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A Manual for Extended Brief Intervention for Alcohol Misuse by People with Learning Disabilities

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Manual for Extended Brief Intervention for Alcohol Misuse by People with Learning Disabilities

A training guide to help clinicians to treat people with communication and cognitive problems about changing their alcohol use behaviour.

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In Part I the section on Motivational Interviewing and in Part II sessions 1 and 2 are adaptations of the manual for Motivational Enhancement Therapy developed by Gillian Tober et al, 2002, based on the UKATT MET Manual.

In Part I chapters 3 and 4 are based on the manual of Cognitive Behaviour Therapy for People with Learning Disabilities developed by Azam et al, 2009.

In Part I the sections on alcohol definition and cognitive theories of addiction are based on Christos Kouimtsidis PhD thesis.

Part II sessions 4 & 5 are adaptations of the UKCBTMM manual developed by Christos Kouimtsidis et al, 2004.

Disclaimer

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Overall introduction

The World Health Organization defines *learning disability* as “a significant impairment of intellectual ability” (i.e. Full Scale IQ less than 70) and “significant difficulties in social and adaptive functioning,” that are present from childhood (WHO, 1993). The recently published Diagnostic and Statistical Manual of Mental Disorders 5th Edition is in line with this definition, while focusing primarily on the impact of impairments in mental abilities on adaptive functioning in the conceptual, social and practical domains. Recent studies have shown that this population is vulnerable to alcohol use disorders (Burgard et al. 2000) as well as other mental health conditions such as depression and anxiety (Azam et al, 2009). Historically learning disability was considered an exclusion criterion for psychotherapy, leaving those affected by such conditions few (if any) options for effective treatment.

There has of late been a growing interest, both within the psychotherapeutic community and in the broader social sphere, in developing psychological therapies specifically designed for people with learning disabilities and providing them with the same services the general population has access to. For example, Valuing People (2001)—a UK government white paper designed to improve the lives of people with learning disabilities—stated that those with learning disabilities should have the same access to healthcare as people without disabilities do. The use of Behavior and Cognitive Behaviour therapy (BT & CBT) with people with learning disabilities with alcohol problems to date has been limited to single case studies and small group settings. However, with a few modifications in therapeutic approach and communication style these early attempts have indicated that BT & CBT may be successful interventions for those with learning disabilities (Lindsay et al, 1993; Lindsay et al, 1997; McCabe et al, 2006; McGillivray et al, 2008). Azam et al, (2009), have developed a manual for trained therapist of how to offer CBT for anxiety and depression. Specific materials were developed for use in the therapy sessions and for homework. It contains also materials and a leaflet to help carers support the treatment.

The current manual builds on the above mentioned developments. It describes the process of treating harmful use of alcohol in people with mild to moderate learning disabilities using extended brief interventions. It is designed for therapists who have experience in alcohol interventions, but have little or no experience with clients who have learning disabilities. For BT & CBT interventions to be successful with this client population, they need to be made more accessible and modified appropriately to cater to their cognitive abilities and complex communication needs. This manual provides instructions on how to do that, and outlines a therapeutic protocol that can be applied in treatment.

Part I: An Overview of Alcohol Disorders and Treatment for People with Learning Disabilities

Chapter 1: Alcohol Use Disorders and Brief Interventions

Alcohol and Definition of alcohol problems

Just over 40% of the world's adult population consumes alcohol and the average consumption per drinker is 17.1 litres per year. There is wide variation across countries on provenance of abstention, level of consumption and patterns of drinking (Shield et al, 2013). It has been estimated that around the world at the start of the 21st century 76 million people were suffering from alcohol use disorders (WHO, 2005). In the UK, the Alcohol Needs Assessment Research Project (ANARP) (Drummond et al., 2005) was the first alcohol needs assessment in England conducted on a national scale. ANARP found that 38% of men and 16% of women (age 16–64) have an alcohol use disorder, which is equivalent to approximately 8.2 million people in England. A smaller percentage, 21% of men and 9% of women, are binge (harmful) drinkers and 6% of men and 2% of women are dependent drinkers.

Addiction is a socially defined concept and refers to a syndrome the centre of which is impaired control over a reward-seeking behaviour; impaired control that is leading to significant harm (West, 2006). One of such reward seeking behaviours is alcohol use. Alcohol use per se does not equal addiction unless there is loss of control and associated harm. It is difficult to define when use of alcohol crosses the boundaries of addiction (becomes out of control and/or causes harm). To that effect problem drinkers are divided in three groups: hazardous, harmful and dependent drinkers. An individual's use can escalate from use to dependence through hazardous and harmful use.

"Hazardous" use is a term introduced by the WHO. The term refers to a pattern of substance use that increases the risk of future harmful consequences for the user. In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user (WHO, 2006).

"Harmful use" is a term used in ICD-10 and refers to "a pattern of psychoactive substance use that is causing damage to health. The damage may be physical (e.g. hepatitis following injection of drugs) or mental (e.g. depressive episodes secondary to heavy alcohol intake). Harmful use commonly, but not invariably, has adverse social consequences; social consequences in themselves, however, are not sufficient to justify a diagnosis of harmful use" (WHO, 1993). The term "abuse" was widely used in the 1980-90s but had various meanings. The term was used in DSM IV but was replaced in ICD-I0 by the more precise term of harmful use (WHO, 2006). The term misuse has been also excluded from ICD-10.

The term "dependence" was first introduced in 1976 by a WHO group of investigators to replace the term alcoholism (Edwards & Gross, 1976). The term in IDC-10 is defined as

“a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state” (WHO, 1993). Therefore dependence refers to both physical and psychological elements. Psychological dependence refers to the experience of impaired control over drinking, while physical dependence refers to tolerance and withdrawal symptoms. In ICD-I0, the diagnosis of dependence syndrome is made if three or more of six specified criteria are experienced within a year.

Psychological interventions based on psychological theories of addictive behaviour are the main treatment approach in alcohol treatment (Curran & Drummond, 2006). A recent review of the effectiveness of treatment for alcohol problems reported that opportunistic brief alcohol interventions which primarily involved motivational enhancement techniques, are effective in reducing alcohol consumption among hazardous and harmful drinkers to low risk levels. This is now widely seen as an important public health measure to reduce hazardous and harmful alcohol use, and is primarily employed in people identified in routine medical care settings (e.g. primary care, accident and emergency) (Raistrick et al., 2006). The same review suggested that CBT approaches to specialist alcohol treatment offer the best chances of success of treatment effectiveness, and that psychosocial interventions can be delivered at a reasonable cost and produce wider social cost savings (Raistrick et al., 2006).

An earlier large systematic review of alcohol treatment outcome research, known as the ‘Mesa Grande’ (Miller et al., 2003), included 381 randomised controlled treatment trials. Many of the treatment modalities that had a large amount of evidence supporting the approach, were psychosocial interventions rooted in cognitive-behaviour theory.

Cognitive theories of addiction

Theories that incorporate cognitive processes in the study of addiction can be considered compatible and therefore can be examined under a common framework (Kuhn, 1962; Alford & Beck, 1997). Such theories include expectancy theory (Marlatt, 1979), social learning theory (Bandura 1977 & 2001), theory of reasoned action and planned behaviour (Ajzen, 1985) and PRIME theory (West, 2006). As with other mental health disorders, several cognitive/cognitive-behavioural models of addiction have been developed and evaluated over the years. Whilst they do not all focus on exactly the same elements of the process of therapy, nevertheless there is an overlap. They are situation specific, meaning that the starting point is a high risk situation either internal or external to the individual. They consider behaviour as the result of decision making processes that include concepts which are either conscious or could become conscious and could be modified.

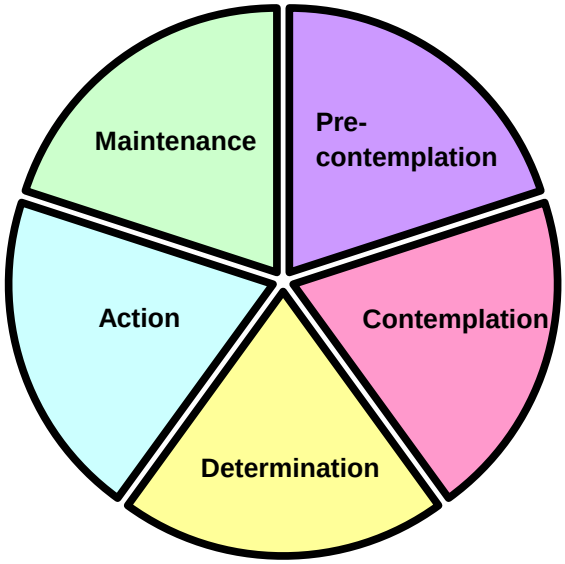
The best known model is the Relapse Prevention model (Marlatt & Gordon, 1985; Marlatt & Witkiewitz, 2005). According to this model, when an individual is exposed to a “high risk situation” (internal or external), the individual is more likely to relapse in the presence of

high positive expectancies and low self-efficacy. The Dynamic Regulatory model is a modification of the Relapse Prevention model, which incorporates the role of conditioned craving in the relapse process (Niaura, 2000). The model proposed that following exposure to external stimuli or activation of internal positive or negative emotional states, if urges, positive expectancies and physiological changes are strong they would undermine existing coping skills through reduced self-efficacy. The Cognitive Coping Skills Training (CCST) model (Monti et al., 1989) proposes that acquisition of new skills (interpersonal and intrapersonal) is the main factor that reduces the risk of relapse by increasing self-efficacy. Beck developed a model similar to the Relapse Prevention model in many ways. In addition to positive expectancies, Beck emphasised the important role of core beliefs (schemas), automatic thoughts and "facilitating beliefs". Following exposure to activating stimuli (internal or external), core beliefs, positive expectancies and automatic thoughts are activated, which lead to the experience of craving and cognitive dissonance, which is resolved by facilitating beliefs which give permission to proceed with action of obtaining the substance (Beck et al., 1993).

Motivational interviewing

An influential model that relies mostly on the choice principle, but addresses how people modify addictive behaviour is the Transtheoretical model of behaviour change or Stages of Change model (Prochaska, DiClemente & Norcross 1992). Although it is described as a model it proposes new theory concepts, therefore it could be seen as a theory. The model focuses on this particular aspect of addiction rather addiction itself and proposes that the process of recovery from an addictive behaviour involves transition through stages: (i) pre-contemplation stage in which no change drinking is contemplated; (ii) contemplation in which change is contemplated for the near future; (iii) preparation, in which plans are made on how to change behaviour in a definite way; (iv) action stage in which the plans are put into action and change takes place; and (v) maintenance in which the new pattern of behaviour emerges, establishes and is maintained.

Figure 1: A Stage Model of Change



Adapted from Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: Application to Addictive Behaviours, American Psychology, 47 (9), 1102 – 1114

Motivational interventions developed in 1990's are partly based on the Stages of Change model and were described as 'Motivational Interviewing. Essentially this approach aims to work with the individual's perception of their alcohol use, rather than imposing the therapist's external view of reality. Most clients, are likely to enter the treatment process somewhere in the contemplation stage, ambivalent about their drug use and the prospect of change. They may already be thinking about changing their drinking but still need consolidation of motivation for change. This phase may be thought of as tipping the motivational balance (Janis & Mann 1977; Miller 1985). One side of the scales favours the status quo (i.e. continued drinking), whereas the other side favours change. The former side of the decisional balance is weighed down by perceived positive benefits from the behaviour and feared consequences of change. Weights on the other side consist of perceived benefits of changing one's behaviour and feared consequences of continuing unchanged. Clients are likely to experience considerable ambivalence when these weights seem evenly balance. The greater the ambivalence, the greater will be their motivation to resolve the ambivalence. The therapist's task is to elicit from the client a shift in the balance in favour of behavioural change and to recognise the discrepancy between their view of self and their behaviour. Miller and Rollnick (1991) have described five basic motivational interviewing practices underlying such an approach:

1 Express empathy
2 Develop discrepancy
3 Avoid argument
4 Roll with resistance
5 Support self-efficacy

Express Empathy
Empathy refers to the ability of the therapist to make sense of the client's experience. Contrasted with approval or identification, empathy is the process of communicating to the client that the behaviour in question has its own rationale. This is different from sympathy, which implies a sense of inevitability and feeling sorry for the client. Empathy is communicated by the therapist through reflective listening and selective reinforcement; through affirmation and the way that the therapist summarises the client's position.

Develop Discrepancy
Motivation for change occurs when people perceive a discrepancy between where they are and where they want to be. The approach seeks to enhance and focus the client's attention on such discrepancies with regard to drinking. In certain cases (e.g., the pre-contemplators in Prochaska and DiClemente's model), it may be necessary first to develop such discrepancy by raising client's awareness of the personal consequences of the behaviour. Such information, properly presented, can precipitate a crisis of motivation for change. As a result, the individual may be more willing to enter into a frank discussion of change options in order to reduce the perceived discrepancy and retain emotional equilibrium.

Avoid Argument
If handled poorly, ambivalence about the current behaviour and discrepancy between the consequences of the behaviour and client goals or aspirations result in defensive coping strategies that reduce the client's discomfort but do not alter the behaviour and related risks. An attack on their drinking or drug using behaviour tends to evoke defensiveness and opposition and suggests to the client that the therapist 'does not really understand'. The MET style explicitly avoids direct argument. No attempt is made to have the client accept or admit a diagnostic label. The therapist does not seek to prove or convince by force of argument. Instead, the therapist employs other strategies to assist the client to see accurately the negative consequences of the behaviour and to begin devaluing the perceived positive aspects of it. In essence when MET is conducted properly, *the client and not the therapist voices arguments for change* (Miller & Rollnick 1991).

Roll with Resistance
How the therapist handles client resistance is a crucial and defining characteristic of MI. MET strategies do not meet resistance head on but rather roll with the momentum, with a goal of shifting client perceptions in the process. New ways of thinking about problems are invited but not imposed. Ambivalence is viewed as normal, not pathological, and is explored openly. Solutions are usually evoked from the client unless specifically requested of the therapist. This approach for dealing with resistance is described in more detail later (see later section on Handling Resistance).

Support Self-efficacy
People who are persuaded that they have a serious problem will still not move towards change unless there is hope for success. Self-efficacy is a critical determinant of behaviour change. Self-efficacy is, in essence, the belief that one can perform a particular

behaviour or accomplish a particular task. In this case, clients must be convinced that it is possible for them to change their own drinking and thereby reduce related problems. Unless this element is present, a discrepancy crisis is likely to resolve into defensive coping (e.g. denial, rationalisation) to reduce discomfort without changing behaviour. This is a natural and understandable protective process. If one has little hope that things could change, there is little reason to face the problem.

Brief Interventions for alcohol

Miller and Sanchez (1993) described six elements which they believed to be active ingredients of the relatively brief interventions that have been shown by research to induce change in problem drinkers, summarised by the acronym FRAMES:

FEEDBACK of personal risk or impairment
Emphasis on personal **R**ESPONSIBILITY for change
Clear **A**DVICE to change
A **M**ENU of alternative change options
Therapist **E**MPATHY
Facilitation of client **S**ELF-EFFICACY or optimism

These therapeutic elements are consistent with a larger review of research on what motivates problem drinkers for change (Miller 1985; Miller & Rollnick 1991). Interventions containing some or all of these motivational elements have been demonstrated to be effective in initiating treatment and reducing long-term excessive drinking, alcohol-related problems and health consequences of drinking (Bien, Miller & Tonigan 1993). It is noteworthy that, in a number of these studies, the motivational interventions yielded comparable outcomes to longer, more intensive approaches.

Chapter 2: Alcohol and Treatment in learning disabilities

Despite the sparse literature regarding substance misuse in people with learning disabilities (characterised by IQ less than 70, developmental delay and adaptive deficits), there is increasing interest in studying such problems in people with learning disabilities because most now live in the community and are likely to be exposed to substances as well as consuming them (Miller & Whicher, 2010). UK and USA population based studies indicate that the prevalence of substance misuse ranges from 0.5% and 2.5% and may be as high as 25% for any substance in clinic samples (Pezzoni, 2010; , McGillicuddy & Blane, 1999; Sturmey et al, 2003; Hassiotis et al, 2008). Approximately 5% of youths in drug and alcohol services have a degree of learning disability (Barrett & Paschos, 2006).

The commonest substances that people with mild to moderate learning disabilities tend to use are alcohol and cannabis, though they may also use heroin or cocaine. Aetiological factors which have been postulated to contribute to use of substances in people with mild to moderate learning disabilities include hyperactivity, lack of assertiveness, low self-esteem, susceptibility to peer pressure, desire for social acceptance, social isolation, early onset of drinking and lack of example setting in childhood. Substances may also be taken as a maladaptive way of relieving stress or developing relationships within local communities (McLaughlin et al, 2007; Taggart et al, 2007).
Those most at risk are young males with mild learning disability or borderline intelligence who live independently and are less likely to engage in activities and/or to experience mental health problems (Barrett & Paschos, 2006).

Various interventions have been evaluated in the general population to tackle hazardous or harmful drinking and alcohol dependence but the literature in evaluating any interventions is very limited in learning disabilities. This may be due to the general lack of empirical research in this field, but also to the belief that interventions that are suitable for typically functioning adolescents and adults are also suitable for those with mild-moderate learning disabilities without need for adaptation. This seems counterintuitive as people with learning disabilities have cognitive deficits that impair their ability to learn or generalise new learning and therefore may require interventions to last longer, to include maintenance sessions and to be supported to seek help and attend appointments.

Most of the treatments that have been applied to people with mild to moderate learning disabilities are in non-substance misuse services and may well be delivered by people ill-equipped to provide such treatment. A variety of approaches to helping people with mild to moderate learning disabilities and substance misuse have been tried, such as education about the risks associated with substance misuse, behavioural modification, adaptation of materials by AA or similar organisations with interventions mostly delivered in group settings (Christian & Poling,1997; Degenhardt, 2000; Didden et al.,2009; Forbat, 1999; Lindsay et al.,1991; McCusker et al.,1993; McGillicuddy & Blane,1999; McMurran & Lismore, 1993) . As a whole, these studies suggest that the capacity of people with learning disabilities to learn new information is enhanced by providing additional cues and using techniques such as modelling, videotaped vignettes and role-playing (McCusker et al.,1993) . Often, sessions are augmented with coping skills lessons and assertiveness

training (McCusker et al.,1993; McGillicuddy & Blane,1999) . However the studies conducted to date are fairly small and usually uncontrolled.

Two studies though merit further attention; one is a study of three sessions of group motivational interviewing over two weeks conducted with seven offenders with learning disabilities in a medium secure unit (Mendel & Hipkins, 2002). The authors found that the participants showed increased determination to reduce drinking at the end of the treatment. The second study (McCusker et al.,1993), is a 10 week evaluation of assertiveness training and modelling compared to waiting list to educate about substance misuse and to help the participants (N=84 randomised to treatment and waiting list controls) to respond appropriately when offered substances in their social network. The authors found that knowledge of the risks associated with use of illicit substances increased at the end of the intervention and this was maintained at six months follow up. The methodological limitations of the studies include the uncontrolled design and possibility of type 2 error in the former study; and insufficient methodological details in the latter to allow appraisal of the findings, as well as the inclusion of several substances which may have compromised the specificity of the intervention.

The National institute for Health and Clinical Excellence (PH24;18) recommends that brief and extended brief interventions are used to help young persons and adults who have screened positive for hazardous and harmful drinking. The interventions recommended are based on motivational interviewing/enhancement techniques, and are delivered by trained professionals. Their aim is to reduce alcohol intake, reduce risk taking behaviour and even to consider abstinence. The sessions are short at 30 minutes and follow-up is offered. At all times, individuals who are referred for treatment have their capacity to consent to it assessed and, where further treatment is indicated, referrals to secondary specialist services are provided.

We have chosen to evaluate the Extended Brief Intervention (EBI) because it is the most often used and evaluated treatment in the literature for hazardous and harmful drinking. It is a low intensity intervention and can be delivered by trained professionals in the public and voluntary sector. Also, it is our experience that people with mild to moderate learning disabilities require longer treatment duration overall and thus we will provide five sessions over five weeks with a follow up one-hour session at two months.

Chapter 3: Therapist Characteristics and the Therapeutic Approach

Warmth

The therapist should convey warmth by being encouraging and offering lots of positive reinforcement where appropriate. The therapist will need to show an empathic approach coupled with an informal and friendly attitude towards the client. These qualities are, in some ways, even more important in treating people with learning disabilities as they will improve response and motivation to engage in therapy.

Genuineness

The therapist needs to be honest with the client without being too harsh or judgmental. When treating people with learning disabilities it is particularly important to be careful that the client doesn't misinterpret directness as criticism, hostility, or rejection. This can be especially tricky as people with depression are more likely to focus on the negative.

The Importance of Rapport

As in all therapeutic relationships, the client has to feel secure and trust the therapist. In some cases it can be difficult to establish trust in people with learning disabilities because these clients are more likely to have had had a variety of negative experiences with therapists, social workers, and/or other authority figures. You may find clients who have developed distorted ideas and representations of therapists or authority figures in general from previous experiences. Overcoming this hurdle is essential to effective treatment. With time and patience it can be done, but it may take perseverance on your part to establish trust.

The Therapeutic Alliance

In carrying out CBT with clients who have learning disabilities the therapist may be required to adopt a more didactic role (as noted above). However, this needs to be done without being coercive or dismissive. To this end, challenging the person's beliefs too early in treatment is not recommended. Rather the therapist should slow the pace of therapy, offer several possible answers to questions the client may otherwise find difficult, yet do this without 'leading' the client.

The key here is to be vigilant of the client's expressions and other nonverbal cues. Communicating with people who have learning disabilities (both verbally and nonverbally) can be challenging for therapists who have little or no previous experience working with this population. However, learning the necessary skills to effectively communicate with those who have learning disabilities is essential for effective treatment. That is why we have focused on helping the therapist develop a specific set of communication skills in Chapter 2.

Accurate Empathy

The therapist needs to try to understand how the client regards him or herself and his or her world. By doing this, the therapist gains a sense of what the client may be experiencing. As the therapist develops empathy that is reasonably accurate, the therapist will be able to understand how the client feels, understands, and responds to

events (Beck et al, 1979). This is essential both for developing rapport and for effectively treating the client.

Cultural Sensitivity

Being sensitive to cultural differences and taking them into account during sessions is extremely important. There is considerable variation in the way mental health disorders such as depression and anxiety are perceived and understood in different cultures. The treatment model in this protocol is flexible and can accommodate racial, cultural, and gender differences and issues. However, you must be sensitive to these issues to use the protocol to that end.

Chapter 4: Communicating with People Who Have Learning Disabilities in the Therapeutic Setting

People with learning disabilities have complex communication needs. Clients may have difficulty forming sentences, have a reduced understanding of key and abstract concepts, his or her speech may be unclear, or the client may need increased time to process and retrieve information. Furthermore, a person with learning disabilities is likely to have reduced vocabulary (Burnip, 2002), and he or she will probably be more susceptible to suggestibility and may tend to change his or her answers to questions when provided with negative feedback (Clare & Gujonsoon, 1993; Everington & Fuller, 1999). This is all further complicated by the fact that linguistic and cognitive ability varies considerably from person to person within this population.

What's more, people with learning disabilities have a lifetime of experiences that have allowed them to mask their difficulty understanding and following verbal communication by drawing on social skills and set phrases that they know are contextually appropriate responses, even if they do not fully understand what is being communicated. This can lead to the illusion that the client has understood something that was said in the therapeutic setting when, in fact, this may not be the case.

If the purpose of B & CBT is to help the client "learn from his or her psychotherapeutic experience" and "begin to incorporate many of the techniques of the therapist"—that is, to "become his or her own therapist" as it were—these difficulties in communication represent a challenge that must be addressed and overcome to successfully apply B & CBT model in this population. You will need to properly modify the way you communicate to meet the needs of individuals with learning disabilities so that you can pitch the material presented at an appropriate level and allow the concepts of B & CBT to be more accessible.

Understanding People with Learning Disabilities: On the Problems with Vocabulary, Verbal Ability, and Speech

Even people with mild learning disabilities will generally have a more limited vocabulary and will acquire fewer and less complex words than the general population. In addition, the ability to form complete, grammatically correct sentences varies within this population—some may be able to do this while others may not. These issues will impact your communication with clients who have learning disabilities from the ground up. You may find they have difficulty finding the words to express certain thoughts and feelings. Similarly, if the language you use is too complex, the client may not follow what you are saying. Difficulties in processing and retrieving information (like word finding difficulties) may mean that it takes more time for these clients to respond verbally. And, if the client cannot form complete sentences, you may sometimes find it difficult to understand the meaning of what has been said.

Speech itself may represent another communication barrier that needs to be overcome since physical disability or anatomical differences can result in a variety of speech-related

difficulties. For instance, the anatomical differences found in people with Down's Syndrome—low muscle tone of the tongue, small mouth, and high palate—results in the characteristic alterations in pronunciation in this population (Kelly, 2000). A person with cerebral palsy may have *dysarthric speech*—weakness in the speech musculature and difficulties with breath support. Other causes of speech difficulties may include *dyspraxia*—difficulties executing voluntarily and on command the neurological sequence of muscle contractions required to produce individual sounds and words (Murdoch, 1990); and *dysfluency*—impairment in the ability to produce smooth, fluent speech—a problem that most often arises when someone feels under pressure to perform or respond and where there may be a need to synthesize many different cognitive tasks to arrive at a conclusion.

The following tips will help you overcome some of these basic difficulties with communication. Note that these tips are based on Winn and Baron, 2009. As you become more familiar with a particular client's communication style, pronunciation, and verbal patterns, you will likely be able to "tune in" to his or her speech and find it easier to understand.

Tips to Help You Understand People with Learning Disabilities

1. **If you do not understand what a client says, it is important that you do not pretend to have understood.** Try to make the client feel at ease while acquiring the information you need. You might say, "Sometimes it is difficult for me to understand, could you say that again please."
2. **Give the person plenty of time to respond, you might have to wait longer than you'd expect.** Remember, these clients do not necessarily take longer to respond because they are unwilling or unable to answer questions, but because it takes them longer to process information.
3. **Make sure you listen carefully.** Pay special attention to speech patterns and pronunciations that are difficult for you to make out.
4. **Make sure you look at the person when he or she is talking.** Body language (more on this below) and watching the words being formed may help you comprehend what is being said.
5. **If you still cannot understand, ask the client if it is okay to ask the support worker for help with communication.** While this is not a technique you want to rely on consistently, it can help in cases where repeated efforts at communication fail.
6. **Be aware of other things that may affect communication.** This could include hearing impairment, visual impairment, physical and mental health issues, epilepsy, medication, time of day (is the client a "morning person") general mood, interest in the topic, and more.

Being Understood by the Client: Presentation of Key Concepts, Abstract Thought, and Contextualizing Communication

The majority of people with learning disabilities will have some difficulty understanding what you say to them at least some of the time. How often this is a problem and the degree of misunderstanding will vary from individual to individual depending on the severity of the disability. While assessment can help tease out how much of a challenge this will be in therapy, there are a few simple guidelines that will help facilitate good communication with these clients.

First, try to stick with simple, straight-forward, everyday language and limit the number of key concepts or ideas you communicate to no more than three per sentence. While some may be able to understand more complex verbiage and sentence structure, most people with learning disabilities will better comprehend simple sentences and language.

Second, keep to concrete examples as much as you can and either avoid, reword, or break down complex abstract ideas when possible. While people with learning disabilities may be able to understand simple abstract ideas such as “What are you doing today?” or “How are you feeling right now?”; complex abstract concepts and questions that revolve around inference or emotions in the context of time are likely to be more difficult for them. You will typically want to avoid questions like, “What would happen if you …?” “What would it feel like if you …?” or “What did it feel like when …?” These lines of questioning are unlikely to be easily accessible by someone with a learning disability.

Let’s look at an example. Imagine you are discussing the events of the day with a client and he or she says, “I couldn’t find my shoes,” in a tone that indicates some sadness and/or frustration around this event. Rather than asking, “How did you feel when you misplaced your shoes?” which would likely be too complex the interaction may be broken down as follows:

Client: *I couldn’t find my shoes.*
Therapist: *Tell me what happened.*
Client: *I put them in the wrong place.*
Therapist: *How did that make you feel?*

You will note in this example, we have deconstructed the “big” question “How did it feel when you misplaced your shoes?” into two component parts so that the action and the feeling are addressed separately. If you think through what you want to say carefully before saying it, in most cases you will be able to find ways like these to communicate your thoughts or questions in a simpler manner.

Finally, make sure you contextualise the information you are attempting to share with the client as often as possible. Contextualising communication will often enable a person with a learning disability to understand what has been said and respond appropriately even if the words aren’t fully comprehended. Good case workers use context as communication constantly. For example, imagine it’s the end of the day and time for the bus to come to

collect Peter from the day centre. Peter has had his afternoon drink which he has as part of his routine each day before the bus comes. The other service users are all getting their coats and when Peter's case worker asks him to "please go and get your coat and put it on as its cold outside today", Peter is able to follow this verbal request, gets his coat, and puts it on. Peter is relying on his routine and the behaviour of the people around him to understand the verbal request. You can use similar methods in your practice.

There is one important caveat to note regarding the reliance on context. As mentioned earlier in this chapter, people with learning disabilities may give appropriate verbal and/or non-verbal responses to questions or comments while not completely understanding what has been said. This is not an attempt at deception, it is simply the product of learned behavioural responses that come from a lifetime of managing social situations.

It is important that you are mindful of this potential pitfall and ensure clients understand what you have said by regularly asking them to summarise or repeat what has been discussed during sessions. If clients cannot sufficiently summarise the topic at hand, it's an indication that they may *not* have understood, despite what they say or what their body language tells you. Don't hesitate to reiterate what you have said or look for new ways to communicate the information you are trying to share if you face this situation. While some people will find it difficult to summarise or repeat back what has been said to them generally, most will eventually be able to do this with a genuine understanding of what has been communicated.

In addition to the above, here are a few more strategies you can employ when communicating with people who have learning disabilities to help them better understand you. Again, the following is based on Winn and Baron, 2009.

Tips to Help People with Learning Disabilities Understand You

1. **Speak slowly using everyday words.** This means simple grammar, short sentences, and plain English—no jargon
2. **Think about how to ask questions.** Open-ended questions can be more difficult for this population. Yes or no questions are also unhelpful as clients may respond the way they think you want them to. The best method is usually to stick with short, simple either/or questions: Do you like tea or orange juice? Do you feel happy or sad? However, make sure the client is not simply repeating the last thing you said by confirming what has been communicated.
3. **Link your explanation with everyday things.** This is especially important if you need to talk about more abstract concepts like time. "Take your tablet at breakfast, lunch, and dinner" is more easily understood than "Take your tablet three times a day."
4. **Write the key information down**. Then share the written information with the client's support person, that way they can go through it together after the session.
5. **Eliminate distractions.** People with learning disabilities have a hard time ignoring distractions. Make sure you are talking to them in a quiet place.

In addition to these tips, there are two more strategies you may consider employing with people who have learning disabilities: the use of pictures or symbols and a strong focus on non-verbal communication. Let's deal with each of these in turn.

Using Picture and Symbols to Communicate

If verbal communication presents a barrier we encourage you to incorporate pictures or symbols to help clients express themselves and/or understand what you are saying. This is an excellent and simple method that can vastly improve communication in difficult situations. As you will see in Parts 2 and 3, we have included pictures throughout the worksheets in this manual. These are from the Photosymbols collection, the primary symbol resource for many of the organisations that produce easy-to-read information for people with learning disabilities. Clients often find the information communicated in these images easier to recognize and understand because they are photorealistic and in colour. They work well in the therapeutic setting because they are simple and extraneous details often found in photographs have been removed. You can learn more about the Photosymbols collection at www.photosymbols.com.

Focus on Non-verbal Communication

You are likely aware that non-verbal communication such as body language, facial expressions, gestures, signing, tone, pitch and intonation, and behaviour all play an important role in conveying messages. This is quite fortuitous when working with people who have learning disabilities, because they tend to be keyed into non-verbal communication both as a method of expression and comprehension.

When working with these clients try to tune in to what their body and other mechanisms of non-verbal communication are telling you. Learn to interpret this silent language and you are likely to find it conveys much more than the person's words do. Conversely, you can use your body, facial expressions, etc. to communicate information to your clients. In some cases, you will find communicating this way enhances their ability to understand your verbal exchanges. So become aware of your non-verbal communication and make sure it accurately reflects what you are saying. Make sure to be active with your body and use lots of non-verbal feedback like nodding your head and changing your facial expression to indicate you are listening and that you understand (or don't' understand) what has been said.

Using these concepts and techniques to enhance your ability to communicate with people who have learning disabilities is essential. If a client finds it difficult to understand what has been said, it is likely he or she will become distracted or unmotivated to participate in sessions. This may make treatment more problematic and less successful. By learning about and integrating the strategies above at the very outset of treatment, you can minimise communication difficulties and provide the client with a better experience in therapy.

Idiosyncratic Communication Issues Specific to Certain Populations with Learning Disabilities

In some cases you may encounter clients with very specific, idiosyncratic verbal difficulties that are associated with their particular learning disability. For example, *echolalia* or *echoed speech* where a person repeats words or sentences spoken by others is often found in people with autism (though you may find it in people with other learning disabilities as well). If a client is affected by this he or she may immediately repeat a word or phrase that has just been said. For example, if you say, "Mary's coming today," the person may start saying "today" or even repeat the entire phrase over and over again.

A similar, but slightly different difficulty that some people with learning disabilities have is called *perseveration*. This is where the individual continues to talk about a distressing event or subject that is of interest to him or her when it is no longer appropriate. The person may repeat the same words over and over again or may continue discussing the same topic with slight alterations.

In cases like these, it can be extremely difficult to break the client out of these patterns and engage him or her in anything other than what they wish to discuss. Interestingly,

their ability to communicate about the topic at hand may be extremely misleading about their ability to communicate in general. The client may discuss these issues with much greater or much less eloquence than they are capable of in everyday life. This can be a challenge, especially when you are trying to assess the individual's overall communication abilities, so it is important to be aware of these issues before entering therapy.

Whether you are facing echoed speech or perseveration, the key is patience. It may be useful to suggest a break or if attempts at distracting the client fail, it may be worth considering a shorter session. Occasionally it helps to draw a "contract" with the client. Agree to a short two- to three-minute talk on the subject he or she wishes to discuss, then go back to the topic at hand in therapy. Continue to encourage the client to come back to their session next time.

Another problem you are likely to face when treating people with learning disabilities is a hesitation to openly express thoughts, feelings, ideas and beliefs. Many people who have learning disabilities have come to believe that what they are saying is either incorrect, unimportant, or both. Luckily, a recent study points toward a way to overcome this problem. The use of "socratic questioning is a helpful way of overcoming this obstacle where, by a series of questions, [the person] is helped to explore, reassess and challenge his or her beliefs" (Stallard, 2002, pg. 21). We encourage you to employ socratic questioning in cases like this, and draw out your clients' thoughts and feelings. When doing this, always remember that questions need to be simple and direct. For example, instead of asking "What did you do yesterday?" you should ask, "What did you do yesterday after you got back from the day centre?"

Finally, it is worth noting that cultural "rules" can come into play with this population just as they do in people who do not have learning disabilities. Be sensitive to any cultural issues the person may have particularly with regard to eye contact, personal space, and gestures that may have different meanings than what you are accustomed to. Make sure you check what language the person is most familiar with and employ an interpreter as necessary.

Addressing Suggestibility

As we noted at the beginning of this chapter, studies have concluded that even people with mild learning disabilities are much more susceptible to *leading questions* than the normal population. It appears this link between higher suggestibility and learning disabilities may have to do with memory. Beail (2002) linked poorer memory to higher suggestibility. The studies cited earlier in this chapter offer further support to this tether between memory and suggestibility as each found that memory recall was poorer in people with learning disabilities.

While suggestibility is always an issue a good therapist is paying attention to, it represents a particular challenge in treating people with learning disabilities. Throughout this chapter we have shown how to simplify communication, reduce abstraction in language, contextualise your thoughts, and use pictures, symbols, and non-verbal

communication as methods for more effectively relating to your clients. All of this must be done while avoiding leading questions and keeping suggestibility at a minimum throughout treatment. Focus on making sure clients understand what has been said and give clear instructions without leading them. Doing this and using the other strategies and tips in this chapter should set the stage for quality communication starting with the very first sessions of therapy. In the next chapter we will outline what these early sessions might look like and provide you the tools needed to assess your client's communication and cognitive abilities.

Chapter 5: Involving a family member or paid carer

It is extremely important for a family member or carer to be invited to support treatment. Depending on client's preference family/carer could be present during the whole duration of the session or part of it. In this case at the beginning of each session the therapist should outline the role of the significant other.

The Role of the family/paid carer

Another important modification in the use of B & CBT in this population is the role of caretakers and/or support workers in the process of therapy. The involvement of a caretaker or support worker is essential in assisting the service user to move successfully through the program. The inclusion of an additional person in sessions represents an interesting challenge to therapists in that you need to be cautious of and regulate the involvement of the caretaker or support worker to ensure that the client doesn't become dependent on or rely too heavily on this person during the course of treatment. You need to emphasise that ultimate responsibility for change remains with the client but that the significant other can be very helpful. It provides the significant other with an opportunity to provide information, and encourages the significant other and client to generate their own solutions.

Having a caretaker or support worker in sessions will also bring up confidentially issues that need to be addressed before treatment begins. Confidentiality ensures that information disclosed to the therapist is not shared with a third party unless appropriate and agreed upon beforehand. It is an essential element of the therapeutic process that allows the client to build trust in the therapist. The therapist, therefore, needs to establish how much and what information the client is willing to disclose to the caretaker or support worker before bringing this person into the room.
When a significant other accompanies the client it is very important that the client is made to feel the main focus of the therapist's empathy and support. Although the significant other's input may be helpful, their role is secondary. This should be made clear throughout by, for example, making more eye contact with the client than with the significant other, by deferring to the client more often, and by sitting closer to the client. In this way the significant other should be involved but should clearly be 'taking a back seat'.

An important goal is to establish rapport - to create an environment in which the significant other can feel comfortable about sharing concerns openly and disclosing information that may help promote change. To begin with, the therapist should ask the significant other about his or her own (past and present) knowledge of the problem behaviour.

- What have you noticed about [client's] drinking?
- What do you see that is harmful about [client's] drinking?
- What do you see that is good about [client's] drinking?

Emphasis should be placed on positive attempts to deal with the problem. At the same time, negative experiences - stress, family disorganisation, job and employment difficulties - should be discussed and reframed as normative, that is, things that are common in families with an alcohol problem.

Feedback provided by the significant other can often be more meaningful to a client than information presented by the therapist. It can help the client mobilise commitment to change (Pearlman *et al*. 1989). In sharing information about the potential consequences of the drinking problem for family members, a significant other may cause the client to experience emotional conflict (discrepancy) about the behaviour. Thus, the client may be confronted with a dilemma in which it is not possible both to continue the behaviour and to have a happy family. In this way, the decisional balance can be further tipped in favour of making a behavioural change.

At the same time, there is a danger of overwhelming the client if the feedback given by the significant other is new, extremely negative or presented in a hostile manner. Negative information presented by both the significant other and the therapist may result in the client feeling 'ganged-up on' in the session and could result in treatment dropout.

Handling Significant Other's Disruptiveness

In some cases, significant other involvement can become an obstacle in enhancing the motivation of the client to change and can even lead to a worsening of the problem. It is important to identify these potentially problematic situations and to deal with them. The following scenarios are provided to illustrate circumstances where significant other involvement might have a negative impact on treatment:

- The significant other makes comments that appear to exacerbate an already strained relationship and to evoke further resistance from the client. Your efforts at eliciting useful information from the significant other are met with resistance. Your own efforts to elicit self-motivational statements from the client are hindered by significant other remarks that foster client defensiveness.

- Comments made by the significant other suggest an indifferent or hostile attitude toward the client. The significant other demonstrates a lack of concern about whether the client makes a commitment or is attempting to resolve the (drinking or drug using) problem. The involvement of the significant other appears to have little or not beneficial impact on eliciting self-motivational statements from the client. When the client does make self-motivational statements, the significant other offers no support.

- The significant other seems unwilling or unable to make changes requested by the client that might facilitate an improvement in the drinking or other drug using pattern or their relationship. For example, despite strong requests from the client (and perhaps from you) to place a moratorium on antagonistic responses, the significant other continues to harass the client about past drinking or drug using habits.

- Of course, it could be the case that the significant other has an alcohol or other drug problem as well, or may refuse to alter their own drinking or drug using pattern in a way that the client has requested, such as not drinking or using other drugs in front of the client, not buying alcohol or other drugs to have in the house.

In these or other ways, involvement of the significant other may prove more disruptive than helpful to treatment. The first approach in this case is to use motivational procedures (reflection, reframing) to acknowledge and highlight the problematic interactions. If usual strategies do not result in a decrease in significant other disruptiveness, intervene directly to stop the pattern.

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Part II: Protocol for Extended Brief Intervention for harmful alcohol use for People with Learning Disabilities

Session 1 (40 minutes): Building therapeutic rapport and the role of the carer
The aim of session 1 is to:

- Build a therapeutic rapport
- Briefly introduce the intervention
- Discuss practicalities
- Introduce the role of the carer

Building therapeutic rapport
The initial session should start with only the client and therapist in the room. Use this first session to start developing rapport and building trust with the client. Take this opportunity to get to know the client and ease them into the session. Present yourself as open, honest and transparent in order to build trust. It is important to present yourself as non-judgemental, patient, understanding, and empathic. Work to develop a collaborative partnership with the client, encouraging them to take an active part in the conversation. Rapport should be maintained and monitored throughout treatment. Particular attention should be paid to the client's communication needs and information should be presented in a manner that fits with these. Some techniques to this effect that should be used throughout the intervention include:

Rapport building methods:

- **Summarising** – Use simple language and short sentences when summarising discussions. This should be done after each topic to help the transition between topics, clarify any misunderstandings and confirm any agreements made.

- **Open-ended questions** – Try to ask the client questions which open up the conversation and encourage the client to freely speak. When asking questions use concrete and simple language, keeping questions short. Avoid asking multiple questions at one time as clients may struggle to remember them. Refrain from using 'why' too often as client may feel they are not answering question correctly.

- **Probing questions** – If you wish to explore a topic in more detail, continue to ask exploratory questions around the topic. This will help the client to delve deeper into the issue.
- **Affirming** – Change talk and self-motivational statements should be recognised and reinforced.

Brief Introduction to therapy

It is important to explore the clients understanding of the intervention, and to confirm their consent to continue with the session.
Briefly introduce the intervention in a non-threatening way. The screening and consent would have provided the client with a general understanding of the intervention. Use clear

and simple language, avoiding the use of jargon. Be transparent when explaining the purpose and outline of the intervention. Use this opportunity to communicate with the client the structure of the intervention and themes covered but beware of providing too much information, which may overwhelm the client. You can also briefly touch upon what the client hopes to gain from the intervention and discuss their thoughts and feelings about engaging in the intervention. The client will be aware that the therapy is aimed at their drinking behaviour. However, they may be very sensitive to any judgement. Hold back from providing personal feedback at this point, as it may elicit resistance.

Discussing practicalities

Take this opportunity to discuss practical issues with the client. Such issues can include:

- Preferable time and place to meet
- Exchanging contact details
- Support needed to attend sessions and reasonable adjustments required
- What to do if they cannot make the session or they are running late
- Confidentiality and information sharing
- Settling into the treatment environment

Role of the carer

At this time, the therapist should discuss the possibility of including the family member/carer. This should include:

- Why including the family member/carer is useful
- How much information the client is comfortable sharing with the family member/carer
- The extent to which the family member/carer will need to participate in sessions and potential homework.
- Offer the client the choice to have the family member/carer present for the whole session or only at the end.

Once a decision has been made, the family member/carer can be invited into therapy.

End of session one

Draw the session to a close by summarising key points discussed in the session. Confirm the client understands the interventions and what is involved. Encourage the client to summarise the key themes discussed to show their understanding. If the client struggles to do this, repeat capsule summaries until the client can summarise back. At this point, check if the client has any questions or concerns. Encourage the client to provide feedback on session. At the end of the session, it may be useful to provide the client with a session hand out, detailing contact details, meeting time and location, and information about the intervention (see Appendix 1). At this point, ensure that you check gently about literacy skills, i.e. is handout okay or is print too small, too many words etc- what size can they read, or does someone help them read, if so who?

Session 2 (40 minutes): Lifestyle and personalised feedback

The aim of session 2 is:

- To explore client's lifestyle
- Give personalised feedback on their drinking

Opening the session

When opening the session, begin by checking-in with the client. This can involve checking the client's mood, how their week has been, and any issues or concerns to discuss. Confirm that the client is comfortable and willing to continue with the treatment before starting the session.

Exploring the client's lifestyle

In order to maintain the therapeutic alliance, avoid prematurely providing the client with personal feedback regarding alcohol consumption. This could be interpreted by the client as threatening and negative criticism. Open the session with an informal conversation to explore the client's hobbies and overall lifestyle activities such as work, friendships, social relationships and activities, leisure, smoking. Use this opportunity to begin to identify lifestyle activities which facilitate alcohol consumption. Recording such activities as they arise throughout treatment will contribute towards latter sessions, particularly when identifying high risk situations and making lifestyle changes.

Personalised feedback on their drinking

The next stage is to begin to sensitively explore the client's thoughts about their alcohol consumption. Use open ended and probing questions to encourage the client to explore their thoughts and feelings about their drinking. Such questions could include:

- What do you think about drinking alcohol?
- How do you feel about drinking alcohol?

Encourage the client to take lead of the conversation, exploring his or her beliefs and feelings relating to their alcohol use. As the client verbalises their drinking behaviour they may begin to make links with their lifestyle activities, triggers and reasons for drinking. The client's ambivalence around their drinking may start to increase and reasons to change may begin to appear.

Now that a collaborative relationship has been formed, personal feedback regarding the clients drinking behaviour can begin to be delivered. This should be done in a non-judgemental and non-threatening way. The client's AUDIT scores can be used to identify their alcohol consumption, drawing links to normative data. It would be useful to present the clients feedback using graphs, pictures, symbols and simple language to make it easy for the client to understand. The therapist should move at pace suitable for the client's level of understanding. Give the client time to process the information and ask questions. A very important part of this process is for the therapist to monitor and respond to the client during the feedback. Regularly reflect upon your own communication techniques, making sure not to elicit resistance. This will demonstrate to the client that the therapist is

listening and understands. It is also useful to paraphrase and summarise the discussion at the end of each point. This will help the client to conceptualise and integrate the points they have made, making reasons to change easily identifiable. If the client is refraining from verbalising their thoughts, use probing and open questions to open up the discussion.

Useful discussion points:

- Memory – has the client had any period of not remembering what happened while drinking or other memory problems related to alcohol?
- Health – is the client aware of any health problems related to their drinking?
- Relationships – has their drinking affected relationships with partner, family or friends?
- Legal – have there been any arrests or other contact with the law because of behaviour while intoxicated?
- Financial – has drinking contributed to money problems?

End of session 2

The final part of this session should be used to summarise the key points discussed and any agreements made. Capsule summaries are useful when ending sessions. Aim to summarise discussion points at least 3 times. Encourage the client to feedback their understanding of the session in order to clarify any misunderstandings. The client should also be encouraged to ask any questions or raise any concerns they may have.

Homework

Homework tasks between sessions can productively bridge sessions and provide insight into the client's lifestyle. Introduce the concept of an alcohol diary exercise. Provide the client with a blank, 7 day, diary card where they record their daily alcohol intake each day at morning, afternoon, evening (see Appendix 2). This can start of very basic, with the total number of alcoholic drinks consumed that day being recorded before bed each night. Check several times that the client understands the homework by asking them to feedback what they have been asked to do. There should be a practice run with the client before the session ends, using examples of their alcohol intake over the last 2 days. Again gently explore the client's literacy skills with them. Ask the client to make a few sample entries with your help so you can check whether they can read and write and are able to complete the homework task.

Therapist's skills for dealing with resistance

- Simple reflection: One strategy is simply to reflect what the client is saying. This sometimes has the effect of eliciting the opposite and balancing the picture.

  CLIENT: I'm fed up of talking about my drinking!

THERAPIST: You're fed up of talking about your drinking.

- Reflection with amplification: A modification is to reflect but exaggerate or amplify what the client is saying to the point where the client is likely to disavow it. There is a subtle balance here because overdoing an exaggeration can elicit hostility.

  Examples are:

  CLIENT: But I'm not an alcoholic or anything like that.

  THERAPIST: You don't want to be labelled.

  CLIENT: No. I don't think I have a drinking problem.

  THERAPIST: So you think there haven't really been any problems or harm caused by your drinking.

  CLIENT: Well. I wouldn't say that.

  THERAPIST: I see; you don't like the idea of being called an alcoholic, (pause); but you think your drinking has caused you problems.

- Double-sided reflections: The last therapist statement in this example is a double-sided reflection, which is another way to deal with resistance. If a client offers a resistant statement, reflect it back with the other side (based on previous statements in the session).

CLIENT: But I can't stop drinking. All my friends do it!

THERAPIST: It's difficult for you to imagine not drinking with your friends, (pause); but you also worry what it's doing to you.

- Shifting focus: Another strategy is to defuse resistance by shifting attention away from the problematic issue.

CLIENT: But I can't stop drinking. All my friends drink!

THERAPIST: You are worried about having to decide right now. Let's just carry on going through your feedback (pause). Later on we can worry about what, if anything, you want to do about it.

- Rolling with resistance: Resistance can also be met by rolling with it instead of opposing it. There is a paradoxical element in this that will often bring the client back to a balance or opposite perspective, This strategy can be particularly useful with clients which present in a highly oppositional manner and who seem to reject every idea or suggestion.

CLIENT: But I can't stop drinking. All my friends drink!

THERAPST: Okay, that's where you're at now, (pause). When we stop meeting, maybe you'll decide that you want to keep on drinking. That it's too difficult to make a change. That's up to you.

Session 3 (40 minutes): Enhance motivation and increase willingness to change

The main aim of this session is to enhance motivation and increase willingness to change. This can be done by:

- Developing discrepancy and resolving ambivalence
- Elicit change talk
- Providing information and advice
- Discussing options and freedom of choice
- Negotiating the treatment goal

Opening the session

Like all subsequence sessions you will start by checking-in with the client. Begin by making a link with the previous sessions. This can be done by reviewing the homework task. If the client has not completed the homework, explore reasons why (see Appendix 3). Firstly, ask the client how they found the exercise and if there were any problems. Next, collaboratively review the client's weekly drinking pattern. Do this in a non-threatening and non-judgemental way. Encourage the client to talk about their thought regarding their alcohol consumption – Is the client drinking more than they expected, is the client unconcerned about their drinking pattern, does the client feel they are drinking more than they should? Encourage the client to explore these statements further, until they start to recognise a need to change.

Developing discrepancy and resolving ambivalence

Now that the client has recognised a need to change, work with the client to identify reasons for changing. This can be done by exploring ambivalence in more detail. One possibility here is to construct a formal 'decisional balance' sheet by having the client consider the pros and cons of change (see Appendix 4). When working with clients with an intellectual disability, try to make the task as engaging and interactive as possible. It is also important to make the task simple and easy to follow. Methods should be creative and can include using blocks to identify pros and cons, charts, pictures, diagrams, board writing, coloured pens and flash cards. Clients may worry about giving the wrong answers, in which case emphasis that there is no wrong answer and their responses will not be judged.

Possible questions to probe ambivalence include:

- What are the positive and negative aspects of continuing the behaviour as before?
- What are the possible costs and benefits of changing problem drinking?

Developing discrepancy can further enhance positive reasons for change. Prompt the client to consider how they perceive their self now and how they would like to be in the future. As discrepancy widens between the actual-self and the ideal-self, intrinsic motivation for change strengthens. A clear motive and desire for change should now begin to emerge.

Eliciting change talk

At this stage the client may begin to express change talk. Change talk may either be preparatory or implanting.

- Preparatory change talk: “I should change”, “I need to change”, “I would like to change”
- Implementing change talk: “I can change”, “I am ready to change”

Change talk should be recognised and reinforced in order to further motivate the client. At this point the client may be willing to change, but not ready to put this change into action. One way to identify the client’s readiness for change is using the readiness-to-change ruler (see Appendix 5). Ask the client to show how ready they feel by marking a score from 0-5 on the readiness ruler. Next, ask the client why they have given that score and not lower. This will help the client recognise their strengths, and reinforce motivation. Next, explore the barriers as why the need not score higher for readiness to change. Enquire about how the client can be helped to progress up the scale. A key issue to bear in mind is the client’s ability to understand the scale. It is advisable to clearly explain the scale, and train the client using practice trails.

Continue to use motivational techniques to reinforce and elicit further self-motivating statement. These include reflecting, summarising, affirming, paraphrasing, probing (see session 1).

Providing Information and advice

Often clients will ask for key information as important input for their decisional proves. In general, however, you should provide accurate, specific information that is requested by clients. It is often helpful afterwards to ask for the client’s response to this information: “what sense does this make to you?” “What are your thoughts about it?” The therapist should also be careful not to lose a motivational opportunity here. This type of questioning is usually associated with the client becoming ready to make a decision about change.

Such questions might include:

- Do alcohol problems run in families?
- Does the fact that I can hold my drink mean I’m addicted?
- How does drinking damage the brain?
- What’s a safe level of drinking?
- How quickly will things start to improve?

If the client makes a request for advice, make a judgement about whether this is a genuine lack of ideas about what we do, or whether it is a form of resistance. If the former is the case then the above example can be used. Remember the principle of avoiding giving unsolicited advice. The client who asks for advice has a genuine desire to know what the experienced therapist recommends in the circumstance. It is quite different from the feeling of being told to do something that comes with being given advice one did not

ask for. It may, however, be useful to keep the advice as objective as possible. For example:

- Regarding change that should be made in the client's drinking: "Many people in your shoes find that it is to stop drinking altogether, at least for a while".
- General kinds of changes that the client might need to make in order to support abstinence: "People generally need to find new ways to spend time that don't involve drinking".

A client may well ask for information that you do not have. Do not feel obligated to know all the answers. It is fine to say that you do not know but will find out. You can offer to research a question and get back to the client at the next session or by telephone. As there is an absence of informational resources suitable for individuals with intellectual disabilities, you may wish consider creative, engaging and simple ways of delivering your responses.

Discussing options and freedom of choice

An important and consistent message is the client's responsibility and freedom of choice to change. Intrinsic change has to come from within and can only be decided by the client. Reminders of this theme should be included during the commitment-strengthening process, for example:

- It's up to you what you do about this.
- No one can decide this for you.
- You can decide to g on just as you were or you can decide to change.

The therapist should now facilitate a shift from focusing on reasons for change (building motivation) to making a decision to change. Client may initiate this by stating a need or desire to change, or by asking what they could do. Alternatively, the therapist may signal this shift (test the water) by asking a transitional question. Such as:

- What do you make of all of this? What will you do about it?
- Where does this leave you in terms of your drinking?
- What are your thoughts about your alcohol use at this point?
- What do you want to do about your worries about your drinking now?

Your goal here is to elicit from the client a clear decision about what they want to do about their problematic behaviour. The overall message to the client is that "only you can change your behaviour, and it's up to you".

Negotiating the treatment goal

Goals and desired outcomes may have been touched upon briefly in session 1. At this point, the therapist and client should work together to establish and agree a treatment goal (see Appendix 6). There are two important factors to remember when eliciting the goal. Firstly, the goal should be realistic and secondly it should be attainable. This means that the therapist should take a professional view regarding the appropriateness of potential treatment gaols. There will be occasions when the therapist is sure that the

most appropriate goal will be abstinence but the client's immediate response is to opt for an attenuated or controlled goal. Ultimately, the client must decide upon the desired goal but the therapist has an important role in steering the client towards the most appropriate goal by using selective exploratory techniques. Whatever the treatment goal might be (abstinence or controlled drinking) the therapeutic steps are similar and they are based on the following principles:

- Modifying drinking involves a decision making proves that the client should be in control.
- The decision making process is specific for specific situations.
- For the change to be sustainable change of drinking should be accompanied by relevant changes of lifestyle.

Changes are usually easier when done in small steps, even if the client's choice is abstinence. These steps are explored in detail in the following session: identifying high-risk situations; developing situation specific coping plans; implementing appropriate lifestyle changes. These steps should be discussed in general in this session. They are complimentary and should start at the same time. Special attention and detailed discussion of what and how it should be done, will be explored in the individual sessions. The order of the following sessions is not obligatory but the therapist might find it helpful to follow it.

It is important to note that if controlled drinking is negotiated as the treatment goal the following principles should be kept in mind:

- The final aim should be drinking within the appropriate gender and age limits.
- Drinking should be in the open. Family/carers should be aware of the client's drinking pattern. In this way, trust would be promoted.
- Drinking should be de-mystified. Alcohol should be used in appropriate circumstances for appropriate reasons and with the appropriate expectations.
- Strategies are in place to monitor appropriate use of alcohol.

<u>End of session 3</u>

The session should be bought to a close by summarising the key themes and agreements discussed. Provide the client with the opportunity to provide feedback and raise any concerns. At this stage the client may be feeling they have reached a clear decision to change but anxious regarding how to go about doing so. This is a good point to reinforce their reasons for change and desired outcomes, whilst informing them that preparation of how to implement such changes will be explored in the next session.

<u>Homework</u>

At this stage, work with the client to develop the alcohol diary exercise further. This time provide the client with a blank weekly grid, with each column broken down morning, afternoon, evening. Ask the client to record (using X) every alcoholic drink consumed throughout the day (time, location, situation), as well as other non-drinking activities at the end of each period of the end of the day (see Appendix 7). This method will reveal

triggers and cue to the client's patterns as well as insight into other activities they engage in.

Session 4 (40 minutes): High Risk Situations and coping skills

The aim of session 4 is:

- Define and identify the client's hierarchy of drinking high risk situations
- Review what past and current coping strategies there are
- Anticipate future high risk situations
- Identify potential unpredictable events
- Develop a personal generic coping plan

Opening the session

When opening the session, encourage the client to discuss his or her mood, concerns or any issues that may have risen since the previous session. Start by reviewing the homework task, linking the current session to the previous. Again, do this in a non-threating and non-judgemental way. Encourage the client to explore reasons behind their drinking and what factors led them to drink each time. Risk situations, triggers and cues to alcohol consumption will start to be revealed. Discuss the client's engagement in non-drinking activities, paying close attention to pro-social hobbies and activities.
The client may have decided to change, but not sure how to go about auctioning the change. This session therefore attempts to prepare the client for change.

What are the High Risk Situations?

High-risk situations can be broadly defined as situations in which the client encounters alcohol related antecedents, triggers or cues. Their nature may vary considerably, but they can broadly be described as internal (beliefs and/or emotional states) and external (situations, cues).

This part of the session includes a discussion of the typical high-risk situations for the client (again, from memory or information from previous sessions or diary of the last few weeks). Explain to the client that *'a high risk situation is where you're at risk of losing control and of drinking more'*.

Typical high risk situations might be:

- Physically being in a situation associated with drinking
- An emotional state such as feeling anxious, depressed, angry, frustrated, bored
- Or perhaps the opposite, feeling good, wanting to celebrate a positive event
- Interpersonal conflict (arguing with a friend, conflicts at home)
- Social pressure to join in (i.e. others encouraging him/her to join them at the pub.)

Client with intellectual disabilities may struggle to comprehend high-risk situation. Useful tools to enhance understanding include short videos clips, pictures, cartoons and diagrams to help the client piece together decisions, actions and consequences.

Identifying high risk situations

The therapist and client should work together, to develop a list of the more problematic situations. This can be done either from memory of examples over the past few weeks, discussion of previous lapses, or using hypothetical case scenarios the client produces of what could lead up to a lapse for them. Memory and abstract thinking are challenging tasks for clients with intellectual disabilities. A recommendable method would be to use the alcohol/activity diary to identify which situations led the client to drink alcohol. This will help the client recognise the high-risk situations their lifestyle exposes them to.

Two important tasks at this stage are to enhance responsibility and explore the impact of decision-making. Individuals who misuse substance often attribute causality of their drinking behaviour on external factors. This serves to justify ad rationalise their behaviour, giving themselves permission to drink. Using the alcohol/activity diary, guide the client to acknowledge the control they have over situations which lead to drinking alcohol. Reinforce that they have options and do not need to engage in high-risk situations. By taking control and responsibility they can avoid such situations.

Secondly, the therapist and client should briefly discuss the decision-making process. Guide the client to understand how decisions can lead to exposure of high risk-situations, resulting in consequences. Client's will intellectual disabilities can have difficulty planning ahead and comprehending the outcome of quick decisions. A situation may be difficult for the client to identify because of the interactive nature if emotional state and external events or it may be so pervasive that the client is not able to the process clearly. Aim to break down complex situations into simple ones and explore each one of them.

For some clients new situations resulting from unforeseen circumstances may have to be faced. Anticipating these situations can be thought of as having *a* well-rehearsed fire drill; you can't say what will cause a future fire but knowing what to do is a worthwhile exercise, although as with a fire drill, you hope it will never need to be used 'for real'. Hence it is important to help the client to develop an all-purpose coping plan for any unpredicted situations.

What to do about high-risk situation: Developing situation specific coping plans

The next step is to enable the client to explore how to cope with the high risk situations. It is essential to review the client's existing coping strategies and the meaning they have for the client. Developing adaptive strategies may involve:

i. Learning how to avoid the situation altogether, e.g. taking a different route home to avoid passing in front of the off licence; or avoid certain friends who are drinking.
ii. Learning how to cope by confronting the situation and resist drinking by:
    - Explore client's expectancies of drinking. Enable the client to challenge them by discussing thoughts and beliefs with a non-using friend or using self-dialogue. Flashcards may be useful reminders for clients outside therapy.
    - Educate client about the process of craving: 'They are common and normal and not a sign of failure. They are like ocean waves that become stronger, but only to a point,

then they start to fade away. Without drinking, cravings will weaken and eventually go away'.

- Develop a specific behavioural plan for when a situation arises, e.g. going to a party cannot be avoided; make specific arrangements about how to resist drinking.

It is important to emphasise that the ultimate aim is to enable the client to cope with high risk situations as avoidance is not always possible. In the earlier stages of treatment avoidance may be the best option until the client has built up a repertoire of coping skills.

Specific examples of high-risk situations

Here we present in more detail some possible/common stimulus conditions and suggestions of how to address them during the session. Remember that these are only suggestions, which follow the points outlined above and the aim is to enable the client to develop his/her own coping plan.

Rows
Interpersonal conflicts are situations involving an on-going or relatively recent conflict associated with any interpersonal (one-to-one) relationship such as a parent, friend, family member, or people at school/college.

How to Cope

Get out of the situation. In future plan ahead, think about the different possible things that could go well/not well and plan how to react. Learn to be assertive instead of aggressive.

Joining the Club
These are situations where a person is responding to the influence of another person or group of people who exert pressure to engage in drinking.

How to cope

Avoid Plan ahead Find excuses Get help from other friends Practise what to say/ways of being assertive

Coping with Anger

How to do it

Express it in words rather than actions. Talk to family or a friend. Get rid of the feelings through exercise. Hit something safe, like a punch-bag. Distract yourself. Go for a walk. Buy something. Watch a video.

Coping with Craving

How to do it

Recognise the craving. Use a brief relaxation technique. Make positive self-statements. Distract yourself from the thoughts and feelings. Going with the craving Recalling negative consequences Use a craving diary.

Anticipating Unpredictable Future high risk situations

Life is unpredictable and not all specific high risk situations can be anticipated. Generalisations of the kinds of events that could become problematic are, however, possible. Crises, negative life events and even positive events (birthdays, pay or benefits day, starting a new relationship) can become a high risk situation. Even without knowing the specifics, it is still possible to develop the equivalent of a 'fire drill'.

Developing a Personal Coping Plan

When clients are stressed, they are more likely to use old coping strategies rather than healthier new ones. It is therefore important for the client to try to develop a generic coping strategy that can be adapted to any major crises. This could include:

- A set of important phone numbers of supportive others who can be relied upon
- Recall of negative consequences of drinking.
- A set of positive thoughts which can be substituted for drink related thoughts
- A set of reliable distracters
- A list of safe places where the client can ride out the crisis with few cues or temptations to drink e.g. parents or non- drug using friend's house

Flashcards may be useful for some of these strategies.

Remember either to role-play with the client what they are going to practise, or in some way go through in detail with them an example of their out of session practice.

End of session 4

Like in previous sessions, the session should be brought to a close in the form of a capsule summary. The client should be encouraged to take lead when summarising the topics discussed in the session, demonstrating his or her understanding. Points should be repeated several times and feedback exchanged between the therapist and client. Any concerns of the client should be welcomed for discussion and eased. To reinforce techniques explored in the session, the client could take away flashcards naming techniques.

Homework

Here you can start to develop the alcohol diary exercise further. This time asks the client to record (using X) every time they want a drink but resist, as well as what they did instead? This will elicit self-efficacy and identify activities which can replace alcohol use (see Appendix 8). The client can also record how satisfying they found each activity throughout the day. This will help the client and therapist establish alternate activities the client can engage as an alternate to drinking alcohol.

Barriers when using cognitive behavioural methods with clients with learning disabilities

- Difficulty linking emotions and events or beliefs and event.
- Little confidence in cognitive ability
- Cognitive deficits, typically stemming from a lack of knowledge
- Poor memory
- Difficulty verbalising emotion
- Lack of comprehension
- Limited attention span
- Masking disability

Cognitive Techniques

- Imagery: The therapist should encourage the client to imagine saying no to alcohol and considering the outcomes.

- Role-play: Clients with intellectual disabilities may struggle with communication skills and use alcohol to build confidence. Role-play can help the client develop effective interpersonal skills without alcohol.

- Distraction Techniques: The client should practice diverting attention when craving alcohol.

- Flashcards: copy motivational statements or behavioural techniques generated during session onto flashcard. For clients with poor literacy skills use images (e.g. see Widgit symbols: www.widgit.com). This will act as reinforcement between sessions.

- Relaxation technique: Self-soothing methods can help the client to de-escalate and think ahead before turning to alcohol.

- Activity monitoring: using a blank grid, the client record activates every hour over 7 days. The client rates the level of satisfaction of the activity on a scale on 1-5. These help the client and therapist to identify alternate activities to drinking alcohol.

- Identifying ‘good’ and ‘bad’ situations: What was it, what did the client think, how did the client feel about was the event related to alcohol (see Appendix 9 and 10).

Session 5 (last session of 1st wave; 40 minutes): Lifestyle change

The aim of session 5 is:

- Assess current Lifestyle and potential changes
- Develop an Alcohol-Free Lifestyle
- Promote Healthy Living Techniques
- Develop coping plans for the following 3-4 weeks until the final booster session.

Opening the session

As in preceding sessions, the therapist should open by discussing any issues or concerns since the last session. Collaboratively review the client's homework, affirming where they have desired a drink but resisted. Use this opportunity to demonstrate to the client the progress they have made. The main aim of this session is to help the client maintain change. The therapist and client should work together to explore ways of adapting the client's lifestyle to facilitate their new life.

Identify and implement lifestyle changes

The most important factor that will help the client to achieve and maintain changes they made or want to make about their drinking is to change their life style. This includes in addition to those changes related to high risk situations explored in the previous session, generic changes such as structuring their day, plan the next day, rewarding themselves and develop pleasurable activities that do not involve drinking.
One of the problems that many drinkers have is that their whole lifestyle has become orientated around drinking in one way or another. A lot of time and effort is put into it, such that when they stop drinking they find that they have a lot of time on their hands with nothing to do. Feelings of boredom and emptiness can inevitably lead to feeling alone and depression which can ultimately result in lapses and relapse. It is therefore important for the therapist to work with the client on these issues.

Assess current Lifestyle and potential changes

- How does the client spend his/her time currently? Explore a recent typical week day and a recent weekend.
- Does s/he have a lot of spare time with nothing to do? If the client experiences this as boredom, leave further work on this for the next topic, but include here as part of the development of the formulation.
- What did s/he enjoy or do before drinking? 'What was life like before you started drinking, how did you spend your time?'
- Does s/he have a good network of non-drinking family and friends? Who is available to develop social activities that do not involve alcohol?
- If the majority of family and friends are drinkers - how can new contacts be made? Is it feasible to maintain contact with close friends who are drinkers without getting back into the network?

- With the client, identify the possible risks (e.g. depression, isolation, relapse) of not filling the vacuum of being a drinker /drug user.

Develop an Alcohol-Free Lifestyle

- Explore with the client how they could structure their day. This should be done by identifying key activities that the client still has and use them as the main building blocks, around which other activities could be added. These key activities could be as basic as eating times or morning, lunchtime, afternoon, evening, night. This could be combined with the drinking events that the client has for the days.

- Identify the new activities that could be added and decide with the client when and how they will be introduced. Make sure you prompt the client to identify their own activities and interests. Offer advice and support when requested but do not impose your views. Invite the family member or carer to contribute.

- To start with you might have to advise the client to break down some of these activities into smaller ones and perform them in smaller time blocks during the day or at different days of the week.

- Make a generic overall structure for the week and a specific plan for each day of the week.

- Encourage the client to re-establish contact or improve contact with non-drinking friends- this may involve exploring potential problems, e.g. ‘they think I’m scum, they won’t want to see me’, and rehearsing and practising getting in touch with them.

- What positive habits might replace drinking? Is exercise/sport a possibility? Any other absorbing activities that could be seen as a positive addiction (craft work; attending self-help meetings e.g. A.A)?

- Explore potential adaptations that need to take place at different times to accommodate special events or duties, such as visits to family, holidays. It is important that the structure is solid, yet flexible and progressive.

- In considering new activities or extending existing ones, discuss support client may need carefully, and how this can be arranged.

The client should be encouraged to review this structure and modify it as his life is changing during abstinence or healthy drinking lifestyle and to add new changes and experiences. This should be an on-going learning process, based on small sustainable steps.

If the client and therapist agree to keep a activity monitoring diary, the therapist should regularly reinforce and support pro-social activities, use the diary to compare the clients

life now to before and reinforcing discrepancy. This will enable the client to recognise their progress made towards the ultimate goal. Another option is to list weekly goals on a flashcard, acting as achievable and measurable milestones to reinforce the client progress.

Promote Healthy Living Techniques

You should also discuss other healthy living techniques that will help reduce stress and increase overall feelings of joy with the client. These may include:

- **Reducing caffeine:** Caffeine is a stimulant and can stay in the system for a long time. Too much caffeine can make individuals feel restless, anxious and irritable. It can also prevent inhibit quality sleep and cause headaches, abnormal heart rhythms, or other problems. You may suggest the client moderate caffeine intake and avoid drinks containing caffeine starting in the mid-afternoon. Tea, coffee, energy drinks, many soft drinks, and chocolate contain caffeine.

- **Improving sleep habits:** Good sleep habits are essential for physical and mental health. To improve sleep habits we recommend you encourage clients to create a sleep schedule, avoid napping during the day, and establish a pre-bedtime routine to help the client realise it is getting close to bedtime. Work with the client and the support worker to decide what may be included in such a routine. Examples include having a warm bath, listening to relaxing music, having a glass of warm milk, or other activities that help the client relax.

- **Promoting exercise:** Regular exercise can improve mood and is good for sleep. Exercise in the morning can help the client feel good throughout the day and relax in the evening. Make sure to keep exercise gentle and encourage the client to avoid exercising close to bedtime as this stimulates the body and is bad for sleep. Exercise should be added to the client's daily schedule.

End of session 5

As usual, the session should be bought to a close using a capsule summary. Any concerns should be discussed here and feedback exchanged between the client and therapist. This is the last session before a 3 week gap. Check with the client they have all the resources they need and feel confident about maintaining their changed lifestyle over the coming weeks.

Homework

Using the activity-monitoring diary, identify pro-social activities which the client has rated as satisfying or used to replace drinking. From this, collaboratively develop an activity schedule for the client to implement their new life (see Appendix 11). Discuss support client may need in planning and completing activities, and how this can be arranged. Over the next three weeks the client can practice living with the changes.

Barriers to clients maintain change

The client may lapse or relapse with their drinking, particularly in the event of a trigger or anniversary. This may significantly reduce their self-efficacy and motivation. Educating the client about the possibility of a lapse, what happens if one occurs and coping skills to get back on track would all help the client to feel more in control and prepared. It is important to keep supporting the client self-belief, developing discrepancy, highlighting progression and reinforcing the end goal.

Session 6 Final session (60 minutes): Booster session, review
This final session aims to:

- Assess and consolidate client's motivation to change drinking
- Review changes achieved and promote further changes
- Review client's goal of therapy

Opening the session

The therapist should open this session by confirming the clients consent to proceed with the session. As there has been a 3 week gap between sessions, start by asking the client how they have found the past 3 weeks, how did they find following the schedule, how do they feel about alcohol now?

Re-assess motivation and self-efficacy to change drinking

The therapist should be sensitive to any verbal or non-verbal communication of ambivalence or lack of self-efficacy to implement changes and achieve goal of therapy. Self –efficacy is defined as the level of an individual's confidence in his or her abilities to organise and complete actions that lead to particular goals (Bandura 1977). Within the context of drinking it refers to the client's belief of his/her ability to achieve and maintain changes in his drinking, these could abstinence or controlled drinking.

Review changes in drinking

Review the identified high risk situations in detail and assess if coping plans discussed in previous sessions have been implemented. Review if these plans are effective and explore with the client any required modifications and further developments. It is also common as the most risky situations have been resolved other less obvious or less regular risky situations to appear. Explore them and develop coping plans using the techniques discussed and practices in previous sessions.
Take the time to provide the client with an overview of the skills you have covered in previous sessions and you practice them with the client as necessary to reinforce learning. This help the client have a clear understanding of what has been covered and the successes he or she has made during therapy.

Review life-style changes

Re-assess client's overall changes in lifestyle as structure of his day, short-term and long term planning, new positive behaviours and healthier lifestyle. It is important to note here that it is possible that new behaviours or activities that were initially considered positive to carry some risks too. For example new friends or social activities might be directly (new friends might drink or put pressure) or indirectly (by increasing stress) associated with risks of drinking. The therapist should be open to explore and address any concerns that the client or the family/carer has.

This review will set the stage for the final sessions where you will close the loop, reinforce the techniques and skills learned, and end therapy with the understanding that the client has acquired the needed knowledge to "become his or her own therapist." In Chapter 10 we will review how these final sessions should look. But before we get to that, let's look at the additional skills and topics you need to address during these middle sessions.

Review goal of therapy

You should also discuss how close the client is to meeting the goals that were established early in the therapeutic process, how he or she feels about meeting these goals, what parts of the goals may need further work, and what, if anything, needs to be added to the original list of goals. As the therapy progresses the initially agreed goal of therapy might be considered by the client as non-realistic. This could be explained by the development of trust and the associated therapy alliance that will give the client the confidence to express any worries or conflicting thoughts. It could also be due to changes already taken place that could promote self-efficacy and the wish of the client to review and achieve more challenging goals. This is usually the case when controlled drinking is the initially agreed goal. The client might feel confident enough to proceed to abstinence or realise that abstinence and the associated lifestyle changes are easier to implement. Sometimes though the goal of abstinence might be proven too challenging and controlled drinking with the associated lifestyle changes might become a more realistic short-term therapy goal.

Develop coping plans and promote lifestyle changes for the following weeks

Allocate time to explore client's thoughts and feelings regarding the forthcoming 3-4 weeks and the gap in therapy. Promote self-efficacy and develop detailed plans for each week. Help the client to be specific and pay attention to the detail. Request help and feedback from family/carer. Overall there are three types of plans:

- Specific to high risk situations
- Generic coping plan that could be used in emergency, not predicted new risky situation
- Lifestyle changes and structure

End of session 6

This is the final session. At this point the therapist should aim to summarise the intervention development. It is important to build on the client's motivation to maintain change and strengthen their belief and ability to carry out such changes. Any concerns of the clients or outstanding issues should be discussed here and feedback provided. The therapists should confirm that the client has enough resources and feels confident in maintaining their changed behaviour independently.

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PART III: Appendices

Appendix 1: Session 1 handout

Add picture of therapist	What is my therapist's name?
Extended Brief Intervention? 	What is an Extended Brief Intervention for alcohol misuse? • You will meet with your therapist for 30 minutes each week for 5 weeks • After 8 weeks you will have a final session for 1 hour • You and your therapist will talk about your alcohol use and ways to live a healthy lifestyle • Sometimes your therapist may give you homework. This is to practice what you did in the session
	How can this intervention help me? It can help you to: • Drink less alcohol or stop • Find other activities you enjoy • Live a healthy lifestyle
	When and where will I meet my therapist?

	What should I do if I have a problem or cannot make my session?

Appendix 2: Session 2 homework

Instructions

- You can either do this homework on your own or ask your carer for help.

- Each day you can write in the diary how many alcoholic drinks you drank

- The diary card is divided into **Breakfast-morning**, **Lunch-afternoon** and **Dinner-evening.** Try to fill in the diary at these times.

Monday		
Breakfast- morning	**Lunch- afternoon**	**Dinner- evening**
How many alcoholic drinks have you had?	**How many alcoholic drinks have you had?**	**How many alcoholic drinks have you had?**
Tuesday		
Breakfast- morning	**Lunch- afternoon**	**Dinner- evening**
How many alcoholic drinks have you had?	**How many alcoholic drinks have you had?**	**How many alcoholic drinks have you had?**
Wednesday		
Breakfast- morning	**Lunch- afternoon**	**Dinner- evening**
How many alcoholic drinks have you had?	**How many alcoholic drinks have you had?**	**How many alcoholic drinks have you had?**
Thursday		
Breakfast- morning	**Lunch- afternoon**	**Dinner- evening**
How many alcoholic drinks have you had?	**How many alcoholic drinks have you had?**	**How many alcoholic drinks have you had?**
Friday		
Breakfast- morning	**Lunch- afternoon**	**Dinner- evening**
How many alcoholic drinks have you had?	**How many alcoholic drinks have you had?**	**How many alcoholic drinks have you had?**

Saturday		
Breakfast- morning	**Lunch- afternoon**	**Dinner- evening**
How many alcoholic drinks have you had?	**How many alcoholic drinks have you had?**	**How many alcoholic drinks have you had?**
Sunday		
Breakfast- morning	**Lunch- afternoon**	**Dinner- evening**
How many alcoholic drinks have you had?	**How many alcoholic drinks have you had?**	**How many alcoholic drinks have you had?**

Appendix 3
Checklist of reasons for not completing the homework tasks
(Adapted from Beck et al, 1979)

Tick the correct response

true 	false 	reasons
		What's the point? Nothing I do will help me get better……
		I don't understand how this task will help me feel better
		I don't know why the therapist has asked me to do this
		I forgot to do the homework
		I don't think the homework is helpful
		I did not have time to do the homework. I was too busy.
		I thought I might get it wrong
		I didn't feel like doing the homework task
		I don't like doing what the therapist tells me
		I don't understand the homework
		I didn't do the homework because I felt too (choose one or more): • Bad • Sad • Worried • Upset
Any other reasons: …… …… ……		

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Appendix 4: Ambivalence record

Good things about drinking alcohol

Bad things about drinking alcohol

Appendix 5: Readiness scale

Appendix 6: Yours Goals

What is your goal?
What do you need to do to change?
How important is this goal?
A Little Important **Important** **Very Important**     
How confident are you in achieving your goal?
A little Confident **Confident** **Very Confident**     
What help do you need to achieve you goal?

Appendix 7: Homework session 3

Instructions

- You can either do this homework on your own or ask your carer for help.

- Each day you can write in the diary:

  1) How many alcoholic drinks you drank
     AND
  2) What activities you have been doing

- The diary card is divided into **Breakfast-morning**, **Lunch-afternoon,** and **Dinner-evening.** Try to fill in the diary at these times.

Monday		
Breakfast-morning	**Lunch-afternoon**	**Dinner- evening**
When and where did you drink?	**When and where did you drink?**	**When and where did you drink?**

What else did you do?	**What else did you do?**	**What else did you do?**
Tuesday		
Breakfast-morning	**Lunch-afternoon**	**Dinner- evening**
When and where did you drink?	**When and where did you drink?**	**When and where did you drink?**

What else did you do?	**What else did you do?**	**What else did you do?**
Wednesday		
Breakfast-morning	**Lunch-afternoon**	**Dinner- evening**
When and where did you drink?	**When and where did you drink?**	**When and where did you drink?**
What else did you do?	**What else did you do?**	**What else did you do?**
Thursday		

Breakfast-morning	Lunch-afternoon	Dinner- evening
When and where did you drink?	When and where did you drink?	When and where did you drink?
What else did you do?	What else did you do?	What else did you do?
Friday		
Breakfast-morning	**Lunch-afternoon**	**Dinner- evening**
When and where did you drink?	When and where did you drink?	When and where did you drink?
What else did you do?	What else did you do?	What else did you do?

Saturday		
Breakfast-morning	**Lunch-afternoon**	**Dinner- evening**
When and where did you drink?	**When and where did you drink?**	**When and where did you drink?**
What else did you do?	**What else did you do?**	**What else did you do?**
Sunday		
Breakfast-morning	**Lunch-afternoon**	**Dinner- evening**
When and where did you drink?	**When and where did you drink?**	**When and where did you drink?**

What else did you do?	**What else did you do?**	**What else did you do?**

Appendix 8: Homework session 4
Instructions

- You can either do this homework on your own or ask your carer for help.

- Each day you can write in the diary:

  How many times you <u>wanted</u> to drink alcohol but <u>did not</u>
  AND
  What you did instead of drinking alcohol

- The diary card is divided into **Breakfast-morning**, **Lunch-afternoon** and **Dinner-evening.** Try to fill in the diary at these times.

Monday		
Breakfast-morning	**Lunch-afternoon**	**Dinner-evening**
How many times did you <u>want</u> an	**How many times did you <u>want</u> an**	**How many times did you <u>want</u> an**

alcoholic drink but did <u>not</u> have one?	**alcoholic drink but did <u>not</u> have one?**	**alcoholic drink but did <u>not</u> have one?**
What did you do instead?	**What did you do instead?**	**What did you do instead?**
Tuesday		
Breakfast-morning	**Lunch-afternoon**	**Dinner-evening**
How many times did you <u>want</u> an alcoholic drink but did <u>not</u> have one?	**How many times did you <u>want</u> an alcoholic drink but did <u>not</u> have one?**	**How many times did you <u>want</u> an alcoholic drink but did <u>not</u> have one?**
What did you do instead?	**What did you do instead?**	**What did you do instead?**

Wednesday		
Breakfast-morning	**Lunch-afternoon**	**Dinner-evening**
How many times did you <u>want</u> an alcoholic drink but did <u>not</u> have one?	**How many times did you <u>want</u> an alcoholic drink but did <u>not</u> have one?**	**How many times did you <u>want</u> an alcoholic drink but did <u>not</u> have one?**
What did you do instead	**What did you do instead?**	**What did you do instead?**
Thursday		
Breakfast-morning	**Lunch-afternoon**	**Dinner-evening**
How many times did you <u>want</u> an alcoholic drink but did <u>not</u> have one?	**How many times did you <u>want</u> an alcoholic drink but did <u>not</u> have one?**	**How many times did you <u>want</u> an alcoholic drink but did <u>not</u> have one?**
What did you do instead?	**What did you do instead?**	**What did you do instead?**

Friday		
Breakfast-morning	**Lunch-afternoon**	**Dinner-evening**
How many times did you <u>want</u> an alcoholic drink but did <u>not</u> have one?	**How many times did you <u>want</u> an alcoholic drink but did <u>not</u> have one?**	**How many times did you <u>want</u> an alcoholic drink but did <u>not</u> have one?**
What did you do instead?	**What did you do instead?**	**What did you do instead?**
Saturday		
Breakfast-morning	**Lunch-afternoon**	**Dinner-evening**
How many times did you <u>want</u> an alcoholic drink but did <u>not</u> have one?	**How many times did you <u>want</u> an alcoholic drink but did <u>not</u> have one?**	**How many times did you <u>want</u> an alcoholic drink but did <u>not</u> have one?**

What did you do instead?	**What did you do instead?**	**What did you do instead?**
Sunday		
Breakfast-morning	**Lunch-afternoon**	**Dinner-evening**
How many times did you <u>want</u> an alcoholic drink but did <u>not</u> have one?	**How many times did you <u>want</u> an alcoholic drink but did <u>not</u> have one?**	**How many times did you <u>want</u> an alcoholic drink but did <u>not</u> have one?**
What did you do instead?	**What did you do instead?**	**What did you do instead?**

Appendix 9: Good card

Think of an activity that you did this week and enjoyed 
What was it?
How much did you enjoy it?
What did you enjoy about it?
How did it make you feel?
How often could you do this activity?

Appendix 10: Bad card

Think of a bad thing that happened this week 
What was it?
How bad it was?
What did you not like about it?
How did it make you feel?
Did it involve or lead to drinking alcohol?

Appendix 11: Weekly activity schedule

Instructions

- You can either do this homework on your own or ask your carer for help.

- Each day you can write in the diary:

  What you did for work OR to have fun

- The diary card is divided into **Breakfast-morning**, **Lunch-afternoon** and **Dinner-evening.** Try to fill in the diary at these times.

Week Day	Breakfast-morning	Lunch-afternoon	Dinner-evening
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			