Cognitive-Behavior Therapy for Substance Dependence:

Coping Skills Training

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Overview of Model

From the perspective of cognitive-behavior theory, alcohol and drug dependence are viewed as learned behaviors that are acquired through experience. If alcohol or a drug provides certain desired results (e.g., good feelings, reduced tension, etc.) on repeated occasions, it may become the preferred way of achieving those results, particularly in the absence of other ways of meeting those desired ends. From this perspective, the primary tasks of treatment are to (1) identify the specific needs that alcohol and drugs are being used to meet, and (2) develop skills that provide alternative ways of meeting those needs.

There are different viewpoints within this general perspective. "Behavioral" approaches emphasize observable antecedents and consequences of behavior, without making reference to internal events, such as cognitions, that can only be known by self-report. "Cognitive-behavioral" approaches, on the other hand, include cognitions, thoughts, and emotions among the factors that are considered to precipitate or maintain behavior. The latter approaches often utilize behavioral methods (e.g., repeated practice, reinforcement) to modify cognitive and emotional processes. The present guidelines employ a cognitive-behavioral framework for conceptualizing drinking and drug-abuse problems, and as a basis for designing interventions that focus on developing more adequate coping skills. The conceptual models that are more strictly behavioral, contingency management and the community reinforcement approach, are both presented in other guidelines that are available at this web site.

The cognitive-behavioral model incorporates the two major types of learning that have been identified in behavior laboratories: learning by association and learning by

consequences. In learning by association (also called 'Pavlovian' or 'classical' conditioning), stimuli that are originally neutral can become triggers for alcohol/drug use, or for cravings, as a result of repeated associations between those stimuli and alcohol/drug use. Triggers may be external to the individual, such as objects in one's environment, settings and locations, or certain people (e.g., the people one uses with regularly), or they may be internal events like thoughts, emotions, or physiological changes. Associations between these various objects/occurrences and alcohol/drug use can develop if they repeatedly occur in close temporal proximity to one another. As these associations are gradually strengthened during the course of repeated occurrences, the alcohol/drug user becomes subject to cravings that can be stimulated by a growing array of stimuli that were previously neutral but have now become potential triggers.

In the learning by consequences model (also called 'operant' conditioning), drinking and drug use behaviors are strengthened by the consequences that follow their use. If after using a substance a person feels sexually aroused, more comfortable in social situations, or euphoric, for example, then the act of ingesting the substance is likely to be repeated in the future, because of it's having received this positive reinforcement. If substance use reduces anxiety, tension, stress, or depression, again the likelihood of future use is increased, this time by the process called negative reinforcement (in which an unpleasant experience is reduced or terminated). To be sure, there are also negative consequences of substance use, such as depression, anxiety, and withdrawal symptoms, which would be expected to reduce the likelihood of future substance use. However, these occur so long after the substance is used that they have little if any impact on the act of using, and are therefore no match for the more immediate reinforcing consequences.

Several treatment approaches derive from these two models of the learning process. The 'cue exposure' approach attempts to identify the trigger events that have become most salient for an individual, and to reduce their impact by extinction, in which clients are repeatedly exposed to their most potent triggers without following them by substance use. With enough exposure of this kind, the trigger stimuli are eventually supposed to lose their ability to elicit cravings and alcohol/drug-seeking behavior. Despite the appeal of this concept of reducing the impact of trigger events by breaking their association with alcohol/drug use, research results from studies of this approach have been mixed. Laboratory studies with alcohol/drug dependent patients have not been consistently successful in demonstrating effects of drinking/drug use cues, and cue-exposure treatment studies have found that the procedure is more likely to reduce the severity of a relapse than to prevent the initial lapse to substance use. Although the cue-exposure approach is believed to hold considerable promise, it is still largely in an experimental stage at this time, and therefore is not offered as a clinical approach in the present guideline.

The coping-skills training approach does not attempt to reduce the impact of triggers. Rather, it accepts triggers as a given and seeks to train alternative responses to them, so that a person will have several ways of coping with the occurrence of a trigger situation, in place of drinking/drug use. With sufficient practice of the alternative coping skills, it becomes increasingly likely that they will be utilized when a trigger situation arises, rather than resorting to drinking or drug use. A related treatment approach is Relapse Prevention, which provides a systematic way (*a*) of assessing the full range of antecedents and consequences of drinking/drug use that influence an individual's relapse

potential, and (*b*) of devising interventions to deal with them that are likely to reduce the probability of a future relapse. The present guideline focuses attention on the coping skills training and relapse prevention approaches to the treatment of addictive disorders.

Two other approaches, contingency management and the Community Reinforcement Approach, focus primarily on the consequences of drinking/drug use rather than on their antecedents. As mentioned earlier, these approaches are discussed in other guidelines that are available at this web site, and are therefore not covered in the present guideline. Behavioral Couple Therapy makes use of various behavioral and cognitive-behavioral interventions, and it, too, is described in another guideline at this web site.

Evidence Base for Cognitive-Behavioral Approaches

Deficits in skills for coping with the antecedents and consequences of drinking/drug use are considered to be a major contributor to the development and maintenance of addictive behavior (Miller & Hester, 1989). As a result, considerable effort has been devoted to studying coping skills training, to determine whether it has practical utility as a means of reducing risk and curtailing addictive behavior. A large body of clinical research has been produced on this topic, and three meta-analyses have ranked coping skills training as either first (Holder et al., 1991) or second (Miller et al., 1995; Finney & Monahan, 1996) based on evidence of effectiveness, as compared to a variety of other treatments for alcoholism. Nevertheless, despite the high rankings in the meta-analyses, Longabaugh and Morgenstern (1999) have questioned whether the research studies provide adequate grounds for concluding that coping skills training is superior to other forms of treatment. They outline steps that should be taken to resolve

the matter, and it seems certain that the question will remain open for a number of years while further studies are conducted, before it is finally settled. In the meantime, coping skills training does receive strong support from the evidence currently available and it is widely employed in addictions treatment programs.

Similar questions have been raised regarding Relapse Prevention (RP) treatment studies (Carroll, 1996). Interventions that focus on relapse prevention have been found beneficial for maintaining the effects of treatment during follow-up periods and for reducing the severity of relapse episodes that do occur, but there are diminishing returns inasmuch as these benefits have been found to decrease with increasing time since treatment completion (Carroll, 1996; Allsop et al., 1997). A meta-analysis focused specifically on relapse prevention treatment outcome studies found that RP treatment was beneficial, but it's impact on psychosocial functioning was greater than on substance use itself (Irvin et al., 1999). Another finding of clinical relevance from RP treatment outcome studies is that among the various categories of risk for relapse specified by Marlatt and Gordon (1985), negative emotions have been consistently identified as a major relapse precipitant (Longabaugh et al., 1996). Based on that, coupled with findings that coping ability is related to treatment outcome (Miller et al., 1996; Connors, Maisto, & Zywiak, 1996), it has been recommended that skills training to foster improved coping with negative emotions be provided as a means of reducing relapse risk (Connors, Longabaugh, & Miller, 1996).

Although a number of important issues have yet to be resolved, the coping skills training approach has strong theoretical grounding, and the evidence supporting it and Relapse Prevention is at least equal to, and perhaps superior to, that for any other

treatment approach currently available. In addition, these closely related approaches are readily compatible with, and easily combined with, several others such as Motivational Enhancement Therapy, contingency management, cognitive therapy, Behavioral Marital Therapy, and the Community Reinforcement Approach.

Coping Skills Training

The value of coping skills training is best conceptualized in terms of psychological dependence. Heavy drinkers and drug abusers may use alcohol or drugs to cope with certain (or, in some cases, most) of the problems in their lives. Through repeated experience of the apparent short term benefits of drinking or drug use, they may become the preferred way of coping, especially in the absence of other coping skills. If alcohol or drugs are the *only* way a person has to cope with certain things, then he/she is psychologically dependent upon them. Such a person has no choice, he/she must drink or use a drug if those needs are to be met. To the extent that this is true for a person, coping skills deficits are a major obstacle to his/her recovery from chemical dependence. On the other hand, if a person has several ways of meeting a need, then he/she has a *choice* about whether or not to drink or do drugs when that need arises. Thus, providing coping skills training is of major importance since it develops alternative ways of meeting needs and thereby modifying the psychological dependence factor.

Determining the skills areas in which training is required necessitates an assessment, often called a 'functional analysis,' to identify the antecedents to a person's use of alcohol/drugs, and the functional relationship of drinking/drug use to the consequences that follow. This assessment may be in the form of structured interviews or questionnaires, or it may take the form of a less structured clinical interview that seeks

to identify the situations in which drinking or drug use are likely to occur, and the outcomes that are sought. A useful assessment instrument for identifying drinking/drug use antecedents is the Inventory of Drug-Taking Situations (Annis & Martin, 1985), and one recommended for identifying the consequences of using is the Inventory of Alcohol/Drug Use Consequences (Miller, Tonigan, & Longabaugh, 1995). They both are composed of 50 items, and computer software is available for the former. The Global Appraisal of Individual Needs (Dennis et al., 1996) provides a broad-based assessment of a wide range of factors that might be related to chemical dependence.

Client interviews that do not employ structured assessment instruments should cover topics such as typical patterns of use, common antecedent situations (e.g., mood states, thoughts, cravings for alcohol/drugs, and life problems), and typical consequences of using. Clients should also be asked to anticipate future situations in which it may be difficult to refrain from using. A range of domains should be explored in search of each client's potential antecedents to cravings and substance use, including social, situational, emotional, cognitive, and physiological antecedents (Miller & Mastria, 1977). Once a list of a client's potential trigger situations has been developed, the situations can be rank-ordered in terms of their frequency of occurrence and seriousness as a problem.

For each antecedent factor identified, the client should be asked to specify what he/she expected to gain from drinking or drug use in that circumstance. Some clients may feel uncomfortable identifying positive expectations from the use of chemicals, which is understandable given that they have made the decision to engage in treatment. They should be given the message that what they sought from alcohol and/or drugs is not unreasonable or abnormal. If, for example, they were depressed and sought relief from it,

or were socially inhibited and sought to feel more comfortable in social situations, those are very reasonable desires. Most people in similar circumstances would have similar desires. The only problematic aspect is the use of alcohol or drugs to meet those needs. An important goal, then, is to identify needs that are likely to trigger a desire to use alcohol/drugs, and develop alternative ways of meeting them. The process of identifying the outcomes that were being sought through the use of alcohol/drugs, and alternative ways of achieving those outcomes, can be organized and facilitated using the scheme proposed by Miller and Pechacek (1987).

Coping skills deficits are viewed as a major risk factor because of the likelihood that they may lead to a reliance on alcohol or drugs as the default coping strategy. To the extent that a person never developed more appropriate coping skills, or having once learned them can no longer apply them due to lack of recent practice or the presence of some inhibiting factor, he/she will need skills training to overcome the deficit or the factor preventing their use. Skills training can be used to teach coping behaviors not currently in a client's repertoire, to refresh or enhance deficient behaviors, and to identify and reduce inhibiting factors. In all cases, adequate practice of skills is essential, both during sessions and as homework, so that clients become 'fluent' in the skills and are able to apply them fairly easily when the appropriate circumstances arise, without having to do a lot of thinking about the various steps involved or figuring out how to apply them.

A number of coping skills training manuals are available. The one by Monti, Abrams, Kadden, and Cooney (1989) provides session-by-session explanations, in considerable detail, of the rationale, skill components, and practice methods for 25 skills related to problem areas that are common among chemically dependent clients. Selection

from among them, in clinical settings, is made on the basis of findings from the

assessment indicating areas of high risk for a particular client, and his/her skills

deficiencies. The overview of these skills that is presented below is organized according

to two broad categories: intrapersonal skills that primarily involve only the chemically

dependent client him/herself, and interpersonal skills for use when one or more other

people are part of the problem situation. A synopsis of the rationale for, and of the skills

taught in, a number of sessions in each of these two categories is provided in the

following two sections. Further details on the implementation of each of the coping skills

training sessions, as well as information on additional skills not reviewed here and on

other topics related to skills training, can be found in Monti et al. (1989).

(It should be noted that as the present guideline is being written, a second edition

of the Monti et al. coping skills guide is being prepared for publication in 2002, by

Guilford Press. Although there will be some revisions, and new sections on the coping

skills training needs of dually diagnosed clients, cue exposure treatment, and smoking

cessation, most of the basic coping skills training elements reviewed below will not be

substantially changed from what appeared in the 1989 edition.)

Intrapersonal Skills

  Managing thoughts and cravings for use. Thoughts about drinking or drug use,

and their more intense version, cravings, are common among people recovering from

substance use disorders, and therefore this training module is generally used with all

clients. They are taught a number of skills for managing thoughts and cravings, including

challenging them, recalling unpleasant experiences that resulted from using, anticipating

the benefits of not using, distracting oneself, delaying the decision whether or not to use,

leaving the situation, and seeking support. Clients are given a 3x5 card on which to record the unpleasant effects of past use and the anticipated benefits of not using, and are instructed to carry it with them and refer to it whenever they think of using. They are also asked to imagine various high-risk situations, and practice coping with the thoughts and cravings that might accompany them.

Anger management. Anger is a very common antecedent to alcohol/drug use. Clients are taught about the warning signs of anger, both external and internal signs, so they can identify them early and begin to manage them before anger grows strong and becomes harder to control. Skills for managing anger include the use of calm-down phrases, identifying aspects of a situation that are provoking anger, and considering options that might help to resolve the situation. These skills can be modeled by the therapist and then role-played by the client. For homework, clients are asked to record their handling of the next anger situation they encounter.

Negative thinking. This is another common high-risk situation. Separate skills training sessions are available for increasing one's awareness of negative thinking and for managing it when it occurs. Clients are taught to recognize various types of negative thinking habits that may occur automatically. Skills for managing negative thoughts include substituting positive thoughts or feelings, thought stopping, and positive self-talk. Exercises give clients practice in identifying their negative thinking and negative self-talk, and provide an opportunity for them to prepare alternative, substitute responses. A related common problem is negative moods and/or depression. Guidelines for skills training to manage them can be found in Kadden et al. (1992).

Pleasant activities. Clients may discover a void in their lives as free time becomes available once they are no longer so occupied with acquiring, using, and recovering from the effects of alcohol or drugs. They may also find that they are leading an unbalanced lifestyle in which they fulfill numerous obligations, with little if any time devoted to recreation or self-fulfillment.   A session on developing a pleasant activities plan is intended to help clients prepare enjoyable, low-risk ways of filling the free time that will be opened up, and achieve a better balance between their obligations and more enjoyable or self-fulfilling activities. A number of strategies for selecting and engaging in these activities are identified.

Relaxation skills. Relaxation may be a useful way of coping with various circumstances that either precede or are exacerbated by alcohol/drug use, such as stress, tension, anxiety, anger, sleeplessness, and cravings to use. Skills training involves alternate tensing and relaxing of various muscle groups, to enable clients to identify tension states and their alternative, relaxation. In addition to relaxation of muscle groups, clients are taught slow breathing and the use of calming imagery. As these skills are practiced and acquired, clients can be taught to apply them in various situations, stressful ones in particular.

Decision-making. Sometimes clients end up relapsing after a series of incremental steps that gradually led them ever closer to craving and then to actually using their substance of choice. Decision-making training can help clients think ahead to the possible consequences of all the decisions they make, even the ones that are seemingly irrelevant to substance use, to increase the likelihood that they will anticipate, and act upon, the relative risks associated with various decision options. They are offered a

variety of practice scenarios and assisted in thinking them through, to identify the relative risks of various options and to select a low-risk option that will minimize the probability of substance use.

Problem-solving. This is a 'generic' skill, not specifically related to chemical dependence. It is recommended to include it among the skills being trained, to provide a means of coping if clients unavoidably enter a difficult situation for which they have no apparent coping response immediately available. The steps in the problem-solving model include problem recognition, identification of the problem's component elements as precisely as possible, brainstorming potential solutions, selecting the most promising approach, trying it out, assessing its adequacy, and refining the plan if necessary. With this skill, clients are provided a way of coping with unanticipated problems that might otherwise stump them and put them at high risk for drinking or drug use.

Planning for emergencies. This one is in some ways similar to problem-solving, inasmuch as it attempts to provide clients a way of coping with situations that were not specifically anticipated in their skills training, and for which no solution is immediately apparent. The difference here is that the precipitating events are so overwhelming, and so likely to precipitate drinking or drug use, that there may not be enough time to initiate the problem-solving process. To cope with such 'emergency' situations, clients are assisted in setting up an emergency plan for use in high-risk situations in which strong cravings develop and alcohol/drug use becomes imminent, or actually occurs.

Interpersonal Skills

These skills are taught for coping with situations in which other people are an important factor or are actually part of the problem.

Drink/drug refusal. Knowing how to cope with offers to use alcohol or drugs is an important skill for the majority of chemically dependent clients because such offers are fairly common. Clients are taught to say 'no' convincingly without giving a double message, to suggest an alternative activity that does not involve substance use, to change the subject to a different topic of conversation, and if the other person persists, to ask him/her not to offer alcohol or drugs any more. With considerable practice of this skill, clients should be able to respond quickly and convincingly when these situations arise. Role-playing of refusal scenes progress from ones that are easy to handle, building to more persistent offers that are difficult to refuse. The homework exercise involves planning how to respond in a variety of different situations in which alcohol or drugs may be offered.

Refusing requests. People often feel discomfort when refusing other peoples' requests for favors, and therefore may tend not to do so. However, failure to refuse to do something they really don't want to do can leave them feeling imposed upon, self-critical, resentful, or angry, any of which may serve as triggers for cravings or use of alcohol/drugs. Clients are taught to refuse unwanted requests by first acknowledging the requesting person's position and feelings, and to then make a firm, clear statement of refusal. They are also taught to consider whether or not a compromise might be appropriate under the circumstances. Opportunities to role-play request-refusal are provided in the session, and for homework clients are asked to formulate responses they might use in situations of this type that they are likely to encounter.

Handling criticism. Criticism, whether giving it or receiving it, can be high-risk since it is often accompanied by feelings of anger. This is even more the case when

receiving criticism about drinking/drug use. When giving criticism, clients are taught to

calm down first, to state the criticism in terms of their own feelings, to use a firm and

clear tone of voice but not an angry one, to criticize specific behaviors and request a

behavior change, and to be willing to work out a compromise. When receiving criticism

they are taught not to get defensive or counterattack, to ask the other person to clarify the

content and purpose of the criticism, to find something in the criticism to agree with, and

to work towards formulating a compromise. In this way, criticism may be transformed

into a potentially constructive communication that could produce positive results for both

parties involved. Clients practice using the skills in various situations including those

that specifically involve criticisms about alcohol/drug use.

Intimate relationships. Some clients may experience difficulty expressing their

feelings, or communicating effectively and sensitively in intimate relationships,

especially where there is considerable conflict and tension as a result of substance use.

This can be a bar to intimacy, both emotional and sexual. Clients are taught about self-

disclosing their emotions, sharing their positive feelings, and the importance of

expressing negative feelings (in an appropriate way) to prevent things from building up.

They may also be taught listening skills, which are an essential component of an intimate

relationship. Clients practice these skills in simulated situations drawn from their recent

past in which they felt angry, anxious, or sad with loved ones. Homework involves

planning how to handle one such situation, and then actually trying out the skills in it.

Enhancing social support network. Support from others often makes people

feel more confident about their ability to cope with problems. Given the number of life

problems caused or exacerbated by substance abuse, a good social support network can

enhance the chances of coping effectively. However, as their substance abuse developed,

clients may have alienated potential supporters and will have to work to rebuild their

support network. They are asked to consider the various types of support that might be

helpful to them, who might be helpful in providing the support they need, and how to go

about developing that support. They are also taught about the importance of reciprocity,

i.e., lending support to others as part of the process of building one's support network.

They are given practice asking for support with particular problems, and offering to

support others with their problems.

General social skills. A number of additional social skills may also be taught to

help clients better handle social situations that might otherwise put them at risk for using.

Various communications skills (e.g., how to start conversations, use of nonverbal

behavior) may be taught to help clients cope with deficits in communications that could

leave them feeling socially inadequate or isolated, and therefore at greater risk for using.

Assertiveness training may be offered to enable clients to express their emotions and

opinions clearly and directly, in a manner that leaves them satisfied that their views were

heard, but without doing so in a way that alienates or antagonizes others.

Coping skills training with significant others. Since problems within an

intimate relationship, such as maladaptive communication patterns, lack of intimacy, and

control struggles, can be precipitants of substance use, having a significant other

participate in skills-oriented treatment can enhance treatment outcome. Issues to be dealt

with in a session with a significant other include deciding whether or not to keep alcohol

or drug paraphernalia in the house, identifying how the sober partner can most effectively

support and reinforce the substance abuser's efforts to change, fostering more positive

communication within the relationship, and learning how to solve problems together. During the session, the couple can practice the problem-solving process as it applies to a current problem they're facing, and begin discussing how they might apply other skills taught in this program to their daily lives. A homework assignment can be designed with their collaboration, to further their discussion and implementation of coping skills.

Skills Training Methods

Clients should be active participants in the training process. The more passive they are, the less likely that they will develop the motivation and sense of involvement needed to follow through with the practice that is required to become fluent in implementing the skills. Clients who engage in treatment, and begin the process of skills acquisition and cognitive restructuring, become increasingly able to accept responsibility for changing their behavior. To enhance client involvement and participation in this process, the selection of skills to be taught should match client needs, based on the functional analysis.

Regarding the sequence in which skills are taught, it would be good pedagogy to train skills beginning with those that are the simplest and easiest to implement, and then adding skills in order of increasing complexity and difficulty. Nevertheless, in the interests of promoting sobriety and enhancing client involvement in what is being taught, it probably makes the most sense to begin skills training with topics that meet clients' most pressing immediate needs, returning at a later time, if possible, to more basic skills that might support implementation of the more complex ones.

Within each skills training session, the client's current status should be assessed at the beginning through self-report and possibly also through the use of a urine test or a

breathalyzer. The client should be given an opportunity to express his/her current concerns and to use problem-solving skills to develop a plan for coping with them. If a client becomes expansive when discussing current issues, and it may be necessary to set some limits in the interest of allowing adequate time in the session to present and rehearse a new coping skill.

Following this initial discussion, the therapist should give a brief review of the skill(s) taught in the prior session, and inquire about the client's attempts to do the homework assignment. It is important to praise any and all attempts at homework completion, regardless of how minimal or poorly performed. Explore obstacles to attempting or completing the assignment, and consider ways that the client might try to overcome them in the future.

A new coping skill is introduced by first providing a rationale for it, both in conceptual terms as it relates to achieving/maintaining sobriety, and in specific terms of its usefulness to the client for dealing with issues that he/she has been facing. This is followed by a description of the steps involved in implementing the new skill. The therapist immediately follows this description by modeling the skill and soliciting the client's reaction. The next step is for the client to role-play the skill with the therapist, or with a peer if it is a group setting.

For many clients, role-playing may at first feel awkward or uncomfortable. The therapist's modeling of the skill may help to dispel client reluctance to some extent. Discomfort can be further dispelled by selecting scenes that are relatively easy at first, in which client success is more-or-less assured. Scenes should be personally relevant to the client, perhaps a past situation in which the skill might have been helpful, or a future one

in which it may be useful. After the role-play, praise the client for participating, regardless of the adequacy of the performance. Try to find some aspect of the client's behavior to compliment, but don't overdo the praise to the point of sounding insincere. Solicit how the client felt using the skill. When offering criticism, be selective and avoid global evaluations. Only criticize one or two of the more important flaws, focusing on specific behaviors in making the criticism, and couple the criticism with constructive suggestions for change. Repeat the role-play to provide the client with an opportunity to utilize the critique. Further role-plays with different scenes will provide additional practice and will enhance the likelihood of generalization of the skill to a variety of different settings. If a client is having difficulty with a skill, or is pessimistic about its impact, try a role reversal in which the therapist assumes the role of the client, and the client plays the role of the spouse, friend, employer, etc. In this way the client can see the skill in action and experience its impact firsthand.

At the end of each session, clients should be given a written reminder of the skill(s) they just learned, listing the specific behaviors involved, for future reference. A homework exercise should be developed in conjunction with the client, to practice the new skill(s) in his/her particular life circumstances. To foster compliance with the agreed-upon assignment, it should be put in writing and the client should make an appointment with him/herself for a specific time at which to practice. Other strategies to increase the likelihood of doing the homework include placing reminder notes in strategic locations at home and making plans to associate the new behavior with already-established daily routines. The client should also plan to reward him/herself for completing the exercise, to increase the likelihood of both using the new skill in the

future and of completing future homework assignments. An effort should be made to anticipate possible obstacles to completing the homework, and ways to overcome them. As the final agenda item in each session, clients should be asked to anticipate high-risk situations that might arise in their daily lives prior to the next session, and plan ways to avoid them or to cope with them.

As with any newly acquired behaviors, coping skills are not likely to be retained or used very much if their acquisition is limited to a single therapy session and one homework assignment. Considerable practice is needed to develop a sense of mastery of each skill and increase the likelihood of its being used in real-life situations. Therefore, therapists should occasionally review previously learned skills. They can also use the discussion of current problems at the outset of each session, and the anticipation of high-risk situations at the end of sessions, to remind clients which of the skills they have already learned might be applicable in those situations.

The duration of treatment will be determined by a number of factors, most notably clinical need and what a third-party payer is willing to cover. Although Monti et al. (1989) described 6 months of weekly sessions, that is hardly a practical recommendation in this era of brief interventions and a relentless focus on cost-containment. In many clinical studies it has been found that approximately half of clients drop out of treatment by about the sixth session, and six sessions may be about as much as most managed care organizations are willing to approve, at least initially. Topics that might be covered in that time frame include coping with cravings and thoughts about using, problem solving, drink/drug refusal, planning for emergencies, anger management, and decision making,

although the actual selection and sequencing of topics will be determined by the functional analysis and client preference.

Whatever number of sessions is held, the treatment must ultimately terminate and the therapist must anticipate the challenges this will present. Clients may experience generalized negative feelings and/or exhibit behavior problems as the time for termination approaches. To help the client cope with these, the therapist should use the same cognitive-behavioral approach as with any other problems that were raised during the course of treatment. Furthermore, a session on developing an emergency plan may help bolster clients' confidence in their ability to cope with unanticipated crises that could arise in the future. Finally, clients may have fears about problems that haven't been fully resolved in the course of treatment, whatever its length. These fears may be alleviated by reviewing skills already taught, suggesting how they may be applied to problems that are likely to persist, and urging that the skills be practiced at every opportunity. In addition, if possible, one or more 'booster' follow-up sessions may be scheduled, at one month or 6 week intervals, to monitor progress and augment skills as needed to cope with new or persisting problem situations.

An additional consideration is the applicability of the skills training approach for group versus individual treatment. The Monti et al. (1989) program was initially designed for use with groups, and works very well in that format. Peers are naturals for role-playing with each other, different members' experiences provide a host of examples to illustrate the applicability of skills and provide scenes for role playing, and group members working together facilitate the brainstorming of possible strategies for problem solving. Peers sometimes trust one another more, or at least sooner, than they trust their

therapist, so that peer support can be a very important asset in treatment. Despite these advantages of the group therapy setting, the coping skills training described here can nevertheless be successfully implemented in an individual treatment context, even though the opportunities for role playing are more limited and clients may feel more 'on the spot' than in a group setting where responsibilities can be shared. Trust issues with the therapist become more central, but if he/she is able to adopt an empathic style (Miller & Rollnick, 1991), client trust of, and openness with, the therapist may be developed fairly rapidly. Thus, although individual treatment does present some challenges, they are not insurmountable and that format can be successfully utilized with this treatment approach.

Relapse Prevention

The Relapse Prevention (RP) approach utilizes coping skills training to a considerable extent. As a treatment intervention, it does not differ all that much from coping skills training, but its overall focus on situations that may be of high risk for relapse is of considerable value. There are several variants of RP. The form of relapse prevention treatment described here is based on Marlatt and Gordon (1985).

The most obvious strategy for avoiding relapse is to avoid high-risk situations altogether. The decision-making skills referred to in the intrapersonal skills section above can be very useful in helping clients anticipate and avoid decision paths that could eventually lead them into a high-risk situation. Another effective strategy for avoiding high risk situations is to review a client's lifestyle, identifying those activities that tend to place him/her at risk for using and fostering development of activities that are incompatible with drinking/drug use.

If a high-risk situation was not avoided, whether because of lack of trying or despite one's best efforts, it must be coped with if drinking/drug use is to be prevented. The first step is recognition that a risky situation is at hand. This requires developing clients' awareness of what their high-risk situations tend to be, and ongoing alertness and attention to the situations in which they find themselves, as well as monitoring of their thoughts and feelings, to detect warning signs of impending risk as early as possible. Risky situations detected early are usually more easily controlled than situations that are ignored until they become intense. Once clients are in a high-risk situation, deficits in coping skills become a major risk factor due to the tendency among chemically dependent people to rely on alcohol or drugs in the absence of adequate coping skills. Therefore, within the RP model, coping skills training is essential, to enable clients to manage high-risk situations without relapsing. The strategies for identifying potential high-risk situations, and the coping skills that need to be trained, are as enumerated above in the section on coping skills training.

In the event that a person's coping in a high-risk situation was not adequate and he/she relapsed to substance use, the RP model offers recommendations for handling that eventuality. Slips should be viewed as a learning experience, an opportunity to identify trigger situations and the expectancies the client might have had regarding possible benefits of substance use in those circumstances. Clients should be encouraged to identify what they actually did in the high-risk situation, what was not helpful, and what turned out to be helpful. Based on that review, they should formulate plans to strengthen the things that worked and compensate for the weaknesses, to enable them to cope with similar trigger situations more effectively when they arise in the future. There should

also be an exploration of feelings of guilt and self-blame that clients may experience in such circumstances, and they should be cautioned that surrendering to those emotions places them at high risk for continuing to use.

Conclusion

A cognitive-behavioral conceptualization of addictive behavior has been described in which abusive drinking and drug use are considered to be learned behaviors that are acquired through the processes of Pavlovian and/or operant conditioning. As such, they can be modified by the application of learning-based interventions. The coping skills approach to treatment was outlined in detail, providing examples of how it can be employed to deal with both the intrapersonal and interpersonal situations that tend to support substance use. The Relapse Prevention approach was also outlined. While there is considerable evidence to support the efficacy of these approaches, it is not clear that they are superior to other interventions. Further clinical research is needed to assess the impact of coping skills training on treatment outcome, to determine the relative effectiveness of the various skills training components and how they can best be matched to particular client needs, and to determine how much actual practice of skills is required for them to be useful in coping with high-risk situations.

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