will help me unwind."). An urge also is linked to individual expectations about substance use, which generally are based on personal experiences or cultural expectations.

Urges to use a substance have cognitive components including thoughts, self-talk, and expectations. The urge is the last link in the substance use behavior chain, and all other antecedents in the chain, which we have discussed in earlier sessions, lead up to the urge. Urges don't appear out of nowhere. They are the result of situations, thoughts, feelings, and cues.

The cognitive components of urges frequently include unspoken, and often negative and critical, self-talk by you to you and about you. You may not even realize you're using self-talk. Besides being critical of you, the self-talk often justifies using substances. You give yourself permission to use substances by rationalizing that they will change what you are feeling or thinking. In addition, your self-talk includes expectations. You use alcohol and drugs because you expect positive, immediate consequences. Typically, you expect substance use to make you feel better or alter your situation temporarily in some way. You often expect positive consequences and convince yourself through self-talk to seek them. The longer you permit the self-talk to continue with the built-in rationale or expectation of the value of substance use, the longer the urge to use will be sustained. However, the urge

eventually will subside, even if you do not use alcohol or drugs. When you get an urge, try to keep these four things in mind:

1. Your negative consequences of alcohol or drug use or misuse of prescription medications

2. Your positive consequences of not using alcohol or drugs or misusing prescription medications

3. Your thought-stopping procedure

4. The steps of the CRASH Model

3. Review Steps to Handling Urges

In our last session, we discussed the steps of the CRASH Model. Let's review them now.

Display newsprint of Figure IV-12, and review Module 8 Handout 1-2 with clients. Review all the steps in the model.

4. Rehearse Sample Situations Using the CRASH Model

We're going to practice using the CRASH Model again. I will read a sample situation, and I want you to imagine yourself in the situation and to think about how you would respond. I'd like each of you to tell the group what you would say to yourself in the situation and what you would do to handle the urge to use alcohol or drugs. Then I'd like other group members to provide feedback. Let's begin.

Practice the CRASH Model with the group, using the following sample situations. Read each sample situation to the group, and ask group members to imagine themselves in the situation and to think about how they would respond. Ask individuals to tell the group what they would say to themselves in the situation and what they would do when faced with the urge to use alcohol or drugs. After each client is finished speaking, ask group members to provide feedback.

Situation 1. Something wonderful just happened, and I feel like celebrating with my favorite champagne!

Goal. Think of ways to celebrate that don't involve substance use. Come up with a detailed plan of how you will celebrate, and rehearse setting up the plan.

How-to statement. How to celebrate without using drugs or alcohol.

Situation 2. I am in a place (e.g., at a party, on the golf course, on a fishing trip) where I used to drink. I am beginning to feel like having a drink.

Goal. Be aware of the cues for drinking, and recall the negative consequences of drinking and the benefits of not drinking. Take steps to weaken the effect of the cues (e.g., leave the situation). Ask others for help. You might call a counselor you have been seeing, your support group sponsor or contact, an understanding friend who doesn't drink or use drugs, or a supportive family member.

How-to statement. How to control the urge to drink in a situation where I used to drink.

Situation 3. I have been out of my treatment program for 3 months. I have not used a substance since I entered the program. However, I am beginning to wonder whether the program did anything to help me, and I feel like using a substance to test the program's effectiveness.

Goal. Remember the negative consequences of using substances. Remind yourself of the positive consequences of not using substances over the past months. Recognize your illogical thinking, and find a way to evaluate the program's positive effects without using substances as a test. Review recent thoughts and feelings to determine what may have prompted your urge to use.

How-to statement. How to evaluate the positive effects of the treatment program without using substances as a test.

5. Reassess Clients' Skills for Handling Urges

You'll recall that at the beginning of our last session I asked you to complete the exercise on this handout. The handout asks you to list the steps you would take to handle an urge. Now that we've practiced these skills some more, I'd like you to complete the form again.

Distribute Module 8 Handout 1-1, and give clients a few moments to complete it. Collect the forms. After the session, compare the responses on these handouts with the handouts completed at the beginning of Session 1 to determine whether clients have mastered the skill. A client who has trouble using the CRASH Model may need additional help in individual treatment sessions.

6. Assign Homework To Reinforce Concepts

In our next session, we will talk about what you should do if an urge leads to a slip. A slip is one brief use of a substance, much like having a slip of your memory and forgetting where you placed an item. When you have a slip, the worst thing you can do is panic or say something like "I've screwed up and might as well drink the rest of this stuff!" A slip can lead to a full relapse or a return to substance abuse if you don't stop it at the earliest stage.

Your homework assignment is to attend at least one Alcoholics Anonymous or mutual-help group meeting this week and to speak with at least one member of that group. Discuss urges with the member to learn what has helped him or her successfully overcome them. Take some notes on your conversation, and bring them to the next session. This homework assignment should help you identify new and different ways of coping with urges.

Also, continue to fill out your substance use self-monitor log.

Overview

As indicated in the introduction, a key component of this treatment approach is relapse prevention. A slip can lead to a full relapse or a return to substance abuse. A slip is the first drink or use of a drug after a period of abstinence. The terms slip and relapse may refer to a return to use or misuse of a substance that was identified during the initial Substance Abuse Profile for the Elderly assessment (appendix A). However, counselors should be attuned to a slip or relapse by clients who use a new substance or one different from the substance identified at the time of admission to the program. Relapse often leads to readmission to treatment.

Before the 1980s, substance abuse treatment programs rarely included information about what to do if a slip or full relapse occurred. It generally was thought that such discussion would create a self-fulfilling prophecy; if an individual believes a slip will lead to a relapse, it will. A slip must be put in perspective for clients. It is unfortunate when a slip happens. However, it is not the end of the world. What is important is preventing a slip from becoming a full-blown relapse. The counselor should give and stress positive reinforcement for not letting a slip become a full relapse.

In the past, substance abuse treatment programs have tolerated and even encouraged confrontation and labeling of clients who experience a slip or relapse. Such an approach discourages clients from being honest when reporting events, behaviors, slips, and relapses. The cognitive–behavioral and self-management intervention does not encourage confrontations or labeling by the counselor or group members. It recognizes that relapses may happen without condoning them. This session focuses on teaching clients skills for handling a slip or relapse.

Session 1 Outline

Objectives

1. To help clients recognize situations that are likely to lead to a slip or relapse
2. To teach clients new methods for coping with a slip or relapse
3. To improve and strengthen client skills for coping with a slip or relapse

Procedures

1. Assess need for relapse training
2. Discuss what to do if a slip or relapse occurs
3. Practice recognizing relapse situations
4. Reassess need for relapse training
5. Conclude treatment sessions

Materials

1. Copies of Module 9 Handout 1-1: Rating Form: Relapse Prevention Behavior Rehearsal
2. Copies of Module 9 Handout 1-2: How To Handle a Slip
3. 3- x 5-inch index cards with do's and don'ts to remember if you have a slip (Figure IV-13)

Session 1 Presentation

Collect substance use self-monitor logs from clients. Photocopy each completed log, and place a copy in each client's treatment chart before returning the original to the client.

1. Assess Need for Relapse Training

Today we will talk about what to do if you experience a slip. I will read a sample situation to you and then ask you to answer the questions on this handout.

Distribute Module 9 Handout 1-1, and select the sample situation below that best matches your group's problem substance and situations. Give clients a few moments to complete the handout. Collect the forms, and score them based on the Rating Form: Relapse Prevention Behavior Rehearsal Scoring Sheet on page 180. At the end of the session clients will answer the same questions about the same situation, and the scores will be compared to determine whether clients have mastered the skill.

Situation 1. You are at home alone. It is your wedding anniversary, and your spouse is deceased. You think about how much you miss him, how bad things have become for you over the years since his death, and how lonely you are. You remember there is some beer in the refrigerator and say to yourself, "Maybe if I drink, I'll feel better." You start drinking a beer and begin to feel relaxed. Then you start to feel a little guilty about having a slip.

Situation 2. You run into an old friend at a party. Even though you're trying not to use any substances, your friend keeps offering. You feel a little awkward about being the only person who hasn't joined in, so you decide to try a little. In a short time, you begin to feel like celebrating.

Situation 3. You've been experiencing frequent tension headaches lately. You remember that your (spouse, son, daughter, etc.) keeps a pain medication in the medicine cabinet. You take one tablet, but the pain doesn't subside. You say to yourself, "One more might do the trick," and you take another. Soon you begin to feel lightheaded and nauseated. You worry that your loved one will be angry with you.

2. Discuss What To Do if a Slip or Relapse Occurs

Your last homework assignment was to attend an Alcoholics Anonymous or mutual-help group meeting and speak with at least one member of the group about urges and how to cope with them. Did everyone do that? How did it go? *(Ask each client for a response.)*

The point of this homework assignment was to practice asking for help when you are clearheaded so that, if a slip occurs, you will know what to expect and realize that people at these groups can offer help. Was this assignment helpful? *(Encourage discussion.)*

Today we will talk about what you can do if you slip. First, let's define a slip. What does it mean to you? *(Encourage discussion.)* A slip is sometimes called a lapse, much like having a momentary lapse in your memory. A slip means that you have made a small error. In this case, it could mean that you had one sip of alcohol or one puff on a marijuana joint. There is a difference between having a small slip or lapse and a complete return to your former use. If you return to your pattern of former use, you have a full relapse.

It is common for some clients to have a slip soon after leaving a treatment program. For this reason, it is important for you to learn how to prevent a small slip from turning into a full relapse.

Have you heard it said that a person who abuses alcohol or drugs cannot stop if he or she takes one drink or uses a drug one time? How many of you believe this? *(Encourage discussion.)* Some of you may believe that one use of a substance—one slip—spells catastrophe. I'll bet most of you have had one drink or used a drug one time and stopped. Research has shown that many people with substance use disorders have taken a single drink, or even two, without losing total control.

Let me be clear. I am not telling you to have a drink or use drugs. I am not saying, "One or two won't hurt you." Just understand that one slip does not have to lead to a relapse. Taking a single drink or an extra pain pill does not have to lead to disaster. There is nothing that dictates that if you decide to have one, you will have many.

Know that you can stop. If you don't remember anything else you learned here, don't forget this: **You can stop.**

Why is it so hard for people who abuse alcohol to stop after one drink? There are several reasons. Maybe you feel as though your mood is not too high when you take the first drink or smoke the first marijuana joint, but it is high compared with your mood after you finish a drinking binge or a prolonged period of drug use. Each time you drink or use a drug, your mood might lift a little, but over time your mood deteriorates.

Why do you have trouble stopping if your mood is sinking and you are feeling worse? Let me explain. You are feeling a little bit down, angry, worried, or maybe even happy. You decide to have a drink or smoke a marijuana joint to improve your mood or to stay happy. However, alcohol and many other drugs are depressants. Shortly after the first use, the depressant effects set in, and you also begin to feel guilty because you have violated your goal of abstinence. Perhaps a spouse or family member comes into the room and gets angry because you are drinking or using drugs. Now you feel depressed, guilty, or resentful. What do you do? You decide to have another one. You get a temporary boost, but the boost wears off faster this time. Now you feel even lower, so you decide to have another. You are caught in a self-defeating cycle of experiencing immediate, seemingly positive consequences followed by increasingly depressive effects, which lead you to have another.

If your goal is to maintain abstinence and you have one drink, you are likely to have feelings of failure. You must be prepared to cope with these feelings of guilt and failure so that one slip does not lead to a full relapse.

Some of you may be convinced that you will be unable to stop if you have one drink or use a drug one time. You may think you're doomed, and so you continue to use. This experience is called the Abstinence Violation Effect, which means that if you think that one small slip makes you a complete failure, you're likely to say to yourself, "Now I've blown it! I've failed! I might as well go all the way!" Essentially, you are a victim of a self-fulfilling prophecy; that is, if you believe a slip will lead to a relapse, it will.

If you have been in other treatment programs or have stopped drinking or using drugs successfully for a while on your own, what triggered your return to substance use? *(Encourage discussion.)* Common reasons include negative thoughts and emotions, arguments with other people, and social pressure. Let's talk some more about the circumstances that may have led you to relapse in the past. *(Encourage discussion.)*

Let's talk about what you can do if you have a slip. This handout lists three simple steps for handling a slip. Let's look at the steps together. *(Distribute Module 9 Handout 1-2, and review the steps with the group.)*

First, avoid negative self-talk. You have learned the destructive consequences of guilt and negative self-talk. Identify a realistic, positive statement you can tell yourself, and remember it. For example, you could say, "I have been abstinent before; I can do it again." Or simply say, "I can stop."

Second, if you keep substances at home, get rid of them. If you have bottles of alcohol, pour them out. If you have drugs around, flush them down the toilet. If you used substances in a place other than your home, avoid the location.

Third, call for help. Call a counselor you have been seeing, a support group sponsor or contact, an understanding friend who doesn't drink or use drugs, or a supportive family member. Keep readily available several names and phone numbers of persons you can call for help.

3. Practice Recognizing Relapse Situations

Now we're going to practice recognizing relapse situations. I'd like you to imagine a situation that likely would lead you again to drink or use another substance. I'll give you a few moments, and then I'd like each of you to describe your situation and say how you would handle the situation. Use the three steps we just talked about.

Give clients a few moments to think of a situation. Call on each client in turn, and ask him or her to describe a situation that is likely to lead to a slip. Make sure that each client can demonstrate the three steps on Module 9 Handout 1-2. For each client response, write the

situation on newsprint, followed by three bullets to list how the client would demonstrate the three steps for handling a slip in that situation.

4. Reassess Need for Relapse Training

You'll recall that at the beginning of this session, I gave you a handout that had three questions that I asked you to answer using a sample situation. I collected those forms and scored your responses. Now that we've talked more about relapse situations, I'm going to distribute this handout again and ask you to answer the questions once more based on what you learned in this session. I will score your responses and compare them with your first set of answers. This comparison will tell us whether you should repeat the session. If so, we will plan for you to do so.

Distribute clean copies of Module 9 Handout 1-1, and give clients a few moments to respond to the questions. Collect the forms, and rate each client's answers based on the Rating Form: Relapse Prevention Behavior Rehearsal Scoring Sheet on page 180. Compare this score with the client's earlier score on the same quiz to determine whether the client has mastered the skill. Clients who have trouble applying the three steps to prevent a slip from becoming a relapse may need additional help in individual treatment sessions. Arrange to repeat this session with clients who do not demonstrate understanding and recall of the three steps.

5. Conclude Treatment Sessions

This is the final session in the treatment program. Before you leave today, I'll give each of you an index card that provides several points to remember if you have a slip. It's not a comprehensive list by any means, but it gives you a quick reference tool for the times you find yourself in a situation that could lead to relapse. It might help to keep the card with you in your handbag or wallet. You also may want to post it in a spot at home where you will see it often. Finally, remember to use everything you have learned in our sessions together, and use it at the earliest stage possible.

Provide each client with a 3- x 5-inch index card of Figure IV-13. Instruct clients to review this card if a slip occurs or when they find themselves in a situation that may lead to a slip.

Figure IV-13. Do's and Don'ts To Remember if You Have a Slip

DO
• Leave the house when you are feeling depressed. • Remember, YOU CAN STOP! if you have one drink or use a substance. • Call _____ (name and phone number of a non-drinking or non–drug-using friend) if you have a slip.
DON'T
• Ever buy alcohol or drugs to take home. • Try to cope with your depression or negative feelings alone.

Rating Form: Relapse Prevention Behavior Rehearsal

CLIENT'S NAME _____ **DATE** _____

RATER'S NAME _____ **PRETEST:** ☐ **POSTTEST:** ☐

Imagine that you have a slip, that is, you have a drink or take an extra prescribed or over-the-counter pill.

1. What should you do? List as many steps as you can.

   _____

   _____

   _____

2. What should you *not* do? List as many steps as you can.

   _____

   _____

   _____

3. If one of the steps you listed in question 1 was to call someone,

   a. What is the person's name? _____

   b. What is the person's phone number? _____

For Counselor's Use Only

Rating Form: Relapse Prevention Behavior Rehearsal Scoring Sheet

1.	What should you do? List as many steps as you can.	POINTS
a.	Tell yourself you can stop.	1
b.	Leave the situation, get rid of the substance, or hand over your prescribed medications to a trusted family member or friend who will monitor your use.	1
c.	Call for help.	1
	TOTAL POINTS:	3

(Client's wording should be close to this wording. Client must score 3 points to pass. If not, the client should repeat this group session.)

2.	What should you *not* do? List as many steps as you can.	POINTS
a.	Engage in negative self-talk, feel guilty, tell yourself you might as well go ahead and keep using the substance because you already had one, etc.	1
b.	Stay in the situation where you are drinking or using drugs, stay at home where you have substances hidden, etc.	1
c.	Tell yourself you can handle it alone, put off calling for help, feel ashamed to call for help, refuse to call for help, etc.	1
	TOTAL POINTS:	3

(Wording does not need to be exact. Client does not need a minimum score in this category to demonstrate understanding of the concept.)

3.	If one of the steps you listed in question 1 was to call someone,	POINTS
a.	What is the person's name? (Client must give at least the first name of someone he or she would call.)	1
b.	What is the person's phone number? (Client must give phone number for the person named.)	1
	TOTAL POINTS:	2

(Client must score 2 points to pass.)

TOTAL POSSIBLE: 8 POINTS

How To Handle a Slip

1. Make a positive statement (e.g., “I can stop!”).
2. Get rid of the alcohol or drugs, or leave the drinking or drug use situation.
3. Call for help.

Appendix A: Substance Abuse Profile for the Elderly (SAPE)

Client's Name:	
Date of Admission:	/ /
Date of Interview:	/ /
Interviewer:	

(Read the following to the client before beginning the interview.)

This interview focuses on certain aspects of your use of substances. Your answers will help in developing your treatment plan. Please answer the questions honestly. Whenever possible, please provide the best answer or estimate. Do you have any questions before we start?

The interview takes approximately 1 hour per part. Following the interview and after the client has left the room, transcribe the client's responses into the table on page 200.

Also draw up the client's antecedents list and consequences list.

Part I: Substance Use and Treatment History

Substance Use

1. To your knowledge, did any members of your immediate family have a substance use problem? *(Read the following choices; check those that apply.)*

   ☐ (1) Father ☐ (4) Brother ☐ (6) Son
   ☐ (2) Mother ☐ (5) Sister ☐ (7) Daughter
   ☐ (3) Spouse

2. Has anyone ever told you that you have or had a substance use problem?

   ☐ (1) Yes ☐ (2) No *(If no, skip to question 6.)*

3. At approximately what age were you told that? _____ Age

4. Who told you, at that time, that you had a problem?
   (Check all appropriate categories.)

   ☐ (01) Parent(s) ☐ (06) Physician
   ☐ (02) Spouse ☐ (07) Substance abuse treatment professional
   ☐ (03) Brother/sister ☐ (08) Mental health professional
   ☐ (04) Friend(s) ☐ (09) Member of clergy
   ☐ (05) Children ☐ (10) Other (identify) _____

5. Did you agree with him or her that the problem existed at that time?

   ☐ (1) Yes ☐ (2) No *(If yes, skip question 6, and go to question 7.)*

6. Do **you** believe that you have or had a substance use problem?

   ☐ (1) Yes ☐ (2) No *(If no, skip to question 9.)*

7. At about what age do you think your problem began? _____ Age

8. What substances did you use the most at the time your problem began?
   (If necessary, read the choices.)

   ☐ (1) Beer/malt liquor ☐ (5) Cocaine (powder) ☐ (9) Over-the-counter drugs
   ☐ (2) Wine/wine cooler ☐ (6) Crack ☐ (10) Other
   ☐ (3) Hard liquor ☐ (7) Heroin _____
   ☐ (4) Marijuana ☐ (8) Prescription drugs

9. During the last 6 months, what is the longest period during which you went without using a substance? *(Enter a number in the appropriate category below, or check "never," if appropriate.)*

   ___ Days ___ Weeks ___ Months ___ Never went without substances
   (If the answer is never, go to question 11.)

10. Next, I will show you a list of situations. Which **one** item might describe why you started using substances again after having stopped? *(Show List A on page 187, and record the answer by placing a checkmark next to the item.)*

- ☐ (01) I was lonely
- ☐ (02) I didn't feel needed
- ☐ (03) My friends pressured me to use
- ☐ (04) I had marital problems
- ☐ (05) I had problems with children/relatives
- ☐ (06) My spouse died
- ☐ (07) A family member died
- ☐ (08) I lost my sense of purpose
- ☐ (09) I was overconfident and thought I could control my substance use
- ☐ (10) I was angry and frustrated
- ☐ (11) I had been having nightmares
- ☐ (12) I was bored
- ☐ (13) I was a victim of violence, crime
- ☐ (14) I wanted to forget my physical problems or pain
- ☐ (15) I had strong urges to use substances
- ☐ (16) I felt depressed
- ☐ (17) I was at a party or other celebration
- ☐ (18) I had financial problems
- ☐ (19) I can't remember/don't know
- ☐ (20) Other (specify)_____

11. Have you ever, on your own, and **without any help**, taken steps to stop substance use?
☐ (1) Yes ☐ (2) No *(If no, skip to question 14.)*

12. If yes, what was the approximate month and year of your first attempt?_____ /_____

13. What did you do to try to stop? _____

Treatment History

I would like to focus on your previous treatment history, that is, formal programs you have been admitted to or counseling you have received because of a substance use problem.

14. Have you ever entered detoxification (detox) or substance abuse treatment before, not including the program you are in now?
☐ (1) Yes ☐ (2) No *(If no, skip to question 25.)*

15. Estimate the month and year of that very first admission (or when you began that therapy). _____ /_____

16. Was this first admission
- ☐ (1) A detox program only?
- ☐ (2) An inpatient treatment/residential program?
- ☐ (3) An outpatient program with groups or individual counseling sessions?

17. Did you ☐ (1) Complete that first treatment?
☐ (2) Drop out of that program?

18. Estimate the month and year of discharge from that first treatment. _____ /_____

19. Over your life, how many treatment programs have you been admitted to **before** the one you are in now? *(Enter a number for each category below. If the response in any category is "none," enter zero.)*

    ____ # of detox admissions
    ____ # of inpatient/residential treatment programs
    ____ # of outpatient treatment programs

Now, I would like you to think about the last substance abuse treatment program (or therapy) you were treated in **before** the program you are in now. *(Probe for best estimates. Do not leave blanks.)*

20. What were the approximate month and year of that last admission? _____ /_____

21. What were the approximate month and year of your discharge? _____ /_____

22. About how long after leaving that last treatment program did you slip and first start to use a substance again? *(Enter a number in the category below that best describes the reported length of time before that first slip occurred.)*

    ____ Days ____ Weeks ____ Months ____ Years

23. Looking at the list we used earlier, which situation best describes why you had that first slip? *(Show List A used in question 10, and record the client's answer below; then take away List A.)*

    _____ _____
    Code Number Reason for Slip

24. Did you continue to use the substance on that same day you slipped?

    ☐ (1) Yes ☐ (2) No

25. Have you ever regularly attended a support group for people who use substances such as Alcoholics Anonymous, Narcotics Anonymous, or Rational Recovery?

    ☐ (1) Yes ☐ (2) No *(If no, stop here.)*

26. When was this? From: _____ /_____ To: _____ /_____

27. Do you now regularly attend these meetings?

    ☐ (1) Yes ☐ (2) No *(If no, stop here.)*

28. How long have you been attending these meetings?

    _____Months ____ Years *(Enter the number of months or years.)*

List A (Use for questions 10 and 23 of Part I)

Why Did You Start Using a Substance Again?

(01) I was lonely
(02) I didn't feel needed
(03) My friends pressured me to use
(04) I had marital problems
(05) I had problems with children/relatives
(06) My spouse died
(07) A family member died
(08) I lost my sense of purpose
(09) I was overconfident and thought I could control my substance use
(10) I was angry and frustrated
(11) I had been having nightmares
(12) I was bored
(13) I was a victim of violence, crime
(14) I wanted to forget my physical problems or pain
(15) I had strong urges to use substances
(16) I felt depressed
(17) I was at a party or other celebration
(18) I had financial problems
(19) I can't remember/don't know
(20) Other (specify)_____

Part II: The Substance Use and Behavior Chain

Recent Substance Use Pattern

1. When did you last use a substance? _____ /_____ /_____
   (Ask for the best estimate. The interviewer can calculate the date based on a response, such as "2 weeks ago." Write the beginning and ending dates for the 30-day period just before this last use on a card or piece of paper, and place it in front of the client.)

2. The next series of questions focuses on the 30 days just before your last use. To help you remember that period, I have written down the beginning and ending dates of that 30-day period. Over that period, what substance or substances did you use the most? *(If necessary, read the list aloud. Check all substances that apply.)*

   ☐ (1) Beer/malt liquor ☐ (5) Cocaine (powder) ☐ (9) Over-the-counter drugs
   ☐ (2) Wine/wine cooler ☐ (6) Crack ☐ (10) Other
   ☐ (3) Hard liquor ☐ (7) Heroin _____
   ☐ (4) Marijuana ☐ (8) Prescription drugs

3. Which **one** substance caused you the **most** problems during that 30-day period?
   *(Enter the name of the substance from the list above.)*_____

   From this point on, we will refer to your use of _____ *(problem substance named in question 3). (State the name of the substance whenever the blank line is used in the question you are reading.)*

4. How many days would you estimate that you used _____ *(problem substance)* during those 30 days? _____

5. During those 30 days, how often were you intoxicated or under the influence? _____

6. How would you describe your pattern of use during that time? I will read some choices, and I would like you to tell me which pattern best describes your substance use during that 30-day period.

   ☐ (1) Steady or almost every day ☐ (3) Weekends only
   ☐ (2) Occasional or binges ☐ (4) Other (describe) _____

7. Now, think about the days you did **not** use _____ *(problem substance)* during that 30-day period. Using this list, can you point to a reason why you did not use _____ *(problem substance)*? *(Hand the client List B on page 194. Record the answer below; then put away List B.)*

☐ (01) Pressure from spouse/family
☐ (02) Concern about my health
☐ (03) Mental problems
☐ (04) Worried about losing job
☐ (05) Couldn't afford it
☐ (06) Afraid my children would see me intoxicated or under the influence
☐ (07) Religious influences
☐ (08) Able to control it
☐ (09) Substance not available
☐ (10) Felt too sick to use a lot
☐ (11) Wanted to stop
☐ (12) Other _____

8. Were there any days you used _____ *(problem substance)* without becoming intoxicated or under the influence?

☐ (1) Yes ☐ (2) No

9. On a **typical** day you used _____ *(problem substance)* during that 30-day period, how much would you use? *(Indicate a quantity, such as 6 12-ounce beers, 4 shots of whiskey, 1 pint of vodka, 2 marijuana joints, 4 tranquilizers or pain pills.)*

_____

10. Did you usually buy the _____ *(problem substance)*?

☐ (1) Yes ☐ (2) No

If yes, where did you buy it? _____

11. If yes, about how much did you spend on it **each week**? $ _____ per week

12. If you usually did not buy it, who gave it to you? *(Check one, or fill in the blank in number 6.)*

☐ (1) Friend
☐ (2) Spouse
☐ (3) Son/daughter
☐ (4) Other family
☐ (5) Dealer/pusher
☐ (6) Other _____

13. Did you keep substances in a particular place in your home?

☐ (1) Yes ☐ (2) No

If yes, where did you keep it? _____

14. Was there a special time of day or certain day of the week you would start using a substance?

☐ (1) Yes ☐ (2) No

If yes, when? _____ *(Specify time or day.)*

15. Was there any particular reason why you used _____ *(problem substance)* then?

_____

16. How would you compare this 30-day period of use we've been talking about with previous substance use in the past? Would you say you used

☐ (1) More in the past? ☐ (3) About the same as before?
☐ (2) Less in the past?

Antecedents to Substance Use

Now we will focus on events that often occurred on a typical day, just before you used _____ *(problem substance)*.

17. Locations

I will show you a list of locations where substance use might occur. Please look at this list, and tell me where you **most often** used _____ *(problem substance)* on a typical day during the 30 days just before your last use. *(Hand the client List C on page 195.)* I'll place a number "1" next to the correct response below.

___ (01) My home
___ (02) A friend's home
___ (03) Bar or lounge
___ (04) Restaurant
___ (05) While driving
___ (06) Outdoors, such as a park, woods, or on a boat
___ (07) Sporting event
___ (08) Crack house
___ (09) Neighborhood drug hangout
___ (10) Other _____

Now, look at the list again, and tell me which place might be the **next** most frequent place of use. *(Enter the number "2" next to the appropriate response.)* And, where is the next most frequent? *(Enter a "3" in that space. Put away List C.)*

18. Activities

Let's focus on some typical things you did just before you used _____ *(problem substance)*. Using List D, what activity were you involved in just before using _____ *(problem substance)*? *(Hand the client List D from page 196.)* Record a "1" next to the correct response below. Is there any other activity? *(Place a "2" next to that response. Remove List D.)*

___ (01) Nothing
___ (02) Watching TV
___ (03) Listening to music
___ (04) Driving
___ (05) At work/job
___ (06) Socializing
___ (07) Entertaining
___ (08) On a date
___ (09) Having sex
___ (10) Arguing or fighting
___ (11) Other_____

19. People

Next, please look at List E. Which of these best describes with whom you **most often** used _____ *(problem substance)*? *(Hand the client List E from page 197. Record a "1" next to the correct response.)* What about the second most often? *(Record a "2"; record a "3" next to the third most often. Put away List E.)*

___ (01) No one (alone)
___ (02) My spouse
___ (03) My girlfriend/boyfriend
___ (04) A particular friend
___ (05) A few friends
___ (06) A large group of people
___ (07) Strangers
___ (08) Members of a club
___ (09) My son or daughter
___ (10) Drug dealer/pusher
___ (11) Other

20. Feelings Just Before Substance Use

Let's talk about how you felt **just before** your first use on the last occasion you recall using _____ *(problem substance)*. Here is a list of words; each describes feelings or emotions. Which three best describe emotions that you experienced during a typical day? *(Hand the client List F on page 198.)*

☐ (01) Happy
☐ (02) Relaxed
☐ (03) Peaceful
☐ (04) Calm
☐ (05) Unafraid
☐ (06) Angry
☐ (07) Sad
☐ (08) Depressed
☐ (09) Lonely
☐ (10) Frustrated
☐ (11) Afraid
☐ (12) Nervous
☐ (13) Tense
☐ (14) Excited
☐ (15) Restless
☐ (16) Secure
☐ (17) Superior
☐ (18) Outgoing
☐ (19) Friendly
☐ (20) Strong
☐ (21) Insecure
☐ (22) Inferior
☐ (23) Withdrawn
☐ (24) Unfriendly
☐ (25) Weak
☐ (26) Guilty
☐ (27) Failure
☐ (28) Shy
☐ (29) Powerful
☐ (30) Other _____

(Probe for situations that lead to client's feelings. For example, if the response is "sad," ask, "What were you sad about?" Record the code number, feeling, and definition below. Then repeat the process for the next two choices. Ask, "Which would be your next most frequent feeling?")

	Code	Feeling	Client's definition or description
1.	____	_____	_____
2.	____	_____	_____
3.	____	_____	_____

(Keep List F close at hand, and use it for the next section.)

Consequences of Substance Use

Now, I would like to ask you a few questions about what you experienced just after your first use of a substance on a typical day of substance use.

21. People's feelings often change shortly **after** they start using a substance. Using the same list we just used, please select which best describes how you typically felt **immediately after** you started using _____ *(problem substance). (Hand List F back to the client. Record the corresponding code and feeling; then probe for situations that led to that feeling. For example, if the client says "guilty," ask, "What did you feel guilty about?" Record the answer next to the feeling. Complete for the second and third most frequent feelings.)*

	Code	Feeling	Client's definition or description
1.	____	_____	_____
2.	____	_____	_____
3.	____	_____	_____

22. Can you describe a situation or something that would make you feel like not giving into an urge for a substance?

_____

23. Other than just getting intoxicated or being under the influence, what did you like about using _____ *(problem substance)*?

_____

24. What did you dislike about using _____ *(problem substance)*?

_____

25. Have you ever experienced any of the following after you stopped using _____ *(problem substance)*?

(Read each answer aloud, and place a checkmark next to every client's "yes" response.)

- ☐ (1) Withdrawal symptoms
- ☐ (2) The DTs
- ☐ (3) Hallucinations
- ☐ (4) The shakes
- ☐ (5) Don't remember any symptoms

26. In your own words, what is the main reason you used substances? *(Summarize client's response on the line below.)*

_____

27. Next, I will show you a list of problems. As I read each one, please answer yes or no to experiencing any of these as a result of substance use. *(Hand the client List G on page 199. Read each response, and place a checkmark next to every "yes" answer.)*

- ☐ (1) Legal problems
- ☐ (2) Employment problems
- ☐ (3) Family problems
- ☐ (4) Social problems
- ☐ (5) Health problems
- ☐ (6) Financial problems
- ☐ (7) Psychological/mental disorders
- ☐ (8) No problems *(only if there are no other checkmarks)*

Motivation for Treatment

28. What are the main reasons for seeking help for your problem at this particular time? *(Read the items below and check any that apply. If none apply, use response number 11, and fill in blank.)*

- ☐ (01) Worried about my health
- ☐ (02) Trying to save my marriage
- ☐ (03) Emotional/mental disorders
- ☐ (04) Pressure from my family
- ☐ (05) Worried about my job
- ☐ (06) Fear of legal consequences
- ☐ (07) Just wanted to stop using
- ☐ (08) Substance not available
- ☐ (09) No money/costs too much
- ☐ (10) Religious influences
- ☐ (11) Other _____

(Read the following, and record any questions or comments.)

Thank you. That completes the interview. Your answers will be very helpful in the upcoming sessions. I will provide you with a copy of your answers for your notebook. Do you have any questions or comments at this time?

List B (Use for Question 7 of Part II)

What Prevented You From Substance Use on Those Days?

(01) Pressure from spouse/family
(02) Concern about my health
(03) Mental problems
(04) Worried about losing job
(05) Couldn't afford it
(06) Afraid my children would see me intoxicated or under the influence
(07) Religious influences
(08) Able to control it
(09) Substance not available
(10) Felt too sick to use a lot
(11) Wanted to stop
(12) Other _____

List C (Use for Question 17 of Part II)

Locations Where Substance Use Might Occur for You on a Typical Day

(01) My home
(02) A friend's home
(03) Bar or lounge
(04) Restaurant
(05) While driving
(06) Outdoors, such as a park, the woods, or on a boat
(07) Sporting event
(08) Crack house
(09) Neighborhood drug hangout
(10) Other _____

List D (Use for Question 18 of Part II)

Activities in Which You Were Involved Just Before Substance Use

(01) Nothing
(02) Watching TV
(03) Listening to music
(04) Driving
(05) At work/job
(06) Socializing
(07) Entertaining
(08) On a date
(09) Having sex
(10) Arguing or fighting
(11) Other _____

List E (Use for Question 19 of Part II)

People With Whom You Used a Substance

(01) No one (alone)
(02) My spouse
(03) My girlfriend/boyfriend
(04) A particular friend
(05) A few friends
(06) A large group of people
(07) Strangers
(08) Members of a club
(09) My son or daughter
(10) Drug dealer/pusher
(11) Other _____

List F (Use for Questions 20 and 21 of Part II)

Feelings Associated With Substance Use

(01) Happy
(02) Relaxed
(03) Peaceful
(04) Calm
(05) Unafraid
(06) Angry
(07) Sad
(08) Depressed
(09) Lonely
(10) Frustrated
(11) Afraid
(12) Nervous
(13) Tense
(14) Excited
(15) Restless
(16) Secure
(17) Superior
(18) Outgoing
(19) Friendly
(20) Strong
(21) Insecure
(22) Inferior
(23) Withdrawn
(24) Unfriendly
(25) Weak
(26) Guilty
(27) Failure
(28) Shy
(29) Powerful
(30) Other _____

List G (Use for Question 27 of Part II)

Problems I Have Experienced as a Result of Substance Use

(01) Legal problems
(02) Employment problems
(03) Family problems
(04) Social problems
(05) Health problems
(06) Financial problems
(07) Psychological/mental disorders
(08) No problems

FOR COUNSELOR'S USE ONLY

Table for Client Responses

Instructions: Following the SAPE interview and after the client has left the room, the counselor should immediately transcribe the information gathered from SAPE into this formatted table.

Situation/Thoughts	Feelings	Cues	Urges

Appendix B: References

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DHHS Publication No. (SMA) 05-4053
NCADI Publication No. BKD525
Printed 2005